Title of Course: Combat-Induced PTSD: Diagnosis, Treatment, & Management

CE Credit: 3 Hours

Learning Level: Intermediate

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Abstract: Psychological trauma seems to be an increasing human condition. Combat trauma, unfortunately, is a part of the history of mankind. The purpose of this course is to educate participants about the physiological and psychological sequelae of combat traumas on victims and their loved ones. It will include discussions of the etiology, diagnosis, treatment, case management and prognosis of Combat-Induced Post Traumatic Stress Disorder. Didactic, pedagogical and case history methods of instruction will be used. The course material is intended to enable practitioners of all fields to understand, accurately identify, and treat combat-related PTSD.

Course Objectives

1. List the two criteria that define the traumatic event causing PTSD
2. Name two historical labels for what we now call PTSD
3. Identify the five “persistent re-experiencings“ of PTSD victims
4. List seven ways PTSD victims persistently avoid stimuli associated with the trauma
5. Identify five persistent symptoms of increased arousal in PTSD victims
6. Name two therapy modalities used to treat PTSD

Post-test questions are located at the end of this document.

Combat-Induced PTSD
Diagnosis, Treatment, & Management

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Please contact me via this email address if you have questions or requests for additional consultations, workshop presentations or program development for PTSD.

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Author’s Notes:

You may freely share any and all of this information (as long as you give credit) to any combat vet, spouse, child or family member of a combat vet for as long as any of us shall live. Their spouses and other family members are probably the ones that will help them the most. They all need to know the information in this course and how to apply it.

I’ve had many combat veterans tell me “I wish I’d known this 30 years ago.” I wish they’d known about it 30 years ago, too. I wish they’d known about it too, given what they have all gone through in the unconscious grip of their past. Help our new guys out...spread the word! Now!

This course is dedicated to all who have risked their lives for their country...be they right or wrong...be they alive or dead.

Caveat 1: This treatment information is NOT meant to be automatically applicable for the severely head-injured soldier. The location and severity of their head injury must be considered to evaluate the soldier’s diminished capacity for cognitive processing and impulse control.

There are some serious brain damage issues that need to be scientifically evaluated by their caretakers. The hallmark of brain damage is lack of impulse control. The signature injury of the Iraqi/Afghanistan Wars is the head injury (from IEDs and RPGs). Add those injuries to the proximity and emotional bonding of soldiers to their weapons and you have the setup for the greatest of all back-home tragedies: suicide and homicide. (See more in the “Danger to Self and Others” section, below).

Caveat 2: This information is most applicable for outpatient treatment and psychoeducational purposes.

Caveat 3: When I write “he”, I also mean “she.”

Caveat 4: I warn the reader that other combat-exposed personnel (nurses, doctors, medics) often have it, too. The healers often need healing. Many of them tell me there is one case that always “got them” even thought they were professionally numb to the maiming, moaning, blood and bleeding. That case often, but not always, involved children.
Caveat 5: I give many horrific but true examples of what those in the fog of war do and experience. This is not for the weak of stomach. However, if you have a visceral reaction to reading about the events, just try to appreciate how much more emotional it was for those who directly experienced it.
History of the Phenomenon

Planet earth has suffered the short-term and long-term effects of war for the entire history of mankind. There are documents and documentaries. There is even a war channel on American television. It used to be called “The History Channel” for some ironic reason. Recently it was appropriately re-named the “Military Channel”.

Unfortunately, the world has known or been taught much less about the effects of war on the solider (besides the obvious...they make it back in one piece or they don’t). American folklore has had different names for the effects of combat trauma for centuries. People called it, “The Reverie” after the Civil War, “Shell Shock” and “The Thousand Yard Stare” for World War I veterans, “Combat Fatigue” for World War II veterans, “Vietnam Vet Syndrome” and “Post Traumatic Stress Disorder” (PTSD) since the DSM-III came out in 1980.

The American military tried to re-label it “combat stress” during the early part of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) but it didn’t stick.

What is the “Thousand Yard Stare”? I have seen it trivialized in popular civilian literature for many decades. They tend to equate it with staring off into space or spacing out. For example, in his novel Strike Force Dale Brown (2007, p. 183) wrote:

Patrick was silent for a few moments, adopting his infamous "thousand-yard stare" as his mind turned over possibilities. ..."

It’s not that at all. They don’t “adopt it” any more than fish “adopt” gills.

Charles Henderson (2001) also wrote:

He could see beginnings of the telltale one-thousand-yard stare, the stoic expression on a face that had seen its share…” (p 35).

That’s wrong, too. It’s not a stoic expression at all, either.

I have seen it in severely abused children and adults. I’ve also seen it in pictures of Holocaust and Bataan Death March survivors. They can be looking at you, but their eyes are hollow. They see you, but you don’t fill their eyes at all. Their eyes are empty. They can be following your movements with their eyes, but they’re not all here. They will talk in response to your words, but they aren’t talking to you. They are talking to the words. They aren’t spacing out. They simply aren’t all here. The personal part(s) of their mind are hiding. The missing part(s) only come back out of hiding when they think they are safe.

The popular depiction of “shell shock” in post WWII movies showed the spaced-out (but sniveling) soldier lying in a hospital bed or in a wheel chair with a bandage around his head. The cure was to give him a pep talk, guilt trip him, try (unsuccessfully) to convince him he was just feeling sorry for himself, slap him around and ship him back to the front. He wasn’t really hurt...he just needed a kick in the pants.

I actually saw this in a post WWII movie but I can’t remember the name of it or the actors.
It was the old notion, “If you fall off a horse, the cure is to put you right back up on the horse and show him who is boss”.

It was, “Patch ‘em up; ship ‘em back”. The WWI military called it the “PIE” method (Proximity to the battle, Immediacy of treatment, and Expectancy of recovery, including return to duty).

The DSM-III PTSD criteria were heavily loaded toward combat trauma sequelae. The application of these criteria to natural disasters and rape victims followed later in the DSM-IV. I believe PTSD became an accepted combat-induced trauma because the Vietnam Veterans of America association (now called Veterans for America), among other veterans groups, were heavily influential in getting the diagnosis officially recognized by the AMA (American Medical Association) and WHO (World Health Organization).

The DSM-IV criteria were modified to be applicable to other trauma survivors (from natural disasters, rape and sexual abuse), but for some reason eliminated Survivor Guilt and other important components relevant to most combat veterans.

The American Myth about War

Before I examine the science of combat trauma, I want to expose and analyze the American myth about the reality of war. It is exemplified by post WWII movies such as “The Longest Day”, all of the other post WWII movies, Vietnam-era movies such as “Deer Slayer” and “Platoon”. The rarities are such films as the Vietnam-era “Casualties of War” with Sean Penn and Michael J. Fox (rape and murder of Vietnamese civilian female) or “Cease Fire” (with Don Johnson, 1985) or the post WWII movie that showed an American unit get shot to pieces by machine guns in a fog-shrouded valley (name now unremembered by me) that show glimpses of the ignobility (rape and murder of civilians) and futility and helplessness that is so frequently the reality of war, in war and back home, then and now.

I grew up watching “The Longest Day” or “The Dirty Dozen,” or the hundreds of other typical Hollywood post-WWII “the-good-guys-kill-the-bad-guys-without-getting-as-much-as-a-scratch” war pictures. “Platoon” kept the fantasy going for Vietnam war junkies as much as possible (except one good guy kills another good guy).

After watching the typical post-WWII movies, I remember I would play-act “storming the machine gun nest” with my brother. I was seven; he was eight. I even thought that if you ran zigzagged you could dodge the bullets. I did, really!

Here’s the myth in slow motion. The good guys are good looking, have all the cool gear (even called “sexy” by some recent, real American military staff), kill the strange-looking enemy with magnificent and noble shots (one shot, one-kill) and never even get a scratch. You only shoot the enemy. The direct hit is what gets you. If you die, you have this sad, farewell discussion with your best buddy. You die with him holding you. You are such a good shot you can shoot the gun out of the enemy’s hand and subdue him nobly.

The screams and explosions are all under 90 decibels. The screams are made consciously, forcing the air out of their lungs as hard as the actor can. The action ends when the enemy
surrenders. The soldier stays young and virile forever. They go back home, get the girl, get
the good job, make babies and live “happily ever after”.

Here’s some of the reality in slow motion (No, I’m not claiming I am a combat veteran. Ask
a combat vet if you’re really curious. Good luck if he tells you anything.):

The good guys are good looking until they take their uniforms off...then they look
like average dudes. Our guys do have the coolest, most sophisticated combat gear
on the planet...but their guys kill our guys with feces-covered sticks, WWI rifles,
WWII bombs buried by the roadside, guns and ammunition we supplied their leader
30 years ago because he said he’d be a democratic ruler, or a box cutter.

I knew a Vietnam veteran who saw an old Viet Cong man shoot down an American
helicopter with one round from a single-shot, bolt action WWI rifle. Fifteen million dollar
helicopter vs. fifteen-cent rifle: the rifle won.

Many of the good guys get wounded and suffer forever both physically and emotionally.

Sometimes you accidentally shoot and/or bomb your own guys (“friendly” fire).

The concussion of a bomb going off 100 yards away can blow your intestines out of your
body or make you deaf forever. I’ve never seen a measure (in decibels) of a bomb or
artillery or IED blast. You don’t merely hear them. The sound goes through your entire
body. You feel them, too.

You gotta “hit the dirt” just right during an air-raid or artillery barrage or the concussion of
the blast will transmit through the earth and jellify your intestines.

The more current, increasingly detailed, supposedly more-lifelike, slow motion movie shots-
hitting-the-soldier (eg, “Platoon” or “Band of Brothers”) always show the blood spurting
from the shoulder or head or wherever. They rarely show the arm being blown completely
off, the head being blown completely off, the eyes being blown out of the socket,
decapitated heads flying off and killing other soldiers, flesh melting from napalm or heat of
explosions. Special effects people either don’t know about real wounds or can’t imitate
them exactly. Trust me, they would if they could.

The screams of the severely or mortally wounded are impossible to intentionally imitate.
The air is involuntarily wrenched out of their lungs causing sounds men and women cannot
imitate...ever. Men scream like rabbits scream when they are getting mauled. Most soldiers
die crying for their mothers. They curse God.

The only smells you get watching the war movie are the popcorn, soda, Gummie Bears,
candy bars and perfume. You don’t smell the blend of sweat, urine, hot blood and feces
that men eject when they die or get so scared they lose body control.

You try to shoot the enemy’s gun out of his hand (to mercifully and nobly disarm him) but
you shoot his hand instead. The super-cool, maximum-lethal round you use in your super-
cool weapon tumbles just like it was designed to tumble. Its tumble maximizes its kill
potential. The effect of the tumble whips his (or her) hand and arm around, hitting him (or
her) in the head, killing him (or her) by crushing the face or skull.
Then you wonder, “Where is God today?” and you puke.

Yes, you’ll find pictures of their families in their pockets. You are horrified.

You are horrified. You vomit. You wonder where God is today. You were just trying to nobly wound him/her. You’re the good guy. God is on your side. Right?

When you go back home, you may not get the good job… or get the good job you gave up when you were called up.

You may not get the brass band and parade.

You may or may not get the girl. If you had the girl, she may have been a ”GI Jodie” (the WWII term for a girl who cheats on her husband-boyfriend-soldier when he is away at war). She may or may not be around when you come back.

You may be such an emotional, drug/alcohol abusing wreck that she and the kids don’t stay around forever if they are there when you return.

Part of the fantasy is what most American soldiers have when they sign up for the military. The training they get prepares them a little bit for the realities of war. (For example, they now use silhouette targets in basic training/boot camp for target practice). During WWII, they used “bulls eyes”…and it was estimated by the Department of Defense that only 5% of the armed soldiers in any group were actually shooting at the enemy to kill them. That “effective firepower” percentage went up to 60% during Vietnam, I was told, thanks to the silhouettes of human profiles used for target practice in boot camp.

That “effective firepower” ratio would go up even more if they used videos to train the troops, now. Oops, I forgot, they are doing that now. They just call them video “games” (not “training-you-to-kill” games). They are available in your nearest video store or gamer outlets or on the internet.

Nothing can dispel the fantasies completely except war itself. Factor in everyone’s illusion of invincibility and bullet-proof-ness, their fantasy of being protected by God, their illusion that bad things don’t happen to good people and by then, it’s too late.

They are soldiers in the “fog” of war and, maybe…survivors.

**DSM-IV POST-TRAUMATIC STRESS DISORDER (PTSD)**

**DIAGNOSTIC CRITERIA**

The following are the *DSM-IV* (APA, 1994) diagnostic criteria for PTSD. I want to detail the many components of PTSD discussed in the *DSM-IV* because they are truly applicable and predictable sequelae for many combat veterans. I urge you to remember the strong positive correlation (relationship) between the amount of tissue trauma experienced (inflicted, experienced or witnessed) and psychological trauma. I will quote the *DSM-IV*, then expound at some length as to how they apply to combat veterans.
Wide-scale, interpersonal mutilation is horrible. However, war atrocities are so horrific for American because wide-scale, interpersonal mutilation is seen so rarely in America. (Thank God, thank democracy, thank the National Rifle Association or whoever).

Most accidents don’t even mutilate in America…and they’re just accidents! People get hurt, not mutilated. That’s why we call them accidents. Even if there is horrible mutilation, there’s usually no malice or “axis of evil” involved. A train crashes, a plane crashes, a bridge collapses. It’s just happened because someone seriously screwed up. They didn’t mean to hurt themselves or the others. They just didn’t pay attention, they just got distracted, they took a foolish chance and lost, they zigged when they should have zagged, etc. It happened, it’s over in a flash, then everybody goes back to the picnic.

The majority of Americans are still horrified by widespread death and destruction. American’s don’t do widespread interpersonal violence...not like other countries have and are still doing. I’ve repeatedly read and heard that America is a violent society. Well excuse me. We’ve never had a Hitler doing mass murder in the pursuit of the “master race”, an Idi Amin slaughter of millions in Uganda or Pol Pot’s Cambodian “killing fields”.

We are a democracy. Everyone gets an opinion. Nobody is supposed to get killed just for having a different opinion.

It is still un-American to kill women or children. Thank God or whoever.

Americans don’t do civil wars for a lifestyle. One was enough, apparently. However, the Shiite’s and Sunnis have fought since Mohammad died (two thousand years ago), and subclans and sub-subclans have gone at it for decades, if not millennia. England’s War of the Roses lasted thirty years. The Alodarian Empire’s 800-year-war lasted...800 years. The only brother-against-brother, father-against-son the Americans do any more are NFL football, NBA playoffs and NASCAR races.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

APA (1994)
These intrusions can be memories, visual images, smells and auditory distortions. They may be what the civil war veterans having “the reverie” were doing. They were probably lost in intense remembering of the horror of seeing tens of thousands slaughtered in one day on both sides.

One Civil War general on one said something like about the carnage, “This isn’t war, it is murder”. (please email me if you know who said that so I can give them credit).

I have repeatedly heard of another subcomponent of these intrusive recollections I call “bleed-throughs”. These bleed-throughs aren’t the full-blown flashbacks and they aren’t the reliving nightmares.

They are partial sensory experiences of the past memories overlaid onto the present. They can be visual, auditory, olfactory (smell) or taste. They are mini-flashbacks.

I had one student of mine in a General Psychology class tell me her combat-veterans-sister saw blood on the inside of a taxi-cab in Indiana. It was not really there. It was a bleed-through of a traumatic scene she witnessed in Iraq. She had pulled civilians women and children people out of a taxi car that had been mistakenly machine-gunned by American troops at a checkpoint.

I’ve heard of returned American combat troops seeing Viet Cong uniforms overlaid on Eurasian civilians back stateside.

Unfortunately, these bleed-throughs also trigger intense feelings that can last for days. The viewer is very confused and emotional for quite a while after misperceiving these things.

(2) Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.

APA (1994)

The information I have from 38-years of clinical practice of both severe combat and civilian PTSD shows that these nighttime “flashbacks” (exactly reliving the trauma in a nightmare) are much more frequent than flashbacks in the daytime. I would be open to other practitioner’s input or researcher data on this issue.

The only full-fledged, daytime combat flashback I ever heard of was with an intoxicated man. He thought he saw NVA tanks on the streets of his Missouri town. He started shooting at them with his service pistol. Luckily, he didn’t kill anyone.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: in young children, trauma-specific reenactment may occur.

APA (1994)
This “acting or feeling as if” is pure “transference” in the Freudian term. We act or feel “as if” the past is happening again. However, it’s not a sexual surge as Freud analyzed it. It’s massive horror, anger, fear and on full combat alert.

There is so much distress now because there was so much distress then. The bizarre part is that they weren’t as aware of the stress back then because the majority of their attention was focused on trying not to get killed!

This physiological reactivity component of PTSD is most misunderstood and vastly underestimated aspect of PTSD sequelae.

It’s not simply that they are physiologically stirred up to stimuli that symbolize or resemble an aspect of the traumatic event. They often react as if they are going to get hurt again.

We’re not talking about being upset. We’re not talking “bumming.” We’re not talking bad-hair-day. We’re talking “fight or flight,” “kill or be killed,” adrenalin-charged, in-the-firefight-again, I’m gonna be shot again if I don’t attack first (if they have been wounded).

“What resembles part of the trauma from the past will trigger the emotional response to the traumas again in the present.”

I don’t know the body’s specific physiological responses to being shot or wounded by any projectile. Part of that depends on what part(s) of the body are hit. I do know there is a massive flood of steroids (adrenalin, noradrenalin, cortisol and others) to help the body defeat the enemy and to help the body recover from the wound. There is also massive central nervous system arousal (increased sympathetic nervous system, decreased parasympathetic nervous system activity).

Adrenalin is the most commonly known of the stress steroids. During attack, or threatened attack, it gets dumped into the blood stream, making your heart pound, your voluntary muscles fed and energized by the flood of sucrose the adrenalin releases, your respiration is hard but slow, your mouth is dry, and all of your involuntary muscles are clamped down. The steroids also help the body heal wounds faster. All parts of your physical body are on a synchronized excited-but-shut-down, ready to go the whole ten yards, do-or-die status.

This steroid-fed mental and physical arousal also makes the central nervous system mentally process things for danger, too.
Guess what? When your body feels like you’re in danger, your mind is going to perceive even the innocent or harmless as dangerous. It’s called “transference-based misperception.” It’s called “emotional overlay.”

“In stimulus generalization, those places that arouse recollections of the trauma contain stimuli (sights, sounds, smells, tastes, and/or tactile events) that are “similar enough” to those in the trauma that they re-awake recollections and intense feelings from the past.”

Physical movements towards the “locked and loaded” vet are going to be felt like an attack. They are going to respond to the misperceived attack with a counter-attack.

All sounds (but especially human voices) are possibly going to be misinterpreted as threats. This goes for how they interpret your tone of voice, what you said and how you said it. You are going to have one very paranoid, “locked-and-loaded” person on your hands. They are an instant management issue.

You will often see that a combat vet is really escalated by other people arguing. Why? Because there is a lot of shouting and commotion during combat. It’s stimulus generalization again. What resembles part of the trauma from the past will trigger the emotional response to the traumas again in the present.

There has been research back to post-Vietnam documenting combat veteran’s adrenalin hypersensitivity. They physiologically react more to laboratory injections of adrenalin with higher sympathetic (arousal of voluntary nervous system) and, therefore, stronger parasympathetic (shutting down the involuntary nervous system) responses.

This is part of the classical conditioning that occurs in any trauma: the initial event automatically triggers adrenalin. That rush gets paired with the all parts from all sensory modalities (sound, sight, touch, taste, smell) of the life-threatening event. Then events that are “similar enough” to the initial trauma can trigger other adrenalin responses, even though the person isn’t really in another life-threatening situation.

The classic combat veteran example is their overreaction to the Fourth of July fireworks. The flashes and, especially, sounds of fireworks are similar enough to the sounds of combat artillery and automatic weapons chatter. Those sounds initially trigger high-alert, flight-or-flight physiological and mental arousal. Every wounded combat vet I knew of was very frazzled and frayed by the end of the Fourth of July holiday.

I find it incredibly ironic and the men who risked the most to preserve our independence by putting themselves in harm’s way are the ones who suffer the most from it (except for anybody who mishandles their fireworks. Then they become civilian PTSD victims).

I have written letters to major newspapers AND the veterans department asking for help developing a special “Spare the Vet” program to reduce the stress of illegal firework detonation on this wonderful (for everyone but the combat vet holiday).

Nobody has ever taken me seriously enough to even bother to respond.
More follows below about the classical conditioning (look for the stick-figure of Pavlov and his dog).

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma

APA (1994)

It is classic that severely traumatized victims initially try to avoid (suppress) all thoughts and feelings and specific memories about the trauma(s). There can also be some automatic forgetting (repression) of the trauma. Repression has been demonstrated among civilian trauma victims. Don’t hassle me about the False Memory Syndrome. I’ve got a “False Memory Syndrome” lecture subsection in several of my other CEU courses.

The tricky thing about trauma is that it teaches the victim significantly different and erroneous (we used to think, pre-911) thinking about our world and about ourselves.

Within the psychological realm (pre-911), children are helpless victims but psychologically healthy adults are potent and powerful. Our parents protect us from abuse and victimization. We protect our kids from the pervert in the bushes. God is on our side.

For our country, all of those illusions went up in smoke and dust and steel and drywall and body parts on 9/11/2001. Those illusions were dispelled on a daily basis in every town and county and state regarding physical and sexual abuse. Regardless of your philosophical take on war (in general or in particular), talking about and examining trauma helps. Most victims won’t know that until they try it…for a year (not just two sessions).

Another tricky thing about trauma victims is that they usually try to cope with it on their own before they seek external, professional help.

The sad thing about how they try to cope with it on their own (with both civilian and combat PTSD), is that they often go through all of the same bad stages, using ineffective coping or avoidance mechanisms before they hit the wall and seek external help.

Those bad stages/ineffective coping mechanisms/ avoidance mechanisms include: taking it out on others, abusing prescription drugs, abusing alcohol, and using illegal drugs, using sex as a tranquilizer, losing your job, losing your marriage, remarrying quickly to someone less functional than your last spouse, doing “antisocial” (criminal) actions.

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.

APA (1994)

This avoidance is because of stimulus generalization. Those places that arouse recollections of the trauma contain stimuli (sights, sounds, smells, tastes, and/or tactile events) that are
“similar enough” (stimulus generalization) to those in the trauma that they rearouse recollections AND intense feelings from the past.

The PTSD victim’s best, initial solution to keep from getting re-stimulated is to reduce and/or control all possible stimuli by staying at home as much as possible. This can lead to “agoraphobia” (fear of crowds) in many cases. I have met many Vietnam combat veterans who still live in the woods because they can’t handle the overstimulations and triggers in typical civilian cities. I met a Vietnam veteran in a bar recently (I do a lot of good work in the bars) who had come in for his yearly beer at the local pub. A mortar round had wounded him in 1968. He didn’t know how 1968 was still affecting him until we chatted.

I take it for granted that most people know the classic types of “triggers,” but that is apparently not the case. (I will elaborate on the different modalities for triggers later in the course). However, I’ll give you an example that astounded me when I witnessed how slight and subtle a “similar” stimulus it took to set off a combat vet’s alarms.

I was doing psychological testing of an Operation Enduring Freedom veteran who had been wounded with a silver dollar-sized piece of jagged shrapnel in his chin from an IED. One quarter inch closer to his neck and it would have sliced his jugular vein, severed his spinal cord, or both. One other partner of his on the patrol was killed in the blast and several others hurt. His current employer wanted a “fitness to return to duty” evaluation. His initial wound had happened over a year ago. He told me he thought he was over the combat trauma because he hadn’t had any more nightmares for a while.

I tested him in his home. As I talked to him, I looked out his front window over his shoulder and something out in the street caught my eye. My eyes must have quit scanning or my pupils must have constricted or dilated or something. Whatever it was that triggered him, he spun around from his waist up, looking at the direction of my gaze, trying to see what I was looking at.

In combat or on a mission, I guess you watch your buddies’ gazes, too. They may see something you don’t.

(3) Inability to recall an important aspect of the trauma.

APA (1994)

The question may be: are they unable to recall important aspects or just unwilling? My answer: I’ve seen both inability and unwillingness. I’ve seen a lot of unwilling but I’ve also seen people mentally struggle to get back full memories.

(4) Markedly diminished interest or participation in significant activities.

APA (1994)

This part contains several aspects. First, the civilian world they return to is usually much less challenging and threatening. Since the civilian world is much less threatening, it is perceived as less important, less noble, less real, etc., by some combat veterans.
Secondly, the release of adrenalin during patrols, combat operations and firefights produces a well-documented high at first and a “coming down” at the end of the adrenalin “dump.” Adrenalin can be just addictive as any other mind-altering drug.

Nothing short of high-risk hobbies, high-risk occupations in the civilian world or robbing banks comes even close to the adrenalin “high” of combat (if you don’t get shot up). This is why many combat vets take up high-risk hobbies (such as sky-diving) and occupations (police and fire). That doesn’t entirely explain bank-robbing.

The other part of this issue is below. They have:

(5) Feelings of detachment or estrangement from others.
APA (1994)

This detachment can be emotional numbing (restricted affect), preoccupation with what is happening to his guys still in the fight, mental preoccupation with what the veteran experienced himself, and the feelings of many combat vets that the civilians around them: 1) wouldn’t understand what the veteran went through, 2) don’t care what the veteran went through, or 3) don’t want to hear about what the veteran experienced. He/she might be correct on all three counts. He/she might not be correct on 2 and 3. He/she is probably correct on 1 except for other combat vets...and they weren’t willing to talk about it at first, either, except since the Vietnam War.

(6) Restricted range of affect (e.g., unable to have loving feelings), sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
APA (1994)

Some of this restricted affect involves a generalized diminished range of affect (flattened affect). The returned combat vets doesn’t get too excited about the normal victories and losses of civilian life because few of them come close to life-or-death matters that are still so fresh in the combat vet’s mind.

The restricted range of affect also includes the inability to love. This is probably because they have lost someone they loved to some degree in battle. This is much more likely in combat troops from the Vietnam War to the present. This is because of the non-national, non-universal conscription that the United States Army has employed to obtain participants for battle since and including the Vietnam War.

In the World Wars and Korean War, everybody went. You were thrown together with people you never met. You banded into groups based on the military’s need and you were all “dogfaces”, GI’s (Government Issue). You were all treated like dirty, expendable socks.

During the Vietnam era, the military developed the recruiting system they called the “buddy system.” You got extra money if you signed up with a “buddy” (a friend from high school or work). You went through boot camp together with your “buddy”, did AIT (Advanced Individual Training) together and you both shipped out together.
Unfortunately, anybody’s horror is magnified when someone you personally know gets killed compared to how you feel if you don’t know the deceased. It’s more enormous when you see your-best-friend-since-2nd-grade-and-were-in-Cub Scouts-together-and-played-baseball-together-and-flirted-with-their-sister get killed.

The same increased familiarity is being caused by deployment of National Guard units to the Gulf Wars who have much pre-war time together, exchange of personal background information (even having family cookouts together), much more shared civilian-life information and usual civilian-life experiences).

Grief-ologists know that your grief is worse when the deceased is someone you knew and cared about. The “buddy” system of Vietnam and the “National Guard” system of the current (early 2000s) middle-eastern wars make the grief of losses harder, more intense, more prolonged, more painful.

It makes the combat vet reluctant or unwilling to get close to anyone else. They don’t want to feel that much pain again. Nothing (including the wonderful soothing of a deep, possibly everlasting love) is worth the pain caused by the unjust, unfair losses they have already experienced.

Their sense of a foreshortened future is based on their direct witnessing of shortened futures of those around them who died. Their hometown buddies, their high school football team members, their fellow trumpet players.

Those unfairly killed now include women and children. The men of WWII witnessed the death of women and children who got caught in the onslaught of counterattack to the Japanese/German/Italian axis. Many of them, to this day, can’t stand to hear children cry. Their WWI father’s didn’t’ tell them about that horror because their WWI combat relatives didn’t shoot at children. They weren’t around. They didn’t shoot women. They weren’t anywhere near the trenches. WWI was fought by men against other men, slugging it out, “mano a mano”, hand-to-hand, bayonet against bayonet.

Unfortunately, the battles of WWII, Vietnam and since are fought in the hamlets, rice paddies, streets, alleys and open markets of civilian life. To make matters even worse, from Vietnam on, innocent men, women children in the to-be-liberated country get caught in the crossfire as our soldiers fight the combatant men, women and children of the Viet Cong, Shia and Sunnis.

Therefore, the combat vet since the 1960s stays more distant from women and children if they have seen women and children combatants or fatalities.

The “Good Death” in America involves the expectation that the typical individual is going to die quickly, painlessly, justly and peacefully at an old age with their children and grandchildren by their bedside.

Wars after WWI showed American soldiers this “Good Death” doesn’t happen to everyone.

Wars after WWII showed Americans that women and children aren’t always warm and fuzzy. They want to kill you sometimes. They try to kill you sometimes.
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) Difficulty falling or staying asleep
(2) Irritability or outbursts of anger
(3) Difficulty concentration
(4) Hypervigilance
(5) Exaggerated startle response

APA (1994)

See more about these five in later sections.

**How long can any or all of these sequelae last?**

I saw a newspaper article about a World War II Battle of the Bulge (very cold, very snowy, very scary) veteran who had a “flashback” when he was caught in a snowstorm (very cold, very snowy, very scary) in Wyoming in 1998. That’s about 43 years later.

I’ve seen many WWII troops well up and cry when they finally talk about their experiences on the history channel programs paying tribute to them.

I still see Vietnam combat vets who are “irritated” (their words, among other things) by the 4th of July fireworks being shot off around that holiday. I’m sure many of the combat vets from the Gulf War actions will experience the same irritability or jumpiness about fireworks.

They are actually being re-stimulated (heightened state of physiological and mental arousal) by the fireworks. What especially bothers them are the strings of firecrackers being set off all at once. Why?

Because that string of rapid pops and cracks closely imitates the sounds of automatic small-arms fire they experienced during combat. That sound – for the combat vet – is associated with death, destruction, pain, anger, fear and guilt. For the teenage boy, those sounds are only associated with pretty colors, watermelon and the drink of choice (for them or their parents).

I know many other combat vets who stay inside their house the two weeks before and the two weeks after the 4th of July (because people shoot fireworks off that early and that late around the actual holiday.

Even severely traumatized civilians carry the scars for decades later. I had a 53-year-old female therapy client who came to me after she had a “flashback” that detailed her father sexually molesting her when she was three years old. That’s 50 years later.

As the following study reports, there are long-term effects of female, civilian abuse victims: “Child abuse and other traumatic early experiences forever alter a woman’s brain chemistry, setting the state for future psychological problems.”
The study in the *Journal of the American Medical Association* (Heim et al, 2000) offers the first evidence in humans that early trauma can change the brain’s response to stress and raise the risk of mood and anxiety disorders later in life, says chief investigator Charles Nemeroff of Emory University in Atlanta, Georgia.

Among the findings:

Women who were abused as children were four times more likely than other women to develop excessive stress responses to *mild* (my underline) stimuli.

Women who were abused and who now have depression or an anxiety disorder are six times more likely than other women to suffer an abnormal stress response.

Note that this study indicated that the women developed excessive stress responses to *mild* stimuli. How long can a “mild” trauma affect an organism? I have seen laboratory studies on rats that showed they have excessive emotional reactions for a month following a one-time immersion in ice-cold water! I have worked with many World War II veterans who were still emotionally overwhelmed by some “triggers” (current reminders of their combat experiences).

**Epidemiology**

Current estimates vary widely on the prevalence of combat PTSD. Dr. Charles W. Hoge, one of the researchers at the Walter Reed Army Institute of Research, reported that one out of eight (12.5%) combat troops was showing symptoms of PTSD. This was published in 2004 in the *New England Journal of Medicine* (Hoge et al, 2004).

Studies in wounded Vietnam veterans have found two- to threefold higher rates of PTSD among this population than among those who returned unharmed (Kulka et al, 1990; Pittman et al, 1989).

In a study of 60 injured soldiers and a comparison group of 40 soldiers (matched by rank, military role, and length of service) who took part in the same combat situations but were not injured, Koren et al (2005) found that ten (16.7%) of the 60 injured survivors but only one (2.5%) of the 40 comparison soldiers met diagnostic criteria for PTSD at the time of the interview. Moreover, wounded participants had significantly higher scores than their non-injured counterparts on all clinical measures.

**Differential Diagnosis in Adults**

The only significant differentiation I want to make is between PTSD (309.81) and Acute Stress Disorder (308.3) is that Acute Stress Disorders tend to occur following natural disasters (tornados, storms, earthquakes, fires, etc). The emotional damage from them will be worse if there is an intentional human involvement (such as if someone intentionally sets the fire that burns your house down).

**Natural Disasters vs. Manmade Assaults** (rapes, sexual abuse [children], physical abuse, combat)
There are some similarities in the destructive aftereffects across these different sources of trauma, BUT there are many specific differences in diagnosis, prognosis, and treatment. Let’s look at each one in turn.

Natural Disasters - floods, tornados, earthquakes, car wrecks, and other natural disasters are more prone to creating Acute Stress Disorders (308.3) (Source: Friedman, 2001). This diagnosis shares many of the same symptoms as PTSD but lasts a maximum of four weeks post-trauma (according to the DSM-IV).

Natural Disasters produce less intense, shorter-duration trauma for three reasons.

1. First, they are not intentional, manmade traumas.
2. Second, there are many warning signs of impending serious natural disasters (cloudy skies, winds pick up, minor tremors that tell you a fault-line is near, etc). Therefore, natural disasters do not create nearly as strong emotional damage as man-made injuries.
3. Third, there are many possibilities for “extinction” of the traumatic pairing (see more about extinction below). Skies darken over with clouds all of the time but don’t produce tornados every time. Winds pick up but don’t always produce tornados. Minor earth tremors occur frequently (even around major fault lines) but don’t often mean major quakes are going to happen. Fires burn everywhere (in your neighbor’s burn barrel, someone’s house, someone’s pasture) but the fire rarely engulfs everything in your neighborhood. It rains a lot without it becoming a serious flood. These are all extinction for the serious emotions tied to major natural disasters.
The Classical Conditioning of Trauma

Most of the sequelae of trauma can be directly explained by the “Classical” (Pavlovian) Conditioning paradigm illustrated below:

![Illustration by Fred Nolen, 2007]

(Author’s note: This diagram is supposed to be humorously pathetic. I can’t draw any better in real life).

Classical conditioning is learning through pairing. Classical conditioning is learning without choice. It is learning without effort. It can even be learning without consciousness.

Let’s use the real situation that gave Ivan Pavlov his understanding of this type of learning.

Ivan Pavlov (1849-1936) was actually a Russian doctor working on digestive physiology. He studied how saliva helped digest food. He had to starve his dogs to make them salivate (to chunks of meat) when he needed them.

One day, he noticed that the dogs salivated when a certain, specific laboratory assistant entered the room. They did not salivate to any other assistant or to Pavlov. He asked the assistant if he could explain their salivation to him. He could not or would not provide an explanation and initially denied he had been subverting the protocol. He eventually admitted he had been slipping them chunks of meat behind Pavlov’s back, in violation of the research protocol. The dogs associated (paired) the assistant to the chunks of meat. They salivated to the assistant as if he were the meat.

In the crude drawing, above, classical conditioning is being produced by pairing a bell ring with meat powder. The animal initially doesn’t salivate to the bell ringing. With enough
pairing (ring the bell, then give them some meat), Classical Conditioning (learning) will occur when the bell alone elicits salivation.

You can notice your classical conditioning next time you salivate when you smell good food. It’s the same process. The smell is paired with the taste which is paired with the past response of food in your mouth: salivation!

According to Pavlov, ALL emotions, good and bad, get learned through pairing or association with events and that event’s stimuli.

When we are children, we feel positive about someone when they treat us nicely, give us food, hugs and praise, and other pleasant stimuli. We associate that individual with positive, nice things, so we like or love them.

Emotional trauma (negative feelings) gets Classically Conditioned in the same way. A traumatic event happens, then all of the stimuli associated with that event can “trigger” almost-equivalent emotional AND physical reactions. (Some examples of different sensory triggers are listed below in the treatment protocols.) Intense trauma that only happens once can produce conditioning for a lifetime.

In the combat-wounded or traumatized, current sights and sounds and smells get paired with the pain and fears and angers of battle and trigger near-identical emotional and physiological reactions, usually without the veteran’s knowing it, at least at first. They are in “full-metal-jacket” mentally and physiologically without realizing they off this planet.

**Extinction** of reactions occurs simply when the bell (in the above example) rings but no more meat powder comes. Emotional reactions extinguish from most natural disasters simply when events similar to the natural disaster (strong winds or dark clouds, for example) occur again but no tornado hits.

Most emotional traumas from natural disasters extinguish more quickly than manmade PTSD because there are more frequent occurrences of the similar events without the recurrence of the disaster. The skies cloud up a lot more times without a tornado tearing up your house. It becomes windy a lot more times without the tornado coming down and snatching your truck two miles down the road.

Note that I said “more quickly”. Some people suffer extended, true PTSD from natural disasters. The severity and duration of PTSD is always easily calculable, be it from natural or man-made events.

**The most accurate predictor of severity and duration of PTSD, regardless of the cause, is always the amount of tissue damage suffered (whether received or inflicted)!**

Can I make it any plainer? Do the math and you’ll see!

**Natural disasters** that don’t involve tissue damage produce shorter, milder PTSD or mere Acute Stress Disorder. Much of that seems to be due to the “accidental”, “it’s not personal” nature of the injuries.
Rape is sexual violence, be it by a stranger, a date or a spouse. Tissue damage can be great; emotional trauma is commensurately great because it’s an intentional interpersonal assault. People who love you, like you, marry you, date you, buy you “stuff”, whisper sweet nothings” in your ear aren’t supposed to brutally assault you. They violated their word and your expectation of them inferred from their words and initially-kind actions.

Treatment and Treatment Issues

I can think of the following ten treatment issues for combat PTSD. I’m sure I (and you) can think of more as we go along. This list is not meant to be all-inclusive. Listen to each vet – he’ll tell you his important ones. Proceed from there.

1) Stimulus Generalization: the first and most important. It is crucial to help trauma victims identify their “triggers”. They can be the classic ones (backfires, Fourth of July fireworks, nightmares) and the unexpected. Some of the unexpected I have seen included close thunderbolts, tree lines, helicopters, leaves coming out in the springtime, children of certain ages, any child crying, the clatter of dropped skateboards and present-day military operations (Desert Storm, Afghanistan, Operation Enduring Freedom). The middle-eastern operations will have desert-type triggers that the Vietnam and northern theater WWII guys didn’t have.

These triggers can provoke massive emotional floods that can go on for months and be triggered decades after actual combat. The “high impact” groups that included Vietnam War-related popular films triggered strong emotional responses, sometimes to a detrimental level. Participants were so stimulated that they could not effectively process their emotions during the 1½-2 hour group sessions. They had to rely on each other and the group psychologist during the rest of the week. I’m not sure if all of them did effectively process their issues. (Also see my comments about medications in the appropriate section, below).

The sounds of helicopters are triggers for Vietnam veterans and ever after because the helicopters were used as the transport mechanism into combat, out of combat and as medivacs for the dead and wounded.

They were also used for transport, fire support, and interrogation of the enemy. One Vietnam vet told me that US interrogators would take off with a group of enemy prisoners and ask one of them a question. If he didn’t answer, they’d throw him out of the helicopter to “motivate” the other prisoners to answer the question. It usually worked.

Helicopters don’t serve as triggers for World War II at all because there were no helicopters during that war. They don’t trigger many Korean War vets because, to my knowledge, they were not used for troop transport, troop support or attack, only medical evacuation. Combat veterans for more recent wars and operations will probably also get triggered by the sounds of helicopters.

The bottom line is: helicopters have many extremely emotional memories associated with them.
Tree-lines trigger Vietnam veterans back in America because the enemy used them to hide themselves for ambushes in Vietnam.

I imagine similar tree lines in America might have triggered World War II veterans who fought in France around the infamous hedgerows, if they saw similar situations back here in America. Unfortunately, they were unaware of what was triggering them and, of course, none of them talked about it.

I knew a Vietnam veteran in mid-Missouri who “went off” every springtime simply because the leaves started coming on the trees. He got so escalated he had to be hospitalized every springtime, in spite of the multiple psychotropics he was taking. He had been a member of an “A-team” (“A” stands for assassination) but had been ambushed himself. He’d been shot four or five times, once about an inch from his heart with an AK-47 round. I have no idea why that shot didn’t kill him. He also got blown up by one of the Air Force’s 500-pound bombs that people told him was a dud. It laid there for weeks, unexploded. Everyone else had been walking around it for weeks. It hadn’t exploded. He walked near it. It blew up, blowing his intestines out his body cavity. I have no idea why that didn’t kill him.

Green colors weren’t the only triggers for him. The “closed in” experience that the leafing of the trees produced was also triggering him, reducing his distant vision.

I have worked with many combat veterans from different wars that got very upset by children of certain ages or by children crying.

One Vietnam vet I worked with told me he was getting very agitated around his four-year-old son. He did understand, after talking with me, that I didn’t see anything about his son’s behavior that would be unreasonably irritating, especially to the level of emotion the vet was describing. We continued to process his combat experiences further until he reported that he had reflexively shot a four-year-old Vietnamese boy. The boy had walked toward him, crying as he walked. Something about the situation spooked the vet and he drew his pistol and shot the boy. The boy blew up. He had been booby trapped with explosives by the Viet Cong who were using him as a suicide bomber.

The vet then understood why he was escalating. His own son had just had his 4th birthday party. The Vietnamese boy may not have really been four years old, but the veteran had set that age in his own head and “four years old” (rightly or wrongly) was the trigger.

World War II and Vietnam War vets (and later veterans, I bet) can also get “triggered” by children crying. This is because these two wars (and the Afghan war, now) swept through civilian areas more than other recent wars America has been involved with. Many women and children got killed during the street and hamlet fighting.

Desert Storm and Enduring Freedom Vets will be no different about the children. Unfortunately, it is also a “close-in” war with close mixture of soldiers and civilians, adults and children.

There are other “treatment” issues for combat veterans that other classes of PTSD victims don’t experience. The most frequent issues they face are “survivor guilt”, loneliness and hatred of authority.
2) “Survivor guilt”, I think, is self-explanatory. Sufferers feel grief and guilt about surviving when their comrades have died. They also felt (and feel) grief that they didn’t “finish the job,” and may feel angry at the politicization of the conflict. Many of them re-enlist in order to “not leave any of ours on the battlefield.” Many of them, now, are angry because Desert Storm didn’t “finish the job” in Iraq. Many of them have re-escalated in response to the conflicts in Iraq and Afghanistan.

They also feel grief about leaving their dead and wounded comrades on the battlefield. This happens in spite of the “no man left behind” ethic in the services.

This grief has been going on forever but I have heard one happy ending. It involved a patient of mine who was in a firefight in Korea that ended in hand-to-hand fighting. He saw a member of his patrol get shot in the back of the head by a North Korean or Chinese bullet. Blood and brains splattered everywhere. The man dropped and was motionless. My patient thought his buddy was dead. My patient was quickly knocked unconscious as a man he killed with his rifle inches away from him fell dead on top of him. He awoke some time later in another spot. His patrol member was nowhere to be seen and my patient didn’t bother wondering about his buddy because he was surely (he thought) dead.

However, months or years later, my patient saw this same man walking down the halls of a hospital back stateside. At first, my patient thought he was seeing a ghost. However, they had adequate interaction to let my patient know the other man was real and (somehow) fully functioning.

It turned out the power of the rifle bullet was simple too weak to kill his buddy.

There is another type of guilt some combat veterans have. That is guilt about what they did while in combat, both to the enemy and to their own. This has occurred more and more since combat has changed from the medieval charges-on-the-plains against opposing troops to urban combat. Our current combat soldiers are still killing women and children both as “collateral damage” in urban warfare and as enemy combatants. There are even extreme cases in which innocent non-combatants are intentionally killed.

Killing women and children has historically been totally “foreign” (ego-dystonic) and repulsive to Americans. I wish it were for the rest of the world, but it isn’t that way in many other (if not most) parts of the rest of the world. I guess it isn’t that way so much for Americans anymore, either.

However, our American fantasy makes it more stunning, revolting and guilt-inducing for American troops if they participate in it themselves, or even witness it.

I have not yet heard of “fragging”-type incidents in the 2002-2007 combat theatre (fragging - an American soldier attempts to kill – or succeeds in killing – a ranking officer with a fragmentation grenade). Very early in the war I heard of American Muslim soldiers attacking (and killing) other American soldiers. That has not occurred since early in the war...or possibly it isn’t being reported any more, at least not that I have heard of. But I could be wrong, given the “fog” of war.
I have heard of several cases where American soldiers suicided after they came back from the field (from many combat theaters) out of guilt over what they had done. However, the more urban, mixed nature of more recent wars (Vietnam and Enduring Freedom), is increasing the frequency of Americans killing women and children) and is probably (I hope) increasing combat guilt.

The strangest case of survivor guilt I ever heard of involved a draftee, non-commissioned officer who went on a POW exchange in Vietnam. His detail was picking up Air Force officers shot down over North Vietnam. One officer was panicked, paranoid and disoriented (probably from torture) and physically clung to the non-com for days. They could never persuade him to let go of the non-com. They eventually feared the non-com would die from the stress so they pried the officer’s grip and forcibly separated the pilot from the non-com. The pilot died within hours of the separation.

The non-com felt guilty he had let them pry the pilot off of him. He felt guilty for not holding on/out longer...as if he had abandoned the pilot and caused him to die.

3) “Friendly-fire” guilt: one of movie myths of war is that we never kill our own. That has probably been false since the inception of mass warfare. The history channel has been informative in showing the cloud of arrows and spears and other hurled projectiles that occurred even in ancient battles of the Middle East. They weren’t doing one man, one shot even back then.

During the American Civil War (and other black-powder-powered engagements), the smoke of the weapons quickly caused a “fog” over the battlefield so thick that each side had trumpeters who blew out to inform their side where their side was.

A major “improvement” reduced that “fog”: smokeless gunpowder.

Unfortunately, the long-range-reach of current weapons, the closeness of support requested and attempted, and the push-the-envelope of enemy identification (night vision) continues to contribute to “friendly fire” deaths. All who know will grieve those innocent, accidental deaths, even if they don’t reach the public media.

4) Atrocity Guilt: We’re the good guys, right? We only do good, right?

Wrong. The “spoils of war” have been plundered forever, and it wasn’t a kinder, gentler plundering. It’s just getting publicized more with the increased media coverage since Vietnam when My Lai was published all over the media. Now the reporters are “embedded”.

And with it has come increased knowledge of atrocities (from Abu Ghraib prison to rape and murder of civilian men, women and children in OIF/OEF), increased publication of it, immense guilt over it by our troops, and...suicide.

5) Loneliness is another issue combat veterans have to face. They feel very lonely in the foxhole but continue to feel lonely and isolated from many of their combat comrades after their fighting is done because the comrades have died or drifted away. Combat creates an intense closeness (a “brotherhood”) among participants (on either side). This intensity is, in part, because of the intense emotional states triggered by combat. It is
also because of the intensely emotional acts of war: death, dying, mutilation, betrayal, abandonment, cowardice and heroism.

They also feel lonely because there are few people they want or can talk to about their combat experiences. Who can they talk to? They (like any PTSD victim) initially want to forget all about it. Can they talk to their wives...their children...civilian peers...non-combatants?

No, they don’t do this because the soldier doesn’t want to talk about it at all, usually from the defense mechanisms of denial, avoidance, suppression and repression.

However, imagine the emotional reaction wives, children and civilians would have if a soldier told detailed events of their combat experiences. What reaction have you had to the combat experiences I’ve shared so far in this paper? Trust me, I haven’t even revealed the worst I know (and this isn’t even on the same emotional planet as for those who experienced it).

There are many sub-cultures in our country. The military is one of them. Sometimes someone from that sub-culture can communicate to others in that sub-culture more effectively than those on the outside.

A warning to all in the “brotherhood”: the “brotherhood” doesn’t necessarily last once the war is over.

6) Hatred/disrespect of authority. There are many examples of failure of leadership in the military. There are too many to detail. There are failures of leadership in civilian life, too, and they also are, of course, too numerous to elaborate.

They all can and do produce life-long emotional reactions, be they combat or civilian failures. In the civilian world, I imagine there are many people, ex-employees, or investors of Enron, who will be haunted forever by strong emotional surges triggered by names, sounds or other stimuli they associate with Enron, Hurricane Katrina or 9/11 World Trade Towers. They can resent the failures of leadership of Ken Lay and associates, the New Orleans levee builders and designers, or the counter-terrorism agencies who had clues but failed to intercept the suspected terrorists.

Combat veterans also have to deal with public and private “failures to lead.” Those can be generalized and erroneous (e.g., Vietnam was a “black man’s war”), public and correct (e.g., fabrication of “weapons of mass destruction” data to justify our invasion of Iraq) or the admissions of Robert McNamara (John F. Kennedy’s secretary of defense) thirty years after the end of the Vietnam War.

Although there are civilian and military failures to lead, the combat vet feels more intensely than most because he has experienced or witnessed first-hand the tragic, violent and degrading results of those errors by those who are in charge. He was feeling very strongly when they occurred. He will continue to feel very strongly about them. The wounded feel more strongly about it because they feel more strongly about all things (due to the classical conditioning of all war-related stimuli with their body’s physiological responses to the life-threatening situations and assaults on their own bodies).
How do you handle the combat vet’s resentments? That will depend on your own political point of view, therapeutic stance(s), and personal issues. It will also depend on the veteran’s political, philosophical and personal issues.

There will be no “right” or “complete” response. I only warn you that everyone in this country needs to be ready to deal with any and all of them for the rest of the veteran’s life.

7) **Pre-morbid** (before the trauma) and **comorbid** (along with the trauma) **factors** need attention, too. Drug and alcohol addictions are frequent. “Hard” drug addiction, if overcome, is frequently substituted by alcohol addiction.

Comments about pre-morbid factors: having Learning Disabilities (or other common childhood low-functioning) in grade school doesn’t equal the impairments of a gaping head wound injury from a sniper’s bullet. I refer specifically to a case from OIF where the VA denied a head-wounded soldier disabilities because he had mild academic problems in school.

Don’t let the government play you off if you have mild pre-existing issues.

8) **Where was God that day?** I expect all men faced with combat are confronted with many existential questions. I imagine all of them evaluate the meaning of life, the meaning of their life, and the meaning of their presence “in harm’s way.” The answers to those questions and the means of reaching the answers (or entirely avoiding the questions) are as varied as all the theories of existential questioning, spiritual searching, religious affiliating and pathological defense mechanisms combined.

However, a repeated experience of combat on combat veterans is a partial or complete loss of religious identity or faith in God.

This often is caused by maximum horror events in war, given the American perspective of being the “good guy”. The American “good guy” doesn’t hurt women, much less kill them. The American “good guy” doesn’t severely hurt children, much less kill them. The American “good guy” doesn’t dream that a woman will try to kill him. The American “good guy” doesn’t dream he will have to kill her in self-defense. The American “good guy” doesn’t dream that a child will try to kill him. The American “good guy” doesn’t dream that he will have to kill a child in self-defense.

But in all wars since WWII, the American soldier has faced these violations of the old time “rightness” of combat. Ignore the fact that Sherman lay the civilian South in ruins during the American Civil War. Ignore the fact that Julius Caesar and Alexander the Great and Genghis Kahn and __________ (you name them) enjoyed the “spoils of war”.

The average American grunt still, I think, believes that he is “the good guy”, is there to help people, is going to kill or “take care of” the “bad guy” and then go home to his wife and kids and live happily ever after.

For some, that happens; for some it doesn’t. And when it doesn’t, vets often feel they have sinned in the eyes of God or that God has let them down.
This is where the spiritual aspect of counseling or therapy is at its greatest level. You become their confessor, priest or forgiver...if they allow you to. If they don’t allow you to, they will turn to fellow combat veterans, their priest, alcohol or drugs, ...or suicide.

9. “Dual Diagnosis” issues: the concept of “dual diagnosis” means that you have a “mental” problem AND a substance abuse problem. This, for the therapist, compounds the problems with case management, since the substance abuse creates high emotional lability (mood swings), irresponsibility (The Games Alcoholics Play), and legal quagmires.

10. Check their DD214: The DD214 is the official discharge paper given to any soldier. It also details (since the Vietnam Era) any operations, medals and type of discharge.

Unfortunately, I have heard several men from the era of WWII up to Vietnam claim to be combat veterans, claim to have done combat, when in reality they were never actually in the military.

Obviously, if you are working as a therapist in a Veteran’s Hospital, you don’t have to check patients’ military status to verify their enlistment in the military. However, keep in mind, verification of enlistment isn’t proof of any claimed heroics.

I almost always find that true combat veterans are very reluctant to talk about specifics. In fact, that is part of the diagnostic criteria. Remember C1, above (persistent avoidance of thoughts and recollections of aspects of the trauma). It is also pretty easy to detect a pretender if you know much about weapons and ballistics, much less had real experience in combat.

GENERAL THERAPY PROCEDURES

Framing

Effective treatment for any client/patient initially demands some general framework. (I say “demands” and underline it because it is crucial to set up this initial framework. If you don’t discuss them at first but later hit one of these issues, it is near-impossible to backtrack and salvage the treatment.)

The general framing for any client/patient minimally involves:

1) Signing of all consent forms and patient rights forms
2) Be clear about “duty to warn” regarding harm to self or others
3) Establishing mutually agreed upon financial aspects
4) Defining boundaries of client and patient regarding touch, phone calls, charges for phone calls, appropriate hours of phone calls, after-hours crises, calls or visits to the therapist’s home, etc.
5) Discussing the positive and negative aspects of therapy (such as negative side effects)
6) Discussing possibilities of negative transference (i.e., I, their therapist, may hit their “buttons”)
7) Discuss “I never promised you a rose garden.” This is the notion that therapy cannot make everything wonderful, forever
8) First dictum of trauma therapy: Getting Better Does Not Mean Feeling Better...At First!!!!
9) Discuss that the trauma victim may also be a victimizer

The Talking Therapies

A. Individual therapy: I have seen talking therapies provide much healing for trauma victims of all sorts. They can accomplish what no medication can provide (but vice-versa, too). The following are some significant common factors to work on.

Discuss/Define “Triggers”- sights, sounds, smells, tastes and touches that remind you of your combat. It can be seeing something that looks like your combat; or hearing something that reminds you of the fight; or smells like the fight, or tastes associated with the war, or touches (areas of the body, tactile sensations. Those stimuli now set off (“trigger”) intense emotional surges.

The importance of “triggers” in treatment of combat vets is as important as the trigger is on a real gun.

In a real gun, you can have bullets loaded in the chamber, you can have the barrel pointing anywhere you want, and you can have the trigger cocked, but if you don’t pull the trigger...it’s just a useless paperweight.

You can have all the stimuli (events) happen to the vet in his post-combat life and everything is fine and dandy until... something pulls his trigger.

It will be most concrete (and therefore helpful) if you have the combat vets chart their triggers. Have them describe the trigger, then describe their reactions (behaviorally and emotionally). For example:

<table>
<thead>
<tr>
<th>Sights</th>
<th>1. Seeing a helicopter: I feel tense, want to hide, I start looking around for snipers.</th>
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</table>
I had a patient who was wounded in hand-to-hand combat in the Korean War. I was working with him at the time the movie “Saving Private Ryan” came out. One week, at the end of our therapy session, he enthusiastically told me he was going to see it. I vaguely
discouraged him but also told him to note how he was feeling during the movie. (I knew the sounds of battle in the movie were going to be “triggers” for his own PTSD).

During our session the next week, he mentioned he had seen the movie. I asked him how he had been as he watched it. His initial response was comments about the movie. I stopped him. I said, “I didn’t ask you about your impression of the movie; I asked you about how it affected you”. He admitted he had caught himself huddled up in the chair in as small a ball as he could get when battles raged on the screen. Those noises were like noises paired to him in reality with horror, survivor guilt and immense pain.

I had a friend who was a combat veteran of Vietnam. He was a dog handler and often led "point" on patrol. He and I saw a Star Wars-type movie together one time. There were enormous explosions on the sound track, emphasized by as-big-as-they-could-get speakers. I knew he was a combat vet. However, he came out of the movie unshaken. He actually enjoyed the explosions. I couldn’t figure out why he wasn’t all stirred up by the similar sounds.

Years later, I figured it out: He had never been wounded. He had been through enormous firefights. He said he was in one firefight where 10,000 rounds (bombs, artillery, rifles, mines) were fired by all sides in five minutes (his approximations). He had seen many killed and wounded. He, himself, wasn’t ever wounded.

The sounds, although similar to the bombs, artillery and mortars that had dropped all around him during firefights, were not paired with the immense pain of wounds for him. They remained...just loud sounds.

You, as a therapist, need to set up a chart to help your combat clients have concrete examples and displays of their “triggers” with old and new coping responses. That chart could look something like this:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heard a helicopter</td>
<td>Go inside, start to drink</td>
<td>Go inside, call my friend, meet them in the park.</td>
<td>Go inside, call my friend, go work out with them.</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This charting may appear to you to be too complex or overdone. However, the veterans needs to start being able to do this in their head as soon as possible. They can see it better internally if they can see it more externally.

In addition, I recommend you push this “trigger” charting to the limit. Keep an ongoing (rolling) chart. Each client/patient will see more/different things as they progress through the forever-after journey.
An “Anniversary Reaction” is a type of “trigger” that is much more difficult to identify and deal with for most victims IF you don’t tell them about it or they don’t learn about it from another source.

Anniversary Reactions are emotional and cognitive reactivations of trauma responses caused simply by the same time of day, month or year occurring. Grief therapists first identified them, but they occur with trauma victims, too. I have seen most Anniversary Reaction emotional triggers set off by the time of year (the seasons or certain holidays). Holidays will trigger children more than time of the year simply because children don’t have an “adult” sense of time.

I have also seen many people with great sadness from any cause(s) be more irritated, agitated, withdrawn and/or grumpy during family-focused holidays.

I believe this is due to what I call the “You Glad, Me Sad” Contrast Effect.

Family centered holidays are “supposed to be” times when scattered family members get together, celebrate the good fortune of the time, catch up on the good fortunes that have happened since the last get-together, and memorialize the strength of the family.

Any recent or severe trauma-victim, regardless of the cause, gets his loss magnified (by simple contrast) by the increased cheeriness, happiness, celebrated prosperity of those around him.

I find the best way to help the Contrasted griever is to acknowledge that they don’t have as much to celebrate at the reveler. Don’t expect much warm-n-fuzzy in return, but it will help them if you acknowledge their continued pain (without being extensively maudlin about it).

Dual Diagnoses: involves diagnoses on Axis 1 of the DSM Multiaxial Nomenclature System with a drug, alcohol or Axis 2 Personality Disorder. See specific treatment paradigms for each. I don’t want to go into detail about any of these at this point.

Drug/alcohol abuse: discuss how trauma victims often abuse alcohol/drugs to:
   a. numb themselves psychologically
   b. be popular and/or accepted by others (often with other abused or neglected peers)

Dealing with Feelings: most significantly, teach them effective ways of coping with their feelings, no matter what they are. Unfortunately, I have come to see a phenomenon unique to severely traumatized people that I call “Emotional Tsunamis”. Psychiatry called them “triggered manic episodes” but that doesn’t capture the “triggered” nature of the “transference” emotion.

A tsunami is a massive tidal wave triggered by an underwater earthquake. The energy of the plates slipping is transferred at the speed of sound and can flow for hundreds of miles, such as the one that occurred in December of 2004 in Indonesia and surrounding islands.

The Emotional Tsunami I am talking about with severe trauma vets is the massive emotional surge(s) that happen after they get triggered by something now that can run full-bore for weeks, even months afterwards. They will be on combat sleep pattern, do
perimeter checks, set up booby traps, sleep with a weapon, and be hypervigilant again (with some increasing drug or alcohol intake probable).

Nobody ever told me about these prolonged surges during my graduate school or post-graduate workshops. Not the vets; not the mental health professionals, not my pastor, not even my combat patients or their families.

They are real, they are frequent in combat vets for many years down the road, and they require intensive and extensive case/crisis management. In some cases, it will require...

**Suicide prevention (we hope!)** – Effective suicide prevention will take “the village” (all facets of society) on call 24/7/365 “till-death-do-us-part” to adequately protect the combat vets from suiciding. Eight to five, Monday thru Friday won’t work. Agony doesn’t know a time clock or calendar. In fact, it prefers to sneak up when your guard is down.

**Sleep problems – helping them while keeping yourself from getting killed (we hope!)** There are a myriad of sleep problems the combat vet faces while in the battle zone and after he or she gets back stateside. These are classic and are documented across all combat actions I am aware of.

The first of these is **sleep onset** disorder – problems getting to sleep in the first place. This occurs with civilians and soldiers alike. There is nothing exotic or significantly different about it in either arena. You are simply so mentally preoccupied with something in your daytime reality (past or present) that you can’t get to sleep. Unfortunately, the combat veteran may be re-stimulated in the “fight or flight” level of adrenalin arousal that keeps him going for days, if not weeks, on end.

The most frequent and healthiest cure for that problem with the civilian is simple passage of time. You solve the pressing issue or you don’t. Your sleep will return to normal if you solve it; your sleep will stay disturbed if you don’t...but your body will physiologically compensate for the sleep loss by many different mechanisms. Your brain can do “REM rebound” (making up for the lost sleep at a later time when the stress dissipates) or even micro sleep episodes (sleeping with your eyes open and not knowing you have gone to sleep).

Although there was a popular fascination and hysteria about sleep deprivation in the 1950s, there has to be severe and prolonged sleep deprivation for intense confusion and even hallucinations to begin.

The average day-to-day stress-related sleep problems resolve with use of effective coping skills, sheer passage of time or both. You may notice that you often “finally” get to sleep about two or three in the morning. This is because your body finally reaches its lowest level of body (circadian) rhythm and physically goes to sleep, no matter what’s on your mind.

There is one simple (but effective) way to stop the train of thoughts that are often associated with stress-induced sleep onset problems. Just write down the concerns you have on a sheet of paper, write down possible solutions, then prioritize all of it. This simple procedure literally helps you get things “off your mind” and you can go to sleep more easily.
Don't take sleeping pills. I have never seen any of them really help and they are all physiologically addictive with some strange (not really) side-effects like “sleep driving”, homicide while sleepwalking and homicidal rages with amnesia when mixed with alcohol.

The second type of (micro sleep) episodes also occur with extreme and severe sleep deprivation. The combat vet’s level of arousal is probably so high at this point that they can only come down with an IM (intramuscular) dose of soporific (sleep medication) or Thorazine.

The second sleep problem is called nightmares. They are particularly vivid and riveting for any severe trauma victim. They often, at first, are pure reliving (flashbacks) of the traumas. They can persist for decades and can be purely mental in process or (usually) include mental and behavioral reenactments. The dreamer can attack or hide from the enemy all over again.

The level of emotion in the nightmares is also tsunami-like and can carry over into the dreamer’s daytime for hours if not days.

The main thing I want to emphasize for spouses, partners, children and anyone else around the nighttime flashbreaker:

1) **Don’t touch them!!!!!!!!!!!**
2) Don’t deal with them from behind, if at all possible.
3) Repeatedly call out their civilian name, reassure them they are safely back in the “world” (or use whatever slang term his combatants called being in the United States), tell them what state, town and street they are in (to physically anchor them back to this world) and that they are just having a nightmare of the war. Do all you can to reorient them to their safe here-and-now.
4) It may take them hours (or days) to decompress from the emotions of the nightmare and/or flashback.

This is prime time to a) try to keep them away from alcohol and b) keep them talking to your or someone else they can relate to about the event(s) behind the nightmare. If you can’t stay with them until they are decompressed, call in support.

This is where I recommend families of combat veterans remain linked together as support system for all other issues but, especially, for periods of decompression from these Tsunamis. These periods are extremely stressful and taxing for all involved. These are the highest probably periods of danger to self or others.

Theory 1: A person who has suffered immense trauma may never completely “get over it”.

Theory 2: A severely traumatized person (civilian or combat) has 58 gallons of tears to cry. The sooner they cry them out, the better they’ll feel.

Combat Vets: I wrote “58 gallons” but that, of course, is an arbitrary number. My real point is: You will need to cry and share and release all of your stored up feelings and thoughts. As you do, your emotional tension will subside and you will be able to deal more with life back in “The World”.
The last sleep problem involves **sleepwalking**. It is more common in people who are stressed. It isn’t exactly “acting out” of a dream because they aren’t officially “dreaming”.

Sleepwalking (and sleep talking) occur in Stage 4 sleep. The sleepwalker is having some mental activity during this stage. I have heard of many combat veterans sleepwalking but haven’t had any type of access to them (direct or through the media) to find out what their sleep mentation was.

I recommend problem sleepwalkers set up motion-triggered lights inside their house (with additional auditory alarms included in the system) to make them alert to their sleep walking. These systems can easily be rigged from the motion-detection yard lights available at many hardware stores.

**Behaviors Therapies:** Systematic Desensitization; EMDR (Eye Movement Desensitization and Reprocessing)

I place Systematic Desensitization and EMDR in the same category simply because they have a similarity in paradigm. Both of them involve repeated exposure parts of the trauma stimuli with the client in control of the exposure intensity and duration. I do not intend to critique EMDR. Repeated exposure without recurrence of the full trauma produces **extinction** of the emotional response.

I have heard the army is doing some systemic desensitization using video games. That may work.

I have also tried to use the “high impact” group therapies. These group sessions involve watching Vietnam War movies like “Platoon.” Those films triggered massive emotional surges for most of the viewers. Sometimes those surges lasted for days. They didn’t want to watch them any more.

Unfortunately, the extinction part of systematic desensitization involves repeated exposure. It is critical the exposure be repeated so that the soldiers’ emotional surges decline (to both the films and to real-life triggers).

**Caveat A:** any way this can be approached that is eventually effective will **initially** trigger incredibly strong, negative feelings.

**Caveat B:** The troop isn’t going to like this version of treatment since it will be so intensely emotional for them at first. It may be so intense as to be counterproductive. The patients and therapists have to decide BUT the patient has to be aware that their arousal will always fade with repetition. Do it fast (five years); do it slow (50 years). Dance your way but you’ll always pay the fiddler.

Look at the chart below for the ebb and flow of “Triggers”.
This is a chart of “extinction” of emotional surging that is produced by reality, Classical Conditioning, traditional talking therapy, and/or EMDR.

This extinction pattern is the same if you chart the emotional response to the same or different triggers of the soldier’s war experiences. For example, if you repeatedly show the vet the same picture of a tank he was in when it got hit by an IED, his emotional response to it will decrease in the pattern shown here. His emotional responsiveness will also decrease if you show him mixed pictures of the tank, the town it got hit in, samples of IEDs, members of his outfit, and his group banner.

Note that the emotional arousal is the highest and lasts longest at point “A”, the original trauma. When the first “trigger” hits at “B”, the arousal goes back very high but is not sustained for as long as the original trigger. When the second “trigger” hits at “C”, the arousal is high but the surge doesn’t last nearly as long as to A or B.

Surges at D, E, F and G don’t produce as intense or as long emotional surges as the earlier ones produce.

Time “X” (when the emotional responses get bearable) is unpredictable. It can be five years or 50. I saw “bearable” because there are studies that show combat veterans have elevated physiological reactivity to even simple medical checkups 20 years post-Vietnam (Gerardi, et.al, 1994). I’ll bet my Korean War vet who was watching “Saving Private Ryan” and was curled up in a ball at the theatre was also having elevated physiological reactivity compared to the other, non-wounded movie viewers. That was 50 years post combat!

Vets: you are going to do this the hard way (unassisted and unexpected and alone) or the easier way (systematically and intentionally). Trust me. It’s going to be tough either way but will save you years of grief if you do it intentionally and with support.
Anger management: This is going to be a primary treatment issue for most traumatized vets. This is due to many factors, both psychological and neurochemical. The psychological factors are obvious to them: “You pissed me off.” The less obvious problem to them is that one of the hormones released during simple stress (cortisol) is also released during full do-or-die. It has been paired in the past with massive physiological arousal and massive threat. Its minor releases during “normal” civilian stresses may put them back in “full metal jacket” for many years.

The literature is rampant with data showing higher anger, domestic violence and abuse of their children. See the additional readings listed at the end of this course for specifics.

Some, but certainly not all, of this violence is specific, unconscious “acting out” what they went through in combat. For example, I had a patient who was a Multiple Personality. Her father had been in the Navy in WWII. His ship had been set afire during a battle at sea. There was heat, screaming, yelling and death. A shipmate of his got trapped by some twisted metal and couldn’t get out from under it. The ship was sinking and he was burning up from the fire on board. He pleaded for her father to kill him so he didn’t drown or burn to death. Her father shot him with a revolver.

He came back from the war crazy. He had no one to talk to except, apparently, her. He would take her into their basement, stoke up the coal stove (even in the heat of summer) and be screaming and yelling. He was unconsciously acting out his ordeal on board his ship. He had no one else to talk to so he could only act it out.

She was terrified. She tried to hide. I don’t know what else he did to her (except burn her hands in the boiling water when she dropped the spaghetti noodles on the floor – she was three years old at the time and trying to cook for him). She could run but she couldn’t hide.

This is a unique example of the effects of the increased aggressiveness of combat vets. The moral to the story: not even their children are safe from their triggered emotional surges. The children can’t help themselves. We adults must offer more help to the entire family.

Chemotherapies: I believe these are absolutely critical IF there has been physical pain and tissue damage, but the medications can’t do it all. Research shows that a combination of chemicals in the SSRI category (Prozac, Zoloft, Paxil, etc.) along with anti-convulsants (e.g., Neuronton) or atypical antipsychotics work best. The anti-anxiety medications (anxiolytics) give faster immediate alleviation of the anxiety component of PTSD (but are more obviously addictive). The SSRIs, atypical-antipsychotics and neuroleptics (anticonvulsants) can help with the emotional lability component of PTSD.

However, I’m not a psychiatrist and don’t have prescription privileges, yet. I’m just reporting the current general information cited in Friedman, 2001.

Hypnosis: don’t bother with the newly returned vet. He or she is too raw.

B) Family therapy – This can be used to educate the veterans and their families about the soldier’s issues of war and all of their issues about readjustment that I’ve talked about in this course. Pray to God you don’t have a “GI Jodie” issue. People get killed over that.
C) Group therapies – these can be structured or unstructured. Most members seem to like structure. As I mentioned before, they can be low impact (talking about things) or high impact (viewing combat footage or movies). I repeat the caveat about the Emotional Tsunamis any high-intensity approach can trigger.

It is crucial the vet be told before any high-impact procedure, that their emotional reactions will eventually fade away.

**Danger to Self and Others**

**A) Suicide prevention: Danger to Self**

Question: How many soldiers really suicided after they came back from Vietnam?

Answer: Nobody really knows. Anti-war groups said twice as many Vietnam veterans suicide after they got back as got killed during the war. One website said that 20,000 suicided from the end of the war to 1993. However, one physician on that same website estimated up to 200,000.

He reasonably explained the discrepancy by stating, “The reason the official suicide statistics were so much lower was that in many cases the suicides were documented as accidents, primarily single-car drunk driving accidents and self-inflicted gunshot wounds that were not accompanied by a suicide note or statement.” (“Suicide Wall, Suicide statistics” at http://www.suicidewall.com/SWStats.html)

There is also another phenomenon called “Suicide by Cop”. This is not unique to veterans but it is another way to self-destruct without getting it labeled a suicide. This involves getting into a shootout with policeman without taking cover. The person often gets the attention of several policemen by doing something outrageous, then begins shooting at them. They– of course – return fire after going through their less lethal maneuvers, which the person – of course – disobeys. The police, in self-defense and as a last resort, shoot the person dead. It’s not an overt suicide but it’s obviously a self-destruction.

Question: How many soldiers from OIF/OEF (Operation Iraqi Freedom/Operation Enduring Freedom) will suicide?

Answer: Too many all ready.

**B) Danger to others:** I’ve seen little data on the other issue of dangerousness …danger or harm to others. Minimally, this involves increased likelihood for domestic and child abuse (see Taft, et al, 2007). At the extreme, dangerousness to others involves murder.

I must repeat again, that this dangerousness to self or others is highest in the troops with brain damage from either penetrated or closed-head trauma!!!!!!!!!!

The effects of brain trauma are very deceptive to the average civilian. They are one of the least understood injuries of the medical profession. Unfortunately, they are being called the signature injury of the OIF/OEF theatre due to the roadside bombs, IEDs, and copper shaped charges devised by the insurgents.
The systematic neurological study of head wounds only dates back to 1848 when a 25-year-old American railroad worker named Phineas Gage accidentally blew a six-foot, dynamite-tamping bar through the front of his cheek and out the top of his head in the front of his skull. He was leaning over the hold the dynamite was in, tamping it with the steel rod. The tamping ignited the dynamite.

The steel rod damaged the pre-frontal lobes of his brain. He was completely lucky it didn’t kill him.

He miraculously physically survived the blast and lived many years afterward, but he was a changed man. He was once described as “a dependable and likeable crew boss” but had become “an irresponsible and rowdy ruffian.” (Damasio, 1994).

To be more specific: before the blast, he was a calm, civil man. After the blast, he was an emotionally volatile (moody) man. When he was happy, he was ecstatic. When he was unhappy, he was morose. When he was sad, he was inconsolable.

His emotions had become greater and more extreme.

His vision was unchanged. The brain under the back part of the skull processes vision, and it had been uninjured.

His hearing was unchanged. The brain under the skull under the ears processes hearing, and it also had been uninjured.

He could taste as usual.

He could smell as usual.

He could move normally.

All of those brain parts were uninjured, so those functions were unchanged. He appeared basically unchanged.

The only part of his brain that was injured was the part that controls impulses (by damping them down) and emotions (by damping them down) and abstract reasoning.

He had become an unreasonable, erratic, uncontrolled ball of affect.

This is what has happened to some of our troops in past and present wars. Our understanding of brain physiology (function) was very rudimentary in wars before Vietnam. We are now at the apex of our understanding of neurophysiology. There is no need to be ignorant of the effects of head injury on personality and self-control. Unfortunately, its occurrence remains disturbingly high.

I have repeatedly evaluated children with subtle epilepsy or other brain damage who have focal spots that impair self-control. They are initially, erroneously diagnosed as ADHD (attention deficit, hyperactive disorder) because they have low self-control.
I have evaluated two adult men who have caused serious injury or death to their children by shaking them. Both of them had undiagnosed injuries that had severely diminished their self-control. The most common factor among convicted murders is brain damage. It goes undetected and is unappreciated (for its potential for lethal violence).

Not all head injuries create murderers. Not all head injuries produce severe lack of self-control. However, the sophisticated neurological screening devices we now have, such as MRIs, functional MRIs, PET-scans, MEGs (Magnetoencephalography) should provide head-injured veterans and their families more scientifically-based evaluation of the consequences of their head injuries AND indicate prudent and state-of-the-art interventions (both short-term and long, long, long-term).

Initial (but frequently replicated) research on murder (D. T. Lunde, 1975; Pitman, Orr, Forgue, de Jong, & Claiborn, 1987) found that most murders occur on weekends, most of them on Saturday night between 8 pm and 2 am, peak in July and December, occur more frequently in Southern states (44% of all murders) and involve, on average, a 20-year-old male killing another under-30-year-old male with a gun. Ninety percent of the time, the victim and the perpetrator know each other.

This typically adds up mostly to be a brain-damaged friend killing another friend or enemy during a late-night drinking/drugging “party” on a holiday.

Can we prevent all injuries to self or others?

No. In the present time there are too many situational factors that can trigger or defuse the emotional surges behind suicide and homicide. The triggers are all situational. Someone says the wrong thing; someone does the wrong thing. The defusers are also situational. Someone talks them out of it; someone finds the right action to calm them. Sometimes it’s just sheer luck.

I had one combat veteran who was in a rage after finding out his wife had been unfaithful to him. He was going out the door with a loaded rifle to kill his wife’s lover when he accidentally knocked over a flowerpot with the barrel of his rifle. He stooped down and cleaned up the flower, pot and soil. His rage had subsided by the time he got the mess cleaned up. He was unemotional enough to unload the weapon, go back inside the house and cry.

There are also many more restrictions (patient’s rights) to institutionalization. I believe those liberal patient’s rights have led to many unnecessary injuries to self and others. Many families of deceased patients also wish there were more authority to institutionalize those needing higher levels of supervision than they were getting.

Descher, et al (2003) found the combined rate of suicide, homicide, or police killings for previously hospitalized PTSD vets was 13.8%. That’s 13.8% of all hospitalized vets, not just those diagnosed with PTSD.

Is 13.8% good or bad? Is 13.8% enough, too much? I don’t know. However, I’ll bet it’s improvable.

I also want you to keep in mind that our current, middle-eastern troops have been in combat situations for as long as four years, in an arena mixed with civilians and
combatants, adults and children, men and women. The mixed arena is the same as the Vietnam combatant faced, but he often was home after one tour (12 or 13 months).

I believe the extended fighting and mixed arena nature of the current middle-eastern conflicts will increase the mental and physical damage to our troops compared to prior wars.

The “stigma” of therapy? I have recently seen much in the public print, especially from military sources (e.g., The Veterans’ Administration Center for Post Traumatic Stress Disorder, Iraq War Clinical Guides), that combat vets won’t reach out for counseling or suicide prevention due to the “stigma” or negative consequences of receiving help. I concur that there might be more reluctance to seek mental health help by troops in the current volunteer army, who view the army as a career.

However, in my 38 years, I have never seen a seriously suicidal patient who resisted seeking help at some point in their decline. It may come early in the progression to the final (sometimes fatal) resolution. It may come later. However, I have always seen that they are seriously seeking a non-fatal resolution to their real agonies and are amenable to sincere assistance.

I was shocked to find out that many veterans’ facilities do not have any organized crisis support.

I was more shocked to find out they do not offer services beyond eight-to-five, Monday-through-Friday schedules. Remember, most murders take place on weekends and in the wee hours of the night.

I was shocked to find out it is common to have a two-month waiting list for VA counseling. As usual, we can find all the money requested for the war, but little for the warriors.

I guess you gotta “fight the war (and the after-effects of the war) with what you got, not what you need” (Vice President Richard Cheney).

It appears to me that the veterans lack of respect for the mental health and perceived (or real) lack of understanding from the mental health arm of the Veterans’ Administration (VA) is an extremely serious impediment to the returning combat veterans trusting, and therefore reaching out to, VA mental health support.

Stigma? Hey, come on! I know a psychologist who was a conscientious objector during the Vietnam War, but many combat vets have opened up to him over the course of many decades. In most cases they even knew about his choice for Nam.

Stigma? What stigma? Unwillingness to open up? What unwillingness? I’ve never seen ANY unwillingness for a combat vet to open up if they felt respected and not condemned.

Stigma? There are ways around them. Many ways.
Theoretical Considerations

I have two general hypotheses about PTSD and the effects of combat trauma. Both of them directly impact the diagnosis, treatment and case management of combat veterans. The first hypothesis postulates a tri-phase nature of PTSD evolution and, therefore, treatment. I am generalizing this hypothesis from the combat and civilian trauma population I have worked with.

This hypothesis is a work-in-progress so don’t hold me to it as currently set in concrete.

Also don’t try to hold me to it because I am well aware of the criticisms of any and all categorization or stage theories. Those criticisms and objections include a) the true number of any distinguishable and reliable subcategories for anything is probably seven (take any of my college classes to find out why), b) not everyone will go through all three (or seven or however many stages), c) people will regress to “lower” stages and progress to “higher” stages in uneven steps, d) some people may never resolve (completely “work thorough”) some issues. Look at the personality theories of Eric Erickson or Elisabeth Kübler-Ross’ Death and Dying for parallel criticisms of their stage theories.

Hypotheses 1: The three phases of PTSD

1) “In the trenches”, “At the front”, “In the boonies”, “In the bushes”, “In the sand pile”, “Outside the wire” (or whatever slang terms the troops in that theater use for still being “in harms way”.

Nobody knows or talks much about being traumatized while they are still in the fight because everyone is still busy trying to keep from getting killed. Part of the syndrome, at that point, is a survival mechanism (hypervigilance, not taking about it, using avoidance, sleep disorders) relying on combat training and instincts instead of processing the death and killing, loading up with alcohol, sex and rock ‘n roll on R ‘n R).

2) Discharged with “brass balls”. Everybody luxuriates in the thrill of being back home at first. The mental focus is on celebrating the survived soldier, no matter what shape he is in. He can have his legs blown off, his jaw shot off or anything else shattered and tattered. He/she made it! That’s the most important thing. Right? Right! Unfortunately, his conscious mind is focused elsewhere (getting back into the “World”) but his unconscious mind and autonomic nervous system are still in high alert, especially monitoring the external world for hints and signs of threat. They simply appear edgy and may have sleep problems. They’ll get over it with simple time. Right?

Wrong!

3) “Un-numb”: The parade is over for the rest of their lives. You get a parade for Veterans Day and 4th of July. The politicians quit coming by for “photo ops”. You quit getting invited to public gatherings. Other than that, you are in the silence everyday, all day for the rest of your life. You don’t want to go to photo ops and give speeches any more. The defense mechanisms the military gave you as part of your preparation to inflict and receive these traumas weaken. Defense mechanisms? What defense mechanisms? Who, me?
The military uses many defense mechanisms to reduce their soldier’s resistance and inhibitions to killing others. Here is a partial list. I saw one decades ago (during the Vietnam era) but can’t find it yet.

“Rationalization” – the military gives the troops many reasons why killing another human being who is a father, son, mother or daughter 34, 340, or 3400 miles away is OK and necessary.

“Intellectualization” – the military training masks the interpersonal horror of killing someone by couching all the actions and weapons in scientific terms or pure jargon.

“Dehumanization” – it’s easier to injure or kill another person if you don’t know them as a person. We call them “the enemy”, “japs”, “nips”, “gooks”, “charlie” “towelheads”, and all the other nicknames coined to describe the opponent. They’ve got their nicknames for us, too. Therefore, we also develop weapons that can kill them 34, 340 or 3400 miles away with just the push of a button over here.

The troops’ individual nicknames for each other dehumanize them and often make them sound like cool dudes. Ask your combat veteran for examples of these.

The night-vision scopes reduce the night killings to video-game-like arcade shots. The kill is just more points toward getting the fantasy R ‘n R, isn’t it?

“Sanitization” – each side in each war develops many “catchy” words to describe their weapons, their operations and the plain-old-killing involved in war. Any name or nickname of any weapon is a good example.

A weapon that is an upgraded version of our civil-war’s Gatlin gun mounted in a slow-moving transport plane gets labeled “Puff the Magic Dragon” in the Vietnam era to romanticize it (with a tinge of sarcasm due to use of an anti-war singing group (Peter, Paul and Mary) song title.

It’s now called a “Spectre” gunship to make it sound exotic. It can kill lots of people at one time. It can put one 50-calibre round in each square of a football field each second it fires. Pretty cool name for a pretty cool weapon, huh? Not if you are on the receiving end.

An upgraded jeep that can climb up very steep inclines, carry several troops to their death at 65 mph, was so thin-skinned that an AK-47 round would go all the way through it during the Battle of Mogadishu until they upgraded their armor in OIF (much less the RPGs and IED’s blowing them to pieces) got called the Humvee. Its civilian version got labeled the “Hummer”. Cute names, huh?

The 15,000 pound bomb that has a minimal kill radius of 300-900 feet (FAS, Military Network) gets labeled “The Daisy Cutter”.

The airplanes all have cool, dangerous sounding nicknames. The Mustang, Tomcat, Hellcat, Phantom, Sabre, Supersabre…on and on. All of the combat planes have them.
Putting a lethal round into as many of the enemy as possible gets called “Taking Care of Business”, “Earning Your Paycheck”, “Kicking Ass”, “Taking Care of the Bad Guys”, to name a few. It’s all just a near-random, lethal dance of anger until someone quits.

“Minimization” – those previous phrases (“taking care of business”, etc.) are also minimizations (defined by me as “describing a complex act in simple, understated terms”). The WWII boys were notorious for it (storming the machine guns at Omaha beach was “bad”. These are all generic understatements. However, I have also heard specific understatements that mask the veterans’ physical and mental pain. For example, one WWII trooper who was on some of the first waves at Omaha Beach on D-day, was wounded but survived and told his family he just got “grazed” by a bullet but went on to become a spy.

After he got back home, he would go around doing the Nazi salute and shout, “Heil, Hitler”. He would spit in other people’s beer at the bars and then finish it off because they wouldn’t want to touch it after he contaminated it. He would sell all of the furniture in the house for more liquor. He could throw things and hit his children from many yards away with anything he could get his hands on if they got noisy.

Many years after his death, I worked with his son and family and started inquiring about his father’s military experiences. A family friend who knew the father before and after the war said he came back very changed. She also said he had one eye blown out by an explosion on Omaha beach, stuck it back in and continued to fight until his disability (brain damage) was noticed.

A simple little bullet grazing his head didn’t cause his bizarre actions. They were due to extensive but undocumented brain damage severe enough to blow one eye out of his head.

So, anyway, then the troops pack up, load up and ship out. They go back to the states, back to parents, back (they hope) to wives and girlfriends, back to kids, back (they hope) to jobs, back (they think) to peace and quiet. They get the brass band.

When the music stops and when those defense mechanisms aren’t needed any more, the memories, thoughts, and feelings about the soldier’s experiences come creeping, flashing and flooding back. They become

UN-NUMB!!!!!!!!!!

The defense mechanisms fade and crumble, tensions build, the “triggers” go off, the emotional damage gets felt for the first time.

I find it so tragic and ironic that the past catches up with trauma victims most often when it is quiet, when they really are safe from further harm from that arena.

Then the “working through” begins. Much of it involves PTSD; much of it involves grief, guilt and shame.

“Denial” – There is the notion that sometimes a bullet “has your name on it” and there’s nothing you can do. That’s denial. If you look and listen to the Vietnam era movies, you hear troops saying, “It’s nothing”, “It don’t mean a thing” and other phrases that the
real combat vets have to say to themselves to try to keep from breaking down in combat or on patrol.

I heard another, much more blatant one on a video produced by a combat trooper in Iraq aired on the Military Channel sometime in the week or two before August 1, 2007. He and his unit were providing protection for a privately owned supply company in Iraq. They were trying to protect four-mile-long convoys from IEDs, snipers, RPGs and “insurgents” attacks. He stated that they get hit by at least one IED per trip. His denial phrase was something like, “You just have to tell yourself they aren’t going to get you today”.

If anyone knows the name of that film and the trooper, please email me so I can give him credit.

**Hypothesis 2: The wounded now are worse off than before.**

I’ve lectured about PTSD for several decades. Early in my career, I coined a phrase that didn’t work right (“The lucky ones only get killed”) and it was insensitive and too clumsy to convey that real message. A Vietnam veteran friend of mine recently readjusted it to the following:

“The lucky ones in war don’t get wounded”

That, too, doesn’t have much pizzazz to it because it’s too obvious. Getting wounded is a bad thing. All soldiers who don’t get wounded feel fortunate if not downright lucky. I’ll work on it and get back to you if I get something better.

The real issue I want to convey is

"The wounded (since Vietnam) are probably worse off than the wounded in previous wars because they have such a higher (physical) survival rate from severe wounds (that will lead to greater physical and emotional suffering) compared to soldiers the fought and got wounded in previous conflicts.”

The wounded ones in pre-Vietnam days were more likely to simply die. The Vietnam-and-after wounded will need more attention for their physical and emotional wounds than the pre-Vietnam troops thanks to a) the helicopters, and b) our vastly improved understanding and treatment of physical traumas.

The WWII combat vets hoped for the “Million Dollar Wound”. It was a wound that wasn’t bad enough to kill or severely maim you but bad enough that they wouldn’t send you back into combat.

Helicopters were nonexistent in WWII operations. They were used in military action during the Korean War, but primarily for medical transport. There weren’t many of them compared to their presence in Vietnam and hereafter. They get wounded troops out of the hostilities much quicker after the wounds and (often) with much less trauma than the WWII open jeeps bouncing along muddy, rutted roads.
What is the wounded/wounded who died ratio? All numbers are suspect, but I think the Department of Defense’s own numbers tell an adequately accurate story of that ratio for purposes of my point. The ratio for both the Civil War and WWII was between 4:5 and 1:2. That means that almost half of those who got wounded eventually died. Vietnam’s ratio was 1:5. That means that only one out of five of those who got wounded died. The current conflict’s ratio is even “better” (1:8). This means that only one out of eight wounded eventually died. The chart below gives some raw numbers.

<table>
<thead>
<tr>
<th>Combat-Wounded</th>
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<tbody>
<tr>
<td><strong>Civil War:</strong> 43,012 (source: Fox’s Regimental losses, Chapter 2 at <a href="http://www.civilwarhome.com/foxschapter2.htm">http://www.civilwarhome.com/foxschapter2.htm</a>)</td>
</tr>
<tr>
<td><strong>WWI:</strong> 20 million wounded Source: <a href="http://encarta.msn.com/encyclopedia_761569981/World_War_I.html">http://encarta.msn.com/encyclopedia_761569981/World_War_I.html</a></td>
</tr>
<tr>
<td><strong>WWII:</strong> 671,801: source: <a href="http://www.skalman.nu/worldwar2/stupade.htm">World War II Factbook</a></td>
</tr>
<tr>
<td><strong>Korean War:</strong> 79,526</td>
</tr>
<tr>
<td><strong>Vietnam:</strong> 304,000 (75,000 “severely disabled“) Source: STATISTICAL DATA ON STRENGTH AND CASUALTIES FOR KOREAN WAR AND VIETNAM @ <a href="http://www.army.mil/cmh-pg/documents/237adm.htm">http://www.army.mil/cmh-pg/documents/237adm.htm</a>. Statistics about the Vietnam War @ <a href="http://www.vhfcn.org/stat.htm">http://www.vhfcn.org/stat.htm</a></td>
</tr>
<tr>
<td><strong>Iraq</strong> 27,000 (as of 7/24/07) Source: CNN</td>
</tr>
</tbody>
</table>

However, there is a flip-side to the higher survival rate. The severely wounded who would have died in pre-WWII conflicts survive now but have serious and life-long physical and mental disabilities. As with all physical deterioration, the medical profession can sustain duration of life, but quality of life is so poor as to be “poor” (I call it grotesque, degrading, depressing, demoralizing and sadistic) at the end for many of the victims.

By the way, many of the surviving elderly do not opt to continue living in that state of misery because the highest rate of suicide (in America) is in the elderly, especially college educated males.

There are many articles available on line if you want to look at this issue further. For example, please refer to Ann Scott Tyson’s *Washington Post* article (U.S. Casualties in Iraq Rise Sharply: Growing American Role in Staving Off Civil War Leads to Most Wounded Since 2004) http://www.washingtonpost.com/wp-dyn/content/article/2006/10/07/AR2006100700907.html for further discussion of this issue. Or simply search “wounded/killed” ratio.
Conclusion

The conclusion many of these writers (and I myself) come to is that the better ratio now doesn’t mean there is less misery for the survivor. I just don’t want the average viewer of the CNN shows such as “Combat Hospital” (or the surviving veteran and their family) to think their battle ends when they come back home. I don’t want those surrounding the surviving veteran to think he has it better with his wounds (the visible or invisible).

Unfortunately, it can and will be a life-long (for all wounded), life-losing struggle (for some) if they don’t get help from their invisible wounds.

If you don’t know the agony that long-term survivors of most serious physical injuries endure, go to the orthopedic rehab unit of your nearest hospital. Visit with the head- and spine-injured. Follow their progress (or decay) for 10 years.

Their pain gets worse, their tolerance for pain gets worse, their need for pain medication increases, their addictions to pain medications always get worse (because all pain medications are addictive), their use of illegal drugs often gets worse, they often get clinically depressed (because losing control of your body and having chronic pain is truly and unavoidably depressing), and their blatant suicide or accidental suicide is high.
Bibliography


Lunde, D.T. Murder and Madness. Scribner’s Sons (NY) and W.H..Freeman (San Francisco, 1975)


Relevant Readings (may be some duplication across topics)

Anger:


**Heightened Physiological Reactivity:**


**Shame and Guilt:**


**PTSD and Partner Abuse**


Resources

Fox’s Regimental losses, Chapter 2 at http://www.civilwarhome.com/foxschapter2.htm
ON STRENGTH AND CASUALTIES FOR KOREAN WAR AND VIETNAM

World War II Factbook @http://www.skalman.nu/worldwar2/stupade.htm, nd

Statistics about the Vietnam War @ http://www.vhfcn.org/stat.htm, ND

CNN: July 25, 2007: 27,000 wounded in Iraq


“Suicide Wall: suicide statistics” at http://www.suicidewall.com/SWStats.html

World War I, Encyclopedia Article
http://encarta.msn.com/encyclopedia_761569981/World_War_I.html
Posttest

1. All of the following terms are historic names for the disorder we now call PTSD EXCEPT:
   a. Shell shock
   b. Pareisis
   c. Thousand Yard Stare
   d. Vietnam Vet Syndrome

2. Which of the following was/were changed in the transition from DSM-III to DSM-IV conceptualizations of PTSD?
   a. DSM-IV criteria were changed to emphasize combat trauma sequelae
   b. DSM-IV added criteria for Survivor Guilt
   c. DSM-IV criteria were modified to be applicable to other trauma survivors
   d. All of these

3. The author emphasizes the strong positive correlation between:
   a. The levels of violence witnessed and psychological trauma
   b. The persistent threat of physical injury and psychological trauma
   c. The amount of tissue trauma experienced and psychological trauma

4. Partial sensory flashbacks are labeled in the course as:
   a. Bleed-throughs
   b. Hallucinations
   c. Meltdowns
   d. Dissociations

5. The author suggests that it is the _____________ component of PTSD that is the most misunderstood and vastly underestimated aspect of PSTD sequelae.
   a. Psychological reactivity
   b. Psychosomatic reactivity
   c. Dissociative reactivity
   d. Physiological reactivity

6. When the body feels as if it is in danger, the mind can perceive even innocent or harmless people/places/things as dangerous. This phenomenon is called:
   a. Sensory misperception
   b. Transference-based misperception
   c. Affective misplacement
   d. Transference

7. When events that are “similar enough” to the initial trauma trigger adrenalin responses, even though the person isn’t really in another life-threatening situation, it is called:
   a. Stimulus transference
   b. Operant Conditioning
   c. Physiological arousal
   d. Stimulus generalization

8. Which of the following can be included in “feelings of detachment or estrangement from others” – as indicated in the DSM-IV criteria?
   a. Emotional numbing
   b. Preoccupation with what is happening to soldiers still in the fight
c. Belief that civilians cannot understand what the veteran went through
d. All of the above
e. None of the above

9. The classic example of “Persistent avoidance of stimuli associated with the trauma” common across all combat vets is:
   a. Flinching at the sound of a helicopter
   b. Avoidance of being in front of windows
   c. They don’t like the 4th of July
   d. They don’t like parades

10. According to an estimate in a 2004 study published in the *New England Journal of Medicine*, one out of ________ combat troops is showing symptoms of PTSD.
   a. 8
   b. 10
   c. 12
   d. 15

11. The author lists a number of reasons why natural disasters typically produce less intense, shorter-duration trauma than manmade disasters. Which of the following is among them?
   a. There are many warning signs of impending manmade disasters
   b. There are many possibilities for “extinction” of the traumatic pairing in the case of natural disasters
   c. Natural disasters are frequently intentional
   d. All of the above
   e. None of the above

12. Helicopters do not serve as triggers for World War II veterans.
   a. True   b. False

13. ________________ are emotional and cognitive reactivations of trauma responses caused simply by certain times of day, month or year.
   a. Emotional Tsunamis
   b. Triggers
   c. Operant responses
   d. Anniversary reactions

14. Over a number of repeated exposures during the process of response extinction, later exposures are __________________ earlier exposures.
   a. more intense, but of shorter duration than
   b. of longer duration, but less intense than
   c. both less intense and of shorter duration than
   d. of about equal intensity and duration as

15. Which of the following is/are among the reasons why official suicide statistics on returning war veterans are thought to be unrealistically low?
   a. Many suicides may have been single-car drunk driving deaths
   b. In many cases with no suicide notes the deaths were seen as accidental
   c. The phenomenon known as “suicide by cop”
   d. All of the above
16. According to the author, the risk of danger to others is the highest in which of the following groups of traumatized veterans?
   a. Those with the most tissue damage
   b. Those with brain damage from either penetrated or closed-head trauma
   c. Those who witnessed the deaths of other soldiers in their unit

17. All of the following are identified by the author as times or situations in which murders occur most frequently EXCEPT:
   a. On weeknights
   b. In July and December
   c. Victim and perpetrator are acquainted
   d. In Southern states

18. Which of the following defense mechanisms used by soldiers to reduce their resistance and inhibitions to killing others involves the use of derogatory nicknames for enemy soldiers?
   a. Rationalization
   b. Sanitization
   c. Dehumanization
   d. Intellectualization

19. Which of the following defense mechanisms used by soldiers to reduce their resistance and inhibitions to killing others involves the use of “catchy” words to describe their weapons and operations?
   a. Rationalization
   b. Sanitization
   c. Dehumanization
   d. Intellectualization

20. The author concludes that the higher wounded/wounded-who-die ratio in recent wars does not mean less misery for the survivors.
   a. True
   b. False