The Puzzle of PTSD

Does the PTSD diagnosis do more harm than good?

By Roy Clymer

At eight o'clock on Tuesday morning, I walk into a nondescript room at Walter Reed Army Medical Center to greet seven soldiers and marines who've been back from Iraq or Afghanistan for a year. Sprawled around a large, coffee-stained table, looking wary, the vets are here because they, or someone else, said they have post-traumatic stress disorder (PTSD).

This is the first meeting of an exposure therapy group I'll be facilitating, and I'm anxious because if the treatment goes well, it'll be painful for them, and everyone prefers to avoid pain. These men and women have been treated with medications or intermittent counseling to help them deal with the emotions and conflicts they fear, but they remain symptomatic. Now they've landed at Walter Reed's Deployment Health Clinical Center to participate in a three-week, multidisciplinary program that helps vets adjust to life after combat. They're guarded, skeptical, but not without hope.

I meet their hope with my faith that I know how to help them. My approach is different from most because it's premised on the belief that the way the field currently understands the effects of war and communicates that to veterans can, however unintentionally, undermine their recovery. I believe the *diagnosis* of PTSD actually hampers our ability to help these vets do the hard work of facing their demons, coming to terms with their experience, and ultimately healing.

I start the group by explaining how exposure therapy came to be the treatment of choice for people suffering the ill effects of horrible events. I describe it as a process by which people can begin to contact their feelings about the devastating events they've experienced, and how embracing those experiences eventually enables them to move on with their lives. When I finish, John, a wiry guy with a blond crew cut, thumps his fist on the table. "Move on?!" he asks incredulously. "What's that about? I will *never* forget! I'm a living shrine to all my buddies who died in Iraq. They can't be forgotten!"

Before I can respond, he launches into his story. Last year, just outside Baghdad, an Improvised Explosive Device (IED) shattered the truck in front of him. He raced to pull the

bloodied soldiers from the vehicle. One of them, his best friend, Larry, was barely alive. John rendered first aid, but Larry died on the medevac flight out.

That was just the beginning. As John picked up another friend's dismembered body and asked a soldier to help him recover the pieces, the soldier croaked, "I can't!" and ran off. Meanwhile, John's platoon sergeant, who should have taken charge, sat frozen in the seat of his Humvee, unable to move or speak. John had to take charge of the rescue and arrange the medical evacuation on his own.

Amid this barely contained chaos, the Quick Reaction Force arrived. *At last!* John thought with relief. Then he watched in horror as their vehicle was almost immediately hit by another IED, engulfing it in flames. "I ran back and forth, trying to approach the men in the truck, but then I had to jump back when the heat became unbearable," he recalled. "Only one man made it out." He stopped, fighting tears. "And that guy burned alive in front of me."

Ann spoke next. She'd come into the program after two years of treatment for third-degree burns that had covered 30 percent of her body, especially her face and arms. She'd suffered the burns in Kunar Province, Afghanistan, when she'd poured gasoline on a 50-gallon drum of human waste, causing the pile to spontaneously ignite. She told us that she'd been directed to burn the waste by a sergeant "who ignored my statement that I'd never done this task before and had no idea how to do it." In fact, the policy at the time explicitly prohibited soldiers from burning such waste, due to numerous reports of burning accidents. "He should have known this," she said angrily. "Actually, I think he did. He already had problems with me. Maybe this was payback."

While in the hospital recovering, Ann discovered that the day after she'd left her base, a vehicle loaded with explosives—in Army parlance, a Vehicle Borne Improvised Explosive Device (VBID)—had crashed the base's gate, killing many of her friends. She still felt guilty for not being there to help. Then, taking a shaky breath, she added in a near whisper: "But I'd rather have been burned than gone through another VBID."

As we sat digesting the horror of such a choice, Ann continued. Two months earlier, she'd just come off watch when a VBID destroyed the tower she'd just left, killing, among others, the sergeant who was her mentor and best friend. "He'd protected me from harassment in the unit. He always stood by me," she explained. She'd given first aid to this sergeant, but he died in her arms.

While recovering from these horrors, she reached out to her family for support. "But every time I tried to explain what had happened and how bad I felt, my parents and husband got angry with me, telling me to get a grip; that what was past was past. So I shut up," she said. Not long afterward, she became deeply depressed.

Our Ambivalence

John and Ann's stories stirred intense feelings in me, as I imagine they do in you. Our reactions are the real topic of this article, because they determine how we think about people who've experienced horrific events, and how the mental health profession defines and treats their problems. Imagine now that these events happened to you or someone you care about deeply. Do you notice any attempt to avoid or move quickly away from the pain, fear, and horror these stories evoke in you? Do you want to distance yourself from the reality of what happened, to diminish or mute the feelings getting stirred? Are you aware of any conflicted feelings about how John and Ann have coped—do you feel sympathetic, yet a little bit critical or judgmental? Are you asking yourself how you might deal with such horrors?

Ambivalence is at the core of our response to such stories. When we hear of a horrific event, we may try to understand it by imagining what it would be like for us to have that experience. We'd like to think that we could surmount such catastrophes, but if we're at all aware of our own vulnerabilities and limitations, we probably doubt that we could, yet we're aware of our internal judgments and how we tend to hold others responsible for their ability to manage life's challenges.

To complicate our feelings even more, we may fear that our struggle to get over something might engender negative judgments from others. Just hearing such stories can raise conflicting feelings, causing us to bounce from sympathy to implicit antipathy. Added to that is the uneasy feeling that *we* might someday be on the receiving end of other people's impatient remarks like, "Bad stuff happens to everybody, but they get on with life—what's wrong with him that he can't get his act together after all this time?"

In subsequent work in the group and individual therapy, John focused on his anger at his chain

of command. He felt deeply betrayed by his platoon sergeant's failure to come to his aid. "That son of a bitch! He let us all down. Because of him, Larry died. And I had to pick up another soldier's body and tuck his guts under my arm."

As a Vietnam combat veteran, I could easily understand his rage. I knew a thing or two about people's failures under fire. "If anything," I said, "you're letting him off easy. He didn't just 'let you down.' That's calling him on a misdemeanor, when you've got him on a capital offense. What he did was dereliction of duty under fire. Not too long ago, he could have been shot on the spot for that."

John listened to that and nodded.

"But how does that help you?" I asked. "It could be that if he'd done his duty, things might have been easier for you. Maybe that's true. But Larry probably would still have died, and you'd still have to deal with that. You haven't mourned his loss yet. Every time you get near to feeling your grief for him, you jump to your anger at the sergeant."

John didn't like that, and immediately changed the subject to his battalion's commanding officer. "That bastard would volunteer us for extra missions—unnecessary ones, dangerous ones! Everyone in the battalion knew why: so he could get promoted. That fobbit, who never once went outside the wire, sat on the base and sent us out to get killed so he could make colonel." (A *fobbit* is a pejorative term for a soldier who never leaves the safety of the Forward Operating Base.)

"They're all liars, all corrupt," he muttered. "That's why I don't trust anyone anymore. And to think I used to want to go into politics, be a leader!" He snorted derisively. "Now all I want to do is go back to my family farm in North Carolina and raise sweet corn." It's on that farm, however, that John's story really begins. His father was a Vietnam veteran, an alcoholic, and a recluse, who'd always belittled and verbally abused him, yet John idealizes him as a hardworking provider and practitioner of "tough love."

Ann's backstory, too, complicates the picture. As the therapy group continued, she revealed deep anger at her husband, who regularly attacked her verbally, calling her a "fruitcake" and much worse. Other group members were appalled by the cruelty he inflicted and she tolerated.

She was openly contemptuous of him in group, but rebuffed any of the group's suggestions or attempts to help, appearing willing to remain locked in a bitter, antagonistic relationship. However, her endurance of her husband's abuse seemed more understandable when she revealed that her father had been a bigamist, who'd surrounded himself with several subservient wives and explicitly espoused the subjugation of women. Her history shed light on her experiences in the Army, which included sexual harassment and male superiors' blatant disregard for her safety.

We may feel tempted to believe John and Ann are at increased risk for PTSD because of their early family life. Since their current troubles have plausible roots in difficult childhoods, we may be inclined to regard them as more fragile than others, lacking "resilience," and less able to "take it" when the going gets rough. This commonly held opinion isn't so different—except for the modern psychologizing gloss—from the way societies throughout history have viewed soldiers who fail the test of battle. In every era, across virtually all cultures, people by and large believed that there could be only one reason that a person feared going to war, abandoned the fight, or had serious "adjustment" difficulties afterward: he was a coward, and his behavior reflected a failure of courage and character.

Consider the viewpoint of the Greeks of Homer's time, a warrior culture if ever there was one. In that heroic age, it was universally assumed that any war-related mental suffering of the kind currently labeled PTSD stemmed from an inherent moral deficit or weakness of character. According to some authorities, *The Odyssey* is a disguised account of Odysseus's struggle with PTSD. They see him as a psychological wreck, crippled by war-induced hallucinations, flashbacks, irrational fears, nightmares, depression, and explosive anger, all of which are recast as a series of adventures with externalized monsters. Using metaphor and exaggerated adventures, Homer succeeded in composing an epic poem about a crippled hero that's endured through the ages.

Most veterans still firmly believe that only the weak suffer psychological wounds from war. In my work with them, it's clear that they expect to be subject to that judgment by their military peers. Indeed, even *physically wounded* vets who've been medically evacuated for treatment are reluctant to go back to their units because they feel such shame for having "abandoned" their buddies, and fear that they'll be judged harshly by their fellow soldiers. The shame and fear of being condemned by their fellows is even greater for those who've been removed from their units for "mental problems."

The idea that a "deficit" of character or moral fiber explained why men fell apart during or after battle reigned unchallenged until World War I, when, for the first time, modern psychiatry offered an alternative: war neurosis. As a result of Sigmund Freud's influence, psychiatrists had begun the process of "medicalizing" humankind's response to extreme experience, suggesting that war neurosis was similar to ordinary neurosis: a resolution to an insoluble, intrapsychic conflict. In the case of combat, the conflict was between one's acknowledged duty and the desire to escape the danger and ghastliness of war. Given the ubiquity of that inner conflict, "It's amazing that more haven't succumbed," observed one physician.

After the Vietnam War, thousands of vets complained that dynamically trained Veteran's Administration therapists often focused on problems in their childhood, suggesting that the vets' emotional breakdowns were caused by preexisting psychological issues, and that the war was only a secondary, or triggering, factor. The fact that not everyone who saw combat developed symptoms reinforced the view that those having problems must have been made vulnerable by a precombat deficit. This "weakness" was then attributed to upbringing, rather than to moral deficiency.

Reacting to this profoundly discrediting stance, veterans' advocates during and after the Vietnam War promoted a new view: emotional and behavioral disturbances after combat were a normal response to the grisly realities of war. They asserted that the veterans had been all right *before* the war, and if they were having troubles afterward, it must be *because* of the war. This position gained support in the medical community, resulting in the decision by the American Psychiatric Association to adopt the diagnosis of PTSD in 1980—another step in the medicalizing process intended to destigmatize the psychological effects of war. At a stroke, life-altering changes in psychological functioning that resulted from the grotesqueries of combat were simultaneously normalized *and* pathologized: it was expected that vets would come home from war deeply impaired (even though many didn't), with a condition officially deemed a psychiatric disorder.

The Problem

There's no doubt that people who go to war are emotionally affected by it—the more intense, terrible, and enduring the experience, the more those who return are troubled, and the more deeply troubled they are. But this has nothing to do with weakness or deficit—moral or psychological—and everything to do with the brutalities of combat. Central to that experience is

the killing of others and the risk of being killed by others, prospects that inevitably stir strong emotions and conflicts—a truth reflected in the arts from the epic poem *The Iliad* (ca. 700 BCE) to the film *The Hurt Locker* in 2009.

War evokes a complicated and conflicted jumble of intense feelings, thoughts, and judgments, which may persist long after, as the person struggles to make sense of it all. The most obvious element of this mix is, of course, fear. Hardly mentioned in *The Iliad* except by women, fear is somewhat more respectable these days, unless, of course, you're a young man who's motivated to "prove your manhood" or become one of "The Few. The Proud. The Marines," as the recruiting slogan says. No matter how a servicemember deals with the *feelings* of fear, however, *showing* fear almost certainly causes shame. So when a servicemember returns to "the world" and finds himself "hitting the dirt" at a loud noise, too afraid of crowds to go to the mall, seeking the seat next to the wall at a restaurant, afraid to drive or cross a bridge, or locking all the windows and doors at night, these fears threaten to become public and hence are powerfully laden with shame.

Fear is a powerful emotion, but it comes and goes: vulnerability, however, is an unchanging, existential fact of life. As thinking, feeling human beings, we all suffer and die, sooner or later. At the same time, if we're young, healthy, and cocooned by privilege (as we tend to be in the West), we can ignore our susceptibility to pain and death. Young males especially seem to wear the invisible armor of assumed invulnerability. But genuinely terrifying experiences—close calls that directly threaten life and limb—evoke the undeniable feeling of fear, which, if intense and sustained enough, can pierce that armor, often permanently. It's common for combat soldiers to hold lost-their-cherry ceremonies for inexperienced soldiers after their first firefight. The change in perspective celebrated in these events is at least as profound as that of the physical loss of virginity, if not more so. Never again will that young man walk quite as freely, with quite the same sense of careless invincibility.

When you're being shot at, you're vulnerable and you know it, but getting angry and shooting back is more adaptive than cowering in fear. After a tour of duty, when his vulnerability has been repeatedly rubbed in his face, a vet frequently has a low tolerance for feelings of vulnerability back in the world. When he reexperiences those feelings by seeing his children running into the street, or even by recognizing his affection for his wife or girlfriend, memories arise of other times he felt vulnerable. If he's unwilling to tolerate the fearfulness associated with vulnerability, he may become angry—yelling at his children and scaring them—yet remaining unaware of

what caused him to do so. After such incidents, feeling confused and ashamed, he's likely to withdraw from his family "to protect them."

Then there's killing per se. In his 1995 book, *On Killing: The Psychological Cost of Learning to Kill in War and Society,* Lt. Col. Dave Grossman presents evidence suggesting that humans are strongly disinclined to kill others of their species, and must be trained to do so. Other evidence indicates that war encourages altruism and cooperation because it causes individuals to "selflessly" risk their own lives to fight those who threaten the well-being of the whole group, thus furthering the evolution of the species. However, killing others is probably the most proscribed human behavior—except, of course, when it's justified by self-defense or war. In the fog of battle, these justifications can become extremely tenuous. John's story suggests a conflict within himself about the legitimacy of killing and the justification for dying when he perceives that he and the other soldiers are being forced to fight, not for the common good of the group, or even for their individual survival, but to further their commanding officer's personal agenda.

Another problem a veteran may face when returning to civil society is rage. Combat is a powerfully ambivalent, emotional experience. Being threatened evokes an intense consciousness of personal vulnerability, which usually triggers some degree of fear. However, fear feels, and often is, disempowering, so during combat, soldiers are likely to tap into their anger, choosing to fight, rather than freeze or flee. In the immediacy of a life-and-death firefight, anger can quickly elevate to an all-consuming rage. Take the need to avenge a fallen comrade, add lethal weapons operated by a soldier whose only constraining authority is that of his immediate comrades, and the result is an intoxicating, powerful, often deadly cocktail, with little accountability because what a soldier and his buddies *say* happened is usually accepted as what *did* happen. That's a lot of power, with a lot of potential for abuse.

When a soldier comes home, he must give up the power to kill when angered, and that's much harder to do than generally recognized. Over there, he could, and perhaps would, shoot someone simply because he felt threatened by their demeanor or behavior. Now, like the rest of us, he must endure the endless slights, inconveniences, and outrages of daily life in civil society (think highway driving). All of these may stir anger: he doesn't have to endure this! He shouldn't have to endure this! So the question becomes: will he put the genie back in the box—the murderous aggression that was encouraged during combat—and find a way to tolerate the constant stream of indignities he faces now in everyday life? Some don't. Some retire into the woods to get away from it all, as John is considering. Whatever the outcome, it's definitely a struggle.

Friends and family of veterans who are experiencing feelings of extreme vulnerability, rage, hypervigilance, and many of the other emotions that often follow the experience of combat, don't know what to make of their strange behavior and want their loved one back. The veterans are fearful of talking to anyone, believing others can't understand and will judge them for what they've done. They're hurting, confused, and looking for answers. Eventually, they'll work their way to a mental health practitioner. What happens then is extremely important because there's nothing inherently disordered about their feelings or conflicts. None of them signal any psychiatric problem or deficit. These are the conflicts *inevitably* faced by those who go to war. Veterans struggle with them and seek resolution to what are fundamentally human problems, but what they encounter when entering a therapist's office may, in fact, lead them away from grappling with these very issues.

The Trouble with Trauma

What does the veteran hear when he's told that he has PTSD? *Disorder,* as defined by the *Diag nostic and Statistical Manual,*
means an abnormal condition that impairs function.
Trauma
is a medical term used to describe the physical damage caused by energy impacting tissue (a bullet shot into a soldier's flesh, for example). It implies a serious, even grave injury—a deep chest wound, not a paper cut.
Traumatic
is defined as "of, caused by, or causing trauma." In the diagnosis of post-traumatic stress disorder,
traumatic
is an adjective describing a particular level or kind of stress that causes damage.
Stress
is defined as a psychophysiological response to a perceived threat, experienced internally and subjectively. If I perceive a threat, it's reflected in my adrenaline and cortisol levels, and the intensity of my resulting stress is determined solely by my perception of the threat. I'm a bit "stressed out" as I try to write this article. Being in an automobile accident would stress me out even more, and it's easy to imagine far worse stressors. These stressors clearly differ in degree, but do they differ in kind? At what point do we cross some line where "normal," subjective stress becomes "traumatic"—a different animal altogether?

So, we have in PTSD the badly fitting juncture of two distinct concepts: a physical wound (which actually doesn't exist) and a varied and variable set of psychological and behavioral symptoms. We might simply replace *traumatic* with another, less evocative and misleading word, like *sever*

e. But *traumatic* seems qualitatively different. There's ordinary stress, and then there's traumatic stress, which is not only more intense than ordinary or even severe stress, but at a level defined by its supposed effect: damage, harm, a wound, or injury that may leave lasting scars. An arbitrary distinction in levels—severe, as opposed to moderate or low stress—becomes a real, somehow concrete entity. Further, when we talk about traumatic *exposure,* we imply that simply being exposed to an event causes damage. The active, thinking, feeling person is removed from the equation, becoming a passive, damaged organism.

Thus, at some arbitrary point, stress becomes trauma, a response becomes damage, the temporary becomes enduring, and the subjective ("I feel stressed") becomes objective ("You have PTSD"). Then the power to define what's happened shifts from the person to the mental health provider, and the person's self-perception shifts from responsible agent to damaged victim of terrible circumstances who's in need of help, now and probably in the future.

What's in a Diagnosis?

It's this implication of passively received damage implied by the word *trauma* in the PTSD diagnosis that I directly challenge. Indeed, the severely stressed person has shot out a lot of adrenaline and cortisol, experienced multiple, intense emotions, and perhaps lost someone close—all of which is shocking, frightening, painful, difficult, and a huge challenge to cope with. But how is it inherently damaging? Undeniably, we have increasing evidence that neurobiological changes can reflect intense or repeated exposures to threats, but the relationship between these changes and the symptoms of PTSD remains unclear.

Unlike any other mental health condition, PTSD *requires* an external event to obtain the diagnosis. Since the experience of an external threat of death or serious injury is necessary for the diagnosis, it's a quick step to assume it's also sufficient to cause symptoms, but it isn't. Many vets whose stressors don't meet the criteria of "traumatic" nonetheless meet symptomatic criteria for PTSD. More troubling still, many people who've endured what most people would consider profoundly horrific experiences never show significant symptoms.

So when our struggling, troubled veteran is told by a professional (who should know) that he "has PTSD," I believe he's being offered a nearly irresistible solution to his problems: his

symptoms don't mean he's weak or crazy or screwed up—he's been "traumatized" by events that would damage anyone. If the choice is between weak or sick, he'll take sick.

Thus my main objection to the way we understand and use PTSD is that it tempts all of us—providers, society, *and* veterans—to view the veteran as a victim. It provides the false balm to the soldier that he's this way because of what happened to him. He's offered a disabling but clearcut condition, which, with the doc's help, he can try to overcome. Imagine the strength it takes to *refuse* such an offer!

The PTSD diagnosis provides what appears to be an easier way out of pain and conflict than struggling with the existential, often terrible, realities of life. The fundamental, universal human dilemma—how to cope with overwhelming feelings, come to terms with inherently opposing realities, find meaning in meaningless chaos—is turned into a "psychiatric disorder" that can be "treated." Like the rest of us when we have an "illness," the veteran hopes that there's a pill that'll fix him and send him on his way. But of course there isn't. Nor is any therapeutic approach that's geared just to alleviating his symptoms likely to work. True healing requires knowing and accepting *all* our experience.

A Different Approach

By the time a patient presents at my clinic, he's usually adopted a solution that compounds the problem: he presents as a sick person, with a condition that I, the doctor, am supposed to fix. So before therapy can proceed, I must reeducate him. This requires that I challenge his belief that he's ill, his symptoms are the inevitable result of his experiences, and his injury is permanent. Challenging a veteran in this way enables him to experience more options for himself. It holds him accountable, and is an essential part of his recovery.

This isn't easy work to do. The therapist must communicate compassionate understanding, maintain a stance of interested curiosity, and gently offer other possibilities for the veteran to consider. To begin with, the therapist is curious about how the vet understands having PTSD. What does that mean to him? What's he been told it means? Does he see PTSD as an injury or an illness? Is it like cancer, a cold, or Type 2 diabetes? Is there any role he sees for himself in the treatment?

The veteran typically regards his symptoms as produced somehow by combat itself, arising mysteriously as if from a virus and in ways beyond his control. So the therapist seeks to challenge this connection between the terrible events—the "injury"—and the client's symptoms (but doesn't challenge the veteran's experiences.) The method is to ask clients to slow down and connect the dots, break up their experiences into pieces, and examine the connections as they see them. By slowing down how they tell their stories, more aspects of their experience become known to them.

The therapist invites patients to pay attention to creative and resourceful aspects of the inner experiences they tend to miss in their rush to judgment. This allows them to access the full experience, in all its complication and uncertainties—which makes new connections and understandings possible and helps patients eliminate straight-line thinking.

As an example of this process, let's return to John. One source of his anger at the Army was how difficult the brass had made it to take emergency leave to be with his dying father, so I asked him more about his relationship with his dad. "He was a tough man," John finally admitted. "He constantly criticized me; nothing I did was good enough. After one baseball game in high school, where I'd pitched a no-hitter but allowed one walk, he ranted on and on, 'Why did you allow that walk and blow a perfect game?' That's when I finally lost it. I turned to him and yelled, 'If you don't stop criticizing me, I'll never play baseball or football again!' I meant it. He got a little better after that—but not much."

"So you were aware that your father got something for himself from your accomplishments?" I asked.

"Yeah," he said, "I'd seen him brag on me to his friends."

"Some of that must have felt good," I suggested, "But were you aware of any resentment about that?"

"Oh, yeah. I hated that he was so damn hard on me, and then took credit for what I did."

"Does that sound like he was protecting you the way he was supposed to?" I asked.

"No, it doesn't," he replied.

We explored other ways his father was supposed to protect John, yet repeatedly and painfully let him down. Eventually I asked: "Do you think your anger at your father played any part in your anger at your platoon sergeant?"

John looked away and shifted uncomfortably in his chair. "I never thought of it that way," he murmured.

"And could it be," I pressed, "that the problem isn't that no one's trustworthy, but that you've grown afraid to trust yourself? You believed you could trust your father, the sergeant, the commanding officer to live up to their roles, and they let you down. Or perhaps you thought that you were to blame for the way you were treated. To protect yourself from ever having your judgment proven wrong again, you adopted a policy of characterizing everyone in power as untrustworthy. It's safer, but at what cost to you?

"It's easy to write everyone else off, harder to be responsible for your own judgments about who is and isn't worthy of your trust. It's harder still to tolerate the uncertainty and vulnerability that come from making such moment-to-moment judgments."

John was nothing if not a fighter, and he didn't just lie down in therapy. He continued to resist my efforts to challenge his self-protective but ultimately self-defeating belief that he'd been screwed. But as I continued to challenge him and remind him of his courage and resiliency, given what he survived in childhood, occasionally he'd let go of his defenses and grieve his losses. Eventually he began to see his symptoms as solutions to the problem of how to prevent the reccurrence of the pain he'd suffered. By extension, he began to view "having PTSD" as a way of coping with more than he could handle at the time.

The knowledgeable reader will note that the therapy I describe above is hardly specific to treating PTSD. Indeed, it's nothing other than basic psychotherapy. This is central to my point. I believe all therapy is a dialogue between two people trying to determine what works and what doesn't as we try to live the best lives we can. I think that when we use any of our limitless ways of avoiding difficult experiences, however self-protective initially, it keeps us from taking responsibility for our lives and ultimately is costly because we become powerless to change. The "injury" of PTSD, like bad parenting, can become *the* reason a life is the way it is. If so, patients become as calcified and stuck with the lives that bring them to our offices as they are with the diagnosis we may "give" them.

A major point of my argument, however, is that it isn't enough for us to know about these issues as they affect the PTSD patient. Because we're all subject to the fearsome risks of life, we all share the combat veterans' vulnerabilities and temptations. Population surveys indicate that roughly 80 percent of Americans have experienced an event qualifying as "traumatic." A survey conducted at an ordinary meeting of highly qualified and experienced therapists revealed that they scored, on average, almost two standard deviations above the mean on a measure of adverse childhood experiences.

Thus these are *our* issues too: they're *everybody's* issues. But we're as guilty of avoidance as our patients are if we, as a field, continue to label common, profound, terrible, human experience as a "disorder." The pathologizing language of PTSD invites us to see others, and ourselves, as damaged, injured, or disabled. Even more dangerous is the risk that this way of thinking about life's most challenging events undercuts our efforts as therapists to help our patients. Indeed, it tempts us to unknowingly collude with patients in their natural but misguided effort to solve one problem by adopting a far more costly solution.

The stakes are high, for both our soldiers and us. To prepare young men and women for combat, we teach them unnatural ways of thinking, feeling, and behaving. Then we send them into the killing fields, where they're exposed to terror, death, and mayhem beyond imagination. While there, they may begin to feel like gods with power over life and death; they may experience a raging blood-lust for revenge, and possibly develop an appetite for destruction and living at the edge, as they constantly confront their powerlessness and vulnerability.

When they return—bloodied, shaken, defended, cut off—they feel that they don't fit in with those who haven't done what they've done. And they don't. They're at huge risk for alienation, isolation, bitterness, and cynicism. We owe it to them to give them a form of help that fully

acknowledges their experience of unimaginable terror and horror. More than this, however, we must convey to them that they're *affected,* but not *damaged,* and they're capable of *responsible,* rather than simply
reflexive,
behavior. In doing so, we may help reignite what's strongest and most capable in them. They survived war: they can do anything.

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