



PsyCombatant: Pre-deployment Psychoeducational Training for Service Members

Instructor's Guide

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Instructions for Use

This program was designed specifically to be presented by U.S. Army chaplains, but can be adapted for many other uses. The language throughout the modules uses “soldiers” and other Army-specific terms. For other services, please feel free to adapt to your own practice. The rationale behind having chaplains present this information is that in the Army, soldiers will almost always have access to a chaplain at the Battalion level. If the soldiers see that their chaplain is informed about the issues discussed in this training, they are more likely to regard him or her as a competent resource if they decide to seek help. In many ways, chaplains can serve as gatekeepers to further treatment, so it is hoped that by increasing the likelihood that soldiers will seek out their chaplain, it also opens the door to Behavioral Health and other professional caregivers.

The lessons are organized into three modules, **Effects of Combat**, **Effects of Killing**, and **Exposure to Trauma**. Each module has been designed to last for about 45-50 minutes. If all three modules are taught in the same day, it is important to allow a ten to fifteen minute break in between the modules so that soldiers can process what they have learned. Although this training has been designed for soldiers who have not yet deployed to a combat zone, it also takes into account and can help soldiers who are combat veterans. The slides have been designed to be non- threatening, but be aware that some veterans may be “triggered” by the discussion of these issues. You may want to brief leaders to be aware of this and to be available during breaks if their soldiers look like they need help.

The instructional modules are designed to roughly

correspond to the Army's Instructional Brief model to be more comfortable (not out of the ordinary) for both students and instructors. The disk included with this book contains three sets of PowerPoint slides. In addition, this book contains a print of each slide, along with a suggested text. Presenters who are not familiar with the subject matter could conceivably just read the text and still be effective teachers. Presenters who are more familiar with the material should feel free to adapt the text as needed. The tone has deliberately been written in a manner that is more conversational than academic. Also, at times, I have put author's notes in italic print. These are usually not meant to be read out loud, but indicate an optional text that can be used, including examples of personal stories, or prompts for your own observations.

For instructors who would like to learn more about the subjects covered in these modules, a **Supporting Research** section has been included in this book that covers some of the important sources and studies that contributed to these modules. It may be helpful for instructors who are unfamiliar with the concepts in these modules, or for those who would just like to learn more about the subjects, to read that section.

Finally, this brief has been designed with the idea of briefing a company-sized element (approximately 120 service members). However, larger groups could conceivably be taught at one time, with the understanding that interaction will be much more limited. On the other hand, this training could be effectively adapted for a small group with much more instructor-student interaction.

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Supporting Research

This review will examine literature covering the fields of psychoeducational interventions and combat-related psychological trauma and recovery, i.e. Posttraumatic Growth (PTG). The United States and its allies have now been at war for more than a decade. Not since the Vietnam War forty years ago has this country been involved in such a prolonged combat engagement. Roughly 2.5 million American warriors have deployed to Iraq or Afghanistan in support of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Many have deployed repeatedly, exemplified by the nearly 37,000 troops who have deployed *more than five times* since 2001.¹ If these men and women are affected by even minimal incidence of the psychological traumas explored in this review, clearly they do (and likely will increasingly) represent a significant challenge to the public health of this country, not to mention the inter- relational networks that make up its society.

This project has been designed as a psychoeducational intervention meant to help reduce the negative impact of combat-related trauma. In order to get a better perspective of the processes that have contributed to this project, this review will be divided into several sections. Section one, Psychoeducation, explores the historical development and current employment of psychoeducational treatment for potential or confirmed psychological casualties. Section two, Military Psychology, surveys works describing the psychological and physiological effects of combat on the soldier. Section two is further broken down into subsections

1. Chris Adams, "Millions Went to War in Iraq, Afghanistan, Leaving Many with Life-long Scars," *McClatchy Newspapers*, March 14, 2013, accessed February 10, 2014, <http://www.mcclatchydc.com/2013/03/14/185880/millions-went-to-war-in-iraq-afghanistan.html>.

covering the effects of combat, the specific dynamics of the act of killing, and related psychological difficulties such as Combat Stress Reaction (CSR) and Posttraumatic Stress Disorder (PTSD). A final subsection will explore research in the field of Posttraumatic Growth (PTG), with the intent of providing a message of hope (recovery) to those who do and will suffer from these maladies.

Psychoeducation

The modern field of mental health has in many ways evolved out of medical practice. Similarly, psychoeducation finds its earliest roots in patient education, or information delivered from medical personnel to patients to facilitate treatment of health problems.² Earlier this century, patients were often ill-informed and scarcely included in the decision making process. A paternalistic worldview perpetuated an imbalance of power in favor of the professional and legal authority of medical providers.³ As researcher and nurse Donna Falvo notes, “There was a time when neither patients nor health professionals expected that patients should be fully informed” because of a “widely held belief that patients did not have the training or background to understand the full explanation of their disease or treatment.”⁴ This traditional relationship between patient and caregiver has resulted in pervasive assumptions that cast the doctor in the role of expert, the health care system as the legitimate gatekeeper for services,

2. Barbara K. Redman, *Advances in Patient Education* (New York: Springer Publishing Company, 2004), 93.

3. Donna R. Falvo, *Effective Patient Education: A Guide to Increased Compliance* (Sudbury, MA: Jones and Bartlett Publishers, 2004), 21; see also Redman, 4.

4. Falvo, 21.

and the ideal patient as “both compliant and self-reliant.”⁵

A simple definition of patient education might be “educating patients about their condition, treatment, risks, and benefits.”⁶ A more ambitious way of stating the goal of patient education could be “to support the patient’s autonomous decision-making” by combatting ignorance as “a primary obstacle to autonomy.”⁷ Certainly this second definition involves much more than just information transfer, instead helping patients “gain knowledge so that they will be able to incorporate the knowledge into their lives through learning of skills, behavior, or attitudes.”⁸ Viewed similarly to the way medical treatments augment the body’s abilities to heal itself and recover from injury, patient education augments the mind’s ability to make good decisions and care for oneself.

It doesn’t take a trained medical professional to immediately see both a positive and negative side to increased patient education. On the positive side, an increase in education can help patients to “be fully informed about health-related matters and . . . be involved in and accept more responsibility for their health and health care.”⁹ Increased patient responsibility allows them to be “discharged from hospitals earlier and asked to assume more responsibility for their own care at home,” a shift that reinforces current trends in medical practice emphasizing “preventing illness, improving outcomes, containing costs, and increasing patient participation in informed decision

5. Sally E. Thorne, Kerstin Ternulf Nyhlin, and Barbara L. Paterson, “Attitudes toward Patient Expertise in Chronic Illness,” *International Journal of Nursing Studies* 37, no. 4 (August 2000): 303.

6. Falvo, 16.

7. Redman, 8.

8. Falvo, 16.

9. Falvo, 1.

making.”¹⁰ On the other hand, there is a belief (based in the dim view of patients’ capacity to understand discussed above) “that full disclosure of information to patients could lead to misinterpretation, causing needless anxiety and perhaps even adverse effects on patient outcome.”¹¹ As we will see, this same argument continues to influence the debate over psychoeducation and treatment for Post-Traumatic Stress Disorder (PTSD).

With modern increases in medical proficiency progressing at an astounding rate, it’s easy to forget that not long ago, “organized health care was viewed as a last resort, and hospitals were considered a final alternative before death.”¹² Many ill were treated at home, with their family members as primary providers. With increases in sanitation and wonderful pharmacological discoveries, the health care industry (with the hospital at its core), became the preferred path to healing. “As a result,” writes Falvo, “programs in sanitation, immunization, and maternal and child health became important components of the public health system” under the general term *health education*—the forerunner of modern patient education.¹³

Alongside an increase in understanding of chronic diseases in post-World War II America, health education expanded to cover not only disease prevention but also management of long-term conditions. Health education gradually narrowed in focus from public health tips for the entire national population (a worthwhile effort that continues today) to patient education directed at individuals admitted into hospitals.

10. Falvo, 21.

11. Falvo, 22.

12. Falvo, 24.

13. Falvo, 24.

A 1971 editorial in the American Journal of Public Health lauded the achievements of national health education but decried the paucity of organized education for patients and their family members, and called for higher standards and guidelines for healthcare facilities.¹⁴ Subsequently, the American Hospital Association published *A Patient's Bill of Rights* in 1975, which included patients' rightful access understandable information about their condition and treatment options.¹⁵

According to Dutch researcher H. W. van den Borne, several categories of educational interventions fall under the greater practice of patient education, including *primary prevention* (preventing direct risks to health), *secondary prevention* (reversing or stopping illness development at an early stage), and *tertiary prevention* (coping with acute or chronic conditions).¹⁶ Additionally, *pre-* and *post-procedural* education prepares patients for medical interventions and subsequent recovery. Prenatal classes for expecting couples are one common example of this last category, with the obvious goal of easing anxiety regarding delivery and increasing basic skills competencies of new parents.¹⁷

Psychoeducation can be viewed in one sense as an evolutionary application of patient education theories and practices (such as van den Borne's primary, secondary, and tertiary prevention) to patients and family members suffering

14. Editorial board, "The Need for Patient Education," *American Journal of Public Health* 61, no. 7 (July 1971): 1279.

15. American Hospital Association, *A Patient's Bill of Rights* (Chicago: American Hospital Association, 1975).

16. H. W. van den Borne, "The Patient from Receiver of Information to Informed Decision-maker," *Patient Education and Counseling* 34, no. 2 (June 1998): 90.

17. See Mary L. Nolan and Carolyn Hicks, "Aims, Processes and Problems of Antenatal Education as Identified by Three Groups of Childbirth Teachers," *Midwifery* 13 (December 1997): 179-188.

from mental disorders. Many of the same issues described above, including provider reluctance to disclose sophisticated information, fears that such information might complicate and even stimulate symptomatic behavior, and increasing social need for information related to diagnosis and treatment options, apply in similar patterns to the mental health field. The initial development of psychoeducation was intended to increase positive outcomes for patients suffering from depression and bipolar disease, schizophrenia, dementia, and eating disorders.¹⁸ Increasingly, clinical development of psychoeducational programs are targeted at the growing specter of PTSD.

In a broader sense, psychoeducation is seen by some of the field's pioneers as simply education about human psychology, or how our minds work. For example, Bernard and Louise Guerney saw the role of the “practicing psychologist following an educational model” as

one whose work would derive directly or indirectly from a concern not with ‘curing neurosis,’ and not with eliminating symptoms (or ‘complaints’), and not with intellectual growth per se, but rather with the teaching of personal and interpersonal attitudes and skills which the individual can apply to solve present and future psychological problems and to enhance his satisfaction with life” (emphasis

18. Redman, 94.

original).¹⁹

Viewed this way, a psychoeducational approach for the patient represents an ongoing personal philosophy of self- or guided education with an aim of improving one's mental wellbeing. Indeed, the term "patient" becomes in a sense obsolete under this definition, because it incorporates the whole of humanity as potential "patients," with "mortality" the illness. Stated another way,

this long awaited practical application of learning principles to clinical problems served as the first force of the psychoeducation movement, but because of its narrow emphasis on the "patient," "symptom alleviation," "cure," and, in essence, adherence to a medical model, this behavior modification era for the most part seemed to avoid consideration of the cognitive, emotional and interpersonal domains of the client. Indeed, an adherence to the medical model prevented the behavior modifiers from conceptualizing their roles as teachers with ability to educate their 'patients' in these latter domains.²⁰

Although they might seem diametrically opposed, both the van den Borne (medical) and Guerney (educational) paradigms contribute to the foundation for preventative efforts such as Master Resilience Training (MRT), a psychoeducational course

19. Bernard Guerney, Jr., Gary Stollak, and Louise Guerney, "The Practicing Psychologist as Educator—An Alternative to the Medical Practitioner Model," *Professional Psychology* 2, no. 3 (Summer 1971): 277. Jerry Authier of the University of Nebraska Medical Center (and one of the important writers in the field of psychoeducation) considered these authors the "founders of the psychoeducation movement," and their definition above "the most fitting." See Jerry Authier, "The Psychoeducation Model: Definition, Contemporary Roots and Content," *Canadian Counsellor* 12, no. 1 (October 1977): 15.

20. Authier, 16.

“intended to serve primarily as a foundation for training resilience skills (preparation) but also to introduce other resilience concepts that soldiers will encounter at other points in their deployment and life cycles throughout their careers (sustainment and enhancement).”²¹

MRT itself belongs to a larger program called “Comprehensive Soldier Fitness” (CSF) that was “designed to increase psychological strength and positive performance and to reduce the incidence of maladaptive responses of the entire U.S. Army.”²² It was intended to be proactive in the sense of van den Borne’s primary prevention; “rather than waiting to see who has a negative outcome following stress, it provides ways of improving resilience for all members of the Army.” This proactive approach is a delayed but welcomed response to the challenges incurred during more than a decade of sustained fighting in multiple theaters. Exposure rates to traumatic incidents is up to 70% among deployed soldiers, with correspondingly unprecedented PTSD and suicide rates.²³

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) have responded by increasing post-deployment screenings for “PTSD, depression, alcohol abuse, infectious diseases, and chronic symptoms.”²⁴ General Rhonda Cornum points out that the DOD and VA approach is more

21. Karen J. Reivich, Martin E. P. Seligman, and Sharon McBride, “Master Resilience Training in the U.S. Army,” *American Psychologist* 66, no. 1 (January 2011): 25.

22. Rhonda Cornum, Michael D. Matthews, and Martin E. P. Seligman, “Comprehensive Soldier Fitness: Building Resilience in a Challenging Institutional Context,” *American Psychologist* 66, no. 1 (January 2011): 4.

23. Cornum, 4.

24. Lisa A. Brenner, Rodney D. Vanderploeg, and Heidi Terrio, “Assessment and Diagnosis of Mild Traumatic Brain Injury, Posttraumatic Stress Disorder, and Other Polytrauma Conditions: Burden of Adversity Hypothesis,” *Rehabilitation Psychology* 54, no. 3 (August 2009): 240.

typical of van den Borne's secondary and tertiary prevention strategies, being "reactive . . . and focus[ing] on treatment instead of prevention."²⁵ CSF is not intended to replace Army mental health treatment, which is already treating a long line of affected soldiers. Instead, CSF (including MRT) is an attempt to contemporaneously reduce the numbers of soldiers who will enter that line.

The Army's good intentions notwithstanding, research is anything but conclusive on the question of whether psychoeducation, preventative or otherwise, is effective in inoculating soldiers from PTSD or reducing symptoms for soldiers already afflicted. Several articles illustrate the ongoing debate in the field. A widely-cited article by Simon Wessely et al. presents a comprehensive critique of psychoeducational efforts to treat PTSD. Perhaps because of the newness of the field, part of the problem is establishing a consensus definition of psychoeducation. The authors define it as "the provision of information to people about a future etiology: either what might happen should they be exposed to trauma," meaning primary prevention, or "having been exposed, should they develop symptoms," efforts that would fall under secondary or tertiary prevention.²⁶

Although Wessely et al. include primary prevention in their definition, in reality there are very few truly preventative programs in the field of PTSD to critique and even less data with which to analyze their strengths or weaknesses. Part of the problem is one of clinical infeasibility; how do you know who would have developed symptoms if they had not first received preventative psychoeducation? The variables involved

25. Cornum, 5.

26. Wessely et al., 288.

in determining control and experimental groups would necessitate a huge cohort, since type and intensity of soldier exposure to traumatic events can vary wildly from soldier to soldier, even within the same unit. As efforts such as CSF are still in their infancy, we must wait for future studies to determine if primary prevention efforts will be found effective.

Accordingly, the majority of programs examined by Wessely et al. represent efforts to mitigate morbidity *after trauma has already occurred*. This is an important distinction; the authors state that they “are concerned not with the treatment of PTSD but with its prevention.”²⁷ It is easy to understand this statement to mean primary prevention, but instead they are speaking of secondary prevention—psychoeducational approaches to soldiers who have already been exposed to trauma, but have not yet been diagnosed with full-blown PTSD.

Wessely’s article lists the assumptions upon which psychoeducation is based: (1) known threats are less damaging than unknown threats; (2) normalization of symptoms reassures individuals; (3) psychoeducation encourages help seeking; (4) psychoeducation (in a primary prevention sense) could change perception at the time of exposure, eliminating maladaptive cognitive patterns (which are thought to contribute in large part to PTSD); and (5) psychoeducation encourages empowerment (through access to self-help material, self-directed healing strategies, etc.).²⁸ On their own, these seem like rational assumptions—why wouldn’t we want to educate soldiers, if there’s a chance that education could engage any of the above outcomes? However, as the authors point out, “Giving

27. Wessely et al., 288.

28. Wessely et al., 288–289.

information, like any other intervention, is not a neutral act.”²⁹ And indeed some interventions, such as Critical Incident Stress Debriefing, have been found to be not merely neutral or mildly unhelpful, but outright damaging.³⁰

Critical Incident Stress Debriefing (CISD) “is a specific, 7-phase, **small group**, supportive crisis intervention process . . . [that] can best be described as a psycho-educational

small group process” with aims at “reduction of distress and a restoration of group cohesion and unit performance” (emphasis original).³¹ CISD is intended to take place within 24–72 hours after a traumatic incident. The seven phases of the intervention are (1) introduction, (2) facts, (3) thoughts, (4) reactions, (5) symptoms, (6) teaching, and (7) re-entry. The paper reviews controlled studies criticizing the use of CISD because (1) emotional expression during phase four might be premature and lead to pathological emotional complications, and (2) review of symptoms during stage five actually increases the likelihood that such symptoms will manifest. With regards to the second point, it is theorized that it would be more helpful to wait and let symptoms manifest naturally in select personnel rather than exposing the entire group to confirmation bias, and subsequent acquisition, of disorder symptoms.³²

The article continues by suggesting that educating soldiers about symptoms of PTSD can encourage them to develop symptoms in order to increase diagnosis and corresponding

29. Wessely et al., 289.

30. Wessely et al., 290.

31. Jeffrey T. Mitchell, “Critical Incident Stress Debriefing (CISD),” Info-trauma.org, accessed December 19, 2013, <http://www.info-trauma.org/flash/media-e/mitchellCriticalIncidentStressDebriefing.pdf>.

32. Wessely et al., 290–291.

disability pay. The authors point to historical military instances like the London Blitz, where very little information about neurosis symptoms was disseminated, and correspondingly few accounts of neurosis development were recorded. They conjecture that “there [is] clearly doubt . . . about whether or not educating people and talking to them about stress before they were to experience it was helpful or harmful.”³³ The article concludes by noting that although there is evidence of both positive and negative aspects to psychoeducational approaches to PTSD, “there is a need for rigorous research that evaluates psychoeducational interventions that are based on components known to facilitate adaption.”³⁴

In response to Wessely and his colleagues, Dean Kilpatrick, Jesse Cougle, and Heidi Resnick offer a counter-critique. They agree that more evaluative studies of psychoeducational interventions are needed, and strongly agree with criticism of CISM, calling Wessely’s argument “convincing evidence that continued use of these procedures is contraindicated.”³⁵ However, Kilpatrick’s group criticizes Wessely et al. as “not sufficiently impartial . . . focus[ing] considerably more attention on the potential limitations of psychoeducation than its benefits.”³⁶ In addition, they note positive research findings that were not taken into account.

With regards to the London Blitz example, the Kilpatrick paper asserts that “the authors have no data on the actual level of problems experienced by civilians . . . because no one measured them systematically.”³⁷ Somewhat tongue-in-cheek, the paper “question[s] the authors’ apparent argument that the lesson to be learned from military history is that informing warriors or civilians about war-related problems they might

33. Wessely et al., 292.

34. Wessely et al., 297.

35. Dean G. Kilpatrick, Jesse R. Cougle, and Heidi S. Resnick, “Reports on the Death of Psychoeducation as a Preventative Treatment for Posttraumatic Psychological Distress are Exaggerated,” *Psychiatry* 71, no. 4 (Winter 2008): 322–323. For his part, Jeffrey Mitchell of the American Academy of Experts in Traumatic Stress argues that “without exception, every negative outcome study on CISM to date has not used trained personnel to provide the service and they have violated the core standards of practice in the CISM field” (Mitchell, under “Research”).

36. Kilpatrick, Cougle, and Resnick, 323.

37. Kilpatrick, Cougle, and Resnick, 323.

have might be more harmful than exposure to war itself.”³⁸ As a counter-hypothesis, Kilpatrick and colleagues find it “plausible that an inability to understand and recognize PTSD symptoms may lead to increased suppression and concealment of such symptoms, a process by which distress may be intensified and treatment- seeking delayed.”³⁹

Both the Wessely and Kilpatrick articles agree that as an alternative to CISM, Psychological First Aid (PFA), although yet lacking in conclusive empirical data, represents the most hopeful secondary prevention currently in use.⁴⁰ In a 2011 guide for field workers, the World Health Organization defines PFA as “a humane, supportive response to a fellow human being who is suffering and who may need support.”⁴¹ PFA is meant as a strategy for helping trauma victims either during or as soon after the traumatic incident as possible, and emphasizes (1) nonjudgmental listening that respects the culture and human dignity of others, (2) providing access to a safe environment and social support, (3) encouragement of self-efficacy, and (4) help seeking when needed.

As we have seen, there are a number of psychoeducational interventions meant to ease suffering through provision of information and subsequent behavior change. In a number of cases, research regarding the effectiveness of these programs has been inconclusive, and further studies are needed to determine which, if any, are helpful. Unfortunately, nearly all programs have focused on secondary and tertiary prevention (treatment after exposure to traumatic material or illness), rather than primary prevention (increased resilience, or resistance to incidence of injury). Hopefully programs such as Comprehensive Soldier Fitness and Master Resilience Training will continue to develop in ways that will benefit soldiers and others.

With this in mind, psychoeducation is used as a model for understanding the effects on military personnel of combat, killing, and

38. Kilpatrick, Cougle, and Resnick, 324.

39. Kilpatrick, Cougle, and Resnick, 324.

40. Wessely et al., 296; Kilpatrick, Cougle, and Resnick, 323.

41. World Health Organization, War Trauma Foundation and World Vision International, *Psychological First Aid: Guide for Field Workers* (Geneva: World Health Organization, 2011), 3, accessed December 20, 2013, http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf.

related psychological trauma and recovery. From the literature review, lesson plans will be developed which focus primarily on preventative measures. However, elements of secondary and tertiary aspects will also be included.

Military Psychology

Combat

Although much has been written about the nature of combat, most of it has been focused on the tactical, strategic, or political maneuvers that have distinguished the winners from the losers in war's arena. The history of warfare has been covered in breadth from the vast battlefields of World Wars I and II to the hidden, intermittent jungle firefights of Vietnam, and chronologically from the phalanxes of the ancient world to modern urban counterinsurgency operations. Yet in all this, very little outside of personal memoirs has lent insight to the psychological cost of war on an individual level.

In combat, two conflicting influences are of particular note. The first, fear, is "the response of the instinct of self-preservation to danger."⁴² The natural response to fear is to either avoid or extricate oneself from the situation that gave rise to the fear. That soldiers feel fear in the combat environment should go without saying. And yet, for some reason, so many of them "hold their ground when every instinct calls upon them to run away."⁴³ Whether you call it courage, willpower, self-sacrifice, or simply a greater fear of one's commanders and sergeants than of one's enemies, there is a force that counters fear's effects and allows men to

42. Charles Wilson, *The Anatomy of Courage* (Boston: Houghton Mifflin, 1967), 16.

43. Wilson, ix.

fight instead of flee. This section will study these and other physiological and psychological aspects of combat.

Charles Wilson, Baron of Moran and personal physician to Winston Churchill, was fascinated by the interplay of fear and discipline in the hearts and minds of soldiers. As a medical officer in the British Army during the World War I, he was at first puzzled by the seeming lack of physical explanations for the poor health of soldiers exposed to combat. As his own experience with combat and fear increased, he began to endorse a psychological model of injury to rival the physical effects of bullets and disease.

Besides his useful commentary on the subject, Wilson himself makes an interesting study precisely because of his transformation from “stiff upper lip” British officer, with casual disregard for danger while pursuing his duty, to self-questioning (and convicting) poser of worries such as these: “Can war in time make any man a coward? Is it a calamity due to some horrible experience and therefore something which might happen to anybody who was in that place at that time? Is it pure chance that some are branded as cowards while others win fame as heroes?”⁴⁴ His own experiences convinced him that the imagination is one of the most debilitating sources of fear—in many cases, the phantom horrors that play through the head of the soldier may be many times worse (and more damaging) than the reality of the situation.

Elmar Dinter’s *Hero or Coward* is a more modern take on Lord Moran’s basic question: what causes some men to act heroically while others show cowardice? Dinter identifies stress as the significant factor—not the typical stress of ordinary life,

44. Wilson, 17.

but a specific and intensified version unique to the battlefield when “the physical or mental survival of an individual is at stake.”⁴⁵ Using an analogy to describe how the accumulation of stress effects soldiers, he compares each man to a lakebed capable of holding a certain amount of general pressures and individual anxieties. Combat stressors are divided into four main categories: (1) fear of physical or psychological isolation, (2) fear of the unexpected and the unknown, (3) fear of mutilation, and (4) physical deprivations or over-stimulations (such as noise, thirst, hunger, heat or cold, and lack of sleep). These stressors hover like a dark cloud over the lake, and pour down additional stress into the reservoir. While the banks can contain a certain amount of increasing pressure, eventually the shore will be washed over and the man will flood (physical and psychological breakdown).⁴⁶

Dinter’s study goes beyond Wilson’s reminiscent musings and finds a practical application for the subject as “the decisive criterion for the selection of personnel, the organization, equipment, training, education, leadership and tactics of armed forces.”⁴⁷ Whereas Wilson was concerned with explaining why some men (perhaps most tellingly, himself) were nearly incapacitated by fear, Dinter aims to predict who will fail (and who will succeed), and prescribes mechanisms

45. Elmar Dinter, *Hero or Coward: Pressures Facing the Soldier in Battle* (London: Frank Cass, 1985), 13.

46. Dinter, 60-61. Interestingly, he extends the analogy by stating that although a period of draught will reduce the water level, increasing capacity for a future stress deluge, it will never run completely dry. He attempts to use this rationale to explain that a veteran soldier who has experienced combat will always have more initial anxiety than the ignorant rookie who has not yet faced hostile fire. Dinter’s conclusion is somewhat controversial; although Dave Grossman acknowledges that the combat veteran may be more prone to pre-fight anxiety, having already witnessed the brutal reality of combat, many veterans also report reduced anxiety because the source of their fears is no longer unknown.

47. Dinter, 1.

for increasing resistance to failure (creating a more resilient force). Reasoning that war will always be determined by the men on the front line, he concludes:

Victory will be gained only by the side which concentrates on the maintenance or improvement of the will to fight of the front-line soldier, the quality of his physical and psychological abilities, his weapons, his equipment, his training, his supplies, his tactics, and his command. Thus it is not only a matter of incorporating the front-line soldier into his group or giving him comprehensive training. It

is a matter of focusing all the psychological and material resources of the armed forces on him.⁴⁸

Dinter thus takes the step of transitioning from exploring the effects of combat stress to understand soldier behavior, to devising psychological training to inoculate soldiers from negative responses to combat stress. In other words, he bridges from using psychology as a lens for understanding behavior, to employing psychology as a “force multiplier” (increases combat capabilities).

Dinter can be forgiven for feeling a certain measure of loneliness in his chosen field of study. Only a few years before *Hero or Coward* was published, English writer Peter Watson called the collective understanding of conflict research “a barren field.”⁴⁹ His own contribution to the subject, *War on the Mind*, focused on three areas of development in the decades between World War II and Vietnam, namely psychological

48. Dinter, 88.

49. Peter Watson, *War on the Mind: The Military Uses and Abuses of Psychology* (London: Hutchinson, 1978), 14.

warfare, combat psychiatry, and leadership. In each case, his emphasis was on how increased understanding of psychological phenomena was being employed to make the war machine more efficient.

Watson blamed the slow pace of intellectual growth in the area of combat psychology on the paranoid secrecy of militarized nations. Given his own background in print journalism, he perhaps predictably believed that “secrecy has spawned its own difficulties in this field which have led to major errors . . . repetition of such errors can only be avoided, surely, by more open discussion.”⁵⁰ After lamenting the shoddy quality of science performed under such hushed conditions, he criticized its government sponsors in stating that “almost inevitably, bad policies must follow.”⁵¹

Setting aside Watson’s political polemic, his thorough exploration of combat-related psychological phenomena began to shed light on the counterintuitive nature of some exhibited behaviors. For example, note this piece on combat fatigue:

Parachutists and amphibious personnel particularly, it has been found, experience a subtle desire for relaxation once the effort of the assault is over. It is important to understand exactly what is meant here. The parachutist feels tired—exhausted—a few moments *after* he has made a safe landing. He has been keyed up in the plane, and during the drop. Once on the ground, he relaxes—he cannot help it. Often this sense of relaxation is so pervasive that he may drop off to sleep without realizing.⁵²

50. Watson, 27.

51. Watson, 28.

52. Watson, 233. Emphasis original.

Watson may have overstated his dour outlook on publically-accessible research in the field. Even as he left the arena to pursue other topics in psychology, momentum was building that would culminate in works published not long after his own. *Contemporary Studies in Combat Psychiatry*, a collection of studies edited by Gregory Belenky, contained an in-depth look at the combat experience as reported by military psychiatrists employed by nations as diverse as Israel, Nigeria, Russia and the United States, among others. While the tacit aim of the collection was to aid psychiatrists in motivating troops toward ever more efficient warfighting, ample discussion of the negative effects of combat was provided.

Some evidence of the uncertain footing in the field can be seen in the different terms used in the titles of the studies, such as battle stress, psychiatric casualties, combat reaction, combat stress, stress breakdown, and war neuroses. Indeed, the editor noted in the introduction that the phenomena lumped together as “shell shock” during World War I became identified as “battle fatigue” and “combat exhaustion” during World War II. By the end of the Vietnam War, these terms fell out of use to some extent with an observed decrease in the acute psychiatric disturbance noted during the earlier global conflicts.⁵³ In their place (and in the lives of retired combatants continuously) rose the modern specter of psychological disturbance, “the late and delayed effects of combat exposure in the form of Post-Traumatic Stress Disorder.”⁵⁴

Belenky’s conclusion on the future of combat and the psychological demands on soldiers can be seen as fairly

53. Perhaps tellingly, Belenky noted that the incidence of drug abuse and alcoholism in Vietnam were high, implicitly arguing that self-medication and underreported symptoms might account for the statistical decline of psychiatric casualties.

54. Gregory Belenky, ed., *Contemporary Studies in Combat Psychiatry* (Westport, CT: Greenwood Press, 1987), 2–4.

prophetic:

The trend in actual military operations is toward low-level (in terms of size and complexity of forces maneuvered into battle) and high-intensity (from the perspective of the combat soldier) conflict. Military forces in the developed world are more likely to be deployed in low-level engagements (e.g., combating terrorism and aiding or countering guerrillas) . . . than in mid- or high-level engagements (e.g., a NATO/Warsaw Pact war in Europe or a US/USSR war in Southwest Asia) involving division-sized infantry or armored forces . . . career soldiers . . . are likely to see action intermittently over the span of their military service.⁵⁵

Belenky (correctly) predicted that the low-level (and highly personal) model of future combat engagements would “increase the likelihood of demoralization, loss of commitment, refusal to fight, desertion, and acts of cruelty and their attendant long-term, corrosive psychological effects (i.e., PTSD),” all of which we have seen in the last decade. He attributed the predicted rise in PTSD to “the highly personal nature of the violence” in low-level conflict such as “face-to-face encounters, small-unit ambushes, [and] terrorist attacks.”⁵⁶

Belenky’s predicted model of future combat engagements was complemented by the work of Richard Gabriel, a military historian and instructor at the U.S. Army War College. Gabriel reviewed the history of psychiatric injury in warfare, reaching back three thousand years, to show that while the nature of warfare may have changed in the modern era, human

55. Belenky, 253.

56. Belenky, 254.

response to combat trauma has been remarkably consistent. His conclusions are chilling:

The simple and horrifying truth is that human beings are very fragile psychic beings . . . no matter how well trained the soldier is, no matter how cohesive battle units are, no matter how good and technically proficient the soldiers' leaders are, no matter how motivated the soldier, men under fire will succumb to the stresses and strains inflicted upon their psyche by the horribly destructive environment of the battlefield. Given enough exposure to combat, every soldier will eventually suffer mental collapse and be unable to continue.⁵⁷

In support, Gabriel quoted American study that “demonstrated that after thirty days’ exposure to combat, no less than 98 percent of the soldiers had manifested severe psychiatric reactions.” As for the other two percent, “they were found to be already psychiatrically ill; they had been aggressive psychopathic personalities before being drafted.”⁵⁸

Gabriel predicted that, highly-intensified by technological development, future combat (such as Belenky’s model) would cause psychiatric casualties at a growing rate unless the human psyche is altered by chemistry. A significant part of his 1998 book, *The Painful Field*, is devoted to examining Russian and American attempts to do just that. The problem of finding a way to reduce soldiers’ anxiety levels through chemical means has been stymied by the equal imperative for them to remain

57. Richard A. Gabriel, *The Painful Field: The Psychiatric Dimension of Modern War* (Westport, CT: Greenwood Press, 1988), 2. The author later muses that “Sooner or later, no doubt, someone will make the case for drafting only psychopaths on the grounds that doing so will reduce psychiatric casualty rates” (Gabriel, 160).

58. Gabriel, 3.

clear-minded and vigilantly aware of their surroundings, two contradictory states that no drug yet developed could deliver. Gabriel pessimistically saw as the end result of such research as an attempt to create a soldier who could fight without fear, an eventuality that could make war even more destructive by deleting the hostility-limiting characteristics of humanity.⁵⁹

Moving from the broad spectrum of Gabriel's "psychiatric injury" to the more narrowly focused Combat Stress Reaction (CSR), a chapter of a more recent work, *Military Psychology*, provided a detailed study of CSR. Campise, Geller, and Campise described a U-shaped course of incidence where the CSR casualty rate is "higher in the first few days of conflict, drops as adaption occurs, and climbs again as fatigue increases and stress accumulates."⁶⁰ The threshold for a "definite decline in performance" was observed at thirty days of continuous combat—a decline that continues until "non-effectiveness" occurs around the ninetieth day. Stating that "the aftermath of combat stress continues long after the fighting stops." The authors linked battlefield CSR to post-deployment development of PTSD.⁶¹

The authors emphatically state that individuals referred for CSR should not be treated as normal casualties, because they should not see themselves as being injured. Rather, the message should be conveyed that "reactions to combat stress are the normal responses of normal people to abnormal events, with recovery expected to occur in days with appropriate

59. Gabriel, 168–170.

60. Rick L. Campise, Schuyler K. Geller, and Mary E. Campise, "Combat Stress," in *Military Psychology: Clinical and Operational Applications* (New York: Guilford Press, 2006), 220.

61. Campise, Geller, and Campise, 220–221.

intervention.”⁶² That intervention is largely cognitively based—helping soldiers to change their self-image from helpless to capable of coping. The authors list four basic principles for assisting soldiers experiencing CSR:

Promptly resuming normal and adaptive functioning, even if symptoms and disturbances are still present; relying on natural social support or, in its absence, creating alternative support, especially given that social support mitigates the intensity of a perceived threat and enhances the individual's and group's evaluation of self-efficacy in coping with the threat; helping the individual to regain the perception of oneself as healthy and coping while rejecting that illness label; and normalizing reactions.⁶³

The authors also list the “basic ingredients” of assistance as “rest, safety, food, reassurance, group support, a reinforcement of military identity (wear uniform, maintains a schedule, engages in productive work, performs duties, and adheres to military discipline), and a focus on crisis intervention and return to duty.”⁶⁴

Campise, Geller, and Campise list the factors that contribute to CSR, noting that the presence or absence of those factors can have a significant impact on incidence rates. Factors can be divided into categories such as environmental, physical, cognitive, behavioral, emotional, interpersonal/unit, cultural, and operational. Each category represents a specific group of stressors associated with military campaigns, and their effects can be both complicated and compounding. For

62. Campise, Geller, and Campise, 223.

63. Campise, Geller, and Campise, 223

64. Campise, Geller, and Campise, 223

example, cold, rainy weather and lack of adequate shelter in the environmental category, nightmares and anxiety in the emotional category caused by engaging with and killing the enemy in the operational and behavioral categories, and lack of confidence in leaders and fellow soldiers in the interpersonal/unit category can be severely detrimental to quality of sleep and subsequent fatigue levels and fitness for duty in the physical category. Conversely, high unit morale and inspiring leadership, warm meals, and operational prowess derived from exhaustive training and preparation can all help a soldier to be much more resistant to CSR.

Considering this last point (increasing resilience by taking these factors into account), it is important to note that the potential for CSR can be reduced through preventative efforts before the unit ever deploys to a combat zone. The authors advise,

Troops and all levels of leadership should be exposed to the principles of combat stress; factors contributing to CSR, with a special emphasis on morale issues; and recognition of and referrals for combat stress and their expected outcome long before troops are ever notified of possible deployment. This education should be a part of annual training that is not rushed through superficially just to meet a requirement but rather designed to ensure that the response to combat stress comes naturally, as a product of repeated training.⁶⁵

This guide is designed in agreement with Campise, Geller, and Campise by proposing a psychoeducational model for providing awareness of these factors and empowering troops to

65. Campise, Geller, and Campise, 233.

become resilient before exposure to combat trauma, maintain healthy perceptions and cognitions during deployment, and harbor hope while seeking recovery.

If a chapter by Campise, Geller, and Campise can be considered an appetizing introduction to the effects of combat on the soldier, then Dave Grossman's *On Combat* should be seen as the main course. A follow-up to the landmark *On Killing*, this later work draws both from quantitative studies on human reactions and qualitative first-hand accounts of combat veterans to explain from physiological and psychological viewpoints both *how* and *why* soldiers react the way they do in combat. Grossman describes the consistently negative reactions of people to combat by proposing that it should be considered the "Universal Human Phobia"—the only thing that will induce debilitating fear in more human beings than snakes.⁶⁶

Grossman's motivation for writing the book is similar to the motivation behind this project: soldiers are at a disadvantage if they are only prepared to be technically and tactically proficient in combat, but unprepared psychologically for the consequences of the actions taken during battle. And why are they unprepared? Because information about what really happens during combat is not being presented, so "combat virgins" are left with false or incomplete mental concepts regarding the nature of war. As one Vietnam veteran expressed (as quoted by Grossman), "There are two things men will always lie about . . . everything you think you know about war is based on 5,000 years of lies." Consequently, when the young, ill-prepared soldier finds himself in the thick of battle "and has just messed his drawers, he will ask himself, 'What's wrong

66. Grossman and Christensen, 2.

with me? This didn't happen to grandpa and it didn't happen to John Wayne. There must be something terribly wrong with me!"⁶⁷

On Combat can be used by soldiers as a comprehensive textbook for understanding the body's reactions before, during, and after combat. The book is divided up into four sections that cover physiology, perceptual alterations, warrior mentality, and psychological aftermath, with the first two sections being particularly pertinent to a psychoeducational preventative intervention for soldiers preparing for deployment. Section one takes a scientific explanation of the sympathetic and parasympathetic nervous systems and breaks it down into practical application for warriors, explaining the tradeoffs of getting "amped up" on adrenaline with the parasympathetic crash after the threat has passed.⁶⁸ The second section explains the perceptual "tricks" the brain plays during combat. For example, 85% of combat veterans report "auditory exclusion," where they can only faintly (or do not at all) hear the sounds of weapons discharging at close range (including their own arms). Eighty percent of warriors also report "tunnel vision," where they perceive everything about their target and nothing else in their range of vision. And the list continues, giving convincing evidence that combat induces a peculiar state of mind that is not easily explained or reproduced in non-combatants.⁶⁹

Killing

While the section above on combat takes a macroscopic view of the full spectrum of hostile operations (including

67. Grossman and Christensen, 10.

68. Grossman and Christensen, 14–17.

69. Grossman and Christensen, 54–55.

environmental factors, physiological responses, etc.), this section will look at one specific subset of the combat experience—the act of killing. Although this information could conceivably be included in the combat module, killing has a huge potential to cause psychological wounds as to merit, on its own, an in-depth discussion. Accordingly, the reader might understandably perceive a significant overlap in the thematic material already presented. While not completely arbitrary, the selection of works for this section versus the one on combat reflects their attention to the specific psychological effects of killing, within the broader field of combat. The object of this module is to help soldiers not only understand the psychological processes that occur while killing (or attempting to kill), but also to help them recover from the aftermath of those actions.

Despite general public discomfort with the more brutal aspects of warfare, killing is central to combat. As author Joanna Bourke writes, “The characteristic act of men at war is not dying, it is killing.”⁷⁰ She finds it strange then, that the majority of war histories have glossed over or completely avoided this reality, substituting top-level strategy and personality-driven narratives for the blood-and-guts accounts of the fighting man. In her book, *An Intimate History of Killing*, she illuminates a dark secret that not many veterans talk about: “although the act of killing another person in battle may invoke a wave of nauseous distress, it may also incite intense feelings of pleasure.”⁷¹ She reasons that this pleasure may come as the result of a soldier’s unconscious effort to avoid the pain of guilt by constructing a narrative in which he plays the heroic

70. Joanna Bourke, *An Intimate History of Killing: Face-to-Face Killing in Twentieth-Century Warfare* (New York: Basic Books, 1999), xii.

71. Bourke, 1.

part. “If combatants became disillusioned,” she writes, “it was because they felt that they were in the wrong film, enacting a strange script . . . more typically, combatants were able to construct a story around acts of exceptional violence which could render their actions pleasurable.”⁷²

One of the difficulties inherent in learning and teaching about killing is that there are so few who can offer first-hand testimony. Military Historian and British Army reserve officer Richard Holmes noted that “battle—or, at least the specifically combative element of it—has always involved fewer men than might be thought,” citing the large numbers of support personnel needed away from the front lines and the sheer random chance that brings one unit into contact with the enemy while another remains uncontested. Thus there are a relative few voices that may give testimony about their experiences with combat and killing, and many of them don’t want to talk about it. The Vietnam veteran from *On Combat* (quoted above) aptly included sex and combat as the two things men lie about, and he is far from the only person to make this comparison. Holmes wrote,

There is more than a superficial similarity between the sense of anticipation which precedes a soldier’s first battle and that which precedes his first experience of sex. In both cases he will have stretched his mind forward in an effort to grasp the sensation, and will probably have talked to those who have already undergone it. He may well regard both experiences as essential milestones along his own route to full masculinity.⁷³

72. Bourke, 31.

73. Richard Holmes, *Acts of War: The Behavior of Men in Battle* (New York: Free Press, 1985), 56.

Holmes' *Acts of War* is one of the few volumes generally recognized as an honest portrayal of the psychological effects of combat and killing. The text seems particularly authentic because of his ample inclusion of first-hand testimonies. He reported that men generally felt a charged excitement at the prospect of confronting the enemy, which gave way to apprehension as the distance between the two decreased. Holmes opined that "it is hard to exaggerate the degree of stress imposed by this feeling of pre-contact apprehension, which usually occurs, with varying intensity, before every battle in which a soldier participates."⁷⁴

Fearful apprehension is almost always more intense before battle, and rapidly gives way to other emotions once shots are fired. Men commonly experience a bewildered sense of shock that someone is trying to kill them, and that the distant sounds of small arms equate to lethal force. Following that bewilderment is a release of the pre-combat tensions. "Although the soldier in action is in immediate physical danger," wrote Holmes, "the very fact that he is at last committed to battle often comes as a relief."⁷⁵

In the modern era, commencement of battle usually is heralded by a rain of metal projectiles, explosive or otherwise. Holmes gathered reports of small arms and artillery efficacy to show the general trend that an incredible amount of ammunition is expended to produce a much smaller number of casualties. "This vast, if surprisingly ineffective, volume of fire, and the noise associated with it," noted Holmes, "helps turn real battle into something which has little in common with the simulated battles of training.....The sheer disorganization of

74. Holmes, 139.

75. Holmes, 147.

battle is at one and the same time the result of the pressures produced by hostile fire, and a contributor, in its own right, to battlefield stress.”⁷⁶

Soldiers are much more willing to fire at the enemy once they have been fired upon. This intent to kill others is facilitated by a determined refusal to acknowledge the humanity of the other side. Holmes explains:

The soldier goes to war with an abstract image of the enemy in his mind’s eye, an image sometimes sullied by officially-inspired propaganda and almost always spattered by the mud thrown by the popular press. His training will have featured ‘aggressor forces’ or ‘terrorists’, and the very language he is encouraged to use will suggest that he is dealing, not with another human being thrust by the turn of the dice into a different uniform, but with a mere object of hostility belonging to some different tribe—almost a different species.⁷⁷

The convention which makes it easier to fire upon enemy soldiers begins to crumble the moment that enemy becomes a fellow human. This can happen quickly after friend and foe are brought into close proximity. One soldier experienced this while searching enemy prisoners:

Old chap of fifty empties his pockets, including his photos of wife and kiddy and his old pipe. Realise [sic] more than ever this business is crazy . . . The prisoners all have a wallet of photos, just as we carry, and we let them keep them, also their little boxes of tobacco. The though often

76. Holmes, 172.

77. Holmes, 360.

comes into my mind: “Are these chaps so different to us?” It is their leaders like ours who can kid us up. They have the same love of home and family as us.⁷⁸

Once that human connection is made, the killing act is much more difficult (and damaging) to carry out. This difficulty can be overcome through the impersonality imposed by engaging at distance, although that is no guarantee of imperviousness to the effects of that action. One WW I Australian sniper remarked after killing a German observer, “A queer thrill shot through me, it was a different feeling to that which I had when I shot my first kangaroo when I was a boy. For an instant I felt sick and faint; but the feeling soon passed; and I was my normal self again, and looking for more shots.”⁷⁹ At grappling range, it is almost impossible to overestimate the urge to avoid impaling the enemy. “Despite all the bayonet training that soldiers received,” wrote Holmes, “in close combat they very often reversed their weapons and used them as clubs.”⁸⁰

The classic work in the genre, Dave Grossman’s *On Killing*, acknowledged a large debt to Holmes’ work. Whereas Holmes seems like an explorer travelling previously unknown lands and explaining what he sees as he goes, Grossman follows his trail as a cartographer, drawing a comprehensive map of the combat arena. Grossman begins with Holmes, continuing on the relationship between killing and sex. But where Holmes merely comments on the surprising inaccuracy of small-arms fire, Grossman provides a detailed and convincing explanation

78. Holmes, 370–371.

79. Holmes, 377.

80. Holmes, 379.

behind the psychological reasons behind deliberate poor aim.⁸¹

Grossman continues by explaining the role of killing in the etiology of combat-related psychiatric casualties. He cites the landmark World War II study that “determined that after sixty days of *continuous* combat, 98 percent of all surviving soldiers will have become psychiatric casualties of one kind or another”—with the remaining two percent having “aggressive psychopathic personalities.”⁸² Grossman organized another section on the role distance plays in killing, starting with long range bombers and artillery and ending with hand-to-hand combat with knives (hint: the closer you are, the more

damaging it is to your psyche).

Perhaps Grossman’s most valuable contribution (considering the paucity of information on the topic) is his brief but revealing look at the stages of psychological/emotional response to having killed another person. He compares the stages of kill-response to Elisabeth Kübler-Ross’ famous stages of grief, noting that “these stages are generally sequential but not necessarily universal . . . some individuals may skip certain stages, or blend them, or pass through them so fleetingly that they do not even acknowledge their presence.”⁸³ Grossman labels the stages as follows: (1) concern about being able to kill, (2) killing circumstance, (3) exhilaration from kill, (4) remorse and nausea from kill, and (5) rationalization and acceptance process.

Grossman calls this last stage (rationalization and

81. Grossman, 17.

82. Grossman, 43–44.

83. Grossman, 232.

acceptance) “a lifelong process” that “may never truly be completed . . . the killer never completely leaves all remorse and guilt behind, but he can usually come to accept that what he has done was necessary and right.”⁸⁴ He proposes that if the rationalization stage fails to satisfy the demands of guilt or other strong emotions associated with killing, PTSD can be the result. As evidence he presents the psychological aftermath of Vietnam, which differed most notably from other violent conflicts of the 20th century in that the country did nothing to help absolve the collective guilt from returning soldiers, but instead heaped additional shame and punishment upon their weary shoulders. This, combined with a rotation policy that eroded the sense of unit camaraderie and cohesion, left many soldiers in a poor position to overcome the negative psychological effects of the actions they had both witnessed and committed. Tying combat service in Vietnam together with PTSD incidence, Grossman cites a 1988 study by Jeanne and Steven Stellman which found that “the victims of PTSD are almost solely veterans who participated in high-intensity combat situations. As far as PTSD symptoms are concerned, soldiers who were in noncombat situations in Vietnam were found to be statistically indistinguishable from those who spent their entire enlistment in the United States.”⁸⁵

Posttraumatic Stress Disorder

The 9/11 attacks started a new chapter in American warfare. Never before was an all- volunteer U.S. military asked to fight intense conflicts in multiple theaters for such a prolonged duration. As the U.S. prepares to finally withdraw from Afghanistan, the last of over two million troops are returning

84. Grossman, 237.

85. Grossman, 283.

to American soil and a semblance of “normal life.” But research shows that life will be anything but normal for a good number of those veterans.⁸⁶

Posttraumatic Stress Disorder (PTSD) has risen in significance to represent one of the biggest threats to psychological wellness for returning troops. Part of what makes PTSD such a threat to public health is the lack of clarity surrounding exactly what it is, and how many people have it. A 2012 study found that the prevalence of PTSD has been reported anywhere between 0.6% to 31% in troops returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), depending on the researchers’ methodology and inclusion parameters for the subject group. Adjusting for those differences, the same study determined that although the overall rate of incidence was only 5% in returning troops using a stricter measure, that number rose to 19.6% for certain populations using a looser measure. As a general rule (and as seems intuitive), infantry units that saw intense ground combat were much more likely to be diagnosed with PTSD than support troops who faced only indirect threats.⁸⁷

It is important to distinguish between PTSD, and Combat Stress Reaction (CSR) or Posttraumatic Stress (PTS). As stated in the above sections on combat and killing, CSR is a normal human response to the abnormal stressors of combat, and should not be seen as a disorder. Although Grossman pointed out that with enough combat exposure nearly all soldiers will

86. Tracy Stecker et al., “Treatment-Seeking Barriers for Veterans of the Iraq and Afghanistan Conflicts Who Screen Positive for PTSD,” *Psychiatric Services* 64, no. 3 (March 2013): 280.

87. Brian C. Kok et al., “Posttraumatic Stress Disorder Associated With Combat Service in Iraq or Afghanistan: Reconciling Prevalence Differences Between Studies,” *Journal of Nervous and Mental Disease* 200, no. 5 (May 2012): 446–448.

eventually break down with some sort of psychological injury, it is also evident that the majority will recover once removed from combat. Also, incidence and intensity of CSR can be reduced by the effects of rotating troops off the front lines, maintaining unit coherence, and strong leadership.

Similarly, PTS can be thought of as experiencing any or all of the symptoms normally associated with PTSD that are experienced during and after combat, that dissipate within a month after exposure. PTS symptoms are a normal response to combat trauma. PTS may develop into PTSD only when all the symptoms of PTSD are present and have a duration of longer than one month after exposure to traumatic material.

The *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-V), contains the current authoritative list of criteria for PTSD. One or more examples from each of the following categories (two in the case of “D” and “E”) must be present to cross the threshold from PTS symptoms to a true disorder:

- A. Exposure to actual or threatened death, serious injury, or sexual violence.
- B. Presence of . . . intrusion symptoms associated with the traumatic event(s).
- C. Persistent avoidance of stimuli associated with the traumatic event.
- D. Negative alterations in cognitions and mood associated with the traumatic event(s).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s).
- F. Duration of the disturbance . . . is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important

areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Additionally, the disorder may be specified as “delayed onset,” meaning “the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).”⁸⁸

Like CSR, the terminology and definition of PTSD has changed over time, and continues to be a source of conflict. Before the American Psychiatric Association (APA) published the most recent (fifth) edition of the DSM, U.S. Army leadership

requested that the term “disorder” be dropped in favor of “injury.” The Army argued that the current label is inherently stigmatizing, and prevents soldiers from seeking help. The APA disagreed, and although changes to the disorder category and criteria were made (PTSD was re-categorized as a trauma-related disorder rather than an anxiety disorder), the term itself was kept intact. A RAND Corporation study found that though a PTSD diagnosis can be stigmatizing to soldiers in particular, it can also legitimize their suffering and serve as the gateway to treatment and compensation.⁸⁹

Although the Army failed to persuade the APA to change the label, the term PTS (in addition to CSR) is still used “in the place of ‘PTSD’ on certain documents and websites and

88. APA, DSM-V, under “Posttraumatic Stress Disorder.”

89. Michael P. Fisher and Terry L. Schell, *The Role and Importance of the ‘D’ in PTSD* (Santa Monica, CA: RAND Corporation, 2013), 1–2, accessed March 8, 2014, http://www.rand.org/pubs/occasional_papers/OP389.

in some statements and presentations by senior [military] leaders.”⁹⁰ Considering the general lack of clarity regarding PTSD in the public arena, the Army’s unilateral redefinition makes little sense and may actually harm soldiers. As Fischer and Schell note regarding the term PTSI, “it is unclear how individuals suffering from PTSD might perceive their ability to seek or continue treatment if they view themselves as *victims* of an injury.” Furthermore, “it is possible that the term ‘injury’ would lead to the mistaken impression that an individual would need to have been *in a position to be physically harmed* in order to obtain the diagnosis and be eligible for treatment”—a significant barrier to treatment for traumatized non-frontline troops.⁹¹

In addition to the psychological symptoms experienced by troops diagnosed with PTSD, physical health can also be negatively affected. A recent study found a positive correlation between PTSD and general health problems such as nausea, constipation, angina, shortness of breath, dizziness, fatigue, headache, and back ache. Additionally, medical conditions such as asthma, irritable bowel syndrome, heart disease, and fibromyalgia were also found to common comorbidities.⁹² Another report found links between PTSD and depression, traumatic brain injury (TBI), substance abuse, and suicide.⁹³

Given the substantial risk to psychological and physical

90. Fisher and Schell, 9.

91. Fisher and Schell, 9 (*italics original*).

92. Maria L. Pacella, Bryce Hruska, and Douglas L. Delahanty, “The Physical Health Consequences of PTSD and PTSD Symptoms: A Meta-analytic Review,” *Journal of Anxiety Disorders* 27, no. 1 (January 2013): 34.

93. Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008), 125–130, accessed March 8, 2014, <http://www.rand.org/pubs/monographs/MG720>.

health represented by PTSD, it is important that affected soldiers receive treatment. The first problem is identifying which soldiers need help. The common practice of post-deployment screening “has never been demonstrated to be effective in improving mental health.”⁹⁴ It is estimated that only 50% of veterans seek care, and of that group, only 40% or so recover, meaning that “current strategies will reach no more than 20% of all veterans needing PTSD treatment.”⁹⁵ Factors that prevent soldiers from seeking treatment (in descending order of prevalence) include concerns about treatment, emotional readiness, stigma, and logistical issues.⁹⁶ Clearly, more must be done to help soldiers overcome these factors.

For those identified as needing help who are willing to participate in treatment, there are several options which are clinically proven to be effective. Each treatment has its own approach and may be more or less effective depending on the individual, but “fundamentally, all psychotherapies with an A-level recommendation for PTSD (good evidence that benefits outweigh harm by US Preventative Services Task Force criteria) involve 5 core components: (1) narration, (2) cognitive restructuring, (3) in vivo exposure, (4) stress inoculation (eg, relaxation) skills, and (5) psychoeducation.”⁹⁷ The Society of Clinical Psychology (a division of the American Psychological Association) lists Prolonged Exposure (PE), Present-Centered Therapy (PCT), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR) all as having strong research support. The Veterans Administration

94. Charles W. Hoge, “Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are,” *Journal of the American Medical Association* 306, no. 5 (August 3, 2011): 549.

95. Hoge, 549.

96. Stecker et al., 282.

97. Hoge, 549.

(VA) employs each of these except PCT, and additionally uses Stress Inoculation Therapy (SIT), which possesses only modest research support but can be much more appealing to service members who do not think they need treatment or are otherwise reluctant to receive any treatment at all.⁹⁸

Posttraumatic Growth

There is a message of hope for all who have been exposed to the horrors of war. First of all, a minority of soldiers who experience combat develop PTSD. Second, there are a number of organizations and resources available for those who suffer from the disorder. Finally, the hope of Posttraumatic Growth (PTG) is a beacon shining for all who have been scarred in one way or another by traumatic material.

Humans have long believed that positive change can be the result of facing and overcoming challenges. Religious literature from a broad spectrum of traditions (as diverse as ancient Greeks, Hebrews, Christians, Hindus, Muslims, and Baha'i) portrays examples of men and women growing through adversity.⁹⁹ Despite the universal and enduring nature of this cultural knowledge regarding transformation through struggle, modern research has only recently begun to examine and confirm these beliefs. The rise of positive psychology in the 1990s shed empirical light on the trend to experience highly positive changes as a result of living through severely difficult challenges.¹⁰⁰

98. Greg Hajcak and Lisa Starr, "Post-Traumatic Stress Disorder," Society of Clinical Psychology, accessed March 9, 2014, http://www.div12.org/PsychologicalTreatments/disorders/ptsd_main.php.

99. Tedeschi and Calhoun, *Trauma and Transformation*, 45–50.

100. Richard G. Tedeschi and Lawrence G. Calhoun, "Posttraumatic Growth: Conceptual Foundations and Empirical Evidence," *Psychological Inquiry* 15, no. 1 (January 2004): 1–18.

PTG can be defined as “a positive psychology change experienced as a result of struggle with highly challenging life circumstances.”¹⁰¹ It is important to note that PTG specifically identifies growth that occurs as a result of trauma, rather than via another mechanism. Although trauma is the essential catalyst for PTG, therapists do not attempt to label trauma itself as beneficial. Instead, the willingness of the sufferer to identify and fight for positive outcomes is seen as beneficial and necessary for growth. Viewed in this way, the focus is removed from the problem, and placed upon possible positive outcomes. For example, a soldier overly stigmatized by the label of a PTSD diagnosis might never recognize that the opportunity for growth exists, and thus be needlessly stunted in recovery. PTG should be treated as the desired outcome and focus of recovery efforts from the beginning of treatment, rather than as a conciliatory afterthought.¹⁰²

It is important to note that PTG does not fit the standard medical model of healing. When the body is wounded, physicians strive to help the body return to the same level of functioning as was experienced before the injury. The paradigm is one of returning to the established baseline. PTG does not claim that a complete return to the state experienced before injury is even possible, let alone advisable. Instead, the person is encouraged to find a new, better state of functioning that is facilitated, rather than inhibited, by reaction to trauma. Research increasingly shows this is a possible outcome for our military veterans. As Richard Tedeschi and Richard McNally write, the ability to “resist or bounce back from adversity is a key aim . . . however, rapidly returning to baseline functioning

101. Tedeschi and Calhoun, *Trauma and Transformation*, 45–50.

102. Bonnie B. Benetato, “Posttraumatic Growth Among Operation Enduring Freedom and Operation Iraqi Freedom Amputees,” *Journal of Nursing Scholarship* 43, no. 4 (August 2011): 413.

is not the only positive outcome following exposure to trauma. Some trauma survivors report posttraumatic growth: positive personal changes that result from their struggle to deal with trauma and its psychological consequences.”¹⁰³

One practical application of PTG for recovering veterans is the THRIVE model proposed by University of Nottingham professor Stephen Joseph. In his book *What Doesn't Kill Us: The New Psychology of Posttraumatic Growth*, he uses the acronym THRIVE to represent “six stages, or ‘signposts’ . . . arranged in a logical sequence, moving from an awareness of your readiness to change all the way to actually changing your thoughts, behaviors, and emotional states.”¹⁰⁴ These stages are: (1) Taking Stock (assessing needs and resources), (2) Harvesting Hope (gaining a vision of positive outcomes), (3) Re-authoring (changing your story from victim to survivor, then thriver), (4) Identifying Change (tracking positive changes), (5) Valuing Change (gaining the most benefit from each change), and (6) Expressing Change in Action (changing lifestyle to reflect changed mentality). Together, these stages can help orient sufferers to the possibility and process of change, providing a framework and direction for growth.¹⁰⁵

Summary

This guide provided a brief overview of significant works in the following fields. The first section, **Psychoeducation**, provided a theoretical justification for presenting psychoeducational material to soldiers before exposure to combat. It was shown that psychoeducation evolved out of

103. Tedeschi and McNally, 19–24.

104. Stephen Joseph, *What Doesn't Kill Us: The New Psychology of Posttraumatic Growth* (New York: Basic Books, 2011), 175.

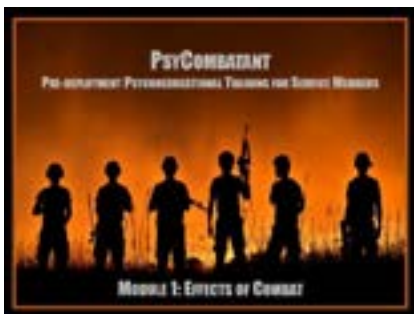
105. Joseph, 175–176.

the medical model of patient education. Several current military programs that use a psychoeducational approach were identified. The trend to use psychoeducation as part of secondary or tertiary interventions (employed after exposure to trauma) was determined to be less-useful in treating soldiers who have been exposed to combat-related trauma. Accordingly, the rationale for psychoeducation as a primary intervention (preventative) was established, and serves as the theoretical foundation of this project.

It also reviewed the literature specific to the fields of military conflict: **Combat, Killing, Posttraumatic Stress Disorder** (PTSD), and **Posttraumatic Growth** (PTG). Although killing might have been included as a subsection of combat, it was given its own section in order to reinforce the primary significance of its effect on soldier mental health. Posttraumatic growth was discussed as a new avenue to finding positive outcomes for soldiers who have been negatively affected by PTSD.

Module 1: Effects of Combat

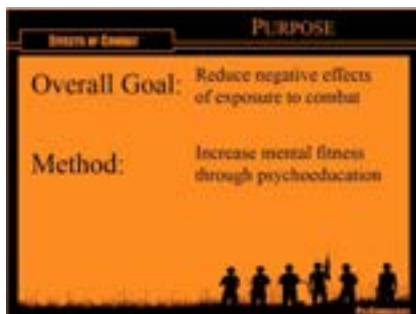
Slide #1: Introduction



Note: Use this slide to introduce yourself and make any administrative remarks before beginning.

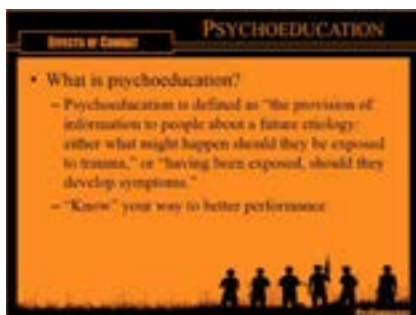
We are about to begin the first instructional module of PsyCombatant: Pre-deployment Psychoeducational Training for Service Members. This first module will focus on the effects of combat on the minds and bodies of the participants. There are two additional modules that address the effects of killing and exposure to trauma. Together, these three modules are meant to help service members prepare mentally for combat deployments.

Slide #2: Purpose



The overall goal of this module is to reduce the negative effects of exposure to combat. The way we are going to do that is to increase your mental fitness through psychoeducational training, so that you will be more resilient when you face combat. If you have already been exposed to combat, this training may help you to understand some of the things that you may have experienced, or observed in your teammates.

Slide #3: Psychoeducation



What is psychoeducation? As you can see, psychoeducation

is defined as “the provision of information to people about a future etiology: either what might happen should they be exposed to trauma,” or “having been exposed, should they develop symptoms.” That’s a really technical way of saying that psychoeducation is just information about how your mind works, and a way of helping you to understand what is going on in your head under given circumstances. In this case, we’re going to be talking about how combat affects your mind, which in turn affects your body. Combat can cause strange things to happen to your mind and body, and having some idea of what is happening and why can actually help you to cope better with those challenges. The better you cope, the more capable you are to continue the mission, whether that’s winning the fight or recovering afterward. In this way, you can actually “know” your way to better performance as a soldier.

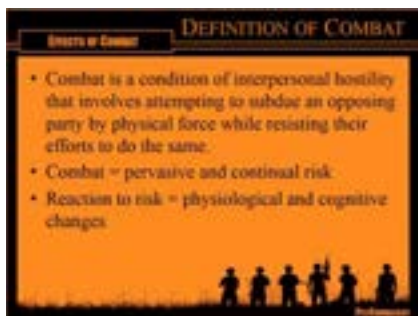
Slide #4: Outline



Here’s a look at where we’re going during this module. First, we’ll take a look at the context of combat, including a definition and a brief history of combat psychology. Next, we’ll break combat down into hostile and non-hostile stressors, and see how they add up to make good performance a real challenge. Finally, we will conclude by providing some suggestions

of things you can do to be better prepared, introduce a few resources you might want to consider, and answer any questions that you may have.

Slide #5: Definition of Combat



Combat can be hard to describe because it can vary so much from one mission to the next. At the heart of it; though, it is a condition of interpersonal hostility that involves attempting to subdue an opposing party by physical force while resisting their efforts to do the same. Sometimes combat avoids the use of deadly force, such as when you're dealing with unruly detainees or civilians. But other times, combat means trying to kill the person that is trying to kill you first.

Combat involves pervasive and continual risk, meaning sometimes you're exposed to risk for a prolonged period of time without any way to really feel safe. Even if you are well-trained as a professional soldier, your body and mind still react to that risk. You can train your body and mind to respond a certain way, but it is very hard to simulate some effects of combat, so there are limits to how much you can keep some

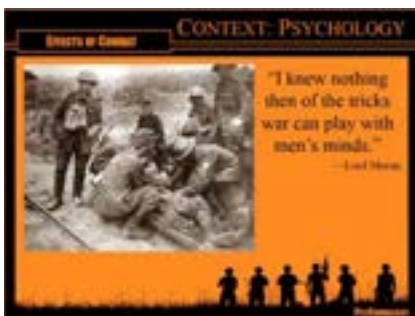
of these reactions from happening. That is why combat keeps producing some of the same experiences to soldiers in vastly different circumstances.

Slide #6: History



Combat produces some universal effects that have been felt by soldiers throughout history. Whether they are using spears, swords, or guns, warriors react to fear and violence the same way today that they did centuries ago. That is because fear and aggression are human emotions that function very similarly in most people, regardless of where or when they lived. Lieutenant Colonel Dave Grossman, one of the top researchers in the world in the field of combat psychology, called combat the “Universal Human Phobia,” meaning that 98% of people in the world would react with overwhelming, uncontrollable fear when confronted with the lethal violence of combat. That doesn’t mean you’re automatically going to turn and run when faced with a fight, but it does mean that you are going to be affected one way or another. Again, training can help you to respond the way you need to when confronted by fear, but it can’t eliminate all of the side-effects you may experience before, during, or after the fight.

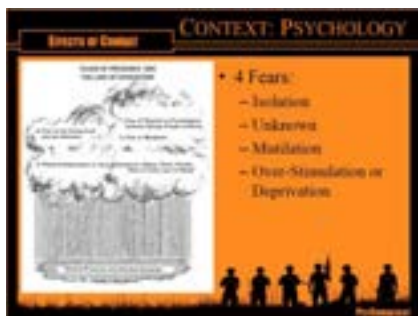
Slide #7: Lord Moran



Charles McMoran Wilson, also known as Lord Moran, was a doctor in England's Royal Army Medical Corps during the First World War. He later served as Winston Churchill's personal physician. In a book called *Anatomy of Courage*, he reflected on the puzzling nature of why soldiers reacted so differently in combat. This story is one example of what he saw: "One day in 1914, when the First Battalion of the Royal Fusiliers was in billets, Wickham who commanded "D" company told me that one of his sergeants was out of sorts. I found him staring into the fire. He had not shaved and his trousers were half open. He seemed a morose fellow; I could get nothing out of him. Wickham did not want to send him sick, away from the battalion, besides he did not appear to be ill. We agreed to give him a rest, to let him stay in his billet till the battalion came out of the trenches. But next day when everyone had gone up the line he blew his head off. I thought little of this at the time; it seemed a silly thing to do. I knew nothing then of the tricks war can play with men's minds. In those early days of the first German War we—the Company officers and I—did not bother about men's minds; we did what we could for their bodies."¹⁰⁶

106. Wilson, 1.

Slide #8: 4 Fears



Historian Elmar Dinter wrote a book called *Hero or Coward*, that took a more scientific look at Lord Moran's basic question: what causes some men to act heroically while others show cowardice? Dinter thought the answer was stress - not the normal stress of everyday life, but a specific kind of stress unique to the hostility of the battlefield, where people are trying to kill you. Dinter came up with an analogy, where he thought of each soldier as a lakebed or reservoir. This "reservoir" can hold a certain amount of pressure and anxiety. Dinter pictured combat to be like a cloud containing four categories of fear: (1) fear of physical or psychological isolation, (2) fear of the unexpected and the unknown, (3) fear of mutilation, and (4) physical deprivations or over-stimulations (such as noise, thirst, hunger, heat or cold, and lack of sleep). His general idea was that as soldiers were exposed to these stresses "raining" down on them, the water level rose until it overflowed the banks and flooded, meaning physical and psychological breakdown. Although we might argue with the specific categories he came up with, he was right about fear and stress having an accumulative effect on a person that can become

overwhelming if nothing is done to help a person cope.¹⁰⁷

Slide #9: Fear Curve



This chart represents a more modern understanding of fear. The curve shows that there are roughly three stages that a new soldier who has never experienced combat generally experiences. In stage one, anxiety is high because everything is unknown. Soldiers doesn't know if they are going to die, or (perhaps worse), turn out to be a coward and let their buddies down. They're not sure how bad the conditions are going to be, and in the absence of real information, their minds invent all kinds of nightmare scenarios in an attempt to prepare them for what might be coming. In this case, the unknown danger is much worse than the known dangers they will be exposed to. In stage two, anxiety is reduced, because soldiers have some experience with their combat zone. Even though it might be really bad, in some ways it is better than what they were imagining, if for no other reason than that they don't have to worry about how bad it could be - they actually know now. This is the stage where the soldier is usually most effective as a fighter. In stage three, anxiety goes up as time, stress and fear begin to have an additive effect. This is where soldiers have

107. See Dinter, 60–62

seen terrible things happen to their friends, and have lived with constant threats to themselves. They are exhausted, running on fumes, and maybe losing hope that their sacrifice has any meaning. As this goes on, soldiers can sometimes begin to breakdown, and become combat ineffective. This is called the Combat Stress Reaction (CSR), which we will talk about more in a moment.¹⁰⁸

Slide #10: Non-Hostile Factors

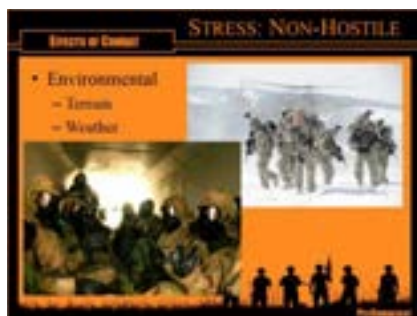


There are a number of different types of stressors that can lead to Combat Stress Reaction. They can be grouped into two broad categories - Non-Hostile, meaning they are part of the combat environment but don't involve somebody trying to kill you, and Hostile, meaning the actual fight with the enemy. Non-Hostile threats can be further broken down into the categories that you see here - Environmental, Physical, Cognitive, Behavioral, Emotional, Interpersonal/Unit, Cultural, and Operational. Let's take just a few of these as examples.¹⁰⁹

108. See Campise, Geller, and Campise, 220.

109. See Campise, Geller, and Campise, 225-232.

Slide #11: Enviromental Factors



These two pictures here suggest very different environments that soldiers have to fight in, that can wear them down. In the top right picture, soldiers are in the cold, exposed to the elements, wearing heavy winter clothing. Each step takes more effort because they have to trudge through the snow. Additionally, your body uses extra energy to try and keep itself warm in cold weather, so they are likely to hit exhaustion quicker in this environment than if they were under better conditions. Now look at the picture on the bottom left. The climate is almost the exact opposite of the other picture. These are soldiers during the first Gulf War, in full Mission Oriented Protective Posture (MOPP) gear, waiting for a possible chemical attack. It would have been really hot without the gear; with all that equipment the temperature is almost unbearable.

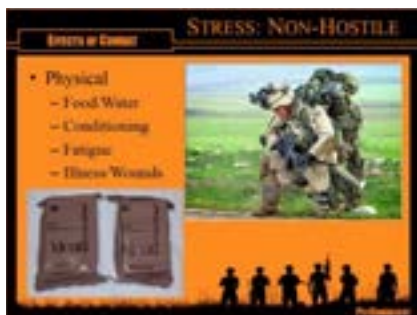
Everything a soldier does takes more energy in that suit, including just taking a drink and breathing. Hot-weather injury (heat exhaustion, stroke, etc.) becomes a real danger that soldiers have to be aware of and vigilant against.

Slide #12: Enviroment: Wildfire



This next slide illustrates another way the environment can be threatening even when people aren't shooting at you. That little guy in the top right corner kept a lot of soldiers from ever feeling really safe in the desert. Although the camel spider didn't really pose a large threat to soldiers, the rumors about their size and appetite gave them a starring role in a lot of nightmares. All it takes is finding one in your boot or on your sleeping bag to never really be able to feel safe again. And that's just a mostly harmless creature. In some areas, the wildlife really does pose a serious threat to soldiers—knowing that a snake bite can kill you as surely as a bullet gives soldiers one more thing to be worried about.

Slide #13: Physical Factors



The physical category includes all of the stressors that affect a soldier's body. For instance, food and water are two things a soldier must always have access to. Both Napoleon and Frederick the Great have been attributed the famous quote, "An army marches on its stomach." Our own combat rations called Meal Ready to Eat (MRE) state right on the packaging that food is a force multiplier, as if a hungry soldier doesn't already know that. And regardless of whether the climate is cold or hot, such as on the previous slides, a soldier still needs to drink enough water to stay hydrated in order to continue the mission.

As you can see from this picture, soldiers sometimes have to carry heavy loads in combat. Their physical conditioning can break down in combat zones if they don't get opportunities for physical training (PT), or if they simply hit exhaustion from continual missions with one hundred pounds of gear. This can lead to fatigue, which can increase the likelihood of injury or illness, all of which adds additional stress to the soldier.

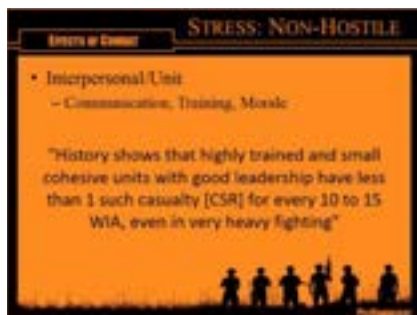
Slide #14: Sleep



After food and water, one of the biggest physical stresses of combat involves sleep. Although some people function differently from others on little sleep, everybody needs at least some sleep just to stay alive, let alone be effective. This slide illustrates some of the most basic guidelines regarding sleep and combat readiness. Generally, a soldier needs to get at least four hours of uninterrupted sleep during a 24-hour period to be sharp. For every 24-hours that a soldier doesn't get any sleep, their mental ability goes down by at least 25%. You literally get dumber as you stay up longer. Depending on the soldier, after 48 to 72 hours without sleep, soldiers can no longer be considered mission capable, meaning commanders cannot count on them to carry out complicated instructions. This is when dangerous mistakes are made, and it's not because of a lack of attention to detail, it's because soldiers in these conditions literally cannot pay enough attention to those details, such as if your (weapon) safety is on, or if the person in front of you is a friend, a foe, or a civilian. And like most of these stressors we are talking about, the effect is cumulative. In this case, that means that even allowing for minimal sleep will still eventually make soldiers combat ineffective, it just takes a

few more days to happen.

Slide #15: Interpersonal/Unit



Although this slide is listed as one of the non-hostile stressors, it also shows how leaders can take a negative and turn it into a positive. Communication, training, and morale have been shown to have a powerful effect on soldiers. The Army's current emphasis on identifying and removing "toxic leaders" shows the importance of these factors, since poor leadership erodes communication, training and morale. On the other hand, strong leaders create an environment that fosters good communication, training and morale.

These things aren't just important because they make for a better "quality of life" for soldiers in good units. These qualities are important because soldiers in units with good communication, training, and morale, are more resilient to the effects of Combat Stress Reaction. Soldiers, NCOs, and Officers, you all have an important role in making your unit into one of these "small cohesive units with good leadership. As you work to improve the communication, training, and morale in your

unit, starting with yourselves, you will be making you and your buddies stronger and more able to bear the burdens you will carry in combat.

Slide #16: SNS vs. PNS



Let's switch now from non-hostile to hostile stressors. These stressors are what people normally think of when they picture combat - the results of someone else trying to kill you. To start, you need to understand that combat triggers a specific mechanism in your brain and body that most people in our modern world don't experience frequently. That mechanism is sometimes called the "fight or flight" response. Let me try to explain how this works. Your brain has an autopilot function that keeps you breathing, your heart beating, cells being nourished, etc., all without you thinking about it. This is called your Autonomic Nervous System, or ANS. The ANS is divided into two parts, the Sympathetic Nervous System (SNS), and the Parasympathetic Nervous System (PNS). This is an oversimplification, but think of it this way: the SNS is the "go" button, getting your body ready for action. It increases your heart rate, releases sugars into the blood stream, and basically gets you ready to react to threats instantaneously. The

PNS is the “stop” button, and calms down your body so that it can take care of the normal functions it needs to like digestion and cell maintenance. The SNS and PNS work in opposition to each other in a “push- pull” relationship, keeping each other in balance. When a threat is perceived, the SNS kicks into gear, the PNS is repressed. After the threat is responded to, the PNS takes over and shuts down the effects caused by the SNS.

It is a really good thing for us that this all happens without our thought or control. Imagine you were living thousands of years ago, hunting food for your family, when you ran into a not-so- friendly sabre-tooth tiger. If you had to stop, decide if the tiger was a threat, and then make a decision to activate the adrenal glands, shut down your digestive process to keep blood where it is most needed, and increase your heart and respiration rates so that you can act quicker, you would probably be eaten before that process was complete. Instead, the body unconsciously makes the decision that you are faced with a threat and prepares itself for action quicker than you could consciously decide by activating the SNS so that you can react quickly enough to avoid dying.

Slide #17: PNS Backlash



Sometimes you hear software developers talk about some glitch in their program as “a feature, not a bug.” The counterbalancing actions of the SNS and PNS are definitely a feature, but they can cause inconveniences that can seem more like a bug. If your SNS stayed activated indefinitely, you wouldn’t last very long before your body simply burned itself out. To keep that from happening, the PNS takes over and shuts the fight-or-flight reaction down. Dave Grossman calls this effect the “parasympathetic backlash.” Let me illustrate what this can look like:

“During the Korean War, a team of psychiatrists accompanied a unit of veteran soldiers into battle. The unit got a night of good sleep and then launched an attack at dawn. By noon they had secured an enemy hilltop position and the immediate danger was over. While they waited for the inevitable counterattack, the psychiatrists were astounded to see that the officers and NCOs had to go from position to position, waking up the troops. The parasympathetic backlash after the battle had been so powerful that the men had fallen into an exhausted sleep, though they knew they would soon be attacked.”¹¹⁰

It is common after combat situations to experience nausea, shakiness, exhaustion, clammy skin, or other shock-like symptoms. These are completely normal results of the SNS and PNS working against each other to keep you alive. They might seem like a “bug,” but it’s really a “feature.”

110. Grossman and Christensen, 16.

Slide #18: Heart Rate

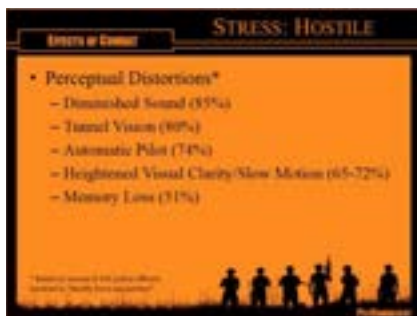


Let's go back to the Sympathetic Nervous System activation. One effect of the hormones released by the SNS involve increased heart rate. The chart on the slide you see comes from Dave Grossman's excellent book *On Combat*, and shows how your body responds at different heart rates. Right now, your heart rate is probably sitting somewhere between 60-80 beats per minute, or BPM. That's pretty good for understanding and thinking about this presentation, digesting whatever you had to eat earlier, and, unfortunately for you, feeling a bit of a desire to go to sleep. Grossman calls this "Condition White." What it's not really good for is reacting to an active shooter coming through the door right now and opening fire on this group. If that were to happen, or to some extent even if you just start to think about and picture that happening, your SNS would kick into gear and accelerate your heart to move you to a greater condition of readiness. As your heart rate increases due to hormonal release, you exchange fine motor skills and higher brain functions for greater physical athletic ability. The range between 115 to 145 BPM (called Condition Red) is probably the optimal rate for peak sustained performance during combat. As you get higher than that, the increases in physical performance

come at a high cost of reduced perception, thought processes, and control of motor skills. Once you get above 175 BPM, you start to see incidence of involuntary behaviors related to fight or flight, including freezing, submissive behavior, uncontrolled aggression or running away, or evacuated bladder and bowels.

The good news is that it is possible to develop some level of control over these functions. Your leaders can help you to train your body to respond correctly and efficiently at higher heart rate levels, even over a sustained period of time. The bad news is that it is really hard to do, because it is difficult to simulate the effects of the SNS. Elevating your heart rate through physical exercise doesn't have the same effect, because it doesn't stimulate the hormonal release caused by SNS activation. So even though a combination obstacle course/firing range can teach you to control your breathing and fine motor skills even when tired, it doesn't do as much to help you learn to work efficiently during SNS activation unless it manages to make you scared or threatened as well. That's part of why during basic training, most of you had the chance to crawl through the sand under barbed wire, while simulated artillery rounds went off near you and fixed machine gun emplacements fired live ammunition over your heads. The goal of training like that is to help teach you to operate correctly when your SNS is going crazy.

Slide #19: Perceptual Distortions



Because of the SNS processes that we've talked about so far, here are some of the effects that can happen to warriors during combat. These statistics come from a survey of police officers who were involved in what was termed "deadly force encounters," or in other words being shot at and/or returning fire. You can see the percentages on the slide. "Diminished sound" means that to the officers, even their own weapons sounded like pop guns. Many of them reported a sort of "tunnel vision," where they were hyper-focused on the enemy and could recall the things they were looking at in great detail, but were completely blind to details they should have noticed that were in their peripheral vision. "Autopilot" just means doing something without thinking about it, or even deciding to do it. "Heightened visual clarity/slow motion" is sort of like the "Matrix" effect, for anyone who saw that movie. In sports, people talk about how "the game slows down" for great athletes. This is because they have trained their bodies to control this slow motion effect caused by SNS activation, and operate efficiently even at elevated heart rate and hormone levels. Finally, about half of the officers reported memory loss, where they could not recall whole periods of time during the

event, but just kind of blacked them out. Again, these effects don't happen to everyone, but when they do, they are normal reactions to SNS activation. To a certain extent, it is possible to train yourself to use these effects to your advantage in combat, but it is difficult to do.

Note: you may want to share a personal story that illustrates these principles, or solicit one if combat veterans are available. This story illustrates “autopilot” and “tunnel vision” effects. The following story is from my own combat experiences:

“During a routine patrol in Iraq, an IED exploded under the vehicle in front of us. After freezing in shock for a moment, I realized that I needed to get up there to help. I tried and tried to get my door open by pushing on the lever, but it wouldn't budge. I panicked, thinking that somehow the door had been jammed by the explosion, and started to yell that I couldn't get out. Finally, I pulled on the handle, and the door swung open easily. We had switched vehicles a couple of weeks before to one with improved armor, and the door opened differently. My brain had instantly reverted back to the vehicle I had trained with, instead of the one I was currently riding in. As I ran to the vehicle in front of me, I didn't even think about looking for secondary IEDs. I know the gunner from that vehicle jumped down and hobbled past me with a broken foot, but I never saw him at all because I was just focused on getting the doors to the vehicle open and getting those guys out.

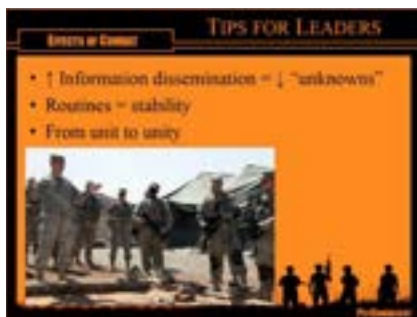
Slide #20: Combat Stress Reaction



As we talk about some of the negative effects that can happen to your mind and body because of combat, we are starting to talk about something called Combat Stress Reaction, or CSR. As you can see on the slide, CSR is the “expected, predictable, emotional, intellectual, physical, and/or behavioral reactions of service members who have been exposed to stressful events in combat or military operations other than war.” An easier way of saying it is that CSR describes normal reactions to the very abnormal conditions that occur in combat. Combat is not a normal thing for people to experience, so we shouldn’t be surprised if they don’t have “normal” reactions, from the civilian point of view. From a warrior’s point of view, these reactions are normal, and are not permanent.

We will talk more about CSR in a later training module, but for now you should remember this: Combat Stress Reaction is a normal reaction to combat, it is not permanent, and it will get better with time. We’ll talk more later about how that happens.

Slide #21: Tips for Leaders

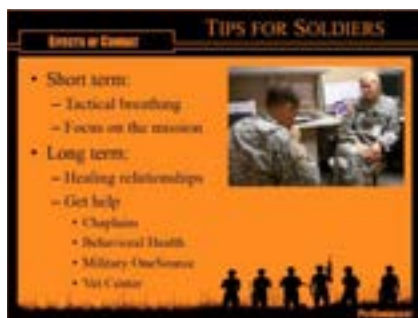


We've talked a lot about different things that can happen to you during combat. I don't want you to leave here thinking that these things are automatically going to happen to you during combat, and there's nothing you can do about it. The truth is that even though some of these things may happen to you, just knowing about them will help you to realize they are normal reactions and you can deal with them in a healthy manner. Also, there *are* things you can do now that can improve your resilience to the effects we've talked about. Think back to the slide on communication, training, and morale, as one of the examples of what I'm talking about.

Let's talk about a few tips for leaders. None of this should really be groundbreaking or new to you, but it never hurts to repeat it. If you have information that you can disseminate to your troops, do it! Keeping troops well informed reduces the anxiety that occurs when there are a lot of unknowns. Another point is that routines help maintain stability. Routines provide activities where soldiers know what to expect, and how they should respond. Again, this reduces anxieties associated with

the unknown. Battle checks and drills are a good example of routines that promote stability. Finally, you should strive to take your unit from just being a bunch of people thrown together, to a group of people with a shared identity and sense of purpose. Group cohesiveness, or unity, is one of the strongest factors that help soldiers to be psychologically strong in combat, and resistant to the negative effects of Combat Stress Reaction.

Slide #22: Tip for Soldiers



Here are some tips for everyone. In the middle of combat, or when you're dealing with the terrible things that happen in combat such as physical injuries, deaths, or moral wounds, there are some things you can do that will help in the short term.

The first is called "tactical breathing." Tactical breathing is a technique that will help you to reduce your heart rate during SNS activation, and can also help you to center yourself and feel a measure of calm and peace when experiencing Combat Stress Reaction. Although you can tailor tactical breathing to your own needs, start with this simple pattern of four cycles

with four counts. Cycle one: breathe in deeply through the nose for four counts, hold for four counts, breathe out through the lips for four counts, and hold for four counts. Repeat as many times as you need to feel calmer. Practice with me for a second, to the pace of this rhythm: “In through the nose, two, three, four. Hold, two, three, four. Out through the lips, two, three, four. Hold, two, three, four.”

Note: You may want to practice this for several cycles, until everyone gets the pattern and possibly feels the basic effects.

Another tool at your disposal in the short term is to focus on the mission. Having an immediate purpose, a job to do, can help you get through some really tough situations. It's easier to tell yourself you have to keep going *until this job is done*, than to tell yourself you have to keep going indefinitely.

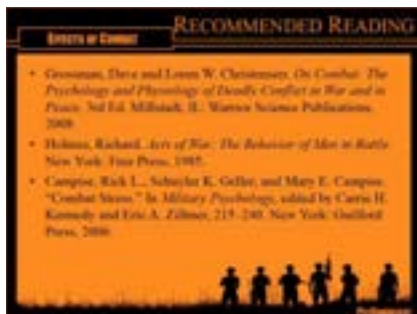
Again, these techniques can help you for a short period of time when you have to keep going, but sooner or later you're going to need to stop and deal with the effects of what you have experienced in combat in a more permanent way. These are some of the things that will help you to recover in a more permanent sense.

The first one is to focus on developing or maintaining “healing relationships.” This might be your relationship with a battle buddy, or with a spouse or significant other, or maybe with a family member or someone in your community that you trust and respect, perhaps a religious leader. In all cases, the relationship needs to be one based on trust and mutual respect, so that you feel safe talking about the things that are on your mind and in your heart. It is not “unmanly” or a sign of weakness to talk to someone about things that are bothering

you; it is a sign of being a healthy, well-adjusted human being who realizes we are not meant to survive just on our own.

The second tip is to get help when you are experiencing the effects of CSR, or anything else that you've gone through that doesn't seem to just go away or get better with time. As a soldier, there are a number of great resources at your disposal. Chaplains have complete confidentiality, meaning you can talk about anything you need to without fear that it will get out to your leaders or buddies. Behavioral Health counselors are trained professionals that can teach you practical ways to recover from what you have experienced. If you want to find help but aren't sure where to turn, militaryonesource.com or armyonesource.com are great places to start. And finally, if you need something off-post and confidential, or know someone who needs help who no longer is on active duty, your local community might have a Vet Center, which provides free counseling to veterans. You might choose one or several of these, but just remember: you don't have to do this alone, and it is a sign of strength to seek help. Combat can cause difficult challenges that might last for a long time, but it can and does get better with help.

Slide #23: Recommended Reading



If you're interested in finding out more about the things we've talked about today, these are some great books you can read on the subject to get you started. If you only have time for one of them, I would suggest *On Combat* by Dave Grossman and Loren Christensen. Feel free to contact me if you'd like this list, or other suggestions.

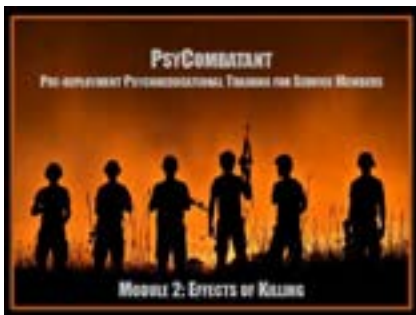
Slide #24: Questions



Note: you can ask for questions here, and then release the soldiers back to their commander or brief them on how much time they have for a break before the next module begins. The quote is just to give the troops something to think about if they are not actively involved with the questions; you can read it or not, as you prefer.

Module 2: Effects of Killing

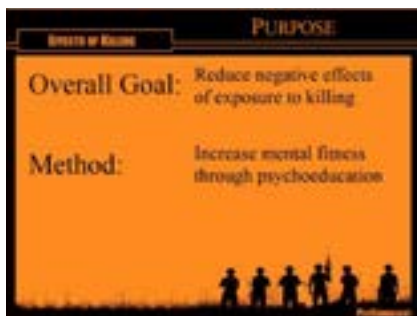
Slide #1: Introduction



Note: Use this slide to introduce yourself and make any administrative remarks before beginning.

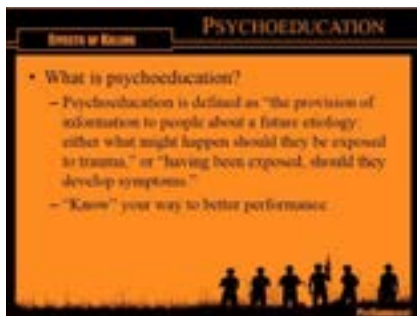
We are about to begin the second instructional module of PsyCombatant: Pre-deployment Psychoeducational Training for Service Members. This module will focus on the effects of killing on the minds and bodies of combatants. There are two additional modules that address the effects of combat and exposure to trauma. Together, these three modules are meant to help service members prepare mentally for combat deployments.

Slide #2: Purpose



The overall goal of this module is to understand and reduce the negative effects of killing. The way we are going to do that is to increase your mental fitness through psychoeducational training, so that you will be more resilient when you face combat. If you have already been exposed to combat, this training may help you to understand some of the things that you may have experienced, or seen happen to your teammates.

Slide #3: Psychoeducation



Note: If this module is being presented shortly after the first

module, you may summarize or skip this slide. If this module is being presented as stand-alone training, or if more than several weeks have passed since the first module, then you may choose to read the following explanation of psychoeducation.

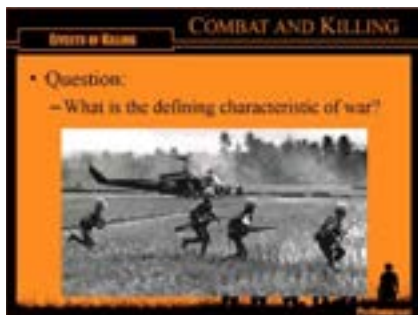
What is psychoeducation? As you can see, psychoeducation is defined as “the provision of information to people about a future etiology: either what might happen should they be exposed to trauma,” or “having been exposed, should they develop symptoms.” That’s a really technical way of saying that psychoeducation is just information about how your mind works, and a way of helping you to understand what is going on in your head under given circumstances. In this case, we’re going to be talking about how combat affects your mind, which in turn affects your body. Combat can cause strange things to happen to your mind and body, and having some idea of what is happening and why can actually help you to cope better with those challenges. The better you cope, the more capable you are to continue the mission, whether that’s winning the fight or recovering afterward. In this way, you can actually “know” your way to better performance as a soldier.

Slide #4: Outline



Here's a look at the outline for this module. We're going to begin by looking at how killing fits into the combat experience. Then we will talk about the natural human tendency to resist killing others (at least for most of us). We will look at what goes on in the soldier's mind during combat, and then look at how soldiers live with having killed the enemy after the fight is over. Finally, we will talk about what you can do to get help if you're struggling with the effects of killing, and what resources are available to you.

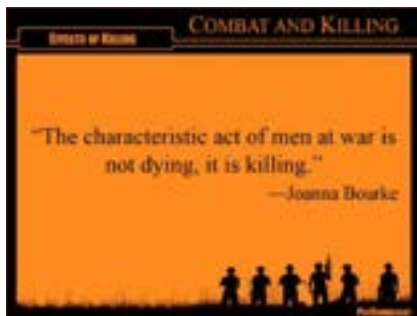
Slide #5: Defining Characteristic of War



Note: Depending on the size of the group and the opportunity for participation, you may want to spend a few moments soliciting answers to this and the next few slides. If the environment is not conducive to interaction with the audience, then you may want to pose these questions as hypothetical statements and allow a moment for introspective thought, before supplying possible answers for the group.

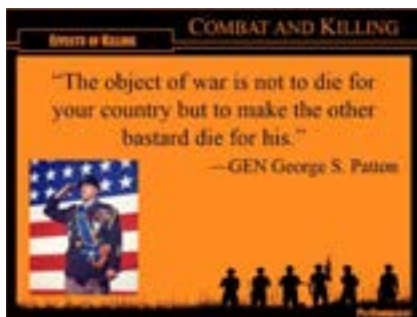
This should be an easy question for a bunch of professional warriors like you. If you had to define war in only a few words, what would you say? What is war all about?

Slide #6: Joanna Bourke



Here is one possible answer to the question on the previous slide. Joanna Bourke is a historian who has written about twentieth-century warfare. What do you think she is trying to say with this statement, “The characteristic act of men at war is not dying, it is killing”? Do you agree with her?

Slide #7: General Patton



Here's another quote on the subject that you may have heard before. General Patton is not remembered as a timid soul, so this quote seems in line with his personality. But I

think his point is very similar to Burke's statement on the last slide. When you get down to the heart of war, it represents the proverbial "stick" the government can use to change the behavior of another nation when the "carrot" isn't working. And the power of that stick is the ability to project lethal force at the enemy—in other words, the power to kill. What do you think of this assessment?

Slide #8: Conspiracy of Silence



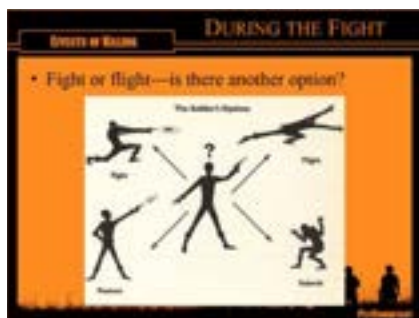
Colonel Milton Mater, who served as an infantry commander in World War II, observed that his soldiers were reluctant to fire their weapons at the enemy. Mater was bewildered that his men would resist attacking even when their own lives were at stake. He was more surprised when he learned that this wasn't something unique to his unit, but was a common phenomenon at the time. If an essential part of war is using lethal force, than why weren't the soldiers doing so, and moreover, why wasn't anybody talking about it? Colonel Mater wrote, "It is as if there were a conspiracy of silence around this subject."¹¹¹ He was right, but the issue was even bigger than he imagined. It's not just that nobody wanted to talk about why soldiers weren't shooting at the enemy, it's that everybody

111. Grossman, 35

seemed afraid to admit that most soldiers are reluctant to kill at all. This truth flies in the face of the brave warrior myth, where real men and women have no problem pulling the trigger for God and country.

Lieutenant Colonel Dave Grossman, a soldier and historian, is one of the leading experts on the effects of combat and killing on soldiers. He wrote, “There are two things men will always lie about,” one of those being war stories, and the other you can guess at. This means that “everything you think you know about war is based on 5,000 years of lies.”¹¹² We’re going to try and look past the lies and get to the truth behind the “conspiracy of silence” regarding killing.

Slide #9: Fight or Flight



You are all probably familiar with the phrase “fight or flight,” meaning that a threatened animal will instinctively respond by either trying to destroy the threat (fight) or escape from it (flight). This is true when animals are threatened by other species, but presents an incomplete picture when they are threatened by their own species. When that happens,

112. Grossman and Christensen, 10.

animals have two choices that are more common: posture or submit. For example, rattlesnakes and piranha are known to ruthlessly attack almost any creature within range. However, when they fight their own kind, rattlesnakes will wrestle without biting, and piranha will flail with their tails instead of their teeth. Eventually, one combatant becomes convinced the other is stronger, and will submit, usually by showing its throat or other vulnerability. The dominant animal will almost never complete the easy kill at that point, satisfied with having exerted dominance.

What does this have to do with you? Historical combat studies have shown that humans use a remarkably similar process in combat. For centuries, soldiers have tried to present themselves to be as threatening as possible to scare the enemy away from a fight. Wearing tall, plumed helmets and bright, bulky armor made warriors seem taller and more formidable. Yelling and gesturing convinced the enemy they meant business. And with the advent of firearms, it was suddenly easy to make terribly loud noises, even while aiming in the sky, above the enemy. These are all examples of posturing—the attempt to win a fight before it gets serious enough to threaten the lives of those involved. When faced with such behavior, it is natural for some soldiers to freeze or submit, as an instinctual effort to preserve their life. Soldiers can overcome these instinctive reactions through training, which is part of the reason the Army uses combatives and pugil sticks to help soldiers overcome aversion to interpersonal hostility.

Slide #10: Resistance to Killing



When we think about hostile situations, the flight response makes sense—sometimes the only way to win an impossible fight is to escape it. The posture and submit responses make a little less sense, unless there really is some force that causes people and animals to resist wanting to kill each other. Whether that force is put in place by God or biology, studies show that it exists. As LTC Grossman wrote, “This resistance to killing . . . is there, it is strong, and it gives us cause to believe that there may just be hope for mankind after all.” He sees this force as a good thing, something that has kept us from eradicating our own race. Even if he’s right and it is a good thing, it can cause a very negative effect on the minds of those who then are forced to kill someone else.

Grossman broke this force down into six different factors that contribute to the overall resistance to killing. You can see these factors on the left side of the slide. The point is that there are a lot of things contributing to a very real resistance to killing. That’s a good thing if you’re trying to preserve society through nonviolence, but not so good if, like General Patton asserts, you sometimes need to kill the other guy to preserve

peaceful society. Let's look at how this resistance operates in soldiers.

Slide #11: One Shot One Kill



In basic training, Drill Sergeants take civilians and attempt to turn them into warriors. There are numerous examples we could point out, but we'll pick one having to do with weapons training. When withdrawing weapons from the arms room, one company forced each soldier to jump through the doorway yelling, "One shot, one kill!" While we can appreciate the reasoning behind this training, history shows that the sentiment is completely inaccurate. Historians analyzing Civil War battles have found that only about 15-20% of soldiers ever actually fired at the enemy. Listen to this example:

Note: The following story can be read, summarized, or skipped, depending on time requirements.

The Civil War soldier was, without a doubt, the best trained and equipped soldier yet seen on the face of the earth. Then came the day of combat, the day for which he had drilled and marched for so long. And with that day came the destruction of

all his preconceptions and delusions about what would happen.

At first the vision of a long line of men with every man firing in unison might hold true. If the leaders maintained control, and if the terrain was not too broken, for a while the battle could be one of volleys between regiments. But even while firing in regimental volleys, something was wrong. Terribly, frightfully wrong. An average engagement would take place at thirty yards. But instead of mowing down hundreds of enemy soldiers in the first minute, regiments killed only one or two men per minute. And instead of the enemy formations disintegrating in a hail of lead, they stood and exchanged fire for hours on end.

Sooner or later (and usually sooner), the long lines firing volleys in unison would begin to break down. And in the midst of the confusion, the smoke, the thunder of the firing, and the screams of the wounded, soldiers would revert from cogs in a machine to individuals doing what comes naturally to them. Some load, some pass weapons, some tend the wounded, some shout orders, a few run, a few wander off in the smoke or find a convenient low spot to sink into, and a few, a very few, shoot.¹¹³

The Civil War was not the only time this phenomenon has been observed. Brigadier General S. L. A. Marshall, a military historian, conducted interviews with many soldiers after World War II. He was amazed to discover that again, less than 20% of the men ever fired their weapons at the enemy. Clearly, something needed to be done to make soldiers more efficient killing machines. Ideas were proposed, and training was changed, and it worked. The firing rate during the Vietnam War rose to over 90%, a staggering increase over every previous

113. Grossman, 20.

conflict involving gunpowder weapons. But this increase in firing did not translate into an increase in kills.

Slide #12: Douglas Graham



This quote by a U.S. Marine who served in the Vietnam War illustrates a phenomenon that continues to baffle soldiers and scholars alike. Douglas Graham said, “One of the things that amazed me is how many bullets can be fired during a fire-fight without anyone getting hurt.” Many soldiers have been amazed by the same thing in today’s conflicts. Although training caused firing rates to increase, and soldiers are just as accurate or more with their weapons as the highly trained combatants of the Civil War, kill rates remain low. Some of this can be attributed to the chaos of battle, something many veterans can attest to. But there is something else going on here that keeps aimed fire from getting to its target. Before we can figure that out, let’s look at how the Army got from 20% to 90% firing rates.

Slide #13: Pop-ups vs. Paper



From the Civil War through World War II, the Army taught marksmanship using stationary targets to gauge accuracy. The paper target on the right of this slide is an example of the kind of targets that are still used in civilian marksmanship competitions today. Becoming proficient at hitting these targets makes you a trained and accurate rifleman, but it does not make you a killer. To do that, we need something else.

The big increase in firing came from the use of pop-up targets. The firing range is now structured to resemble a game, complete with earning as many points as possible and declaring winners and losers. Firers are assigned to a lane, and told to basically shoot anything that moves. A green, man-shaped silhouette pops up, and the firer immediately shoots at it. If the bullet hits the target, the silhouette falls down, and a point is registered for the firer. Afterward, the soldier gets a badge to wear to show how many enemies were hit. Psychologically, this is a great example of conditioning soldiers to behave a certain way. They see something move, it looks like a soldier, they shoot at it, and if they did well, it falls down. Because points

are awarded, that falling silhouette triggers a little reward in the brain of the soldier, a positive reinforcement to the behavior of shooting at the enemy. If you aren't convinced of the effectiveness of this kind of training, think back to the last time you were on a pop-up range. Did you ever shoot at a target that you were sure you hit, and watched it stay up? How angry did you get at the apparent malfunction? How much did it make you want to knock down the next little bad guy, and the next, and the next?

Training like this caused a dramatic change in helping soldiers get over their aversion to shooting at the enemy, because it took all the thinking out of the action. Once thinking is eliminated, we'll look at the next obstacle to eliminate, which is *feeling*.

Slide #14: Dehumanization



Research shows that the more you see the enemy as someone like yourself, the less likely you are to try and kill them. So the best way to get over this aversion is to see the enemy as anything but someone like yourself. As historian Richard Holmes noted,

The soldier goes to war with an abstract image of the enemy in his mind's eye, an image sometimes sullied by officially-inspired propaganda and almost always spattered by the mud thrown by the popular press. His training will have featured 'aggressor forces' or 'terrorists', and the very language he is encouraged to use will suggest that he is dealing, not with another human being thrust by the turn of the dice into a different uniform, but with a mere object of hostility belonging to some different tribe—almost to another species.¹¹⁴

So what do these three historical enemies of ours have in common? The Krauts, Charlie, and Hajji have all been depersonalized so that you don't feel any more affinity toward them than you do to the target on the right side of the slide.

Note: if you are in a smaller-group setting or if time allows, you may wish to solicit comments or opinions at this point regarding how soldiers feel about depersonalization of the enemy.

Slide #15: Finding a Balance

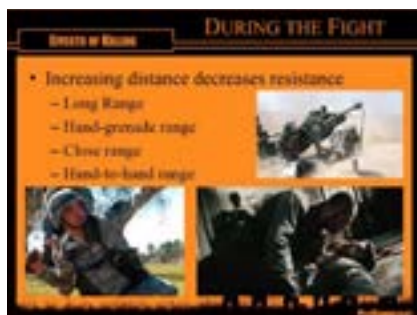


114. Holmes, 360.

Depersonalization of the enemy works well to help soldiers overcome their resistance to killing. The problem is that it works too well. The Holocaust is only one example of what happens when this mechanism is encouraged to run unchecked. So as a soldier, and as an Army, our challenge is to find a balance between these two forces, enmity and affinity. If we reduce the resistance to killing through dehumanization completely, there is nothing to keep us from becoming war criminals who kill indiscriminately. On the other hand, if we see the enemy too much like ourselves, it can be very difficult to overcome the natural resistance to killing our own species, perhaps leaving our only choice to be conscientious objectors—perhaps a suitable choice for a civilian, but not so much for a warrior.

Note: As a presenter, you should give some thought to how you would respond to questions regarding the best way to find this balance. Part of the reason this training was designed to be delivered by chaplains is the hope that their unique role as non-combatants who are nevertheless combat multipliers will allow them to offer some wisdom in this area.

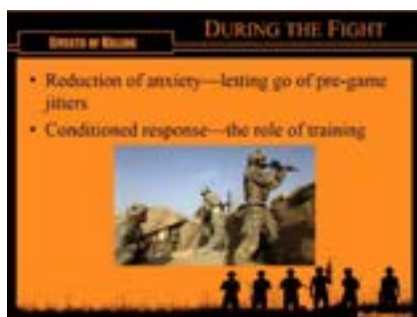
Slide #16: Distance



Up until now, we've been talking about how resistance to killing can be overcome through training, or before the fight is joined. Once combat commences, new factors come into play. One of the biggest effects in combat on the reluctance to kill is the distance at which that killing must happen. Years ago, a popular song proclaimed that "from a distance, you look like a friend, even though we are at war." The truth is the opposite. Studies show that it is not only much easier to kill at long range, it can be less psychologically damaging to the combatant. For instance, the bomber pilot or artilleryman who never sees the people they are killing (even if in large numbers) usually has a lower incidence of negative psychological issues related to remorse over their actions than the soldier who puts their front sight post on a person, pulls the trigger, and watches them fall. Psychologically, the most potential for damage exists at the closest range. Some of you might recognize the scene from the movie "Saving Private Ryan" in the bottom right image. Impaling the enemy with a sharp object at hand-to-hand range is considered the most difficult action to commit, with regards to the resistance to kill, because you can see, hear, smell, and feel the results of your action on someone who looks remarkably human at that distance. To illustrate how this works in combat, during the first World War, soldiers had bayonets fixed to the end of their rifles, and would use them in charges at the enemy. However, once soldiers got within stab range, they often preferred to use their rifles as clubs against the enemy. Prince Frederick Charles asked one of the German infantrymen why he did this, and the man replied, "I don't know, when you get your dander up the thing turns around in your hand of itself."¹¹⁵ It is possible that the soldiers were unconsciously choosing to use a form of combat that would be less scarring to their own minds.

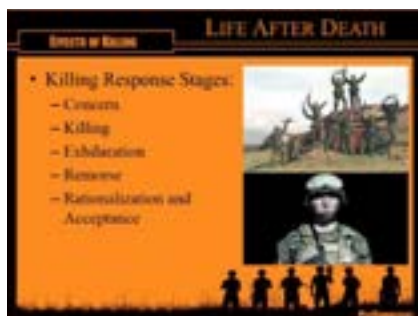
115. Holmes, 379.

Slide #17: Training Reduces Anxiety



One thing that you may notice in combat is that before the fight, when the patrol is just beginning, or when you think the enemy might be preparing to attack, you might feel a noticeable surge in anxiety or nervousness. This is a normal effect of your body releasing adrenaline and preparing you to fight, and you may have experienced similar feelings before a sports match or other contest. Once the first shots are exchanged, soldiers often report feeling that anxiety quickly and completely disappear, as the training of warrior tasks and drills takes over and the soldier goes to work. One common source of anxiety is the worry of whether you will fight courageously, or find out that you are a coward. The encouraging thing to remember is that soldiers almost overwhelmingly fight as they have been trained. If you are trained well, then you will most likely acquit yourself well on the battlefield.

Slide #18: Killing Response Stages



Once the fight is over, and training no longer controls the instinctive actions of the soldier, reflective thoughts begin to assert themselves. Stage one, concern, actually happens before the fight, and describes the anxiety we just discussed on the last slide. Stage two, killing, happens during the heat of battle, and can be at any of the distances we've talked about. As a result of modern training techniques, most combat kills come without any thought, as a reflexive action. He's up, I see him, he's down. There is no time for reflection during the fight. Stage three, exhilaration, often follows immediately after the kill, or after the battle is over.

Note: you may want to share personal stories of your own or others during this portion to illustrate the concepts. The following is from my own experiences and may be shared:

As an intelligence specialist assigned to an infantry platoon, I had been training several Navy reservists on how to use the equipment necessary for our mission. Finally, I decided that they were ready to go out on a patrol without me looking over their shoulder. As the Humvees left the

compound, I felt a nagging worry about not being with the guys during a patrol. I waited anxiously for them to come back, trying to keep myself occupied with a book I could barely pay attention to. Finally I heard the trucks pull in, accompanied by the whooping shouts of my teammates, "Dude, you missed it, you've got to come see this!" The soldiers climbed out of the vehicles, obviously pumped up more than normal. The trucks had bullet holes in several places, and I noticed some stringy material hanging from the window where I normally sat. It turned out to be human intestines, I found out, donated by an insurgent who had the bad fortune to get shot before throwing his grenade. As the soldiers enthusiastically described the battle they had just gone through, I couldn't get over the shock of what I was seeing and hearing. But since the blood and guts didn't belong to any of our guys, they were in a total state of triumphant victory.

After the exhilaration stage wears off, remorse can set in. During this stage, the soldier relives the event, perhaps with intrusive memories or in nightmares. Soldiers can be consumed with thoughts of what the person they killed was like, if they had a family, or any other personal details. The soldier might also during this stage become preoccupied by his or her own mortality. If the soldier progresses rapidly from kill to exhilaration to remorse within a matter of seconds, this stage can manifest itself through vomiting and extreme disgust. For many modern soldiers who need to continue fighting even after traumatic events like this, they become quite competent at compartmentalizing, or shutting away these difficult emotions. When that happens, these soldiers are often much more capable of subsequent killings, becoming cold and hardened. This is a natural and perhaps effective coping mechanism for

dealing with such horrific circumstances in the short term, but it rarely works out well long-term and is considered by some experts to be one of the essential causes of PTSD. At some point the soldier usually needs to progress through the last stage, rationalization and acceptance, where they come to terms with what they've experienced.

Slide #19: Restructuring the Narrative



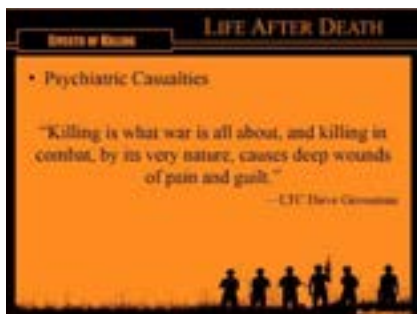
Joanna Bourke referred to this last stage as “restructuring the narrative.” She claimed that during the rationalization stage, soldiers had to reimagine what had happened in terms that made their actions acceptable in their own eyes. As she described it,

Note: you may read the entire quote, or only the underlined portion, according to time or preference.

Fantasy and experience were intertwined, but not indistinguishable.....In the act of killing, however, the two could not be easily separated and, in terms of moral survival, it was crucial that it remained that way. If combatants became disillusioned, it was because they felt

that they were in the wrong film, enacting a strange script, rather than because they wanted to repudiate aggressive dialogues. When combat servicemen cried out (in the words of one Vietnam veteran) “hey, this isn’t a movie,” what they meant was “I don’t recognize this movie.” More typically, combatants were able to construct a story around acts of exceptional violence which could render their actions pleasurable. The emphasis on the beauty of war—the colour of napalm, the shine of steel, the maternal bulk of the tank—distracted attention from the smell of burning flesh, gaping wounds, and dismemberment. Carnavalesque rites and fantasies drawn from a wide range of combat literature and films enabled combatants to refashion themselves as heroic warriors. Fear, anxiety, pain; these are only too familiar in combat. But excitement, joy, and satisfaction were equally fundamental emotions, inspired by imagining that they had scored a good, clean “kill”.¹¹⁶

Slide #20: Psychiatric Casualties



Even if soldiers are able to successfully pass through the rationalization and acceptance stage (and especially if they

116. Bourke, 31.

are not), it is possible that they might become psychologically wounded by their actions. A big part of the burden soldiers bear as a result of killing seems to depend on their perceptions of what happened. If they see themselves as having carried out their duty correctly in the defense of their buddies or other innocents, they are much more likely to be able to deal with the pain and guilt associated with those actions. On the other hand, the more they see themselves as having done something wrong, the more likely it is that they will have lasting emotional difficulties, including incidence of PTSD. The good news is that behavioral health specialists are very good at helping soldiers through the process of understanding their actions in a way that facilitates acceptance and healing. Yes, killing does damage to the soul, but that damage can and does heal.

Slide #21: Tips for Leaders



Leaders, the good news for you is that one of the best things you can do to help your soldiers is to simply be very good at your job. The better you are able to train your soldiers to correctly respond to combat situations, and the more clearly you can explain the Rules Of Engagement (ROE) so that they understand and act within the law, the better the chance is

that they will be able to perceive themselves as having acted correctly, thus reducing the likelihood that they get “stuck” before completing the acceptance phase.

Also, be sensitive to soldiers who might be working through the stages of reaction to killing, and encourage them to get help when possible. You can help to break down the stigma associated with asking for help that might be keeping some of your soldiers suffering in isolation.

Slide #22: Tips for Soldiers



Every soldier can commit to breaking the conspiracy of silence by not being afraid to tell your story openly and honestly, without fear of having to conform to the mold of popular views.

Note: the following is a personal story related to the author that you can share if you wish to illustrate, or you may choose your own illustration, or skip this step.

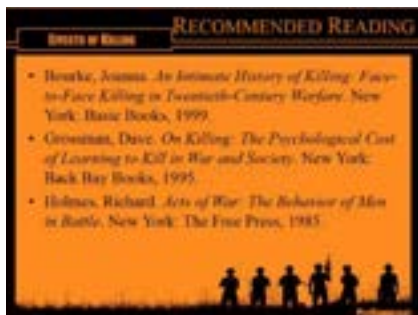
A Vietnam veteran struggled for years with memories of his combat deployments. Wounded in action, he

consistently and in great detail recounted how his patrol had come under ambush by the Vietnamese, and had taken casualties, including a head wound suffered by the veteran. After many years, the veteran broke down sobbing and confessed that the ambush had never happened. Instead, his patrol had come under friendly fire as they returned in the dark to their own firebase. His shame at having been wounded by his own guys instead of the enemy kept him from completely accepting the event years after the fact. After finally telling the story the way it actually happened, he was visibly relieved and was able to receive the loving support and confirmation of those who thought more, not less, of his heroism and sacrifice.

You can support each other best by being a member of a team, and helping each other to do the right thing. Morale and group cohesion are consistent factors that support resiliency in soldiers.

Finally, if you or someone you know is suffering with troubling memories or feelings, encourage them to seek help from one of the people or resources listed on this slide.

Slide #23: Recommended Reading



This slide shows just a few of the books that contributed to this module. If you are interested in this subject and would like to know more, the best place to start would be to read Dave Grossman's *On Killing*, which is considered to be the best for this subject.

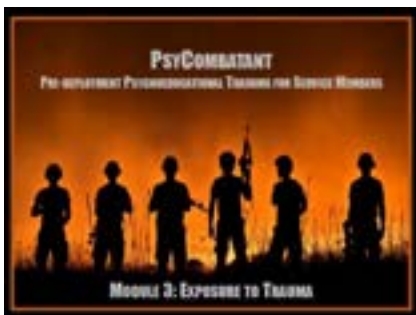
Slide #24: Questions



Note: you may take questions at this point, or release the soldiers back to their unit or on break before the next module begins.

Module 3: Exposure to Trauma

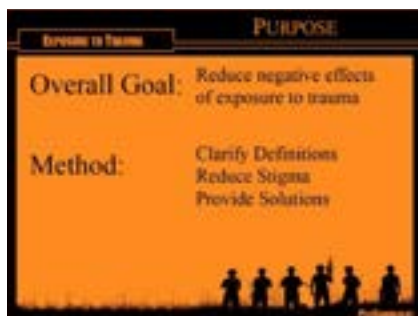
Slide #1: Introduction



Note: Use this slide to introduce yourself and make any administrative remarks before beginning.

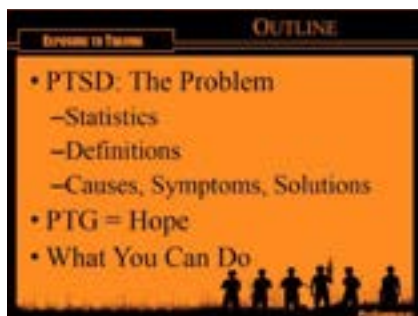
We are about to begin the third and last instructional module of PsyCombatant: Pre-deployment Psychoeducational Training for Service Members. This module will be focused on the effects of exposure to trauma on the minds and bodies of participants. There are two additional modules that address the effects of combat and killing. Together, these three modules are meant to help service members prepare mentally for combat deployments.

Slide #2: Purpose



The overall goal of this module is to understand and reduce the negative effects of exposure to trauma. The way we are going to do that is to clarify the definitions of some terms you may have heard, reduce stigma associated with symptoms and seeking help for traumatic events, and provide practical solutions that you can do to keep yourself and your buddies mentally fit and resilient.

Slide #3: Outline



Here's where we are going in this module. I'm sure almost all of you have heard of Posttraumatic Stress Disorder, or PTSD,

but you might all have different ideas about what it is and what causes it. We're going to talk about it and related problems, and find out how to recognize and get appropriate treatment for them. We're also going to talk about Posttraumatic Growth (PTG), something you might not have heard of. We'll wrap up by talking about what you can do to stay healthy.

Slide #4: PTSD: USA Today



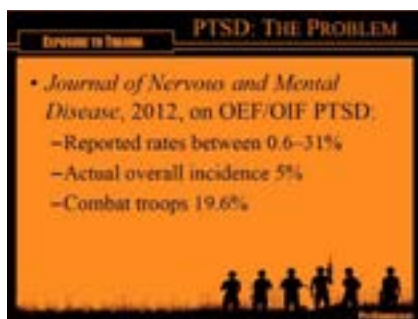
Note: This slide represents the current news regarding PTSD and the military at the time these slides were developed. You may wish to use this only as an introduction to current events or news on PTSD at the time you are presenting. The following text is optional:

This headline is from only a few days before these slides were developed, when Specialist Ivan Lopez opened fire on Fort Hood, killing several soldiers and wounding many others before turning the gun on himself. The shooting immediately brought PTSD back to the front of public discussion, as America remembered that soldiers have been deploying and fighting for over a decade. You can see the headline, "Military Playing Catch-up on PTSD," and the article contained the following statistics released by the Pentagon: 1,000 Iraq and Afghanistan

veterans are diagnosed with PTSD every week, and over 155,000 troops in total have been diagnosed, with more than three quarters of them combat veterans.

Headlines and news such as this present a very alarming picture of PTSD and combat veterans, but what do these numbers really mean?

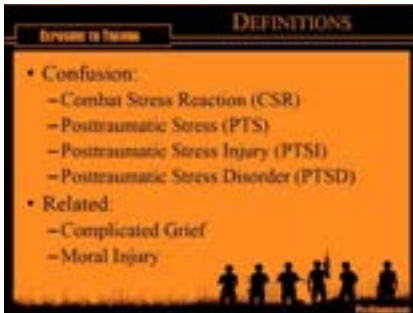
Slide #5: Journal of Nervous and Mental Disease



A 2012 article in the *Journal of Nervous and Mental Disease* found that reports of diagnosis rates are all over the map. As different studies used different criteria to include or exclude certain populations, they came up with vastly different rates to show how many soldiers are affected by PTSD. Studies have reported rates anywhere between half a percent all the way to almost one third of all soldiers who served in Operations Enduring Freedom or Iraqi Freedom. When the authors of this study adjusted those reports to allow for what most would consider a fairly strict definition of PTSD, they found that about five percent of service members were diagnosed with PTSD, a fairly low number, and not much different from what you would see among civilians. Where the rate climbs sharply is

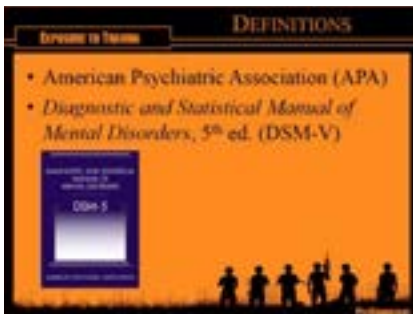
when the population is limited to just troops that were exposed to combat, then it jumps to almost one in five soldiers who were diagnosed.

Slide #6: Definitions



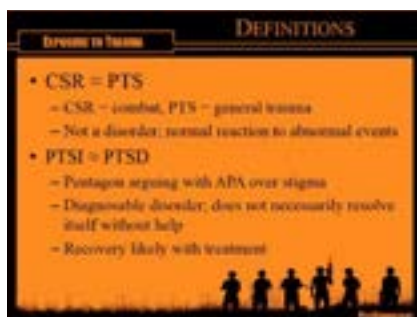
When we talk about PTSD, there is some confusion over exactly what it is. To further complicate things, there are other terms we throw around, like Posttraumatic Stress, Posttraumatic Stress Injury, or Combat Stress Reaction. And that's not even touching related issues like Complicated Grief or Moral Injury.

Slide #7: APA and DSM-V



So who gets to decide what PTSD is anyway? The answer is the APA, the American Psychiatric Association. Every so many years, they publish a new edition of what's called the DSM, the *Diagnostic and Statistical Manual of Mental Disorders*. Each time they publish a new version, they change some of the categories, and add or refine some of the disorders described. If you've ever thought someone might be crazy, the way to find out would be to see if they match up with any of the disorders described in this book, since this is what mental health professionals use to classify what different patients are experiencing. So the APA gets to make the rules about what PTSD and every other mental disorder does or does not mean.

Slide #8: CSR, PTS, PTSI and PTSD

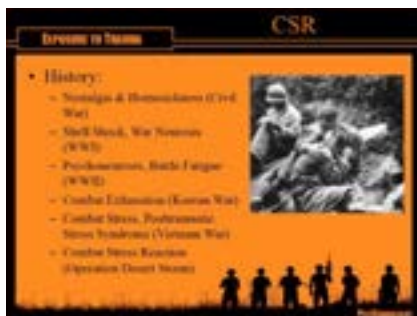


Here's what you should know about some of the terms we mentioned a few slides ago. Combat Stress Reaction, or CSR, is closely related to Posttraumatic Stress, or PTS. Neither one of these things is actually defined in the DSM, because neither one is a mental disorder. Instead, they are both normal reactions that people go through when they are exposed to events that are *not normal*, which is why they can be traumatic. CSR specifically deals with symptoms associated with trauma related to combat, whereas PTS involves symptoms of exposure

to any kind of trauma, not just what we would find in the military.

You probably have heard of PTSD, but you may or may not have heard of Posttraumatic Stress Injury, or PTSI. Before the fifth edition of the DSM was published, the Pentagon asked the APA to change the term PTSD to PTSI. Their reasoning was that the word disorder carries a lot of stigma with it, and keeps soldiers from seeking help. They wanted it changed to injury, which they thought would make it more likely that soldiers would be willing to seek treatment. The APA refused, and a study by the RAND corporation showed that changing the name made little difference to soldiers—most of them didn't want to get help, no matter what it was called. That didn't stop the Army from continuing to call it PTSI, or in some cases PTS, just to confuse you. In any case, what makes PTSD or, if they're calling it PTSI different from CSR or PTS, is that PTSD is a diagnosable disorder in the DSM, and does not necessarily resolve itself *without help*. However, recovery is likely when treated by competent behavioral health professionals.

Slide #9: History

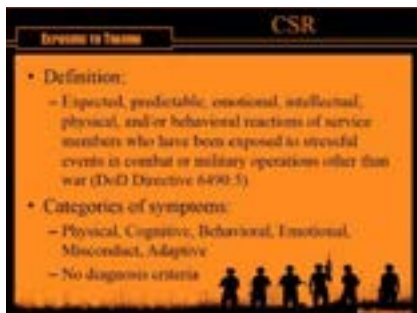


Combat Stress Reaction is only the latest name that people have come up with for a group of symptoms that soldiers have experienced for centuries. In the Civil War they called it nostalgia or homesickness, in World War I they called it shell shock or war neurosis, and twenty five years later they were calling it psychoneurosis or battle fatigue.

Note: if this module is taught shortly after module two, you may want to mention that General Patton, who was quoted in that module, was widely criticized in the press for reports that he slapped and berated soldiers suffering from “battle fatigue” and ordered them back to the front lines, showing how much leaders’ views have changed (or not in some cases) on this issue in recent years.

During the Korean War it changed to Combat Exhaustion, and in Vietnam it became Combat Stress or Posttraumatic Stress Syndrome. By Operation Desert Storm it was called CSR, which is one of the main terms used today. Whatever you want to call it, we’re talking about the same thing—the normal reactions most people have to the extreme conditions of combat.

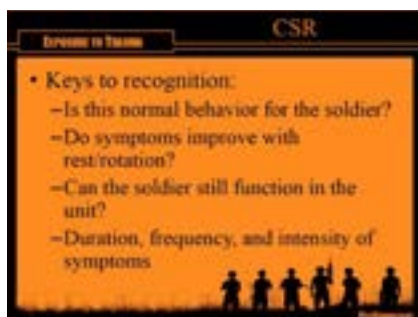
Slide #10: CSR Definition



The problem with CSR is that there is no good diagnosis or even definition of what it is. The Department of Defense calls it the “expected, predictable, emotional, intellectual, physical, and/or behavioral reactions of service members who have been exposed to stressful events in combat or military operations other than war.”¹¹⁷ This would be a great definition except that it still doesn’t describe the symptoms.

There are at least six different categories of symptoms that might be expressed, which you can see on the slide. There is no official criteria to diagnose CSR—there’s no good way to say “if you have X number of symptoms for Y duration of time, with Z intensity, you have CSR. So what is it, and what do you do?

Slide #11: Keys to Recognition



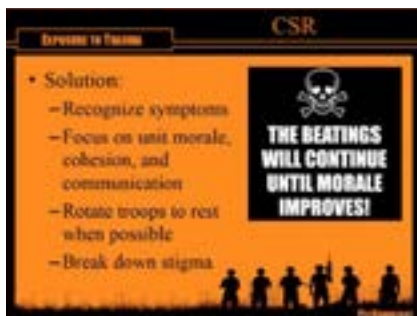
There are some simple keys to recognizing CSR. First of all, these symptoms are expressed in combat environments. That doesn’t just mean when you’re actually getting shot at, but can be associated with the different stresses of the combat environment that were talked about in the first module of this training. There are some questions you should ask to help

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determine if soldiers have CSR, which you can see on the slide:

- Is this normal behavior for the soldier, or is this out of character for him or her?
- Do symptoms improve if the soldier gets some rest, or is rotated out of combat for a few days?
- This question is considered one of the most important: Can the soldier still serve as a functioning part of the unit, and carry on with the mission?
- Finally, you need to judge how long the symptoms have been present, how often they occur, and how much they manage to interfere with the soldier's ability to do his or her job.

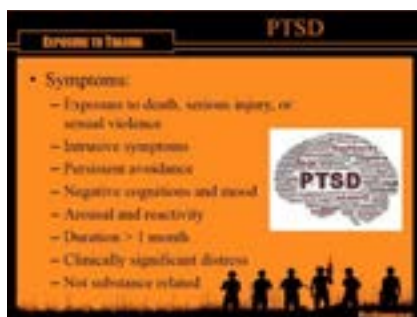
Slide #12: CSR Solutions



Here's what you can do about CSR. First of all, recognize the symptoms. Leaders, you should know your soldiers, and the rest of you should know your buddies. Look for signs that they're not themselves, or that behavior has changed as a result of being in the combat environment. Leaders and soldiers can focus on improving unit morale, cohesion, and communication, since those are the top characteristics of

units that have low incidence of CSR. When possible, soldiers who seem to be struggling should be rotated to rest. If they are struggling with CSR, symptoms should improve within a few days. Finally, help break down the stigma of struggling with psychological challenges. Again, these are normal reactions to stressful events, and any of us could experience them. It doesn't make us bad soldiers, it just makes us human. Recognize that it's ok to talk about these things; just the fact that we are talking about this right now may make you more resilient to the effects of CSR.

Slide #13: PTSD Symptoms



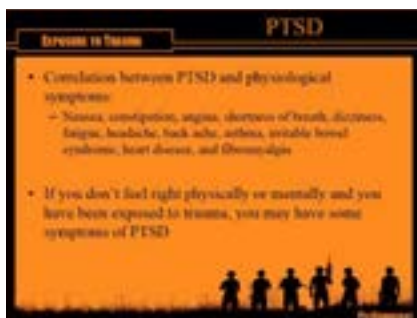
Now let's talk about PTSD. There is a very specific set of criteria that need to be met in order for someone to be diagnosed with PTSD. First, they need to have been exposed to a serious traumatic event where they either were themselves or witnessed first-hand a death, serious injury, or sexual violence. After the event, there is some manifestation of the following:

- Intrusive symptoms. These are unwanted memories or feelings associated with the event that won't go away, and keep coming up in the person's life. Flashbacks or

nightmares are one example of this.

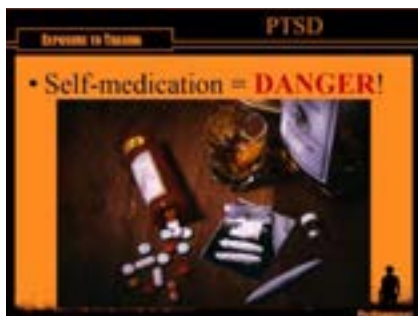
- Persistent avoidance. This is where the person goes out of their way to avoid anything associated with the traumatic event. This might look like a refusal to talk about, or even think about, the things that happened, or a reluctance to even be around people or things that remind them of the event.
- Negative cognitions and mood. This can look like the symptoms of depression, or negative thought patterns regarding the event. Bottom line is, the person really didn't like what happened.
- Arousal and reactivity. Think of this as the jumpy veteran who is overly startled by backfiring cars or people standing too close. Or when a person reacts way out of proportion to something that happens, such as trying to ram someone who cuts them off in traffic.
- Symptoms from all of these categories have to be present, and it has to be for longer than one month for it to be PTSD. Additionally, it has to cause clinically significant distress in their lives, and not be caused because of another medical condition or substance use.

Slide #14: Physiological Symptoms



In addition, there are some cases of association between people with PTSD and some of the physiological symptoms that are listed on this slide. Basically, your brain and your body obviously affect each other, so PTSD doesn't just affect your mind, but can affect the rest of your body as well. Stress manifests itself differently in different people, but usually it finds a way to make itself known when it gets bad enough. As a baseline for seeing if you or others should get help, use the following standard as a guideline: If you don't feel right physically or mentally and you have been exposed to trauma, you may have *some* symptoms of PTSD. If that is the case, it is a good thing to see a professional who can determine the extent of your symptoms and get you the help that you need. Remember, one of the characteristics of PTSD is that it doesn't necessarily get better on its own. If you've been struggling for more than a month and you fit some of the criteria, it is a sign of courage and strength to get help from a professional.

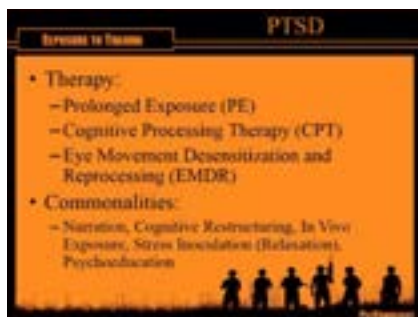
Slide #15: Self-Medication



One of the biggest problems the military has with the current struggle against CSR and PTSD is the tendency for soldiers to self-medicate. This can look like almost any addictive

behavior, from excessive video gaming, movie watching, pornography addiction, or thrill seeking (adrenaline junkie), to illegal drug usage or substance abuse, especially alcohol abuse. If you or a buddy have been exposed to trauma and are drinking a lot, there's a decent chance that you're using alcohol as a self-prescribed medical strategy to reduce the severity of stress you might be feeling. That's a completely normal thought process, but it's not healthy, and it can lead to some real problems. Please, if you see this happening to yourself or others, don't just think it's their life and their choice, and leave it at that. Have the courage to have an open, honest discussion about what they might be experiencing, and suggest that they get help. Remember, PTSD does get better with professional treatment. On the other hand, self-medication often leads to unwanted consequences that only compound your struggles.

Slide #16: Therapies



So a lot of people wonder about what would happen if they received help for PTSD? Sometimes a soldier has a bad experience with a certain kind of therapy, and then rumors spread about how terrible therapy is in general. The truth is that there are different clinically approved therapies that can

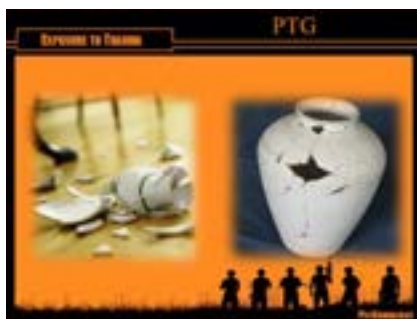
be used to treat PTSD, and different approaches work better or worse for different people. These are a few of the currently approved types of therapy used by the VA. You may have heard of some of them. Regardless of whichever the therapist ends up using, they all have some things in common. There is some element of narration, where you tell your story of what you experienced, cognitive restructuring, examination of meaning, and perhaps changing negative thoughts and feelings associated with your perception of the event, in vivo exposure, or gently being guided through confronting the traumatizing stimulus, stress inoculation (which are just relaxation techniques), and psychoeducation (which is just learning about how all this works, and you're doing it right now). In addition, for soldiers that are completely unwilling to have anything to do with thinking about the event, there is something called Stress Inoculation Therapy, which is just the part where you learn some ways to relax and let go of stress, without touching the things that might be causing the stress. This can be a good way to help people who would otherwise be completely unwilling to try any kind of therapy. I mean, who doesn't want to get better at relaxing?

Slide #17: PTG



Finally, let's talk about something that you might not have heard about, that is really important to this discussion. Posttraumatic Growth, or PTG, is the idea that people can actually become stronger, not weaker, because of the traumatic things that they have experienced. Take a look at the picture on this slide, to get an example. Some might think that the struggle this plant goes through to break through the hard soil will leave it weakened and withered, and perhaps that's possible. It's also possible though, that the plant will become stronger because of the effort it takes to overcome the challenge of growing in tough soil, and become much more resilient against storms and other challenges because of what it has already overcome. For those of you who like PT, it's the same theory behind weight lifting. A certain amount of trauma to your muscles is actually good for them, because even though they are torn down on a cellular level, they build back up stronger as they repair.

Slide #18: Broken Vase



Let's look at PTG another way. Look at the vase on the left. It falls and smashes into a million pieces. If you try to take that vase and put it back together, you're probably not going to find all of the pieces you need to make it whole. In addition, how

strong does that vase on the right look? Even if you glue it, there are still structural flaws that make it difficult for it to be as strong as it was before. Here's the thing, what if you didn't try to make it back into the same vase it was before?

Slide #19: Mosaic



What if instead you took the pieces, and made it into something different? In this case, the pieces of the vase could be made into a mosaic, or a cool piece of art. The vase is gone, but something new and perhaps even better is made as a result of the trauma that happened.

Note: the following text is optional, or you may use it as an example if you feel that soldiers might not be understanding the value of the metaphor:

You might be thinking, "Yeah, but the vase was useful, it could hold water or flowers. The mosaic doesn't do anything." It all depends on your perspective. There are absolutely beautiful churches in Europe that have incredible mosaics on the walls that form pictures telling the stories of the Bible. There isn't a need for vases in those churches, but the mosaics are absolutely

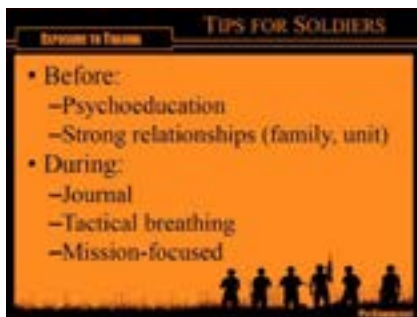
essential for the church to perform its function in blessing the lives of those who worship inside. So no, the broken vase hasn't lost its only chance to be useful, but can become useful and productive in any number of new ways.

Slide #20: THRIVE



This model, called the Thrive model, was taught by Dr. Stephen Joseph. Basically, he uses these principles to help people move from trauma survivor, to thriver. And yes, he might have made up that word. Again, the overall idea is that you don't have to just think of yourself in the medical model where you have an injury, and have to get healed from that injury to get back to the same as what you were before. Instead, think of the weight-lifter model where progressing through trauma in a positive way can make you stronger and more capable than what you were before. Of course, all of these analogies have their own weaknesses, but hopefully you get the point that you can experience growth after trauma in ways that might not have been otherwise possible. It really is all about attitude, but sometimes you need someone to help you get there. That's not a sign of weakness, that's being smart and using the resources available to you.

Slide #21: Tips for Soldiers: Before and During



Here's some tips that you can use to make yourself and your buddies more resilient to the effects of CSR or PTSD. Before combat, you can learn through psychoeducation. Congratulations! You're doing that right now, so you've already started getting stronger. Another thing you can do right now is to build on the important relationships that you have, or develop new ones. Think especially about building up your family relationships, or with buddies in your unit that you really trust. You're more resilient when people completely accept you and want the best for you, and are willing to support you.

During a combat deployment, you could keep a journal. This helps you process your thoughts and perceptions as they occur, which actually can help you to change how your brain feels about the things that have happened. Also, this can be a good resource after traumatic events to help you distinguish between what actually happened and what memories might have become altered because of the emotions associated with those events. Tactical breathing is another tool you can use.

Note: if tactical breathing was already taught in another module, you can move on. If not, you may want to take this opportunity to teach and practice tactical breathing for a few moments. Use the following text as a guide:

Tactical breathing is a technique that will help you to reduce your heart rate during SNS activation, and can also help you to center yourself and feel a measure of calm and peace when experiencing Combat Stress Reaction. Although you can tailor tactical breathing to your own needs, start with this simple pattern of four cycles with four counts. Cycle one: breathe in deeply through the nose for four counts, hold for four counts, breathe out through the lips for four counts, and hold for four counts. Repeat as many times as you need to feel calmer. Practice with me for a second, to the pace of this rhythm: “In through the nose, two, three, four. Hold, two, three, four. Out through the lips, two, three, four. Hold, two, three, four.”

Staying focused on the mission at hand is another short-term tool you can use. Having a job to do, and focusing on doing it, can get you through some really difficult situations until you have an opportunity to stop, assess, and seek help if needed. It might not be the best solution in the long run, but for a short period of time the best answer might be to just work through it.

Slide #22: Tips for Soldiers: After



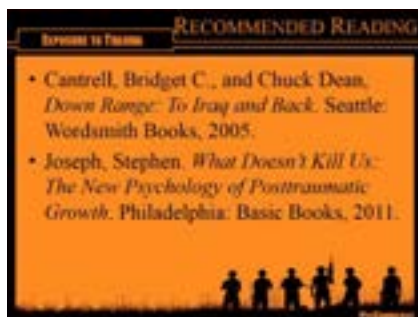
After you've been through combat and redeployed, there are additional things you can do to stay healthy. You remember the relationships we talked about a few slides ago? That point stays the same before, during, and after. Having a close-knit unit where soldiers trust each other and their leaders makes them more resilient to combat stress. Your loved ones at home might not understand everything you went through, but they can love, support, and accept you all the same. Your closest buddies might be your best bet for understanding what you've gone through, especially if they were right there beside you. Assess each other for signs that you might not be coping well, and care enough to get help. That's what true friends do for each other.

Another thing you can do is to tell your story. In one of the other modules we talk about breaking the conspiracy of silence. A lot of soldiers don't want to talk about what happened, or if they do, they are exaggerated and self-serving stories. It can be really beneficial for you to honestly and openly tell your story, what happened to you, what you experienced. You can do this in conversations with trusted friends and family, or maybe just

in the privacy of your own journal. If you do choose to share your story with someone you trust, it can be really healing to see that they do not judge you poorly because of what you have experienced. On that same note, you may want to be discerning in who you choose to share with, and under what circumstances.

Finally, I can't stress enough how important it is to get help if you are struggling with CSR or PTSD. There are things that you can do that will help you to feel better, and professional caregivers can help you to do them. If you're worried about whether someone will find out that you think you need help, talk to your chaplain. The chaplain has complete confidentiality, and will safeguard the things you tell him or her. Also, chaplains have been trained in pastoral counseling, and can help you to work through some of what you might be feeling, especially but not exclusively if you would like a spiritual perspective. They are more than happy to have non-spiritual conversations as well. Behavioral health professionals are clinically trained experts in using the therapies that we talked about earlier. They can authoritatively use the standards of the DSM to determine the extent of whatever you might be suffering from, and give you the appropriate help you need. If you're having trouble trying on your own to find out where to get help, try militaryonesource.com. They have links to helplines and other resources to get you hooked up with someone who can help. For soldiers who have already left active duty, or who don't want anything to do with on-post resources, the VA administers Vet Centers in most communities, where trained counselors can help you with the therapies we've already talked about, or just talking through what's on your mind. Many of their counselors are veterans themselves, so they are committed to finding answers for you.

Slide #23: Recommended Reading



If you are interested in learning more about what we've talked about, there are a couple of good books I can recommend as starting points. Bridget Cantrell and Chuck Dean make a pretty good combination; Bridget is a psychologist and the daughter of a vet who suffered from PTSD, and Chuck is a Vietnam veteran. Their book *Down Range* is an easy to read primer on PTSD and reintegration, full of really useful information.

If you'd like to learn more about Posttraumatic Growth, Dr. Stephen Joseph is one of the leading minds in the field. *What Doesn't Kill Us* goes into convincing detail about some of the concepts we have discussed here. Both of these books contain references that can point you toward further reading if you're really interested in research.

Slide #24: Questions



Note: This concludes the PsyCombatant training modules. You can take questions here from the group, or invite soldiers to approach you individually if you prefer.

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