

The Return from War

Templates for Trauma and Resilience

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As I write this chapter, the movie *The Hurt Locker* has just won the Oscar for Best Picture. It is a movie about an Army man whose job it is to defuse explosive devices. He daily faces death to protect both his comrades and civilians in the Iraq war. When he returns home to his wife and child he finds himself confronted with the intrapsychic conflict of how to adjust to peace. Unable to reconcile peace with war, he re-ups and returns to the war zone.

The wars in Afghanistan, Operation Enduring Freedom (OEF), and in Iraq, Operation Iraqi Freedom (OIF), have finally reached our national consciousness, but they have also left permanent psychological scars on soldiers, veterans, and their families. In this chapter I look at some of the firsts these wars represent. I discuss the need to build bridges between the military and civilian cultures. I look at trauma as a result of repeated deployments for soldiers and families. I examine the psychodynamic concepts that can inform our work with this population and their families. I consider the treatment of veterans and their families and, finally, models for best treatment.

The Iraq and Afghanistan wars mark many firsts. These are the first wars with only 2 percent of the population serving in our volunteer military. Many volunteers are socioeconomically challenged, and some are documented

aliens seeking an accelerated path to U.S. citizenship. These are the first wars where the experience of and the sequelae of repeated and prolonged exposure to combat for veterans and their family members have been ignored by many whose higher socioeconomic status makes military service an unlikely choice. OEF and OIF are the first wars in which citizen-soldiers have served for multiple stints in the war zone alongside career military.

In Iraq and Afghanistan, over 1.8 million soldiers have deployed in OEF and OIF. Over 800,000 of these soldiers have come from the National Guard or other reserve components, so families of citizen-soldiers suddenly became military families, pushed into roles to which families of active-duty soldiers are accustomed but that are foreign to the families of citizen-soldiers. Furthermore, the improved ability to assure the survival of severely wounded soldiers has resulted in the challenge of helping veterans and family members cope with the psychological and physical injuries of war. This is the first set of wars whose signature wounds, post-traumatic stress disorder (PTSD) and traumatic brain injury, are invisible to the eye.

I have borne witness to the psychological impact of these wars since 2005 when I cofounded SOFAR (Strategic Outreach to Families of All Reservists). SOFAR is a pro bono mental health project that provides support, psychotherapy, psychoeducation, and prevention services to the extended family of National Guard, other reservists, and veterans who have served in OEF and OIF. My voyage to advocate for military families began in an unlikely place. In the late 1960s, when I was a vociferous opponent of the Vietnam War, I condemned the war and the military as part of the military-industrial complex and standing for values I abhorred such as might makes right. Every man I knew avoided the draft by being declared 4-F (not fit for service), receiving exemption by attending medical school or teaching in an inner-city school, or fleeing to Canada. I was more conversant in how to beat the draft than in what it meant to serve. Clearly, I had labeled those who fought as "other," dismissing any interest in their experience. We have learned that my approach was a common one, leaving the Vietnam War veterans marginalized at best and reviled at worst. Many years later I befriended someone whose brother died serving in Vietnam. I was confronted by the impact of the war on her. The next time I visited the Vietnam War Memorial in Washington, D.C., I could feel my disavowed affect surfacing as I faced the destruction of young lives and the decimation of families wrought by that war.

Thus I began this project as both a response to a sense of personal helplessness as I saw our country involved in wars I opposed and as an effort to right wrongs done during the war in Vietnam, when my peers and I ignored and sometimes vilified those who fought the war, rather than the policy makers who owned the moral burden of our country's actions. I also felt that in the current wars, fought by an all-volunteer military, those of lower socioeconomic class were disproportionately affected. These wars further forced me to reflect on myself and my family. My father was a World War II veteran, as were most fathers of his generation. We spoke of his war service in a jocular way, as if World War II had been a giant lark. Only several years into this project did I ask my then elderly father about his service, about when he was wounded, and about how the war had affected him. I was astonished to learn that, fifty-five years later, he still had a startle response to loud noises and that he still worried that, despite two medals, he had not been a good soldier.

The sustaining impact of the war trauma from World War II has been largely dissociated in our society. That generation returned from World War II to make up for lost time and to participate in a world marked by economic growth. Those soldiers returned from fighting a just war in which the barbaric and inhumane actions of the Third Reich and of the Japanese army left no moral ambiguity about who was good and who was evil. The escape from the horror and violence of fighting these enemies seemed to be culturally sanctioned. We have studied how the victims of the Holocaust dealt with the unbearable and unspeakable horrors of genocide and how the painful legacy has affected many subsequent generations of offspring. But we have paid scant attention to how fighting affected the World War II soldier, his family, and his children and grandchildren. Underlying the "greatest generation" was silence about what they had endured. Ken Burns's documentary about World War II began to give voice to the horror that soldiers who were deemed heroes experienced in Europe, Africa, and Asia and their lifelong suffering.

The Military

The military has traditionally served as a route toward upward mobility for those who come from lower socioeconomic classes. For the rural poor, the

military offers a way out of small towns with no job prospects by providing job training. For other working poor, the military is a path to a college education, either while serving or by using the GI Bill to attend school after discharge. For many, continued service in the National Guard or other reserve component is a second job in which, in exchange for drilling one weekend a month and two weeks a year, reservists earn added income and affiliation. Hence recruitment for the military often involves many of the poorest and most economically vulnerable men and women in our society. Furthermore, the military is a hierarchical organization that encourages order, discipline, and affiliative bonds with other soldiers to ensure each is keeping the others safe. The Soldier's Creed (2003), learned by every army recruit, emphasizes this philosophy:

SOLDIER'S CREED

I am an American Soldier. I am a Warrior and a member of a team.

I serve the people of the United States and live the Army Values.

I will always place the mission first.

I will never accept defeat.

I will never quit.

I will never leave a fallen comrade.

I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills. I always maintain my arms, my equipment and myself.

I am an expert and I am a professional.

I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat.

I am a guardian of freedom and the American way of life.

I am an American Soldier. I am an American Soldier.

Psychodynamically, we might understand the military functioning as a giant ego that provides a structure that creates an average and expectable environment in which young men and women internalize ways to control their impulses, to be centered, and to learn to subjugate their individual needs for the good of the whole. For young recruits, the military is a place to transition from adolescence to adulthood. The military is also a place that idealizes the ability to fight and to kill, which may normalize aggressive feelings and behaviors that would be unacceptable in civilian life. While the military may teach a soldier to be thoughtful about how a

mission is executed, the soldier is also discouraged from questioning or reflecting about the purpose of the mission. Soldiers ask, "How?" not "Why?" The Military Code of Conduct acts as the arbiter of right and wrong and requires soldiers to recognize this external superego as their guide. Civilians find it hard to believe that atrocities of war are not sanctioned by the military but are a product of a group psychology overriding both personal and organizational moral strictures.

The military also serves as a model group in terms of diversity and racial equality. President Truman issued Executive Order 9981 on July 26, 1948, calling for equality of treatment and opportunity regardless of race in the U.S. armed forces. The last segregated unit in the military was abolished in 1954. The military's record in dealing with gays and lesbians, on the other hand, serves as an unfortunate model of how not to handle diversity in sexual preference. During the draft, declaring oneself homosexual was a guaranteed way to be declared unfit for service. Many of us may recall the character Klinger in the television series *MASH*, who constantly dressed as a woman as a way of seeking a psychiatric discharge that would enable him to return home from the conflict in Korea. Yet in one episode he adamantly refuses the offer of such a discharge, speaking to his own homophobia and the rampant homophobia of the 1950s in the United States. Our volunteer military is also a coed military, with 14 percent women. Until 1993, when President Bill Clinton established the Don't Ask, Don't Tell policy, someone identified as gay or lesbian would face immediate discharge from the military. Clinton's policy forbade asking about soldiers' sexual orientation and guaranteed that gay and lesbian soldiers could continue serving if they did not reveal their sexual orientation. This, however, forced many men and women to mask who they really were, with the psychological consequence of being forced to develop a false self.

As I write this in March 2010, President Barack Obama and Admiral Mike Mullen, head of the Joint Chiefs of Staff of the military, have committed themselves to end Don't Ask, Don't Tell, and to allow gays and lesbians to serve openly. Yet many commanders still allege that the lifting of the ban would threaten group cohesion, as if sexual orientation would reduce one's effectiveness as a soldier.

Randall, a thirty-seven-year-old marine sergeant, consults a social worker after he returns from his third deployment to Iraq. He has been tearful, forgetful, and irritable for the past month. He describes himself as being rescued from juvenile delinquency by enlistment in the marines at age seventeen. Now because of

pressure from his wife, who cannot tolerate the stress of the repeated separations caused by his deployments, he is considering retiring from the military. After several sessions with the social worker he understands that to leave the marines is to leave the only cohesive family he has ever known. He is dealing both with anticipatory grief about the loss and with fear that he will be unable to channel his aggressive thoughts and feelings when he leaves the marines, where his aggression is both encouraged and contained. The therapist helps him reflect on his needs and his ability to control his impulses. He chooses to seek a civilian job working with young delinquents, where he will be able to use identification with the drill sergeants who changed his life to provide order to his internal chaos, and where he can aggressively work to get other delinquent youth into job training programs.

In the military, soldiers have two families, the family of comrades alongside whom they fight in battle and the family to whom they come home. When soldiers return, they may feel closer to their battle buddies than to their spouses, partners, parents, and children. Spouses who have spent months longing for emotional and physical intimacy may be confronted with a partner by whom they feel ignored and undesired. As one woman, the levelheaded wife of a multiply deployed soldier, said, "You get a soldier home first. If you are lucky, your husband returns six months later." At a group support meeting, another young wife asked poignantly, "What happens when one member of a couple wants to listen and the returned soldier doesn't want to talk?" The old joke used to be that "if the army wanted you to have a spouse, they would issue you one." Fortunately, in our volunteer military, the Department of Defense has come to realize that, to retain soldiers, they will have to do a better job of supporting families. Compelled by the skyrocketing divorce rate and the mental health problems suffered by returning soldiers and their spouses (Mansfield et al., 2010), the military is now mandating a longer time at home between deployments so that families and soldiers may reintegrate and renegotiate relationships altered by time, separation, and developmental changes in children and in the family.

Latoya, a twenty-five-year-old mother of a four-year-old, is distressed and angry at her daughter's preference for her husband, who has cared for the daughter during Latoya's twelve-month deployment. Latoya had comforted herself during the nights in the desert with fantasies of holding her daughter on her lap or taking her shopping and showering her with gifts and "mommy time." She has returned to a little girl who rebuffs her efforts, saying, "Daddy does it better; get away." Latoya was already plagued by guilt because she had been excited about

deploying. Thus a part of her felt she deserved the rejection. The social worker she sought out helped her explore her own history, which included a father who left the family for good when Latoya was four. She came to understand how envious she felt of her daughter's bond with her dad at the same age Latoya had felt rejected by her own father. The social worker also helped Latoya learn about child development and how it might be normal for a four-year-old negotiating early Oedipal issues (the task of separating from the same-sex parent by desiring the opposite-sex parent) to prefer her dad.

In lesbian and gay families a similar dynamic plays out, where the parent who is experienced as the primary caregiver is often rejected and the other parent becomes the desired one. This Oedipal struggle, usually completed by age six, presages the child's move into latency, during which school and friends become more central in the child's life. This may also reflect attachment behaviors as described originally by Bowlby (1969) and more recently by Ainsworth and Bowlby (1965) and Main and Hesse (1990). Latoya's daughter processed her mother's deployment as a personal rejection. Thus her mother's return was dealt with by anger and rejection.

The Invisible Wounds of War

According to a Rand report (Tanielian & Jaycox, 2008), at least 300,000 returning veterans will suffer from PTSD and major depression; 320,000 veterans will suffer from traumatic brain injury. Some will suffer from all three. Additionally, 50 percent of National Guard and reserve component soldiers, 41 percent of regular military, and 31 percent of marines will return with a diagnosable mental health condition—anxiety, mild depression, transient stress reactions—that does not meet *Diagnostic and Statistical Manual of Mental Disorders* criteria for either PTSD or major depression. These are conservative statistics yet alarming nonetheless. We know that, untreated, these veterans will turn up in the medical system with somatic complaints, in the legal system because of heightened rates of road rage and of domestic violence, in divorce courts because of marital strife, and in homeless shelters when they fail at work and relationships. We know that the children of parents with untreated PTSD are 33 percent more likely to suffer from PTSD than the normal population. Children in military families who experience multiple deployments of a parent show

more emotional, learning, and peer-related problems than a control group (Chandra et al., 2010).

The diagnosis of PTSD was established after the Vietnam War because of the pressure to change the way we viewed psychological sequelae to war. While shell shock had been a diagnosis from World War I onward, there was always an implicit view that it resulted from cowardice or moral weakness. By diagnosing disorders as post-traumatic stress, we moved to seeing these reactions as a disease. The new term served to unite work with other populations that we came to understand had PTSD, such as Holocaust survivors (Krystal, 1969), rape survivors (Burgess & Holmstrom, 1974), and other groups subjected to unbearable emotional stresses. In the Civil War, veterans suffered from soldier's heart, a condition marked by rapid heartbeat, secondary to anxiety. In World War I, soldiers suffered from shell shock and were viewed by many not as victims but as cowards. In World War II, soldiers suffered battle fatigue. Many fewer soldiers were thought to suffer from these conditions in these prior wars. The high rate of PTSD in OEF and OIF have fostered a movement to define war trauma as a war wound rather than a psychopathology. Declaring war trauma a wound destigmatizes the diagnosis and increases the likelihood that both those who currently serve and veterans will seek mental health treatment.

Unlike World War II, the Korean conflict, or the Vietnam War, the wars in Iraq and Afghanistan have taken place on an asymmetrical battlefield, a 360-degree battle theater. The use of improvised explosive devices (IEDs) and the presence of suicide bombers have created two wars with no front. Soldiers are always in danger, even when off duty. How do soldiers cope? Two ways to adaptively cope are to be hypervigilant, in a state of constant alert, or to dissociate, the defense by which people distance themselves emotionally from affectively overwhelming experiences. When used flexibly along with other defense mechanisms, people are able to maintain a sense of well-being and psychological unity. In the face of overwhelming helplessness and the failure of dissociation to provide protection from the crushing affects of fear, anger, or hopelessness, however, a person becomes traumatized.

In a single-episode trauma, such as a car accident or a robbery, the victim may be aware of emotional startling and numbing, feeling fearful and panicky, sleep disturbances, somatic complaints, and intrusive thoughts about the traumatizing event. When one is repeatedly exposed to trauma in war, one develops complex PTSD, where the behaviors and the feelings

of startling, numbing, fear, sleep disturbances, and intrusive thoughts become part of the victim's normal way of functioning. Behaviors meant to protect one from being retraumatized continue in the absence of the original dangers. Soldiers returning home from deployment may zigzag down the highway in their hometown as if there were IEDs in the road, or they may become hypervigilant in any crowd, even at the supermarket. When external events remind the veteran of a prior danger, such as the smell of charcoal bringing the memory of burning gasoline after a tank blows up, the veteran may be triggered and relive the earlier event as if it were in the present. The following describes the actions of a veteran suffering from complex PTSD.

“Look, Mom, Poppa has a gun,” says Sam, the three-year-old son of an army reservist recently returned from Iraq. His mother pushes her two small children into the hall as she confronts her husband, armed and dressed in battle fatigues. “They killed my buddy, but they can’t kill me,” he snarls. Then, as he is pulled back into the present by the look of horror on his wife’s face, he sobs, “I could have shot Sam.” Sam cries out, “I don’t like the daddy who came home,” and begins to run frantically around the house. His mother goes numb. She has a husband with PTSD, two children who are terrified, and no one who can begin to understand what she is going through. In her neighborhood she is the only one with a husband in the army reserve forces. When her husband reconstructed the experience, he recalled that he was having a flashback triggered by the sound of a truck backfiring outside his window. He armed himself to “protect the perimeter.” His reaction toward his son was a glimpse of the effect his condition had on his family.

After World War I, Freud and his followers became interested in what they labeled *war neurosis*. Abram Kardiner was a follower of Freud who developed a theory of war neurosis (Rado, 1942). He found that all chronic cases, however diverse, were characterized by the following invariable features: irritability; proclivity to explosively aggressive reactions; stereotypical dream life marked by endless re-creations of the war scenes, frustrations, or threats of annihilation; a lowering and lessening of exteroceptive (responses of the nervous system to external stimuli) personality functions; a change in the patient's conception of himself and of the world; a craving for compensation; and a traumatic war experience as the origin of all these morbid developments.

Kardiner understood pathogenic trauma as the sudden loss of all effective control over common situations, wreaking lasting damage on the

patient's adaptive capacities and his perceptive, coordinative, and manipulative skills and instilling in him a feeling of helplessness. Kardiner explained how the soldier's outer world then changed "from a friendly to a hostile place" (Rado, 1942, p. 363). He went on to describe a continual and often fruitless struggle to recapture the tools of mastery that had been lost through the trauma and, in serious cases, a final acceptance of defeat in the form of major depression or suicidality. Ironically, while psychodynamic theorists such as Freud, Kardiner, and later, Krystal (1969), who described PTSD occurring among Holocaust survivors, made early contributions to the field, many now see PTSD as the disorder least amenable to psychodynamic methods of treatment. This is the result of a common confusion between psychodynamic theory as a theory of mind, a way of thinking about how we make meaning of our thoughts and feelings, and psychodynamic theory as informing therapies of longer duration than those who practice cognitive-behavioral therapy (CBT) and other brief therapies. We see in the earlier clinical vignettes and in the treatment section that follows that psychodynamic concepts offer a framework to inform both our treatment and our experience of working with traumatized populations, and that brief therapies can be psychodynamic too.

The Diagnosis and Treatment of PTSD

We cannot treat someone's PTSD before we assess and understand the person's history, culture, current environment, and available social network. While anyone can become traumatized if exposed to external horror, certain aspects of a person's history and culture prepare the backdrop on which the trauma will be imposed. For example, those with prior trauma histories are more vulnerable to PTSD than those who enter danger with robust coping mechanisms. Since many join the military to escape intolerable situations at home, some soldiers arrive with a predisposition for anxiety, depression, and even PTSD. Some who grew up in neighborhoods where gunshots were commonplace may be triggered at the onset of the battle rather than as the result of the battle. Children of veterans with untreated PTSD, a common occurrence in children and grandchildren of Vietnam veterans, may unconsciously enlist as a way to gain closeness to the parent by seeking out a shared war experience. They might also have identified with the parent's poor coping skills or may be unconsciously

seeking out punishment because of guilt at their anger at the parent's emotional unavailability.

We know that trauma occurs in isolation and heals in connection. Someone who has a good social network, friends, family, or a solid religious or spiritual community will be more socialized to talk about the pain and the problems than someone who is more isolative or discouraged from expressing emotions.

Unfortunately, mental health help is stigmatized in the military community. The hardest task might be convincing the soldier, veteran, or family member to seek services. The reluctance to access care has been shown in the burgeoning suicide rate among soldiers, veterans, and even family members. The military functions as a closed family system, wary of outsiders. Most military are distrustful of civilian therapists. Therapists working with soldiers, veterans, and their families must develop cultural competence about the military to serve military clients well. Elliot Mischler (1986) said, "There is no meaning without context." Therapists cannot help military and their family members make meaning if the therapist does not understand the structure, the culture, and the language of the military. To build cultural competence a therapist needs to know about the chain of command and where the power resides. The military has two lines of authority. Commissioned officers take command. Noncommissioned officers such as master sergeants have power over the day-to-day life of most military. Military exist in an acronym soup, and therapists need rudimentary knowledge of it or a willingness to ask when they don't understand. We need to be acquainted with the stages of deployment and with the terms used to describe a deployment, such as *cross leveling*, which refers to deployment with another group because of a shortage of people performing the needed function in the group that is deploying. Therapists need to have some sense of the anticipated psychological challenges at each stage, from notification of impending deployment through service in combat to the rigors of reunion and reintegration. These orientations are available via volunteer groups, continuing education courses, and even on the Web by groups such as the Center for Deployment Psychology of the Department of Defense. Armed forces members and their families do not want to train their therapists. As a group they tend to be xenophobic, and cultural competence is a precondition to building a therapeutic alliance.

The impact of trauma is both psychological and neurobiological. We know that repeated exposure to trauma changes the way the nervous system

functions. Treatment of war trauma requires a multimodal approach that includes therapy, psychotropic medication, stress management, and behavioral techniques to manage symptoms. We cannot erase someone's trauma as if it were a symptom. We can help clients metabolize their traumatic memories so they can control when they recall the memories of the trauma and gradually bear as much of the affect of the trauma as they can. We can also help them bear their guilt and shame, because in war soldiers commit and witness acts that would not be acceptable to them in another context. In some ways, recovery from war trauma is a lifelong process. The appearance of PTSD symptoms may be delayed months or even years. Freud coined the term *nachtraglichkeit* (Faimberg, 2005), referring to a change in the way a past event is interpreted as psychic development progresses. In *nachtraglichkeit* an old event takes on new emotional significance in the present because of a changed understanding by the client stemming from maturity and new experiences.

Jorge, a twenty-seven-year-old Latino, has just returned from his fourth deployment, his first since he became a father. During this deployment he was more concerned about his safety because he felt a strong need to return to participate in the upbringing of his six-month-old son, Carlos. In prior deployments, as a gunner, he had shot enemy soldiers and seen civilian casualties.

This time he was haunted by feelings of guilt that he might have killed some other child's father, and when he saw a wounded child he identified with the pain and anguish of the child's parent. The change of becoming a father had altered his ability to depersonalize the enemy troops and to distance himself emotionally. His discovery of his capacity to be a loving father raised his empathy for other fathers, and that trumped his ability to maintain emotional distance in battle. Luckily, Jorge was aware of this shift.

Someone who had neither the awareness nor the words that he did might have arrived in therapy with intrusive images, somatic complaints, irritability, and other symptoms of PTSD. But because Jorge worked with a social worker, he was more able to hold his ambivalent feelings, which included the wish to do his job as a soldier, protecting his country and his comrades, and his guilt that his job called on him to harm others.

Jorge was being helped to assume what Melanie Klein called the "depressive position," to hold contradictory views of himself as the good object that protects and the bad object that kills. When we read of atrocities committed in the name of war—burning down villages, raping women and children—we can assume the soldiers involved in these atrocities had

become fixed in the paranoid-schizoid position, where the other and the self can be experienced only as either totally bad or totally good. When the enemy becomes totally bad, any atrocity can seem justified. If we combine this with the concept of *nachtraglichkeit*, we might see how symptoms may appear years after an event, when the soldier is able to move from the paranoid-schizoid to the depressive position.

The treatment of complex PTSD is best done in stages (Herman, 1992). How do we diagnose complex PTSD? Jean Goodwin (1990) offers a mnemonic, FEARS, to remember the symptoms of complex trauma:

- F = fugue state—person is spacey, numb, flat
- E = ego diffusion—person seems to be disorganized and all over the place
- A = acting out and antisocial behavior
- R = repeating and reenacting—person may continue to commit aggressive acts or to act as if the original trauma is still happening
- S = self-harming behavior and suicidality—person may cut or burn himself, place himself in danger, or attempt to kill himself

Unlike someone with PTSD from a single-episode trauma, someone suffering from complex PTSD may be unable to pinpoint the specific etiology of the trauma because the condition is a result of repeated and cumulative trauma. The constant use and overuse of dissociative defenses and fight-or-flight reactions cause the symptom to be woven into the day-to-day functioning of the soldier until it feels a part of the self. Let us elaborate on Goodwin's helpful mnemonic.

Victims of chronic complex trauma may alternate between periods of affective numbing, marked by affective flatness and what we often think of as a zombie-like state—the living dead, the vacant stare—and periods of hypervigilance. They may lose time, be unable to account for segments of time because actions committed in a dissociative haze may be unavailable to them in a nondissociative ego state. At other times, they may be in states of hyperarousal, easily startled by noises and smells. They may appear almost paranoid in the way they scan the horizon. Many veterans find themselves unable to be amidst crowds at stores or restaurants unless they can situate themselves in a corner so they literally don't have to watch their backs.

When a person is a victim of a single-episode trauma, the victim often becomes constricted. Victims of complex trauma may appear to have

compromised executive functioning. Victims may have trouble with organizational skills and certainly have trouble with organizing their thoughts and feelings. The potential for intrusive thoughts and images of trauma exacerbate this disorganization. Flashbacks of traumatic memories feel real to victims and upset their affective self-regulation. We believe that traumatic memories are not encoded as whole narratives that are repressed but as fragments of affect and thought that are dissociated. The lack of a cohesive narrative interferes with the ability to talk about the trauma under conscious control, so the experience is often unconsciously acted out. Since the feelings evoked may include helplessness, rage, guilt, and shame, the behavior evoked may be antisocial. A veteran who witnessed a truck blowing up ahead of his may develop road rage in traffic jams because a forced stop evokes panic and a feeling of danger. A sudden move by a stranger may elicit a reflexive punch because the unexpected movement activates a defensive response. These repetitions and reenactments can be understood psychodynamically as efforts at mastery, the hope that the story will end differently this time. Unfortunately, these repetitive behaviors may lead to consequences that intensify the trauma, such as involvement with the legal and criminal justice systems. Some states are starting veterans' courts in which PTSD can be considered as a mitigating factor when veterans break the law.

Finally, we must understand why self-harm and suicidality may be a result of complex PTSD. In the numbing phases of trauma, people may feel depersonalized or dead inside. They hurt themselves to assure themselves they are alive. By feeling physical pain or seeing his or her blood, the person knows he or she can feel something. Flooded by flashbacks, intrusive thoughts, and deep diffuse psychological pain, people become desperate to localize and thus feel the pain. Suicide is usually understood by psychodynamic therapists as turning the anger on the self or as the murder of an unwanted part of the self, which we call an introject. With this severely traumatized population, suicide is understood as the ultimate respite from the unremitting psychic pain. Many of the antisocial behaviors cited earlier may also be aimed at provoking death by cop, another form of suicide.

As we can see, most of these symptoms interfere with the soldier's ability to provide safety and self-care. The initial phase of therapy, then, must help the client maintain safety. We view the behaviors described above as misplaced efforts at self-soothing. When dissociative defenses fail, a soldier or a veteran is flooded with intrusive thoughts and feelings that recall aspects of the trauma or with a pervasive numbing that may leave the client

feeling as if he is no longer alive. Certain actions such as excessive drinking and use of illegal substances or the overuse of legal drugs are ways to restore a dissociative state where feelings are not felt. Repeating actions, such as carrying a gun at all times, are efforts to gain mastery over what cannot be mastered, or what we call a repetition compulsion. For clients to relinquish these self-destructive behaviors, we must teach them alternative coping skills. Before a client can tell his or her story, the therapist and the client must create a Winnicottian holding environment in which the therapist helps the client become a “good enough mother” to the self.

When Caleb first consulted his social worker, Lydia, he had been discharged from the army for three years after serving three deployments in Iraq. He was drinking excessively, sleeping all day, and engaging in high-risk behaviors at night: driving fast while drunk, picking fights in bars, and having unprotected sex. His mother, with whom he lived, issued an ultimatum: he must get sober and get a job or move out. Caleb confessed to Lydia his intrusive flashbacks of a friend dying in front of him after encountering an IED. These flashbacks interfered with his sleep and could be held at bay only by the drinking and drugging behaviors. Lydia and Caleb worked on affect regulation by helping him develop alternative behaviors that would help him turn off the images. These included practicing relaxation breathing, calling a friend when he became panicky, starting to work out at the gym, and drinking hot cocoa, a drink he remembered fondly from childhood that helped him calm down.

The establishment of safety took many months, but as Caleb came to trust Lydia they developed a therapeutic alliance, enabling him to persevere with their work. Lydia also sent him for a consultation with a psychopharmacologist, who prescribed medication to help him sleep. She also encouraged him to attend drop-in groups at the local vet center so he could see that others shared his problem. Only then did Lydia and Caleb embark on the journey in which he could begin to tell his story.

Treating traumatized clients presents a unique challenge to both client and therapist. The most important rule is that the clinician not retraumatize the client. The rules that apply to psychodynamic therapy, “Tell me everything you are thinking and feeling,” must be modified so that we are saying to clients, “Tell me a small amount of your story so that you will not be traumatized.” Likewise, the stories that clinicians hear are traumatizing and often undermine their own sense of safety and stability in the world. Hence we must always be asking ourselves how much of the story we can bear to hear without becoming vicariously traumatized ourselves.

As clinicians, we can never presume to think that we or our clients have unlimited capacity to bear witness to stories related to war. Each client must digest the trauma bit by bit, and we, the clinicians, need to help the client anticipate his or her reactions and review coping strategies for dealing with the reexperiencing of previously disavowed or dissociated affect. The ultimate goal of treatment with those traumatized by military combat is to enable the client to tell his or her story under conscious control with the ability to stop telling it at any point the client feels affectively dysregulated. Trauma cannot be eradicated but can be mastered, and this requires knowing that clients and therapists need time and space to tell their stories in incremental ways.

Trauma and the Transference

When a therapist and a client move from the first phase of trauma therapy, assuring safety, to the second stage of treatment, working on understanding the impact of the trauma and mastering the trauma, certain transference-countertransference dynamics tend to unfold. As therapists we may bear witness, but we know our job is more complicated than that. A traumatized client is filled with anger, rage, sadness, despair, vengeful thoughts, and loving thoughts. A traumatized client has lost faith that the world is a safe place. In the course of treatment, we as therapists will find ourselves immersed in the intrapsychic world of the client in the hard work of understanding and experiencing what he or she has endured.

At times, limited roles are available to us. The traumatized client may interact with the therapist as if the therapist were the victimizer, the victim, or the bystander. Here the client will unconsciously elicit the therapist's reaction by playing out different parts of the trauma scenario. We may find ourselves feeling sadistic or helpless or as unwitting bystanders, unable to help. We may find ourselves in role reversals, in which the client turns passive into active, or as the bystander who did nothing to help.

The consulting room becomes the stage for the appearance of disavowed affect states that are fragmented and for dissociated feelings about the self and other. The therapist will feel some of these states, while the client may not, as therapist and client work to construct a cohesive narrative that will allow the client to move from victim to survivor. Therapists will be challenged to bear anger, accusation, fear, and potential fragmentation of the

self with the transient loss of reality testing if they commit themselves to working with soldiers and veterans. This work is therefore not for the faint of heart.

After months of treatment, Gerry, a thirty-two-year-old Caucasian marine, who served in both Iraq and Afghanistan, and his social worker, Jim, were beginning to explore what Gerry had witnessed in combat. They had established a good rapport, marked by bantering and Gerry's appreciation that Jim too had been a marine in Vietnam, a brother in arms.

During a check-in about Gerry's symptoms, his panic attacks, and his sleep problems, Jim commented on Gerry's need to cut back on his smoking. Gerry began to steam up and accused Jim of sneaking up on him and ambushing him with this new request.

In this interaction, Gerry perceived Jim as the insurgent who performed a sneak attack. For his part, Jim felt shame and guilt for causing Gerry pain, being a victimizer not a helper. Both needed to name and give back these feelings for the work to proceed. When Jim could verbalize the thought that Gerry may have felt frightened by Jim's sudden change of topic, Gerry could begin talking about how he smoked before going on a mission to ready himself for being attacked. In that moment in the transference, he felt that Jim was asking him to give up something that gave him courage, and he became fearful and angry.

Jim had also experienced another disavowed part of Gerry's experience, his shame and guilt about what he had done. Both the therapist and the client participated in an enactment (Jacobs, 1986; Renik, 1998). Out of conscious awareness they engaged in an affectively laden interaction that then needed to be translated into words to allow each to understand what was previously unconscious.

Many of us become psychodynamic therapists because we want to see ourselves as good people who understand others with depth and complexity. When we sit with traumatized patients who begin to behave as their abusers do, we are uncomfortable with the amount of rage evoked in us (Davies, 2004). Often we deal with the rage we see in our patients by seeing them as helpless and victimized. But we, too often, find ourselves feeling enraged, helpless, and victimized.

In the movie A Few Good Men, Jed starts to yell at his therapist, "You're not man enough to face the truth! You're too much of a coward to take me on!" He then accurately lists many of this therapist's least favorite character traits and attacks his competence. At that moment, Gary, his therapist, a social worker at the Veterans Administration, has no idea what elicited this barrage. He is unable to think or to mentalize—to represent himself as a person with separate thoughts

and ideas (Fonagy & Target, 1998). In Winnicottian terms, the creative play space between therapist and client has collapsed. Suddenly, Gary is in touch with his wish to harm Jed, to smash in his face and to humiliate him. These thoughts serve only to disorganize him more. He feels backed into a corner, unable to set a limit or to say anything helpful. He finally regains his therapist self long enough to end the hour. When he goes home that evening, he is haunted by the pleasure he felt in imagining humiliating Jed. His whole self-representation had been challenged. Luckily, he is about to meet with his peer-supervision group. Anyone doing trauma work needs a good support network. In the group, he recounts the events of the hour and his colleague Joe asks what preceded the outburst. Gary reviews the beginning of the hour, recalling that he was a few minutes late to greet Jed because of a note he was trying to finish. They had begun the hour by checking in on Jed's progress with his job search. Upon hearing that Jed had not only not looked for a job but also increased his alcohol and drug use, Gary asked Jed why he was being so self-destructive. Jed felt slighted by the extra minutes he waited and already felt shame and guilt about his behavior during the week. When Gary asked about his behavior, he morphed into both his abusive father and a superior by whom he felt belittled in the military. By identifying with the aggressor, he then humiliated his therapist, as he had felt humiliated by his father and the superior. Gary in turn was horrified to find himself capable of thinking of performing the same violent and demeaning acts in which his client had engaged. With the support of his peer group, Gary was helped to tolerate his own sadism, to regain his empathy for Jed, and to use this understanding to empathically help Jed understand some of his own contributions to his interpersonal problems at home and at work. At the next therapy session, Gary was able to comment on how worked up each of them had been the week before and how frightened and angry Jed must have felt in past dealings with his father and his superiors who had devalued and humiliated him.

Let me provide a second example.

Marianne was a Latina army sergeant who returned from a deployment in Iraq where she had witnessed civilian casualties. She exhibited symptoms of PTSD: psychic numbing, flashbacks, sleep problems, hypervigilance, and a fear of crowds. She became triggered whenever she saw small children too far away from their mothers, as she was reminded of child casualties that occurred when they left their mothers' sides. She began the therapy hour with her social worker, Janet, in an agitated state. When Janet asked what upset her, Marianne muttered, "You know, and you are not going to do anything about it." Janet, who did not know, guessed that something happened in the waiting room. She stuck

her head out her door and saw a small child coloring a picture. Janet asked him, "Who is taking care of you?" He replied that his father was in an office and that he could go see him whenever he wanted, but he preferred to finish his picture. Janet closed the door and conveyed the story to Marianne, who calmed down. Janet said to her, "You feared I was one more bystander who would do nothing to help a child in danger, so how could you trust I'd help you?" Marianne then began to speak of her own anger at herself, the military, and the Iraqi civilians, who she felt were all complicit in endangering children.

Military Sexual Trauma

Women have served in the U.S. military since the Spanish-American War but never in combat. Women now account for 14.3 percent of active-duty forces, 17.7 percent of reserve components, and 15.1 percent of National Guard forces (Department of Defense, 2009), for a total of 3,018,099 women. With this increase in women in a male-dominated culture, we have also seen an increase in sexual assault, known as military sexual trauma. The problem has become so rampant that the secretary of defense has named a task force, Defense Task Force on Sexual Assault in the Military Services, to investigate the problem. The task force issued a detailed report on December 1, 2009, outlining the scope of the problem and recommending changes in military culture. The report calls for sweeping changes in how victims of sexual assault are treated and how perpetrators are held accountable and punished. The culture of the military, with its hypermasculinity and emphasis on conformity to group values, exacerbates the risk of sexual assault. When an assault takes place, the victim, usually a woman, is discouraged from reporting the event. There has been a culture of silence around the issue, which may be alleviated by the institution of clear procedures for reporting these incidents and the establishment of military sexual trauma programs in military and Veterans Administration facilities. Therapists working with women who have served must be aware that PTSD symptoms may come from military sexual trauma in addition to or instead of trauma from battle.

Angelica, a twenty-seven-year-old African American air force pilot twice deployed to Iraq, came to treatment because of depression and irritability after her return home. Working with her social worker, Ella, she had metabolized the haunting episodes from the battlefield, including her memories of ferrying

wounded in her helicopter to the hospital unit. One day she arrived at therapy looking vacant and pale, in contrast to recent sessions where she was upbeat and optimistic. Ella asked her what was wrong. Angelica said, subaudibly, "I saw him." With support from her therapist, she began to recount multiple sexual assaults from a superior, the executive officer of her company. He had threatened her with less flying time if she did not submit to his advances. Less flying time would have reduced her chances for promotion. She had also acquiesced to him to protect the younger women with whom she served, because she felt she could withstand the assaults but they might not. She was triggered by seeing her abuser for the first time since the assaults. After her unit returned home, her perpetrator had attended a six-month training program, and Angelica had thought she was safe. She was a brave warrior who could fly into battle but felt helpless to battle this man. With support from her therapist, she developed empathy for the choices she made. Where previously she had felt only self-hatred, she and her therapist created a space where she could view herself with a new sense of agency and mission. Just as she had submitted to protect others, she now pursued legal redress to stop him from abusing again. As Angelica told Ella, "I feel better jeopardizing my career to fight this than jeopardizing my sense of self-worth by remaining silent."

Trauma and Comorbidity

We must remember that clients can suffer from both trauma and other emotional problems not directly related to their trauma. In the second stage of working with trauma victims, the symptoms of the trauma may become manageable, but the client's life may continue to be difficult because of preexisting personality problems.

Ronald continually clashed with his platoon mates long after his PTSD symptoms had subsided. His social worker, Rick, finally realized that Ronald behaved inconsiderately, was demanding, and rarely considered the feelings of others. Rick switched the focus of their work from his PTSD to exploring these interpersonal difficulties. He realized that Ronald had a narcissistic personality disorder that left him barely able to empathize with the needs of the other. Rick began employing principles from self psychology, mirroring Ronald's wish to be recognized and valued even as he devalued others. As Ronald felt himself to be more understood and less vulnerable, he related better to both peers and superiors. Rick

and Ronald were both delighted when he was promoted because of his new ability to motivate his coworkers.

Since many PTSD symptoms are similar to those of a borderline personality disorder and of bipolar disorders, it is especially important to assess for preexisting personality disorders and treat them accordingly.

Families of Soldiers and Veterans

When a soldier deploys, the whole family serves. When a soldier returns home, the whole family is affected. The military used to define *family* as a spouse and dependent children. We now know that mothers and fathers, siblings, grandparents, aunts, uncles, and cousins of military also compose family. Many soldiers and veterans live in what the military labels as nontraditional families. The couple may not be married, the children may belong to a partner from a previous relationship, or the partner may be of the same sex and so cannot be acknowledged without violating Don't Ask, Don't Tell. Like ripples created by a stone tossed in the water, a soldier's service affects the lives of many people. When a soldier is deployed, the family copes with the absence of a loved one. The challenges include taking responsibility for tasks usually performed by the soldier and missing and worrying about the safety of the soldier who is in harm's way, while continuing to maintain the functioning of the family at home.

Families of active-duty soldiers have the support of a military community in which many others are sharing the same experience. They may also witness families coping with a wounded soldier or mourning a soldier killed in action. Families of National Guard and other reservists, on the other hand, cope with isolation. They may live in a community where anti-war activists belittle their soldier for serving.

When the soldier returns, reunion and reintegration pose more challenges. Families and soldiers have to adjust to the return when both have changed. Children have moved on to new developmental stages; wives and husbands may have assumed new roles they do not want to relinquish. Even if the soldier returns without apparent injury, a person who has been in a war needs time to ratchet down his or her nervous system. If the soldier suffers from PTSD or traumatic brain injury, everyone at home is affected.

Her primary care physician referred Gloria, a thirty-three-year-old biracial woman, to a social worker because she was anxious and had sleep problems. Her social worker asked about changes in her life. Gloria's husband Rob had just arrived home after deploying for ten months. The joyous reunion she anticipated was a disappointment. He could not go to noisy public places so her dreams of help with the grocery shopping and nights at the movies or at restaurants were quashed. She could not sleep because of Rob's nightmares, which awakened her several times a night.

Her therapist, Melinda, allowed her to get in touch with her anger and her disappointment. She explained the concept of ambiguous loss (Boss, 1999). When Rob was in Iraq, he was physically absent but psychologically present. Now that he had returned home, he was physically present but psychologically absent. This ambiguity had interfered with Gloria's ability to mourn for her old life and to adjust to the new normal. Melinda also found Gloria a support group for spouses of recently returned soldiers so she could realize that others share the same problems. She encouraged Gloria and Rob to enter couple's therapy so they could work on restoring emotional and sexual intimacy.

Secondary Trauma, or Compassion Fatigue

Working with traumatized people as a therapist or as a family member takes a toll on the helpers. They may become traumatized by proxy, developing the symptoms of PTSD. Listening to the details of another's trauma may overwhelm the helper or the family member.

Family members confronted by abhorrent behavior in a soldier or veteran may become symptomatic. Family members who spent months fearing the knock on the door telling them their soldier was killed in action may continue to fear the doorbell ringing months after the soldier is home. Therapists may become overwhelmed and mimic trauma symptoms: having irrational fears about their own safety, being hypervigilant, or feeling helpless and victimized. Therapists may become inured to the suffering of their clients, deadened inside as a defense against the pain of the stories that cumulatively overwhelm them. Therapists who work with traumatized clients, then, need to seek out forms of renewal as well: support groups, supervision, meditation, relaxation, and other forms of stress release.

Fran complains to her supervisor that she has lost interest in her work. Her supervisor helps her trace the beginning of her disinterest to the beginning of her

work with a veteran who deployed to Iraq three times. He witnessed a suicide bomber blow up a market, maiming and killing soldiers and civilians. Fran remembered wanting to tell him to stop describing the carnage; she resisted the urge because she felt she needed to bear witness for him. Her supervisor suggested she take some time each day to attend to her own needs. She also coached her so she could ask clients to stop if the story became too much for her to bear.

We would say that Fran was suffering from compassion fatigue: the cumulative cost of listening to and absorbing too much trauma. But in secondary-trauma reactions, family members may find themselves having symptoms too.

When Sonya's husband was wounded, she spent months sitting at his bedside at the military hospital. Each day she witnessed the agony he endured as he underwent repeated surgeries and painful physical therapy. Months later, when he could walk on his prosthetic leg, they came home. One day at the dentist, Sonya began to gag, filling with panic. The antiseptic smell of the office had triggered her, and she became flooded by all the feelings she had dissociated during his ordeal. With the help of a social worker, she began to process the horror she felt from the moment she learned of his wounds and throughout his convalescence. Sonya suffered from secondary trauma.

Soldiers, veterans, and their families are an underserved population. The socioeconomic incentives for entering the military are designed to recruit those who grew up confronted by poverty and lack of opportunity. The military offers a path out of this life by providing structure, job training, and affiliation. Since the United States began waging war in Afghanistan in 2001 and Iraq in 2003, soldiers have had multiple exposures to combat and the carnage that accompanies it. The result has been profound traumatization that is just being realized and addressed. Female soldiers are also subjected to sexual harassment and sexual assault. PTSD and traumatic brain injury are the signature wounds of these wars. Clinicians who work with soldiers and veterans need expertise in treating complex PTSD, which may be superimposed on earlier trauma histories as well as on earlier personality problems. Psychodynamic principles provide us with ways of understanding and treating PTSD, as well as understanding that coping mechanisms developed earlier in life will influence the level of trauma or resilience in any soldier or veteran.

Family members also are vulnerable to mental health problems stemming from the burdens of separation and loss during a deployment and the rigors of negotiating reunion and reintegration. Therapists whose caseload

includes work with traumatized soldiers and veterans need special skills, including an understanding of the culture of the military. Therapists must also attend to their own self-care so they may continue to bear witness to the bravery and the suffering of military men, women, and families.

This is a poem that appears in *Operation Homecoming*, an anthology of writings by soldiers, veterans, and family members who served in OIF and OEF.

The ghosts of American soldiers
 wander the streets of Balad by night,
 unsure of their way home, exhausted.
 the desert wind blowing trash
 down the narrow alleys as a voice
 sounds from the minaret, a soulful call
 reminding them how alone they are,
 how lost. And the Iraqi dead,
 they watch in silence from the rooftops
 as date palms line the shore in silhouette,
 leaning towards Mecca when the dawn wind blows.

Sgt. Brian Turner, "Ashbah" (transliteration
 of the Arabic word for *ghosts*)

Let us help them quiet the ghosts of war.

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