CHAPTER 10

The Breaking Points of Moral Existence --- What Breaks?

When a soldier is broken by combat, what breaks? The reader has already had many glimpses of the post-traumatic existence of combat soldiers. It is now time for a more extensive and systematic discussion of combat PTSD. Here is Shakespeare's account of what seems very much like the symptoms of PTSD; the person speaking is a combat veteran's wife:[1]

0, my good lord, why are you thus alone?	Social withdrawal and isolation
For what offense have I this fortnight been A banish'd woman from my Harry's bed?	Random, unwarranted rage at family, sexual dysfunction, no capacity for intimacy
Tell me, sweet lord, what is't that takes from thee Thy stomach, pleasure	Somatic disturbances, loss of ability to experience pleasure
and thy golden sleep?	Insomnia
Why dost thou bend thine eyes upon the earth,	Depression
And start so often when thou sit'st alone?	Hyperactive startle reaction
Why hast thou lost the fresh blood in thy cheeks,	Peripheral vasoconstriction, autonomic hyperactivity
And given my treasures and my rights of thee To thick-eyed musing and cursed melancholy?	Sense of the dead being more real than the living, depression
In thy faint slumbers I by thee have watch'd,	Fragmented, vigilant sleep

And heard thee murmur tales of iron wars, Speak terms of manage to thy bounding steed, Cry "Courage! to the field!" And thou hast talk'd Of sallies and retires, of trenches, tents, Of palisadoes, frontiers, parapets, Of prisoner's ransom, and of soldiers slain, And all the currents of a heady fight. Thy spirit within thee hath been so at war And thus hath so bestirr'd thee in thy sleep,	Traumatic dreams, reliving episodes of combat, fragmented sleep
That beads of sweat have stood upon thy brow, Like bubbles in a late-distrubed stream;	Night sweats, autonomic hyperactivity

THE OFFICIAL DIAGNOSTIC CRITERIA FOR PTSD OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Of the five official criteria that make the diagnosis of PTSD, all but the first (criterion A, which I shall discuss below) are straightforward clinical description, broadly stated to apply to all PTSD, not only to combat PTSD. I believe at this point the reader will be interested in seeing them exactly as they stand in the official diagnostic manual (known as the DSM-III-R). The dry criteria may come to life if the reader tests them against Shakespeare's portrait and decides whether Harry Hotspur, the most formidable fighter among the rebels against King Henry IV, has it:

A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence.

B. The traumatic event is persistently reexperienced in at least one of the following ways:

(1) recurrent and intrusive distressing recollections of the event (in young children, repetitive play in which themes or aspects of the trauma are expressed)

(2) recurrent distressing dreams of the event

(3) sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)

(4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

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

(1) efforts to avoid thoughts or feelings associated with the trauma

(2) efforts to avoid activities or situations that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma (psychogenic amnesia)

(4) markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills)

(5) feeling of detachment or estrangement from others

(6) restricted range of affect, e.g., unable to have loving feelings

(7) sense of a foreshortened future, e.g., does not expect to have a career, marriage, or children, or a long life

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

(6) physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event (e.g., a woman who was raped in an elevator breaks out in a sweat when entering any elevator)

E. Duration of the disturbance (symptoms in B, C, and D) of at least one month.[2]

Criterion A is not at all as straightforward as the others. The linchpin of this diagnostic standard is its implicit claim to ethically and culturally neutral knowledge of *"usual* experience."

In the twentieth century, combatant deaths in all wars worldwide have averaged 180 per million population per year. This

makes war casualties, and their witnessing, sound very rare, less than two in 10,000 (0.02 percent). But life happens in particular, not as a worldwide century average. Four hundred died or were seriously wounded for every 10,000 who served in the U.S. armed forces during the Vietnam era, whether or not they went to Vietnam; 1,200 (12 percent) died or were seriously wounded for every 10,000 who served in Vietnam.[3] The percentage of combat veterans, as defined here, who died or were wounded cannot be determined from the available data, but it is surely higher than the 12 percent for all high- and low-combat-exposure servicemen lumped together. Findings from the *National Vietnam Veterans Readjustment Study (NVVRS),* a rigorously designed and executed nationwide epidemiological study of a random sample of Vietnam-era veterans and a random sample of demographically similar civilian controls, showed that 35.8 percent of male Vietnam combat veterans met the full American Psychiatric Association diagnostic criteria for PTSD at the time of the study, in the late 1980s. This many men had grossly unhealed psychological injuries—almost twenty years after their war experience. This is a thirty-two-fold increase in the prevalence of PTSD compared to the random sample of demographically similar civilians More than 70 percent of combat veterans had experienced at least one of the cardinal symptoms ("partial PTSD") at some time in their lives, even if they did not receive the full syndrome diagnosis.[4]

Given the luck of assignment to a combat unit, it is *not* "outside the range of usual human experience" to undergo "serious threat to one's own life or physical integrity; serious threat or harm to ... close . . . friends; . . . or seeing another person who has recently been, or is being, seriously injured or killed. . . ." This is the *normal* experience of a combat soldier. "Outside the range of usual human experience" pretends that the "usual" deployments of social power have nothing to do with events that cause psychological injury.[5]

The official definition almost totally fails to convey the ease with which PTSD can be confused with other mental disorders. For example, the numbness, mistrust, hallucinated voices of the dead, and social withdrawal of combat PTSD are easily confused with schizophrenia. Some combat veterans remain in an emotionally deadened, socially withdrawn state for prolonged periods, and many have been misdiagnosed as schizophrenic. Another

common misdiagnosis is bipolar affective disorder, the current term for what the general public knows as manic-depressive illness. When intrusive relived experiences predominate and the veteran is flooded with emotions of fear and rage, he may stay awake for many days at a time and engage in driven, frantic activity. He may meet the descriptive criteria for mania and have a history of depression and despair—like Shakespeare's Harry Hotspur—and *voika,* the diagnosis of bipolar affective disorder is made. A cycle of alternating states of numbness and intrusive reexperiencing is common enough in PTSD for most authorities in the field to regard it as intrinsic to the disorder. Combat veterans in our program who first made contact with the mental health system in the early 1970s were almost universally diagnosed as paranoid schizophrenic, if first seen in the late 1970s as manic-depressive or schizo-affective, and if first seen in the mid-1980s as suffering from PTSD. PTSD can unfortunately mimic virtually any condition in psychiatry.

PTSD AND THE RUINS OF CHARACTER

Regardless of when they were first seen, most of my patients have also been diagnosed with borderline or antisocial personality disorder, as well as other personality disorders. I do not believe the official PTSD criteria capture the devastation of mental life after severe combat trauma, because they neglect the damaging personality changes that frequently follow prolonged, severe trauma. The World Health Organization's *Classification of Mental and Behavioral Disorders* offers the category "Enduring personality change after catastrophic experience," defined as these personality features that did not exist before the trauma:

(a) a hostile or mistrustful attitude toward the world;
(b) social withdrawal;
(c) feelings of emptiness or hopelessness;
(d) a chronic feeling of being "on the edge," as if constantly threatened;
(e) estrangement.[6]

More than simply inflicting the set of symptoms described in DSM-III-R, prolonged combat can wreck the personality.[7]

PERSISTENCE OF THE TRAUMATIC MOMENT—LOSS OF AUTHORITY OVER MENTAL FUNCTION

The everyday experience of authority over mental processes is denied to the survivor of severe combat trauma. Many combat veterans made their first contact with mental health institutions because of fears for their sanity. Much as we expect effortless control over voluntary physical activities of our bodies—and are profoundly disturbed by paralysis, involuntary movements, or loss of bladder or bowel control—so is effortless and confident control over perception, memory, and thought an essential part of feeling sane. Many veterans who sought help could only express their affliction by saying things like, "I ain't right."

UNTRUSTWORTHINESS OF PERCEPTION

A human enemy strikes not only at the body but at the most basic functions of the soldier's mind. The Vietnamese enemy defeated the soldier's perception by concealment and his ability to understand what he saw by camouflage. The basic mental state of intention and will was attacked by ambush, deception, surprise, and anticipation. I recall canoeing with veterans along tranquil meanders of the Saco River in Maine, when one of them, who had served on riverboats in the Mekong Delta, pointed out the tan mudbank on the outside of a curve. He said that such an innocent riverbank would be riddled with tunnels and invisible machine-gun and rocket-propelled-grenade positions. The cumulative effect of prolonged attacks on mental function is to undermine the soldier's *trust* in his own perceptions. Another veteran said:

> Nothing is what it seems. That mountain there—maybe it wasn't there yesterday, and won't be there tomorrow. You get to the point where you're not even sure it *is* a mountain.

In such a situation, "hypervigilance" is a rational response. Everything must be looked at twice, three times, to be sure that it is what it appears to be.

I speculate that a soldier's trust in his own perceptions and cognitions usually recovers spontaneously upon return to civilian life, *unless the soldier has also experienced major betrayals* by his own leaders. Without recapitulating the kinds of betrayal described in

chapter 1, I want to focus on the extremely common experience in Vietnam of being told by military superiors, "You didn't experience it, it never happened, you don't know what you know." One multitour airborne veteran recalls a particular denial of perception and experience with great bitterness. I shall start with a portion of this former sergeant's narrative that we have heard earlier, and then allow the reader to hear how it continues:

> Daylight came [long pause], and we found out we killed a lot of fishermen and kids.
>
> What got us thoroughly fucking confused is at that time, y'know, you turn to the team and you say to the team, "Don't worry about it. Everything's fucking fine." Because that's what you're getting from upstairs. The fucking colonel says, "Don't worry about it. We'll take care of it." Y'know, uh, "We got body count! We have body count!" So it starts working on your head. . . .
>
> The lieutenants got medals, and I know the colonel got his fucking medal. And they would have award ceremonies, y'know, I'd be standing like a fucking jerk and they'd be handing out fucking medals for killing civilians. So in your mind you're saying, "Ah, fuck it, they're Gooks."
>
> I was sick over it, after this happened. I actually puked my guts out. You know what had happened, but—see, it's all explained to you by captains and colonels and majors that "that's the hazards of war. They were in the wrong place." Y'know. "It didn't have anything to do with us. Fuck it. They was suspects anyways." And we was young fucking kids. That reasoning didn't come to effect right away, with me anyways. All I could see was anger building up. And what they did is they played on my anger. "You guys did a great job." Y'know, "Get drunk. You guys deserve it." Y'know, "You guys party." Y'know, "If yous wanna go downtown and get laid, go ahead." Y'know, and everything's fine, y'know. "RECON! AIRBORNE!" Y'know, uh, "We made it! We got body count!".. .
>
> As a young fucking kid, which we were, but we were old men. I don't know if you can understand what I'm saying. We were young in the heart and the body but they made us old men. . . . Y'know, "Erase that. It's yesterday's fucking news." "Ain't got nothing to do with us." "Move on."

This man suffered the nullification of perception and experience by his superiors. In high-stakes situations this is a major betrayal in itself. American soldiers in Vietnam experienced repeated era-

sure and denial of their own experiences. And this was not limited to enlisted men.[8]

Some loss of the trustworthiness of perception may be purely biological and independent of what others say about reality. Some survivors of heavy combat report persistent illusions of movement in their peripheral vision. One veteran tells that after he returned from Vietnam he shot at rats he saw moving out of the corner of his eye. His bedroom wall was peppered with bullet holes—"but there were not rats!" Because of the way our vision works, everyone has a fair amount of jiggling about in the far peripheries of the visual fields. However, our brains effortlessly filter this out before it attracts our attention. The inability to filter out trivial and harmless sensations may relate to chemical or even anatomical changes in the brain. A growing number of medical researchers are currently finding abnormalities of brain chemistry, function, and even gross structure in those suffering from combat PTSD. This is a rapidly advancing field.

MEMORY

Severely traumatized individuals lose authority over memory. Amnesia is common for traumatic events. In amnesia the trauma survivor has no authority over his memories of events because they cannot be recalled at will like ordinary memory. On the contrary, memory has authority over him.

Traumatic memory is not narrative. Rather, it is experience that reoccurs, either as full sensory replay of traumatic events in dreams or flashbacks, with all things seen, heard, smelled, and felt intact, or as disconnected fragments. These fragments may be inexplicable rage, terror, uncontrollable crying, or disconnected body states and sensations, such as the sensation of suffocating in a Viet Cong tunnel or being tumbled over and over by a rushing river—but with no memory of either tunnel or river. In other instances, knowledge of the facts may be separately preserved without any emotion, meaning, or sensory content. Often the only clue to a traumatic event may be an utterly bland statement of fact slipped into another context, such as ". . . just near the vale where Porker got his shit scattered [killed]."

In the overwhelming emotion of a fire fight in which a friend's jaw is shot away and he is seen suffocating on his own blood,

words such as *terror, rage,* and *grief* do not do justice to the merging of powerful feelings in this hyperaroused state. We must bear in mind that when the traumatic moment reoccurs as flashback or nightmare, the emotions of terror, grief, and rage may be merged with each other. Such emotion is relived, not remembered. The naming of these as separate emotions, creating a *language* of emotion—which may be in plastic and musical arts, not only in words—is an important part of gaining mastery over the traumatic memory. Naming is one of the early stages of the communalization of trauma by rendering it communicable, however imperfectly.

Once reexperiencing is under way, the survivor lacks authority to stop it or put it away. The helplessness associated with the original experience is replayed in the apparent helplessness to end or modify the reexperience once it has begun. Fortunately, some learnable psychological techniques can be taught to survivors to gain substantial mastery over flashbacks and other intrusive phenomena and to mitigate the dangers that they present to the veteran and to others.

So long as the traumatic moment persists as a relivable nightmare, consciousness remains fixed upon it. The experiential quality of reality drains from the here-and-now; the dead are more real than the living. This is a cognitive aspect of the detachment of the trauma survivor from his current life and is intimately connected with the persistence of numbing, one of the basic skills of surviving prolonged, inescapable terror.

PERSISTENT MOBILIZATION FOR DANGER

Vigilance, the mental and physical preparation for attack, is a combat survival skill that needs no explanation. It is difficult, however, for anyone who has never been in combat to grasp the extent to which vigilance invades sleep.

The modern soldier's sleep can hardly be said to be sleep. In Vietnam, one veteran in our program always slept on his back with his rifle across his chest, or sitting up. It is not safe to shut out sounds and shadowy movements, so they are not shut out but instead are acknowledged during the light, unrestorative doze that is the soldier's sleep. By contrast, Homeric warfare was apparently suspended every night from sunset to sunrise. The

Trojans slept in their own beds behind the city walls. The Greeks slept in huts in a permanent encampment. Many veterans continue to sleep the same way they did in combat, on their backs with weapons, facing the door or window, ready to attack. For the veteran with unhealed PTSD, no place is familiar enough to completely shed combat vigilance.

Split-second, unthinking, self-defensive responsiveness when surprised is another combat survival skill. The metallic arming click of an enemy RPG, once heard, meant a searing explosion seconds later. Several of our patients will involuntarily hit the ground to this day when they hear a similar sound. One vet threw himself down on hearing such a sound and fell from a metal walkway where he was working above a post office sorting hall. Family, friends, and co-workers of Vietnam combat veterans have learned that it is most unsafe to approach these men unannounced from behind. The persistence of combat reflexes when surprised is not the same thing as recurrence of the berserk state, although the former may trigger the latter. The link between the two appears to be the adrenaline rush that accompanies surprise, which in turn can trigger the berserk state. Veterans who are prone to going berserk live in dread of such triggering and protect themselves from surprise for this reason. Suppression of the adrenaline rush by adrenaline-suppressing drugs called B-adrenergic blockers has permitted some veterans to venture out of their surprise-proof basement bunkers.

Exposed to the continuous threats of warfare, the body remains mobilized for battle indefinitely. There is no longer any baseline state of physical calm or comfort. Over time the combat veteran's body may seem to have turned against him. He begins to suffer not only from insomnia and agitation but also of numerous types of somatic symptoms. Tension headaches, gastrointestinal disturbances, skin disorders, and abdominal, back, or neck pain are extremely common He may complain of tremors, choking sensations, or a rapid heartbeat. Some veterans become so accustomed to their condition that they cease to recognize the connection between their bodily distress symptoms and the climate of terror in which these symptoms were formed. It should come as no surprise that Vietnam combat veterans have been hospitalized for physical problems about six times more often than Vietnam-era veterans who never served in Vietnam.

A person "broken" by combat has lost the capacity for a sense

of well-being, self-respect, confidence, and satisfaction—all attributes that we lump together in our concept of "happiness." It can come as no surprise that Vietnam combat veterans rate themselves as "very happy/satisfied" less than half as often as civilian counterparts and "very unhappy/unsatisfied" more than six times as often. For roughly a third of Vietnam combat veterans—a proportion 4.5 times as large as that found among civilian counterparts—demoralization is pervasive, encompassing a sense that their bodies are not working right, that they have lost their capacity to think, that they are helpless, hopeless, and full of dread. The word *demoralization* is very apt for this state of being, because it invites us to think of the social and moral ground of these apparently private miseries.[9]

PERSISTENCE OF SURVIVAL SKILLS

Humans are biologically equipped to learn. The result of learning is persistence through time of the thing learned. Things done to survive in the danger of death and mutilation are learned very well indeed. Survival skills, such as vigilant sleep, brought back into the civilian worlds of family and employment, are actually more destructive of the veteran's well-being than the intrusive persistence of the traumatic moment.

Control over attention is one of the fundamental survival skills of people in captivity everywhere. All modern warfare is a condition of terrorized captivity for the combatants, whether in a static position under bombardment, and constant threat of ground attack, or patrolling from a helicopter landing zone.[10] The latter is no less a condition of inescapable captivity, even though the captive does much moving about in the open. Displacement, restriction, and detachment of attention are fundamental survival skills under all conditions of inescapable terror." One 101st Airborne veteran, who had spent every summer as a child on Plum Island off the Massachusetts coast, literally hallucinated lying on the beach there with his extended family nearby, during any moment it was safe to turn his attention away from the enemy. It is not clear at present what relationship these dissociative skills have to the release of numbing, opiumlike substances in the brain, although under some conditions, both probably happen simultaneously.

The destruction of time is an inner survival skill. These words, written about concentration camp prisoners, apply equally to soldiers in prolonged combat:

> Thinking of the future stirs up such intense yearning and hope that . . . it [is] unbearable; they quickly learn that these emotions ... will make them desperate. . . The future is reduced to a matter of hours or days.
>
> Alterations in time sense begin with the obliteration of the future but eventually progress to obliteration of the past. . . . [At first they] cultivate memories of their past lives in order to combat their isolation . . . [and then they] lose the sense of continuity with their past. The past, like the future, becomes too painful to bear, for memory, like hope, brings back the yearning for all that has been lost. Thus prisoners are eventually reduced to living in an endless present."

For combat soldiers, the temporal horizon shrinks as much as the moral and social horizon. Only getting through *now* has any existence. With this loss of a meaningful personal narrative that links past, present, and future comes a shrinkage of volition. Combat restricts and arrests the personal exercise of *will* as absolutely as the harshest imprisonment. A key survival skill in both circumstances is suppression of the will, which goes hand in hand with suppression of thoughts of the future. A depleted state of apathy, an inability to *want* anything, to will anything, often persists into life after combat, when it is no longer needed as a survival skill.

Rules, formal task descriptions, and written orders play a more visible role in the military than in any other setting. The combat soldier's attitude toward them often evolves into one of profound hostility and suspicion, both during and after military service. The soldier in combat experiences his situation in all its life-or-death specificity, where the *general* rule can get him killed. Orders, rules, and procedures often come to the soldier from the vast distance of safety in the rear, rules devised to cover general situations that may be lethally irrelevant:

> So you gotta pull devious shit. Y'know what I'm saying?
>
> Like we changed our [radio] call signs in the middle of fucking things. The Gooks some way or another got the roster of our shit. The fucking yo-yos in the back used to have all these fucking Indigenous Personnel working for them. So we were in the field

> and we were called, like, Robin Hood, Robin Hood One, Robin Hood Six, Broken Arrow. And they started to get our flicking call signs. And [the enemy] started talking to us on the fucking radios. ... So when we went to the field, the six teams going had already talked.
>
> And we said, if the shit hits like it again, we'll all use something that we used back home. So like all of a sudden we became Batman and Robin, Snoopy and Pigpen. Y'know, "Snoopy, have you seen Pigpen?"
>
> "He's with Schroeder." Right? So we knew where everybody was.
>
> And fucking everybody in the rear fucking flipped out, because we weren't using proper radio procedures. And these motherfuckers were on the radio with us, "Use proper radio procedures!" Y'know? "You guys are in deep trouble."
>
> You fucking got the radio, and you're saying, "I'm in deep fucking trouble? You people fucking serious?" Y'know? "What the fuck you going to do? Send me to jail? Do me a fucking favor." I'm out there getting fucking murdered, and they're telling me I'm in fucking trouble.

Other examples are not so benign or funny. Another veteran recalls one instance in which his lieutenant ordered him to take his squad into a senseless death trap in a rice paddy, and he refused. The lieutenant found three other men more compliant and sent them sent across the paddy, rather than around it. All three were killed by mines.

At the deepest level, survival in war trains or selects men for the skills to ignore, deflect, pervert, or circumvent orders, rules, and standard operating procedures. The reason for this lies in the nature of war against a human enemy—who is diligently stealing and studying training manuals, directives, standing orders, procedures, etc. The enemy's power of intelligent observation and thought give rise to what Georgetown University military historian Edward Luttwak calls the "paradoxical logic of war."[13] No matter how sound the rules and procedures in "the book," the enemy will very shortly know "the book" better than you do and will turn "doing it by the book" into a death trap.

The soldier quickly grasps that following rules can get him and the people close to him killed. It is clear that the skill to ignore and subvert rules often persists into civilian life, accounting for antisocial traits apparent in some combat veterans. However, the

atmosphere of mortal danger also persists into civilian life and in my view is the main engine behind subversion of institutional rules by combat veterans.

A shared narrative future—as expressed in such statements as "Yes, I'll come to the picnic next Friday"—defines socially shared predictability of behavior. Prolonged contact with the enemy teaches that *predictability is fatal.* Being unpredictable is a basic survival skill in combat, where the enemy is ever observant. Many of the veterans in our program take different routes to the clinic every time they come. Carried into civilian life, this ingrained tie between unpredictability and survival negates the shared narrative consciousness assumed by social life in families and at work.

Readiness to react instantly and violently when surprised, a learned skill in training and combat, often comes to haunt and impair veterans in civilian life. If a veteran instinctively strikes or throws to the ground a family member, friend, or stranger who surprises him, the veteran's mood afterward is usually one of profound shame.

PERSISTENCE OF BETRAYAL

Severe, prolonged traumatization can bring wholesale destruction of desire, of the will to exist and to have a future. Betrayal of "what's right" is particularly destructive to a sense of continuity of value in ideals, ambitions, things, and activities. When some major ideals have been betrayed, the trustworthiness of every ideal or activity may be called into question. Undoubtedly this overlaps a great deal with the other topics in this section, particularly morale, and with the depression that is pandemic among combat veterans, who are seven times more likely to have suffered a major depressive episode than a demographically similar civilian control group, and eleven times more likely to have suffered from dysthymic disorder, a chronic, fluctuating state of depression, hopelessness, loss of self-respect, and loss of energy for living. Sometimes combat veterans appear to have a memory deficit for things, activities, or ideals that once carried intrinsic merit and a sense of satisfaction for them. Even the value of one's own home and possessions and of familiar places can be lost: Vietnam

combat veterans are three times more likely to have been both homeless and vagrant than their civilian counterparts. According to a report compiled by the National Coalition for the Homeless, at least one-third of homeless males are veterans, with 150,000-250,000 veterans homeless on a given night and at least twice that number homeless at some time in the course of a given year. Alienation from a valued image of marriage may contribute to the fact that combat veterans are 3.5 times more likely than age-matched civilian controls to be living with partners "as if married" but not legally married.[14]

PERSISTENCE OF ISOLATION

Shrinkage of the social horizon after betrayal of "what's right" may persist long into civilian life. Safe, nonviolent attachments to others can become virtually impossible. The idea of a "freely cooperating partner" ceases to be a conceivable category for others or for oneself. Personal relationships of work, love, or friendship therefore become extraordinarily difficult. In the *National Vietnam Veterans Readjustment Study,* combat veterans were about twice as likely to have a highly unstable occupational history and to have had two or more divorces than demographically similar civilian counterparts.[15]

PERSISTENCE OF SUICIDALITY

Thoughts of suicide are common symptoms of combat PTSD. Paradoxically, they are also signs of life. If a person enters the zombielike state of indifference beyond despair, rage, suicidality, and fear, he or she simply dies. This is the testimony of concentration camp survivors and combat veterans. The ability to kill oneself is the bottom line of human freedom. Many combat veterans think daily of suicide. Knowledge that one has this freedom seems to be sustaining Vietnam veterans assert that twice as many of their brethren have died by suicide since the war than died at the hands of the enemy. I, for one, have no inclination to dispute this number, though accurately estimating suicides in this population is even more difficult than counting the homeless.

PERSISTENCE OF MEANINGLESSNESS

When a survivor of prolonged trauma loses all sense of meaningful personal narrative, this may result in a contaminated identity. "I died in Vietnam" may express a current identity as a corpse. When the "I" who died is understood to be the bearer of a civilized social morality, what remains may reflect a tainted, evil identity, one deserving punishment. I have heard more than one veteran declare that God kept him alive to torture him: If God had loved him, He would have let him die in Vietnam. Many combat veterans speak of the dead as the lucky ones.

Since the earliest studies of concentration camp survivors, it has been known that severe trauma shatters a sense of the meaningfulness of the self, of the world, and of the connection between the two. The same obliteration of meaning has subsequently been confirmed for rape victims, Hiroshima survivors, survivors of the Cambodian genocide, and Vietnam combat veterans. In present-day America, religious educators have been extraordinarily successful in claiming hegemony over experiences of Meaning and Right and Wrong. This is so well entrenched in our culture that many combat veterans have no way of thinking or speaking about these matters apart from God.

DESTRUCTION OF THE CAPACITY FOR DEMOCRATIC PARTICIPATION

Unhealed combat trauma devastates the civic and political life of the returning veteran. To see how this can happen, let us consider some of the assumed and unnoticed features of mental and social life that make democracy possible.

Democratic process embodies the apparent contradiction of *safe struggle.* Combat veterans with unhealed PTSD have the greatest difficulty conceiving of any struggle apart from killing and dying. Passionate struggle conducted within rules of safety and fairness simply doesn't make sense to them or seems a hollow charade. For them it is psychologically impossible to win a struggle without killing or to lose without dying, and they do not want to do either. Many veterans' response is to withdraw and not participate. Democracy embodies safe struggle over the shape and implementation of a future. An unhealed combat veteran cannot

think in terms of a future. Democratic political activity presupposes that the future exists and that it is meaningful. Combat taught the survivor of prolonged combat not to imagine a future or to want anything. Prior to seeing the point of one's voluntary participation in a social process, one must feel that it is safe to want something.

Veterans with unhealed PTSD feel that it is not safe to commit to attending political meetings—there may be a crowd, and it may be impossible to cover one's back. Appearing at a known time and place, especially over and over again, invited death in Vietnam. Going to a second meeting, after a first meeting proved tolerable, may provoke a disabling panic attack. The persistent survival skill of unpredictability devastates the simplest forms of democratic participation. "Show up at the polls? Forget it."

Democratic process entails debate, persuasion, and compromise. These all presuppose the trustworthiness of words. The moral dimension of severe trauma, the betrayal of "what's right," obliterates the capacity for trust. The customary meanings of words are exchanged for new ones; fair offers from opponents are scrutinized for traps; every smile conceals a dagger.

Unhealed combat trauma—and I suspect unhealed severe trauma from any source—destroys the unnoticed substructure of democracy, the cognitive and social capacities that enable a group of people to freely construct a cohesive narrative of their own future.