

After-Action Report

"Some things that count can't be counted, and some that can be counted don't count."

— Albert Einstein

Those of you accessing this site via contact from Jefferson Barracks are aware of the shift from Hocking Primer to Operator's Manual. The Primer made sense when the group was continuing. It was our effort to craft an operating system. But with the conflict at work, the group became an on and off situation. Moving forward without it made no sense for the Primer was to be a collaborative effort. With the group ending it became necessary to gather our principles rather than work on new ones. We faced winter, not spring.

That has changed. At this time we shall continue to meet and our focus again goes back to the Primer. All my efforts on this site connect. They deal with resolving psychological conflict. The Primer and the Manual address this issue, although the Primer addresses it from tomorrow while the Manual focuses on today. This is not confusing for those of us who meet regularly, but I am trying to explain this shift to those who access this site from elsewhere.

So we are back to learning lessons again, and difficult times such as the recent conflict can provide important ones. They offer choices more important than coffee, tea, or milk. Those of us who went through the recent campaign are likely seeking a way to understand it. After action reports require that we attempt to do so.

During the skirmish I heard post-traumatic stress disorder described as a mental illness. That is not strictly correct. While there are symptoms, they do not constitute an illness. Is poison ivy an illness? How about a fractured leg? These appear to be conditions, not illnesses. They come from external events, not internal dispositions. Illness is about dispositions—osteoporosis disposes to fractures, arteriosclerosis to heart attacks. But there is no disposition in the genesis of PTSD.

We are described as a therapy group, but even that presents issues. Therapy suggests a medical condition, and we are not conceding that. I really do not care if people call us green pumpkins, but wrong names suggest wrong solutions. A stressor for this condition is best defined as an experience



that anyone would find difficult to integrate. That defines a life problem, not an illness. The woman in Sophie's Choice did not suffer from a mental illness. She suffered from the consequences of being able to keep only one of her two children at Auschwitz. No one would escape that situation unscathed. So is everyone mentally ill?

Let me digress briefly about making the diagnosis of PTSD. According to the diagnostic manual (DSM-IV) it requires experiencing a specific type of stressor, followed by symptoms that cluster into three groups: intrusive, avoidant, and hyperarousal. You need one symptom from intrusive, three from avoidant, and two from hyperarousal to make the diagnosis. A committee thought it out and actually picked this system as the best!

This scheme presents several problems:

One: The description of a stressor reads like a legal brief. It becomes broad enough to include anyone. And it focuses only on physical injury. There are other things that cause processing difficulties, such as your brother telling you he killed an intruder but elected to dispose of the body rather than inform the police. What do you do with that? Might it cause nightmares?

Here is a complete description of the diagnostic manual's view of a stressor. Read the whole thing (it becomes tedious) and see if it works for you, let alone whether you could remember it during an interview.

"The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior)

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious ac-

cident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase."

That was a mouthful. It is purely descriptive, posits no causality, and is hardly objective. How does one measure the horror, fear, or helplessness one experiences upon reading that a close (how close is close?) associate was injured in an accident. Taking the person's word for it leaves the door open to anyone filing a compensation claim. There is only one way to measure such things and that is to use your self as the reference. I have been in two accidents that totaled my/our car, and I found a body on the way to work. These things did not affect me. So I shall not be sympathetic to someone who claims damage from reading about an injury to a coworker. And there is no way I could keep this list in mind during an interview. In fact that is a terrible idea. With PTSD you want to make a connection. One does not do that by checking little boxes. If the patient wants a diagnosis of PTSD that fulfills DSM-IV criteria, let him do it on a computer. I intend to bring myself to the interview, and the question I ask is whether this sounds like a difficult situation to me. Sophie's choice does; reading about an accident with injury doesn't. It's that simple.

PTSD is a valent diagnosis. People have negative feelings about this diagnosis because it can be associated with a claim for compensation. And the all-encompassing definition of a stressor listed in the diagnostic manual complicates the problem. Everyone knows someone who has been involved in a serious accident. But not everyone had to shoot a prisoner because he couldn't take him, couldn't leave him, and couldn't stick around. PTSD is about big lose/lose situations. They do not happen every day—except perhaps in war.

Pursuant to this there is the behaviorist quest for objectivity in mental disorders. We lie to ourselves about this for there is no way to avoid subjectivity. A GAF score supposedly measures one's effectiveness in living on a scale of one to 100. That exceeds our capacity for discrimination. At best we could use a scale of one to ten. There will never be an argument in court about whether the GAF is 64 or 65. What would be the evidence? The scores are in large part subjective. We are stuck being people even as physical scientists, but for sure when dealing with the mind. How intrusive are intrusive thoughts? We have little way of knowing other than to ask, but cosigning the patient's subjectivity does not make them objective. So we guess at it. Intrusive thoughts do not show up on x-ray.

Two: The diagnostic criteria are simply descriptive. The scheme involves no comprehension. And it suggests that if a person eliminates any of the required symptoms the diagnosis disappears. This leads to treating symptoms, which are not causes. Behaviorism outruns its leash. Pure description is not sufficient. One needs to understand how the parts relate. Without that we are merely treating the fever and rapid heart rate rather than the pneumonia.

Three: The whole system is arbitrary. How do they decide there are three entries from the avoidant group and two from the hyperactive group? Why not the other way around? The answer is that they convene a committee, usually comprised of those with a research bent (not full-time—or even part time—clinicians), and they vote. It might look insightful, but I doubt that researchers understand PTSD like clinicians. I am saying that the official template for diagnosing this disorder is high on cognition and low on common sense. It reflects the tendency in mental health to present itself as empirical (i.e., the product of external observation) rather than introspective (i.e., the natural way we experience ourselves). No matter how hard people try, we cannot figure out a way to objectify experience (i.e., the color green or the feeling of pride). Scientific authority should not be worshiped at the expense of personal experience. Our best guide comes from our own reads. Perhaps combat vets know that better than civilians.

The crucial element in post-traumatic stress disorder is the mechanism of causation. One possibility is that the stressor itself produces the syndrome. That would be an actual illness. The trauma might change the body much like radiation or a stroke. People viewed it that way when they called the disorder shell shock. The agent was thought to be concussive damage to the brain. Current theories hypothesize anatomical changes mediated by biochemical agents. If that is the case this syndrome would also be a physical disorder and therefore would likely require a physical solution. Drugs might be prescribed—or perhaps stoicism.

Shifting from brain to mind leaves us with a less secure footing. It is easy to see how a blocked artery could produce atrophy, but what forces affect the mind? Usually we jump



to physical analogies, but still we have ideas that offer guidance. One might be the concept of Pavlovian conditioning. In this phenomena one image pairs with another, say the past with the present, and yesterday feels like today. This is not my bailiwick but you get the idea—thoughts connect to thoughts and help derives from altering the connections. Enter cognitive/behavior therapy. The mind is perhaps a canvas to paint any color you wish. Some in our group call this bluebird therapy.

Maybe memories fade like scars. Perhaps the veteran, for example, should make an active effort to avoid thinking about Vietnam. I do not know how a person does that, since to not think about something one has to remember what not to think about, but suppose this could be done. Then out of sight (mentally) would mean out of mind. That is part of the recovery model, which essentially says “that is in the past, let’s move forward from today”.

Another principle that we would have trouble explaining physically but which is helpful conceptually is that of turning passive to active. Freud felt this was a fundamental principle of the mind. Life itself can be seen as a progressive expansion of personal agency upon the world. We strive to attain control. This makes sense. People get sand kicked in their face and head to the weight room. They score badly on a philosophy test and vow to study harder. (Well, maybe there are limits.) People do not like to be driven. They prefer to drive. Post-traumatic stress disorder can then be seen as a condition that blocks our efforts to change passive to active. Our mind strives to give meaning to experience. Meaning gives order and offers control. But some events are difficult to grasp. They entail unpleasant affects and make no sense with everything else we believe. Because of that we fail to address them and they remain rogue elements in our minds, outside our control. So the trauma itself is not the cause. The problem comes from our inability to incorporate the trauma.

Causal mechanisms are important because treatment models are based on them. If the problem is associative, then minimizing or ignoring it makes sense. But if the difficulty is a processing problem, it must be confronted.

I do not need to make a case for which is correct. People will choose sides for emotional reasons, and logic is not likely to carry the day on this issue. But suffice it to say that both cannot be right. One group turns away from the trauma; the other turns into it. One group must let go of the experience before they can hold it. The other must hold it before they can let go. Pick one.

Experiences that cause PTSD are difficult to face because the medium is the message. Significant stressors can only be grasped on an emotional level; and fear, guilt, pain, shame, and grief are not easy to embrace. In addition, the message shatters our security. The dark side of life is revealed, which fits poorly with everything we have constructed, and few people who maintain their illusions care to observe it. That includes most in our society.

PTSD is a painful intrusion of truth that upsets balance and sets one apart. There appears to be no going back, and trying to do so produces futility. One of major components of our approach is to stop the secondary bleeding that comes from trying to fit back into yesterday. From our perspective there is no return and no treading water. The only option is to continue forward and try to make peace with the dark side. Studies show that society can turn savage in less than two days. That is the truth, but few care to notice. Better to be “normal” and float along with illusions—unless disaster strikes. Then, however, it is too late for preparation. (Truth has its advantages.)

There is a loss in PTSD. One no longer fits with the rest of society. Handling PTSD means charting a new course. The last thing one needs is being labeled sick and being told by the un-sick how to feel and react. Disavowing honest feeling and reactions contributes to emotional detachment. The price of remaining true to one’s experience is not being able to swim with the other fishes. One needs to craft a new operating system that fits into the new (and disturbing) truth. That is not easy. Having to do it alone dooms most people to failure.

But a few could fly solo and they offer help. Spinoza had to face his personal truth by himself. Holding on to his beliefs cost him his native culture. He fit poorly in his adopted one. He wrote what some consider the finest work in philosophy in an effort to chart his personal course. He felt it necessary to understand the whole universe. We probably must consider the big picture also. This is a whole new operating system and cannot just be a plug in to Windows XP. But we have the work of Spinoza and others to support us and shall likely be able to spend most of our efforts closer to home.



Hocking's work is where I intend to resume my efforts. It is quite a comfort to have a guide. Perhaps we can all benefit from following the paths identified by others. They might even consider information other than consensually based. Why not? Doing so opens more paths.

So we are back to the Primer, at least for now.