**What Some Combat Veterans Said About Themselves for Seeking Psychological Treatment**

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The fifteen powerful statements below are the written responses of veterans in a VA inpatient PTSD program who were asked: “If and when you get down on yourself for needing to come for help what names do you call yourself?”

I’m no good… I’m a piece of shit…I hate myself

Shit bag… piece of shit…garbage…waste of space

stupid…sick…loser .psycho

Quitter…Loser…Asshole

Telling myself I’m a piece of shit

I’m way better than this

I’m a dumb ass…Can’t concentrate

Nothing

Whats wrong with me? Fucked up

Worthless and weak Pussy

Bitch Assness > Addict > Abuser> Avid User

Retarded, Stupid, Dumbass, Idiot

Weak – Only as strong as the weakest link – I’m that weakest link. I pray

that it works this time.

This question was asked to two different groups of veterans participating in a psycho-educational group covering topics such as the prevention of destructive anger and stigma related to seeking mental health treatment. Reading the responses back to the vets appeared to be helpful in relieving some distress, likely in part due to Yalom’s (1975) curative therapy factor, “Universality”. It also appeared that it was a helpful way to introduce psychotherapeutic ideas outlined in papers available at [www.HowardLipke.com](http://www.HowardLipke.com), which provide some novel approaches to understanding and limiting the destructive effects of self-evaluation, or self-stigma if you will. In addition, the exercise appeared to increase beneficial cohesiveness among the members of this psychotherapeutic community. These results led me to offer them this variation of the Golden Rule: “Do not do unto yourself as you would not have done unto other veterans”.

Beyond the value this exercise had for the veterans in those psychoeducational groups, the results are potentially valuable for mental health professionals in at least three ways:

1. Some mental health professionals might gain a better understanding of the virulence of the veterans’ self-reproach. It is no mystery to many counselors who have worked with veterans that their hidden thoughts and feelings about themselves can be profoundly damaging to their ability to participate in life in fulfilling ways. However, the level of underlying pain is still not understood by some. Part of the reason for this failure is that veterans’ pain is often masked by apparent numbness to emotion and powerfully expressed defensive anger. This may then lead to protective numbness or anger in the counselors over their fear. At least partly related to their perceived inability to help. Quite a cycle.

The contention that the above list of responses from veterans may be new information to some therapists is supported by

a) the underestimation of client pain I have heard from some mental health professionals over my many years of contact with therapists working with veterans.

b) the frequency in which veterans apologize for using “offensive” language in therapy, which suggests that some hold back.

c) the response of some therapists when I gave a presentation on psychotherapy with combat veterans and shared the language they use to describe themselves. After the talk some evaluations of me were quite negative, one referred to me as “Non-professional – out of control – offensive” and another as having “Utilized language which I found unprofessional and offensive”. (To be fair, others praised the presentation as “refreshing” and “informative”.) It is possible that when therapists have that attitude toward veterans’ actual language many veterans sense it,and limit their openness.

2. We can project that if this is how many veterans evaluate themselves for asking for help, then their self-evaluation for things they did or didn’t do in combat theaters may be much worse. In this self-evaluation their genuine helplessness to have produced good outcomes in combat escapes them[[1]](#footnote-1). As Dollard (who studied fear in combatants in WWII) and Miller (1950) wrote:

*Children cannot understand the world and cannot control their emotional reactions. Therefore, young children can be subject to more extreme conditions than adults endure, except in times of war. In combat and in infancy the extremes of hunger, fear helplessness, confusion, and timeless strain are reproduced. Only in childhood and in combat are the individual’s own capabilities to control his life so meager and ineffectual. (p 130)[[2]](#footnote-2)*

3. To practitioners of EMDR informed psychotherapy knowing the above veterans’ responses might be particularly helpful. In EMDR the client is asked to identify a visual image of the worst moment of the target traumatic incident, as well as the attached negative self-beliefs, emotions and body sensations just prior to beginning sets of the signature repetitive eye movements. As the work unfolds, at times the processing is blocked, (e.g. the level of distress and other aspects of the memory are unchanging). There could be for a number of reasons, one of which appears to be that a client would be resisting opening themself up to the true extent of the negative self-evaluations which are part of associative network of the memory. The above list of self-evaluations related to the need for mental health treatment gives a clue to the possible virulence of beliefs that might be associated with the traumatic incident itself. So, if processing is blocked and the client had offered a weak negative cognition (i.e. “I am not good.”), then the avoidance of a worse, but hidden, self-evaluation may be the cause of the failure to process. If the therapist wishes to pursue a cognitive path to promote processing, then an as gentle as possible discussion of the issue can be helpful in continuing processing. Questions such as: “Do you sense that you are blocking out other troublesome self-evaluations, and if you are, what bad thing do you worry might happen if you let this in?” or, “Not now, but In your worst moments, when you think of this, what do you say about yourself?” or “Even if you know it isn’t really true, what are the worst things that you sometimes think about yourself.?” The client can be reminded that they do not have to vocalize the thought, only not block it from awareness.[[3]](#footnote-3)

I would not recommend that the therapist challenge a weak negative cognition just before processing is to begin. If, however, the therapist has obtained a weak of negative cognition during the history taking, where I have suggested some of the “Assessment Phase” questions first be asked, a therapeutic discussion might take place then. I have discussed this idea in a paper at my website [Structured Questionnaire for Trauma History: The GLEQ](https://howardlipke.com/structured-questionnaire-trauma-history-gleq/)

In brief summary, veterans can be harder on themselves than some others know, including fellow veterans. You could call this a destructive self-stigma. The sharing of this knowledge among veterans and with clinicians may have beneficial effects. The method of anonymous surveys in psychoeducational context can have psychotherapeutic benefits and also provide clinicians with knowledge not otherwise as efficiently gathered.

References

Dollard, J. & Miller, N.E. (1950) *Personality and Psychotherapy*. New York: McGraw-Hill.

Yalom , Irvin (1975). *The Theory and Practice of Group Psychotherapy, Second Edition.* New York: Basic Books. But, any edition will do.

Addendum

Based on feedback from a learned friend (Dr. William Zangwill) on an earlier draft of the above paper I decided to add the results of questions asked on a different issue in psychoeducational groups between 1992 and 2001. The questions were designed to provide a platform to consider self- disclosure in a non-threatening context.

The intent was not to convince respondents to “spill their guts” if they didn’t want to, but rather to help them more fully consider the pros and cons of sharing more information with therapists. Clients were asked the following questions orally, but to be answered anonymously on note cards. The questions were:

“Do you have any secrets that bother you a lot that you have told no one and do not expect to tell anyone?

1. from before the military

2. from during the military

3. from after the military

There were 98 participants in 5 groups in the same inpatient PTSD program described in the main section of this paper. Eighty-one answered “Yes” to secrets from at least one time period, 17 responded “No” to all time periods. Surprisingly (to me) the responses to time periods were fairly even ranging from 41% reported having secrets from before the military, 48% from during and, 50% from after.

These results add to the probability that combat veterans often do hold back in revealing the extent of their self-criticism.

1. When I have alluded to General Sherman’s famous statement, “War is hell” and interpreted it as meaning that you are damned if you do, damned if you don’t and there is no escaping the choice, no vets have ever disagreed. I also share that this “double bind” used to be considered the formula for producing schizophrenia, and while that is no longer accepted as the cause of schizophrenia, it might be good for creating PTSD. [↑](#footnote-ref-1)
2. I can’t help but mention that Dollard and Miller may be underestimating other situations that can produce this effect, but the point is made. [↑](#footnote-ref-2)
3. It should be noted that the standard EMDR protocol limits asking about cognitions to those present at the moment the question is asked. In this situation that limitation might be overridden by the need to more accurately access the cognitions in the underlying associative network. [↑](#footnote-ref-3)