among American soldiers. While harsh punishments can still occur, soldiers are now offered treatment for substance abuse as well.

The psychology of combat

Most soldiers never experience combat; but for those who do, a lifetime of learning about the rules of society and morality must be suppressed in the interests of survival. Military psychologists must help soldiers act effectively in combat—and suffer a minimum of emotional fallout afterward.

One facet of the psychology of combat is integrating humans with increasingly sophisticated weapons systems. Military psychologists are researching what display formats can help soldiers make split-second sense out of complex computer-screen images that carry life-or-death importance. Others focus on the effects of harsh environmental effects such as weather on soldiers’ performance. Virtual reality has become an important focus for more effective combat training.

Military psychologists also study the emotional aspects of combat. Early military psychologists suspected that combat stress reaction (CRS)—a progressive psychological breakdown in response to combat—was a matter of psychological “weakness.” Today, most agree that any human being will break down if exposed for long enough to enough death, fear, and violence.

Modern treatment for CSR stresses short-term desensitizing therapy and a quick return to combat. While this may seem harsh and self-serving on the part of the military, wartime studies indicate that soldiers with CSR who are treated in this fashion are less likely to suffer from post-traumatic stress disorder than those pulled to rear-echelon units for treatment.

Some soldiers who have experienced battle—as well as some victims of disasters or violent crime—suffer from a lingering version of CSR called post-traumatic stress disorder (PTSD). A person with PTSD may chronically re-experience traumatic events, in nightmares or even in waking hallucinations. Other PTSD sufferers “close up,” refusing to confront their emotional trauma but expressing it in substance abuse, depression, or chronic unemployment. PTSD has proved possible but difficult to treat successfully—hence the military’s focus on preventing PTSD through proper CSR treatment.

One somewhat controversial school of thought holds that the inhibition against killing is so strong that the emotional cost of killing—rather than fear of death or loss of comrades—is the most defining aspect of CSR and PTSD. Adherents believe that increasingly realistic weapons training conditions soldiers to kill reflexively—a desired outcome for the military, but one that can contribute to emotional problems among combat veterans in the absence of psychological support that recognizes this problem.

The ethics of military psychology

As both therapists with a duty to their patients and subordinates with a duty to the military command structure, military psychologists must sometimes carry out a tricky ethical balancing act. Patient confidentiality is a particular problem, since commanders have the right to examine their subordinates’ medical files when making decisions in assignments, promotion, and punishment.

Military psychologists have been sanctioned by the American Psychological Association for following legal military orders that violated APA ethical rules; they have also been disciplined by the military for following APA rules that violate military regulations. Both the military and the APA are working to establish clear guidelines to help military psychologists avoid the trap of the “company doctor.”

See also Television and aggression

Kenneth B. Chiacchia

Further Reading


Minimal brain dysfunction was formally defined in 1966 by Samuel Clements as a combination of average or above average intelligence with certain mild to severe learning or behavioral disabilities characterizing deviant functioning of the central nervous system. It can involve impairments in visual or auditory perception, conceptualization, language, and memory, and difficulty controlling attention, impulses, and motor function. Minimal brain dysfunction is thought to be associated with minor damage to the brain stem, the part of the brain that controls arousal. A likely cause of this type of damage is oxygen deprivation during childbirth. While such damage does not affect intelligence, it does have an effect on motor activity and attention span. Minimal brain disorder usually does not become apparent until a child reaches school age.

Minimal brain dysfunction has also been linked to heredity; poor nutrition; exposure to toxic substances; and illness in utero. Other symptoms that may be associated with the disorder include poor or inaccurate body image, immaturity, difficulties with coordination, both hypoactivity and hyperactivity, difficulty with writing or calculating, speech and communication problems, and cognitive difficulties. Secondary problems can include social, affective, and personality disturbances.

### Minnesota Multiphasic Personality Inventory

Gathers information on personality, attitudes, and mental health.

The Minnesota Multiphasic Personality Inventory is a test used to gather information on personality, attitudes, and mental health of persons aged 16 or older and to aid in clinical diagnosis. It consists of 556 true-false questions, with different formats available for individual and group use. The MMPI is untimed and can take anywhere from 45 minutes to 2 hours to complete. This is normally done in a single session, but can be extended to a second session if necessary. Specific conditions or syndromes that the test can help identify include hypochondriasis, depression, hysteria, paranoia, and schizophrenia. Raw scores based on deviations from standard responses are entered on personality profile forms to obtain the individual results. There is also a validity scale to thwart attempts to “fake” the test. Because the MMPI is a complex test whose results can sometimes be ambiguous (and/or skewed by various factors), professionals tend to be cautious in interpreting it, often preferring broad descriptions to specific psychiatric diagnoses, unless these are supported by further testing and observable behavior. A sixth-grade reading level is required in order to take the test. However, a tape-recorded version is available for those with limited literacy, visual impairments, or other problems.

### Further Reading


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**Salvador Minuchin**

1921-

Argentinian physician, one of the founders of family therapy and of structural family therapy.

The eldest of three children born to the children of Russian-Jewish immigrants, Salvador Minuchin was born and raised in a closely knit small Jewish community in rural Argentina. His father had been a prosperous businessman until the Great Depression forced his family into poverty. In high school he decided he would help juvenile delinquents after hearing his psychology teacher discuss the philosopher Rousseau’s ideas that delinquents are victims of society.

At age 18 he entered the university as a medical student. In 1944, as a student, he became active in the leftist political movement opposing the dictator Juan Peron who had taken control of Argentina’s universities. He was jailed for three months. Upon graduation in 1946 he began a residency in pediatrics and took a subspecialty in psychiatry. In 1948, as Minuchin was opening a pediatric practice, the state of Israel was created and immediately plunged into war. He moved to Israel and joined its army where he treated young Jewish soldiers who had survived the holocaust.

In 1950 he came to the United States to study psychiatry. He worked with psychotic children at Bellevue...