

31 Lessons Unlearned From Vietnam to Iraq About War and Its Impact.

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1. Various studies of veterans from Vietnam onward reveal that 15% to over 30% of war veterans suffer PTSD and/or other major psychiatric problems sometime during and/or following their return from deployment. This appears to be the human cost of war on Americans---regardless of the war.

2. Numerous studies clearly document that it is the amount of exposure to combat stressors that is by far the greatest predictor that someone will eventually develop post-traumatic stress; thus, military personnel whose tours of duty in the war-zone are extended, or who are sent back for two or more additional tours in the war-zone, are at the greatest risk to eventually develop post-traumatic stress.

But our military personnel and their families are *rarely if ever* told this truth. And the third Army mental health survey of Iraq veterans (Dec, 2006) reported that soldiers serving a repeat deployment reported higher acute stress than those on their first deployment.

3. There are numerous myths and realities that are misunderstood about war and its impact; such myths have been around for decades and compound the readjustment challenges facing armed forces personnel and their families. These include:

- “Heroes and normal healthy persons do not have problems during or following a war”
- “Time heals all wounds”
- “I must be crazy or weak to still remember and be bothered by the war after all this time;”
- “If I can just forget the war, I can move ahead with my life;”
- “If I didn’t break down during combat, then I must be the problem if I am having difficulties months and years later.” (Reality: soldiers rarely break down in the midst of battle---if they do break down, it happens later--- days, weeks, months . . . and so just because you seemed to get through the worst of it okay, doesn’t mean you will necessarily do okay later . . .)

4. The military medical mission, to “conserve the fighting strength”, and the practice to medically evacuate personnel out of the war-zone “only as a last resort” and to return them to duty ASAP, clearly may not be in the best longer-term mental health interest of the individual psychiatric casualty.

Everything in the war-zone drives the decision to return a psychiatric casualty to combat. This is understandable from the military medical mission. However, what is not clearly communicated is that this does not necessarily mean that this will be in the *best interests of the individual psychiatric casualty*. Indeed, the practice to return almost all psychiatric casualties to their duty stations ASAP obviously results in their facing yet additional and recurring trauma and thus becoming even higher risks of developing PTSD.

5. What is reinforced by military training and by military mental health practices in a war-zone are such strategies as denial, suppression, avoidance, minimizing of significant problematic emotions or issues. Unfortunately, these very same strategies too often are the source of significant problems when trying to readjust to civilian life if the veteran cannot let them go to a considerable degree---and too many cannot.

6. The acute psychiatric rate (that occurs while in the war-zone and within the first several months following return from deployment) always is less than the longer-term rate. This lesson should give national policy makers great cause for concern that the Department of Veterans Affairs (the VA) requires significant funding and staffing to handle not only the needs of our veterans today, but the even greater needs that are almost sure to come tomorrow.

There are numerous factors that contribute to under-reporting such problems:

- Lack of trust to confide such problems to military mental health personnel
- Fear of stigma or other negative reactions from unit command and peers
- Fear of damage to one's military career
- The natural tendency for trauma survivors to deny to oneself one's problems in an attempt to put them aside and move on with one's life. And this can work for awhile
- The military community is a tight-knit milieu that offers support, resources and camaraderie for both military personnel and their families that simply are just not available after being discharged from active duty
- The military community reinforces the "suck-it-up, soldier-on, deal-with-it" mentality to suppress any mental health issues and/or not admit them to anyone.
- Family members and friends also want and typically tell the veteran to "just forget about the war and move ahead with your life. You shouldn't be bothered by this after all these months (years)"

7. Medical evacuees from a war-zone face a whole host of stressful and traumatic experiences from the moment they are wounded or hurt in the war-zone until long after they are returned stateside. Most of these experiences are not talked about or adequately addressed---a conspiracy of silence about additional traumas and stressors that many of the wounded experience, i.e., what happened:

- right after being wounded and while still in harm's way at the immediate scene
- during medical evacuation transport from one site to another
- while hospitalized alongside many others who were in worse condition, or who died
- while receiving treatment from some medical personnel who may have been insensitive to emotional issues
- where not being told honestly or completely about one's medical condition—or lied to
- with family members' reactions who could not handle emotionally what has happened to their loved ones
- when confronted with negative or non-sensitive remarks from others back home, i.e., "it's a shame that you had to lose your legs for nothing."

8. The military spends *only a fraction* of the time and effort to help military personnel return from war and "unlearn" being a war-zone combatant---in great contrast to the amount of time and effort that goes into turning military personnel into war-zone combatants. This is critical, in that all of the common strategies used to prepare one to kill and survive while deployed in a war have corresponding and potentially very negative impacts after returning from deployment. And returning military personnel are left to "unlearn" all of these strategies on their own, i.e.

- conditioning military personnel to dehumanize the enemy---to see and treat the enemy not as human beings like we are but rather to denigrate them, treat them as less than human; and racist attitudes and behaviors are central to such dehumanization. And this can be brought home into one's relationships with others.
- teaching and reinforcing the numbing of one's emotions and becoming expert at emotional numbing, denial of the reality of what is going on, avoiding underlying painful emotions, etc. And this can be brought home to where the veteran has extreme difficulty being emotionally accessible even to family members or is not able to be in touch with one's own emotions.
- facilitating and encouraging the *discharging of one's anger through violence onto the enemy*. And this can be brought home as what happens when one becomes angry or enraged---taking it out physically on others; for other returned veterans, there is *extreme preoccupation* that one will lose control and become violent, again, like during the war.

9. Pro-war and pro-military advocates and politicians oftentimes are not pro-veteran adherents: this is because there *always* are *extremely strong competing priority funding tensions* between funding the existing war *versus* funding programs and benefits for veterans---those who favor funding for expensive technology, weapons, etc., *oftentimes are resistant* to more funding for veterans' benefits, health and social programs.

10. The Secretary of the VA essentially serves at the behest of the President and his/her policies. Thus, the Secretary typically is *more responsive to current Administration policies* (i.e., cutting the federal budget except for DoD funding) than to *veterans' health, mental health and benefits needs*.

11. The extent of the killing and maiming that occurs to the *civilian* populace in the country in which the U.S. is fighting *almost never* has any meaningful impact on the war policy or on funding decisions.

This devaluation of the loss of life among the civilian population in the country in which we are fighting is utilized to mask the intolerable realities of the full human costs of war. For example, estimates of the number of Vietnamese killed during the Vietnam War range from 2.4 to over 3 million—and some 300,000 still unaccounted for. Was it worth it?

12. There is a *remarkable angst* created by having a *veterans' benefits system* that in effect *financially rewards veterans for having psychiatric disorders*, and that *punish them financially if they improve significantly*.

- Indeed, the system in place literally requires that veterans be given a psychiatric diagnosis to be eligible to receive financial and priority medical services.
- This is an extremely powerful dynamic that inevitably *inflates* the numbers of veterans who are given and who maintain a PTSD diagnosis.
- Tragically, the pressures *to get, and keep*, a PTSD diagnosis in order to qualify for, and keep, a service-connected disability, are enormous and can lead to labeling many veterans with a PTSD or other psychiatric diagnoses who may well have a *normal and expectable* response to the trauma of war.

13. There are serious problems with the validity and usages of a PTSD diagnosis in terms of being able to differentiate between a “normal” or “expectable” response to trauma versus a “disordered” response, and this is particularly so for the trauma of war.

- This is one reason that military health refers to “combat stress reaction” and not to “PTSD” for the vast majority of psychiatric casualties in a war-zone.
- What is “normal” and “expected” for veterans to present days, months, years and decades later after being in a war, versus when is the reaction “disordered?”
- Indeed, some of the *core psychiatric symptoms of PTSD* as defined by the American Psychiatric Association also are very common and extremely important and functional *methods of survival in a war-zone*, e.g.,
 - Detaching from or numbing one's emotions
 - Denying or minimizing the horror of what one is seeing and experiencing
 - Hyper-vigilance
 - Exaggerated startle response
 - Experiencing the environment as unreal

14. Core PTSD treatment interventions *almost never* significantly address a core issue of vets—their relationship with their country, their government, and their communities. And when the nation is experienced or perceived by our veterans *as having forgotten them* and their sacrifices and the sacrifices of their families, this is experienced as a profound betrayal. And almost nothing is more hurtful to veterans than to be forgotten, or put at the bottom of the priority list

This is essential to address as part of the post-war healing process; there is a *sacred covenant* that society and our military pledge to each other: military personnel are willing to go into harm's way and maim and kill human beings, and put themselves and their buddies at great risk, on behalf of our country. In return, the country agrees to honor and remember our military's sacrifices and to provide varying health, educational and other benefits. And then if and when these are perceived or experienced by veterans as broken promises, the sacred covenant may be broken and veterans can feel totally betrayed. The result is devastating and alienating to many veterans . . .

15. For a substantial number of war veterans, the negative impact of war trauma *exists for decades*, i.e.:

- trauma is literally unforgettable, and so it is useless and counterproductive to encourage or attempt to focus on “helping the veteran to forget” the trauma
- many of the symptoms of PTSD are actually also functional ways to survive in a war-zone, and *many vets do not want to let them go*, as these behaviors may be perceived by many vets as conducive to post-war survival back home, i.e., detaching from one’s emotions, denying or minimizing the horror of war and what one is seeing and experiencing; hyper-vigilance and exaggerated startle response.
- the profound memories, both the positives and the negatives that are the legacy of war, are ingrained into the veterans’ psyche. I have written about this as being a “combat cocktail” in which both remarkable “highs” and devastating lows are inextricably enmeshed together. Thus, many vets are resistant to let go of the negative memories and impact because they *cannot separate such out* from the remarkable positives of the war and military experience—the adrenaline rush, the thrills, the sense of power, comradeship bonded in war.

16. Aging veterans (as well as survivors of other trauma) have been found in long-term studies of WW II, Korean and Vietnam veterans to include a substantial minority for whom their PTSD symptoms *not only persist over decades but such symptoms may be exacerbated and worsen.*

This seems to be associated with such factors as:

- Loss of employment and/or retirement
- Increasing health problems
- Increasing frequency of deaths among family and friends
- Issues that may arise or reappear related to the war, such as spiritual/religious, that are triggered by the impending ending-of-life on this planet

17. There are over 20 important “do’s” and “don’ts” about how to interact with someone who has returned from deployment to a war-zone. Unfortunately, family members oftentimes learn these only through needless trial and error---or are never learned. And yet these have been experienced following all wars.

Family members have the right to be educated about such do’s and don’ts, and our government the responsibility to see that they are, before veterans return from deployment, i.e.:

- *Never* tell a veteran that “you understand” what he/she went through during war—or afterwards
- Do *not* say, “Did you kill anybody?”
- Do *not* take it personally when your veteran does not want to talk about the war with you, or about what he/she is going through now.
- Be familiar with and aware of warning signs in your vet
- Do not ignore *your own* wants and needs
- Do put your own oxygen mask on first. You cannot be of adequate support and help for your veteran if you don’t
- Do not be a Lone Ranger---seek out support groups, Vet Centers or other sources of assistance

Brief listing of some of the additional lessons unlearned:

18. “The government sends us to war, the military uses us in war, and society forgets us after war” (Ray Scurfield)

19. Front-line combat forces *always* have been the cannon fodder during war.

(from Ulysses the movie: “War is young men dying and old men talking. It’s always been that way.”)

20. Military veterans inevitably accept total or an exaggerated degree of responsibility for every trauma that occurred in the war-zone—versus when a nation goes to war, *every* citizen of voting age bears a share of the responsibility for all that happens during the war.

21. For every enemy you kill in a guerilla war, you create (at least) two new ones (Galloway).

22. Western countries continue to justify “conventional” warfare are being much more defensible than an enemy’s guerilla warfare or terrorist acts.

Of course, anyone who is a vilified terrorist in the eyes of one side is almost always seen as a heroic resistance fighter by the other side, a “heroic resistance” against overwhelming technological superiority of massive and sophisticated amounts of weaponry. Facing such an overwhelming force, of course the other side will resort to guerilla and terrorist acts

23. Governmental and military authorities inevitably issue highly optimistic reports that the mental health services for this war are unparalleled in our history and are doing a good job to minimize mental health casualties. Even when true, there is no mention that the acute psychiatric casualty rate has absolutely no relationship whatsoever to longer-term psychiatric rates.

24. The initial euphoria and adulation paid to our Armed Forces inevitably dissipate and many active duty personnel will move on to become very proud and/or perhaps very invisible, lonely and isolated Veterans of One.

25. Once again there is a paucity of coordination and collaboration between the DoD and the VA, with a prevailing DoD attitude that those who do not perform well can be discharged “for the VA to take care of.”

26. Our country, especially to include the VA, provides extremely minimal services for the partners and children of veterans.

27. Occupying troops in any foreign land initially may be welcomed as liberators, but the longer they remain, they inevitably will become despised as foreign occupiers.

This is not a new phenomenon in Iraq. It has *always* been this way---throughout history.

28. Key issues facing Armed Forces personnel that have little if any attention paid to them include racism (towards the enemy, civilian population, and between Americans), sexism and gender-based trauma, and homophobia.

29. Returning years later to the land in which a veteran fought may provide extraordinary post-war healing opportunities not otherwise available.

30. A current war *always* has a significant impact on many veterans of previous wars. This impact ranges from extremely disturbing, as old psychological war wounds are torn asunder and exacerbated, to renewed pride and determination that our current Armed Forces will be treated fairly and with full respect and support.

31. For every negative legacy that a veteran brings home after the war, there is a countervailing and potential positive aspect---and vice-versa, i.e., “nothing means nothing anymore” versus “a clearer sense of priorities—what is really important now?” “disturbing loss of trust and loss of faith in our nation’s institutions”, versus “development of a very healthy questioning of the motivations and behaviors of those institutions;” “I must be crazy to still remember and be bothered by . . . “ vs. “it is a sign of health not to forget and remember what should be remembered about it—and if you don’t remember, who will?

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