Beyond Trauma

FEATURING:

Dr. Ray Scurfield
Vietnam Veteran, Katrina Survivor
War and Natural Disaster Trauma Expert
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Combat Stress is a quarterly magazine, published in February, May, August and November. Each issue contains news and advertising designed with Service Members, veterans and their families in mind. It appeals to all those interested in the myriad and complex interrelationships between combat stress and health because technical jargon is avoided and it is easy to understand. Combat Stress is archived online at stress.org. Information in this publication is carefully compiled to ensure accuracy.

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Dr. Ray Scurfield is professor emeritus of social work at The University of Southern Mississippi, Gulf Coast. He is in private practice with Advanced Psychotherapy in Gulfport, MS. He has been internationally recognized for his expertise in war-related and natural disaster psychological trauma. He has published a multitude of books and articles exploring the effects of post traumatic stress disorder (PTSD) in both combat veterans and disaster survivors, including a trilogy of books about war’s impact. The trilogy’s third installment, War Trauma: Lessons Unlearned from Vietnam to Iraq, was published in October 2006. His two newest books are Scurfield, R.M. & Platoni, K.T. (Eds.). War Trauma & Its Wake. Expanding the Circle of Healing. New York & London: Routledge (2012); and Scurfield, R.M. & Platoni, K.T. (Eds). Healing War Trauma. A Handbook of Creative Approaches. New York & London (2013).

Scurfield has also written substantially about the impact of Hurricane Katrina, and the most innovative of all interventions to address post-Katrina mental health recovery. Scurfield has been recognized as a "Hero of Katrina" by the University of Southern Mississippi (2006), the 2006 Mississippi Social Worker of the Year by the Mississippi Chapter of the National Association of Social Workers, the 2006 and 2007 College of Health Distinguished Teaching Awards and 10 additional awards and recognitions during his tenure at Southern Miss. He most recently received the 2012 Mississippi Lifetime Achievement Award from the Mississippi chapter, National Association of Social Work, and the NASW National Lifetime Achievement Award. NASW PRESS RELEASE: Raymond Monsour Scurfield, DSW, ACSW - Lifetime Achievement Award: Dr. Scurfield is Professor Emeritus of Social Work at the University of Southern Mississippi. In his 45-year career, Scurfield has made extraordinary contributions to the profession and society. Dr. Scurfield has a distinguished reputation in posttraumatic stress disorder (PTSD) as a clinician, innovative therapy and program developer, educator, and researcher publishing on topics such as Vietnam War and other war-related trauma, post-disaster interventions, race-related trauma, and exposure and experientially-based therapy.

In his USM teaching career (1998 – 2011), he was awarded 15 teaching, scholarship and service awards. He was the Mississippi State NASW 2012 Social Work Lifetime Achievement Award winner “for his outstanding contributions to social work education, research and veterans services”, and the 2006 Social Worker of the Year for his post-Katrina efforts in helping faculty, staff and students. His MSW (1967) and Doctor of Social Work (1979) are from the University of Southern California.
Dr. Scurfield was an Army ROTC Distinguished Military Graduate, Dickinson College, and served four years active duty as a social work officer, to include a year in Vietnam on one of the Army’s two psychiatric teams. Then, during Dr. Scurfield’s 25-year career with the U.S. Department of Veterans Affairs, he was a leader of regional and national PTSD programs in Los Angeles, Washington, D.C., and Tacoma, WA, as well as the initial Director of the VA’s National Center for PTSD in Honolulu. He co-led two return trips to peace-time Vietnam with combat veterans. He received numerous awards and recognitions, to include the VA’s prestigious national Olin E. Teague National VA Award recipient “... in recognition of your extraordinary contributions benefiting war-injured veterans. Your achievements in the study and treatment of PTSD have become landmarks in psychiatry.” [President Ronald Reagan. Nov. 21, 1988]. Also, he received the National Lifetime Achievement Award from the National office, National Association of Social Workers (NASW): “Dr. Scurfield is Professor Emeritus of Social Work at the University of Southern Mississippi. In his 45-year career, Scurfield has made extraordinary contributions to the profession and society. Dr. Scurfield has a distinguished reputation in posttraumatic stress disorder (PTSD) as a clinician, innovative therapy and program developer, educator, and researcher publishing on topics such as Vietnam War and other war-related trauma, post-disaster interventions, race-related trauma, and exposure and experientially-based therapy.” NASW, National Office. December 22, 2012.

Dr. Scurfield’s 70 publications include articles, book chapters and his Vietnam Trilogy of single-author books about war trauma, the most recent War Trauma. He has made over 350 media appearances, conference and training presentations to include 60 Minutes (in which the program he founded and directed, the Post Traumatic Stress Treatment Program, Tacoma, WA, was featured as a model VA program), Nightline, New York Times, Washington Post, Boston Globe, Christian Science Monitor, National Public Radio and numerous NPR-affiliated stations nationwide. He is the lead author of a three-part video series on PTSD group therapy with veterans of three eras of war (WW II, Vietnam and Persian Gulf War), A Journey of Healing, produced by the VA National Center for PTSD in Honolulu (1997) and distributed nationally. Also, the return trip to Vietnam in 1988 that he co-led, the first such trip with a PTSD therapy group of Vietnam veterans, was filmed and produced as a PBS documentary video and released nationally in 1999, Two Decades and A Wake-Up. He is recognized nationally and internationally through his writings and presentations as an expert in the field of war-related post-traumatic stress and natural disaster mental health and he has been a consultant for several organizations, to include ArtReach, Project America and Not Alone.
GET INSIDE OUR HEAD

It’s Not Our Credentials That Make AIS So Impressive, It’s the Fellows That Go with Them.

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It has been more five years since Nidal Hasan opened fire on American Soldiers at Fort Hood Texas, the deadliest mass murder on any military installation on American soil in US history. For those of us who were there and lived to tell the story, it happened 5 seconds ago. This will always be the case. There is every reason to believe that the remainder of the American populace has long forgotten. Our collective memory is a short one. For the survivors and the families of the deceased, there is no file folder or file drawer or file cabinet in which to stow this away that will ever diminish the horror show that this will remain for all our days to come, destined to repeat itself incessantly, whether daylight or darkest hours. November 5, 2009 will live into infamy for all of us who continue to face the ultimate betrayal by the very government these Soldiers swore to protect and defend.

At 1:34 PM at Building 42003 on that fateful day, a US Army major and psychiatrist opened fire in the Soldier Readiness Processing Center, gunning down 43 defenseless Soldiers readying for or returning from wartime deployments, and one civilian physician’s assistant, a retired Army warrant officer. Fourteen innocents lost their lives, including one unborn child, many of these heroes charging the shooter to spare the lives of their fellow Soldiers and civilians, sustaining mortal wounds in the process of their courageous deeds.

After pausing to bow his head, the shooter, armed with an FN 5-7 pistol and a Smith and Wesson .357 magnum revolver, stood up, suddenly shouting, “Allahu Akbar!” (God is great), seconds before spraying a hail of bullets throughout the room and before taking direct aim at Soldiers in uniform, one a pregnant
Soldier who pleaded for the life of her unborn child. In the ten minutes following and without regard for their own safety, dozens of Soldiers rushed to save the lives of the fallen and to remove them from harm’s way.

According to eye witness statements, the shooter continuously reloaded his weapons as Soldiers dropped to the floor, desperately trying to escape, as he fired on them repeatedly; his goal to kill as many Soldiers as possible in support of his Islamic militant brothers. The systematic manner in which he attacked, maimed, and killed his fellow Soldiers embodies what is considered true evil by the multitude of victims of these cold-blooded, vile acts of violence and hatred.

As the rampage continued outside the building, although accounts differ slightly, medical personnel dashed into the building 42003, secured the doors with a belt, and began rendering emergency medical treatment to the wounded and dying. Because the floors were so slippery with the blood of so many fallen Soldiers, it became impossible to reach many of them in time. As the shooter continued to fire at fleeing Soldiers outside the building, he was confronted by civilian police officer, SGT. Kimberly Munley, exchanging gunfire with her and striking her in the thigh and femur. As she fell to the ground, her weapon reportedly jammed and the shooter kicked it from her grasp. Officer Mark Todd stepped in to end the rampage, paralyzing the shooter with his firearm. A combined total of 214 rounds were fired by the shooter and civilian police officers, who rushed to the scene, including 146 shell casings found inside the building and 68 in the area surrounding the SRP (Soldier Readiness Processing Center) Complex. When the massacre ended, medics retrieved 177 rounds of ammunition from the magazine-filled pockets of the shooter in both 20 and 30-round magazines. I know all this because I was there. My beloved friend, CPT John Gaffaney, died at my knees. I was to have been the shooter’s direct supervisor, later being informed that I was at the top of his hit list. To this day, survivor guilt consumes me.

Per the Lieberman-Collins report published in 2011 and entitled “A Ticking Time Bomb”, the FBI and the Department of Defense had in their possession, collected over a period of 5 to 6 years, sufficient information to have detected Hasan's radicalization to violent Islamist extremism. Both failed to understand this or to act upon it. Hasan was merely “flagged for additional scrutiny”.

Hasan, a commissioned officer in the United States Army, swore, in his Oath of Office, to uphold and defend the Constitution against all enemies, foreign and domestic. During his years of military medical training, he routinely, visibly, behaviorally and unmistakably violated strict military standards and regulations through regular communications with suspected terrorist Anwar al Awlaki. As part and parcel of his anti-American activities, he e-mailed this known terrorist 18 to 20 times and even asked al Awlaki for recommendations for the selection of a wife.

Clear and unmistakable evidence of Hasan’s radicalization to violent Islamist extremism was on “full display with superiors and colleagues” alike during his military medical training. His conduct, ig-
nored by superiors every step of the way, was considered shocking. An instructor and colleague both referred to Hasan as a "ticking time bomb." It is an undisputed fact that not only was no action taken to discipline, court martial or discharge him from the military, but additionally, his Officer Evaluation Reports "sanitized his obsession with violent Islamist extremism into praiseworthy research on counterterrorism". At the very least, this is negligence of the highest order. At its worst, everyone responsible for doing nothing, looking the other way, and feigning ignorance in the land of make believe is an accomplice to mass murder and the proliferation of pure evil. Hasan’s design to kill as many Soldiers as possible was premeditated by his own admission on the stand during his court martial. Far worse is the fact that due to political correctness, to which the military continues to bow, allowed complaints about his extremist behavior to remain ignored for widespread fears of career-ending EEO complaints. Even during medical school, Hasan openly demanded that he held Shari law above the Constitution. When this was reported by fellow students, they were ordered to remain silent by superior officers. Hasan’s religion offered him full immunity from punishment by the Army. “He got a pass because he was a Muslim”. (Mark Thompson, TIME Magazine November 10, 2009).

Hasan’s protected status as a Muslim enabled him to continuously demonstrate bizarre and menacing behavior and in the long term, to execute as many infidels as possible in the name of Allah. The scholarly psychiatric presentation he was required to present during his residency training at Walter Reed Army Medical Center was instead, a completely off-topic lecture about Islam and the Qur’an. In his original Power Point presentation, he stated that nonbelievers should be beheaded and set on fire and that the presence of Muslim-Americans in the military posed the risk of fratricide (2007). Though his supervisors recommended changes, he was allowed to go forward to present his extremist views and to assert very clearly that, “We love death more than you love life”. (From the American Thinker, 2012.)

Despite a wealth of indicators of Hasan’s evolvement into a homegrown terrorist, he was selected for an elite two year fel-
lowship at the prestigious Uniformed Services University of the Health Sciences. During his fellowship, he offered another off-topic presentation, demanding that since the US was at war with Islam, suicide bombings and other forms of violence against US infidels were justified. His classmates protested so vigorously, the presentation was stopped by the instructor. Hasan also informed his classmates that his allegiance to Allah far outweighed his military Oath of Office. Hasan considered suicide bombers as the moral equivalent of Soldiers who throw themselves on grenades to save the lives of their fellow Soldiers. These statements alone may be considered treasonous. Still, political correctness reigned supreme. Let us neither forget that Hasan donated $20,000-$30,000 annually to radical Islamic charities overseas.

And today, Nidal Hassan is free to communicate openly with ISIS, the Pope, and presumably anybody he desires from his death row cell, as he petitions the beheaders in black to become one of them....a Soldier of Allah. He continues to have more rights than any of than his victims. The magnitude of the injustice here is incalculable. In the meantime, pro golfer Jack Nicklaus, is being considered for the Congressional Gold Medal for promotion of excellence and good sportsmanship with the nation’s highest expression of distinguished achievements and contributions. I begrudge Mr. Nicklaus nothing, however this is further earsplitting evidence of the continued torrent of assaults upon the Fort Hood WIA, KIA, families, and survivors of the largest massacre on US soil since 9/11, whose sacrifices are rendered meaningless in comparison. Where has America gone?

Nevertheless, it will be a glorious day when the Fort Hood Massacre wounded and the families of those who lost their lives at the hands of an Islamic terrorist madman, are presented their long overdue Purple Heart Medals and the civilian Defense Medal for the Defense of Freedom, posthumously in the case of the deceased. Finally, their service and sacrifices will be recognized and celebrated, but there is so much more to the story left unsaid. Justice is finally being served, but sadly, only in part. That the Obama administration labored for years to quash these provisions listed in the National Defense Authorization Act remains a travesty of justice.

It is certainly appropriate to deliver thanks to the Secretary of the Army, John McHugh, for providing some degree of closure to the wounded and the families of the deceased. More importantly, Representatives Carter, Williams and Thornberry and Senators Cornyn and Cruz deserve even greater commendation for endeavoring to assure that long ago warranted benefits are granted for these victims.

Still, it is inconceivable that the Fort Hood Heroes Act was never even subjected to a vote and never made it out of committee. This act would have guaranteed full benefits, compensations and entitlements due the wounded and the families of the deceased. Instead, more than 5 long years had to pass before Congress rewrote the language that entitles the wounded and the dead to their Purple Hearts, political correctness having reigned supreme until Congress came to their senses.

It is equally mind-numbing and a miscar-
riage of injustice that none of the members of the Department of the Army who supervised the shooter and that overlooked his extreme radicalization, promoted him, and awarded him an elite fellowship in order to simply transfer the problem elsewhere, have never been held accountable. This is the highest form of moral bankruptcy. That this massacre continues to be labeled one of workplace violence committed by a disgruntled employee is purely delusional, contemptible and just plain vile. That three Secretaries of Defense, including Gates, Panetta, and Hagel refused to change this designation exceeds disgracefulness. To add to these despicable inactions, victims of the 9/11 attacks on the Pentagon were awarded Purple Hearts. Enough said. Though the news is good, this is far from the end of the story:

1. Only those physically wounded are eligible to receive Purple Heart Medals. Those who have been unable to return to the work force because of their wounds will not be compensated for their losses in income and financial ruin. Those who have suffered severe psychological injuries, rendering them unable to sustain employment either, will never be compensated. PTSD is rampant among many of the survivors, even those who were not physically wounded. There is no such

2. lifeline for those whose emotional lives lay in ruins, as if any of us could ever or would ever be the same.

3. Between two and four Soldiers have taken their own lives in the aftermath of the massacre, including SSG Joshua Berry, of Cincinnati. The colossal path
of destruction created by the shooter and the issue of suicides among survivors has been completely ignored by the Department of the Army. Though he was physically wounded during the systematic assassinations of 12 Service Members and one retiree, his family qualifies for nothing because, according to one senator, doing so would demean the sacrifices of those who died in combat. What an abominable thing is this to say to the father of one who could not sustain life in the aftermath of the battleground created on American soul by Hasan the Executioner?

4. That those wounded will receive combat-related special compensation pay upon retirement and be offered burial plots at Arlington National Cemetery does not even begin to offset the immeasurable damages done.

5. In essence, the wounded, the survivors have been betrayed by unfilled promises and largely abandoned by this administration until now.

6. In the meantime, the shooter has been given free rein to tell the Pope to advocate for jihad and to lobby ISIS to welcome him as a Soldier of Allah and citizen of the Islamic State. He is on death row at the Disciplinary Barracks at Fort Leavenworth. Why is he allowed to have any contact with Islamic extremist organizations that seek to kill all of us as infidels? Why does he have any rights at all?

7. Lastly, the Department of the Army has failed to acknowledge the heroic acts of the many Soldiers and civilians at Fort Hood, who, on one of the most tragic pages in United States history, placed themselves at the mercy of this vicious killer and destroyer of lives to rush headlong into building 42003 to render emergency medical treatment under fire and to drag their brothers and sisters to safety. Though some units have stepped up to award Meritorious Unit Citations to all members of their units, this has not been universal and many of these awards, five years after the fact, remain in large piles on desks at Human Resources Command, including those that should have long ago been presented to my unit.

By the same token and with respect to the reclassification of eligibility criteria for awarding of the Purple Heart in the case of the Fort Hood Massacre, we have yet to acknowledge or recognize the sacrifices of the many who, without regard for their own safety or for their very lives, again, while under fire. This should absolutely and unequivocally qualify them for the awarding of the Combat Action Badge or the Combat Medical Badge. The shooter waged war against unarmed Soldiers and civilians. These first responders, heroes in their own right, saw no cost too high to rush headlong into their own Valley of Death to save the lives of their brother and sister Soldiers. We cannot afford to repeatedly allow the valor of heroes to be stolen away by political correctness. Doing the right thing, once again, requires the stroke of a pen.
Guidelines for Vet's Families

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Pre-publication excerpts: War Trauma: lessons Learned from Vietnam to Iraq [New York: Algora Publishing]

What is the Family to Say and Do After The Vet Returns From Deployment?

There is no adequate “cookbook recipe” of do’s and don’ts that all families of all veterans returned from deployment should do and not do. This is for a very simple reason: no one can package a bottle that contains “the appropriate response to suffering.” And words intended for everyone will almost prove worthless.

For one individual person, if you go to the sufferers themselves and ask for helpful words, you may find discord. Some recall a friend who cheerily helped distract them from the illness, while others think such an approach insulting. Some want honest, straightforward confrontation; others find such discussion unbearably depressing.

Recognizing that there is no magical set of responses for the family to carry out, the following are offered in the spirit of a general set of principles or precepts. And I am writing this section directly to you, the partner (and other family members/significant others) of a war-zone veteran.

You must consider how each of the following may fit or not and is relevant or not for you and your family and for the veteran returned from deployment. Your reasoned judgment will take into account, rather than rigidly following in cookbook fashion a recipe of do’s and don’ts, how such do’s and don’ts match well or not with the strengths and shortcomings of all of your personalities, the quality of your past history and relationship, and any unresolved personal and relationship issues stemming from before and/or during deployment with your veteran partner and that may arise with the re-entry of your veteran partner into the family life.
It has been asserted that what people in pain (physical and/or psychological) most need is love, “for love instinctively detects what is needed.” In this regard, Jean Vanier, founder of the l’Arche movement, said:

Wounded people who have been broken by suffering and sickness ask for only one thing: a heart that loves and commits to them, a heart full of hope for them.

Never underestimate the power, even if it is not immediately noticeable, of simply communicating with your veteran partner through words and actions that you are available, you are here for him/her. It is our mere presence (affirming that) The world will go on. I am with you in this scary time . . . We will not leave you alone. We will bear this pain with you. This is a most powerful gift to offer to your veteran spouse, in that:

People who are suffering oftentimes feel an oppressive sense of aloneness. They feel abandoned, by God and also by others, because they must bear that pain alone and no one else quite understands. Loneliness increases the fear, which in turn increases the pain, and downward the spiral goes . . . .

These words perfectly describe the angst that many veterans troubled by their war experiences evidence, sooner or later, after returning from deployment. I want to emphasize “sooner or later” in that most veterans will not show such angst or the depth of such angst in the glow of the “honeymoon” period immediately following return from deployment. However, inevitably the honeymoon glow fades and then if there are serious underlying issues from the war, such will start to reveal themselves.

Finally, it is important to emphasize that the development of stresses and strains following the veteran’s return from deploy-
ment, even the most severe problems that are war-related, will not necessarily result in disaster or a splintering apart of the relationship and the family. Nor will it necessarily result in the family pulling together and becoming closer and stronger. This dynamic is eloquently described by Yancey in a conversation with a couple whose relationship was sorely challenged when the wife found herself battling Hodgkin’s disease.

I asked Claudia and her husband why that crisis seemed actually to pull them together, whereas more frequently a life-threatening crisis creates tension and pushes a couple apart. ’Claudia responded: ‘In the movies, couples who have fought for years suddenly in the face of danger forget their differences and come together. But it doesn’t work that way in real life. When a couple presents a crisis, it magnifies what’s already present in their relationship . . . the crisis of the illness merely brought to the surface and intensified feelings already present.’

In my clinical work with hundreds of veterans of all wars over the past three decades, I have noticed how many vets strongly over-endorse the source of any post-war problems to be the war and the transition back home, period. ”I’m this way because of the war,” or ”It’s because of the war.” What typically is missing from many veteran’s thinking and beliefs is to also consider the important role that their life before the war may have played. And it is essential to note the word “also”, along with what happened during the war. I have used the ”blank tablet metaphor” to get this critically important point across when talking with vets: Let’s be very clear. No one went to war as a “blank tablet.” No one. We all went as some-one, as some-body. We all had personalities, strengths and shortcomings, values, beliefs, prejudices, relationships, successes, problems, issues and dreams. And you, this some-body, entered the military and went to war. And you brought inside of you to the war all of those personality characteristics, strengths and shortcomings, values, beliefs, prejudices, relationships, successes, problems, issues and dreams with you---we all did. And what we brought with us to the war somehow interacted with what each of us experienced during the war, resulting in unique combinations arising out of who were before the war and during war. And so, there is no way to begin to understand the possible impact of war unless you have a clear sense of your personality before, during and following exposure to war trauma---both those aspects that changed and just as importantly, those aspects that remained the same or seemed to go underground during the war but reappeared later. Long-standing personality characteristics, personal strengths and issues, and positive and problematic relationship patterns that existed before deployment within the veteran and in the veteran’s relationship with partner, children, extended family members, all will come back with the veteran following deployment. However, these pre-deployment factors are now mixed inextricably together with the remarkable highs and depths of the experiences of war. And all that, together, comes home with the veteran and into the family. And so, it is inevitable that the mixture of pre-war and deployment factors will be exacerbated by the veteran’s post-deployment readjustment. Such long-standing issues and problems will require their own atten-
tion and must not be ignored or sub-scribed to focusing entirely onto the veteran’s war-related problems as “the” problem.

The partner back home, the children, significant extended family members all also have their unique combinations of pre-war characteristics, strengths and problems. These inevitably become intermingled with their life experiences while the veteran has been deployed. And, similar to the veteran, their combination of pre-deployment and life experiences and characteristics and patterns during the partner’s absence while on deployment now come face-to-face with the returned veteran who has been extraordinarily impacted by war.

And so, just what is the family to say and do in regard to a veteran who has recently returned from deployment and who appears to be quite different, appears to have been significantly impacted by the war? Should the partner and family remain silent and just avoid talking with the returned active duty about these noticeable changes (that are negative) in the hope that he/she eventually will revert back to how he/she was before being deployed? And, of course, there also could be positive changes.

But the rest of the family has needs and wants right now. And the family has just as much right and needs as does the returning veteran to be reached out to, listened to and understood, and their issues and feelings respected and addressed. Therefore, it is essential to focus on the big picture, to be very aware and sensitive to the mental and emotional state, and the wants and needs of the veteran, and of you the partner, any children and any extended family members important in your lives.

All have the right for your wants and needs to be considered in a balanced and meaningful way.

To put a singular focus on the veteran’s needs and wants, or on yours, or on your children’s, or on extended family members, is not fair, is not sufficient and just will not work. To be of optimal help to your veteran partner, you first must understand what your primary needs and wants are right now, as you and the family are readjusting to the veteran being back and adjusting to someone who has been profoundly touched by war.

Are you resentful, relieved, entrenched in daily habits developed while your veteran partner was deployed, resistant or very ambivalent that your veteran partner has disturbed whatever homeostasis you had achieved in his/her absence?

Do you want to just drop all the responsibilities onto your veteran partner, because you are exhausted and angry and needy and want your own space that was impossible to have while your partner was deployed?

Or, are you so happy to have him/her back that you choose to bury or deflect all or most of your or the family’s pent-up feelings and issues and defer to your veteran partner’s needs and wants?

Of course, you also must pay close attention to what is going on with your veteran partner recently returned from deployment overseas. Look closely and be
aware, to the extent that you can, of what is going on with your veteran partner.

The vast majority of veterans who are recently returned from war appear to be all right, do not want to dwell on what has happened to them while they were in the war, don’t want to spend much time talking about it, thinking about it, or feeling about it. Rather, they want to put it aside, deflect it or bury it and get their lives back. This is normal and expectable.

There is a substantial sub-group of returned veterans who remain totally or partially preoccupied with the war and what happened, are obviously impacted about what they have experienced, are either sorely troubled and/or become quite isolated. Ironically, most of this group of returned veterans, similar to the first group, also do not want to dwell on it, don’t want to talk about it, think about it, or feel about it. They too want to put it aside, deflect it or bury it and get their lives back. This is normal and expectable.

There is a third and the smallest sub-group of veterans. This sub-group reveled in the war, misses it, yearns for it, talks about it, immerse themselves in the memories and happenings about war. This third group is of critical immediate concern; they probably are extremely resistant to changing anything about themselves, don’t really like much about normal civilian life, and make it almost impossible for you to connect with them in a meaningful way. You will need help to be able to deal with such veterans, and they need help (if they have any motivation to be back in the normal world) but in all likelihood will not avail themselves of it.

So, the most fundamental “do” is: do take care of yourself. Get help for you, learn how to take care of yourself with a
veteran partner who wants or seems compelled to relive and stay in the war, even though he or she is now stateside.

The only “cure” may be for your veteran partner to head off on another deployment. Some relationships stay intact precisely because the veteran partner does go on relative frequent deployments and because both partners prefer it this way. When you put all of the above together, it is clear that this is a most challenging set of tasks. Yes, the Service Member returned from deployment has the personal responsibility to let the family know when he/she is ready or available to connect with you or not. However, the family also may well find it necessary to become adept at the rhythm of contact and withdrawal. ‘I’m here, my ears and heart are available when you want to talk.” Then, you pull back some and give space, repeating this dynamic countless times over weeks, months and perhaps years. You stay around and make it clear that you are available when your veteran partner is more ready to connect with you and the family.

Furthermore, readjustment requires a remarkable balancing act by both the returned Service Member and the family. The veteran is responsible to be aware of when he or she is struggling with deployment-related issues and problems, and doing something about it. However, the Service Member may be in denial about this. And so, the family may have to decide if it is necessary to confront the Service Member about his/her denial and/or do a balancing or juggling act to some degree between and amongst the array of competing needs and wants of the veteran, partner, any children and any involved extended family members. Yes, everyone has some responsibility in this regard. Even so, the partner may find her or himself in the position of having to decide if and when to become more assertive with your concerns to your veteran partner and not just allow a bad situation that is not showing much sign of improving to stagnate or become entrenched and chronic. Did anyone say that life was fair? The vast majority of vets who are trying to deflect, deny, minimize or bury what has happened in the war and what may be going on inside themselves about the war, may need a wake-up call about their denial and avoidance. This might be from a close friend, religious confidant, and/or perhaps from the partner. The family may be put in the position of having to decide if you are willing to engage in strategies of interacting and balancing competing needs and priorities, and perfecting the art of contact with and withdrawal from your partner and/or insisting that the Service Member become more responsible. Either or both actions may be pivotal to the mental health and happiness of both of you and of your family. And the Service Member of course has personal responsibility to do what he or she has to do to deal with possible deployment-related problems and issues. And the family may have to decide if you are willing to do what you have to do to stay---or get---skilled at balancing patience and persistence, diplomacy and assertiveness, and giving to your veteran partner while also being vigilant to taking care of your and your family’s needs and wants. This is not an easy row to hoe, and why getting assistance and support for you may be very advisable.
The Do Not's

Do not say, “I understand,” or “I know you feel.” No, you don’t understand. And you don’t know how the vet is feeling. If you weren’t in war, you don’t understand. Period. However, you may well understand from your own life experience how it feels to not want to talk to anyone, or how it is to feel that no one will be able to understand about something you have experienced, or how you may have hoped if you could just ignore something festering inside you that it would eventually go away.

Do not push or insist that your veteran talk about the war if he/she does not want to. It is too sacred a subject to attempt to pry the details out of someone ---you are trampling on hallowed ground. Do not say, “Did you kill anybody?” Or, “How did it feel to kill someone?” If the vet wants to share this, the vet will share it. Otherwise, this is received as an invasive and unwanted demand for the most extremely personal of information.

One returned Iraq vet is described while being interviewed by a reporter at a small coffee shop.

*His voice rose as he talked. It was loud, too loud, his sentences laced with expletives. People moved away as he talked about “stupid” people at home asking him if he’d killed anyone in Iraq. ‘I just told them to shut up or I’d kill them!’*

Do not take it personally when your veteran does not want to talk about it. The fact that you are not a combat veteran is important; your veteran partner will probably be, by far, most comfortable talking about the war.
experiences in any detail with another combat veteran. It is crucial to remember that the reluctance and difficulty in your veteran partner relating intimate details about the war to you has much less to do with you than it has to do with the veteran feeling that no one but other combat veterans could possibly understand. And that may be true for many . . . Also, the veteran typically is concerned about “taking the lid off” of all the marked and severe pent-up feelings and memories that have been buried. Because, you see, the fear is, “If I open the lid (of the memories, emotions, trauma) I may not be able to put it back on again.” This reluctance to want to open the lid because of the preoccupation with fear that you won’t be able to cover it over again is why there are a number of other war veterans who just don’t want to talk much to anybody, not even to other vets, about what happened in the war. As one such Vietnam veteran told me:

When I got back from Nam, the only people I could relate to were other Vietnam vets—and they were the last ones I wanted to be around.

Do not make ultimatums or threats that have severe consequences and deadlines attached to them unless you are absolutely at the end of your willingness to wait, like, “you need to get it together now, it’s been ___weeks or ___months of being withdrawn, moping around, etc. If you don’t go see a counselor this week, I’m going to leave you.” Big mistake; most combat vets do not respond very positively to threats. This isn’t a poker game where bluffing and deception go hand-in-hand with winning.

Do not try to lay a guilt trip on your vet about how it’s time to stop being so self centered or it is a test of your relationship, i.e., “If you really loved me, you would share more with me”.

Your veteran partner, I can guarantee, already has more than enough guilt about what he/she did in the war or about the hard ships you and the family may have gone through while he/she was deployed. So piling on yet more guilt trips will only exacerbate war-related issues (that your veteran partner needs to deal with) and intermingles those with your relationship dynamics. Does this mean that there is not anything that you can or should do? On the contrary:

Do not ignore warning or trouble signs in your vet that there is stuff going on inside or behaviors that indicate potentially serious problems---such as excessive drinking, isolating, mood swings, anxiety and sleep disturbance. You need to point such things out, but not dwell on them, at least for awhile, depending on how severe such problems are.

Do not ignore your own needs and wants. You are a person who has the right to have at least some of your needs and wants met, no matter how troubled your veteran partner is. And so do your children and perhaps important extended family members such as parents or siblings.

Do not ever allow your veteran partner to treat you meanly, or disrespectfully, or in a threatening way. And absolutely do not ever tolerate your veteran partner hurting you or your family. Violence in war is one thing. But to bring it back into the home
is quite another matter; it is never excusable. If you can’t protect yourself or your family, then immediately go talk to someone who can help you.

The Do’s

Do remember to reach down deep within and get and stay in touch with the love that you have for your veteran—-even if it is love more for how he or she was before deployment than how he or she is behaving right now.

Do remember that it is your relationship that should be at least as important as the individual needs and wants of each of you; what is best for your relationship right now, not what is best for you or what is best for your veteran partner.

Do hold hands and look each other in the eyes. I don’t remember much of anything specific that I was taught in almost ten years of undergraduate and graduate study. But there is one thing I remember very clearly from a favorite social work professor, John Milner. He said, if you and your partner are having a serious argument or harsh words or tempers are rising, both of you stop. Be silent for a moment, compose yourselves, stand in front of each other, hold hands, look each other in the eyes, and now start talking to each other while continuing to hold hands and looking in each other’s eyes. You almost surely will calm down and start relating to each other rather than talking meanly at each other.

Do be out front by saying: Do you want to talk a little with me about the war? Are you willing to share with me some of the good times, some of the bad times? If not now, possibly later? And I need to be able to ask you these same questions again at another time, because otherwise you may never come to me first and start talking about it. Tell me the best way to approach you.

Do remind your veteran partner about the literature you have in the house that describes the warning signs and triggers about post traumatic stress and lingering combat stress reactions and that are reminding you of him or her. And if you don’t have any such literature, get some ASAP from a military family support agency or ombudsman/family support volunteer, a partner support group, a VA Vet Center or a Veteran’s Service Organization and become familiar with the contents.

Do recognize that your veteran partner will probably be very resistant to going to talk to anyone, including you, about what is going on. The veteran may not respond positively to your suggestions today or tomorrow or next week, and so you have to be both persistent and diplomatic/gentle in continuing to bring up your concerns.

Do say: I know I can’t fully or perhaps at all understand what is going on with you, because I wasn’t there in the war.

Do say (if you genuinely mean it). I really do want to better understand, and request that you help me better understand. If you don’t tell me anything, then you are shutting me out and it will be impossible for me to ever really understand. Please don’t shut me out completely.

Do say: I don’t need or want to hear all the gory details. I just want you to please share at least some of what is going on in-
side of you, some of what you are feeling angry about, or sad about, or anxious about, or any other important feelings. Are you willing to share at least a little of that with me today? And gently yet persistently make this request at other times. Do ask your vet: Are there any books, articles or other readings about war and what happens in war, or any movies, or any songs/music that are personally meaningful that you could recommend to me that could give me at least a little better understanding of what it was all about, about what was so meaningful for you? And then I would like to talk with you a little about it. [Many vets will be much more comfortable with you learning in this manner, rather than you expecting your veteran partner to talk in great detail and express heavy pent-up emotions.]

Do say: Please let me know if I am saying something offensive, or that hurts you, or when it feels like I’m trying to pry you open and you feel that I am trying to invade into your most deep and personal feelings and issues. And I really want you to tell me that gently, in a respectful way. Telling me in an angry way doesn’t help anything—and I don’t deserve or need your anger being directed at me. And that goes both ways. I am going to let you the veteran know when you may say something offensive to me, or that hurts me, or when it feels like you’re trying to invade my most deep and personal feelings and issues. And I want to tell you that gently, in a respectful way. Telling you in an angry way doesn’t help anything and you don’t deserve or need my anger being directed at you.

Do say: I’m here for you. And I want you to be here for me, even if you can’t be here for me as much right now as I want you to. Because I am in this for the long haul. (However, if you are having serious doubts that you still committed to this relationship, then that is another matter entirely that requires your immediate attention.)

And do put on your oxygen mask first. This is the bottom line do or don’t—to first take care of yourself. As we all know, the proper procedure on an airplane when the oxygen masks drop down is to put your oxygen mask on first; otherwise you will be in no position to help anyone else. The same principle applies to you at home. Seek help if you are hurting, whether or not your veteran partner does and whether or not your veteran partner wants you to. This is your right. And one of the most powerful sources of support and understanding will be with and from partners of other veterans who have returned from deployment.

Again, please remember that the above-mentioned information merely offers some guidelines for you to consider. Your veteran partner’s situation, yours, your family’s, may not be similar to what has been described above and you have your own distinctive issues and challenges to deal with. Two most important truths to remember are that: war always has a long-standing impact on all combatants and others who serve in a war-zone this impact on them is brought home and absolutely will have a significant impact on the veteran, you (the veteran’s partner), children and significant extended family members.

No amount of hoping will wish this reality away. And if you and your veteran part-
ner are not able or willing to deal with it today or tomorrow or next week or next month, it almost surely will still be an issue and then even more entrenched and complicated several months from now or next year or next decade---if you are still together at that point.

Readers are encouraged to read some of the excellent writings that focus on the dynamics of families of veterans mentioned earlier, visit some of the web sites established regarding children of veterans, and web sites regarding wives or families of veterans. It is critically important not to be a “lone ranger.” If you are family of a veteran still on active duty, please contact a military family support center or community service center, military base ombudsman or family readiness group, wives support group or military chaplain. If you are family of a veteran who is no longer on active duty, contact the local VA Vet Center, VA social work department, VA specialized PTSD program, or county or state veteran’s service officer or veteran’s service organization representative who can refer you for family assistance.
Possible Positive Impact Of War And Deployment

It is important to note that the preceding discussion has emphasized the potential and actual negative impact, both short and longer-term, of being in war---because this amount of information typically is never given routinely or comprehensively. There is a whole other side---the remarkable positives, the comradeship, heroism extraordinary valor, strengths, and humanity that can characterize what goes on in wars, and can be brought home and remain a powerful positive within many veterans.

Families may be blessed with the development of resilience, strength, and a very positive identity as a military family or as the family of a veteran, proud of the service their spouse or parent or sibling has given to our country, and the sacrifices made both by the active duty military person or the veteran and by the family. And the experience of being part of a family with a member who has served in war can help equip both the returned veteran and the family with a strength, courage, pride, perspective and grace that is profound. They truly know what the price of freedom is, and it is not free.

Such was revealed in the stories of the brave and proud veterans as described in the first two books of the Vietnam Trilogy series who participated in such amazing experiences as the dedication of the national Vietnam Veterans Memorial in Washington, DC, our helicopter ride therapy and Outward Bound adventure therapy, who returned to Vietnam in 1989 and in 2000 and the many wonderful attributes that will be further described in a later chapter.

In the words of a Vietnam veteran 20 years after the war:

*Maturity, self-esteem, teamwork, accomplishment, pride, excitement, and adventure are certainly as much a part of the war-zone experience as anything else. For these, I am extremely gratified.*

In the words of an Iraq veteran while still in Iraq:

*These two deployments have taught me a degree of patience and tolerance that I never thought possible. I have been forced to live in terribly deprived conditions and with ungodly levels of frustration and uncertainty, far more than in any arena of my life as I knew it before OEF and OIF. I have learned to live without the most basic comforts of life for months on end, without privacy and with restrictions I have never known before. To this end, I will have learned to appreciate why freedom has a tremendously high cost. I am grateful to be among the finest in this struggle to bring democracy to the people of Iraq so that someday they can live as we do in America.*
Combat Social Work In Vietnam: Lessons Learned For Iraq and Afghanistan

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Scurfield standing in front of the MHC in Nha Trang, Vietnam in 1968 with the 98th Medical Detachment (KO Team) psychologist, Captain Lynn.
I served as a social work officer in the Army for four years after I graduated as a Distinguished Military Graduate of the Army ROTC program at Dickinson College, Carlisle, PA in 1965, and following my subsequent deferment from active duty for two years to complete MSW studies at the University of Southern California, Los Angeles, CA. My active duty service (1967-71) and post-military career included one year as the Social Work and Administrative Officer on one of the Army’s two psychiatric teams during the height of our troop mobilization in Vietnam (1968-69). This writing describes why I joined the Army and significant personal, professional and military experiences before, during and following deployment to Vietnam. Finally, I describe salient lessons learned over the years regarding war, its impact and healing from war trauma derived from several pivotal pre-Vietnam experiences, my social work officer role in Vietnam and subsequently as a clinician and PTSD program director over the following 45+ years, serving veterans of WWII, Korea, Vietnam, Persian Gulf, Afghanistan and Iraq.

Why did I Join the military?

When I got to Dickinson College as a freshman, we had the choice of taking a required “gym/exercise” course or could take Army ROTC courses for the first two years of college. I chose Army ROTC and found myself enjoying the camaraderie, discipline and shared efforts with my fellow student cadets. Also, there was a modest monetary stipend to continue on with ROTC in the 3rd and 4th years of college. I enjoyed the experiences and successes that I had in rising up through the ROTC ranks to become the Executive Officer (#2 in command) of the ROTC student corps. Finally, the draft was getting hot and heavy and I decided that I did not want to take the chance to be drafted as an enlisted person but would prefer to become an Army officer, even though that meant making a two-year commitment to active duty. In addition, because I wanted to become a social worker, this gave me the opportunity to get a deferment from having to enter active duty immediately after undergraduate graduation while attending the MSW program at the University of Southern California School of Social Work. This deferment also guaranteed that I would be able to finish my MSW studies uninterrupted and enter the Army as a Social Work Officer in the Medical Service Corps. So, it was a very “practical” decision that appealed to my serving my country as a military officer. Also, I would be in the military in a position that was closely related to my MSW degree and hence would be of very practical advantage when I left the military to pursue a civilian social work career.

Lessons Learned Prior to Deployment

I had several very meaningful pre-Vietnam experiences -- in the year before deploying -- that strongly influenced my attitudes and learning about war and its impact.

The first meaningful experience occurred during my second year of MSW studies at the University of Southern California at my field placement at the Sepulveda VA Medical Center in the San Fernando Valley, Los Angeles (this was during the last semester of my deferment from active duty). On the locked psychiatric ward I was assigned a young Marine who had a diagnosis of schizophrenia. He had suffered a psychotic break in Vietnam and had been med-
evaced back to the U.S. and eventually transferred to the VA. One day, in a moment of lucidity, he said to me: “Ray, you have to help me get back to Vietnam. I have to go back to prove that I am a man.” He elaborated that he “had deserted his buddies in battle” (by suffering a psychotic break and having to be evacuated) and had to go back to prove his worth.

This young Marine left an indelible impression on me—that what his buddies thought of him and his carrying out his part were so extraordinarily vital to him. Additionally, that his (self-defined) “failure” could well haunt him for the rest of his life -- because he would never have opportunity to go back and undo what had been done. What I didn’t realize, too, was that this experience soon would strongly reinforce to me the military psychiatry axiom that was prevalent in the war zone.

This prevailing axiom, with which we were repeatedly inculcated, was that the worst medical disposition for a psychiatric casualty would be to “prematurely” evacuate him out of country because it would almost surely lead to a “fixation of psychiatric symptoms” back home; in other words, that: it was in the best mental health interests of the individual psychiatric casualty to return him to duty rather than to evacuate him.

The second indelible pre-Vietnam experience happened during the Medical Officers’ Basic Training course at Ft. Sam Houston, San Antonio, Texas, in the summer of 1967 (and there were similar experiences during my summer Army ROTC training course in 1964 while at Dickinson College). What stood out then, and still (along with the experience that one of our primary military instructors in 1967 suffered from a significant speech impediment that made it extremely difficult to understand half of what he was imparting to us) was the rampant usage of racially and culturally derogatory phrases and attitudes—gooks, chinks, slopes, slant-eyes. Such pejorative terms were ingrained into us, fostering of course negative racial and cultural stereotypes about the Vietnamese people – and you could see the results of this type of dehumanizing conditioning in particular in the attitudes of a number of front-line, direct combat troops in Vietnam.

I also remember being taught that since most Vietnamese were Buddhists and believed in reincarnation, that “they didn’t care about death the way that we (Christian) Americans did”; that thus somehow they did not grieve the death of loved ones like we Americans. I found myself extremely uncomfortable with the racist and culturally derogatory/ignorant attitudes and information, perhaps partly from my being of Syrian-American descent and sensitive personally to racial and cultural prejudices. And Asian-American military personnel would be used to depict enemy Vietnamese and bore the brunt of such derogatory language and attitudes. I often wondered how our racial minority troops reacted to such racist attitudes.

The third indelible lesson related to my choosing to verbally complain about my initial duty assignment at William Beaumont General Hospital in El Paso. I knew that there was a good chance that by so complaining to my commanding officer...
that there could be serious consequences—and there were—even for an officer. This sensitized to me to the fact that troops, and especially those in the enlisted ranks who might choose to complain or otherwise not be “model” “yes, sir, no questions asked”, could well get into trouble with their command. And, indeed, in Vietnam many of the cases referred to us were by command who viewed and were treating some troops with mental health problems as discipline problems.

The fourth important lesson was what the reactions were by several people when I told them that I had gotten orders for Vietnam. My two roommates (also Social Work Officers), from my memory seemed to be most concerned about who they could get to take my room to keep rent expenses down rather than about what might happen to me—perhaps partly due to the attitude that I had brought this onto myself by speaking out to our command. And colleagues at the Mental Hygiene Clinic seemed to be more concerned about the increased caseload each would have until and if a replacement were brought in for my position. It was almost “out of sight, out of mind” was happening—and I hadn’t even left yet...No wonder many troops deployed perceive that too many people back home seem to not think too much about or perhaps even care about what is happening to them in the war zone.

The fifth significant pre-Vietnam experience involved my desire to attend Vietnamese language school. After I had received orders for Vietnam, I requested to go to Vietnamese language school in that I assumed that knowing the Vietnamese language would be important and beneficial. However, my request was denied “because my MOS (military occupational specialty—Social Work Officer) ‘did not warrant’ my attending language school.” I even had offered to add as many months to my active duty commitment as I would have going to language school, but it made no difference. I was extremely disappointed and knew that this would seriously handicap any efforts I might make with the Vietnamese people—but it did not deter my drive to do so. It also made me realize how rigid or seemingly arbitrary military regulations and policies are (and even to officers). It also impelled me to seriously question just how sincere was the military to actually fulfill the oft-repeated motto “to win the hearts and minds of the Vietnamese people.”

The sixth significant pre-Vietnam experience occurred on the civilian plane I boarded in Pittsburgh to begin my flight to Seattle/Tacoma and then on to Vietnam. As I was on official military orders, I was in uniform and took my seat. When the plane had filled up, the seat next to me remained empty. And then into the plane appeared a Vietnam veteran (readily identifiable by the military fatigue jacket and booney cap that he wore). He had a black patch over one eye and he was using arm crutches, very slowly and jerkingly moving down the aisle on what obviously were two prostheses where his legs used to be. And he came, unerringly -- to the empty seat next to me!

I don’t remember much about what we might have said to each other on the flight, but I do remember two comments
this brave young veteran said to me. "This is my second convalescent leave to go home for several days, Sir (meaning going home to test how he would do adapting to life with two prostheses and then to return to the hospital for further adjustments to his prostheses, etc.). I am a little worried how I will react because the first time I went home several of my high school buddies told me that it was a shame that I had to lose my eye and legs for nothing...That really hurt." And a little later he said, "You know, Sir, I am the lucky one—no one else in our foxhole survived." I was speechless, so impacted by this incredibly courageous young man. And I had not realized it at the time, but this young physically disabled veteran had just given me my first powerful lesson about the power of positive thinking and the importance of recognizing and emphasizing positives that can be essential elements intertwined in even the most horrific of traumas.

My Initial Reactions When I Got Orders for Vietnam

I need to give a little background. My ROTC commission incurred a two-year active duty commitment, and when I was given my first duty assignment (William Beaumont General Hospital in El Paso, TX) it was understood that I almost certainly would spend my entire two years of active duty there. I found this problematic, as I was doing in El Paso what I could be doing in any hospital setting in the U.S.—being a “generalist social worker” providing outpatient counseling to military personnel and their families, especially family and children’s counseling. I did not feel like this made very good use of my ROTC training. Finally, one of my assignments was to provide pre-natal psycho-educational classes at nearby Ft. Bliss to spouses of active duty Army personnel. I was a young (age 24), single (never married) male teaching this class to female dependents. One day while teaching this course, it hit me like a bolt of lightning -- this was a *ridiculously* poor-fit for me and I felt like it would be a travesty to spend my entire two year active duty commitment doing this in El Paso. I decided to complain about my duty assignment to my commanding officer—and two weeks later I received orders for Vietnam! (I had heard of enlisted personnel being sent to Vietnam as a “disciplinary” action, but didn’t think through thoroughly that this might be what would happen to me!).

I do remember getting the letter with my orders in it, and remember being surprised and shocked. I also remember experiencing a substantial wave of excitement and anticipation about what I might face, and felt that I would be very good at my new job. THIS is what I had spent four years being trained for in Army ROTC and in Officer’s Basic Orientation in San Antonio, Texas. Of course, I had no actual realistic understanding about what it would be like to be a social worker in a war zone. And somehow I felt pride that I really would become a real ARMY social work officer and not just someone wearing the uniform in what was very much like a civilian setting in El Paso, Texas. As far as the “danger” of being sent to a war zone, I do remember that I was preoccupied with losing a hand or arm in the war and hence not being able to continue playing the guitar or piano.

As far as the war itself, I was very apolitical at that time in my life and really had
bought in to what we had been taught in ROTC classes. Firstly, the “falling domino” theory: if Vietnam fell to the Communist North Vietnam, then the rest of Southeast Asia would fall like dominos to the Communists as well (sound familiar to current-day justifications for U.S. military presence abroad?). Also, I understood that the South Vietnamese (Saigon-based) government was pro-Western, that there was a significant Catholic Vietnamese population in South Vietnam that was very anti-communist, and that democratically oriented South Vietnam was valiantly fighting against a communist take-over and desperately needed our help. Thus, this felt very much like the right thing to do, and I became increasingly excited at the opportunities awaiting...

**What I Did During Deployment to War Zone**

I was assigned to one of the Army’s two psychiatric teams in Vietnam—the 98th Medical Attachment, attached to the 8th Field Hospital in Nha Trang—a huge military port complex—to do “psychiatric sick call”. Military personnel, literally, would be lined up to be seen by us. A third duty was to travel to surrounding units to do mental hygiene consultations with commands who had Soldiers that were psychiatric and/or behavioral problems and to evaluate and give recommendations about such personnel.

*What Kinds of Mental Health and Adjustment Problems Did We See, Assess and Treat?*

Ironically, most of the patients and issues we saw at the outpatient clinic were generated by problems that were occurring “back in the world” – hearing that one’s spouse was being unfaithful or who was falling apart with all of the family’s responsibilities on her shoulders, a family member with a medically emergent condition, a troubled teen who was acting out severely, a death of a mother or grandparent, a financially dire situation with one’s family. And the Service Member is a half a world away, in a war zone, helpless to DO anything to help, trying to focus on his or her mission in the war zone and be vigilant to make it more likely that he or she would actually survive—but being torn apart by the distance of thousands of miles. What to do? Who to help? Tunnel vision on my job in the war—but torn apart by worry, anxiety, fear for family members back home...and as the social work officer, I had to help Soldiers in such circumstance
“Soldier on” in the field, to better cope to be able to take care of business so that neither he nor any of his buddies were injured or killed because he was too pre-occupied by troubles back home. Or, the troubles back home were so severe that it could be justified working with the Red Cross to try to get command to authorize an emergency leave for the Soldier to return home for 30 days to help with the family emergency.

Another group of Soldiers were traumatized by sights and events that were experienced on the battlefield—the Vietnamese child blown to bits accidentally in the cross-fire with enemy forces, the seemingly never-ending close encounters with blown-up bodies of Americans and Vietnamese, the near-miss in which one’s buddy was killed but I was somehow spared—how, why? “I should have been able to prevent his death.” The sleepless nights, unable to turn off the hyper-vigilance so necessary during missions, the recurring nightmares, the anxiety so strong that it paralyzed necessary reactions, the depression so deep that the alcohol and drugs no longer helped, becoming “kill-crazy” after losing a best buddy and wanting to kill any Vietnamese out there, the paranoia that has crept in to turn every shadow into a Viet Cong lurking, having to treat one catastrophically injured Soldier too many, having yet another patient die on you – and another in spite of your best efforts, strung out on heroin because that was the only way to numb yourself enough to go out on yet another mission of death. Yes, much about war is hell on earth...

And at the same time, there were the unparalleled highs that came with working together as a brotherhood and sisterhood to venture into the most demanding and dangerous of missions, to reach down and pull up strength and courage that one didn’t even know was there, to help a Vietnamese family or child in desperate need of assistance, to do that which many ran away from and avoided having to do, to sacrifice for one’s brother and sister. The worse the Soldier described his/her situation, the more compelling the case for the incredible courage and strength and bravery that it took to survive and persevere...

The Psychiatric Paradox.

Our psychiatric team operated under the then-prevalent premise that the worst thing we could do would be to “prematurely evacuate” a psychiatric casualty back to the States. The psychoanalytically oriented rationale was that with such a disposition, evacuated psychiatric casualties would have a “fixation” or “entrenchment” of psychiatric symptoms that had surfaced in Vietnam and would be at very high risk to become chronic psychiatric patients. Contrastingly, we were inculcated with the military psychiatry operating principle and, indeed, mandate, that it was by far better to stabilize psychiatric casualties as best we could in a short timeframe (30-days maximum) and return them to duty (RTD) as soon as possible. In this way, psychiatric casualties would be facilitated to resume more normal functioning and in essence be able to “overcome” their temporary psychiatric casualty status by successfully resuming their military duties in the war zone.
A variation of this mandate was that for some psychiatric casualties, they were reassigned to other duty in Vietnam when it appeared that they would not be able to return to an acceptable level of functioning in their original duty assignment.

What I only came to realize several years later was that we never thought much if at all about the reality that by returning psychiatric casualties to their duty (or alternate) stations in-country, that we would be returning them to, in effect, be exposed to yet further trauma. And would such re-exposure to additional trauma be “worse” for their ultimate psychiatric stability and healing than to be evacuated out-of-country? The reality was that the pressure was almost entirely on returning psychiatric casualties to duty in-country—in no small part due to the additional factor that to evacuate a psychiatric casualty meant that there would be a vacancy in that Soldier’s unit—and that vacancy would remain vacant or would be filled with a dreaded “newbie” or FNG (F--king New Guy). And to have a more seasoned psychiatric casualty return to duty if at all possible was perceived to be more conducive to maintaining the fighting strength than evacuating and having a vacancy or a vacancy filled by a FNG.

The stone cold reality as I have come to see it (but certainly not at the time I was in Vietnam) is that military psychiatry is not in the business of primarily facilitating what is the best disposition for promoting and safeguarding the mental health of individual Soldiers; rather, the mission is “to conserve the fighting strength” – a mission that is not necessarily most conducive to the ultimate mental health of the psychiatric casualty. Yes, war inevitably has a extremely high price in terms of longer-term mental health casualties -- partly because the military psychiatry mission is to conserve the fighting strength and that results in returning many psychiatric casualties to duty rather than medically evacuating them. And subsequent research consistently reports that the greatest single predictor of PTSD is the amount of exposure to trauma. And that is exactly what happens when military personnel return for multiple deployments (what has become prevalent among Iraq and Afghanistan veterans). But while in the war zone, this reality is and must be weighed against the medical mission to conserve the fighting strength—what I call the “psychiatric paradox” – is a trooper too sick to return to duty, or to healthy to be evacuated out of country (Scurfield, 2004)? That puts social workers and other military mental health professionals in an extremely challenging position in terms of what is the “right” disposition for a given psychiatric casualty. And I struggle with this paradoxical reality even today, some 45 years after my deployment to Vietnam.

Administrative Officer of the Day. The last primary duty I performed was not a social work function. Rather, I was on a rotation with other non-medical officers to provide coverage overnight to the 8th Field Hospital as AOD (Administrative Officer of the Day). This was by far the most demanding and difficult position I have ever had in my adult life. As AOD, one key function occurred when med-evacs landed (medical casualties evacuated from the battlefield and flown by
often there would be a number of casualties arriving at one time who would be carried by litters into the emergency/triage room. I, as the AOD, was responsible to go around the room to collect, inventory and safeguard any valuables that the wounded Soldiers waiting for medical treatment had in their possession. This typically included watches, wallets and wedding rings. There also was a great deal of cash that Soldiers would be carrying—as anything that one did in Vietnam was on a “cash-only” basis.

The really difficult part was being in the emergency room in the midst of acutely wounded, bloody Soldiers, most in great physical pain, many very fearful as to the extent of their injuries and/or to the medical treatment that they were waiting to receive, oftentimes in shock, crying/swearing or silent, perhaps concerned about the fate of fellow Soldiers left back on the battlefield, etc. And there I was, the AOD, with my clipboard and inventory list, approaching a Soldier to explain who I was and why I was there, questioning about valuables, listing such on the inventory list, having many times to be the one to put my hands into their pockets to try to extract wallets and money from blood-soaked pants while trying to be as calm and soothing as I could be to these brave, wounded young Soldiers.

Sometimes the room was crammed so full that it was difficult breathing, the sights so catastrophic, sounds and smells so vivid and pungent, that it was very difficult to maintain a calm exterior and do what I was there to do. Sometimes it was close to overwhelming and I would do what you NEVER should do—stop and look around at the totality of what you were in the midst of. At many such times—and there were many (this was 1968-69, at the height of the troop mobilization in Vietnam)—oftentimes I would cry out silently to myself while standing there, “Why didn’t I study medicine or nursing, so that I could be of some actual help here in the midst of such carnage and not just be fricken walking around the frickin room with my fricken clipboard, inventorying valuables of all things?”

It got to where I dreaded hearing the sound of incoming med-evac choppers—because YOU KNEW what the cargo was... And yet -- I also found myself mesmerized and the adrenalin coursing turbulently through my body as I hastened to be the greeting party for yet another round of casualties—I HAD to be there for these brave and scared young men, to do my assigned part, to provide a small measure of hopefully helpful diversion and solace from the pain and angst and fear... And I learned how so very very brave so many young men in such tragic circumstance could be. I was blessed to be in their midst and bear witness to their strength, their courage, their pain, their angst, their loss, their uncertainty as to what the future held for them—and their concern for their brothers back on the battlefield.

Activities with the Vietnamese People

The location of the 98th Medical Detachment in the thriving city of Nha Trang was very fortuitous for me as it offered many opportunities to interact with the Vietnamese people. Quite a number of Catholics had fled North Vietnam during the Communist take-over there and had re-
settled in the Nha Trang area. This contributed to the Nha Trang population being a very strong supporter of the Saigon-based government and the U.S. military presence. The presence of many higher-educated Catholic Vietnamese also contributed to the opportunity to interact with Vietnamese beyond just rural villagers.

I was extremely interested in being very active with the Vietnamese people and took to heart the U.S. military slogan “to win the hearts and minds of the Vietnamese people.” I wish I could say that most of my brother and sister American military felt the same way, but they did not. There was a minority who were like-minded and this made it possible to have very meaningful experiences with the Vietnamese civilians. I took a leadership role in this regard.

**MEDCAP to Xom Bong Hamlet**

I used my position as the 98th Medical Detachment Social Work Officer to lead the establishment of a MEDCAP (Medical Civilian Aide Program) to the nearby fishing village/hamlet of Xom Bong. We had medical personnel from the 8th Field Hospital who participated, and I coordinated the MEDCAP with the Vietnamese Health Service. We would go to Xom Bong Hamlet regularly to provide immunizations and do a “general sick call” with the hamlet residents. It was very gratifying to be able to offer basic medical services to rural villagers who had essentially extremely minimal access any medical services otherwise. Also, it was very rewarding to be able to utilize my leadership and organizational skills to be able to arrange for military vehicles and medical supplies and to bring together several of my 8th Field Hospital colleagues to participate and offer their medical skills.

This photo was taken in Xom Bong Hamlet, just outside of Nha Trang, 1968-69, during a MEDCAP that Scurfield had organized with 8th Field Hospital medical personnel. As the "administrative" officer for the MEDCAP, Scurfield was writing down immunizations and other treatments that various villagers had received.
I established a teaching of English activity in Nha Trang. I taught English weekly to Vietnamese children and adults. I did not have any background or training in teaching English as a second language and am not sure how much of my teaching was effective. However, it was a lot of fun and very rewarding to interact with the Vietnamese who came regularly to my classes; they were so enthusiastic and interested to learn and I did my best. I remember in particular one scheduled class that was on a day that a major tropical storm was approaching (the flimsy wooden building that I taught the class in was right next to the beach). The wind had picked up dramatically and the rain -- and I of course had no way to contact any of the students to postpone the class. I decided that I would make my way through the stormy weather just in case any of the students showed up. Remarkably, it turned out that practically all did. And since they did, I tried to conduct the class. However, the storm was increasing in ferocity and it was difficult to hear. We all agreed that it would be best to terminate the class early and hasten back to our homes before the weather conditions deteriorated even more. I will never forget that night and how dedicated the adults and adolescents were to come out in the storm; it was a highlight positive experience for me.

Providing Supplies to a Vietnamese Orphanage

Our unit established a relationship with a near-by Vietnamese orphanage. We would travel there on a regular basis and take excess food rations to distribute at the orphanage. This was a small service to provide, and our interacting with the orphans in unloading and taking the food supplies inside was very positive and rewarding. Again, I don’t know how important this was to improve the lives or prospects of the orphans, but it sure felt good to give this support to the orphanage. An unfortunate cost of any war is that parents are killed and the orphan population skyrockets in numbers. These orphans are part of the “collateral damage” of war that never get sufficient attention.

This experience left an imprint on me that I did not know at the time was as profound as it was. The reason I subsequently realized the impact is that when I later was stationed on Okinawa to work in Army Community Service (1969-71), I jumped at the opportunity to become (in my off-duty time as a private practitioner) a part-time inter-country adoptions worker for the HOLT Korean Adoption Program. There were many mixed-race and other orphans in Korea and Korea at that time was one of the few Asian countries willing to allow inter-country adoptions. This involved doing home assessments on American Military families interested in adopting Korean orphans and coordinating the adoption process with the HOLT Program in Korea, to include placement and follow-up visits post-placement. The satisfaction was bountiful to match orphans in desperate need of adoptive parents with interested and qualified American military families. And perhaps this was at least partially an outgrowth of my experience in Vietnam realizing how so many surviving and orphaned children there were.
The Roller Coaster of Being In a War Zone

Being a social work officer in Vietnam truly was an emotional roller coaster. Like most everyone else, I of course missed family thousands of miles away. And the only contact was writing and receiving letters that would have many weeks of delay involved. There always was the balancing act of sharing some of what was going on but consciously downplaying the dangers and horrors that were faced in a war zone. One extremely positive aspect of being in Vietnam was becoming immersed in a culture and with a people and land that I had had no realistic or meaningful experience with previously. There was something remarkably exhilarating being bombarded with sights and sounds and smells that were so remarkably different and interacting with a number—but not all—people who genuinely wanted us to be there and help them protect their freedom and way of life. This exhilaration was fueled by being in a war zone, where danger was potentially lurking around every bend in the road, and realizing that a number of the Vietnamese who appeared to be so friendly and supportive could well be Viet Cong or others who hated us and our presence.

And while the area of Nha Trang was a very well protected area and devoid of much direct combat, our medical mission was such that the war would come to us through the medical and psychiatric casualties that were medically flown in from throughout I and II Corps (the upper half of South Vietnam). It was a very schizophrenic existence to be stationed in a peaceful, very pro-Western city and yet having the war raging throughout Vietnam and treating medical casualties of the battles. I felt blessed not to be immersed in battles and having to kill the enemy, and being able to utilize my fledging social work skills to be of some help to casualties. And I loved the Vietnamese people. And death and maiming continued, and the Tet Offensive of 1968 (that happened a couple of months before I arrived) brought home to everyone that the war was not going anywhere nearly as well as our political and military leaders had been telling us it had been going. (Do troops ever get accurate news?)

And then I am on a plane after one year going “back to the world” on the Freedom Bird flight . . .

Back in the U.S. and Feeling Very Alienated

I arrived at my new duty station at Valley Forge General Hospital outside of Philadelphia. It was an idyllic country setting. And I was assigned as the Supervising Social Worker on the psychiatric ward, assessing and treating psychiatric patients who had been evacuated from both Asia and Europe. Now I was seeing what it was like on the “other end” of the medical evacuation chain—the receiving rather than the sending end.

However, I don’t like to admit this, but I was even more struck—indeed, profoundly so—by the fact that I felt very out of place, a stranger in my own country. It just did not feel right being back in the U.S. Now it was being in the U.S. that felt foreign and strange and I was the outsider looking in. My discomfort
was palpable and profound. This was not where I was supposed to be. No, I felt that I needed to be back in Asia—that felt much more comfortable and familiar to me than to be here, where people were all caught up in sports and what car to drive and busily living their lives while concomitantly seemingly blissfully unaware that every day there were people being killed and maimed in Vietnam—both Americans and Vietnamese. And so it is back home when a war is going on. And I missed the Vietnamese people and culture.

But, I knew that I did not want to go back to Vietnam; it was like, to go back again would be really pushing against the odds of making it through. But I didn’t want to be here, either. And so, I extended my active duty commitment by 18 months and was deployed to Okinawa—kind of halfway between America and Vietnam. I needed to be back in Asia—and I needed to not be here in the U.S. of A.

As it turned out, I had a fantastic 18 months on Okinawa, becoming very involved with the Okinawan people, establishing a big-brother program with International Social Service, teaching English to Ryukyan University students, working in the HOLT Korean Adoption Program and really liking my role at Army Community Service helping families of American military personnel—many of whose spouses were serving in Vietnam while their families were in Okinawa. And I felt that my experiences in Vietnam prepared me very well for this role.

And to make a longer story shorter, I loved my time in Okinawa but after 18 months, I felt that now I was more ready to leave the military and go back to the U.S.

**Lessons Learned**

There are many very important lessons that I learned regarding three different time periods: (1) in the year before I went to Vietnam, (2) from my psychiatric social work experiences during the Vietnam War, and (3) my post-war experiences with literally thousands of war veterans since during my 25-year career with the U.S. Department of Veterans Affairs and since (Scurfield, 2006).

**Lessons Learned in the Year Prior to Deployment**

The several pivotal experiences that I had in the year before arriving in Vietnam were critical events that contributed significantly to my understanding about war, its impact and healing from war trauma. To remind the reader, these included the young Marine psychiatric patient I was assigned at the Sepulveda VA during my second year MSW field placement, experiences during Medical Officers’ Basic Orientation course, the result of complaining about my duty assignment in El Paso and reactions of people around me when finding out that I had received orders for Vietnam, the Army turning down my request to attend Vietnamese language school, and the young physically disabled veteran who sat next to me on the plane as I was heading to Vietnam.

These several pivotal pre-Vietnam experiences helped me to realize many years post-Vietnam that it is a mistake
and a serious oversight to think that we can fully understand an active duty military or veterans war experience by focusing only on what happened during the war and afterwards. Rather, I learned that when doing assessments of war veteran clients, to make sure that I assessed their relatively immediate pre-war life context. Understanding their relatively immediate pre-war life context would provide vital clues as to what had been disrupted in their lives and what might be pivotal experiences pre-war that they carried with them into the war zone and that might significantly influence their war experiences.

**Lessons Learned During Deployment**

There were several lessons learned while immersed in the war.

*One of the first lessons learned was that it seemed just as likely that support troops could become psychiatric casualties as could direct combat troops.* It should be mentioned that there were perhaps 8 to 10 combat support troops in-country (those not engaged as their primary duty in carrying a weapon and seeking out and destroying the enemy, such as those involved primarily in such support services as food, supplies, transportation, medical, personnel services) for every direct combat troop. Unfortunately, it took civilian mental health and the VA decades to fully realize this fact, with an overemphasis on only giving credence to direct combat trauma and discounting or not even thinking about assessing the presence of non-direct combat stressors -- such as simply being in a war-zone and surrounded by the stress of never knowing if and when the enemy would attack, the stress deriving from sleep deprivation and exhaustion, the horror and for some the profound numbing/detachment from witnessing the maiming and deaths of American military personnel and Vietnamese civilians, or finding out about there being severe family problems or deaths of significant others back home.

*A second lesson learned was how different my experiences with and attitudes about the Vietnamese people (many of whom were higher educated, city folk and Catholics who vehemently and genuinely supported the U.S. military presence) deeply contrasted with the experiences and attitudes of many direct combat troops.* Many direct combat troops' experiences with Vietnamese were almost solely with rural villagers and with the Viet Cong (Vietnamese in the south who clandestinely opposed the Saigon government and U.S. Forces). Hence, direct combat troops oftentimes were in situations where they could not tell who were true friendly Vietnamese, versus those "caught in the middle" and trying to figure out how to survive, versus those who were intimidated by the Viet Cong to ally with the Viet Cong versus those who were totally sympathetic with the Viet Cong but pretended otherwise). And many such Vietnamese were the agents of death and maiming of fellow U.S. military. Hence, too many such combat troops (but certainly not all) generalized their hatred of enemy Vietnamese to a hatred of most all Vietnamese -- and treated them as sub-humans. I quickly realized how different our attitudes were and at the time found it very hard at the time to fully understand their hatred and dehumanizing behaviors to-
wards most Vietnamese.

And many of our hospital medical personnel, through seeing first-hand, day after day after day, the severely wounded and dying U.S. troops who were flown in for medical treatment, also developed hatred for the enemy—and then generalizing this negative attitude towards most any Vietnamese. Other hospital personnel were indifferent to the Vietnamese people. And there was a third, smaller group of hospital personnel with whom I shared what turned into a love and respect for the Vietnamese people, their culture, their strength and courage and dedication to their families’ welfare while faced with the almost impossible situation of trying to live a normal life in a war zone. And they would remain long after we Americans had completed our deployments and departed...

*It quickly became very clear that there was oftentimes a conflict when assessing a psychiatric casualty between what might be “in the best interests of the mental health of the individual Soldier” versus what was in the best interests of the Soldier’s military unit and the military mission. In other words, most any psychiatric casualty arguably would stand a better chance of healing from war trauma if he(or she) were evacuated Stateside rather than being returned to duty to face yet more war trauma. But the medical mission “to conserve the fighting strength” dictated returning psychiatric casualties to their duty stations (or reassignment in-country) except for those with the most compelling psychiatric instability.

*There were three basic categories of psychiatric casualties. One group was focused on getting better and returning to their unit ASAP, their primary focus on being back with their comrades and their comrades’ safety. A second group of psychiatric casualties was in great psychiatric distress and pain and preoccupied with their mental health and/or physical safety—to the point that they were a danger both to themselves and to their units. And there was a third group—troops who were faking or exaggerating their mental health issues and/or engaging in disruptive or criminal behaviors (not following or resisting orders, causing trouble in the unit with peers, etc.)—saying or doing seemingly anything for the sole purpose of getting out of Vietnam or getting reassigned to less dangerous duty. And at times it could be extremely difficult to discern who was a legitimate psychiatric casualty versus character logical—and of course the distinction between the two could be very blurred or overlapping. After all, who ever said that someone with a personality disorder, for example, could not also be suffering a legitimate traumatic reaction to war stressors? And this diagnostic and appropriate disposition (medical versus administrative) conundrum and issue is relevant to a number of veterans post-deployment since then and today.

**Lessons Learned After Return From Deployment**

The following lessons have been learned through a combination of applying my perspectives gained during deployment to Vietnam with the innumerable clinical and social advocacy experiences with over a thousand Vietnam veterans as well as with WW II, Korean, Persian Gulf, and
veterans of Iraq and Afghanistan.

*The irreplaceable and profound role of military peer relationships both during and following war. If there is one thing I have learned about war, it is how the welfare of one’s battle buddies is of paramount importance during deployment—even more important for most than carrying out the military mission. How one is perceived and accepted by one’s battle buddies is of paramount importance to the self-esteem of warriors and veterans. And how former battle buddies and fellow and sister veterans of war typically are by far the people that veterans are most likely to trust and believe can understand them and not prejudge and stigmatize them.

Unfortunately, the VA and other mental health organizations and facilities do not do enough to recognize and capitalize on this most-powerful resource—to prioritize strategies to foster and facilitate peer self-help networks among patients as a critical element within the provision of professional services (promoting self-help groups, buddy systems for suicide-prevention and relapse prevention, peer veterans to engage with new patients and clients and peer group treatment).

The Negative and Positive Polarity of Serving Our Country in War

The first and perhaps most salient two lessons learned are at first blush seemingly contradictory: that war, indeed, is injurious to both the mental and physical health of many combatants; and that a substantial majority of war veterans value more the positive aspects of their war experiences than the negative aspects. The injurious aspect is reflected in a number of studies that report that between 15% and over 30% of combatants suffer PTSD and other mental health issues that are related to their war experiences (i.e., Cozza, 2005; Kulka et al, 1990; Seal et al, 2005).

*The striking linear relationship between amount of exposure to war zone stressors and PTSD. Many studies reveal that the amount of exposure to war trauma bears a striking linear relationship to the development of PTSD and other mental health problems (Cozza, 2005). This is a quite critical finding in that extended lengths of deployments and multiple deployments have been characteristic of the wars in Iraq and Afghanistan and that such are of course highly associated with increased exposure to war zone stressors.

*The collective amnesia regarding the negative impact of war that resurfaces soon after every war has ended and the failure of our nation to fully honor its obligations to those who have served in harm’s way. Tragically, our nation as a whole (both government and the public) has repeatedly, and seemingly after every war, engaged in a profound denial and recognition of the negative impact of war on military personnel. How else to explain the recurring dynamic where our nation’s military and veterans’ medical facilities repeatedly do not prepare adequately in advance to be at the front end of the curve of the increased demand by returning military personnel for medical, mental health and readjustment resources? And where the benefits’ system related to military service is overwhelmed and unable to process without inexcusable lengthy delays the granting of necessary (and hard-earned!) service-related benefits?

If our nation truly were cognizant and ap-
precipitrous of the short and medium-length impact of war and deployment on military personnel, and the continuing longer-term impact on veterans years following their discharge from active duty, our federal medical, mental health and service-related benefits would be sufficiently addressed prior to when the increased demand for such services arises. But it has never been that way. There is a continuing catch-up that occurs in an attempt to lower the gap between available resources and the need—and it is continuing today in regards to too many veterans of Iraq and Afghanistan. This gap is inexcusable and furthers the suffering, stress, anger (if not rage), vocational displacement and alienation of many who have served in the military and gone into harm’s way.

*The powerful potency and duration of war trauma to persist over time. One World War II veteran that we treated in Hawaii in 1996 came in for the first time for treatment for his war-related PTSD at age 70. Outreach, community education and being vigilant regarding the possible presence of PTSD-related issues throughout the life cycle (for example, to build PTSD assessments as a routine element in services to geriatric populations) are essential if we are ever going to address such issues in a much more timely manner and not allow untold numbers of veterans suffering from PTSD to remain unidentified and untreated for their PTSD.

*The impact of racism in the military and towards civilian populations in the war zone and the importance of specifically assessing such. Over the years, the specific impact of racist language and attitudes and behaviors used in basic training and in the war zone, concomitantly with on-going racist experiences back home and in our country, has become quite evident— and is a factor typically avoided or minimized in assessing the impact of war and readjustment.

I became sensitized to this early on, and co-authored one of if not the first published writings that elucidated specific interview prompts to utilize with racial minority veterans that addressed their racial identity and race-related experiences (Scurfield & Blank, 1985; see also Loo, Singh, Scurfield & Kilaulano, 1998. For an elaborated model to assess race-related factors see Scurfield & MacKey, 2001). I also was co-investigator of the first research study on the impact of race-related stressors on Asian American Vietnam veterans and the distinctive race-related stressors they experienced. Perhaps the most telling finding was that exposure to such race-related stressors was more predictive than exposure to combat stressors to the presence of war-related PTSD (Loo et al, 2001). And I have witnessed where racism and denigration of local cultures is a not uncommon by-product of serving in Iraq and Afghanistan.

*The remarkable courage and strength that most war survivors manifest during exposure to war trauma and in the aftermath over the ensuing months, years and decades. The more that a veteran emphasizes how traumatic his or her war experiences were, and how difficult his or her post-war readjustment has been, the more I emphasize directly to the veteran how much this fact proves how strong and courageous the surviving Service Member or veteran is to have survived and not be totally psychotic or dead by now.

*The very special and profound relationship between warriors and their country that
permeates all aspects of serving our country and in the post-war and post-deployment and readjustment that follows.

*Our government sends us to war, Our military uses us in war, and Our country forgets us after war.*  
(Scurfield, 2006)

There is a vital relevance of attending to the relationship between veteran and country/society as a legitimate element of the therapeutic relationship. Indeed, there is the perspective that post-war readjustment can only occur in the context of the community (Shay, 2002). Sherrill Valdes (2013) goes one step further: the community must be involved for true healing to occur and it is a reciprocal relationship: *It takes a village to heal a warrior, and it takes the warrior to teach the village how.* (Valdes, 2013).

As mentioned earlier, the sacred covenant that is promised to Service Members and their families in return for their service to our country is a profound commitment. And to the extent that veterans have current issues with how well or if at all they perceived society fulfilling this sacred covenant, their relationship with their community, country and government must be meaningfully assessed and attended to as part of therapeutic assessments and interventions. *In other words, relationship with country is a legitimate and profound element to consider and actively assess and intervene regarding in therapeutic activities and in community activities and events that recognize and honor the service and sacrifice among military personnel, veterans of current and past wars, and the families of all who have served their country.*

For most -- but not all -- veterans traumatized by their war experiences, healing efforts require a “therapeutic re-exposure to an aspect of the original trauma in some way” (Fairbank & Nicholson, 1987). Almost all recognized effective therapeutic approaches to healing war trauma include an aspect of exposure in some way to the original trauma experience. At the most basic, this involves remembering and talking about the original trauma in some fashion. Cognitive-behavioral manualized approaches to trauma treatment proceed to systematized and repetitive strategies of imaginable (thinking about) and/or in-vivo (viewing, listening to and/or viewing pictures of, listening to video-taped recordings of talking about the trauma, participating in in-action activities (going to a military base, flying in a military helicopter or riding in a military vehicle, returning to a former battlefield, etc.) that are reminiscent of the original trauma in some way.

*Conversely, for a number of war veterans traumatized by their war experiences, healing can involve activities therapeutic in nature but that do not require a “trauma exposure” element (Scurfield & Platoni, 2012, 2013). For example, there are structured therapeutic activities that do not necessarily specifically talk about or raise questions about one’s military experiences, but the very activity in some way helps to face trauma-related injuries (such as fear, damaged self-esteem, etc.) and heal psychic and emotional wounds of war (equine- and canine-assisted therapy, scuba diving (Cortani, 2013; Buckley & Raulerson, 2013), cranial electrotherapy stimulation (Kirsch, 2013) and mindful-awareness practices (Mizuki, 2013).

*For a number of veterans, a valid and im-
pactful healing activity is to engage in advocacy efforts—but not necessarily in war- or veteran-related activities (Zacchea, 2013). It is important to note that healing war trauma must not be restricted to typical, talking-only therapy that is conducted entirely within the four walls of an office. In this regard, it must be understood that it is a very legitimate avenue of healing for a number of veterans to be facilitated to participate in selected areas of social and political advocacy. In other words, that the very involvement in advocacy efforts can be very therapeutic and healing.

On the other hand, it is equally important to recognize that for a number of veterans such advocacy efforts should involve advocacy that is not veteran or active duty military related in that such activity can become all consuming and maintain the veteran in preoccupation with war-related symptoms and issues. For such veterans, advocacy in activities that do not involve military or veteran issues, such as working for child or animal rights, can be most beneficial to being able to move beyond a preoccupation with veteran-only issues.

*All ex-addicts are not effective addiction counselors—nor are all veterans necessarily effective counselors with other veterans. And yet, a number of veterans can be extremely helpful and effective peer counselors and support persons for other veterans—such as veterans of the Vietnam era becoming mentors and support for struggling younger veterans of Iraq and Afghanistan.

*There are many more salient similarities than there are differences in regards to the impact of war trauma of different wars and eras. Being given that sacred covenant by our government to serve in harm’s way and in return being promised related services and benefits, being involved in killing and being in harm’s way, being immersed in death and maiming of both military personnel and of civilians—especially innocent women and children and the elderly, being deployed far away from home and from loved ones—all of these are the most profound similarities regardless of the specific war or era -- that have a very similar, direct and telling impact on those who serve in uniform. Conversely, there are unique aspects of different eras of service that can have more idiosyncratic impact—such as engagement in an insurgent or guerilla war in which the enemy are not readily identifiable and employ brutal tactics that blur the line of western-conceived ideas of what are appropriate rules of engagement”.

Well, when there are no rules, anything goes—to include civilians becoming primary targets and casualties—but yet we continue to abide by certain rules of engagement. The results can be devastating and deadly and lead to enormous internal conflicts because of deaths and wounding that occur as a result of this disparity between friendly and enemy forces. Also, if a particular war is strongly endorsed and personally supported by our citizens (i.e., WW I, WW II), versus out of sight and mind (Korean War and the Afghanistan War prior to about 2008), versus extremely mixed attitudes about (Iraq and Afghanistan Wars) versus vehemently opposed by a significant portion of our population (Vietnam), there is a corresponding profound impact on combatants. This is because too much of the civilian populace inevitably confuses the warrior with the war—and both tend to be treated the same.
*There is one profound difference between exposure to war trauma versus exposure to civilian trauma. Military personnel are sanctioned by our country to be that which otherwise is condemned by our society and treated as anathema – to become perpetrators of killing and maiming of other human beings—in the name of service to our country. And this profound sanctioned role brings with it enormous inner conflict within many military personnel—if not at the time of deployment, increasingly so at some time following return from deployment. And to reconcile having been a sanctioned perpetrator carries with it enormous challenges to the recovery process that almost no civilian trauma survivors have to face (one notable civilian exception—law enforcement officers).

*In contrast to the inclusionary symptoms for a diagnosis of PTSD prior to DSM-5 in 2014, extensive clinical experiences indicates that issues of exaggerated responsibility and blame for what happened regarding war trauma are among the most, salient post-trauma symptoms of war zone veterans (Scurfield, 2006; Scurfield, Platoni & Rabb, 2013; Scurfield & Platoni, 2013). And many such issues are directly related to the preceding point in which veterans are sanctioned by our society to go into harm’s way with one’s brother and sister comrades-in-arms and become agents of death and maiming.

It has been a privilege to serve our country in uniform during the Vietnam era and four years of active duty, and to continue to serve our nation’s military, veterans and their families during my subsequent 25-year social work career with the VA, in various activities while a professor of social work at the University of Southern Mississippi and since as a 2011 as a licensed clinical social worker in private practice where my clients include active duty military, veterans and their family members.

Our profession, and our nation, have much still to learn if we are to ever more fully repay and help to provide an optimal extent of healing commensurate to even a fraction of the sacrifices that so many have given, both in- and out-of-uniform, and to their families. I hope that this writing provides at least some fruitful thoughts as what that sacrifice is all about and some idea of what is needed to do justice to those who have served and to their families who also have served.
REFERENCES


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