

# War and Natural Disasters: Post-traumatic Stress and Combat Operational Stress

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I’m appreciative that the Navy has invited me—in spite of the fact that I am an Army veteran ☺ ---to this extremely important conference in support of our nation’s finest who serve their nation in harm’s way and their families. On the other hand, I do feel at least somewhat like a Navy spouse having been married to Margaret, Director, Seabee Fleet & Family, in Gulfport, MS, who has worked with the Navy for over 20 years and bleeds Navy blue. Yes, I have almost become accustomed to being introduced as “Margaret’s husband.” ☺

I am truly humbled and honored to have been asked to speak with y’all here today. If anything I say helps even one of our nation’s finest or his or her family, then my time with you has been worthwhile.

## **HURRICANE KATRINA**

Before talking about war and its impact, which is the primary focus of my presentation today, I would be remiss not to briefly mention August 29<sup>th</sup>, the two-year anniversary of Hurricane Katrina---in many ways the most devastating natural disaster in the history of the United States. Just a few significant facts about the destruction caused by Katrina in the state of Mississippi (Scurfield, 2006a):

- More than 235 confirmed deaths and 68 missing as of December 7, 2005
- 68,700 homes and businesses destroyed, 65,000 sustained major damage, and 60% of the forests in the coastal communities destroyed along with much of the shipping and fishing industry
- There was a 34 feet high storm-surge from Katrina in western Mississippi that was propelled inland as far as 10 miles or so from the coast, through the myriad rivers and bayous, severely damaging or destroying homes and communities that had never previously been flooded by storm surges. And numerous hurricane-level winds and tornadoes swept through central and north central areas of the state.

- About 350 buildings listed in the National Register of Historic Places were destroyed, along with most of the evidence of 300 years of Mississippi Gulf Coast history. This makes Katrina the worst historic preservation disaster in our nation's history.
- As of March 13, 2006, about 100,000 Mississippians were living in FEMA trailers and hundreds of other displaced residents not eligible for FEMA trailers. As of last week, some 17,200 FEMA trailers were still occupied.

Perhaps the two most problematic areas facing the Mississippi Gulf Coast are (1) the remarkable absence of affordable housing—rental units destroyed and not rebuilt, and rents skyrocketed where they are available, coupled with (2) insurance nightmares, to include thousands of unresolved lawsuits and disputes, marked increases in insurance rates, etc.

The time-lag for rebuilding destroyed homes and buildings is daunting. It took more than a decade for the 28,000 homes in Florida wrecked in 1992 by Hurricane Andrew to be rebuilt. And Mississippi alone has some four-times that number of homes to be rebuilt.

It is important to note that one of the most effective ways to cope with such an unprecedented tragedy is the use of humor. For example, jokes about the bungled federal response abounded.

- Do you know how to tell the FEMA Mardi Gras float? It's the one that came three days after the parade ended.
- Do you know what the FEMA evacuation plan was? [I will clean up the language here.] It was on many t-shirts on the Gulf Coast; "Run, mother-f, run."

And two days after Katrina when I found my university office and building for our department destroyed, with ruined contents scattered everywhere, I just had to sit on my colleague's small couch that was perched in the middle of the debris, pick up a water-logged book, and look studious, as my wife and daughter took a photograph of the sight. If I had not done that, I probably would have broken down sobbing at the irretrievable loss of 30 years of my professional life's records, data from three research studies, et al. And my loss paled in comparison to so many others.

## **CONNECTIONS BETWEEN HURRICANE KATRINA AND WAR**

The connections between Hurricane Katrina and the military are quite substantial. Firstly, the Seabees in particular were extraordinarily helpful in post-Katrina debris removal and reconstruction efforts. And many FFSC staff volunteers rotated through Gulfport over months to assist the overwhelmed Gulfport FFSC staff in their services to the military community.

Furthermore, as a Vietnam veteran I am acutely aware that there are significant parallel

experiences and reactions post-Katrina and post-war that triggered war-related symptoms and issues in a number of active duty personnel and veterans (Scurfield, 2006a, b). These included:

- The physical devastation—markedly similar to what one might have seen in a war zone. Indeed, one combat vet described Katrina’s destruction as “just like a war zone, except there was no gunfire.”
- The overwhelming smells—from gasoline and generators to the terrible stench from the debris, storm surge muck and rotting organic materials strewn over miles.
- The marked heat and humidity—oppressive and omnipresent;
- The marked disorientation—returning (from war or after Katrina) home to a world that was now so unfamiliar and strange. In fact, I still, two years later, find myself getting lost and missing turns driving down Highway 90 due to the destruction of almost all familiar landmarks.
- Being forgotten—the powerful and painful reminder of how forgotten many war veterans have felt and feel is now intertwined post-Katrina with how many Mississippians (as well as Louisiana survivors of Hurricane Rita) have discovered how forgotten we seem to have become—versus the media coverage of New Orleans—and we do not begrudge New Orleans receiving all the attention and assistance possible as the destruction there is extraordinary. Is “out-of-sight” also now “out-of-mind” for much of the rest of the country and our national officials? Oh, yes, too many of our nation’s war veterans and their families know *exactly* how that feels.
- Be in Iraq and Afghanistan—or home on the Gulf Coast? There were a number of letters and e-mails in the local newspaper about the anguish and agony of various Mississippi active duty personnel being deployed to or who were overseas at the same time that their own families and communities were suffering terribly from Katrina.
- The financial costs of post-Katrina recovery and the federal response. How can we possibly adequately fund and wage a war overseas and rebuild an entire nation while doing justice to our own citizens in Katrina-ravaged Mississippi and Louisiana (and some in Alabama and Texas)? As one protestor said, “Make levees, not war.” Yes, the clash of national priorities is an extreme challenge.
- There is great concern that much of our National Guard units and their equipment and their energy have been depleted by being overseas, as well as reserve units. Has this compromised their ability to be able to respond adequately to a new natural disaster that might befall the United States? Can our military units really do justice to serving the OEF/OIF mission and the historic missions back home?

## **WAR-RELATED POST-TRAUMATIC STRESS AND COMBAT OPERATIONAL STRESS**

I want to spend the remainder of my first presentation discussing war-related post-traumatic stress and combat operational stress. I especially want to give y'all a historical context to the extent, duration and nature of the human impact of serving in wars.

I had two pivotal experiences prior to going to Vietnam that have had a life-long impact on my understanding of war-related combat stress and post-traumatic stress:

Firstly, when I received my commission as a 2<sup>nd</sup> lieutenant in the Medical Service Corps in June, 1965, I obtained a two-year deferment to get my MSW degree—just up the interstate at the University of Southern California. During my second year internship at the Sepulveda VA Hospital, I was assigned a young former Marine on the locked psychiatric ward who was diagnosed with schizophrenia. It turns out that he had suffered a psychotic break while in Vietnam and had been medically evacuated back to the U.S., and eventually discharged and transferred to the VA hospital system. And, by the way, it is important to note that it is very rare for combatants to break down in the middle of battle. Rather, typically such breakdowns occur later—days or weeks later while in the war zone--or months, years or even decades later post-war. Every now and then, this young former marine would have periods of lucidity; at one such time, with tears welling in his eyes, he looked directly at me and said, “Ray, can you please help me get back to Vietnam? I deserted my buddies, and I have to go back . . . to prove that I am a man.”

My heart sank; I knew this young marine would never be back on active duty, let alone sent back to Vietnam. And I had my first critical lessons about war and combatants. In combat, nothing is more important than the bonds forged in danger and blood among comrades-in-arms, and doing your part to protect the welfare of the men and women in your unit—nothing. And if something happens about which you feel that you did not do your part, or that you felt you did not do it perfectly—and, of course, since no one is perfect---mistakes, errors in split-second judgment, and events beyond your control do occur that do have tragic consequences and comrades are maimed or killed—this can haunt you for a life-time. [And even when, logically and reality-wise, trauma occurs that is literally beyond your control to prevent, you still may well feel responsible.] And extraordinarily deep-seated guilt and shame can become unwanted companions that can haunt you for decades.

By the way, I have found that war-related guilt and issues of responsibility and blame are perhaps the most frequent and disturbing significant issues that face many combatants and veterans. To address such issues, I have developed a cognitive-reframing strategy and technique, “determining the percentages of responsibility,” that is described in one of the handouts in your packet. [This technique also is described in detail in two clinical case transcripts in my third war trauma book (Scurfield, 2006b)]. I have found this technique to be

remarkably palliative in addressing such issues in literally hundreds of war zone veterans I have treated from WW II onward.

The second profound pre-war experience occurred after I boarded a civilian plane in Pittsburgh, in March, 1968, on my way to Vietnam. I was in my uniform with my 2<sup>nd</sup> lieutenant's shiny single brass insignia (also known as "butter bar")--which I came to learn was the absolutely lowest rank one could possibly have in the military—indeed, much lower than a Private. And the plane filled up, although the aisle seat next to me was vacant—and I thought, "Wow, I get to stretch out, relax and not have to talk to anyone." And then, appearing at the front entry to the airplane entered the last passenger, a Vietnam veteran—obvious by his veteran's garb—and the fact that he had a patch over his eye and had prostheses where his legs used to be, walking with two forearm crutches, ever so slowly down the aisle. And as he got closer, I realized that he was going to sit next to me! And he did. And I was awkward, saying hello and then becoming self-absorbed in my own thoughts about the irony of being on my way to Vietnam and my own fantasies about being wounded.

And a little later, this vet started talking to me. I distinctly remember to this day one particular part of the conversation. "Sir, it sure was hard going home for the first time from the hospital on convalescent leave---some of my high school buddies told me that it was shame that 'I had to lose my eye and legs for nothing.' That really hurt . . ." And, after a pause, he said, "but you know, sir, I'm the lucky one—no one else in my foxhole survived."

. . . And I was struck by how terribly hurtful comments from others can be when interacting with military personnel returned from deployment. But also I was amazed at how this so severely wounded and disabled—but not handicapped---combatant was attempting to put a positive onto something so tragic. And I pray that he and his family feel that way today---counting his blessings and not cursing his severely damaged body.

[The profound meshing together and imprinting in veterans' psyche and bodies of both the horrific lows, coupled with the remarkable highs is part of the legacy of war that all veterans carry with them for a lifetime. And I have written about how this remarkable intertwining of the polar highs along with the unforgettable traumatic memories is a powerful dynamic that prevents many vets from being able or willing to let go of the lows—because they want to keep the highs. And there are important clinical strategies to address this profound issue that I have written about (Scurfield, 2004).

I then arrived in Vietnam, seven months after receiving my MSW degree, and served 12 months on one of the Army's two psychiatric teams. There isn't time to discuss that experience here. However, I would like to mention that I sent a copy of the first book in my war trauma trilogy, which was about my Vietnam experience and the ensuing 20 years, to Army Lt. Col

psychologist, Kathy Platoni, while she was deployed with a Combat Stress Control unit in Iraq in 2005. Kathy, who has since become a good friend and dearly valued colleague, told me that she must have underlined at least half of my book---and was amazed that I was describing exactly what she and the troops she was seeing in Iraq were experiencing now—almost 40 years after Vietnam!

I might also mention that one of the most memorable experiences I had when I returned with three Vietnam veterans to a peace-time Vietnam as part of a study-abroad course with the University of Southern Mississippi in 2000 occurred on a very congested street in a city in Vietnam (Scurfield et al, 2003; Scurfield, 2006C). Coming towards me in the midst of a sea of Vietnamese crowding the streets was a young adult male Vietnamese who was wearing a baseball cap with the inscription (in English), “I know Jack Shit.” . . . It struck me a little later that this could have been our motto on our psych team in Vietnam. Yes, we did not really know practically anything about war-related acute stress, but we did as all good military personnel do in every war—we were dedicated to do the very best that we could, under the circumstances.

I also realized that while on the Army psych team treating acute psychiatric casualties, that in essence we were faced with a psychiatric paradox, which I write about in my war trauma trilogy. We had to decide—was the combatant psych casualty too sane to be evacuated back to the U.S.—or too crazy to be sent back to killing? And that is exactly the decision that must be made today by COS units in the Iraq/Afghanistan Wars.

## **VETERANS FOR PEACE CONFERENCE AND SUPPORTING OUR TROOPS**

I just have to mention, before going further, that being here today feels a little surreal, in that just two weeks ago in St. Louis I was making two presentations at the Veterans for Peace Annual Convention where I had flashes of being back in the 1960’s protest movement—with a major difference. I must tell you that it was my experience that even many of those *against the war* in Iraq are trying to differentiate that they do support our troops; indeed the Military Families Speak Out organization’s motto is” support our troop, bring them home now.”

Of course, there are those who would counter that this is an inherently conflictual message to give to our troops. On the other hand, even that message is in vivid contrast to the Vietnam War, where anti-war protestors “confused the warrior with the war” and denigrated and demeaned and discriminated against returning Vietnam veterans. We were like pariahs in our own country, strangers in a strange land, spit upon and called baby killers and dope addicts, and many were shamed into hiding their veteran identities from civilians [Note: one conference participant here came up to me and shared that in his coming home from Vietnam, his unit was met by screaming protestors at the airport and someone threw animal blood on him—a vivid

event that remains seared into his memory as he rushed into the airport bathroom to try to scrub off the blood . . . ]. I pray that no era of U.S. veterans ever again is tarnished and tainted by elements of our society with such a heavy weight to bear—which is on top of the cost of serving in harm’s way.

## **“POLITICS” AND WAR**

By the way, I have been coached several times by my wife, Margaret, not to make any “political” comments, and this absolutely is not the place for such comments. Indeed, I want to emphasize that in many ways it does not matter whether you are vigorously pro-the Iraq War, vehemently anti the Iraq War, or somewhere in-between—there is, regardless, a profound and oftentimes indelible imprint from serving in a war zone. And this imprint is due mainly to what are the most profound universalities that transcend all wars and eras of service.

At this point, I wanted to show a brief (10 minute) video entitled *Inside the Surge*. It is a documentary by a British filmmaker, Sean Smith, who was embedded with a U.S. military unit in Iraq for two months. This video offers a brief window into the realities of daily life in a war zone. This video provides a meaningful reality-check about what is the context of war time deployment that is the theme of this conference and the context in which PTSD/Combat Operational Stress” is embedded.

I do want to also mention that there are some strong “political” comments expressed by some of the military personnel near the end of the video. Whether you or I agree or not with such political expressions is not really important; what is important is to grasp that what you see and hear in these 10 minutes is a slice of the brutal reality that many combatants, as well as Iraqi civilians, face day after day after day after day. And try to put yourselves in the shoes of these valiant men and women, American and Iraqi alike, and imagine how such experiences, multiplied many times over, can impact those who are exposed to such experiences.

[Unfortunately, the video “Inside the Surge” did not arrive in time from Great Britain. However, you can view this video by doing a Web search on “Inside the Surge”, which I strongly advise you to do.]

## **THE UNIVERSALITIES OF WAR AND THE ENDURING AND PROFOND IMPACT—OF ALL WARS**

When a former combatant, or a veteran, or a mental health professional, or any so-called expert, tells you that such war zone experiences have had no markedly enduring impact on those who

have been there—the response should be, pardon my French, “bull-shit.” Combat always has an enduring impact—not necessarily post traumatic stress disorder---but always a markedly enduring impact on combatants.

It is critical to note that many experts, politicians and others, to include combatants themselves, will go out of their way to emphasize how different and how unique this current war is from previous wars. And of course, there are differences in different wars. However, over the decades of doing clinical work with over a thousand veterans and their families from WW II onward, I have become much more impressed with the universalities that transcend all wars and eras.

The most fundamental universality of war is that our country sends us into harms way and sanctions us to be perpetrators to kill and maim when necessary, and to be killed and maimed, and to put our comrades at risk for the same, and to put civilians in the country in which we are waging war at the same risk. And it is what men and women have to do to be able to function and survive day-after-day, week-after-week, month-after month and perhaps year-after-year in such a milieu that is brought home and into the families and into our communities. [I will be talking more about this in the clinical large-group combat operational stress workshop later this morning.]

A second and profound universality of war that has been documented in numerous studies from WW II through OEF and OIF is that the most powerful predictor of whether troops will develop post-traumatic stress is the amount of exposure to combat conditions. And current deployment patterns where many troops are required to extend their deployments, or must go back on second and multiple re-deployments, thus puts them at the highest risk to ultimately develop mental health problems.

This fact of the salient role of exposure (see also Cozza, 2003) is confirmed by recent Army surveys that indicate that those who have gone back on a second deployment have higher rates of mental health problems. By the way, perhaps the most troubling combat-related incidents that come with increased exposure, based on my decades of clinical work and various studies, include:

- being wounded
- witnessing comrades-in-arms being maimed or killed
- feeling somehow responsible for the deaths of maiming of fellow and sister comrades-in-arms
- being involved in the “unnecessary” or “mistaken” killing and maiming of civilians, especially women, children and elderly.

And the emotional wounds that accompany physical wounds are often obscured by the natural tendency for everyone involved—medical providers, the wounded veterans themselves and their families—to focus on physical recovery . . . An entire chapter in my second book was co-authored by my good friend, Steve Tice, who was hit with a rocket-propelled grenade at Hamburger Hill and describes many of the important traumatic experiences that those wounded in battle face from the moment they are wounded back through treatment at a stateside hospital. (Scurfield, 2006c).

Of course, for a number of troops, exposure to one or two singularly traumatic events or experiences, regardless of how long deployed, can be deeply impactful for years or decades. Indeed, it is my experience that even when vets have been exposed to innumerable tragic events in the war-zone, almost always there are one or two singularly impactful experiences that stand out above all the rest. And it is uncovering and fully addressing those one or two singularly unforgettable, traumatic experiences that oftentimes is the key to helping to heal from unresolved war-related issues.

Another important point. Oftentimes I have been asked, “Well, what about W II veterans, or Korean War veterans? They don’t seem to have had anywhere near the post-war problems that Vietnam vets had. Why did they do so well?” This is an extremely important question—because, you see, the reality is that there is absolutely no factual evidence whatsoever as to the national prevalence of post-traumatic stress or combat stress or mental health problems among WW II vets following WWII, nor of Korean War veterans. Indeed, there is factual evidence concerning the national prevalence rates of PTSD or mental health problems among only ONE era of veterans—Vietnam.

Yes, the National Vietnam Veterans Resocialization Study (Kulka et al, 1990) (that I was the chair of the VA Headquarters committee that drafted the RFP and reviewed the research groups for this study) was the first and remains the ONLY national psychiatric epidemiological study of veterans of ANY war. Hence, any figures or impressions you hear about WWII vets, Korean War vets, etc., are impressions only. And most are based only on generalizations of studies of clinical populations of veterans—not a national randomized sample that is required for accurate prevalence data.

I wish I had a nickel for every time I have given a presentation on Vietnam (or later) wars and describing combat stress and PTSD, how many time afterwards someone would come up to me and say one of two things: (1 )“You just described exactly my father (or my uncle, or my brother) who served in WW II or in Korea;” or (2) “My father (or uncle or brother WW II or Korean War vet) only started talking about having serious troubling memories from his war experience in the last years of his life . . .”

As a side-note, a common lay-person's expression to describe a number of WW II vets after the war was "nervous from the service."

There is one 20-year follow-up study of WW II and Korean War vets by Archibald & Tuddenham (1965) published in the *Archives of General Psychiatry* that is particularly revealing). To quote one of the summary conclusions:

"The data presented above make it clear that tension and anxiety reactions still characterize these combat patients two decades after the [combat] events which traumatized them. While the man in the street, and some psychiatrists, are inclined to urge such patients to "forget it," these particular veterans cannot blot out their painful memories. The passage of time, even after two decades, has not sufficed to free them of their symptoms. Indeed, there is a distinct possibility that changes incident to age are exacerbating their problems and reducing their power to cope with the stresses of civilian life."

Six years after the study by Archibald and Tuddenham was published, I had a parallel clinical experience. In 1971 I co-led the planning process to establish the first methadone treatment program at the Brentwood VA Medical Center in West Los Angeles. This program was being established in response to the many studies and reports that drug abuse problems were rampant among Vietnam veterans.

Well, when we opened the doors to this clinic, we were shocked to find that we were flooded, not with Vietnam veterans, but with WWII and Korean War veterans! Because, of course, substance use and abuse in one of the most common ways that veterans use to try to detach and numb themselves from unresolved war trauma.

Finally, another 20-year follow-up study, this one by Solomon and Mikulincer published in the *American Journal of Psychiatry* (2006) concerning Israeli combatants, reported findings very consistent with Archibald & Tuddenham's findings from 40 years earlier:

- 52% of Israeli combatants who were diagnosed with combat stress reaction during the 1982 Lebanon War reported full-blown PTSD 20 years later, as did fully 26% of Israeli combatants who had not been identified as combat stress reaction casualties during the Lebanon War.
- Indeed, 20 years later there was a "delayed" onset of war-related PTSD in 16.1% of combat stress reaction casualties and in 23.8% of non-CSR casualties! [Please note that this is one reason why the acute psych casualty rate *always* is less than longer-term rates.]

The bottom-line conclusions by Solomon & Mikulincer include: “these findings suggest that the detrimental effects of combat are deep and enduring” and “. . . the exacerbating effects of aging reawaken past traumatic wounds . . .”

## **THE NEGATIVE AND POSITIVE IMPACT OF WAR AND OTHER UNLEARNED LESSONS**

I would be remiss not to mention that I don’t want the attention being paid to “negative” impact of war to obscure the fact that, clearly a substantial majority of our nation’s veterans have been much more positively impacted by their war and active duty experiences than they have been negatively impacted—pride, enhanced patriotism, convictions, strength, courage, ability to function well under severe stress, etc. Conversely, a substantial minority has suffered at least as much negatively, if not more than benefited positively. Indeed, the figures from various studies over the decades indicate that between 15% and over 30% have experienced serious post-traumatic stress and other mental health problems.

Another unlearned lesson involves how the troops and veterans themselves who are having problems oftentimes are blamed for having their problems--rather than the war being the primary explanatory etiological factor. In other words, it is not uncommon that military and civilian mental health practitioners oftentimes state and believe that the deployed or returned troops who are having problems are problematic people and the war has had little to do with their problems! What is the unfortunate (and false) message here? The message is that it is not the war that is an important factor in their current problems. This is a profound unlearned lesson—that war itself can be and often is (although certainly not always) the most important etiological factor in understanding current presenting problems.

Interestingly, two of the most common explanations given by mental health experts about why so many Vietnam veterans were having so many post-war problems were (1) that we were “a troubled, angry, rebellious generation” (I guess I could be an example of this stereotype!), and (2) because we were so young when we had been deployed—19.2 being the average age of a Vietnam combatant.

Ironically, guess what is being used today as an explanation as to why so many Iraq veterans are having mental health problems? It is because so many are in the reserves and guard units and are much older—thus having their established lives disrupted! So, is it younger, or older, vets who are most susceptible to having war and post-war related mental health problems? How about—it can be most anyone who is exposed to enough combat trauma and stress!

This dynamic is interrelated to another unlearned lesson: the acute psychiatric casualty rate during war ALWAYS is lower than the longer-term psychiatric casualty rate. For example, near the end of the Vietnam War military psychiatry proudly proclaimed that it was highly successful in Vietnam—the psych casualty rate in-Vietnam was ½ that of Korea and that was ½ of WWII. But, then there was an explosion of mental health problems years and decades later in which 15.2% of Vietnam veterans had full-blown PTSD and another 11.1% had partial war-related PTSD (Kulka et al, 1990).

The politics surrounding every war are extremely important for a couple of reasons. Is the country united behind the current war, or is our society divided within. And if divided, that typically evolves into hardened positions of being “pro-this-war” versus “anti-this-war.” This is extremely important for at least two reasons:

- it impacts deeply on how our deployed and returning troops are treated and received;
- it impacts on the internal thinking and feelings of the individual member of the Armed Forces. If you believe strongly in the merits and moral rightness of this war you are fighting in, that belief can help to sustain you through the horrors you will experience and must commit and witness while deployed. Conversely, if while you are deployed, or sometime after returning from deployment, you become against this war, or are or become extremely ambivalent about its rightness, this can be devastating to one’s own rationalizations about how you feel about what you had to do to survive.

And, realistically, while on active duty and a member of the military community, there is a strong tendency for both war trauma issues as well as “political” issues, especially against the current war, to be suppressed or not discussed openly. And such issues might be at the heart of some of the inner turmoil being experienced by some of our troops.

The challenges are:

- Can you be someone whose own strong feelings and issues about the current war make it difficult for a troubled vet to be willing to talk to you about his or her deep-seated issues?
- Does your attitude impede or facilitate deployed or returned troops being willing to talk about that which is hurting them deeply and that they must sort out in their own minds and hearts.

## **PTSD VERSUS CSR/COS VERSUS PTS**

These terms have really critical distinctions that cannot be underestimated. Firstly, the nature of “PTSD” as a diagnosis is such that it is by far the exception rather than the rule that someone

“only” has PTSD, period. No, the prevailing rule is that you might have PTSD, and another anxiety disorder, and a possible substance use disorder, and a mood disorder, etc.

It is important to note that PTSD has become, in effect, the Purple Heart for non-physical wounds. If you believe that you have been damaged mentally, emotionally, socially and/or spiritually by the war, just about the only way that you can receive service compensation or recognition of such is with a PTSD diagnosis! “PTSD” has become, in effect, a lay-person’s term used to describe to being damaged (other than physically) by the war—and the fact that PTSD actually is a psychiatric disorder has become blurred or obscured. For example, I was requested to provide some editing input on two recent information books prepared for veterans and their families. And both booklets/pamphlets had the phrase in them that “PTSD is not a psychiatric disorder.” Wrong. PTSD is a psychiatric disorder; PTS (post-traumatic stress), CSR and COS are not.

I totally agree with the military practice to talk about “combat stress reactions” or “combat operational stress” rather than about PTSD. If we really went by the actual DSM-IV-TR criteria for a PTSD diagnosis while seeing troops in a war-zone—we would have epidemic numbers of psychiatric casualties. Absolutely no doubt about it.

One reason is that the DSM does not do a very good job in differentiating between a “normal” and a “disordered” response to trauma. In other words, many who are experiencing what could be considered within a normal range of response to trauma are inappropriately labeled as having a psychiatric dis-order! This is partly because many of the core psychiatric symptoms of PTSD actually also describe common functional and coping behaviors in a war-zone (Scurfield, 2004, 2006b):

- Detaching from or numbing ones emotions
- Denying or minimizing the horror of what one is seeing and experiencing
- Hyper-vigilance
- Exaggerated startle response
- Experiencing the environment as surreal. [Duh, isn’t this what the heck a war-zone is!!!]

Yes, the above are both official DSM symptoms of PTSD—and common, functional coping behaviors during war! And so, the catch-22 is that we too often are labeling normal and expectable responses to the trauma of war as a psychiatric disorder! No, this is part of the human cost of going into harm’s way to serve our country, and in most cases is not a psychiatric disorder *per se*. But, unfortunately, the service-connection compensation system requires a psychiatric disorder diagnosis to warrant receiving compensation for damage that is not

physical in nature—and you are, in effect, paid to remain “sick” and financially penalized if you improve or become “better” in mental health terms. This is a terrible quandary and practice.

To me, as a clinician, it is irrelevant if someone has PTSD or PTS. What is most critical is—what is the impact of combat or war on this person, period?

Indeed, I suggest that the most important red flag to screen for possible war-related PTS is not even a symptom of PTSD in the DSM:

- Does the vet’s significant other say: “He or she is really a different person since returning from deployment”? Or, “The war changed him (her).”
- Or, the vet says something similar: “I am not the same person I was before I went.”

Of course, if there is one DSM PTSD symptom that is ubiquitous among psych casualties, it is sleep disturbance.

## **IMPORTANT “UNIQUE” VERSUS UNIVERSALITIES OF OEF/OIF AND THE VIETNAM WAR**

It is important to mention the powerful role that military training and combat world realities of “dehumanizing the enemy” play—in all wars. During the Vietnam War, we were inculcated in basic training—and it was reinforced daily in Vietnam—the enemy was called “gooks, chinks, slopes, dinks, slant-eyes, Charlie.”

And what is the enemy in Iraq/Afghanistan referred to today? Hajji’s, towel-heads, and a particularly heinous slur that also reflects racism towards minority Americans among those who use it—sand-niggers. What does such terminology and thinking do? It helps you to not consider the enemy as human beings like we are—they are less than us, bad people, not really humans like us with morals, beliefs, values, etc. And that makes it easier to kill them—and to live with yourself afterwards. In VN we had the mantra (pardon my French): “‘F\_\_\_ it, it don’t mean nothin’.” If you say a little kid dead alongside the road, F\_\_\_ it, it don’t mean nothin’.” . . . If you saw a dead woman, “F\_\_\_ it, it don’t mean nothin’.” And what are you doing? You are anesthetizing yourself to the horrors that you must be in the midst of, day after day after day.

And too many VN vets ultimately generalized their dehumanization of enemy Vietnamese to ALL Vietnamese—and some even to ALL Asians. And how many WWII vets I have met over the years who still hate all Germans or all Japanese. And Korean War vets who still hate Koreans . . .

And now, I hear increasingly about OIF vets who hate the Iraqi people. As an example, one family member mentioned that their son was so full of hatred towards Iraqis that “he was obsessed with returning to Iraq to kill as many Iraqi’s as he could.”

What is unique about the war in Iraq that is worth mentioning? To me, there are only two such elements:

- The unprecedented usage of reserve, guard and contract personnel
- The unprecedented usage of extended deployments and sending troops back on multiple deployments (and this is something we will discuss in the following workshop).

Conversely, there are many profound similarities to the Vietnam War. These include:

- The guerrilla/insurgent/terrorist nature—a war in which enemy combatants do not wear uniforms and are not easily identified as enemy—until it is too late.
- Having to take, and retake, and retake, the same terrain over and over and over again.

Both of these similarities provoke profound numbing and detachment behaviors, frustration, hatred---and acting out violently. It is no surprise that alleged violent acts by American military personnel against Iraqi civilians have been reported; indeed, it is at least partly a testimony to their excellent training and when good leadership is present that the incidents of such are as infrequent as they are (as well as the “code of silence” that inhibits combatants from reporting such violations).

Also, there are three more very important similarities to mention here:

- The increased usage of IA’s (individual augmentees)—which, by the way, is very similar to the deployment pattern utilized for most military personnel sent to Vietnam—going and returning as an individual, which has profound impact on experiences while in the war zone (such as being the “FNG—F—ing new guy”), as well as support for the family while the veteran is deployed and after the veteran returns from deployment.
- The growing divisiveness back here at home about the war, and
- Severe criticisms of and problems with the active duty and veterans health care services, and the fairness and timeliness of the administration of disability ratings.

## **THE SACRED COVENANT BETWEEN OUR COUNTRY AND OUR VETERANS AND THEIR FAMILIES**

These last two similarities are critical to mention. Because, you see, when our nation sends us off to war, our nation vows a sacred covenant: in return for going into harm’s way and putting our lives and our comrades’ -in-arms’ lives and health at risk, our nation promises a life-long

commitment to honor our sacrifices and provide humane and timely war-related financial benefits, health and medical/mental health services (Scurfield, 2006b).

And when this sacred covenant is perceived as being broken, or worse yet, is broken—even though I know very well that the vast majority of military and civilian care providers are committed, dedicated and skilled---there is despair, isolation, rage and alienation that cascades in turbulent waves over our war-wounded and their families. As one mother of a severely wounded Iraq vet said, “When he was no longer of use to the military, they forgot about him.”

Let us not allow Walter Reed to be only a wake-up call. I know that you here agree and are committed that our nation must rally to support the full range of services to address the duration of physical, psychological and social casualties of war, and that our nation must be held accountable to fully honor that sacred covenant that has been forged in blood and sacrifice and heroism . . . We owe our troops and veterans and their families no less. (Scurfield, 2007)

Thank you.

Ray Scurfield

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