It is my honor and pleasure to have been invited to give the Day 2 Keynote Address, entitled: “Expanding the Circle of Healing.” Considering the amazing gathering of resource people here today from the DoD, the VA, the state of Georgia and the community, and the really impressive range of topics and agenda items being covered in this conference, I will try to be careful to not simply state the obvious and “preach to the choir.” I only wish, fervently, that the expertise, commitment, planning and collaboration represented by y’all in this room were being replicated in all 50 states.

I have been impressed by the challenges that we have repeatedly faced when our nation goes to war in terms of being able to provide services that are knowledgeable, timely, relevant and comprehensive to our troops and their families ever since I arrived in Long Binh, South Vietnam in the Spring of 1968. At that time, I was a fresh 2nd LT (also known as a “butter bar”) some eight months out of my graduate MSW program and was assigned to be the social work officer on one of the Army’s two psychiatric teams in Vietnam.

Before arriving in Vietnam, I had two pivotal experiences that have infused my thinking and convictions about this critical subject – and that are central to some of the principles that I hope we all keep in mind as we continue to forge partnerships to provide necessary assistance to our servicemembers, veterans of prior wars and to their families.

The first experience occurred during my MSW field placement at the Sepulveda VA Hospital in the San Fernando Valley north of Los Angeles in 1966-67. As a social work intern, one of the psychiatric inpatients assigned to me was a young Marine who had a diagnosis of schizophrenia. In reading through his records, I found out that he had suffered a psychotic break, decompensating while on the battlefield and had been medically evacuated out of country.

[I might note that, later on, I came to find out that it is extremely rare for any troops to break down psychiatrically while in combat in a war-zone. Usually, such a breakdown does not occur until sometime after the battle is over -- perhaps several days or a week or two later when back in base camp or back behind the wire after a mission, or perhaps not until sometime after returning from deployment -- and that some time can be weeks, months, years or even decades later.]
As you might know, the condition of schizophrenia oftentimes is characterized by a waxing in and out of lucidity. It was at one of those lucid times when this Marine was clearly in touch with his surrounding reality, that he said to me, in a conversation that I will never forget: “Ray, you have to help me get back to Vietnam. I “deserted” my fellow Marines on the battlefield” and, he continued, “I have got to go back to Vietnam so that I can prove that I am a man.” [He had equated his having suffered a psychiatric break during battle and being medically evacuated as desertion!]

My heart was breaking as I heard this young Marine plead for me to help him return to Vietnam. Of course, it was obvious that he never again would be admitted on active duty into the Marine Corps, let alone be deployed to any war zone. What I learned from that poignant encounter was that nothing is more important to a deployed servicemember than the powerful peer relationships forged in the fires and dangers of combat with the other members of his or her operational military unit – nothing is more important. He felt that he had inexcusably let them down, and his self-esteem had been sorely damaged.

I also learned my first lesson about one of the prime mental health axioms of military psychiatry, although I didn’t realize it at the time---only as a matter of last resort do you medically evacuate someone out of the war zone -- not only because of the medical mission to “conserve the fighting strength”, but also because such a medical termination of one’s deployment in harm’s way could end up haunting that person for years or decades, with no way to “go back and make it right . . . “

The second pivotal life experience happened after I had received my orders for Vietnam and had just finished being home for a couple of weeks prior to being sent off to Vietnam. I boarded a commercial plane in Pittsburgh, on a flight to Philadelphia, to catch a connecting flight to Seattle/Tacoma. Because I was traveling on military orders, I was in my uniform. Once seated, it seemed like all of the passengers had boarded, and the aisle seat next to me still was not occupied. And I thought, wow, I have caught a break and can stretch out and not have to converse with anyone.

And then, I noticed a late-arriving young man appear in the front of the plane. He obviously was a veteran, by the hat, and insignia on his clothing, and he shuffled into full view at the front of the cabin. He slowly moved down the aisle with the assistance of two forearm crutches, and I quickly noticed the patch over one eye and the apparent two prostheses where his legs used to be. As he slowly made his way down the aisle, my gaze was transfixed on him -- and then suddenly I realized that he was heading, inexorably, toward the empty seat -- next to me!

I don’t remember a lot about what happened next, other than remembering that I felt extremely awkward, thinking “what am I going to say to him?” and suddenly caught up in my own self-centered thoughts about how ironic that I was on my way to Vietnam and a blown-up Vietnam vet was going to be seated next to me. He sat down, and we said hello to each other. After we had taken off, I did not find myself wanting or knowing what to say. And then, I remember that this young soldier
turned and started talking to me. What stood out were two comments he made. The first comment was that this was his second trip home from the hospital on convalescent leave, part of the rehabilitation process of adjusting to his prostheses outside of the hospital setting. And I will never forget what he then said to me. “Sir, I am not looking forward to this second visit home, because the first time I went home on convalescent leave, several of my high school buddies told me that it was a shame that I had lost my legs and eye for nothing . . . That really hurt.”

I have no recollection as to how or if I had responded to this intimate revelation, but I do remember what this brave young Marine then said to me. “But you know, sir, I’m the lucky one. No one else in my foxhole survived.”

I didn’t realize it at the time, but I had just learned two remarkably vital lessons from this young Army veteran and survivor. Firstly, that one of the worst things that can befall those who have served their country is to be told, or to believe themselves, that their sacrifices have been in vain—let alone that they are not honored and recognized positively for their service to our country. The second lesson was that this young, severely physically disabled Army veteran had taught me, long before I started reading decades later about “the strengths approach” to mental health, and the description of the principle of “post-traumatic growth”, that someone who had lost and suffered so very much, had somehow been able to reframe that loss and suffering into a positive.

And aren’t we here today being guided, indeed driven, to be and remain engaged in serving our servicemembers, vets and their families, fueled by some of these very same lessons that I first came to understand through these two fateful encounters, one with a psychiatrically disabled Marine veteran, and a second with a physically disabled Army veteran—before I had arrived in Vietnam?!

These two pivotal experiences, coupled with many others over the past four decades, have contributed to my thinking about an expanded circle of healing that is so vital to the post-war readjustment and enhancement of the lives of those who have served our country and now need and deserve the recognition and help that they have so richly earned. In many ways, my talking with y’all here today is an ironic de ja vu of a national presentation that I gave back in September, 1991, as the VA and the DoD were engaged in joint trainings to gear up for the anticipated casualties to be forthcoming from the Persian Gulf War. I presented, on a joint VA and DoD Satellite Teleconference regarding the VA/DoD Continuing Response to our Returning Veterans”, a training entitled “Where Do We Go From Here?”

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1 PS: some of you might not know that the VA is the medical back-up system for the DOD, and prior to Persian Gulf War I, contingency plans were being made to discharge or transfer VA hospitalized veterans to civilian hospitals to free-up VA hospital beds—with extremely conflicted reactions by the hospitalized vets: “of course our country needed to be ready for the anticipated mass casualties, and yet ‘what about us’ – here we are being pushed aside and forgotten once again.”
And, I am very sad and frustrated to say that, much of what I discussed almost TWO DECADES ago, has only relatively recently been implemented nationally to any degree, if at all, in 2010!! (And, by the way, if you are interested, you can download a transcript of that presentation from my Southern Miss web page.) I might note that this presentation in 1991 is just one illustration of the many lessons unlearned about war and its impact that led to the title of my third war-trauma book, *War Trauma. Lessons Unlearned From Vietnam to Iraq*. ²

I want to briefly mention several main points that I made in this 1991 teleconference; this is to illustrate what was forgotten between the Persian Gulf War and OEF/OIF. I am convinced these points remain crucial to our mission of serving those who have served our country and their families. Many of these recommendations have only relatively recently been made, let alone fully implemented.

1. That there be an established, on-going systemic liaison and dialogue between the U.S. Department of Veterans Affairs and the DoD. This linkage would focus on traumatic stress and other adjustment/readjustment challenges of both an acute and chronic nature facing returning veterans and their families. It is essential that such linkages exist, whether or not a war happens to be going on; otherwise, the lessons learned will continue to be forgotten and may or may not be rediscovered years or decades later. Such standing linkages include:

a. At the national or departmental level: an on-going joint VA/DoD task-force or liaison committee concerning traumatic stress and readjustment-related policies and nationally sanctioned strategies for veterans and their families, both those still on and those discharged from active duty;

b. At the regional or state level: a designated staff person at each of the VA Medical Regional offices with DoD liaison oversight functions AND a designated VA Headquarters position to oversee such activities in the VA;

c. At the local level: one or two designated mental health liaison persons from each VA medical facility and from each VA Vet Center to coordinate with the closest military installations; in turn, designated contact persons from the local DOD facilities with nearby VA facilities.

2. [In addition to the above]: national, regional, state and local sanction and support occur for the following types of activities [some of which are demonstrated by various programs in attendance at this conference]:

a. Perhaps the most efficient and influential local or area activity may be to help facilitate ongoing networking meetings among various providers in your geographic area. It is our experience in the Pacific Northwest, for example, that many DoD service providers are very isolated and feeling somewhat overwhelmed by the debriefing task at hand. REGULAR networking meetings can serve the primary needs of the local providers and would probably include the sharing of strategies, information, referral facilitations, in-service trainings and care-giver support to each other;

b. There is a significant need for expert provision of critical-incident-type debriefings. [Please note that the use of the term “debriefings” in this presentation in 1991 is not relegated only to CISD format interventions, but to a range of psychological and counseling interventions that are oriented to help participants talk about and reflect on what might be troubling aspects of their active duty experiences.] Many returnees are very likely not to have had adequate or any critical incident type debriefings, either on an individual, group or unit basis. One problem is the critical need to differentiate between an operations type debrief that reviews military operations, tactics utilized and operational lessons learned; VERSUS a critical-incident type debrief which attends to the cognitive, attitudinal and emotional aspects of participation in stressful military-related activities.

c. We also have observed that a number of officials and debriefing facilitators seem more oriented to a cognitive only clarification and reframing debriefing model versus also assisting returnees to be willing to reveal and attend to underlying emotional issues of terror, anxiety, guilt, rage, etc. The operational principle and policy that seem missing at all levels is that ANYONE who has served in a war-zone has both the RIGHT and in all probability the NEED to receive a critical-incident type debriefing process. . .

However, even if adequate debriefings were offered to ALL regular military, and Reserve and National Guard personnel during trainings, and that is a major if, that still leaves unattended ALL the returnees who are now civilians and who did not receive any or received an inadequate debriefing. WHO has taken responsibility and has been given adequate and recurring resources to reach out in a systematic way to these returnees and their families to do adequate needs assessments and provide debriefings? A CONTINUING NATIONAL MANDATE to provide this service is essential, even though a number of returnees will refuse any brief services that are offered and will remain isolated and avoidant concerning possible war-zone related issues for months, years or in some cases decades.

d. Military alcohol and drug treatment programs, as well as community substance abuse programs, are PRIMARY sites where Gulf War returnees and veteran of previous wars with undiagnosed traumatic stress may be in treatment. All such programs within reason should
be contacted to offer in-service trainings on post-traumatic stress and its relationship with addictive disorders. . . .

e. **Military and community family advocacy programs** that deal with domestic violence, child abuse and neglect, etc., are another primary site where returnees and families may be reflecting at least in part war-zone related issues that were caused or exacerbated by the Gulf War. Cross-training of family advocacy staff in war-related traumatic stress and critical diagnostic and treatment indicators is a must. . .

f. If **realistic traumatic stress information** is not being passed on or allowed by various unit commanders, then you can assume that it is not getting to many returnees previously or still on active duty. We must be active with various military and other service providers, such as chaplains, social workers, psychiatrists, psychologists [and nurses, occupational therapists, recreation therapists, physical therapists, etc.], and family service and community service centers. *Sharing of information, offering to do collaborative trainings and developing a partnership relationship are essential.* In addition, such relationships can facilitate access to key military unit personnel in the chain of command.

g. Key issues and dynamics that must be openly addressed as part of any group, family or individual debriefings include:

i. The oftentimes *unspoken lack of trust* by the military returnee still on active duty or the family to reveal any “personal problems” to military authorities . . . Lack of trust derives in part from feelings such as betrayal and fear as to what governmental authorities will DO with the information received, as well as shame, guilt and perhaps not feeling that one’s own military experiences “compare” with “heavier-duty” war-trauma that others experienced.

ii. A number of returnees have issues that “the military did not treat us with honor and dignity,” and may feel betrayed. [I might note that in 1991 this included being forced to take a series of anthrax immunizations in the Gulf, that these immunizations might not have been entered into their military medical records, that full disclosure of side effects or longer-term health implications were not provided and that such were “covered-up” and not acknowledged publicly or to the media.] I might note that today, many OEF and OIF veterans and their families also have serious trust issues, to include for example with the inexcusable delays in providing properly armored and designed vehicles until years after the normal issue humvees were found to be extremely vulnerable to IEDs.

iii. There is the widespread myth that “time heals all wounds” – by the way, I surely wish that this myth were true—that would mean that old folks like me would be paragons of mental health! 😊 *“Time heals all wounds” is a myth that critics state is used by some authorities*
and some clinicians, to claim that most returnees or their families who continue to present readjustment difficulties must have been predisposed to having problems. This is a bogus argument to minimize or not recognize the longer-term risks of combat -- and to reinforce the attitude that debriefings for war-related stressors are both unnecessary and are not the responsibility of any governmental resource to provide to returnees and their families!

iv. In addition, servicemembers’ and veterans’ families tend to have very strong emotional reactions not only to what they have perceived to be troublesome changes in their loved ones, but also to blame someone for what has happened—which oftentimes is the veterans themselves, the military and/or the government. Also, families have their own reactions to their own issues about war, violence, physical injury, psychiatric disorders, abandonment and perhaps feeling “used” by the military or the government—and then forgotten.

v. Finally, the DoD and the VA can have their own organizational cultures that do not necessarily fully trust or understand each other. For example, some DoD personnel believe that VA staff will try to “oversell” the presence of PTSD, or imply that any readjustment problems will require years of intensive therapy, and want to help counsel active duty personnel to get out of the military. In turn, VA staff must be aware if we DO fit any of these perceptions and what if any issues and agendas we might have concerning the military and war-veterans and their families [such as in some cases feeling that the DoD traditionally has viewed the VA as a “dumping ground” for servicemembers when they no longer are of use to the military].

Please remember that almost all of what I have said so far in my presentation is taken directly from the talk that I gave to the VA and DoD back in 1991 -- to remind us how persistent and chronic are so many of the problems and issues that we face today. I exhort each of us in this room to do our part to insure that the wonderful work that y’all are doing and are planning to do will not dissipate and evaporate once the current wars in Iraq and Afghanistan have ended. If we allow that to happen, then once again our country will have to rediscover all over again and too long after the next war has begun, what it is that our nation must do to be prepared and timely in providing the full range of services that are so sorely needed by each new era of veterans and their families.

Please do not let our country relapse to a recurring amnesia that has afflicted our nation after every war about the human impact of war and what needs to be done about it. In addition, we must be vigilant to insure that we are doing justice to providing needed services to BOTH military personnel and their families of any current wars being fought, as well as to veterans and their families of previous wars and eras.

Four Special Populations Not Mentioned in my 1991 DOD/VA Teleconference Presentation

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I might add that four “special populations” of veterans not mentioned in my 1991 teleconference are physically disabled veterans, incarcerated veterans, homeless veterans and Traumatic Brain Injured veterans. Time does not permit me to do more than briefly identify each of these:

- **Physically disabled veterans**: It can be too easy to forget that severely physically disabled veterans and their families face a life-long series of challenges and issues related to the physical disabilities, to include in many cases accompanying family, mental health and substance use issues. Let us not leave severely physically disabled veterans and their families alone in the decades following the initial wounds and injuries.

- **Incarcerated veterans**: Back in the late 70’s, I was privileged to be the supervisor at the Brentwood (West Los Angeles) VAMC of an extensive VA Veterans-in-Prison program in which we did “in-reach” to veterans at over 10 correctional facilities and at the LA County Forensic Mental Health Unit. I understand that such in-reach has been prohibited since a 2002 VA initiative that in my opinion deprives veterans with war-related readjustment issues that have become intertwined with legal difficulties from receiving the services they so desperately require.

- **Homeless veterans**: We are all well aware of the continuing high proportion of our nation’s homeless population who are veterans; it is absolutely tragic that veterans’ readjustment issues and chronic mental health issues are such prominent factors among our nation’s homeless.

- **Traumatic brain injury (TBI) and PTSD**: these are considered by many to be the “signature” injuries of the Iraq and Afghanistan Wars, and we must be vigilant regarding the very strong correlation between TBI and PTSD and overlapping of a number of symptoms that are common to both conditions.

### Elements of an Expanding Circle of Healing

To combat the recurrence of our country’s collective amnesia about the impact of war following the ending of each war our country has fought in, and to do justice to our servicemembers, veterans and their families, I want to summarize the key elements of an expanded circle of healing that is so sorely needed to more fully and adequately address the readjustment needs and issues that face a substantial number of our nation’s servicemembers and veterans and their families – and that y’all here today are such a vital part of.

It is important to note that there continues to be admirable efforts by so many military, VA, state, veterans service organizations and community groups, and an amazing commitment and efforts of many front-line health, mental health and benefits providers in these organizations, and advances in recognizing and understanding war trauma and its impact. Even so, numerous studies (several
of which accolades are due for having been conducted by the military) indicate that anywhere from 15% to over 30% of servicemembers at some time during and/or following deployment evidence significant mental health and other behavioral and social symptoms. In addition, studies such as the Army’s Mental Health Advisory Team-5 (2008) by Lt. Col Paul Bliese et al, report the significant relationship between amount of exposure to war zone trauma and the greater likelihood of the emergence of mental health symptoms. In other words, going on multiple deployments and extended deployments is a significant risk-factor.

There is one thing that you should never believe coming from someone who has been deployed to a war zone: when any servicemember or veteran ever says that “combat had no impact on me.” Bull crap. Absolutely not true. The unmitigated reality is: combat always has an indelible impact -- although not necessarily “disordered”-- on all who are exposed to it.

I do want to recognize that there have been impressive advancements over the past 15 or so years, in particular in the development of cognitive-behavioral and manually-based approaches to trauma treatment that have brought a degree of reliability and consistency to interventions across settings and practitioners that were just dreamed about even two decades ago. However, the major strengths of such CBT approaches also are major limitations, in that (#1) they typically have a very narrow psychiatric symptom-focus, oftentimes primarily if not exclusively on the “core” DSM criteria for PTSD, (#2) a very regimented intervention is strictly adhered to (#3) it is primarily applied in individual therapy sessions; (#4) a number of participating veterans reportedly find it difficult to actually complete the full treatment protocol, and (5) such interventions oftentimes ignore or considerably downplay potent factors that are intrinsic to the experience of military trauma—factors essential to an expanded circle of healing for servicemembers, veterans and their families.

I contend that for full healing from military trauma to occur, there must be significant attention to an expanded circle of healing. I have been impressed over the decades with the fact that there are many paths to healing, that the primarily cognitive-behavioral talking, office-based approaches (such as Prolonged Exposure Therapy and Cognitive Processing Therapy, as helpful as they are to a number of veterans, are not the path for everyone or are sufficient. Indeed, “one size does not fit all” and critical additional elements of and approaches to healing must be considered. This is the first element of an expanded circle of healing that is so needed—making sure that a range of healing interventions beyond cognitive, office-based interventions, is available.

For example, back in the last 1980’s when I was the director of the Post-Traumatic Stress Treatment Program at the American Lake VA Medical Center in Tacoma, Washington, we pioneered the utilization of “helicopter ride therapy,” in collaboration with the Washington State Air National Guard. We also collaborated with your very own Augusta VA Medical Center on a treatment project utilizing low and high ropes courses and “Outward Bound” or adventure-based therapeutic activities with both emotionally and physically disabled veterans. We found that such adventure-based therapeutic activities offered benefits beyond those derived from our more traditional talking therapies. And today at Ft. Bliss in El Paso, Texas, the very creative Warrior Adventure Quest (WAQ) program combines high adventure, extreme sports and outdoor recreation activities such as rock climbing, mountain biking, paintball, scuba and ropes courses with a leader—led after-action debriefing to help soldiers transition their military operational experiences into a “new-normal” enhancing military readiness, reintegration and adjustment to garrison or “home” life.

The VA and community organizations also have taken the initiative to implement creative beyond-the-office interventions. For example, about 20 VA medical centers have gardening programs, such as a 12 acre parcel at the West Los Angeles VA Medical Center on which veterans have


grown fruits, vegetables and flowers, in recognition of how “working the earth” can be good therapy for war veterans. And the non-profit Farmer-Veteran Coalition helps returning veterans find jobs, training and places to heal on America’s farms.

Also, the use of the expressive arts as a healing avenue has been wonderfully demonstrated by the ArtReach program, founded by Susan Anderson and based out of Atlanta. ArtReach has been facilitating veterans’ personal writings, music, movement, art and verbal expression as part of their healing. Finally, an example of the therapeutic use of writing and performing music is wonderfully illustrated by U.S. Army Reserve sergeant Sandi Austin, who wrote and performed in late December 2003, the song entitled, “In The Hangar,” for her fellow soldiers in the 3-2 Stryker Brigade. At the time, they were living on an old air base just outside of Samarra, Iraq. This video clip is from Muse of Fire, a documentary on the National Endowment for the Arts Project, Operation Homecoming. Writing the Wartime Experience. (VIDEO, first two excerpts).

Besides the use of music, the video clip of Sergeant Austin also illustrates the vital peer connections among military personnel that underlie the salient importance of the profound interpersonal aspects of healing from the experience of war that are distinctive and crucial to war veterans. Combat or war-zone trauma never is an individual experience that occurs in isolation. Quite the contrary, the experience of war, and indeed of military service, is inextricably embedded within the context of the small, operational military unit in which profound bonds of comradeship occur among peers and with their small unit command.

EVERYTHING in one’s military experiences is enmeshed within this remarkably powerful interpersonal constellation of influences and interactions among military comrades—the circle of profound and intense relationships that comprise this band of brothers and sisters. Indeed, once in harm’s way, it is well-understood, by those who have been there, that by far the most compelling factor that overrides EVERYTHING else is the welfare and safety of one’s fellow and sister comrades in the small operational military unit, carrying one’s share of the load, and caring most of all by how one is perceived and accepted by one’s military peers. Once in a war-zone, this typically takes precedence over one’s own safety, and indeed over the commitment to fighting for one’s country.

This is why, if after returning from deployment, a veteran is going to talk with anyone about his or her war experience, it is not with family members or old high school buddies; rather, it almost universally will be with others who have fought in that same war. And the same is true for military families—the bond and understanding that only can come from other military families who have have been there and done that. This is the first and for many the most powerful element in an expanding circle of healing to help one come to terms with the unspeakable so that one can then

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7 See the website for the Farmer – Veteran Coalition, “Farmers Helping Veterans; Veterans Helping Farmers.” http://www.farmvetco.org/
move on in post-war life. Thus, we should have this uppermost in our thinking in terms of anything that we can do to make such peer resources available as part of our services to servicemembers and veterans and to their families — and where your peer mentoring planning and participation by VSO’s et al, I so vital a component of the healing circle..

Beyond the profound importance of relationships with one’s military peers, an expanded circle of healing recognizes that for a substantial number of servicemembers and veterans who have been sorely impacted by their war and military experiences, there are additional sets of fractured, alienated and/or voided relationships that inevitably have been affected — and that your efforts are helping to address. For too many veterans the indelible impact of combat is a legacy embedded within that can contain, to varying degrees, alienation, loss, grief, anguish and for some bitterness, resentment and/or hatred. Such veterans have not sufficiently, if at all, expanded their healing circles to positively and increasingly include relationships that have been fractured, alienated or voided. ⁸

From An Intra- to an Inter-Personal Journey

• Veterans need to be facilitated to expand their healing circle to include existing significant others in their current lives—if any such relationships are still active—such as a partner, parent, child or other relatives and close friend.

• However, for many veterans the most likely persons that the veteran will allow initially into their healing circles are not so much family members but, as I mentioned earlier, a select number of other veterans. [Indeed, the identity of being a veteran oftentimes literally transcends or overshadows or is at least as strong as identity based on gender, age, race, ethnicity, religion, and socio-economic status]. This veteran identity fuels the strong initial tendency for war veterans, if they are not totally isolated, to mingle with other veterans of the same era, generation and war—World War II veterans with other World War II veterans, Vietnam veterans with other Vietnam veterans, OIF and OEF veterans with other OIF and OEF veterans, etc.

• And yet, as powerful as this peer comradeship is, for too many veterans, this is where the expansion of the healing circle stops.

⁸ My thinking about the veteran’s healing circle is indebted to important sources. One is my American Indian (Seneca Tribe) heritage that perhaps has made me particularly receptive to the traditional American Indian healing circle ceremonies, in which the power of giving testimony and bearing witness as warriors share their war experiences in a supportive circle. Of course, the circle has even more ancient roots as both a physical and symbolic unity. See J.P. Wilson, Trauma, Transformation & Healing. New York: Brunner/Mazel., 1989. Also, there is the very insightful and more recent writing of William Glasser that I have become familiar with in using his work as a text in my graduate social work advanced interventions course. Glasser’s viewpoint is that satisfying relationships are the essence of a healthy and fulfilling life. Also, readers will note my adaptation of Glasser’s “the solving circle” in my discussion of the circle of healing. My thinking about the healing circle obviously has parallels to Glasser’s solving circle and relationships constructs. See W. Glasser (1998), Choice Theory. A New Psychology of Personal Freedom. New York: HarperCollins Publishers, Inc., 94-106.
Further Expansion of the Circle of Healing

Who if anyone else does the veteran most need to allow to enter into his or her circle of healing, the relationships that are required to further enhance a more complete post-war recovery?

The specific additional relationships that I will briefly identify that are distinctive for war veterans include the following:

- veterans of different eras, theaters and generations
- family members and other civilians who are not veterans
- the veterans’ government and country
- the intrinsic relationship of potential powerful positive aspects of military trauma experiences that are embedded within salient negative aspects of trauma.
- altered relationship with a higher power or God; or absent such beliefs, the inevitable alteration or impact concerning beliefs about the inherent goodness and interconnectedness of humankind
- and finally: the powerful relationship b/w the veteran and the people and land of the country in which the war was fought

Firstly: Veterans of Other Generations, Eras and Theaters. Beyond veterans letting into their inner circle of healing veteran peers of the same era and war, an additional level of veteran-to-veteran association that is very powerful is with veterans of eras different from the veteran’s era. For example, this can occur in a therapy group with veterans of different eras participating. Besides a therapy group, veterans of earlier wars can and have become mentors in other settings with the “new” Iraq and Afghanistan veterans who are facing many of the very same kinds of post-war challenges and issues.

- The power of this vet-to-vet connection across eras and generation is illustrated in the following brief video clip from a unique 20-session trauma-focus outpatient trauma-focus therapy group that I co-facilitated with veterans of World War II, Vietnam and the Persian Gulf Wars when I was the Director of the VA’s National Center for PTSD in Honolulu in the 1990’s. ¹ This particular video clip is the ending of a session in which Ben, a 73 year old WW II ex-POW had shared about his 4 ½ year imprisonment in a Japanese POW camp in Shanghai. (By the way, Ben came in for PTSD treatment for the first time at age 70!) Time does not permit showing Ben’s poignant sharing of this experience or of the struggles and efforts he then had and continued to have in reestablishing relationships with his family, especially with his daughter. What you will see here is what happened at the end of this group session, in which Ben shares how meaningful his relationship with the other group members has become (and the therapist in this video is my 15-year younger twin brother). [VIDEO: BEN]

¹ See: Journey of Healing. R. Scurfield, I. Powch and A. Perkal. Department of Veterans Affairs: National Center for PTSD, Honolulu, HI. Copies of this three-tape video series can be obtained free of charge (plus mailing costs) through the former media coordinator of the NC-PTSD in Honolulu, Allan Perkal. Contact Allan at: perkman@mac.com.
Secondly: Expanding to Non-Veterans  At another level, a set of fractured and at times toxic relationships for many veterans is with non-veterans:

A wife of an Iraq War veteran described how difficult her adjustment has been to “what the war did to her husband.” She couldn’t help feeling left out since her husband seemed to prefer being with other soldiers than with her, and she is very aware of the distance between them that she cannot seem to bridge: I know there’s a lot of things that he can talk to his (soldier) friends about . . . But I’m sitting here thinking, ‘Why can’t he talk to me?’

And yet, sadly, for example, almost all veteran treatment programs that I am aware of never move the veteran beyond the veteran-to-veteran circle—to include, for example, a mixed treatment or support group comprised of BOTH veterans and non-veterans -- in order to facilitate discovery of the universality of humanness & trauma experience. Clearly, it is not necessary for veterans to reveal the most horrific details of combat trauma with family members or with other relatives or friends; however, it is clear that walls do go up between many veterans and their family members and with other non-veterans. What are we doing to help there to be a willingness for these walls to be breached, to SOME degree, so that veterans can allow others back into their world—and others can allow and show veterans that they are wanted back in the civilian world.

Thirdly: the US Government and American Society Unfortunately, many veterans believe this statement: “the government sends us to war, the military uses us in war, and society forgets us after war.”

A natural extension of allowing non-veterans into one's healing circle is related to the distinctive and powerful relationship between active duty military personnel and veterans on the one hand, and our government and political leaders and society on the other hand. This is based on one compelling factor: our government, our military leaders and our society sanction the members of our Armed Forces to do something that is otherwise both forbidden by society and severely punished: to maim and kill other human beings (albeit in defense of our country) as well as to put ourselves in harm’s way for our country.

- This singular, compelling factor is interwoven with a sacred covenant between our society and the veteran: our country promises a life-long commitment to honor, support and assist active duty military & vets in recognition & various forms of benefits in return for this extraordinary risk
- This covenant is crucial to a successful post-war readjustment for many war veterans—the belief that our country will fully honor the promises that were made to our nation's active duty military personnel while they were being recruited and after they entered active duty.
- However, a number of active duty military & vets & their families experience this as an empty promise, that this trust relationship has been diluted or voided by our government, our leaders & by society and that they have been betrayed. This is a central issue for many vets & families. And this betrayal must be addressed as part of the healing process. Part of the solution is for veterans to see that there are caring and active persons like you in this audience and organizations that are sincere and walk the walk—beyond empty promises. Also, what can we offer to such veterans as meaningful ways to become active positive change agents and/or

10 Scurfield, R.M., War Trauma. Lessons Unlearned From Vietnam to Iraq.
contributing members in meaningful activities? This includes challenging the veteran to consider what he or she is willing to do about this issue, rather than perhaps to continue to be immersed in rage, mistrust and alienation?

War Trauma Resources Listing: I did want to mention that a wonderful illustration of how so many community folk have become involved in myriad ways to assist our nation’s servicemembers, veterans and their families is reflected in a War Trauma Resources listing, that I have compiled and periodically update. I have been told by many that it is an extremely helpful resource guide. And it is available on my university web page. This listing includes some 500 resources, many of them non-governmental, that are on the web and accessible. The reality is that our government never will have sufficient resources to do full justice to the legitimate needs of our servicemembers, veterans and their families – and this War Trauma Resources listing exemplifies the incredible contributions that non-governmental resources must and do provide.

Simply for illustrative purposes, let me mention just four such resources. I have arbitrarily selected four web sites beginning with the letters A, B, C and D, respectively, out of several hundred!

Lest we forget, the first web site I want to mention was founded by and for widows (and widowers) of OEF and OIF vets. I want to exhort that all of our very important efforts for those who have survived war also include remembering and attending to the family members who are living with the life-long losses of loved ones who did not survive their deployments. Who do they have to turn to?

- **The American Widow Project.** Founded by Taryn Davis, widowed at age 23 in 2007 when her husband was KIA in Afghanistan. “The American Widow Project is a non-profit organization dedicated to the new generation of those who have lost the heroes of yesterday, today and tomorrow, with an emphasis on healing through sharing stories, tears and laughter . . . Military Widow to Military Widow… Services include a free 75 minute video documentary that gives a candid look into the stories, struggles and perseverance of 6 military widows. Everything is covered from meeting the love of their life to the knock on the door, life as a single parent, and decorating a headstone. The Web Site includes ideas, stories, and advice, and a multitude of resources to help with the lifetime of struggles that come along with being a military widow; and there is a hotline staffed entirely by widows who are going through the same trials and tribulations as other widows.

- **Brain Injury Peer Support.** The American Veterans with Brain Injuries organization, was founded in 2006 to provide a web-based peer support network for brain-injured veterans and their family members.

- **Cell Phones for Soldiers.** Founded by a 12 and 13 year old brother and sister, Robbie and Brittany Bergquist, in 2004, with $14 of their own money, It has since raised $5 million in donations and paid for 30 million minutes of prepaid calling cards as of December 2009 to soldiers serving overseas. “As long as soldiers are away from home,” Robbie says, “I hope that we can continue to support them.”
Daughters of Vietnam Veterans International. “To help organize and network Daughters and Sons of Vietnam Veterans from America, Canada, Australia, Vietnam, and New Zealand. “Daughters of Vietnam Veterans International" is organized as a support group for DOVV’s who are active in humanitarian and peace-making efforts across the globe. Our mission is to enable "sisters" to use this organization to network with other "sisters and brothers" with advocacy projects working with Veterans, and Children of Veterans.”

It is hard to put into words my amazement and gratitude in having gotten started on compiling and maintaining this War Trauma Resources listing and discovering the incredible array of persons who are committed to varying missions to be of assistance to those who have been impacted by war – to include y’all here today. Absolutely amazing.

Going back to the expanding circle of healing: Fourthly: The Relationship Between Trauma Negatives and Potential Positives

- Many vets and family members remain fixated, preoccupied with the hurt, the losses, the horrors of war and negative experiences post-deployment. Thus, it is essential to also give appropriate attention to the opposite of those hurts and losses. This is something that the veterans may be very resistant to want to acknowledge—the potentially positive aspects of the war-and post-war related traumatic experiences. Typically, these positives have been embedded beneath negative preoccupations and are largely if not completely overlooked or minimized by the survivor—unless a re-framing is facilitated to enable self-acknowledgment that the positive aspect also is true and relevant to them.

- The timing of when to explore any of the following is a judgment based on when it is assessed that the veteran has sufficiently “owned” and expressed the negative polarity and can understand that looking at the possible “positive” polarity does not require denying or forgetting the negative aspect . . . and that both the negative and positive polarities are the reality.

- To come to recognize, and then to accept, both elements of the following polarities is a dramatic expansion of the veteran’s circle of healing. 11 I will just mention a few of these companion polarities here that I have written about in War Trauma. Lessons Unlearned from Vietnam to Iraq:

| Negative aspect. | “Nothing means anything anymore.” Profound feelings of confusion, despair, not being clear about what is valued in life, or where I am going with my life; versus |
| Positive aspect: | Priorities: “What is really important now?” 12 Development of very healthy questioning and/or a reaffirmation of my values, what my priorities are, what is & is not important and meaningful |

11 G. Schiraldi, The PTSD SourceBook, took my original explication of these trauma polarities (Scurfield (1994) and composed them into this tabular format that this section is adapted and elaborated from.

12 Such is described by Bob & Penny Lord (1989) as the one positive that can be grasped when one’s physical body has been ravaged by disease. Saints and Other Powerful Women in the Church, Westlake Village, CA: Journeys of Faith, pp. 387-88.
Negative aspect: Very low self-esteem, shame and/or guilt at the fact that I was “imperfect” during the war as part of surviving, and there has been continuing difficulty to adjust post-war; vs

Positive aspect: Appreciation of the strength and courage that it took for me to survive both the war and the difficulties since the war.

Negative aspect: Having little tolerance or acting out when confronted by depersonalized and insensitive behaviors of authority and institutions; versus

Positive aspect: The development of very strong convictions that I am not just a number and am entitled to be treated with dignity and respect.

Negative aspect: I am in deep and unrelenting pain, and believe that I am weak or sick because I repeatedly remember the troubling and horrible aspects of what happened (to me and/or to others); versus

Positive aspect: I understand and appreciate that it can be a sign of health and virtue not to forget what happened. Those experiences and the lessons of war that should have been learned must not be forgotten by anybody or by our country----or we will be doomed to have them repeated, again and again. After all, if I and my fellow and sister survivors do not remember, who will?

Negative aspect: Accepting total or exaggerated degree of responsibility for the trauma that occurred in the war zone; versus

Positive aspect: I now realize and appreciate that when our nation goes to war, everyone in our nation bears some degree of responsibility for everything that happens in that war.

In facilitating the recognition and acceptance of these and many other polar truths, the discovery is made that:

I would add that this potential positive applies equally to the aftermath of exposure to human-induced trauma.
Aspects of both negative preoccupation and the accompanying positive dialectic are valid, and even the most horrid traumatic experiences also can and do contain extraordinary lessons about life and extraordinary growth possibilities.

Fifthly: There is one more polar truth that involves impact on one’s belief or faith in God and/or in humanity

Negative aspect: Loss of belief in God, religion or faith in humanity; versus

Positive aspect: Marked positive changes in outlook, expansiveness of world view, and profound insights, perceptions, & quasi-religious or religious/spiritual insights, potential for religious/spiritual rebirth &/or renewed optimism for humanity.

Why was I allowed to live? It’s luck . . . we all traded bullets with the enemy for a heck of a lot of times, and we’ve seen a lot of buddies go down and I think God was with me . . . That’s why I’m here today. (World War II vet) 13

- Some veterans believe that their survival was totally a matter of luck, of random chance. “Your time didn’t come. My time didn’t come. Their time didn’t come.”

- Homer’s Greek soldiers clearly attributed good and bad luck in combat to the gods: “Damn this day,” he said. “A fool would know that Zeus had thrown his weight behind the Trojans . . . As for ourselves, no luck at all, our shots are spent against the ground.” 14

Many war veterans have had the opposite experience: the trauma of war has led to a crisis of faith, and for some an alienation, a fracturing, of their relationship with God.

“Why God? Why Me?” “This is God’s will?” “How could you let this happen, God?”

- Those veterans who remain obsessed with the question about “why” or the cause of their problem (“What did I do to deserve this?” “What is God trying to tell me?” “Am I being punished?”) often turn against God. 15 Conversely, there are vets who focus their attention not on the cause but on their response to the trauma---their individual responsibility for their own responses and trust in God despite the pain. 16

- As Philip Yancy wrote: A quality like perseverance only develops in the midst of trying circumstances . . . We rejoice not with the fact that we are suffering, but in our confidence that the pain can be transformed . . . what we make out of it. And survivors who are able to view

13 Journey of Healing video. Clinical excerpt with Chuck a World War II veteran infantryman.
14 17F:713ff. Quote from the Iliad in J. Shay, Achilles in Vietnam, pp. 139-140.
15 Yancey, p. 106.
16 Ibid., pp. 106-108.
the pain as not meaningless lead to rejoicing in the object of their faith, a God who can effect that transformation. 17

Even without a belief in a higher power or God, survivors can still be helped immeasurably by understanding the negativity, entrenchment, self-defeating attitude and behaviors that result from focusing on the “cause” of our pain rather than on our response, what we are doing about it.

Inclusion of this most profound and transcendent of all relationships into one’s circle of healing, if this is part of one’s belief system, is an absolute requirement if one is to be able to optimize one’s post-war healing, and chaplains and lay ministers, priests, rabbis, Muslim clergy of all faiths and traditional healers and spiritualists, all have a vital role to play.

Finally: The People and Land of the Country That Our Country Has Fought In

At yet another level of a healing circle, two return trips to a peacetime Vietnam have taught me an invaluable lesson. This is the unique & precious opportunity to both witness & experience how an entire land and people have survived and regenerated, a land & people once ravaged by war. And this learning and opportunity will be just as relevant to veterans of Iraq and of Afghanistan in the coming years. [This expansion of the healing circle is discussed last, in that most war vets will not be able or willing to want to return for many years -- if not for decades or ever -- to the former war-zone that is now a land of peace.]

• It is not just any land or country, but the land and country in which a war was waged in considerable part by Americans against and with very specific peoples in a distant land.

First, let me take Vietnam as an example – and then a comment about Iraq and Afghanistan. The people and land of Vietnam have been excluded by many Vietnam veterans from their circle of healing. This exclusion typically is based on the veterans’ personal and continuing fixation on associating the Vietnamese people and land with negative and horrific experiences from the war---and remaining fixated on grief and loss, if not hatred, bitterness, or marked discomfort towards Vietnamese people and Vietnam.

Many Vietnam veterans, and other Americans, have continued to refuse to admit to ourselves that:

• There is an impermeable bond between our veterans and country and the Vietnamese people and land and country: We are bound together, forever, through the profound experiences that were forged in the crucible of death, blood, mayhem, loss, comradeship, heroism, courage, thrills and other absolutely unparalleled polarities of peak-life experiences that have remained compressed within each veteran’s personal history of the war and between two nations.

• For veterans who deny the reality of this impermeable bond, here are two tests:
  1. Relate to Vietnamese-Americans living here in America (or Iraq vets to Iraqis in the US).
  2. Consider going back to peace-time Vietnam (or view videos of the same or talk with vets who have returned) and allow yourself to simply observe or become immersed in the Vietnam of today. This presents new indelible positive memories to juxtapose alongside the

17 Ibid., p. 108.
decades-old war-memories. You may discover that the most extreme elements of negatives and positives, have been bonded within for decades—and will continue to be, forever.

And yet, so many veterans try so hard to not accept the unmitigated and indelibly imprinted reality: that my fellow and sister veterans, and our country, are, indeed, war veterans of both “The Vietnam War” and what Vietnamese refer to as “The American War.” And so are the Vietnamese people and country. This realization has been necessary for me & other vets to be able to integrate & synthesize within ourselves the formation of a more complete gestalt, to help make each of us more whole. 

I might add that I was contacted just last month by a former Baghdad war correspondent who was going to accompany a group of severely disabled OIF veterans back to Iraq. One of the OIF vets, who had both of his lower extremities blown off by an IED, said that “he wanted to go back so that this time he could walk out of Iraq on his own.”

I would like to close with this very short video clip of a Vietnam veteran, John Young, who was part of our (University of Southern Mississippi) Study Abroad to Vietnam course in 2000, in which three Vietnam veterans were accompanied by 16 history students who all paid a tuition surcharge to help fund expenses for the three accompanying veterans. The inclusion of 16 history students turned out to be a wonderful element of healing that exemplifies an expanding circle of healing, in this case In which 16 students were allowed into the sacred worlds of three war veterans and the results were so enriching for both the vets and for the students.

[SHOW VIDEO CLIP, John Young]

After the video: PS: It was some 35 years removed from John’s war experience for him to be able to go on this journey of healing. I pray that with the wonderful work that everyone in this room is committed to, that we won’t have many OEF or OIF veterans who will have to wait 35 years to be able to experience the type and depth of healing that they might require as part of their post-war healing journeys.

And as a Vietnam veteran, I personally thank you all for your work. Thank you.

*Pax mentis* (“peace of mind” – the motto of our psychiatric team (the 98th Medical Attachment, attached to the 8th Field Hospital, in Nha Trang, Vietnam) and *Semper fi*

“Doc” Ray Scurfield

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