In a time when resources are at a premium, we must all be creative in exploring the most effective and efficient strategies possible concerning unmet and undermet need of our returning veterans and their families. To that end, I would like to briefly enumerate the following examples of critical activities to be considered.

1. That there be an established, on-going systemic liaison and dialogue between the Department of Veterans Affairs and the DoD (and whenever I mention the DoD I am of course including the Reserve and National Guard). 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 that might occur include:
   A. At the national or department level: an on-going 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 four VA Medical Regional Offices with DoD liaison oversight functions, and a designated VA Central Office 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 Vet Center to coordinate with the closest military installations; and, in turn, designated contact persons from the local DoD facilities with nearby VA facilities.

2. That national, regional, state and local sanction and support occur for the following types of activities, some of which are demonstrated by the various programs described earlier on this telecast.
   A. Perhaps the most efficient and influential local or area activity may be to help facilitate on-going networking meetings among various providers in your geographic area. It is our experience in the 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. 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 attitudinal;
there is a 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 war-zone related activities.

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 operating 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.

Another problem is geographical and is particularly critical with many reservist personnel and those who were in units that disbanded with persons who did not go and return with an intact unit, of which there were a number. For example, one Navy Reserve Fleet Hospital has 16 reserve detachments scattered over five states. To get Gulf War returnees from such widely dispersed detachments together for a critical-incident type debriefing requires higher-level directives in the Reserves in all branches of the service to insure that priority is given and funds are available for travel and per diem costs to staff and attend such debriefings.

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 an adequate 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 debrief services that are offered and will remain isolated and avoidant concerning possible war-zone-related issues for months, years or in some cases decades.

C. Military alcohol and drug treatment programs, as well as other substance abuse programs, are primary sites where Gulf War returnees and veterans 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 PTSS and its relationship with addictive disorders. For example, that substance abuse is a primary form of self-medication against painful recurring memories and sleep disturbances, as well as being a retraumatizing behavior that reinforces detachment, denial and blaming.

D. 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. For example, it may be that there is at least some relationship between some domestic violence and other family disruption now and the remarkable lack or absence of opportunity while in the Gulf for many U.S. personnel to actually engage the enemy or to have alcohol and other stress release activities readily available in the face of months of battle readiness trainings and attack alerts.
E. 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, family service and Army 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.

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

1. The oftentimes unspoken lack of trust by the returnee still on active duty or the family to reveal any “personal problems” to military authorities (ironically, it appears that VA staff seem to be more trusted at this point by active duty personnel, and less trusted by veterans who have been discharged from active duty!) Lack of trust derives both 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 experiences “compare” with “heavier-duty” war-trauma that others experienced;

2. A number of returnees have issues that “the military did not treat us with honor and dignity,” and may feel betrayed. For example, a number report that they were forced to take a series of anthrax immunizations in the Gulf as a precaution against biological attack, yet claim that these immunizations were not entered in their medical records, that they have yet to be given satisfactory explanations of possible side effects or longer term implications and that such were “covered-up” and not acknowledged publicly or to the media. Other returnees feel betrayed by the downsizing of the military and consequent losing of promised career military opportunities.

3. There is the widespread myth that “time heals all wounds,” and that most returnees or their families still presenting readjustment difficulties must have already been unstable to begin with; unfortunately, this attitude reinforces the belief among some authorities that debriefings for war-related stressors are both unnecessary and not the responsibility of any governmental resources to provide to such returnees and their families! Of course, it may be that both are true, e.g., some folks were unstable to begin with and the war was a legitimate stressful if not traumatic experience in their lives.

4. Families tend to have 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 veteran, the military and/or the government. Also, families have reactions to their own issues about war, violence, physical injury, psychiatric disorders, abandonment, and perhaps feeling “used” by the military or government. Some family members react with jealousy to the attention paid to the veteran and lack of attention and recognition to their sacrifices and needs. Teaching skills in such areas as communications, coping with stress, relationships and problem-solving are sorely needed.
there must be clarification of the specific role that VA staff are providing to DoD staff and returnees and their families. For example, some DoD personnel believe that VA staff will try to “oversell” the presence of posttraumatic stress disorder, 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. The VA and the DoD must be willing to be openly and honestly explore where our perceptions, attitudes and missions may overlap and be divergent, where we can share knowledge and skills about healing from war, and recognize the special knowledge and influence that each of us possesses.

Before closing, I want to reemphasize that trauma in life is cumulative and interactive. This is dramatically demonstrated by the number of veterans of previous wars who had their own unresolved war-issues from Panama, Vietnam, etc., exacerbated or triggered by the Gulf War, to include some who had never previously seemed troubled by their war experiences. As a generally somewhat older population, Reserve and National Guard personnel who were deployed overseas and those subjected to the possibility of deployment were more likely to have had prior war-zone trauma issues triggered. In our laudable resolve to not overlook our most recent population of war-zone veterans and their families, let us not forget our veterans of all previous wars and their families. Finally, I want to emphasize the very positive and enhancing consequences of the Gulf War that may be denied or overlooked. These positives must be illuminated as part of any balanced debriefing or counseling process. For example, most returnees and their families appear to be very proud of their service and believe that they did the best they could, oftentimes under very trying circumstances. For most Gulf War veterans and their families, it was not just a “100 hour war;” there was severe strain, for example, from experiencing months of seemingly unceasing SCUD missile and biological/chemical attack alerts and seemingly endless full-scale and dangerous readiness drills under constant threat of possible imminent attack. And, during all those months, many families knew little or received inaccurate information about how much danger their loved ones might be in. Many returnees gained a self-confidence that they can accomplish almost anything that they decide to put their minds to, and that they learned to creatively adapt “by-the-book” learning’s and at times inadequate or out-dated supplies to the harsh realities of the war-zone. And, family members may have discovered inner strengths and accomplishments that they should be very proud of. On a larger community scale, many here in the U.S. learned the powerful sense of true community in coming together for a common cause and service to others. And finally, many learned, as have war-zone veterans from many wars, to appreciate – both simple pleasures that all of us tend to take for granted such as three hot meals, a cot and a shower—and more profound matters, such as the value of our freedom, and our rights, and our self-worth….

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