

We Are A Gentle Angry People

Rev. Deane Oliva ~ November 11, 2007

Barry Cooper former Narcotics Officer from several Texas towns on NPR Wednesday Oct 31st, discussed his strategy for stopping cars for possible drug possession. It was eye opening. First of all, know that he is so successful that he travels around the country training officers. When he does training in other cities, after he finishes his workshop, he goes out with a squad car. If he does not make one arrest in that night the whole training is free. He has never had to pay a dime. How does he do it? Well, he says, first he looks for for a veteran's license plate since he knows so many of them came back with a habit. . .

Vietnam stole my childhood innocence. At first as a girl, and a preteen I was oblivious. I did not know anyone worried about the impending war. I could not be drafted, so war did not directly affect me. Soon however, the nightmare became too big to ignore. Once filled with optimistic idealism, I became harshly aware of the realities of war. Veterans started returning home, some in boxes, some physically injured, many mentally maimed. Throughout that period I did not know one veteran who returned from combat unharmed. For each and every one, Vietnam was life altering for themselves, their family and their friends. They returned, not to honor and respect but instead to ridicule, despair and addiction. They returned to a country of people that did not know how to interact with them and did not hire them.

One veteran noted:

“Nothing prepared me for the physical and spiritual violation of war. I stayed for three tours because I lived so much with death that I couldn't come home.”

Donald M. Murray wrote:

“After the bombs, the firefights, the mines, we have a lifetime of silence. Those who were on the front lines rarely speak of their war if and when they do speak, it is done to develop excitement in the story, to create humor, and enjoy the companionship of exchanging stories that grow bigger and better after 3 or 4 beers carefully rehearsed by advancing years. Having been to many American Legion meetings, VFW, and ship reunions, I have heard veterans expound their exaggerated tales. With an open mouth, they are telling their tales, but keeping secret their deepest emotional substance. I know, despite my hate for the taste of the flavor of alcohol, for about 5 years I also used alcohol to disguise and relax my inward pain.¹

Another mourned:

“I thought I was going crazy, waking up in a sweat trying to choke my wife, seeing signs of Charley around every corner when the weather was hot and steamy. I'd always kept my feelings to myself, but now I didn't seem to have any feelings except anger. I couldn't get through a day without getting into a fight, and when I tried to numb the pain with alcohol, I jut got more angry and out of control. I left my wife and kids because I was ashamed and afraid of what I was doing to them.”

¹ Murray, Donald “Shutting down emotions is a way of life in combat” Boston Globe, 9/26/06.

This man suffered from Post Traumatic Stress Disorder, a condition first identified after Vietnam. Persons with PTSD suffer from flashbacks, nightmares, difficulty sleeping, numbness, detachment and unpredictable behavioral outbursts. Symptoms often have a delayed appearance, from three months to years after the precipitating incident. Clinically, about half of Vietnam veterans have experienced significant mental health problems since their return. They make up 1/3 of the homeless in this country. Dollar for dollar they earn less money than those who did not serve in the war. They are imprisoned more than their peers, abuse alcohol and drugs at higher rates, have higher rates of divorce and report more parenting problems. Many seem distant, with anger problems, bad dreams or flashbacks. They will not talk about their experience and many cannot get the services that they need. Now we are in the fourth year of a military struggle that parallels the Vietnam experience in tone and lack of popularity. Once again we are tearing our country apart.

Two years ago it was estimated that 17 out of 100 soldiers who served in Iraq would face mental health problems. Last year they raised the statistics. Perhaps one out of four soldiers will have significant mental health problems. Now folks are talking, one out of three. This is not difficult to understand. Almost all soldiers in Iraq know someone who was seriously injured or killed. 70% have seen dead or injured soldiers and almost half have had to uncover or handle human remains. "In Vietnam there were safe areas where people could go to rest and recuperate. That doesn't happen in Iraq; every place is a war zone.² Although our generals did not expect the fighting to turn to guerrilla warfare, it is clear that service folk in Iraq are always wary of attack, attack often from non traditional, unexpected sources. "Collateral damage," referring to the injury and deaths of innocent civilians, women and children, is rampant. (Parenthetically, it is ironic that we go through such pains to avoid the death of an innocent person on death row and then routinely bomb sites which will kill innocent victims.)

Wade Kane wrote to Journalist Tom Engelhardt³:

"People here got really worried about a flashlight at a Starbucks (which might have been a bomb). Had it been a bomb, which it wasn't, it would have weighed about 1/500th of what we routinely drop in residential neighborhoods in Iraq. It's like most people don't seem to realize what devastation we inflict there on a frequent basis."

A diagnosis of PTSD does not mean treatment. Col. Elspeth Ritchie, the Army's top mental health expert, stated in 2006 that the policy of sending service members diagnosed with post traumatic stress syndrome back into combat, has been driven in part by a troop shortage. Major Andrew Efaw, a judge advocate general officer in the Army Reserves who handled trial defenses for soldiers in northern Iraq in 2005 said commanders don't want to send mentally ill soldiers into combat. "But on the other hand, the commander doesn't want to send a message to his troops that if you act up, he's willing to send you home."

The hallmark of the Iraq war is repeated deployments and we know that service members in their second tour of duty are 50% more likely to encounter mental health problems. With over 200,000 homeless veterans, still mostly from the Vietnam era, it is estimated that half of them have mental illness and 2/3 a drug problem.

Behind the door of Army Specialist Jeremy Duncan's room, part of the wall is torn and hangs in the air, weighted down with black mold. When the wounded combat engineer stands in his shower and

² Robinson, Steve National Gulf War Resource Center

³ Engelhardt Tom Dispatch.com "The Devastation We Inflict: Two Letters from Vietnam Vets on 'Collateral Damage' in Iraq" 1/22/06

looks up, he can see the bathtub on the floor above through a rotted hole. The entire building, constructed between the world wars, often smells like greasy carry-out. Signs of neglect are everywhere mouse droppings, belly up cockroaches, stained carpets, cheap mattresses.

This is the world of Building 18, an auxiliary part of the Walter Reed Army Medical Center, a holding ground for almost 700 soldiers and marines while they await extended treatment. The numbers have grown so exponentially that they now outnumber medical patients 17 to 1, taking up every available bed on post and dozens of nearby hotels and apartments leased by the Army. The average stay is 10 months; some remain for two years. Some days it's the sick in charge of the sicker as they manage each other; staff is disengaged, overworked or unqualified.⁴ According to reporters from the Washington Post⁵ the soldiers say they feel alone and frustrated. 75% said their experience was stressful. Suicide attempts and unintentional overdoses from prescription drugs and alcohol which is sold on the post are part of the narrative here.⁵ The typical soldier is required to file 22 documents with eight different commands to enter and exit the system. Sixteen different information systems are used to process the forms, but few can communicate with one another. The Army's three personnel databases cannot read each other's files and cannot interact with each other. Forms disappear regularly and must be redone. Many give up and simply go home.

Just recently on November 7th 2007 Veterans for America published a report on the treatment of veterans suffering from psychological trauma and traumatic brain injuries. After visiting every demobilization site in the US and overseas, the VFA found three major patterns: inadequate medical care, misapplication of military justice and leadership deficiencies. Specific medical problems included the screening and treatment of TBI, the delivery of care and continuity of treatment to those with psychological wounds; responses to alcohol and substance and the conduct of the Medical and Physical Evaluation Boards.⁶

According to their report, over 1.6 million American service members have deployed to Iraq and Afghanistan and over 525,000 have deployed more than once. As a group these service members are older, an average age of 27 as compared to 19 in the Vietnam War era. In previous wars most service members were single men who deployed only once. Today 60 percent of those deployed have family, 10% are women; 16000 women who have deployed are single mothers.⁷ For women, there are only two inpatient facilities devoted solely to treating service connected injuries for female veterans. From March 2003 and through November 10th, 3860 US service members have died in Iraq. Almost half leave behind a spouse and/or children. Hundreds of thousands have sustained TBI or psychological trauma. Many have not been properly diagnosed.

Once home there are few qualified mental health providers available.

Nearly 65% of all service members wounded in action in Iraq are injured by a blast injury, a major cause of TBI. Almost 1/3 of those who served in Iraq treated at Walter Reed Army Medical Center have sustained TBI. Since symptoms of the PTSD and TBI are often the same, without adequate diagnosis inadequate treatment is possible.

⁴ Priest, Dana and Hull, Anne "Soldiers Face Neglect, Frustration at Army's Top Medical Facility: Washington Post February 18, 2007 <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/17/AR20070217011172>

⁵ *Ibid.*

⁶ Veterans for America, formally Vietnam Veterans for America, published a report entitled: *Trends in Treatment of America's wounded Warriors: Psychological Trauma and Traumatic Brain Injuries: The Signature Wounds of Operation Iraqi Freedom and Operation Enduring Freedom*, p. 2

⁷ *Ibid.* p. 3

Meeting the family needs of injured service members is one of the largest challenges facing America. It is universally admitted that there is inadequate assistance available to spouses and dependents. They need information, support groups, ongoing assistance. National Guard and Reserve service members are half as likely to file a claim and twice as likely to have that claim rejected.

The most effective treatment for PTSD is not medication alone, but medication and therapy. Since there are so few providers there is no continuity of care. It should also be noted that even when an initial diagnosis of PTSD is correctly made there is often, over time, a recharacterization of the diagnosis to severe anxiety and then finally to pre existing personality disorder – There have been more than 22000 preexisting personality diagnoses since 2001. This is important because, with the change in diagnosis these folks are removed from the system and deprived from the care necessary since the illness is not combat related.⁸ Unfortunately legal representatives tell service folk that the personality disorder diagnosis will get you out of service quicker but then give them misleading information often stating that the soldier will be able to keep their bonus and VA benefits, neither of which is true. The transfer from a PTSD diagnosis to one of personality disorder is a move that President Bush is also making, stating that many of the soldiers do not have combat related injury but, instead, have a personality disorder.

PTSD is only one combat related diagnosis. The words to the song Sam Stone by John Prine introduce us to the concurrence of PTSD with drug and alcohol dependency.

Sam Stone came home,
To his wife and family
After serving in the conflict overseas.
And the time that he served,
Had shattered all his nerves,
And left a little shrapnel in his knee.
But the morphine eased the pain,
And the grass grew round his brain,
And gave him all the confidence he lacked,
With a Purple Heart and a monkey on his back.

Sam Stone's welcome home
Didn't last too long.
He went to work when he'd spent his last dime
And Sammy took to stealing
When he got that empty feeling
For a hundred dollar habit without overtime.
And the gold rolled through his veins
Like a thousand railroad trains,
And eased his mind in the hours that he chose,
While the kids ran around wearin' other peoples' clothes...

⁸ *Ibid*, p. 9.

Sam Stone was alone
When he popped his last balloon
Climbing walls while sitting in a chair
Well, he played his last request
While the room smelled just like death
With an overdose hovering in the air
But life had lost its fun
And there was nothing to be done
But trade his house that he bought on the G. I. Bill
For a flag draped casket on a local heroes' hill.

Army policy requires that a soldier with service connected PTSD and a substance abuse problem complete drug rehabilitation before PTSD rehab. However, since drugs are used to relieve the symptoms of PTSD, drug rehab is often ineffective. A strong recommendation of the VFA study is that treatment for addiction and PTSD rehabilitation should be concurrent.

But the problem is huge. At Fort Richardson the Army Substance Abuse Program cannot offer individual therapy because of lack of funds. 46% of their \$186000 annual budget goes to drug and alcohol testing alone. Fort Richardson has one non-prescribing psychologist, three social workers and two substance abuse counselors to serve almost 4000 soldiers! There is no psychiatrist. Family members are not allowed on base, depriving soldiers of important support systems. They are expecting another 3700 troops in December 2007. So if 1/3 have a mental health problem, it is not difficult to see that they are grossly understaffed. Couple this with the fact that Fort Richardson will have only four hours of sunlight a day during the Arctic winter when this influx of soldiers is due to arise...has suggested to some providers that the number of mental health problems will rise to 45 %.

During this whole reentry process service members must be evaluated by medical boards. However, the soldier is only assigned legal representation if and when there is a final, formal Physical evaluation Board. Yet, because of the nature of psychological trauma, many members are in a compromised state of mind, not able to adequately advocate for themselves. VFA recommends legal representation from the beginning of the Medical evaluation process.

Military justice, TBI and PTSD. If folks exhibit bad behavior, - domestic abuse, fights – and are brought before the courts they are given a less than honorable discharge and may be subject to a less than honorable discharge which would deprive the soldier of benefits including treatment and pension.

At Fort Pendleton, VFA found that there is little to no use of disciplinary actions (either administrative or non-judicial) other than court martial for all classes of offenses and little consideration of combat related neuro-psychological problems. There is a propensity of Marines to desert when faced with these challenges.

Many commanders do not understand these diagnoses. Sometimes there is intentional misdiagnosing in order to get rid of dead wood. Providers are instructed not to work more than 40 hours per week. Understaffing is rampant.

Finally, according to the Mental Health Advisory team 59% of soldiers and 48 percent of Marines believe that seeking mental health care would cause their leaders to treat them differently, mostly to see them as weak. It is no surprise then that only 42% of soldiers and 48 % of Marines who screened positive for a mental health problem in Iraq sought treatment. The VFA recommends that staff be

trained, that PTSD and TBI be de-stigmatized and that staff be increased. Financial incentives may be helpful.

This excellent study is about treatment within the system. After discharge . . .

I hate war. I hate the human cost of war. Psychological injury results in a breakdown in the soldier's belief system. It is a theological decompensation. The bottom has fallen out of their pre war world and been replaced with the chaos of warfare. The abrupt halt to the killing field with discharge from service does not erase the reality which has infiltrated the mind. These soldiers need our help. Our fellowship through its board has passed an anti war resolution. As our denominational president chants, "Not another dollar, not another life." This is a good thing. What next?