A Dissident Approach to Understanding Veterans' Psychological Distress

With Nine Proposals for Further Consideration and Action

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I eagerly welcome reader comments and suggestions.

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I. Far too many veterans are experiencing devastating psychological suffering.

1. The bellwether indicator is their suicide rate, an estimated average of 22 a day. Although this figure is shockingly high, it may actually underestimate the extent of veteran suicides: sampling for that figure represents only 21 states and less than half of the US population; among those left out are homeless veterans, those who leave no notes, and those not enrolled in the VA system; and, there is no uniform suicide mortality reporting system in the US (Basu 2013). Suicidal intent falls on a continuum of risk-taking behaviors such as reckless driving, and that rate is particularly high for veterans as well (MacQuarrie, 2009). It is often up to conscientious reporters to ferret out the extent of actual suicides through local investigations (Jones 2013).

2. Studies indicate that OIF and OEF veterans suffer from disproportionate frequencies of substance abuse and a range of mental disorders as well. A 2012 survey of studies by the Substance Abuse and Mental Health Services Administration (SAMHSA) summarizes them.

II. An emerging model of suicide causality specific to veterans builds on established factors but also emphasizes social relationships seen among veterans at risk.

- Access to a method for killing oneself and diminished fear of pain.
- The belief that living is a burden to others.
- *Social alienation.*

(Based on Monteith et al. 2009)

III. We hypothesize that veterans' social alienation result from a *cumulation* of military experiences that generate a profound loss of trust in human relationships at all levels-- institutional, community and personal: the key experience here, acting in an ugly synergy with horror, helplessness and guilt, is ***betrayal***. The following facts and concepts develop that hypothesis. ***To truly comprehend them we must rid ourselves of a positive attitude toward militarism and American military institutions.***

1. Those who have killed in combat have a higher incidence of PTSD, a phenomenon now referred to as Perpetration-Induced Traumatic Stress (PITS). Rachel MacNair's pioneering study of perpetration-induced traumatic stress among combat veterans (2002) opens the door to further research concerning the harmful effects of active combat behavior and participation in atrocities, as opposed to passive experience of life-threatening events.

2. The conduct of modern war exacts psychic tolls among combatants that far exceed the horrors of combat experienced in archaic empires. War today victimizes the innocent on an unprecedented scale. Soldiers of today do share similarities with combatants in ancient wars (Shay 2002, 1994), in particular existential horror, PITS, and profound stress from exposure to the enemy's lethal intent. Nevertheless, present-day

weapons spread indiscriminate destruction and death far beyond the capabilities of early armaments. In a clear historical trend over the last century, combatant-noncombatant distinctions have evaporated, and civilians have become targets of attack (Hobsbawm 2002; Tanaka & Young 2009). America's counterinsurgency wars of choice in the last half century are no exception.

3. All of the "Conditions of atrocity," in which normal people do terrible things, are occurring in America's recent wars:

- counterinsurgency in support of an unpopular government, eliciting indifference or outright animosity toward Americans among local inhabitants;
- fighting in the midst of civilian populations into which antagonists fade and blend, with casualties occurring randomly and in scattered places;
- extreme counterinsurgency policies and strategies (among examples, forced relocations, torture in various forms, body counts, and nighttime raids);
- bad “intel” (among examples, kicking down the wrong apartment door and terrorizing its innocent occupants or abducting uninvolved civilians);
- characterization of the enemy as amorphous and apocalyptic (current examples include “Islamofascists” and “global terrorists”); and,
- Inconsistent rules of engagement.

(Based on Lifton 1973, with supplementary observations from Rieckhoff 2006 and Wood 2006)

4. The distinction between "comrade" and "friend" challenges the idealized image of camaraderie among "battle buddies." Mutual protection in mortal combat creates a powerful bond of comradeship but it differs in nature from friendship: the war comrade dynamic resembles "the enemy of my enemy is my friend," and only the threat of violence and death sustains it. We should investigate the nature of this relationship further, particularly in dyads and small groups in which the protector exhibits psychopathic tendencies. Psychopaths constitute two percent or more of the soldier population, and they do the most killing (Hedges 2002, 2003). In the My Lai massacre, for example, "a couple of crazy guys" precipitated the mass killing (Goodman 2010).

5. The United States Department of Defense is, above all, an enormous bureaucracy, and it exhibits all the abuses of one. Extreme stratification in "command and control" means layers of incompetence, careerism and indifference that jeopardize the lives of the lower ranks, condone misallocation of resources, and cover up lethal mistakes. It is no accident that the terms SNAFU, FUBAR and "Cluster Fuck" originated in the armed services, in a culture whose top leadership devotes more attention to public image than rectification of errors.

Bureaucratic abuses and interpersonal conflicts include:

- broken recruiter promises regarding personal safety, education, and career development, coupled with aggressive recruiting tactics
- rape and sexual harassment amidst a culture of misogyny

(DOD bureaucratic abuses, continued)

- water shortages and spoiled food in theaters of operations
- friendly fire casualties
- inadequate or defective equipment
- antagonistic differentiation: FOBBITs (OIF, OEF), REMFs (Vietnam War era)
- arrogant officers indifferent to enlisted members' well-being
- endemic careerism, cynicism, corruption and systematic dishonesty

Selected Sources: Astore 2015; Dick 2012; Government Accountability Office (GAO) 2006; Jones 2013; Mazzetti 2005; Rieckhoff 2006; Tucker 2015; Wheeler 2011; Wong & Gerras 2015; Wood 2006. Instances of bureaucratic abuse and internecine antagonism also appear in accounts contained in other bibliography items but are not listed here.

6. Working class and poorer Americans bear the brunt of casualties. This fact has important but as-yet poorly explored ramifications for vulnerability to psychological trauma. Several studies have found that social class strongly influences personality configuration (Lareau 2003; Jensen 2012; Leondar-Wright 2014). Although mainstream psychology recognizes "low level of education" and poverty as risk factors for PTSD (Price 2015), we sorely need sociopsychological analyses informed by contrasts in class-related personality factors and values.

Recruiters target poorer communities because youth there have few or no alternatives for building their lives (Bacevich 2010; Kriner and Shen 2010). We have reason to suspect that soldiers and marines from violence-prone communities and dysfunctional families have fewer mental resources for overcoming psychological trauma (Finley 2011; other cites pending). Fruitful insights regarding working class personality formation and values have resulted from studies of class differences, particularly in childraising (Lareau 2003; Williams 2012), but we need research that explores connections between such findings and vulnerability to military trauma. We need to conduct research regarding the effects of a betrayed working class pride in undertaking unpleasant and dangerous work, response to abusive authority, and dependence on protective figures.

7. Disillusionment with "the mission" and its execution, together with civilian indifference, may pose another psychological liability. We have yet to know accurately the psychological toll of fighting in futile wars (Benjamin 2006), but we do know that the United States does not treat its veterans well when it loses (Glantz 2009). Current "Support our troops" symbols and rituals may comfort some veterans, but others regard them as a cheap cosmetic sop (Bacevich 2011). There is a widening sociocultural divide between military families and our dominant civilian culture that refuses to share the sacrifices and burdens of war. Andrew Bacevich summed the civilian attitude thus: "although we don't know you, rest assured that we admire you--now please go away" (2005, p.29).

IV. We can apply our insights to programs and projects.

We can readily apply the assertions and hypotheses posed above by translating them into specific projects and programs. They appear here under three subheads: Programs and Policies for Direct Interventions, Data Base Creation, and Professional Development.

Programs and Policies for Direct Interventions

Proposal One. Advocate for separating veterans' care, teaching, and research from programs geared primarily to serving active duty personnel and their families. The Department of Defense's procedures and institutional culture do not necessarily prioritize individual healing and may indeed frustrate it (Finkel 2013; Jones 2013).

Create an environment for providing outreach and services that is free of military iconography and ritual. We need to bring in and care for those veterans who want no reminder of military life in any form. Consider this observation regarding civilian settings for veterans' psychological health care services in the United Kingdom:

> Services need to be in place that are culturally sensitive to the particular needs of veterans. ... in the UK ... the emphasis is on providing treatment within the National Health Service. *Some individuals may want very little to do with the Armed Forces once they have left and this provides a further rationale for provision of interventions within civilian health systems* (While & Kapur 2009, p 230, emphasis added).

Craft a clearly defined, nurturing niche in the professional provider community via an organizational structure such as the proposed Concerned Clinicians and Researchers Network, organized for those of us whose first obligation is to serve our individual clients and their families and not to "support the mission."

Proposal Two. Apply selected practices from victim-offender reconciliation in service to healing. Just as restorative justice (RJ) benefits a selected subgroup among criminals and the people they have wronged, some veterans could experience the healing, redemptive power of forgiveness. Testimonials from Vietnam War veterans who have returned to Vietnam to visit the Veterans for Peace Friendship Village and Soldier's Heart are instructive (Jones 2008 and assorted personal correspondence).

Proposal Three. Support programs that repair veterans' severely damaged sense of interpersonal trust and belonging. Encourage their involvement in tight-knit but welcoming communities that have a shared goal orientation and a range of hands-on work activities that contribute to realizing group goals. This proposal builds on the centrality of love and work to human meaning and fulfillment. Sustainable agriculture offers a superb example.

We can help encourage alliances between interested veterans' groups and progressive reform movements that focus on issues that deeply affect the well-being of both veterans and civilian society as well. The success of sustainable agriculture, for example, requires changes in public resource allocation and laws and regulations at many levels of government to succeed (Rogers 2010). Health care in the United States is a chaotic mess that adversely affects veterans and their families. The country's current economy is still in tatters and employment prospects for many are grim.

These fundamental affronts to social justice may be revealed in a remarkable statistic: people who enter the army in their late twenties suffer three times the suicide rate of those several years younger. General Peter Chiarelli offered this interpretation:

> ...why does a young man or woman decide to join the army at twenty-eight or twenty-nine years old? They're either a tremendous patriot, or *they've lost their job, have a couple of kids, lost their medical care*, and are coming in as kind of an opportunity to get their life straight again. They come in with all these stressors, and we say, hey guess what, buddy? You're going downrange in six months (quoted in Finkel 2013 p. 79, emphasis added).

Could we envision social justice movements in which veterans and civilians join forces in the mutual recognition that neither sector of society could accomplish reform alone? Such efforts could also create an effective avenue for generating more genuine respect and understanding of veterans' lives and aspirations among civilians.

Data Base Creation

Proposal Four. Create reference data sets that contain aggregate recruitment information categorized by cohorts exhibiting important contrastive features. Examples: an "Immediate post-9/11 Cohort," marked by a patriotic idealism among recruits who joined to avenge the Twin Towers attack victims; a "Post-economic Collapse Cohort," in which gainful employment represented the strongest motive to join; and, "Eligibility Trough" periods representing recruiters' greatest difficulty in filling quotas, resulting in compromised recruitment standards for intelligence and criminal records (Turse 2006). We should explore, for example, the ramifications of depending on "category fours" for cooperation and mutual protection.

Proposal Five. Create data bases for specific theaters of operation that contain accurate information regarding features of the local population and details regarding military engagements and other operations, including civilian casualties. This suggestion is based on psychiatric social worker Sarah Haley's observation that Vietnam War-era Veterans Administration therapists who acquired an in-depth knowledge of such facts as weapons, villages, and specific battles, could give veterans an enhanced sense that the therapist was "'being there'," as well as an awareness of the veteran's avoidance of certain issues, including atrocities (Haley 1974, p. 196).

This type of information of course demands extreme care in its clinical application, including attention to all of the complexities of countertransference. (One prominent

psychiatrist who treats veterans categorically rejected the suggestion of such a data bank at a recent public panel on moral injury.) As clinicians, we follow first and foremost the commandment to do no harm. We must also ask ourselves, however: *when is the truth therapeutic?* Consider these observations in Judith Lewis Herman's classic, *Trauma and Recovery*: the resolution of guilt felt by combat veterans requires "a detailed understanding of each man's particular reasons for self-blame rather than simply a blanket absolution" and, on the part of those who bear witness to violence, "not absolution but fairness, compassion, and the willingness to share the guilty knowledge of what happens to people in extremity" (1992, p. 68, p.69). We must be able to look our veterans in the eye when they say, "No one would believe what I did," and tell them honestly that we do not run away from the truth.

What actually happened on the ground may also determine a diagnosis. By way of example, Sarah Haley recounted the diagnosis given a Vietnam War combat veteran who presented at the Boston VA with severe anxiety and agitation. He claimed that he had witnessed a massacre and was warned by other soldiers there that they would kill him if he were to reveal the incident to anyone else, and he feared for his life. At a staff meeting, Haley contested the diagnosis of paranoid schizophrenic on the intake log, arguing that "*there were no other signs of this [diagnosis] if one took his story seriously*." She recounted that she was "laughed out of the room" (Scott 1990, p. 298, emphasis added). The massacre burdening the veteran was the one that had actually taken place at My Lai. Note that the DSM-5 diagnostic Criterion D for PTSD, "Negative alterations in cognition (and mood)," lists so-called "distortions":

> Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous...").
> Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others (American Psychiatric Association 2013, pp. 271-2).

The distinction between truth and distortion forms the indispensable basis for every determination of serious mental illness.

Proposal Six. Collect both aggregate statistics and individual information on recruiters' promises of career training versus actual post-induction assignments. The agreements in the DD Form 4/1 contract that recruits sign are *not* legally binding on the Department of Defense. Section 9 (5) b of the form states that explicitly. A recruit's disappointed expectations constitute one more experience of institutional betrayal. [Citations pertaining to recruiter deception in addition to GAO 2006 are pending.]

Proposal Seven. Conduct thorough research on the actual extent of veterans' suicides, including creation of a nationwide high-validity, standardized mortality reporting system. Current statistics regarding veteran suicides are clearly inadequate. We envision a data base built from the ground up that makes use of sophisticated concepts from epidemiology and demography, informed by observation-intensive ethnographic studies and the advice of clinical psychologists and social workers. Only in

this way can we adequately comprehend differential mortality among veterans, including self-inflicted death.

Professional Development

Proposal Eight: Learn from abroad. Reject the "Not Invented Here" assumption that the United States occupies the cutting edge of knowledge and enjoys a monopoly of effective interventions. How did the Russian helping professions deal with veterans from *their* Afghan War? Did dissident French therapists create novel approaches for veterans of the Indochina War or the Algerian War of Independence? The recent British experience also call for more collaboration with counterparts abroad.

Proposal Nine. Revitalize our intellectual heritage. In particular, study and build on the work of such pioneers as Robert Jay Lifton, Chaim Shatan, and Sarah Haley. Chapter Four in Gerald Nicosia's 2001 book, *Home to War: A History of the Vietnam Veterans' Movement*. provides a valuable account of institutional resistance in the 1970s to diagnoses based on recognition of traumatic stress unique to war. New approaches that question the dominant ideology need organized constituencies to defend and promote them, particularly in university settings. After recounting the struggle to recognize psychological trauma and the study of the sexual molestation of females, Judith Lewis Herman observed that, "without the context of a political movement, it has never been possible to advance the study of psychological trauma" (1992 p. 32). This observation most certainly applies to dissident analyses of veterans' problems.

V. Engage the Mainstream Professional Community

1. American society today is steeped in militarism. It would be hard to overstate the extent of militarism in American society today. Consider our current involvement in the longest wars in American history, public acquiescence to the vast sums spent on our military, our empire of overseas bases, and our country's national security complex (Johnson 2010; Bacevich 2005). A 2013 Gallup poll found that 74 percent of their sample of Americans expressed either "a great deal" or "quite a lot" of confidence in the military, making it the most trusted of 16 public institutions. In contrast, organized religion only rated 45 percent. Consult Bacevich 2005 for a thorough analysis and explanation of America's post-World War II bipartisan embrace of militarism.

2. We cannot expect mainstream clinicians to resist the influence of militaristic thinking and related taboos on their own perceptions of veterans' problems. As a pillar of ambient ideology in American society today, militarism supplies a default set of assumptions and predilections that operate among psychologists unless they are specifically challenged. "Moral injury" provides a striking example. This belated recognition of guilt and anxiety from perpetrating atrocities (or, in another version, experiencing commanders' incompetence and treachery) is evolving into a disorder category, but the mainstream sanitizes its depiction of acts of atrocity by portraying them as unavoidable wartime accidents or protective moves and rarely, if ever, as acts of gratuitous cruelty. Mainstream discourse regarding moral injury attributes risk to

individual characteristics such as personal religious beliefs as opposed to a universal human psychobiology of empathy.

Militarism also imposes a taboo on examining class differences because they call attention to the injustice of unequal sacrifice for war among America's social classes.

3. We explicitly acknowledge our own ideological leanings and abide by proven standards of proof for our assertions. In our role as dissident clinicians and researchers we must reject explanations that simply gratify our ideological predilections. Instead, we must test and refine our arguments in crucibles of practice and research that adhere to the highest standards of proof. We commit to subjecting research emanating from our orientation to rigorous tests of logic and fact, but we also assert that high-validity observations from very small samples deserve recognition as seeds for development in more generalizable research projects.

Despite all of the flash points of ideological conflict, we seek common ground with mainstream clinicians in the name of healing veterans.

4. The research and implementation programs proposed here do not assume a 'one size fits all' application to veterans, who comprise an extremely diverse population whose members have had quite positive as well as negative military experiences. We also firmly believe, however, that our own approach will succeed where others have failed in eliciting cooperation from an otherwise extremely alienated sector of the veteran population. It is these men and women who, after all, are the most vulnerable to intense psychological pain. Listen carefully and you can hear them (Gutmann & Lutz 2009).

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