Since the beginning of World War II the United States has been at war more than 40 percent of the time. In terms of human sacrifice 375,000 soldiers have been killed in action and another 940,000 severely injured and maimed. These data do not include the uncounted millions of civilian casualties in countries where the fighting occurred. And the devastation doesn’t end with the death or injury of a soldier. It continues to affect individuals and/or their families for decades. Recent wars in the Middle East (i.e., Afghanistan and Iraq) present a unique challenge for social workers charged with meeting the needs of warfare survivors—those who were injured as well as surviving family members—needs that will continue for many years to come.

Social workers in hospitals and veterans’ outreach centers play a central role in the recovery process—for both survivors and their loved ones. Social workers in military hospitals help patients and their families maintain communication. They arrange for transitions to other forms of care that might be necessary for rehabilitation or for the development of new job skills. They also address psychological injuries. Social workers in other human service agencies, too, have a role in the aftermath of war. They play a critical role in helping survivors and their families overcome the often unrecognized long-term consequences of war.

Working with survivors of war is not new for social workers. The first paid social workers in the United States were appointed to help with issues experienced by soldiers and their families in the 1860s, during the Civil War (see Chapter 4).

This chapter was prepared by Joanne E. Clancy, Clinical Social Worker with the Trauma Recovery Team, Veterans Affairs Medical Center, Houston, Texas, and Bradford W. Sheafor, Professor of Social Work, Colorado State University.
Trattner notes that, “Like all wars, the ‘War Between the States’ created enormous relief problems, not only for wounded and disabled soldiers but for bereaved families who lost their male breadwinners during the conflict.” Social workers continued to provide these important services not only during the seven wars subsequent to the Civil War, but also during the intervening years when physical and emotional scars persisted.

Today and in the foreseeable future, social workers will attend to survivors of wars. Some will serve as social workers in the military. Others will be civilians employed by the Veterans’ Administration and other veterans’ organizations. Social workers employed in schools, hospitals, courts and prisons, mental health centers, child welfare agencies, drug and alcohol rehabilitation centers, nursing homes, and other practice settings will also serve survivors or families impacted by war. Because survivors of warfare present for services in multiple settings, all social workers should develop skills in grief counseling and management of trauma survivors’ complex needs.

As in other areas of the human services, social workers are the professionals most likely to make referrals. They must not only know the general resources available to clients, but must also be informed about services specifically designed for veterans and their families. If needed services are not available social workers must advocate for their creation. Social workers, unlike individuals in the general population, are in a position to observe the far-reaching aftermath of war as it affects members of society for years after the hostilities have ceased. It is from this vantage point that social workers have special insights to contribute regarding the prevention of wars.

Social Work with Soldiers and Veterans

The recent wars in Afghanistan and Iraq are the most sustained combat efforts initiated by the United States since the Vietnam War. This new generation of combat veterans requires the focused energies of many service providers (physicians, nurses, psychologists, occupational and physical therapists, and social workers) as the veterans strive to reintegrate into society. The social work profession has a unique opportunity to take the lead in this stabilization and recovery process because the systemic manner through which social workers approach problems, coupled with their ability to provide multiple levels of service in a variety of settings, maximizes their ability to impact the lives of both veterans and their families.

People die in wars. An even greater number survive but sustain serious, life-changing injuries on the battlefield. During World War II one out of every three wounded soldiers died. In Vietnam one out of four wounded soldiers died. Soldiers serving in Iraq have even better odds of surviving; only one out of every eight wounded soldiers die. Despite this “good news,” many surviving soldiers return home with catastrophic injuries that disfigure and emotionally scar them for life. Advances in field medicine may save their lives but, as one former medic quite eloquently stated, “I’m not sure we did them any favors. These men and women
were young, healthy people in the prime of life. They went home with missing arms, legs, and eyes. A lot of them have psychological problems as well. Even the lucky ones, the ones who have people to help and support them, face decades of physical and emotional pain, discrimination, and the challenge of learning to live a life very different from the one they planned. Yeah, I’m not sure we did them any favors.”

Adjustment to the traumatic loss of one’s physical integrity, especially when functional ability is seriously compromised, is a long and painful process. Simple tasks once taken for granted become impossible or require Herculean effort to accomplish. Depending on the nature and severity of the loss, the affected individual may require months or years of physical therapy to regain even a fraction of his or her former independence. Dramatic changes in body image, coupled with others’ reactions to the veteran’s altered physical appearance, further complicate the recovery process. One young soldier, a quadriplegic, stated, “I want to commit suicide but I can’t move my arms or legs. No one will help me do it. My mother keeps telling me things will get better if I just have patience. I’m 21 years old . . . how can things ever get better? I was an athlete. I planned to become a physical therapist. I wanted to get married and start a family someday. Who would want me now? I am completely helpless until someone cleans me up and sits me in my motorized chair. All my dreams are gone, what’s the point?”

Sustained exposure to potentially life-threatening experiences escalates the risk for psychological problems. This is especially true in a war zone where death and serious injury are not only feared, but also expected. In a recent study targeting the effects of combat on the mental health of soldiers in Afghanistan and Iraq, researchers discovered a strong correlation between combat experiences (being shot at, handling dead bodies, witnessing the death of a peer, killing enemy combatants) and the prevalence of posttraumatic stress disorder (PTSD). The presence of PTSD increased proportionately with the number of battles in which soldiers engaged during their deployment. Mental illnesses most commonly identified among study participants include acute stress disorder, posttraumatic stress disorder, generalized anxiety disorder, major depression, and alcohol abuse.

Despite the high incidence of mental distress among combat troops, few soldiers express interest in pursuing mental health treatment. This holds true even when the soldiers are presented with opportunities to visit “wellness tents” in the field, participate in debriefings post-deployment, or meet with mental health professionals in more formal settings. Researchers in one study determined that only 38 to 45 percent of soldiers whom met criteria for a mental disorder were interested in receiving help. Even more startling, only 23 to 40 percent of those expressing a desire for assistance actually sought help post-discharge. The stigma of mental illness (i.e., “I am weak, crazy, not normal”) and the fear that seeking mental health care will adversely impact future career opportunities were primary factors in their decision-making process.

All stories told by soldiers and veterans throughout this chapter were reported to social workers in veterans’ centers and hospitals.
Social Work with the Families of Soldiers and Veterans

Combat survivors struggle to escape traumatic memories that assault them through intrusive thoughts and nightmares. At the same time, their loved ones struggle to understand what happened to the individual they sent to war. The person who returns is altered in ways that cannot always be seen or explained. One soldier’s mother poignantly stated, “I sent my son to war. The person they sent back is not my son ... it is a shell that looks like my son. He is angry and distant. My heart is breaking because nothing I say or do can recapture what he, and we, have lost.”

When soldiers receive orders for deployment into a combat zone, a kaleidoscope of emotional reactions emerge from both the soldier and from his or her family members: Denial, “this isn’t really happening ... it is?”; Fear, “what if he or she is seriously injured, crippled, or killed in combat?”; Anger, “I never really thought he or she would be sent to war.”; Confusion, “what will become of our family before, during, and after my loved one’s deployment into a war zone?” The emotional impact of impending deployment is magnified by the reality that war, even under the best of circumstances, results in death and sacrifice.

The free-floating sea of emotional reactions within and between family members can wreak havoc on a family’s ability to prepare for, endure, and recover from the deployment experience. Individuals process and cope with emotional distress in ways uniquely their own. Age, gender, and past experiences influence each family member’s willingness and ability to openly challenge and move through their collective emotional experience. During this critical time in the family’s life cycle, forging a united front is crucial to the healthy adjustment of all involved. Without adequate guidance and support, many of these “at risk” families will become “collateral casualties” of war.

Social Programs for Soldiers and Veterans

In the event of the death of a soldier, family members not only must deal with the death of a loved one, but most families will also be poorer. Initially, government programs help to offset expenses and the wages of the soldier who died, but these resources are designed to decline over time, thus challenging social workers to help the families develop alternate sources of income.

The National Military Families Association calculated the benefits for the family (a wife and children ages 1 and 3) of an enlisted man with a salary of $38,064 a year, including a housing allowance and combat pay. Apart from the lump-sum payments (i.e., $12,420), his wife would receive the equivalent of an annual income of $57,624, falling to $45,804 after two years, then declining in steps as the children reach adulthood. By the time the younger child turns 23, the wife’s check would amount to only about a quarter of her husband’s active-duty salary.6
Further, many families require emotional assistance as they experience the grief process. Social workers in hospice agencies and mental health centers regularly provide valuable counseling to parents, siblings, spouses, and children of soldiers killed while performing military duty.

Social workers also encounter soldiers returning from a war zone who experience problems meeting basic social needs. If the individual is a professional soldier who has not yet fulfilled his or her commitment to military service, reassignment to a new duty station often occurs. This forestalls any immediate concerns about housing and income. If, however, the individual has fulfilled his or her military obligation, an additional challenge of separation from service and transition to civilian life ensues. Housing and finances may or may not be an issue for these individuals. The presence or absence of extended family support during this time of transition is a primary variable in determining post-discharge outcomes.

The financial issue is more complex for reservists and National Guard personnel mobilized to an active duty status. Although job security is guaranteed, many of these individuals incur significant financial reversals while on active duty. The military cannot, and does not, match the salaries these individuals receive from their civilian employers. This disparity in income often generates far-reaching consequences for these individuals and the family members they leave behind. In one instance a young mother of three stated, “What does the military expect us to do? My husband made over $100,000 a year as a computer analyst. I am a housewife. How am I supposed to pay the mortgage and keep our household running on what the Army is paying him? We will probably have to file bankruptcy. So much for supporting those willing to serve their country!”

Social Work Practice during Reintegration Efforts

Outreach and Resource Mobilization

Although several disciplines work with active duty military personnel and veterans, social workers are best qualified to address their subsequent emotional and social needs. Historically what sets the social work profession apart from other disciplines is the willingness to meet individuals “where they are,” emotionally and geographically. Social workers display great flexibility in their willingness to engage in outreach efforts designed to identify and engage elusive populations. This willingness to aggressively pursue populations most at risk “where they work, live, and play” allows social workers to intervene early on, before the problems escalate.

Social workers assigned to active duty military positions, and those working civilian contracts for the Department of Defense or other divisions of the federal government, play a critical role in outreach efforts. Their presence at military bases, in the field, and at veterans’ outreach centers and hospitals across the country provide opportunities to identify the needs of soldiers and veterans at each stage of the deployment process. The following case study highlights the role social work plays in promoting a health transition for soldiers and their family members.
Mr. X is a 22-year-old, married Marine sergeant recently discharged from the military after a tour of duty in Iraq. He was discharged approximately 2 months before the social worker’s initial contact with him at a local veterans’ outreach center. The social worker assigned to his case identified a number of problem areas. The veteran had limited income and needed temporary financial assistance. He was interested in securing employment and in returning to school, but had no idea how to access vocational services. He and his spouse were experiencing a variety of marital problems they had not been able to resolve on their own. Both partners had little understanding of the emotional problems this soldier was experiencing.

The social worker immediately set forth to identify and mobilize available resources. The veteran and his wife received referrals to community-based agencies for financial services. A referral to the vocational counseling department at the local veterans’ hospital was initiated to assess his readiness for training and/or job placement services. The social worker also initiated a referral to the hospital’s PTSD program so the veteran and his spouse could receive assistance coping with the veteran’s psychiatric problems. The couple also received a list of Internet referrals where they could download information pertinent to issues encountered by veterans of Middle Eastern wars.

The social worker met with this couple weekly at the outreach center for several months. She provided emotional support and monitored their progress accessing identified resources. When the couple expressed frustration due to snags in the referral process to several agencies, the social worker assumed an advocacy role. Several months later when the veteran returned for follow-up services at the veterans’ hospital he was asked what had been most helpful during the initial months following his military discharge. The veteran replied, “The Vet Center social worker. We felt lost, alone, and confused. Our social worker was very kind. She guided us through a maze of resources we would never have figured out on our own. She seemed to really care about what happened to us and gave us hope that, in time, things would get better. I don’t know where we would be if this caring professional had not stepped up to bat for us.”

**Education and Skill Building**

The transition from soldier to civilian, especially after serving in a war zone, is challenging. If physical and/or mental disabilities factor into the equation, the adjustment process becomes even more complicated. Through individual, group, and family sessions social work professionals provide knowledge about specific conditions, identifying existing treatment options and introducing coping skills so those affected can more readily navigate the challenges at hand. The simple act of “naming the problem” brings relief and provides direction. As one veteran so aptly stated, “Now that I know what the problem is, I can begin identifying ways to attack it.”

Skill building is another critical piece of the recovery process. The majority of combat veterans are young and they possess a limited range of coping skills. Exposure to a variety of problem-solving techniques, offered through educational classes and skill building sessions, provides them with a “toolbox for recovery.”
These tools, once acquired and reinforced, empower individuals to assume the lead in creating their own solutions. The social worker’s role during this process is to impart knowledge and guide individuals through role-play sessions designed to enhance their effectiveness in skills application. The case of a young female amputee clearly illustrates this point.

Ms. P is a 23-year-old female soldier severely wounded during a terrorist attack in Iraq. She was standing guard when a jeep carrying explosives crashed into a building near her position. She lost both legs below the knees. Emotionally devastated by her loss, this young veteran had no idea how to cope with the drastic life changes brought about by her amputations. Her family was equally at a loss. The social worker assigned to her case provided information about typical reactions experienced by amputees and their family members. He invited them to attend a support group with other amputees and their families. This provided opportunities for mutual support and the exchange of ideas and information. He also invited the family to attend a series of classes that focused on independent living skills. During these classes the veteran developed strategies to assertively communicate her needs. Role-plays where family members assumed the role of amputee helped sensitize them to the challenges faced by their loved one on a daily basis. The veteran and her family also received instruction on the variety of prosthetic devices she would need to normalize her life. Stress management and play therapy classes introduced healthy alternatives for coping with distress inherent after traumatic losses.

When asked to describe this educational experience Ms. P replied, “My first reaction . . . this is a big waste of time. I didn’t see how going to classes would help me or my family deal with the fact I have no legs. I attended grudgingly at first to humor the social worker. Then, as the weeks went by, I realized things were getting better. We were learning new ways to get things done that really worked. I learned to communicate with my family more productively and they stopped being afraid to tell me how they really felt. We have even learned to laugh together when the going gets tough. Meeting with other amputees and their family members was also helpful. We learned a lot from each other and made some new friends, too. I never realized how important these classes would be to my recovery. I hope all the other veterans coming back with injuries like mine have a chance to participate in this kind of program. The classes made me realize I still have a life to live, but it is up to me to get out there and live it.”

Supportive Interventions

Taking a human life or witnessing the traumatic death of another human being produces far-reaching consequences for even the most psychologically sound individual. Although loss is a normal part of the life cycle, most humans never encounter the type of traumatic losses identified above. During the heat of battle most soldiers report feeling numb. One young soldier described his experience by saying, “I was on auto-pilot. I saw people dying all around me and all I could focus on was staying alive. I had to kill several enemy soldiers and didn’t think much of it at the time.”
The psychological impact of one’s actions in combat may take days, weeks, even months to surface. Another young veteran reported the following experience. “I was a helicopter door gunner in Iraq. My job was to kill enemy soldiers on the ground. One day we came across a band of rebels and they started shooting at our helicopter. I returned fire, knowing I would kill at least some of them. After the battle we landed to do a body count. Among the dead were a young woman and her baby. As we flew back to base camp it felt like I was dying inside, one piece at a time. Things have never been the same since that day.”

Survivors of combat trauma face three significant challenges as they strive to recover from traumatic losses incurred on the battlefield. First, taking human life, even in the name of self-preservation, transforms them into “old souls.” An old soul is a young person who has seen the darkest side of him-or herself. Although all humans have the capacity to kill when confronted with life and death situations, few of us ever cross this line. Thinking you can kill someone, and knowing you have, are very different experiences.

Second, the taking of a human life generates tremendous conflict between one’s beliefs and values, and actions taken during the heat of battle. One young soldier participating in a PTSD program expressed the following thoughts. “I grew up in the church. I learned that harming others was a mortal sin. I remember one day, when my unit was preparing for battle, a preacher stopped by our tent to pray with us. He asked God to protect us and keep us safe. Then he told us to go out there and kill those bastards. His comment really confused me. He sanctioned behavior that is in direct conflict with what I spent the first 18 years of my life believing. It really messed me up. Now I question if God even exists. I also worry about my soul . . . if there is a God, am I doomed to hell because of what I did in Iraq?”

Finally, returning combat soldiers often experience profound guilt. This guilt stems not only from taking human lives, but also for surviving when others do not. One young man, traveling in a convoy, described the following experience. “My buddies and I were driving supplies between two base camps. My truck was scheduled to take the lead, but the other driver begged me to let him go first. He was new in country and wanted to prove himself. I said yes against my own better judgment. We were on a narrow road with a steep ravine on one side. The truck in front of me hit a mine. All I could do is watch in horror as the truck plunged over the cliff. Bodies flew everywhere. I stopped my truck and we scrambled down the cliff to rescue survivors. There weren’t any . . . we ended up collecting dead bodies instead. If I had refused to let the new guy lead the way this wouldn’t have happened. It’s a hell of a burden to carry around each day.”

Social workers provide the bulk of mental health services to individuals seeking assistance from veterans’ outreach centers, hospitals, and mental health trauma programs. The focus of treatment is empowering veterans to identify, process, and move beyond their traumatic experiences. Social workers conducting individual and group therapy sessions encourage trauma survivors to “remember and let go” of traumatic memories, since forgetting is not a realistic option. Multifamily group therapy adds yet another dimension to the recovery process. Allowing veterans and family members to share their common experiences
Mr. M. is a 25-year-old, married combat veteran who served two tours of duty in Iraq. During the second tour his unit encountered a group of insurgents, which resulted in intense hand-to-hand combat. Several of his buddies were killed during the attack. Mr. M. sustained only minor injuries. Unfortunately, his traumatic experience continued to haunt him after discharge. He reported a great deal of inner conflict about having killed several enemy soldiers during the battle. He also felt guilty for surviving when many of his peers did not. During his first session with a social worker in an outpatient trauma program he shared the following information. “I have been a wreck since I got back from Iraq. I have nightmares about killing and being killed. I think about the war all the time and have to avoid watching the news or I get all stressed out. I am irritable a lot of the time and don’t want to be around anyone. Life just doesn’t seem worth living anymore.”

The social worker’s first intervention involved consultation with the clinic psychiatrist. The psychiatrist prescribed medication to help alleviate Mr. M.’s symptoms. Next, Mr. M. was enrolled in both individual and group therapy. The goal of individual therapy was to provide a milieu where the veteran could discuss the most painful aspects of his combat experience. The social worker identified a number of techniques to aid him in redirecting painful thoughts when they occurred. Mr. M. was also assisted in challenging self-defeating thoughts about his survival and reframing his feelings about killing enemy soldiers in the line of duty.

During group therapy sessions the focus was helping Mr. M. realize he is not alone in his struggle. Opportunities to process thoughts and feelings with other veterans experiencing similar reactions helped him develop a new appreciation of his own situation. It also provided exposure to others’ coping strategies, some of which he adopted with great success. During one session he remarked that things at home were not going very well between him and his spouse. This resulted in a referral to a multifamily group. In this context Mr. M. and his wife learned how to join forces so they could combat symptoms of the veteran’s PTSD instead of fighting with one another.

After 3 months of treatment the veteran and his wife met with the treatment team to discuss his progress and identify ongoing issues for work. Both expressed great relief that things were beginning to improve. Mr. M. was less irritable and anxious. His nightmares were less frequent and intense. He noted a return of optimism about the future. His wife reported that participating in the multifamily group was the best possible thing that could have happened. She felt supported and validated both by the social work leader and other members of the group. She stated, “Attending family group made me realize we are not in this alone. I heard our story coming out of the mouths of other veterans and their wives. Some of them have been in treatment longer than we have. Their testimonies gave us hope that things can and will get better if we just hang in there. I don’t know what might have happened if we hadn’t come in for help. We still have a long way to go, but at least we are moving in the right direction!”
Special Considerations Regarding Today’s Victims of War

It is clear that social workers have an important role to play in assisting individuals and families who are survivors of war. There is, however, special knowledge and unique insights required of social workers as they serve these individuals.8

Serving an All-Volunteer Force

Previous generations of soldiers resulted from a combination of draftees and enlistees. Present-day soldiers are members of an all-volunteer force who have elected to spend at least part of their careers in the military. This difference affects the characteristics of who is in the military and how they respond when they face physical or mental injuries, presenting special challenges for the social workers who serve them. For example, over 50 percent of soldiers serving in Afghanistan and Iraq are between the ages of 20 and 29. Although early intervention and outreach efforts are much improved since the Vietnam War, youth often deters returning soldiers from accepting available support. Young veterans tend to minimize symptoms and avoid seeking professional help. When problems are psychiatric in nature, these problems are even more difficult to identify and young soldiers are more reluctant to engage in treatment.

Also, this group of war veterans is more educated than veterans from previous wars. Ninety-five percent of active duty soldiers have either a high school diploma or have passed the General Education Equivalence Exam (GED). This challenges clinicians to develop new and creative ways of selling the idea that early intervention, for both medical and psychiatric conditions, can assist with the re-integration process.

Further, over 50 percent of service members are married, and about 11 percent of marriages are to other service members. This generates serious concerns when married couples are simultaneously deployed to high-risk areas, especially when minor children are involved. Complex issues facing couples in this situation include: the constant worry that one’s partner will be injured or killed; child care during the parents’ deployment; the impact of separation from parental figures on offspring at critical points during the developmental process; and reestablishing family ties once members reunite. Of even greater concern are the consequences for children when one or both parents die in combat.

Finally, the ability to choose whether or not one engages in military service impacts post-discharge adjustment, especially for individuals deployed to a war zone. When an individual is free to choose whether or not to join the military it creates a sense of self-determination (i.e., “This is something I elected to do, and going to war may or may not be part of the package”). When one is conscripted it generates a sense of powerlessness and anger, especially when bad things happen (i.e., “I had no choice . . . the government ruined my life”).
Women in the Military and Associated Gender Issues

During previous wars female soldiers were forbidden to participate in direct combat. Present-day women can and do select military occupation specializations (MOS) that place them on frontlines of the battlefield. As a result, female combat veterans face the same physical and mental health risks as their male counterparts. This role transition creates far-reaching consequences in regard to treatment. Patients currently treated by veterans’ hospitals are predominately male. When females do seek treatment, the primary focus, until now, has been military sexual trauma and health-related issues. The influx of females joining the military is changing the face of post-military intervention. As female veterans become a larger percentage of those seeking care, clinicians must create and implement programming designed to meet the unique needs of this population.

The Need for Cultural Competence When Serving Returning Troops

In the 1960’s the civil rights movement was a major focus of the American people. The inequity between racial groups in the 60’s was nowhere more evident than for those serving in the military. Soldiers of color were drafted and sent to fight in foreign lands for freedoms they were themselves denied back home. One African American veteran stated, “I fought a war to free the South Vietnamese people from oppression. Then I came home and had to use separate facilities instead of the restrooms white folks used. I had to enter restaurants from the back or was refused service altogether. Many privileges white people took for granted were not even an option for me. I am still angry that I was drafted to fight for something I could not even enjoy myself.”

America has made great strides in addressing racial discrimination since the 1960’s. Today, ethnic minorities make up a portion of military personnel that is very close to the minority distribution in the United States. As of September 30, 2004, combined deployment lists from the Afghanistan and Iraq wars report the following racial analysis of troops: 70 percent white, 15 percent African American, 9.5 percent Hispanic, and 5 percent other/unknown. These figures do not include soldiers deployed within the United States.

Despite these gains, in addressing racial discrimination, however, prejudice is still very much present in certain segments of the population. Professionals working with returning veterans of color must be careful to avoid assumptions based on race or ethnicity. It is imperative to remember that strategies applied to the dominant culture with great success might fail miserably with minority groups. Cultural and racial sensitivity affords clinicians the opportunity to learn, from their patients, what is most and least helpful during the reintegration process.

The Affects of Guerrilla Warfare and Acts of Terrorism

As opposed to the more traditional forms of battlefield warfare, in Iraq and Afghanistan the greatest sources of danger are guerrilla warfare and terrorist acts,
not direct combat. In an urban war threats are ambiguous. Anyone, anywhere, might be the enemy. This lack of an “identified enemy” places soldiers in a constant state of alert. During the Iraq War the ratio of seriously wounded to those killed in action was the highest in U.S. history. Ninety-four percent of soldiers in Iraq reported exposure to hostile small arms fire, 86 percent reported knowing someone who was seriously injured or killed, and 68 percent reported seeing dead or seriously injured Americans. The majority of these losses were the result of random acts of violence. One young Iraq veteran relayed his feelings by saying, “I never felt safe over there. I was a truck driver, not a combat soldier, but every time I got in my vehicle I worried about being ambushed or hitting a mine. I saw too many of my friends die that way . . . I always worried I might be next.”

Social Work and the Prevention of War

Social workers serve the survivors of war, but it is important to also address the broader issues that are the causes and consequences of war. Identifying the cause of war is a complex issue. Surely one factor is the grossly unequal distribution of wealth and resources throughout the world. As identified in Chapter 11, “Social Work throughout the World,” a few rich and developed countries (and especially the United States) possess a significant part of the world's wealth and use a substantial proportion of the earth's natural resources (e.g., oil, timber, minerals), allowing their people to enjoy a substantially higher quality of life than exists elsewhere. It is not surprising that others who experience the social consequences of such poverty (i.e., poor housing, inadequate diet, poor health, limited transportation, etc.) are willing to go to war to correct this inequality. Another factor contributing to wars is growing religious fanaticism, both in the United States and throughout the world, in which one extremist religion attempts to force its religious beliefs onto others. This condition polarizes people and leaves little room for compromise, often preempting efforts to address other human concerns. Finally, excessive emphasis on “nationalism” and “patriotism,” although laudable in spirit, too often leads to a false sense of superiority and unwillingness to compromise national desires for the greater good of the world's people.

The cost of war in terms of both human and economic resources is enormous. The loss of life and the maiming of human beings not only have a substantial emotional impact on those affected, but also have a significant economic drain on the nation. Resources that might have been devoted to resolving the social, health, and economic issues discussed elsewhere in this book are diverted to maintaining a military presence throughout the world, protecting homeland security, and absorbing the direct costs of active battle. For example, the following 10-year change in U.S. expenditures reflects the diversion of resources from before the Afghanistan and Iraq wars to FY2004.

Clearly, the cost of war has shifted resources away from meeting the needs of vulnerable U.S. citizens. The spiraling national debt resulting from this action must be paid off by future generations—with financial interest.
chapter 14  •  Social Work with U.S. Casualties of the Middle East Wars

Table 14.1


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<th>1995</th>
<th>2004</th>
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<td>Income security</td>
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In its policy statement on “Peace and Social Justice,” the National Association of Social Workers takes a stand on three issues related to war.

► Although we have recently gone through a new military buildup and actions against terrorist groups and the countries that harbor them, the United States needs to emphasize economic support rather than Western dominance. Whenever possible, the United States must foster cooperation in its foreign policy rather than unilateral military action. A long-range goal should be the reduction of military spending and diversion of the subsequent savings to social needs.

► Even in the face of overt terrorist attacks on the United States, it is still vital that we work in creative ways with other nations and international organizations to reduce violence against innocent civilians.

► The United States needs to continue using qualified professional social workers to serve the armed forces and military dependents to ensure that a high priority is given to human values and social welfare needs in those settings.

Concluding Comment

War has far-reaching consequences for combat soldiers, their family members, and society as a whole. Without timely and effective intervention, soldiers returning from Afghanistan and Iraq are at risk for a lifetime of maladjustment and misery. Social work professionals, acting as teachers, guides, and advocates, can significantly reduce this risk. Strategic placement of social workers during all stages of the recovery process will enhance soldiers’ potential to move beyond their combat experiences. Although social workers cannot stop wars, prevent deaths during combat, or undo physical and/or psychiatric injuries incurred during war, they can empower survivors to live happier, more productive lives. Further, they can use their advocacy skills to help prevent wars and improve the quality of life for all people throughout the world.
The Practice of Social Work

KEYWORDS AND CONCEPTS

Role of social work during reintegration efforts
Effects of guerrilla warfare and terrorist acts on combat troops
Social implications of war for returning veterans
Consequences of deployment for families
Challenges imposed by traumatic physical injuries
Impact of combat on soldiers’ mental health
Women in the military
Cultural competence in social work practice with soldiers

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