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Nathan Anthony Tilton

University of California, Berkeley, nathantilton82@berkeley.edu

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It All Falls Down: The Disabling Effects of American Institutions on Veterans

Nathan A. Tilton

University of California, Berkeley

Abstract

This article will examine how American institutions disable veterans. This excerpt (Chapter 1) from my honors thesis will specifically challenge how the Department of Veteran Affairs (VA) disciplines, creates dependency in, and disables veterans through punitive actions, barriers to resources, and highly addictive medications. To do so, I employ Agamben's model of bare life, the life devoid of value concept, and Brigg's concept of the unsanitary citizen. Combined, these core concepts and models form a hybrid model that I refer to as the Hybrid Disposable Bodies model (HDB). For this project, I interviewed 12 hetero-cis male and female veterans for an average of 1.5 hours between June 2019 and December 2019 in the San Francisco Bay area. I employed ethnographic collaborative inquiry, focusing on Kleinman's (2006) eight-questions approach. Together, these models allow for the researcher and interlocutor to search for the answers to questions together and holistically.

Keywords: Anthropology, Disability, Veteran, Institution

Preface

When I first started this research, I envisioned conducting interviews with millennial veterans aged between 22 and 39 years old. However, I had trouble recruiting veterans between 22 and 39. Frustrated by my lack of progress, I spoke with my Veteran Counselor Sal. Sal's

insight was invaluable because he told me that "some of these older vets 20 years ago wouldn't

talk about their experiences, and some still won't talk about their experiences 20 years later. I suspect it will be similar for the [millennial] veterans you want to interview. They just aren't ready to talk yet." I had previously entertained the idea of interviewing older vets about their experiences, but not for inclusion in the study. Once I began interviewing older veterans, I found my interviewing experience went much smoother until I finished my interviews and found that my data did not corroborate my hypothesis. I had wanted to gauge the impact of regional cultures on veterans. However, that is not what my interlocutors talked about. Again, I found myself stumped, but remembered what my mentor Dr. Karen Nakamura once told me "You've got to listen to what your interlocutors are saying and tell their story." I reanalyzed the data and I found that my interlocutors were all talking about the importance of particular social institutions, specifically the Department of Veteran Affairs (VA), work, and family. For the purpose of this article, I will be focusing on the VA.

Introduction

Drawing on Agamben (1998), I understand "bare life" as the result of a state or institution that has the power, autonomy, and authority to exercise totalitarian control and punitive action over the lives of individuals with little or no consequences (Agamben 16). I couple this with Brigg's concept of unsanitary citizens, which I define as the result of a state or institution that actively maintains a power imbalance while refusing to recognize the rights of a people or care for certain individuals by defining them as "unsanitary" because they want alternatives to medical science. The way in which the VA uses the complexity of its language and bureaucratic mazes maintains its power over veterans and disciplines and disables veteran bodies. When a veteran engages with the VA, they find themselves in a limited or even no-power situation with an institution that has total control over them. The VA has power over veterans' information (biographical information, personnel information, etc) and medical treatment (mental health, physical health, rehab, and medications, including when, what, and if they will refill them). Of

private health care and will not miss the money that comes with disability compensation (and which the VA controls).

Dr. Van Der Kolk started his career in psychiatric medicine working for the VA in Boston, MA in 1978, and he documents the lack of control that he witnessed that the veterans had working with the VA.

Our (VA) clinic was inundated with veterans seeking psychiatric help. However, because of an acute shortage of qualified doctors, all we could do was put most of them on a waiting list, even as they continued brutalizing themselves and their families. We began seeing a sharp increase in arrests of veterans for violent offenses and drunk brawls--as well as an alarming number of suicides. (Van Der Kolk 44)

Van Der Kolk's experience in 1978 could describe veterans' experiences in 2020. Very little has changed in 42 years. Like Dr. Van Der Kolk, many VA doctors feel powerless and, as a result, leave without questioning the VA. Not only does the institution persist then, but the doctors who remain tend to be underqualified. Overall, the VA as an institution still does not value veterans' lives over the institution.

For the last 300 years, Western Civilization's concept of "life devoid of value" (LDV) has impacted peoples who have been deemed "incurably lost" (Agamben 139). Agamben argued the Nazis used this concept as a justification for executing over six million "incurably lost" peoples (Seltzer). In the 1700s, the French Constitution first recorded the concept of LDV. In the French Constitution, the passive and active rights of men were seen as the natural and inalienable rights of the citizens of the state. However, the framers outlined that people who were "children, insane, minors, women, those condemned to a punishment either restricting personal freedom or bringing disgrace (on the state) will not be citizens" and thus would not be afforded the same rights until years later (Agamben 130). Not everyone has made it off the modern LDV list, which

still includes the disabled, the condemned, and people who could be seen as an embarrassment to the state. Veterans are not above the concept of LDV and often fall into one or more of these categories. Agamben argued that the concept of LDV is connected to bare life and used it to measure the treatment of people under totalitarian regimes and how much power they have over their people. For my purposes, I engage with Agamben's model of bare life and Brigg's concept of unsanitary citizens to analyze how the VA employs totalitarian power and the concept of LDV to justify their actions.

My hybrid disposable bodies model directly challenges how the VA disables veterans. This article examines how the VA uses medication to discipline and disable veteran bodies to guarantee the VA a certain number of patients. The VA uses a lack of resources and barriers to treatment access to guarantee a certain number of patients for the VA. They perpetuate the veterans' continual state of need by enforcing punitive actions that prolong or exacerbate their illnesses and/or disabilities and thus leaving veterans in a state of suspended animation.

History of the VA

The Department's (VA) mission is to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive the care, support, and recognition earned in service to this Nation. The 26.8 million living veterans and the estimated 43.5 million dependents and survivors of veterans total 70.3 million potential beneficiaries of VA benefits and services.

The VA is the second-largest Federal Department and has over 266,000 employees. About 1 of every 10 Federal employees works for the VA. Among the many different professions represented in the vast VA workforce are physicians, nurses, counselors, statisticians, architects, computer specialists, and attorneys. As advocates for veterans and their families, the VA community is committed to "Putting Veterans First" in providing the very best services with an attitude of caring and courtesy. (VA Mission Statement)

The VA has had many forms over the years. The idea of the VA came from a 1636 British colonial law, which awarded colonial defenders a pension. During the war for American Independence, the Continental Congress needed a way to deter mutinies and mass desertion. In

half pay for life for officers who became seriously disabled, such as through the loss of a limb. Unfortunately, the Continental Congress did not have the authority or money to distribute pensions to veterans. Ultimately, out of the 217,000 Revolutionary War veterans who applied for the promised disability pensions, only 3,000 received pensions (Teipe).

WWI veterans advocated for veteran rights and better disability pensions. They bravely camped on the steps of several buildings in Washington D.C. over a span of several weeks to protest for these rights. Sadly, their pleas were not heard, and they were violently forced from their makeshift camps and never received their pensions. In 1930, Executive Order 5398 established the VA as an independent agency. However, it was not until after World War II that veteran benefits started being taken seriously. The Servicemen's Readjustment Act of 1944 established benefits like the GI Bill and the Veteran Home Loan. Unfortunately, these programs aided mostly white veterans, and veterans of color discovered that there were barriers to their benefits, like denials of service or admittance by realtors and colleges. In 1989, the VA was elevated to cabinet level. This means that the VA answers to the legislative and executive branches and not the veterans. Despite its mission statement, the VA is self-serving and will contribute to the disabling of veterans in order to maintain its existence.

Methods

In order to conduct this research, I gathered ethnographic interviews from male and female veterans in the San Francisco Bay Area. I recruited veterans using flyers and distributed the flyers at the Concord Vet Center in Concord, CA and the UC Berkeley Veteran Center in Berkeley, CA. My target recruitment was 15-30 veterans, I recruited 12 veterans. Each interview session lasted an average of an hour and a half. I recorded and transcribed all interviews for analysis. The University of California, Berkeley IRB approved my research March 2019.

For anthropological methodology, I employed a variant of Kleinman's (2006) Eight

Questions. This method entails asking a smaller number of more in-depth questions, such as

where the participant grew up or how their military to civilian transition has gone. This serves as a question guide for semi-organized interviews but allows for an organic feel. The questions chosen indirectly probe veterans' backgrounds, including military experience and what kind of healthcare they would like to receive. Additionally, I used the Ethnographic Collaborative Inquiry (ECI) methodology, which provided a holistic tool for veterans attempting to decipher the disabling effects of American institutions and allowed for reflection on veteran experiences (Berg 2017).

Problematic Military Healthcare as a Source of Trauma

LL reached out to me after seeing my research recruitment flyer at the Concord Vet Center. LL is a female, Vietnam-era U.S. Army veteran who has had first-hand experience of the VA's 'growth' since the mid-1970s in several different states, including California, Texas, and Rhode Island. I met with LL at a local coffee shop in Concord, California in late October 2019. When I arrived at the coffee shop, LL was already waiting for me and quickly sifting through some paperwork in a medium-size black computer bag (15 minutes early is the rule in the military).

LL joined the Women's Army Corps (WAC) at the tail end of the Vietnam War in the early 1970s. She attended basic training at Fort Jackson, South Carolina, and her basic training platoon was the first group of female soldiers required to perform basic rifle marksmanship in order to graduate basic training: "60 Minutes came to interview us because we were the first group of females that had to qualify [with rifles]." She was stationed at Fort Sam Houston in San Antonio, Texas. "I was working as a medic at the hospital. It was the equivalent to a Licensed Vocational Nurse. We had to do case studies on patients." While stationed at Fort Sam Houston, LL's barracks were infested with "whole families of cockroaches." This led to LL's barracks being fumigated, but the fumigation was done incorrectly, and LL and her roommate were hospitalized as a result. During LL's army hospitalization she was heavily medicated,

misdiagnosed, overdosed, sexually assaulted, and she was eventually released from the army in March 1975 and signed into her mother's care in Rhode Island:

I don't even want to remember everything... sexually attacked... and it was a woman. I try not to go there... I've learned that everything that happened to me has affected everything in my entire life... It's caused me a lot of hardship...it affected me and my children. They actually took my children from me. I lost everything... I never had any problems before I went in [the army].

LL suffered from Military Sexual Trauma (MST), a mental illness that is the result of trauma that the military and the VA does not take seriously or address well.

LL's mother felt that there was "something wrong with her" and she brought LL to the Providence VA. In the VA psychiatric ward, LL was once again heavily medicated and misdiagnosed with schizophrenia for a year. At this time, there was no diagnosis for PTSD in the DSM, and veterans were given all sorts of diagnoses: alcoholism, substance abuse disorder, depression, mood disorders, and even schizophrenia (Van Der Kolk 46). There were little to no activities or resources for struggling veterans at this time at the VA or from the military. "In the VA, it was all hippy vets... the rest of the day you are sitting on your bed because of...the [prescribed] drugs." Many veterans had such terrible medication fog that they could barely function (Van Der Kolk). LL feared a return trip to any VA psychiatric ward. Even when she moved to San Francisco and had to go to the VA for annual checkups, she tried hard to act "well" to avoid prolonged contact with the VA.

Over 40 years have passed since LL's first experience with the VA. In that span of time the VA has experienced veteran advocacy movements, pushes for change, and bureaucratic scandals. The VA built facilities nationwide to help combat veterans with their post-service healthcare needs. Still, despite all this thoughtful attention to the returning veterans' needs, the psychological scars of war went unrecognized and traumatic neuroses disappeared entirely from

official psychiatric texts. However, the VA's need for funding did not change. Today, the VA manages the care of over 20 million veterans from over eight different conflicts. With each new conflict, the VA has only grown in scope and power to the detriment of veterans, including veterans from recent conflicts in Iraq and Afghanistan. New veterans still face problematic access to healthcare like their earlier peers.

Lost in Civilian Life: Veterans' Experiences Back Home

I met Jose in 2009 at Camp Shelby, MS. We were both young brown men in the California Army National Guard and were going to be augmenties¹ for a unit that was already downrange². It turned out to be a rough deployment, but Jose and I had both been previously deployed with other units and we got each other through it. When we returned home from Iraq, I extended my orders and deployed to Afghanistan, and Jose went home. We did not see each other again for almost a decade.

When I reached out to Jose to see if he wanted to participate in my research, he was more than willing. I was surprised to discover that after he got home, he went back to school and got his BA from UC Irvine and later earned his Master of Social Work from USC. He currently works with homeless people, including homeless veterans. Jose grew up in Southeast LA as the child of 'illegal' immigrants, and he watched them work hard and strive for a better life for their family. In Jose's high school no one ever talked about going to college, how to get into college, or even the benefits of college. This happens all too often to many people of color. When Jose graduated from high school, he felt lost and decided to do something he always wanted to do so he joined the military.

When Jose got to his first duty station, he proved to be high speed³ and was sent to many

¹ Augmenties are replacements or fillers for units not at full strength.

² Downrange= Deployed

³ High speed- military jargon used to describe someone that is quickly up and coming.

different military schools. He attended airborne school, was tabbed as a ranger,⁴ and received his E5 (Sergeant rank) in two years.⁵ Jose deployed to Iraq and participated in many combat operations. When Jose's unit returned, he (as well as many other) soldiers began self-medicating in order to deal with the trauma of war:

I was off--especially after the first one [deployment]. My experiences out there weren't good, you know? Some of the guys I was with... when I got back it wasn't only the deployment but seeing them... You know I just started drinking-- started just being out there... just risky behavior. (Jose)

Within a year of returning from Iraq, Jose decided to get out of the military. I asked Jose if the military prepared him for civilian life:

When I got out in 2006, not at all... I had no idea what was going on. All I knew was that I was tore up. I had no idea how to function in the civilian world. I had friends... but they did not get my experiences, ya know? (Jose)

Jose found himself lost in the civilian world. He continued to self-medicate with alcohol. He tried to go to community college and get work. However, he just found himself getting frustrated. In 2008, Jose re-enlisted in the California Army National Guard and quickly volunteered for the deployment that we would meet on. Yet, "When I got back in 2010 the VA... I got back, and I had a hard time getting service connected [with the VA]" (Jose). This difficulty with the VA frustrated Jose and he went back to "risky behavior." Eventually Jose, like many veterans, who self-medicate by heavily drinking, was arrested: "I was arrested for obstructing an officer and some other charges... because of my drinking" (Jose). It is common for many veterans to transition to law enforcement after serving, and Jose had thought about becoming a law enforcement officer, but due to criminal charges on his record, he had to give those thoughts

⁴ Army Rangers receive a 'tab' they wear to signify that they are Ranger qualified.

⁵ It is an achievement to make the rank of sergeant in two to three years. The average time to make sergeant is between four to six years.

up. Jose found himself without direction.

“Hitting Rock Bottom:” Barriers to VA Access

Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), chronic pain, and hearing loss are just a few of the conditions that many veterans suffer from. However, many of their injuries often go unseen and misunderstood, with PTSD being the most prevalent. Quinn (2008) reports that many veterans who develop PTSD symptoms may have an increased lifetime prevalence of alcohol and drug abuse that may ultimately lead to family issues, unemployability, incarceration, and death. These issues manifest and grow when veterans transition from military to civilian life and become vulnerable because of a loss of support and increase in isolation (Gorman).

Going back to school helped Jose reacclimate to civilian life, but then he had a family to provide for. Between family and work life, Jose had no time for healing. Jose went to a community college in LA, then transferred to UCI and earned his MSW at USC: “Being in college helped me transition. It helped me to reacclimate. Now I’m helping people [veterans] that are homeless” (Jose). As Jose continued to work, he found himself falling back into self-destructive behaviors. He recognized these behaviors and knew he needed to go into therapy, but he found barriers to accessing therapy through the VA, which is typical of other veterans’ experiences with the VA.

Veterans as Professional Patients

Veterans are treated exceptionally by the VA, and this means they are not guaranteed the same rights as other citizens when accessing healthcare. For example, in private health care, if a

patient does not like your primary care physician (PCP) or therapist, they can change them relatively easily. If they do like their PCP or therapist, chances are that the patient will be able to stay with them for twenty years or more. With the VA, however, it may take years for a veteran to change their PCP. In the meantime, they still need to have annual physicals or risk punitive action like losing their disability compensation or having it reduced for not completing an annual physical exam. Veterans often joke about this: that if they do like their PCP or therapist, they will not have them for long. Most of the likeable PCPs, therapists, and staff at the VA are students, fellows, and other temporary staff. As a result, a veteran will often have to reconnect with new temporary staff over and over. This process is very frustrating for veterans--as it would be for anyone--and it leaves many veterans feeling betrayed, annoyed, and out of control:

The deal with that is when you go to therapy you have to have time for it. When you're working it's really hard to do. Instead of getting help I have to work. I have a daughter... So now I'm a dad. Now I have a mortgage--I have to choose between my mortgage and therapy--I'm trying to finish getting my MSW license hours first before I go to therapy and save money... I'm trying to hold on until I'm done... I'd have to quit my job or they (VA) would say "oh you have a job already--you're functioning." They want you to hit rock bottom first before you ask for help. How long do you have to hold on for? (Jose)

When I spoke with Jose, he had two years left to complete his MSW licensing, which means he has two years before he can reach out for help and start receiving treatment for his trauma. It is a sad irony that a licensed clinical social worker, who works with homeless veterans and recognizes that he needs help, has to wait two years before he can even get help for himself. As a result of these barriers, Jose tried alternatives to treatment: "I had a service dog-- when I was training him everything was good. But it just got too much--between work, commute, etc."

(Jose). Jose could not use the VA: the VA would not work with his schedule, wanted more hours

from him, and frequently changed his providers. The VA demanded that Jose adapt to them instead of the VA adapting to the veteran, which put Jose in a difficult position.

Although the VA as a system boasts a wide range of treatment methods for many ailments and has many treatment assets at its disposal, this is also why there are problems. The VA runs on a traditional 9-5 workday, which does not allow many working veterans the time that they need to get treatment. Veterans like Jose find themselves having to choose between their jobs and healing. The VAs are also broken into districts, much like schools are. In Northern California, the VAs fall under the VA Sierra Pacific Network. Within this model, the VAs are further split up. In the Bay Area, we have three separate districts (Palo Alto, SF, and Sacramento) headed by one large facility with many outpatient clinics. This system is incredibly problematic because it means much of the VA's resources are at one large facility that is located in an inconvenient location for many veterans.

For example, VA Martinez, despite being located in the East Bay, falls under Sacramento. So, if an East Bay veteran needs to go to the emergency room or attend more intensive therapies they will need to travel three hours and over a hundred miles per round trip. This is highly problematic because any successful intensive treatments must be continuous to be successful. How long can a veteran maintain a treatment program if they need to commute three hours or more and take a day off of work or school to get there? The veteran's only alternatives are private insurance and private treatments, if they could afford them receiving treatment from a local provider after paying upwards of USD 1440 or more in copays. Many veterans cannot afford insurance or copays and resign themselves to the VA. However, when engaging with the VA, veterans must play by its rules.

Medication

People often tell veterans to go and get help from the VA. Unfortunately, one of the VA's (unwritten but seemingly widely applied) rules is that veterans have to get on and stay on medication. The VA doctors' silence and willingness to medicate veterans into compliance is similar to what the Nazi doctors did in WWII: they went along with the Nazis' euthanasia program and facilitated it despite it going against the Hippocratic Oath.

There were no protests on the part of medical organizations when the bishops brought the (ethnic cleansing) program to the attention of the public...the euthanasia program contradicts the passage in the Hippocratic oath that states, "I will not give any man a fatal poison, even if he asks me for it." (Agamben 143, on Nazi doctors' stances during the Holocaust)

Agamben makes the point that doctors were hypocritical in this case and went against the best interests of the patients in favor of their own interests. The Nazis saw no value in their victims' lives except as medical experimental subjects, whereas the VA values veterans as a battery that keeps the institution powered.

"The psychiatrists at the VA are just like pills, pills, pills; they want me to take all these pills, and when I don't want to take these pills they get mad at me. I wasn't trying to be difficult." (Jose, Army Veteran OIF). It is not uncommon for veterans to joke about and compare "cocktails."⁶ Since 2003, the VA and the Department of Defense (DOD) have spent over a combined USD 4.5 billion on antidepressants, antipsychotics, and anti-anxiety drugs. However, drugs cannot "cure" trauma (Van Der Kolk 413). Out of the 12 veterans I interviewed, the average amount of medications prescribed was 5.5 medications. These medications include various pain killers, selective serotonin reuptake inhibitors (SSRIs) like Prozac, and sedatives. It needs to be said that veterans most of the time do not request these medications. In addition,

⁶ A cocktail is several different medications that a patient takes at the same time.

SSRIs like Prozac have been shown to have little to no effect on combat veterans' PTSD (Van Der Kolk 76). Yet, between 2001 and 2011, the VA spent around USD 1.5 billion on Seroquel and Risperdal... despite a research paper published in 2001 that shows that Risperdal is no more effective than a placebo in treating PTSD. Similarly, between 2001 and 2012, the VA spent USD 72.1 million on benzodiazepines--medications that clinicians generally avoid prescribing to civilians with PTSD because of their potential for addiction and the lack of evidence that they significantly treat PTSD symptoms (Van Der Kolk 417). Many of these medications are taken together and often this increases the various drug's side effects and/or worsens the veterans' symptoms.

Many of the medications that are regularly prescribed to veterans like Gabapentin have been recently linked to increased suicide risk. Gabapentin is an anti-seizure drug that is commonly prescribed to veterans for chronic pain, but a 2018 study found that some users of Gabapentin with psychiatric disorders/issues/challenges had notable mental changes after taking it that included depression, aggression, and suicidal ideation (Ghaly and Van Der Kolk 416). Many of these veterans have been prescribed these medications despite medical professionals knowing that the veteran who they are treating has psychiatric challenges (Ghaly and Van Der Kolk 416). Veterans are generally not told about the side effects of the drugs they are prescribed and will go months without seeing their prescribing doctor in order to check their medications' interactions. However, if a veteran does not take their medication, they are found non-compliant. If a veteran is found non-compliant, the VA can and will take punitive action by reducing the veteran's benefits. The logic that the VA uses is that if a veteran does not want to take the prescribed medication, the veteran must be better. The doctor will give a veteran a urinalysis to see if they are actually taking the medication. Despite these strict and exceptional measures, a 2010 report on 49,425 veterans from Iraq and Afghanistan with newly diagnosed PTSD who sought care from the VA, showed that fewer than one out of ten actually completed the

recommended medication treatment (Van Der Kolk 409). It is worrisome that the VA prescribes enormous quantities of medications to veterans, often without providing other forms of therapy --and in the face of such widespread resistance or non-compliance.

JD is a Marine Corps Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veteran. Before leaving the Marine Corps, JD as a Staff Sergeant was a squad leader in charge of twelve or more Marines. Since getting out of the Marine Corps, he has had many jobs, including working in the oil fields, and, as of late, owns his own business. By many standards JD had successfully transitioned from military to civilian life. However, the reality was that JD fell apart but tried to hold himself together. He began seeking help at his local VA, and after a lengthy wait for an appointment, his doctors began prescribing him a ‘cocktail’ of medications. Shortly after starting his VA prescription medications, JD found himself “running down the street naked with a firearm and his wife chasing after him trying to calm him down” (JD). Following this experience, JD began fighting the VA in order to cut back on his cocktail and began to explore alternative ways to heal:

I want the VA completely out of vets’ lives: they are too political! I want all the opiates out of the VA!.. They (people) say get help.. But what help? They are just giving us *drugs! Cocktails!* We (VA) will give you 3500 dollars if you just lay there in that spot and take these pills and be quiet. And people are fine with it. (JD)

JD’s experience is not unique. This is a common story within veterans’ circles. The VA gives disabled veterans a monthly stipend in return for their compliance and participation in the VA’s treatment program, if they go to the doctor and take the medicine. The VA uses treatments, disability compensation, and medication as a way to regulate and discipline veterans’ bodies.

The VA, Veterans, and Suicide: “Man’s expression of sovereignty over his own existence”

(Agamben 136)

The lack of control and agency that veterans face at the VA often creates barriers to treatment and other resources that frustrate them. Many veterans get so frustrated with the VA they just ‘give up.’ Some veterans turn to various forms of self-medicating, like alcohol or drug use (and abuse) just to stop going to the VA and suffer in silence or desperately try to take back control by ending their own life. The same thing that Dr. Van Der Kolk describes happening 40 years ago is still happening today. Today’s veterans know other veterans who have died by suicide because they couldn’t get the help they needed.

People [veterans] are scared to go to the VA. People [veterans] are dying in the parking lot of the VA... My buddy woke up and told his wife he loves her...pulled his gun from his nightstand and blew himself away... he was an awesome marine... Beautiful awesome wife... and pops himself in bed with her in it. (JD)

Many people think that veterans who die by suicide are homeless or down on their luck and they turn to suicide as their only option. However, JD’s story explains that conventionally successful veterans still die by suicide and use it as a means of asserting control.

German Jurist Karl Binding argued that “suicide was man’s expression of sovereignty over his own existence” (Agamben 136). The combination of appointment problems, staffing issues, and limited follow-up from the VA has led many veterans to take their own lives (Cheney). The VA and the Institute for Clinical Research have found that veterans are the least likely to seek care out of their peers who have not served and are the most vulnerable during their first three years out of the military (Harpaz-Rotem; Kang). According to stopsoldiersuicide.org “veterans are at a 22 percent higher risk of suicide than their peers who have not served” (stopsoldiersuicide.org). This dire issue has resulted in over 6,000 veterans dying by suicide annually since 2008--that is over 16 to 22 veterans dying by suicide daily

(Kemp). This disturbing trend has continued for well over a decade and has shown no signs of

stopping. Despite the statistics and veterans' advocacy work, the VA has not altered the way it conducts business and has shown no signs of doing so in the future. They refuse to try different types of treatments because of the difficulty quantifying results or because they are too expensive. Although a 2018 study revealed that alternative therapies like mindfulness practice can help holistically manage PTSD symptoms, the VA does not make it a key part of a holistic care plan for veterans (Schure).

Conclusion

Often people use hyperboles to describe certain people as parasites who take advantage of an institution, like 'welfare queens' who take advantage of government support programs. However, I argue that, in fact, the opposite is usually true, and the VA is a parasite feeding off of the veteran host. Similar to many predatory insects who use a sting or bite to paralyze and consume its prey, the VA purposely maintains the 20 million veterans' need for tertiary care. It uses disability compensation, medication, punitive action, and barriers to treatment as a way to disable veterans, maintain numbers, and keep veterans in a state of suspended animation. American culture and the VA has isolated veterans and relegated the idea of veteran problems as, just that, veteran problems.

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