Generational Cohorts: A Military Perspective

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IMPROVING CARE FOR VETERANS
FACING ILLNESS AND DEATH

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EDITED BY
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Foreword by Chuck Hagel, U.S. Secretary of Defense
In a 1986 Presidential Address to the American Sociological Association, Matilda White Riley noted the often-neglected study of age cohorts. Riley reiterated that age cohorts, or generations, were often overlooked in sociology. To Riley, generational cohorts were a significant source of diversity; each cohort or generation was shaped by unique social, historical, and demographic factors that influenced their attitudes, values, and behaviors. As such they shaped the ways that a generation responded to crises such as life-limiting illness and end-of-life care as well as the way members of a cohort might interact with counselors and health professionals.

This may be particularly true with military cohorts. Here two factors converge. First are the generational differences that exist between veterans of different wars. Regardless of whether there was military service, each generation shared distinct and differentiating experiences. There are differences between the GI Generation shaped in the forge of the Depression and World War II and those of the Baby Boomers primarily born after World War II. Second, each cohort of veterans also was affected by their shared combat experiences. Those who fought in World War II had very different experiences than the veterans of the wars in Korea and Vietnam. In understanding the importance of generational cohorts, we need not lose the individual. As with any source of diversity, it important to remember what is called the ecological fallacy; that is, that generalizations that hold for a group may not necessarily apply to all members of that group.

The study of cohorts, though, reinforces an important point; systems of care need to be reassessed and reinvented as each new cohort ages. Such reimagining involves intergenerational considerations, such as Baby Boomers managing care of Traditional Generation parents. It is also important to recognize that cohorts are socially constructed; thus different writers may use somewhat different years or terms to define cohort. In this chapter we primarily follow the listings offered by Strauss and Howe (1991).
THE VETERAN EXPERIENCE

There is a proverb that states: *Every person is like all other persons, some other persons, no other person.* Certainly all humans share basic characteristics and needs. And as noted earlier, we can never lose sight of the uniqueness of every individual. Yet individuals who share a culture, a lifestyle, a social class, spirituality, or experience (among other factors) do share certain commonalities.

Military culture often values hierarchy, interdependence, respect for authority, heroic sacrifice, patriotism, and risk-taking. Stoicism is prized. These values may not mesh well with end-of-life care as individuals may be forced into dependency and encouraged to make autonomous choices. Moreover, the shared experiences of military veterans in combat may result in difficult memories and even the re-emergence of earlier symptoms of Posttraumatic Stress Disorder (PTSD) at the end of life. These experiential components may clash with the practices often employed in end-of-life care that affirm open emotionality and grieving, as well as those that encourage reminiscence and life review.

While these elements of military culture are common to most veterans, cohorts also matter. Often the GI Generation (born between 1901-1924) and the Silent Generation (born between 1925-1942) are now grouped together as the Traditional Generation as they share common experiences of later life; many of their formative experiences were not radically different, such as growing up in intact homes, utilizing savings accounts, and experiencing radio and newspaper as major informational sources. As a group, the members of the Traditional Generation often accept the fact that life is unfair, and may be more accepting of their fate. Traditionalists, after all, grew up at a time when medical treatments were limited. They lived in an era prior to penicillin and other antibiotics, and some remember the many epidemics such as the Flu Pandemic. They also lived through the demographic transition; many saw parents or siblings die from diseases easily cured now. Children died from polio or whooping cough, and heart attacks were fatal. Therefore, some may be fatalistic and view medications and hospitals with suspicion. Yet they were a group that accepted authority. Raised in the Depression and war years, they looked to the government for assistance. Since they learned to follow orders, they remain generally adherent, often seeking a doctor’s advice for anything health-related and rarely questioning physicians.

While end-of-life preparation meant wills and other estate planning, Traditionalists will now accept the need for healthcare proxies and advance
directives. With increasing dependence they may have conflicts with Baby Boomer caregivers on "downsizing." Living through a depression may have made them wary of the perceived wastefulness of their Boomer children as their offspring attempt to toss out "clutter." Because they struggled to achieve prosperity and regard savings accounts and homes as prized symbols of achievement and security, Traditionalists may seriously struggle with difficult decisions regarding savings and assets when considering eligibility for government programs.

Traditionalists tend to be quiet about emotions and feelings and are generally resistant to therapy, as they defined therapy as being for persons who were "crazy." They are, though, the first generation to embrace widow/widower and other grief support groups, perhaps as a reflection of their "can-do" orientation, which values strength in the face of difficulty.

There are distinct ethnic differences among Traditionalists. African Americans in these generations experienced harsh discrimination and prejudice, themes that may emerge in life review. Many persons may have a pride of survivorship, a sense that they have lived through a range of life experiences both as individuals and as a race, from harsh segregation to the election of an African-American president. African-American Traditionalists remember the Tuskegee Syphilis Study, which caused distrust of medical professionals. Many also have strong spiritual beliefs such as a strong trust in the miraculous action of God and the strong value placed on life and the pride of survivorship. These beliefs, combined with a general mistrust of medical authority, may lead to reluctance to consider palliative care.

The military experiences of these two "traditional" generations, though, are quite different. The GI Generation fought in World War II, a war of shared sacrifice. While the experiences of the GIs were often difficult, they perceived national support. As they liberated countries from brutal Axis occupiers, they were greeted by delirious populations. They returned to victory parades that honored them for their service. The Servicemen's Readjustment Act of 1944 (commonly known as the G.I. Bill), passed by a grateful nation, opened up opportunities such as higher education and home ownership.

While the Silent Generation, the generation now often seen in end-of-life care, shared many of the cohort experiences of the GI experience, their combat experiences were very different. The Silent Generation veterans fought, for the most part, in the Korean War. This war was one of the first armed conflicts of the Cold War as the communist North Korea invaded the South. It was a
difficult conflict. Cold was as much an enemy as the communists. For those on the front, there was often tedium and isolation; much of the fighting was at night. There was the frustration expressed by General Douglas MacArthur that political considerations to localize the war meant that the US was not using the full force of their offensive capabilities. For three years, American and United Nation armies battled North Korean and intervening Chinese armies until both sides accepted an armistice and cold peace that essentially confirmed the pre-war status quo. Yet nearly half of the American casualties occurred after the peace talks commenced.

These veterans returned to a war-weary population largely content to ignore the sacrifices made. The war did not have a glorious conclusion, so it was quickly forgotten, relegated to the history books. There were few parades to honor veterans. Moreover, veterans returned to the US during a recession, finding limited opportunities for employment.

The Baby Boomer Generation, born between 1943 and 1960, also had very different experiences. Births deferred by the Depression and World War II soared as servicemen began to return home from that war. The sheer size of the Boom, now 73 million, meant that Baby Boomers faced competition and crowds at every stage of life. They were the first generation influenced by television. Boomers were a generation of worsening trends as divorce and delinquency rates rose. Their experience of government was shaped by Watergate and Vietnam, a far different outlook than their parents' experiences of the New Deal and a unified war effort.

The Boomer Generation is also very diverse both ethnically and spiritually. The 1965 Immigration Act eliminated quotas and allowed migration from countries previously limited or excluded. Spiritual diversity was also evident in the growth of non-Western religions. The Baby Boomer Generation experienced the sexual revolution and was active in the women's and gay rights movements.

Military experience is another source of significant diversity for Boomers. Veterans of this generation primarily saw combat in the Vietnam War, in many ways creating a generational rift that may still persist. This was a war against a shadowy guerrilla army; it was unclear as to who was friend, neutral, or foe. While returning Korean War veterans may have been met with indifference, Vietnam Veterans often encountered hostility, particularly from their peers. Unlike World War II, only a minority of peers actually served in the armed forces. There were other differences as well. Unlike the liberated people of WWII or even the Koreans, few Vietnamese welcomed the Americans. There
was no sense of shared purpose and there was ambiguity about goals; both factors eroded morale as did the open and robust organized opposition to the war in the US and Europe.

Boomers changed every social institution they encountered. Boomer values of individuality, personal autonomy, and distrust of authority challenged colleges and workplaces. Boomers are now aging; by 2030, when all Boomers are over 65, 18% of the U.S. population will be 65 or older. It will be interesting to see the ways that Boomers may challenge how we age and die.

Boomers are likely to offer challenges to traditional end-of-life care. Medicine made great strides in the Boomer Generation. Boomers saw the conquest of polio and tremendous advances in all forms of treatment, so they may be reluctant to accept that care may now be palliative and not curative. Moreover, Boomers will expect to be actively involved in determining their medical care rather than simply accepting medical authority. Boomers are heavy consumers of alternative treatments including chiropractors, acupuncture, herbal and natural treatments, and vitamins, and may also be more prone to use non-prescribed drugs. The Boomer Generation was one of the first to widely experiment with recreational drugs.

Boomers value “death with dignity,” as well as effective pain management; they were at the forefront of the hospice movement, so that portends well for hospice use as Boomers age. On the other hand, control and options might make hospice more attractive if it offers concurrent care, the option to receive hospice care along with disease-modifying treatments. Wright and Katz (2007), for example, recount a case where a woman opted out of hospice since it did not offer life-extending treatment nor nutritional support, and the patient wanted to survive until her daughter’s wedding. In addition, Boomer focus on autonomy and control may lead to some interesting ethical dilemmas. For example, some Boomers have stated in advance directives that if they do not know enough to eat, they do not want to be fed.

As a generation, Boomers grew up with guidance counselors so are not generally averse to therapy, although receptiveness to therapy is mediated by other variables such as class or ethnicity. Boomers too embraced self-help movements, especially as self-help turned from prohibitory to enhancing; that is, from keeping an individual from doing something such as turning to alcohol to helping them cope with and transform their life. Strength-based approaches are often useful as Boomers are independent, accustomed to challenging authority, and often have a strong sense of
self-efficacy. Life review can assist Boomers in identifying the ways they responded to earlier challenges. Yet Boomers may very well have issues that arise in counseling. Boomers were the first “Me Generation,” often putting their aspirations ahead of others’ needs. High divorce rates, more women in the workplace, and higher rates of single-parent families meant that their children were the first latch-key generation. Wanting first to be friends to their children, they were often permissive. Living in a highly competitive world, relationships took a back seat. Thus issues of guilt and regret may arise in counseling.

Clinicians need to be aware of both generational differences in general and the ways that military experience may have interacted with those generational differences in ways that might influence care. There are instruments such as the Military History Checklist that can be a useful part of intake assessment. (A copy of the Checklist can be found in the Resource section of this book.) At a very basic level, this may have residual health effects. World War II veterans who fought in the South Pacific may have suffered a variety of tropical diseases such as malaria. Korean War veterans may have experienced extreme cold, suffering from frostbite and hypothermia. Many Vietnam veterans were exposed to Agent Orange and have high rates of testing positive for the Hepatitis C virus. While few veterans of the Gulf Wars are yet in care for life-threatening illness, they too may have been exposed to chemical or biological agents. Combat experience is also associated with manifestations of PTSD. And, for yet unknown reasons, persons who served in the military, with any cohort, seem to be at significantly higher risk of ALS (amyotrophic lateral sclerosis), popularly called Lou Gehrig’s disease. In fact, in 2008, amended VA regulations granted presumption of service connection to any veteran with the disease. This means that veterans with the disease are covered through the VA since the disease is considered connected to their prior military service.

Military service was for many individuals a major life-transforming experience. Many men and women have been changed by their combat and military experience, for better or for worse. Only by understanding that experience can mental health and health professionals provide the individualized and sensitive care veterans, as well as all other patients, so merit.

Editor’s Note: Material from this section on veterans is drawn from PowerPoint presentations of Scott Shreve, Deborah Grassman, and Julie Phillips.
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