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American Veterans and the Evolutions of Mental Health: A Historical Review of Diagnoses and Depiction

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Abstract

This article reviews the interwoven history surrounding mental health diagnoses and military veteran depictions of the twentieth and twenty-first centuries. Including a detailed historical review focusing on three major time periods: WWI-Korean War (1915-1950s); Vietnam War (1960s-1980s); and the Gulf/Middle East conflicts (1981-Present). By noting prevailing connections throughout these time periods, including the continuity of stigma and the depictions of veterans as well as the evolution of changing interpretations in what images and depictions of veterans mean including their associated social and political usages. Finally, a number of implications, both positive and negative surrounding the interconnected nature of veterans and mental health (namely PTSD), are offered, with recommendations for future inquiry and policy.

Keywords: veterans, mental health, PTSD, US military, shell shock

Introduction

The invisible wounds of war are fundamentally and continually associated with the United States' (US) perceptions of its war veterans. The image of the traumatized war hero returning home with physical, mental, psychological, and emotional wounds is one oft seen in the public sphere, whether as a patriotic recognition or political gamesmanship. Wounded warriors, particularly those with wounds not visible to the eye, have become synonymous with the whole of American military veterans returning from the battlefields. This is certainly not a recent development: "in…military conflicts of the twentieth century, behavioral/psychiatric symptomatology continued to be noted in military personnel with combat experience" (Shively & Perl 2012: 236). As early as World War I (WWI), images and stories were prevalent of American veterans whose experience in war and conflict had left an indelible imprint on who they were, how they functioned, and inevitably how they interacted with the world and society.

These images and depictions of wounded veterans become an inherent component of the social representations of the time. They are used by social forces, political means, and special interests. While the inherently interconnected relationship between war veterans and mental health have been continuous across the twentieth century and thereafter, the interpretations of such portrayals and their associated messages have evolved in accordance with the particular social and political forces of the times. These evolutions and diversity of representation are particularly evident in the time periods surrounding the world wars, the Vietnam War, and the recent conflicts in the Gulf and Middle East. These three component time periods starkly reflect the interwoven relationship between veterans and mental health over the course of the twentieth century and into the twenty-first century, as well as the variety of interpretations of this relationship and their subsequent portrayals in American society. Throughout the course of this evolution, mental health diagnoses have been intrinsically tied to the depiction and perception of veterans amongst the American populace. This includes not only how veterans are represented, but also what social forces, policies, and political movements surround them. Are they weak malingerers, heroes, victims, villains, or the

unfortunate? The purpose herein is to illuminate the interwoven relationship between veterans and mental health diagnoses utilizing a historical framework. *Given the interwoven relationship of military war veterans in America and mental health over the course of the twentieth century, what are the connections and differences in the portrayals of veterans and their subsequent implications on social perception and interpretations?*

Methodology

Given the broad date range of the entirety of the twentieth century covered herein, sources have included a variety of forms, including academic sources, photography, medical journals, and video sources. The common linkage throughout has been the prevalence of mental health as a common depiction of returning American military veterans. Primary and secondary sources were selected in the connected areas of military war veterans and mental health, shell shock, trauma, and stress disorders. The sources were subsequently reviewed to determine whether they were responsive to the research question, removing sources not relevant to the US context, or which did not deal with veterans and mental health in concert. Ultimately, a number of primary and secondary sources were identified including magazine articles, a documentary, poetry, interviews, a photographic collection, the first formal medical diagnosis of shell shock in the medical journal The *Lancet* circa 1915, academic journal articles, associated books, and the *Diagnostic and Statistical Manual for Mental Disorders*.

This review is organized in three main sections. Initially, a chronological depiction of the interwoven history surrounding the evolution of mental health and military war veterans as well as their associated depictions is provided. Emphasis herein is placed on three key turning points in the timeline: the first and second world wars, the Vietnam War, and the recent conflicts in the Gulf and Middle East. Secondly, a discussion of the continuous threads of stigma and veteran portrayals, as well as the changing course of interpretations of depictions surrounding veteran mental health is articulated. Finally, implications and recommendations for future courses of action across a variety of stakeholders, suggestions for future research, as well as predictions for future considerations of this topic are presented.

For the purposes of this review, the author has utilized a dictionary definition for the term veteran. Thereby, the term veteran identifies any former member of the Armed Forces (Merriam-Webster Inc., 2019). This notably differs from the legal definition of veteran within the US, as outlined in Title 38 in the Code of Federal Regulations, which denotes that "(d) *Veteran* means a person who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable" (Government Publishing Office, 2018). This distinction allows for the inclusion of servicemembers which may otherwise be excluded from veteran status due to discharge characterization, and who may have not yet had the opportunity to apply for a review of discharge or dismissal. With regards to the term Armed Forces, "(a) *Armed Forces* means the United States Army, Navy, Marine Corps, Air Force, and Coast Guard, including their Reserve components" (Government Publishing Office, 2018).

An Interwoven History

The horrors and associated trauma of war are by no means a novel invention of the twentieth century. They are noted as early as Ancient Greece, where Homer's *Iliad* notes Achilles's various emotional and psychological reactions during and after battle (Maseda & Dulin 2012: 3). Ancient Roman Horace writes of the glories and horrors of war which must be endured. "He plunges through a tide of blood! What joy, for fatherland to die! Death's darts e'en flying feet o'ertake, Nor spare a recreant chivalry, A back that cowers, or loins that quake" (Horace 23 BC). Napoleonic troops who

continued to dwell on past conflicts were simply nostalgic for the glory of war; Civil War troops suffered from war neurosis, and more recently, soldier's heart (*Shell Shock* 2016). Prior to WWI, invisible wounds of the mental or psychological variety were generally attributed to such nostalgia, an idle malingering, or worse, an affliction similar to female hysteria: distilled to an inherent personal weakness of the individual rather than a reflection upon war itself (Lembcke 2016: 80; McDonald, Brandt, & Bluhm 2018; Maseda & Dulin 2012: 4; Alexander 2010; Scragg 2016: 175) Inevitably, formal military and medical responses were simply akin to "suck it up and be a man," and societal reactions were generally those of avoidance, ignorance, or scorn: a depressing and oft disregarded consequence of war. Those whose wounds could not be managed or failed to recover, were retired to convalescence reflective of their station and subsequently lost to the collective memory.

1915-1950s

"War has historically been a crucible that catalyzes advances in medical care" (Hoge et al. 2016: 334). In 1915, at the height of WWI, unseen numbers of wounded, both physical and other, were being reported in hospitals across battlefronts. Military medical professionals were faced with sending obviously symptomatic men back to the front, since they possessed no identifiable or treatable injury. It was in direct response to this dilemma which saw the first medical acknowledgement that such wounds were more than just displays of cowardice or weakness. With the permission of Army medical leadership, Capt. Charles Myers, MD, studied three soldiers with physical symptoms and no visible malady. He later identified their diagnosis as shell shock in *A Contribution to the Study of Shell Shock*, stating that "comment on these cases seems superfluous. They appear to constitute a definite class among others arising from the effects of shell-shock. The close relation of these cases to those of 'hysteria' appears fairly certain" (Myers 1915: 320). The shell shock diagnosis, or as the trenches called it, the 100-yard stare, would eventually become the all-encompassing diagnosis for any non-physical ailment amongst military servicemembers and veterans throughout the first world war (Loughran 2012: 104; Stagner 2014: 256).

However, this diagnosis was fraught with complications. Since it encompassed any and all physical, mental, emotional, and psychological symptoms without visible physical injury, it included injuries not necessarily derived from the blast of nearby ordnance shells. "During the war, shell shock was understood in many different ways: as a psychological reaction to war, as a type of concussion, or as a physiological response to prolonged fear" (Loughran 2012: 257). Though debated, estimates list shell shock cases as somewhere between 15,000 to 76,000 (Stagner 2014: 257). Subsequently, the military would mark all those who derived the diagnosis from proven ordnance detonation as pension-eligible, and all those not as service-connected but not pensionable injuries (Alexander 2010). This approach and understanding of the broad diagnosis of shell shock would continue into World War II (WWII). Over the course of WWII and the Korean War, the understanding of those shell shock cases not directly resulting from artillery blasts grew to encompass all those ailments associated with a general war weariness or combat/battle fatigue, subsequently leading to a greater acknowledgement of the previously non-pensionable cases.

As veterans of the wars of the first half of the twentieth century returned to American soil, they were hailed as conquering heroes who defeated the great enemies of mankind and defended the American ideals of liberty and freedom. Given the demographics of American veterans, nearly every member of American society was directly connected in some fashion to a veteran of the time and had personally felt the hardships of a nation at war (US Department of Veterans Affairs, 2018). As such, veterans of the time were welcomed home to great fanfare. Yet not all the images of returning heroes were joyful images of victory and heroism. For perhaps the first time, the realities of war were portrayed to the American populace with images of physically, emotionally, mentally, and

psychologically wounded warriors returning home. "…Post war, shell shock created a new understanding that circumstances could cause mental breakdowns, which had nothing to do with moral fiber, and that mental illness was something that could be transient and wasn't necessarily genetic or degenerate" (*Shell Shock,* 2016). While there remained negative connotations both within the military and in civilian society, for the first-time, veterans returning with invisible wounds at least had a diagnosis.

Shell shock put a name to what had previously been a stark but unspoken reality. Veterans were able to seek treatment and pensions if their diagnosis demonstrated a direct connection to ordnance detonation. What would come to be known as the Bonus Expeditionary Force, a group of WWI veterans and families, lobbied the federal government for war compensation. Congress would eventually pass the World War Adjusted Compensation Act (US Congress, 1926). Public portrayals of mental health associated with the trauma of war grew into the public sphere. This trend would endure with WWII, when returning veterans would continue to promote a greater acknowledgement of those invisible wounds. Seeking solace while recuperating in military and veteran hospitals, these veterans sought outlets to express the inerasable traumas of war, "...drunk with fatigue, deaf even to the hoots of disappointed shells that dropped behind" (Owen 1920: 461).

1960s-1980s

By the 1960s, medical and military professionals were recognizing that a number of attributes exhibited in shell shock, were prevalent in civilian medical cases surrounding trauma of some facet (Shively & Perl 2012; Summerfield 2001). Soon after, the Vietnam War saw unprecedented numbers of servicemembers and returning veterans displaying symptoms associated with shell shock. In an effort to address those cases not ordnance-related, military medical professionals coined the term post-Vietnam Syndrome (Lembcke 2016: 78) or Vietnam Syndrome (Shively & Perl 2012: 236).

While this diagnosis enabled the encompassing of broader cases and a more concrete acknowledgement of the mental and psychological damage inflicted by military conflicts, it failed to reflect the similarities displayed in civilian cases or to provide a connection across time and armed conflicts. As greater numbers of Vietnam veterans sought treatment upon return, their frustration with the lack of civilian medical professional acknowledgement and understanding of their diagnosis grew. Vietnam veterans lobbied strongly in support of official representation and were central to the formalized medical establishment of Post-Traumatic Stress Disorder (PTSD) as a medical diagnosis in the 1980 *Diagnostic and Statistical Manual of Mental Disorders* (DSM) third edition (APA 1980). This diagnosis reflected the broad spectrum of symptoms and causes for PTSD, but was not strictly limited to military service and associated injuries. In the later part of the 1980s, the National Vietnam Veterans Readjustment Study estimated nearly 30.9 percent of Vietnam War veterans suffered from PTSD (Fisher 2014: 1).

Recognition of PTSD as a treatable, legitimate medical condition, served two purposes for veterans in the 1960s and 1970s. It would enable the greater reach of medical care and it served to change the harsh image perceived of veterans in light of their association with the Vietnam War. The Vietnam War was perhaps the most unpopular war in American history and veterans returning home were its visible and tangible image to the American populace. It mattered little that these veterans were conscripted draftees in a war they may not have even supported. Their very relation to a uniform served as a target for a population frustrated with government and political actors (Summerfield 2001: 95). Subsequently, this perception in society of a battle-hardened warrior returned, was exacerbated by unprecedented numbers of veterans with mental health issues. The predominant image of the war would become a hyper-violent anti-social veteran (Maseda & Dulin 2012: 9). The formalization of PTSD as a diagnosis would aim in reorienting this portrayal to one

where Vietnam veterans were unfortunate victims of political machinations—heroic individuals forced to serve their country and become victims themselves (Botti 2008: 12; Maseda & Dulin 2012: 12). Vietnam veterans would become survivors rather than warriors or perpetrators even in the supposed defeat of the war itself. This reimagining has continued ever since with the focus in American dialectic being that of the drafted soldiers lost in conflict and "only images of veterans healing at the wall remain" (Maseda & Dulin 2012: 19). The American populace hearkens to Vietnam veterans and their experiences following the war more so than the war itself, and the stereotype of a mentally scarred and psychologically wounded veteran lingers in the public consciousness (Botti 2008; Satel & Mcnally 2018). Vietnam veterans no longer coincide with the political narrative surrounding the Vietnam War.

1981-Present

In the waning of the twentieth century, and the turn of the twenty-first, PTSD has become a well-documented, studied, and treated diagnosis in both civilian and military spheres. Additionally, in 2012, a Congressional resolution designated June 27th at National PTSD Awareness Day (Purtle 2014: 505). The narrative established in the Vietnam era surrounding veterans and mental health now pervades popular American discourse. PTSD as a medical diagnosis has continued to evolve, and now reflects a more nuanced understanding of the malady, which has grown to include associated injuries such as Traumatic Brain Injury (TBI). Military veterans remain at the forefront of mental health and PTSD awareness; approximate numbers show between five and twenty percent of veterans suffer from PTSD (Fisher 2014: 1). Efforts continue amongst veteran organizations, military leadership, and governmental entities to enhance support capacities of a growing number of veterans suffering from the invisible wounds of war.

An oft thrown around number is 22—the notional number of veterans who commit suicide every day, generally as a result of some form of untreated mental health issue like PTSD or TBI. This dialogue has become the forefront in American perception of returning veterans. "The discourse of trauma has displaced almost all else from the coming-home news coverage of the current generation of veterans returning to the United States from operations in the Middle East" (Lembcke 2016: 78). The legacies of Vietnam imagery and memorialization have dictated mental health as the highlight of veterans' issues, distorting the perception of the American public as to the numbers associated with it. The dominant image is one of a "broken hero" (Phillips 2015). While such portrayals certainly highlight the need for support for mental health and PTSD, it has also served to alter public perception of veterans as emotionally unstable citizens on the verge of breakdown who may self-medicate with drugs or alcohol (Phillips 2015.

Continuity and Change

Throughout the course of the twentieth century and the evolution of what is now called PTSD, there have been two continuous aspects: the stigma surrounding mental health in the military and veteran community, and the continually linked representations of these maladies as illustrations of veterans as a whole. In contrast, these portrayals are oft used as fodder for the social and political forces reflective of the time. The relatively similar depictions may be used in a number of facets to provide an interpretation aimed at furthering whatever aim is sought.

Continuity of stigma and depiction

For the former (continuity), the stigma associated with mental and psychological illness is likely as old as war itself. As aforementioned, prior to WWI and even during the Great War, victims of such injuries were generally met with disdain and disbelief. "There are two main criteria used to

evaluate acts of heroism: risk to self and benefit to others. The solider who risks physical peril for benefit of country is an archetypal hero in most contemporary societies" (Purtle 2016: 13). Men who went to war and came home were heroes, the masculine ideal, who fought to defend their nation and liberty, returned victorious and proud to rejoin society. Those who did not fit into this archetype, were seen as weak malingerers who failed to do their duty as men of war—cowards who hid in their bunks while their comrades fought for them; sentimental, nostalgic fools who failed to move on and insisted upon dwelling on the past. With the advancement in acknowledgement of 1915's shell shock diagnosis, the stigma associated with such illnesses may have waned. However, 100 years later, the stigma of seeking mental health treatment still discourages veterans from seeking help. Little progress has been made despite the continued evolution in medical understanding. Not only do veterans stigmatize such injuries amongst themselves, society still retains that those contrary to the masculine standard are inherently weak. Even a strong desire to provide care and support for those wounded warriors afflicted with PTSD cannot overcome an inherent stigmatization of those seeking treatment.

> That is, many individuals who emphasized a need to reduce PTSD-related stigma in the military also conveyed other messages which could lead to stigmatization of servicemembers and veterans expressing symptoms of or seeking treatment for PTSD. For example, some labeled them as individuals with an invalid diagnosis or as malingerers, assertions that may be stigmatizing and serve as barriers to PTSD treatment in military contexts (Fisher 2014: 6).

Here, the lack of social evolution has hindered progress. Despite the advancements socially and medically in the recognition of mental health and PTSD amongst veterans, there remains an inherent stigma associated with such perceived personal weakness, an antithetical counter to the very archetype of the strong, masculine, war hero. For American veterans, mental health and PTSD remains a socially stigmatized condition.

As with the continuity of stigma, so too have the depictions of veterans in relation to mental health and PTSD remained a continuous entity across the twentieth century. In this, the very nature of their depictions has been relatively streamlined. In each of the aforementioned time periods, returning veterans were marked by a constant depiction in mainstream society of the returning warrior traumatized by the horrors of war and suffering from some invisible wounds, unseen to the human eye, which can only be understood by those who have also seen such trauma (Maseda & Dulin 2012; Phillips 2015). Yet even at its height in the Vietnam War, diagnosed cases of PTSD were only 30.9 percent (Fisher 2014: 1), and are even less in the present conflict. However, this prevalence of the topic in veteran discourse, would imply far greater numbers, and generally paints the diagnosis as a broad and widespread condition of nearly all returning veterans: war is inherently traumatic and as such all veterans are traumatized. The depictions and images of PTSD and veterans have been a continuous thread since WWI and grow ever more present in the national conscious.

Changing interpretations

These portrayals often have dire consequences by coloring American perceptions. In the early twentieth century, such portrayals lent to the stigma of personal weakness: Vietnam veterans were subject to the political agendas of the time, and modern veterans have suffered from higher rates of unemployment, substance abuse, and suicide (Maseda & Dulin 2012: 25). Though these statistics have continued to improve over recent years (US Department of Labor, 2018). The reality herein lies in the "sticky-thicket of political history and cultural imagery and medical science" (Lembcke 2016: 79). The depictions of wounded military veterans suffering from psychological trauma from war, spur public emotions surrounding national identity and patriotism (Lembcke 2016: 84). These constructs are cannon fodder for changing social and political forces and agendas. National identity and

patriotism were key components to the war efforts in the first and second world wars. Acknowledgement and discussion on the horrors and traumas of war was rarely a topic in popular portrayals, but if it was, it was reflective of the issue as one of weak character. Rather, more nuanced depictions of the conflicts' legacy would come later in more artistic expressions such as Owen's (1920) *Dulce et Decorum Est.* and McCullin's (2011) *Shaped by War*.

The Vietnam War was particularly subject to the political and social forces of the 1960s and 1970s. Vietnam veterans were subject to constant political machinations by both supporters and detractors of the war as the veritable face of the conflict. Eventually, the veterans themselves would work towards distancing themselves from the conflict and taking ownership of their representations (Lembcke 2016: 83; Maseda & Dulin 2012: 8). Later imagery and film portrayals would focus on the veterans themselves as victims of the horrors and trauma of war. The national desire to simply forget the war and its complexities have served to focus instead on the victimized veterans (Maseda & Dulin 2012: 19). Legacies of the Vietnam War era have made modern debates on the conflicts in the Middle East dangerous topics for politicians, public officials, and society. Critics must be careful to not mistake political critique for disparagement of American troops and veterans. The establishment of the all-volunteer force has further complicated such examinations. No longer are most Americans directly connected to military service. Unlike in previous conflicts where upwards of eleven percent of the population served, and draftees were garnered across the US, contemporary volunteers number less than one percent, and hail from communities with histories of military recruitment and service (*The War Comes Home* 2014). Additionally, patriotism has become synonymous with military and veteran support. Sports leagues have military recognition events, companies promote veteran friendly efforts, yet "mostly, veterans said they felt invisible, anonymous, and ignored by the public" (Satel & McNally 2018). Supporting wounded warriors, particularly those with PTSD, has become a veritable cornerstone of popular American culture. The changing interpretations of relatively continuous depictions of veterans with mental health and PTSD issues, reflects their usage in social and political forces not necessarily reflective of veterans themselves.

The varying nature of interpretations of veteran representations are stark when seen through the light of their inherent similarities. However, these at times similar portrayals and veteran depictions are used to support the unique narratives of their time: to demonstrate the enemies' evils as well as the heroism (and at times weakness) of American veterans in the first and second world wars; the frustrations and anguish of Vietnam veterans victimized by political intrigues; and the patriotism and psychological trauma of more than a decade at war in the Middle East and a failing mental health support system and US Department of Veterans Affairs (VA).

Implications, Recommendations, and Conclusion

Throughout the course of the American veteran mental health medical evolution, the diagnoses have been intrinsically tied to the depiction and perception of veterans amongst the American populace. This includes not only how veterans are represented, but also what social forces, policies, and political movements surround them. Are they the weak malingerers, the heroes, the victims, the villains, or the unfortunate?

Implications

The interconnected nature of veterans and mental health has a number of implications for the present and future. To its benefit, the high value placed upon research surrounding PTSD has continued the evolution of veterans' mental health and PTSD, incorporating greater nuance and understanding to the diagnoses and treatments, as well as other mental health injuries such as TBI (Hoge et al. 2016). It has encouraged a popular and significant level of support amongst the

American populace for services in aid of veterans with mental health injuries and other invisible wounds, as evidenced by the continually increasing numbers of veteran service organizations (US Department of Veterans Affairs 2017). However, the prevalence of representations of veterans with PTSD, risk not only overrepresentation as we have seen in the general assumption amongst Americans that most veterans possess the malady, but also in oversimplification, that PTSD is a common and easily treated illness not limited to warfare. Such generalization risks misunderstanding the context that war and conflict has upon PTSD and its sufferers. "As it turns out, the more we know about shell shock, the more problematic PTSD and TBI become as touchstones for generalizing about war and trauma" (Lembcke 2016: 79). The trauma of war is unavoidable; it is war after all. However, that does not inherently make each experience the same, nor do veterans of war experience PTSD the same, nor make veteran PTSD the same as any other form of traumatic experience. For PTSD in general, the definition and criteria for such diagnosis has continued to evolve, both in concert and separately from the veteran community. With each emerging edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) growing awareness and knowledge has continued to evolve, within an iterative process, the definitions, criteria, and aspects of the diagnosis of PTSD. Within the fifth edition of the *DSM* (APA 2013), a number of changes reflect the growing knowledge surrounding PTSD.

> Changes to the diagnostic criteria from the DSM-IV to DSM-5 include: the relocation of PTSD from the anxiety disorders category to a new diagnostic category named 'Trauma and Stressor-related Disorders', the elimination of the subjective component to the definition of trauma, the explication and tightening of the definitions of trauma and exposure to it, the increase and rearrangement of the symptoms criteria, and changes in additional criteria and specifiers (Pai et al. 2017: 1).

Each of these changes incorporates the growing streams of research surrounding PTSD both within the veteran context and disparate from veterans and warfare. As such, diagnosis and treatment must reflect the multifaceted nature of PTSD and other mental health injuries particularly when associated with veterans. Overrepresentation and oversimplification are particularly dangerous, as fewer American serve, and the all-volunteer force draws from fewer communities (*The War Comes Home* 2014).

Additionally, whilst not all, veterans may face higher rates of suicide and unemployment. These raise concerns over the quality of support services available to veterans regardless of how "supportive" the American populace appears. The aforementioned stigmas of mental health and overrepresentations may deter servicemembers and veterans from seeking help. At the same time, veteran services are at an all-time high. The sheer numbers of veteran service organizations are staggering (US Department of Veterans Affairs 2017); yet either veterans are not seeking treatment, or if they are, it is insufficient to meet the needs of the veteran experience. Nevertheless, the image of a veteran suffering from PTSD remains a dominant narrative and poignant image used by any number of social and political forces.

Recommendations

In light of the entwined relationship of veterans and PTSD, there requires a more multifaceted and reflective representation of veterans as a demographic. Future portrayals and representations of veterans should highlight the realities of those suffering from mental health not as a sole depiction of veterans, but as one of many experiences of war. Continuing that growing representation should highlight and incorporate a more diverse reality of American veterans, recognizing race, ethnicity, and gender, etc., in both PTSD and other depictions of the veteran

experience. The archetypal young, white, male as the American hero of the twentieth century no longer accurately depicts the realities of veteran demographics.

The narrative legacies of the Vietnam veterans have brought to the forefront the invisible wounds of war. However, there remains a continued need for research and support development surrounding mental health and PTSD. Further inquiry must include community building within the veteran community itself and the greater civil society, ensuring the depictions and representations of veterans are accurate portrayals. While support for veterans and mental health has swelled, veterans maintain a sense of isolation only exacerbated by such invisible wounds.

Conclusion

It is certainly no great surprise that one of the most enduring images of the American twentieth century, is the veteran suffering from some invisible wound of war. They may be on the battlefield or returned to the homeland, it may take the form of shell shock, post-Vietnam Syndrome, PTSD, or some other unseen psychological or mental trauma, but this image permeates the American consciousness. It is a lasting and continuous reflection on the past and a visible narrative of the present. Its image, though, is used in a variety of capacities and for a multitude of agendas. The implications for veterans themselves are often subject to the social and political forces of their time. The interpretation of such images ebbs and flows with time and differing conflicts, while the fundamental components and the associated stigmas remain: a veteran struggling with the invisible wounds of war.

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National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

Understanding PTSD and PTSD Treatment



Table of Contents

Laurent G. Taillefer II, US Army (2003–2006)

Get help if you're in crisis

If you feel like you might hurt yourself or someone else:

- **Call 1-800-273-TALK** (1-800-273-8255) anytime to talk to a crisis counselor. Press "1" if you are a Veteran. The call is confidential (private) and free.
- **Chat online with a crisis counselor** anytime at http://www.suicidepreventionlifeline.org/.

You can also **call 911** or **go to your local emergency room.**

What is PTSD?

PTSD (posttraumatic stress disorder) is a mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault.

It's normal to have upsetting memories, feel on edge, or have trouble sleeping after this type of event. At first, it may be hard to do normal daily activities, like go to work, go to school, or spend time with people you care about. But most people start to feel better after a few weeks or months.

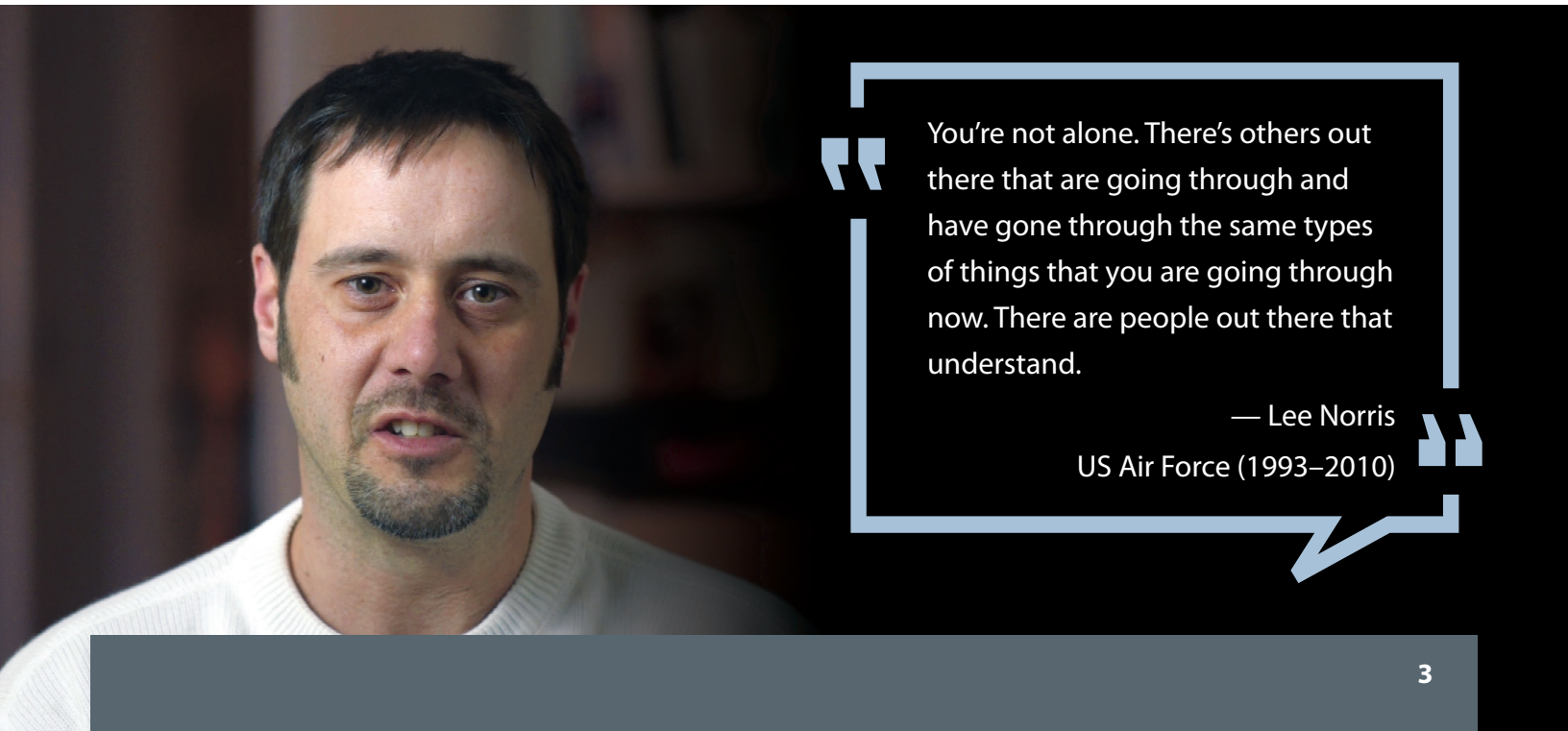
If it's been longer than a few months and you're still having symptoms, you may have PTSD. For some people, PTSD symptoms may start later on, or they may come and go over time.

If thoughts and feelings from a life-threatening event are upsetting you or causing problems in your life, **you may have PTSD.**

Here's the good news: you can get treatment for PTSD — and it works. In this booklet, you'll learn about types of treatment that are proven to help.

For some people, treatment can get rid of PTSD altogether. For others, it can make symptoms less intense. Treatment also gives you the tools to manage symptoms so they don't keep you from living your life.

PTSD treatment can turn your life around — even if you've been struggling for years.



"You're not alone. There's others out there that are going through and have gone through the same types of things that you are going through now. There are people out there that understand."

— Lee Norris
US Air Force (1993–2010)

What can cause PTSD?

Any experience that threatens your life or someone else's can cause PTSD. These types of events are sometimes called **trauma**. Types of traumatic events that can cause PTSD include:

- **Combat and other military experiences**
- **Sexual or physical assault**
- **Learning about the violent or accidental death or injury of a loved one**
- **Child sexual or physical abuse**
- **Serious accidents, like a car wreck**
- **Natural disasters, like a fire, tornado, hurricane, flood, or earthquake**
- **Terrorist attacks**

During this kind of event, you may not have any control over what's happening, and you may feel very afraid. Anyone who has gone through something like this can develop PTSD.

Trauma can take many forms.

A traumatic event could be something that happened to you, or something you saw happen to someone else. Seeing the effects of a horrible or violent event can also be traumatic — for example, being a first responder after a terrorist attack.

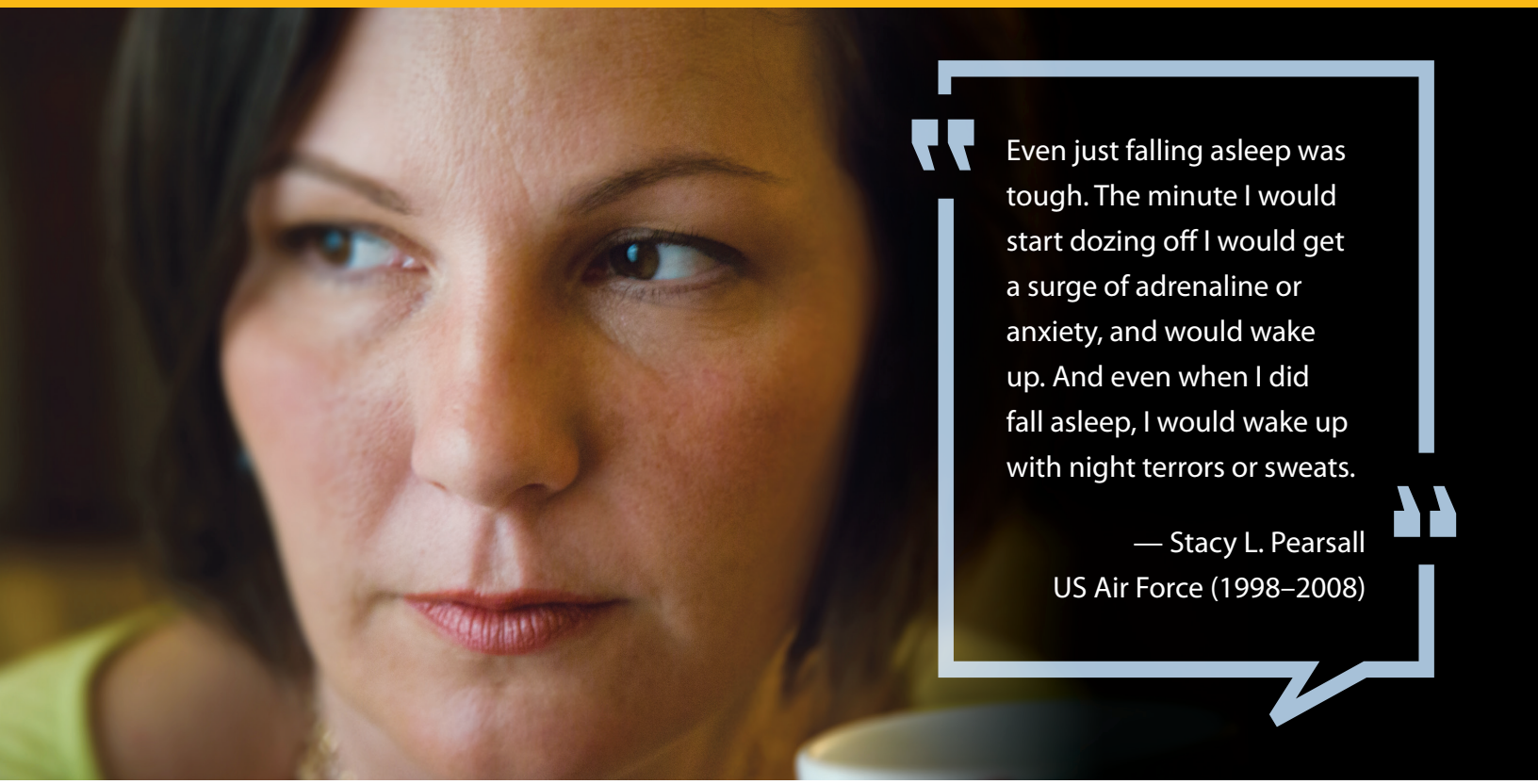
You're not alone.

Going through a traumatic event is not rare. At least half of Americans have had a traumatic event in their lives. Of people who have had trauma, about 1 in 10 men and 2 in 10 women will develop PTSD.

There are some things that make it more likely you'll develop PTSD — for example, having very intense or long-lasting trauma, getting hurt, or having a strong reaction to the event (like shaking, throwing up, or feeling distant from your surroundings).

It's also more common to develop PTSD after certain types of trauma, like combat and sexual assault. But there's no way to know for sure who will develop PTSD.

> "I was awarded a Silver Star for bravery. You're not going to tell me I'm a coward. If somebody like me has PTSD, then anybody can have it."
>
> — MAJ Joshua Brandon
> US Army (2002–present)



> Even just falling asleep was tough. The minute I would start dozing off I would get a surge of adrenaline or anxiety, and would wake up. And even when I did fall asleep, I would wake up with night terrors or sweats.
>
> — Stacy L. Pearsall
> US Air Force (1998–2008)

What are the symptoms of PTSD?

There are 4 types of PTSD symptoms, but they may not be exactly the same for everyone. Each person experiences symptoms in their own way.

1. Reliving the event

Unwelcome memories about the trauma can come up at any time. They can feel very real and scary, as if the event is happening again. This is called a flashback. You may also have nightmares.

Memories of the trauma can happen because of a trigger — something that reminds you of the event. For example, seeing a news report about a disaster may trigger someone who lived through a hurricane. Or hearing a car backfire might bring back memories of gunfire for a combat Veteran.

2. Avoiding things that remind you of the event

You may try to avoid certain people or situations that remind you of the event. For example, someone who was assaulted on the bus might avoid taking public transportation. Or a combat Veteran may avoid crowded places like shopping malls because it feels dangerous to be around so many people.

You may also try to stay busy all the time so you don't have to talk or think about the event.

3. Having more negative thoughts and feelings than before

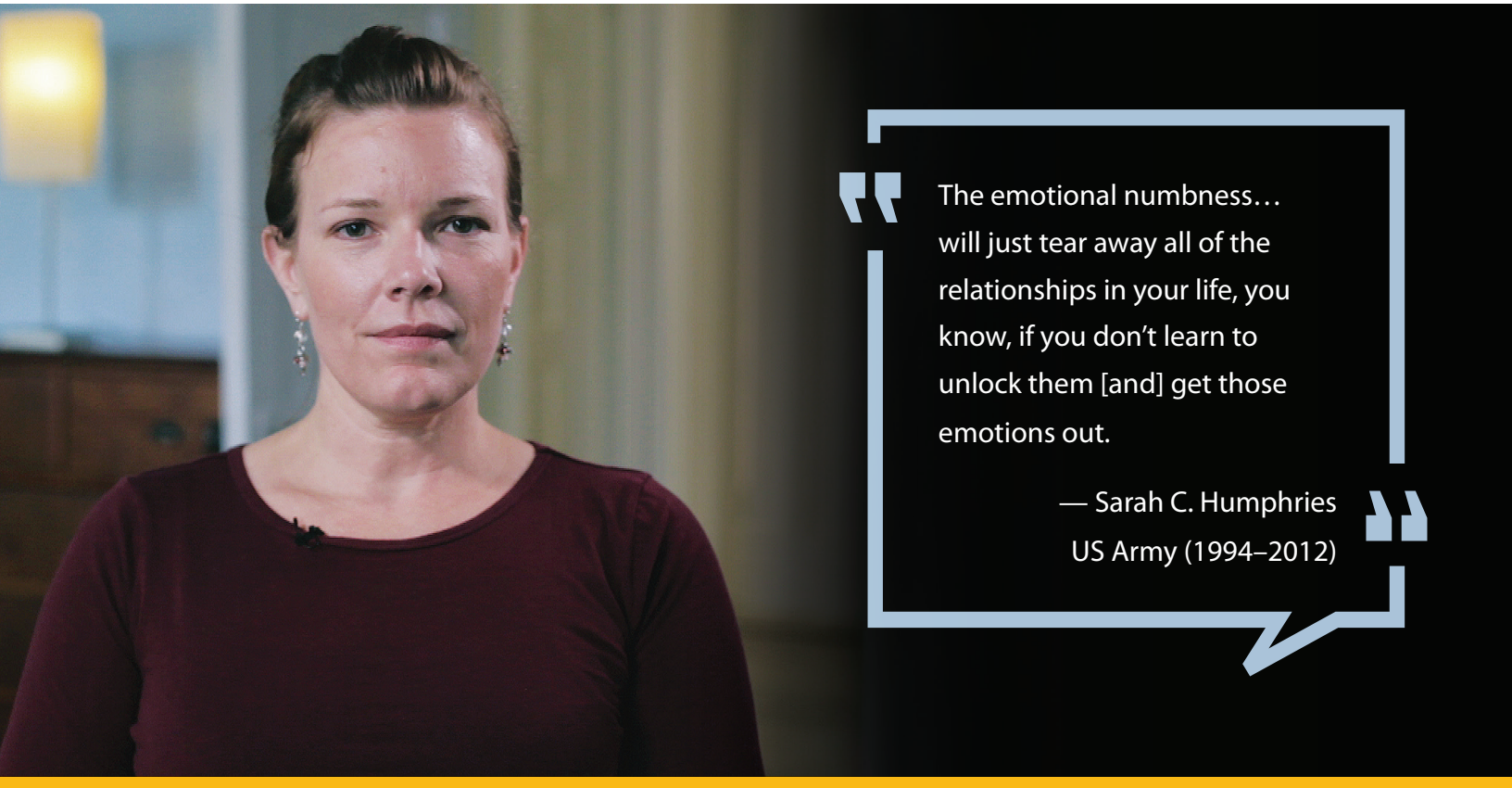
You may feel more negative than you did before the trauma. You might be sad or numb — and lose interest in things you used to enjoy, like spending time with friends. You may feel that the world is dangerous and you can't trust anyone. It may be hard for you to feel or express happiness, or other positive emotions.

You might also feel guilt or shame about the traumatic event itself. For example, you may wish you had done more to keep it from happening.

4. Feeling on edge

It's common to feel jittery or "keyed up" — like it's hard to relax. This is called hyperarousal. You might have trouble sleeping or concentrating, or feel like you're always on the lookout for danger. You may suddenly get angry and irritable — and if someone surprises you, you might startle easily.

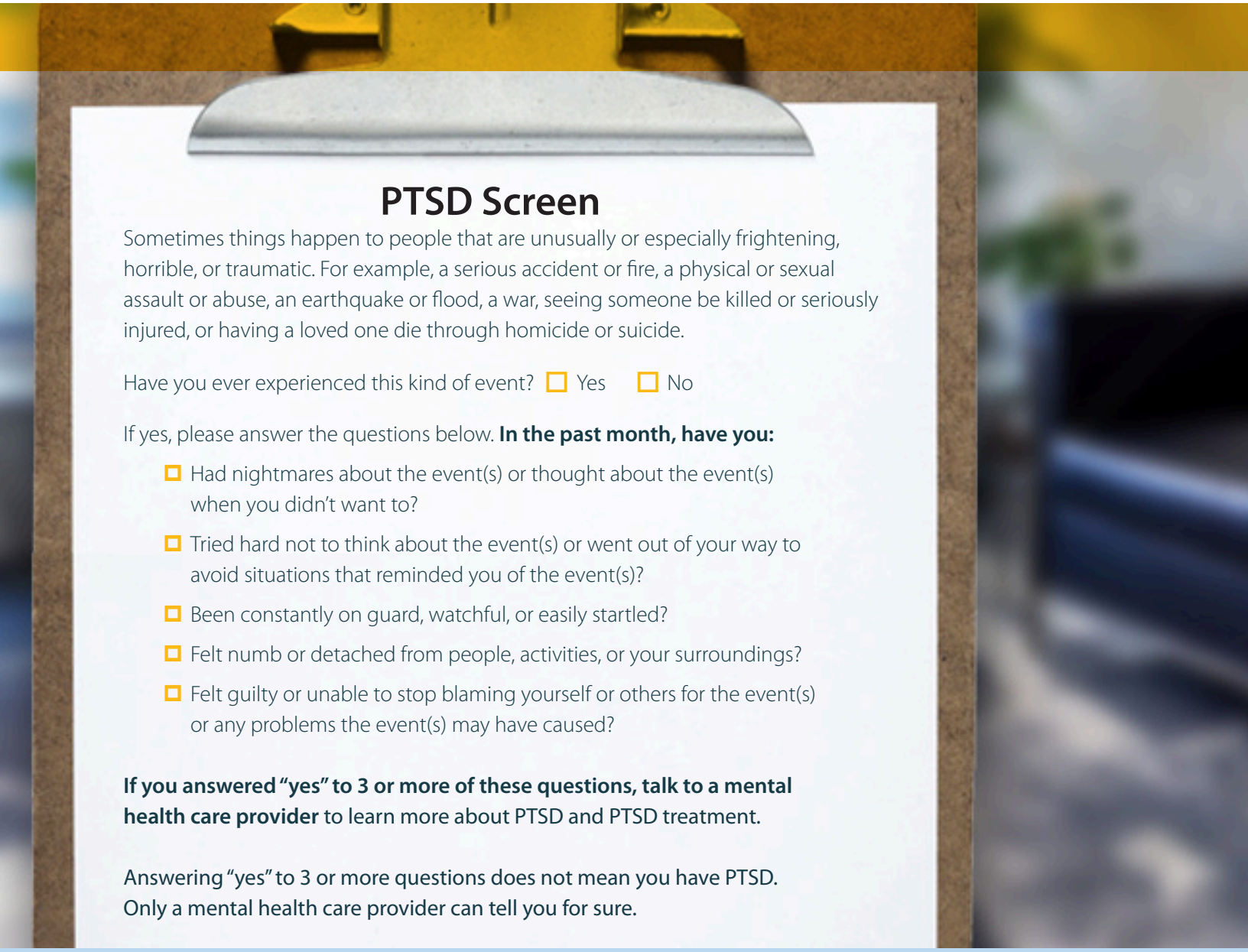
You may also act in unhealthy ways, like smoking, abusing drugs and alcohol, or driving aggressively.



How do I know if I have PTSD?

The only way to know for sure is to talk to a mental health care provider. He will ask you about your trauma, your symptoms, and any other problems you have.

If you think you might have PTSD, answer the questions in the screening tool below.



PTSD Screen

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example, a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, or having a loved one die through homicide or suicide.

Have you ever experienced this kind of event? ☐ Yes ☐ No

If yes, please answer the questions below. **In the past month, have you:**

- ☐ Had nightmares about the event(s) or thought about the event(s) when you didn't want to?
- ☐ Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
- ☐ Been constantly on guard, watchful, or easily startled?
- ☐ Felt numb or detached from people, activities, or your surroundings?
- ☐ Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

If you answered "yes" to 3 or more of these questions, talk to a mental health care provider to learn more about PTSD and PTSD treatment.

Answering "yes" to 3 or more questions does not mean you have PTSD. Only a mental health care provider can tell you for sure.

What if the screening tool says I don't have PTSD?

You may still want to talk to a mental health care provider. If thoughts and feelings from the trauma are bothering you, treatment can help — whether or not you have PTSD.

What do I do if I have symptoms of PTSD?

After a traumatic event, it's normal to think, act, and feel differently than usual — but most people start to feel better after a few weeks or months. **Talk to a doctor or mental health care provider** (like a psychiatrist, psychologist, or social worker) if your symptoms:

- **Last longer than a few months**
- **Are very upsetting**
- **Disrupt your daily life**

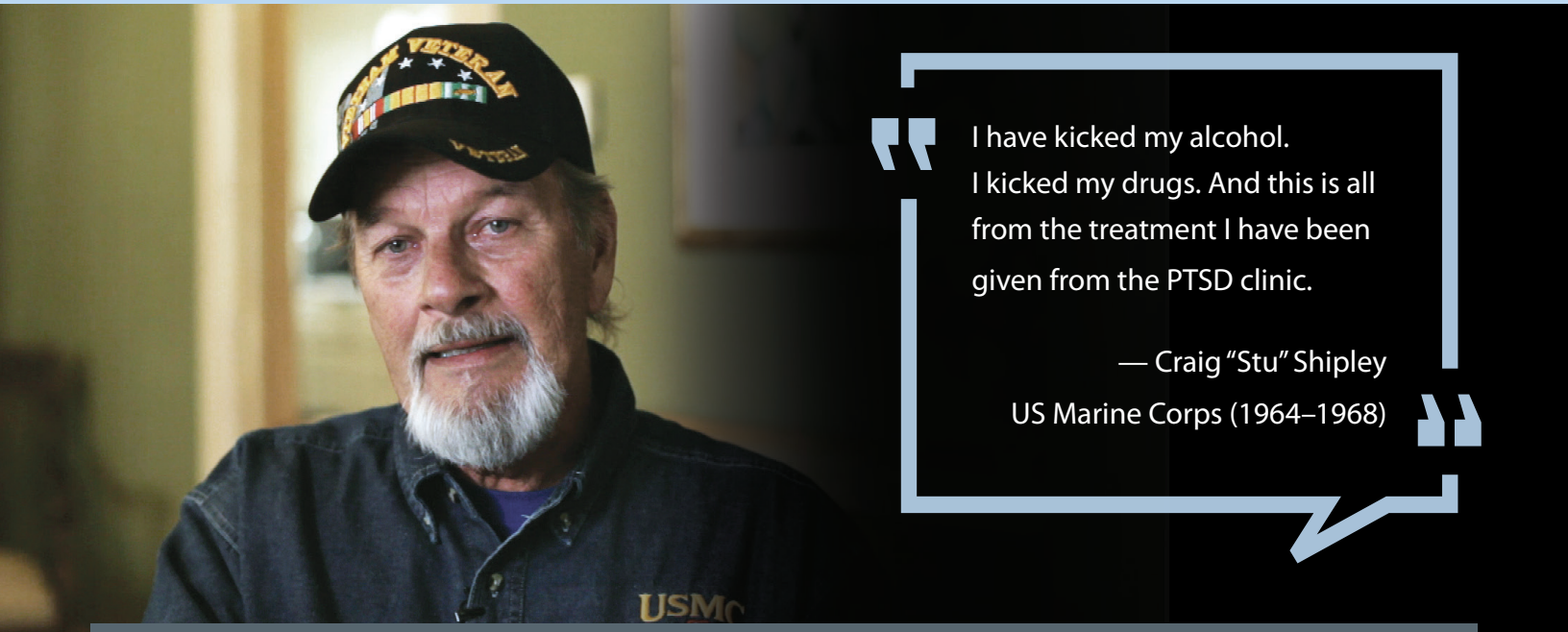
Treatment can help — you don't have to live with your symptoms forever.

What other problems do people with PTSD have?

Many people who have PTSD also have another mental health problem — like depression, anxiety, alcohol and drug abuse, or thinking about harming themselves or others. It's also common to have problems at work, in relationships, or with your physical health.

Sometimes, these problems happen because of your PTSD symptoms. For example, feeling numb and avoiding places can make it hard to have good relationships with your friends and family.

Getting treatment for PTSD can help with these other problems, too.



> I have kicked my alcohol. I kicked my drugs. And this is all from the treatment I have been given from the PTSD clinic.
>
> — Craig "Stu" Shipley
> US Marine Corps (1964–1968)

> Treatment has turned my life completely around. I'm a lot more comfortable in my own skin.
>
> — Jeremiah Civil
> US Marine Corps (2001–2005)

Why get treatment for PTSD?

Treatment works.
There are many treatment options for PTSD. In this booklet, we'll tell you about different talk therapies and medications that are proven to help people with PTSD.

For many people, these treatments can get rid of symptoms altogether. Others find they have fewer symptoms or feel that their symptoms are less intense.

After treatment, most people feel they have a **better quality of life.**

> It was difficult, that first time going, because I didn't think I really needed it. But once I got there and spoke with the counselor, I felt better when I left that day. I already felt better after the first session. — Michelle Rentas, US Army (1992–1995)

When PTSD isn't treated, it usually doesn't get better — and it may even get worse.

It's common to think that your PTSD symptoms will just go away over time. But this is very unlikely, especially if you've had symptoms for longer than a year. Even if you feel like you can handle your symptoms now, they may get worse over time.

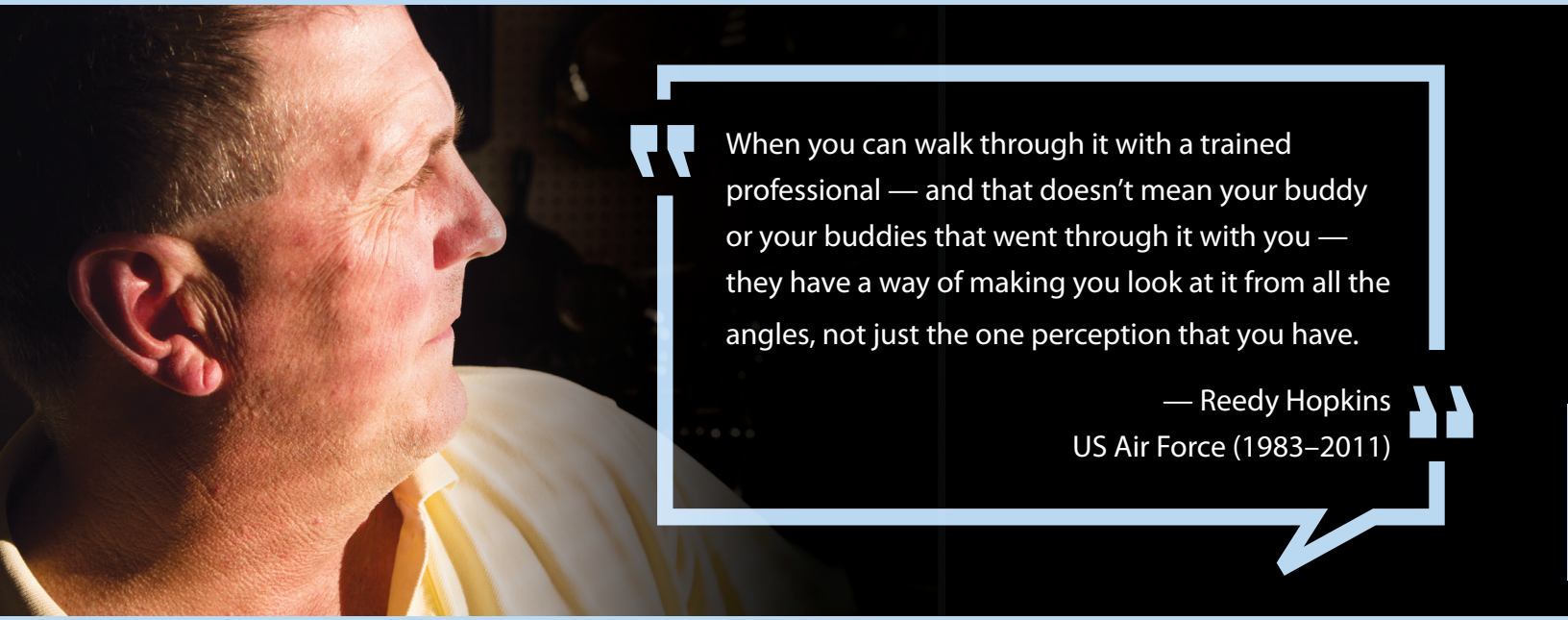
Getting treatment can help keep PTSD from causing problems in your relationships, your career, or your education — so you can live the way you want to.

> And she said, 'You're not afraid that it will affect your career?' And I said, 'No, it doesn't matter how it affects my career because I can't go on living the way I'm living…'
> — Reedy Hopkins, US Air Force (1983–2011)

Common questions about treatment

Can a therapist really understand what I've been through?

Therapists can treat your PTSD whether or not they have been through trauma themselves. What's important is that your therapist understands how you think about your experience, so she can teach you the skills you need to manage your symptoms.



> When you can walk through it with a trained professional — and that doesn't mean your buddy or your buddies that went through it with you — they have a way of making you look at it from all the angles, not just the one perception that you have.
>
> — Reedy Hopkins
> US Air Force (1983–2011)

Is it ever too late to get treatment for PTSD?

It's never too late. Treatment can help even if your trauma happened years ago. And treatment for PTSD has gotten much better over the years. If you tried treatment before and you're still having symptoms, it's a good idea to try again.

What if I don't feel ready for treatment?

It's normal to feel like you're not ready for treatment, or to come up with reasons why now isn't the right time — like you can't afford it or you're too busy. But not wanting to talk or think about the trauma can actually be a symptom of PTSD.

You may never feel truly ready to get help for PTSD — but if you're having symptoms, it's better to get treatment now than to wait. **The sooner you get treatment, the sooner you can start to feel better.**

> Getting ready for treatment is like, how do I know I'm ready to get in better shape? How do I know I'm ready to be a better father? How do I know I'm ready to be a better person? **If you're feeling pain, you're ready for treatment.** — Dr. Ron Acierno, Clinical Psychologist

What happens during PTSD treatment?

Your therapist or doctor will start by talking with you about your PTSD symptoms and your treatment options. Once you've chosen a type of treatment, he'll explain what will happen, how it will help you feel better, and why it works. **Remember, you can always ask questions about your treatment.**

Both trauma-focused psychotherapies and medication are proven to treat PTSD.

Trauma-focused Psychotherapies

Trauma-focused psychotherapies are the most highly recommended treatment for PTSD. "Trauma-focused" means that the treatment focuses on the memory of the traumatic event or its meaning. In this booklet, we'll tell you about 3 of the most effective trauma-focused psychotherapies for PTSD. In each of these psychotherapies, you'll meet with a therapist once or twice a week, for 50 to 90 minutes. You and your therapist will have specific goals and topics to cover during each session. Treatment usually lasts for 3 to 4 months. Then, if you still have symptoms, you and your therapist can talk about other ways to manage them.

> PTSD therapy helps change your relationship with the trauma. Therapy isn't for erasing your memories. — Dr. Rebecca Liu, Clinical Psychologist

Prolonged Exposure Therapy (PE)

People with PTSD often try to avoid things that remind them of the trauma. This can help you feel better in the moment, but in the long term it can keep you from recovering from PTSD.

In PE, you expose yourself to the thoughts, feelings, and situations that you've been avoiding. It sounds scary, but facing things you're afraid of in a safe way can help you learn that you don't need to avoid reminders of the trauma.

What happens during PE? Your therapist will ask you to talk about your trauma over and over. This will help you get more control of your thoughts and feelings about the trauma so you don't need to be afraid of your memories.

She will also help you work up to doing the things you've been avoiding. For example, let's say you avoid driving because it reminds you of an accident. At first, you might just sit in the car and practice staying calm with breathing exercises. Gradually, you'll work towards driving without being upset by memories of your trauma.

> I learned with the Prolonged Exposure, by re-living some of the most scariest moments of my life when I was in Iraq, you learn that it's there, but the intensity of the memory goes away. — Andrew Reeves, US Army (1999–2009)

Cognitive Processing Therapy (CPT)

After a trauma, it's common to have negative thoughts — like thinking what happened is your fault or that the world is very dangerous. CPT helps you learn to identify and change these thoughts. Changing how you think about the trauma can help change how you feel.

What happens during CPT? You'll talk with your therapist and fill out worksheets about the negative thoughts and beliefs that are upsetting you. Then your therapist will help you challenge those thoughts and think about your trauma in a way that's less upsetting.

Eye Movement Desensitization and Reprocessing (EMDR)

People with PTSD react negatively to the memory of their traumas. EMDR can help you process these upsetting memories, thoughts, and feelings. You'll focus on specific sounds or movements while you talk about the trauma. This helps your brain work through the traumatic memories. Over time, you can change how you react to memories of your trauma.

What happens during EMDR? Your therapist will ask you to choose a memory from the trauma and identify the negative thoughts, emotions, and feelings in your body that go with it.

You'll think about this memory while you pay attention to a sound (like a beeping tone) or a movement (like your therapist's finger moving back and forth). Once the memory becomes less upsetting, you'll work on adding a positive thought.

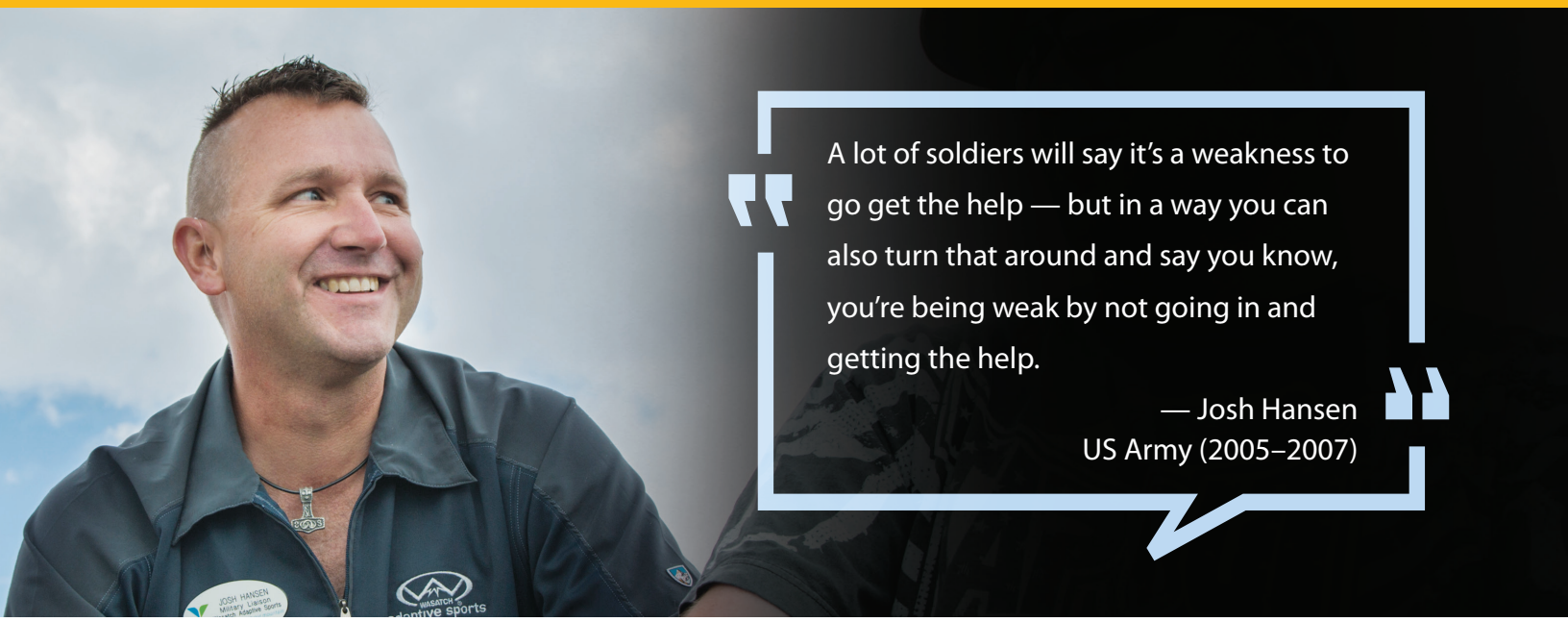
How can I decide which treatment is right for me?

The online PTSD Treatment Decision Aid (https://www.ptsd.va.gov/apps/decisionaid/) is a great way to learn about your options and consider which treatment is right for you. You can watch videos of providers explaining how treatments work, then build a personalized comparison chart of the treatments that appeal to you. You can share a printout of the chart with your provider as you decide together which treatment best meets your needs.

What about support groups?

In a support group, you talk about your day-to-day problems with other people who have had similar experiences. They can be a good addition to PTSD treatment, or something you can do after you've gotten treatment — but they won't treat your PTSD.

Horace "Ace" Carter, US Army (1977–1999)



> A lot of soldiers will say it's a weakness to go get the help — but in a way you can also turn that around and say you know, you're being weak by not going in and getting the help.
>
> — Josh Hansen
> US Army (2005–2007)

Medication

When you have PTSD, you may not have enough of certain chemicals in your brain that help you manage stress. SSRIs (selective serotonin reuptake inhibitors) and SNRIs (selective norepinephrine reuptake inhibitors) are medications that can help raise the level of these chemicals in your brain so you feel better. Sertraline, paroxetine, and fluoxetine are SSRIs that work for PTSD. Venlafaxine is an SNRI that is effective.

Before starting to take medication to treat PTSD, you'll talk to a psychiatrist (a doctor who specializes in mental health). When you first start taking medication, you'll check in with the doctor often to talk about how the medication is working. You may need to try a few different medications to find one that works.

Medications can treat PTSD symptoms alone or with therapy — but only therapy treats the underlying cause of your symptoms. If you treat your PTSD symptoms only with medication, you'll need to keep taking it for it to keep working.

What about benzodiazepines?

Some doctors may prescribe a type of anxiety medication called benzodiazepines (or benzos) — but benzodiazepines aren't a good treatment for PTSD. They can be addictive, cause other mental health problems, and make PTSD therapy less effective.

If you've been taking benzodiazepines for a long time, talk to your doctor about making a plan to stop. Ask about PTSD treatments that are proven to work and other ways to manage your anxiety.

Where can I go to get help?

If you're a Veteran, check with the VA about whether you can get treatment there. Visit http://www.va.gov/directory/guide/PTSD.asp to find a VA PTSD program near you.

If you're looking for care outside the VA, ask your doctor for a referral to a mental health care provider who specializes in PTSD treatment, or visit https://findtreatment.samhsa.gov/ to search for providers in your area. When choosing a mental health care provider, here are some important things to consider:

- **Find a provider who uses PTSD treatments proven to work.**

  It's best if you can find someone who offers one of the treatments we've talked about in this booklet, since these treatments have strong evidence showing that they work. Many mental health centers in hospital or university systems offer these treatments.

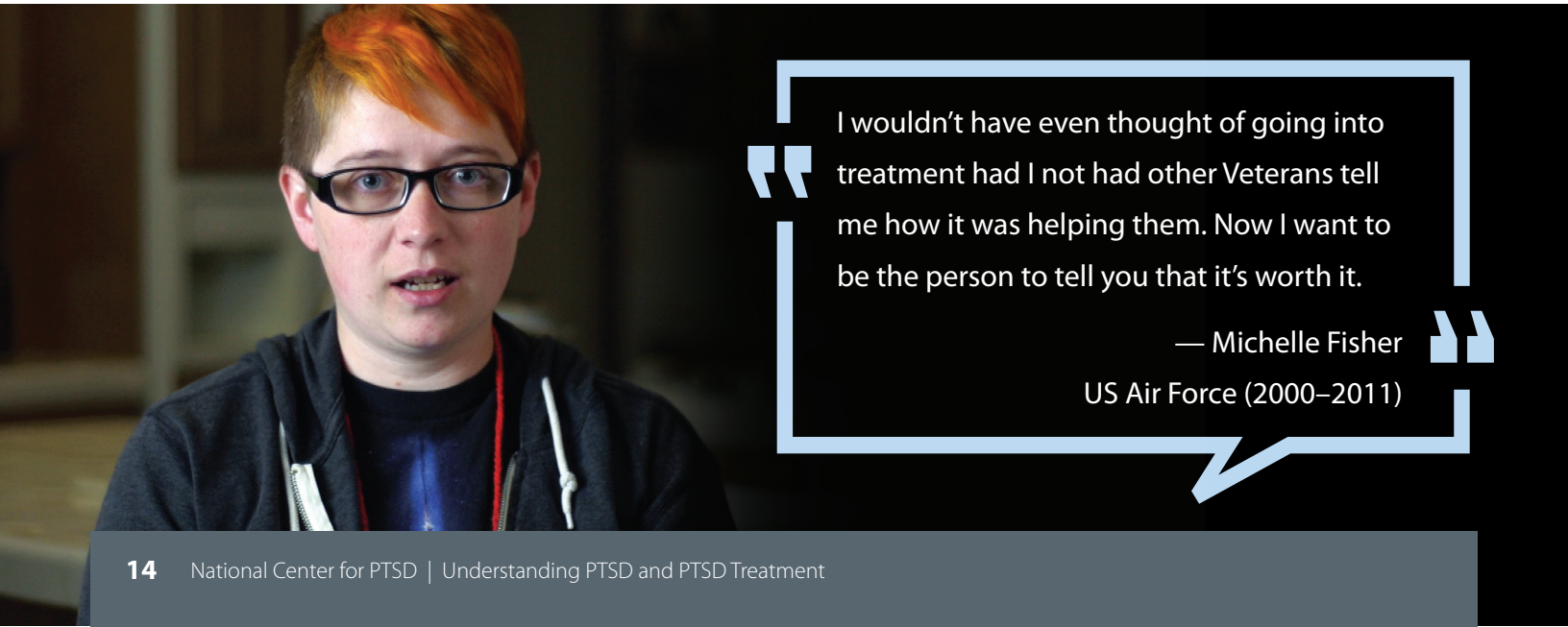
  What if I can't find anyone who offers these treatments? Many doctors can treat PTSD with medication, but it may be hard to find therapists who use the other treatments we've talked about. If you can't find a therapist who offers CPT, PE, or EMDR, ask about trauma-focused cognitive behavioral therapy. General cognitive behavioral therapy can also be a good alternative.

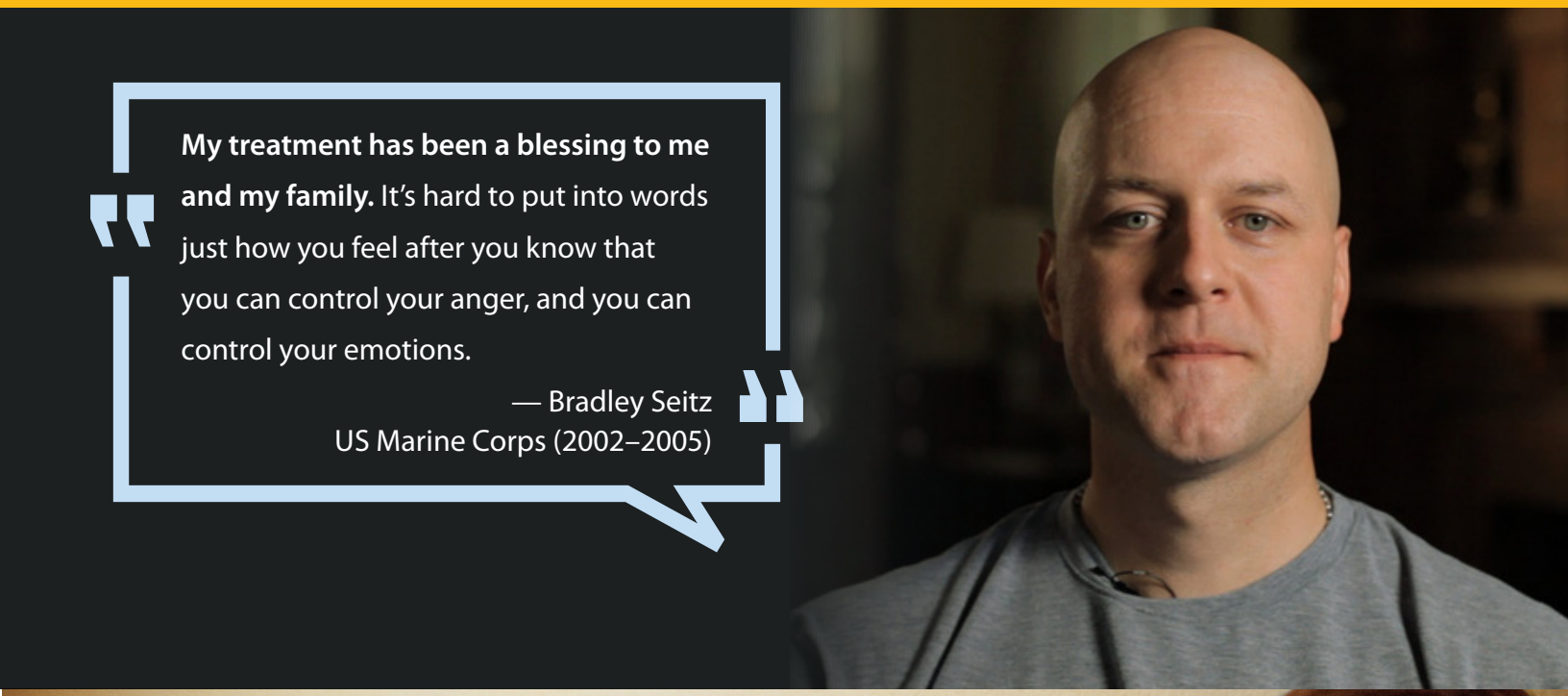
- **Find out what your insurance will cover.**

  If you have health insurance, check to see what mental health services are covered.

- **Find someone who is a good fit for you.**

  You and your therapist or doctor will work closely together, so it's important that you feel comfortable asking questions and talking about problems in your life. It's always okay to look for a different therapist or doctor if you're not happy with the person you're seeing.





My treatment has been a blessing to me and my family. It's hard to put into words just how you feel after you know that you can control your anger, and you can control your emotions.

— Bradley Seitz
US Marine Corps (2002–2005)

"Besides my daughter and my wife, it's the best thing that's ever happened to me."

I can carry on with my life and not feel so much guilt, so much anger and resentment. Besides my daughter and my wife, it's the best thing that's ever happened to me.

— Joe Duarte, US Army (2002–2008)

PTSD treatment can turn your life around

Arthur Jefferson, US Army (1978–1998)

ABOUTFACE

Find out about PTSD and PTSD treatment from Veterans who've been there.

www.ptsd.va.gov/aboutface

For more information and resources

visit the National Center for PTSD website at:
www.ptsd.va.gov

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POSTTRAUMATIC STRESS DISORDER