**Post-Traumatic Stress Disorder among War Veterans**

Azmin Pedraza

Psychology is among the youngest sciences in medicine. It consists of many constructs that are not fully accepted by the medical world. Psychological terms and diagnosis are not as easily accepted by society as diagnosis of heart or kidney disease. Consequently the process of agreeing on a psychological diagnose is highly politicized. This paper will attempt to demonstrate this claim by examining Post-Traumatic Stress disorder and its political acceptance. Unlike other diagnostics that can be supported by physical evidence and are accepted by practitioners, psychological disorders often face greater social and political pressures before they become widely acceptable. By examining how Post-traumatic stress disorder (PTSD) was eventually included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in the 80’s I hope to show that psychological diagnoses such as PTSD are shaped by political forces and not simply by objective scientific data. Actually, alike many other psychological disorders, PTSD existed well over hundreds of years ago, yet there was not enough information and experience regarding the disorder to explain and classify it. As a result, the diagnostic of Post-traumatic stress disorder particularly among war veterans became highly controversial.  In this research project I will examine the history of the PTSD diagnosis in order to show that this psychological diagnosis faced many political crosscurrents. Additionally, this paper will also show that even after general acceptance of PTSD there is still gender, regional and racial differences among those who are diagnosed with the problem and the services provided to them. Ultimately this information can demonstrate that even almost twenty years later the acceptance and treatment of Post-traumatic stress disorder, it is still far from being perfect.

**Key words:** Post Traumatic Stress Disorder, veterans, politics, differences, benefits, diagnostics

**Introduction**

War is inevitable when a country’s safety is at risk. It can be damaging towards a country’s economy and its people. Throughout history, wars have resulted in the independence of countries, gains of resources, compromises among nations, and a variety of other outcomes. These outcomes are almost immediately evident following a war, however, the aftermath and the lasting effects of a war often get pushed to the side. Rarely, have the effects of war on the combat soldiers been a central focus of the government. Although economic recovery should be a key focus for a country that recently came out of a war, the effect it has on a country’s society, in particular the soldiers who fought in combat should not be overlooked. The negative effect that war has on a country’s society has grown immensely within the past half century. However, it is uncertain as to why this has occurred. It can be assumed that war itself has changed in the past half century. Combat exposure is far more dangerous now than it ever was before due to the advancement of combat weapons such as artillery, explosives, and gases. These weapons not only pose a threat to the enemy but also our own U.S troops. The physical effects that these weapons have on the soldiers can often be long lasting and severe; disabling soldiers to return to a normal life. However, injuries after a war has been an issue for thousands of years, it’s almost an absolute for many soldiers to lose their lives or suffer extreme injuries due to war, making it one of the reasons why war is negatively seen. However, until the recent past half century, the effects of combat exposure were mainly limited to physical injuries that the soldiers suffered, often overlooking psychological trauma suffered due to combat exposure. Now, psychological trauma is far more accepted than it was before mainly because it is the result of known psychological disorders due to combat exposure. This shift of thought did not occur overnight, nor was it easily accepted; more or less it resulted from a definite truth that our society could no longer overlook this problem and needed to find a way to minimize it.

It is very common for war veterans to be the victims of physical injuries and trauma related disorders due to incidents occurring during combat. However, the second half of the 20th century saw the introduction of a new type of trauma due to war and combat exposure. It became more and more evident that some soldiers, although not suffering from a serious physical injury, were unable to return to their everyday normal lives and families. Unfortunately, the United States and presumably other nations around the world were inexperienced to this new idea of trauma and were not fully aware or capable of dealing with it.

As mentioned, the common type of trauma in soldiers resulted from physical injuries caused by combat exposure such as being shot at, attacked, etc; however, following the wars in the mid-twentieth century it became more evident that the scopes of these traumas were far larger than it had been expected. Soldiers returned home physically capable of returning to their daily routines, yet were unable to be a fully functioning citizen. Returning soldiers experienced psychological trauma due to combat exposure no matter how severe the combat exposure they experienced was. Soldiers who suffered from psychological trauma shared a variety of common symptoms as early as World War I and World War II, however it was the Vietnam War that revolutionized the idea of psychological trauma due to combat exposure, whether the soldier experienced physical damage or not. As history comes to see, this process was not easy nor was is a quick one. However, through pushed efforts by notable advocates and supporters, the disorder, later known as Post Traumatic Stress Disorder was finally noted in the Diagnostic and Statistical Manual of Mental Disorders in the late 20th century.

Prior to the First and Second World War and the Vietnam war psychological related trauma was not publically supported as a result of combat exposure although there is evidence that Post Traumatic Stress Disorder and other similar disorders were already existent. The Vietnam War resulted in a series of consequences that the American government and public had not experienced before and were therefore unaware or ready to handle them. It’s common for the public to be supportive of their country during times of war; however, this wasn’t completely the case during the Vietnam War. After many years of combat public interest and support decreased greatly and American citizens were no longer completely convinced the Vietnam War was a smart choice. This trend of thought definitely took a toll on the American people and the support they offered their government. The lasting effects of the Vietnam War triggered what was yet to come. Additionally, the Vietnam War highlights the introduction of psychological related disorders particularly Post-Traumatic Stress Disorder since it was one of the most common disorders suffered by combat soldiers and personnel.

This paper aims to discuss the phenomenon that is known as Post-Traumatic Stress Disorder which was commonly seen in Vietnam War veterans upon returning home to the United States. At that time, due to a lack of knowledge and experience pertaining to post-traumatic stress disorder the issue was misdealt with. Since psychologists and psychiatrists themselves were unable to fully explain such phenomena, the criteria and treatment was unclear among the medical world. This resulted in a high rate of post-traumatic stress disorder cases among the war veterans because many of them were undiagnosed, and even those who had the diagnosis were unable to receive accurate treatment. The acceptance and introduction of post-traumatic stress disorder was complicated to understand within itself. Following its acceptance posed another set of struggles to fight towards correct treatment given that Post traumatic stress disorder varies on a large spectrum of severity.

Additionally, this paper also aims to stress the importance of the effect that post-traumatic stress disorder had on politics and society shortly after the Vietnam War. It will also address the effect that post-traumatic stress disorder is having on American society in present day due to the Iraq and Afghanistan war which can demonstrate that perhaps the solution to dealing with post-traumatic stress disorder is still afar. Similar to war, post-traumatic stress disorder can sometimes be inevitable, however, the way in which such a problem is handled can greatly shape the outcome of a situation. In the case of post-traumatic stress disorder shortly following the Vietnam War, both the government and society failed to successfully deal with the issue at hand which resulted in higher cases of post-traumatic stress disorder among Vietnam War veterans and a malfunction of the Veterans Affairs Department.

This is an important issue to consider because a vast amount of previous research has shown that due to a lack of acceptance and knowledge regarding post-traumatic stress disorder many war veterans have been stripped of their rights and have also had a difficult time adjusting to life upon returning home after war. Many Vietnam War veterans were the victims of a failed Veterans Affairs system which resulted in them being unemployed, alone, and unaccepted by society. Similar problems are arising due to the Iraq and Afghanistan war; many soldiers are returning home with symptoms of post-traumatic stress disorder and are not receiving the appropriate benefits and treatments they need in order to be a well-functioning citizen.

**What is Post-Traumatic Stress Disorder (PTSD)**

Post-traumatic Stress Disorder can be described as being the result of experiencing a traumatic event, but the meaning is far more complex and difficult to understand. It raises many other questions that have contributed to the complication of the disorder altogether; a main question being, what is considered a traumatic event? The undisputable phenomenon of how two different people can experience the same incident yet one gets PTSD and the other does not. Not only do such questions make it difficult to understand, but Post-traumatic stress disorder varies greatly in severity based on specific symptoms. As it will later be mentioned, Post-traumatic stress disorder will not be diagnosed as a disorder until 1980 in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The Diagnostic and Statistical Manual of Mental Disorders is a guidebook for the medical world that establishes the guidelines of existing mental disorders. The American Psychological Association is extremely supportive of the guidelines, and as practitioners are the ones they closely follow. However, according to Allan Young, a contributor to the *British Journal of Psychiatry,* symptoms of PTSD can be dated to as early as 1666 in the *Diary of Samuel Pepys.*  In Pepys self recorded diary he describes events following the Great Fire of London in 1666. Here, Pepys fulfills most symptoms that are described in the DSM-III criteria for post-traumatic stress disorder: graphic images of the great fire, feeling detached and numb front others and the current state, feeling guilty for having survived while others did not, and a lack of memory, etc. As a matter of fact, symptoms of PTSD can be dated back to the time of the great Shakespeare (Young, 1995). Although this evidence shows that post-traumatic stress disorder existed well before its diagnostics, it also proves that events causing post-traumatic stress disorder vary as well. A person experiencing a traumatic event doesn’t guarantee the development of post-traumatic stress disorder but does not necessarily rule the possibility out even though the traumatic even could have been a minor one.

In Allan Young’s brilliant work, he credits many psychologist and psychiatrists experiences related to PTSD and their opinions on how it can be explained. . Young is an anthropologist who describes himself as an ethnographer and attempts to describe many aspects to the phenomena of post-traumatic stress disorder. His work mentions the many complications of PTSD among the patients who have it. Post-traumatic stress disorder has been around for hundreds of years ago he argues, yet it was not completely recognized until late 20th century. What strikes most about his work is an argument he proposes, Young claims that PTSD is a disease of time, which through his book is an agreeable claim. What is interpreted from Young’s opinion is that Post-traumatic stress disorder was not diagnoses hundreds of years ago because such constructs were easily overlooked and label as pure mania. Hundreds of years ago medical professionals were unaware of the many things the brain can do as well as the many things the environment can do to our brains; with insufficient knowledge it was almost impossible for them to be aware of such disorders. Nonetheless, recent advancement have facilitated such diagnostics but to a certain extent.

Trauma can be described differently depending on the situation experienced. According to the Oxford English Dictionary (1656), in its earliest entry of the word *trauma,* traumatic means belonging to wounds or the cure of wounds. The word pertained to a physical injury rather than a psychological injury; it wasn’t until there was an understanding of a *psychological* injury that a resulting trauma from it was even considered a possibility. John Erichsen, a professor of surgery published a book that reflected his encounters with patients who had been victims of railway accidents. In his work, *On Railway and Other Injuries of the Nervous System* (1866), he mentions cases that originated from shocks, blows, and other physical damage to the neural tissue during a railway accident to which then turned into trauma of the spine. However, there were cases where these damages were invisible; the symptoms reported were fairly the same, however without physical prove, there was an unclear declaration of compensation rights as well as treatments.

If trauma can come from both physical and non-physical occurrences what other factors contribute to defining an event as traumatic. Edwin Morris, another expert in surgical operations and injuries claims trauma can be attributed to fear. Morris outlines the links of deaths of fearful patients before surgery to the power of their emotions. These findings open yet more doors to the understanding of trauma. Similar to Erichsen, Morris believes trauma doesn’t always occur instantly or even days after the event. He describes the “uninjured” patient. They are described as not being physically injured or of possessing only minor injuries and seen to be fairly calm about the incident. However, as time progresses, the same patient who was once calm and content can no longer sleep at night, has a hard time communicating with others, and is unable to function as a normal human being. They begin to relive the incident month after it has occurred and can seem very vivid although they are only memories going through their minds. At times most of sensory and cognitive abilities are fainted and blurred during episodes of recollection which contributes to the fear and pain they experience as they remember the incident. This example can be described as symptoms of post-traumatic stress disorder. The patient would then be presumed to start feeling *shaken or bruised all over* for no obvious physical reason.

The way in which fear is produced can alter whether psychological trauma occurs or not. If this is so, then what does fear arise from? According to Young’s, almost meta-analysis book, fear can come from the memory. Events stored in ones memory can contribute to the fear we feel towards the particular event. Of course, this may seem close to common sense; however, in psychological trauma the memories of particularly traumatic events are usually suppressed. This can explain why patients don’t show symptoms quickly following the traumatic event (Young, 1995).

Repression of the memory often occurs due to misinterpreting the severity of the incident as it occurs or due to feeling ashamed. Combat soldiers are expected to be brave and overcome any obstacle that it thrown their way, reacting scared or sensitive to combat exposure can diminish their credibility among their platoons which would be seen as unacceptable. This example can also to individuals who are victims of rape. Rape differs greatly from combat exposure but nonetheless can still be described as a traumatic event. In the case, individuals who are victims of rape or sexual assaults may unconsciously suppressed memories and clues that could potentially help catch their perpetrator yet they have no recollection of specific details. It is also possible the people who experience a traumatic event to repress their memories because they do not know how to communicate their experiences with others who cannot understand or relate to them.

In my opinion the definition of post-traumatic stress disorder and the many reasons as to why it results after a traumatic effect are very complex and impossible to bottle down in one answer. This contributes to the understanding of how to treat it and learn to accept it. The brain is one of the most complicated organs of the human bodies and although may be similar in weight among people, no two people share similar brains, thoughts, and cognitive process. People experience different incidents differently, there is no doubt in that, this in turns makes it difficult to develop a concrete idea of what trauma is. All that can be done is create different guidelines that can help establish a general understanding of trauma and even then, those guidelines can often fail to support a diagnostic.

The main problem proposed here is that despite its rough understanding given its complexity, once Post-traumatic stress disorder was beginning to be more apparent especially among war veterans its full acceptance was disabled and disagreed upon. War veterans were evidently showing symptoms that could have potentially indicated a post-traumatic stress disorder however there was an immense stubbornness among politicians and the American Psychology Association to agree on the diagnostic and how it classify and treat it. America simply brushed this problem under the carpet with no regrets as to how they were harming the American public, particularly the returning war heroes.

**Accepting Post-Traumatic Stress Disorder**

As previously mentioned Post-traumatic stress disorder was first introduced as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders in the year 1980. The diagnostic appeared in the DSM-III as a psychological disorder suffered by people who have experienced a traumatic event. According to Wilbur J. Scott, post-traumatic stress disorder symptoms include re-experiencing the event after it has already occurred, along with many other autonomic, dysphonic, and cognitive symptoms. Additionally, a person who suffers from post-traumatic stress disorder lacks the ability to engage in the external world after the traumatic event has occurred (Social Problems pgs 294-310; 1990). Post-traumatic stress disorder is commonly the result of experiencing a traumatic event such as combat exposure and sexual abuse. Although it is still unclear of how such a development takes place, it is important to note that post-traumatic stress disorder can prevent a person from having a normal life even though they lived a normal life prior to the traumatic event.

Although post-traumatic stress disorder wasn’t an accepted diagnosis until appearing in the DSM-III in the year 1980, a similar yet different diagnostic was mention in the DSM-I. The DSM-I was released in 1952 and contained a diagnostic called the Gross Stress Reaction. The diagnostic was based on the work done by many psychiatrists following World War II on returning soldiers. According to the DSM-I, gross stress reaction occurred among soldiers during combat. They attributed this diagnostic to combat because soldiers faced stressful environments on a daily bases. The diagnostic stated that the stress was only present when the person was under extreme environmental stress, once the person removed themselves from the stressful environment then the symptoms would disappear as well. Alike post-traumatic stress disorder, gross stress reaction was said to occur among people regardless if there was a previous history of mental problems. Even after the many findings of related symptoms of war neurosis among soldiers, this disorder got very little attention. This can explain why the diagnostic failed to acknowledge that symptoms sometimes persisted even after the person was removed from the extremely stressful environment.

The DSM-II was released years later; unfortunately a diagnostic associated with stress resulting from an extremely stressful event was not included in the updated version of the mental guidebook. The absence of such a diagnostic caused great confusion and controversy for a variety of reasons. During the development of the DSM-II American troops were being sent out to Vietnam War to fight one of the bloodiest wars of all time. As seen in previous wars, military leaders expected to see cases of war neurosis given it had been a significant problem in previous wars. However, according to W. J. Scott less than five percent of total soldier evacuations in Vietnam were due to psychiatric reason. Such findings made people believe that experiencing stress after a stressful event was not something that deserved great concern.

The lack of concern on behave of army officials was extremely negatively effective at allowing such mental disorders like post-traumatic stress disorder to even be recognized for their existence among the public back in the United States. The failure to acknowledge there was a problem at hand resulted in misguided information as to what the disorder could possibly be and the amount of damage it was capable of inflicting.

The delayed acceptance of post-traumatic stress disorder began on the battle fields themselves. During World War I, British military physicians associated similar symptoms seen in post-traumatic stress disorder as being the result of exploding artillery shells. These symptoms were directly related to being the result of physical damages to the brain due to explosions which caused soldiers to become disoriented. Such symptoms were acceptable among soldiers who had physically experienced an explosion. However, when similar symptoms were found in soldiers who had not experienced an explosion first hand, their symptoms were associated with being cowardly and unfit for battle which was negatively looked down on. As a result of the negative associations given to combat stress related symptoms many soldiers withheld information regarding their psychological state.

Bourne, a team member of the Walter Reed Army Institute of Research believed that the low numbers regarding war neurosis during the Vietnam War were the result of an evolutionary change of what war neurosis was and treatment techniques that were implemented in the combat zone. Military personal began to see the commonality of similar symptoms among soldiers following a battle, thus a Salmon program was quickly put into place as soon as the Vietnam War began. The Salmon program which had been originally introduced during World War I was a treatment given to soldiers who experienced war neurosis. Although this program addressed the problem soldiers faced due to combat exposure, the treatment itself was insufficient, at least based on the knowledge of treatment we have today. However, at the time the Salmon program was introduced very little was known about combat related disorders; therefore several days of resting and an expectation and need to go back into battle seemed to suffice as treatment. Surprisingly the Salmon program played out to be a great success during World War I, according to program directors “sixty-five percent of those treated returned to duty on the front lines” (Scott, 1990).

The Salmon program was seen to be just as successful among the Vietnam soldiers as it had been among the World War I soldiers, at this point military psychiatry seemed to believe they had found a solution to a problem they had struggled with for many years. Unfortunately, this almost arrogant discovery may have contributed to the omission of the gross stress reaction in the DSM-II. Symptoms of war neurosis were not considered a disorder because according to military psychiatrist the symptoms were dealt with and cured in Vietnam. Additionally, another common explanation as to why such a disorder was not included in the DSM-II is that none of the writers had first-hand experience and therefore could not make a claim regarding a diagnosis they were unfamiliar with.

In a way, the military made sure that issues regarding mental disorders related to combat exposure did not make it to the desks of medical professionals and government official. By handling the problem how they saw fit, they actually made things worse. They absolutely underestimated the symptoms of mental disorders related to trauma and as a result this “hidden passenger” went unacknowledged.

The push came after several studies were conducted regarding war neurosis symptoms seen in veteran’s years after combat exposure. In their follow-up studies, Archibald and Tuddenham found that World War I and Korean War veterans still experienced war neurosis symptoms even after being detached from the combat scene, contradicting prior claims of war neurosis. This raised concern as to whether prior judgment of the disorder had been correctly made. However, many medical professionals like Archibald were negatively looked upon due to their opinion and new insights regarding mental disorders. Since there was little information about mental disorders like Post-traumatic stress disorder any claims that contradicted the established science and facts were shut down and noted as preposterous. Some practitioners restrained from suggesting a post-traumatic stress disorder diagnostic with fear of upsetting the American Psychology Association and everyone who was a part of it.

As a result, average citizens sought ways to have their opinion heard regarding mental disorders like Post-traumatic stress disorder. Many Vietnam War veterans formed organizations to advocate the acceptance of post-traumatic stress disorder. Robert Lifton, an advocate of post-traumatic stress disorder acceptance began to criticize military psychiatry’s forms of war neurosis treatment. Lifton believed that the central focus was getting soldiers back into the battlefield regardless of whether or not they were mentally fit to fight in battle. The military psychiatry clearly had the military’s interest in mind with undermines ethical guidelines that any medical practitioners know to follow.

The need for a post-traumatic stress disorder diagnostic gained popularity among the American public as more war veterans seemed to suffer from these recollection of events. Another advocate of post-traumatic stress disorder acceptance was Jack Smith. Smith served as a Marine in the Vietnam War and the director of the National Veterans Resource Project (NVRP). However, getting post-traumatic stress disorder accepted was a great challenge because many people believed it consisted of “made up” symptoms. Doctors believed that people made up stories about remembering events vividly, labeling them as delusional, even borderline manic. Based on prior understanding, there was no way patients could be experiencing such pain and discomfort without any physical signs of injury.

This was a great set back because the disorder did actually exist among war veterans and this mindset would potentially disabled veterans who required further assistance from receiving the proper care and benefits they were entitled to. As a result of an absence of diagnosis insurance agencies did not cover such treatments and even treatments through the Veteran Affair facilities were limited or scarce.

Fortunately, with the ongoing occurrences of similar symptoms among the returning Vietnam War veterans some light was shed on to the idea of possibly accepting Post-traumatic stress disorder as an official mental disorder. After a long struggle and nearly having to battle with the American Psychiatric Association, post-traumatic stress disorder was finally accepted as a disorder. However, this was only the beginning of the problem at hand. Even after including Post-traumatic stress disorder in the DSM-III many practitioners were not fully educated on the disorder. They were unaware of how to diagnose and treat it.

People who did not experience post-traumatic stress disorder or had a relative or friend who experienced it was unaware or falsely informed of what the disorder was. Many people who suffered from post-traumatic stress disorder became alcoholics and drug abusers and in the eyes of those who weren’t as educated about the disorder they were simply alcoholics and junkies who were purely suffering of a substance addiction. The lack of acceptance of post-traumatic stress disorder as a mental disorder is evidence that although there is a medical diagnostic of a particular disorder, especially one that does no demonstrate any physical incapability often faces setbacks based on social and government opinion since the disorder is not easily explained.

**Diagnosing Post-Traumatic Stress Disorder**

Diagnosing post-traumatic stress disorder originates from a variety of concepts. According to William J. Koch and colleagues, there is an interesting debate that claims PTSD had sociopolitical origins. The advocacy efforts on behave of psychiatrist who sought to help treat post-traumatic stress disorder among a disadvantage population that was used as reference to Vietnam War veterans. Although it could have been supportive effort, because so much emphasis was placed on the controversy of acceptance, there was a lesser focus on actually understanding PTSD and developing a way to help war veterans cope with their problems.

Post-traumatic stress disorder was hard to diagnose because of the multiple variable and predictors that affected the result of the disorder. Practitioners we cautious to rule out personal individual predictors over objective predictors based on the actual traumatic experience and how traumatic they believed it to be. In other words, since people were likely to have experience other type of trauma prior to the current incident it was difficult to assume that previous experiences had nothing to do with the current situation or that they could have potentially triggered the current trauma to occur.

This placed a great responsibility on medical practitioners and how reliant their diagnostics were. However, expert clinicians had a list of criteria readily available for their use in assessing a patient who showed symptoms of PTSD. A very common scale that is accessible to clinicians is the Clinician Administered PTSD Scale (Blake et al., 1998). This scale was highly reliable in measuring PTSD and its severity among patients. However, although there are scales and other means of measuring PTSD due to the variety in cases there was often a disagreement of a diagnosis which sometimes resulted in the diagnosis of another disorder instead (Koch et al., 2005).

**Who gets Post-Traumatic Stress Disorder (PTSD)**

Once Post-traumatic stress disorder was accepted as a mental disorder in the DSM-III in the late 1980s immense doubt arose within society and among practitioners themselves. Just because post-traumatic stress disorder was now classified as a mental disorder resulting from trauma did not mean doctors and researchers had the answers to diagnose and treat such a new phenomenon. Psychologist and psychiatrist who excelled in their work and possessed PhD’s in both fields were still inexperienced and untrained to rightfully evaluate a patient who displayed PTSD symptoms. Post-traumatic stress disorder is a very complex diagnosis. It results from experiencing a traumatic experience. Although it is commonly associated with combat exposure and sexual abuse it is certainly not limited to those two experiences. For many years since the diagnosis appeared in the DSM-III, physicians have tried to explain how two different people could experience the same situation and yet one gets post-traumatic stress disorder while the other doesn’t. Unfortunately there isn’t a specific profile associated with post-traumatic stress disorder.

Potentially, based on prior research almost anyone is capable of suffering from post-traumatic stress disorder. However, after considering the research I have came to wonder if there are particular characteristics that can possibly serve as predictors for post-traumatic stress disorder. Of course, a causational assumption cannot be made given there is no way to possible determine such a claim, however, perhaps a correlation can be existent among certain characteristics and whether or not someone suffers from post-traumatic stress disorder.

Many researchers have taken interest in determining if possessing certain personal qualities and characteristics could heighten someone’s chances of having post-traumatic stress disorder. In my opinion I would hypothesis that a person who is anxious and is constantly worrying about their surroundings may be more prone to suffering with PTSD in comparison to someone who doesn’t have that characteristic. Being familiar with psychology I can also speculate that family history and a person’s general life history can greatly influence whether or not they are more susceptible of suffering from post-traumatic stress disorder.

Additionally, some have also been concerned to know if gender affects whether or not a person gets PTSD. According to Katherine N. Boone, females are more likely to suffer from PTSD mainly because women display more psychological distress (Wilson Quarterly, 2011). Other research has found that men have higher rates of PTSD based on PTSD approvals given to them by the Department of Veteran Affairs. However, this doesn’t necessarily mean that men are more likely to get PTSD; this could be because mean are usually more likely to be exposed to combat. Women on the other hand have higher rates of PTSD due to sexual assault than men do.

Many studies conducted on war veterans show that gender and race could have possibly contributed to their chances of getting PTSD. As mentioned before PTSD became very common among Vietnam War veterans. According to Dohrenwend, based on a representative sample of Vietnam War Veterans 30.9% of them had developed PTSD after combat and 15.2% of them were still suffering from it many years after exposure (Dohrenwend et al, 2006).

A main argument that supports the development of PTSD is that those who are directly exposed to many explosions and chemically related occurrences are more prone to get PTSD over those who were not exposed to explosions and hazardous chemicals. For example, a combat soldier was more likely to show symptoms of post-traumatic stress disorder than someone who was in charge of providing food for the soldiers (Gray & Kang, 2006). Their role during the war can likely be an implication of whether or not they were at risk of suffering post-traumatic stress disorder due to the events they were experiencing. However, although one can assume this is how it can be determine whether or not a victim of trauma experiences PTSD it is not an absolute fact because no two brains are alike. A soldier in charge of kitchen duty can witness the injury or another soldier and develop trauma.

Psychologist believe that the reason why two people could experience the same traumatic event and one can get PTSD while the other one doesn’t relies on how the person deals with the trauma after it has occurred. Additionally, Murdoch mentions that prior circumstances such as depression or anxiety or even where a person grew up can increase the vulnerability to the development of PTSD (Medical Care, 2003).

Although being a certain gender or race, or having a particular has been shown to increase the likelihood of getting PTSD, based on previous finding it is very important to consider that although some people may have a higher chance of getting PTSD, the way in which it is dealt with is also a great contributor. It is very common for a person to experience stress after combat exposure or any other type of extremely stressful event because such events naturally create stressors, however, the severity and persistence has been highly seen to be affect based on whether or not a person receives support and treatment.

Even still, there is still this remaining *paradox* of post-traumatic stress disorder that has yet to be answered. According to Katherine Boone, in her article *The Paradox of PTSD*, she proposes the idea that we may never know who gets PTSD. Her argument raises great interest regarding the topic because it almost stresses the idea that someone who is “normal” is bound to suffer some type of trauma when exposed to an environment that causes great stress. This is of particular interest to me because it makes me question this almost ironic idea. Someone who experienced combat exposure was almost automatically expected to suffer from some sort of trauma, of course the severity would vary among different cases. Nonetheless, if such an occurrence was seen as “normal” then this could have been a reason why many cases went unreported. If people believed that if these recurrent memories were common for war veterans they perhaps failed to seek help. Returning to the idea of never really knowing who gets PTSD, some war veterans from the Iraq and Afghanistan war were unaware that they had actually temporarily suffered from post-traumatic stress disorder (Boone, 2011).

According to Ozer and Weiss, people who experience Post-traumatic stress disorder were most likely constantly exposed to the event that caused the trauma. When military officials fail to acknowledge that a combat soldier is unable to partake in war and continuously expose them to missions they are heightening their chances of suffering from post-traumatic stress disorder. The more a person is exposed to the trauma the greater effect it can have on them resulting in unavoidable memories of the incident (Ozer & Weiss, 2004).

It is important to take into consideration that although someone can suffer from post-traumatic stress disorder the severity of the trauma as well as the duration of trauma can be greatly affected by the events that follow the traumatic exposure. In other words, once a person shows symptoms of PTSD they enter a critical period that can determine how severe of long the trauma will last.

**The importance of Support for Post-Traumatic Stress Disorder Patients**

Research has shown a correlation between social support and lower levels of PTSD among Vietnam War and war veterans in general. According to Ozer and Weiss the development of PTSD is very unclear but a very important factor is the emotional support that follows the traumatic event. The type and amount of support that is given during and shortly after trauma greatly affects the outcome and can either lessen or worsen the chances of getting PTSD. In other words, the more support a veteran receives the less likely they are to experience severe or any symptoms of PTSD. Although these findings are important to keep in mind, there have been cases in which a person has social support but still develops symptoms of PTSD. Therefore these findings do not always apply to every war veteran (Ozer & Weiss, 2004).

. According to McNally, support doesn’t always prevent the disorder from occurring. In some cases even psychological debriefing did not help prevent the disorder from happening. Based on previous research provided, a causational relationship between social support and levels of PTSD is not strongly supported because circumstances vary from case to case. In some cases people are able to recover from PTSD without major support from their family and friends. In other cases, having strong positive support from those around them helped people deal with and get through PTSD (McNally et al., 2003).

This introduces confusion among those who are left to help someone overcome PTSD. There is no actual right or wrong; based on previous findings a person can developed PTSD ultimately whether or not they had some sort of support following the incident. This makes me question what kind of support is good support. Knowing the answer to this question can potentially help treat PTSD in war veterans because it would provide a more developed mechanism of coping to help them overcome their trauma successfully.

In a recent article posted in *The New Yorker*, David Finkel writes about a young veteran of the Iraqi and Afghanistan war who struggles with PTSD. The young veteran is admitted into a psychiatric facility and feels completely helpless and disturbed. He is unable to sleep at night and recollections of the events during combat haunt him day and night. This article explains the devastation this young man felt because of PTSD. It is mentioned that the disorder also takes a negative toll on his wife who also happens to be expecting their first child. Although he is going through an extremely rough time his young wife stands by him through it all. Alike other cases, having spousal support has been proven to help veterans deal with PTSD because they are able to talk to someone about their feelings instead of keeping them bottled in. On the other hand, some veterans found it hard to express themselves and tell detailed stories of all the dead bodies they saw while in combat, or even worse speak of a time in which they had to take someone’s life.

A lack of support can help explain why there was such an outburst of PTSD cases within the years that followed the Vietnam War. According to Boone, the paradox of PTSD is that it could have possibly had a lower rate of occurrence had people taken it more serious. Instead of providing support to those displaying symptoms of PTSD, the problems pertaining to PTSD were overlooked and ignored which could possibly attribute to large numbers of PTSD among war veterans. Post-traumatic stress disorder is a very young diagnosis which could also attribute for how physicians classified and treated it.

**United States Department of Veterans Affairs**

Social support is not the only kind of support that seemed to help lower the rates of PTSD. Government support was also very important in relation to PTSD. Once the DSM-III classified Post-traumatic stress disorder as a diagnosis war veterans that showed PTSD symptoms were eligible to collect benefits from the Department of Veteran Affairs. The Department of Veteran Affairs had provided benefits for veterans for many years, however PTSD was a new and very complex diagnostic which made it difficult to determine who received benefits and who didn’t. This caused many gaps and errors in the VA system because in some cases people who were eligible for benefits didn’t receive them.

People who fulfilled the symptoms of PTSD were classified as “Service connection”. Service connected veterans referred to veterans who have a documented condition as a result of military service. Veterans who are classified as being service connected are given a priority advantage to health care through the Veterans Affairs. Unfortunately, unlike physical injuries or diseases, PTSD was harder to detect and was not taken serious due to a lack of expert knowledge making the criteria for benefits very unclear (Scott, 1990). As a result there was an imbalance distribution of benefits among the war veterans. These imbalances occurred among both males and females and race also seemed to play a major role in the benefits discrepancies. There are also some findings that show regional disparities among the distribution of VA benefits as a result of service connection classifications among veterans with PTSD. However, most of the demographic disparities only elongated the processing time; in some cases veterans who lived in a location in which PTSD was uncommon their wait to receive benefits for PTSD was longer in comparison to those who lived in areas where PTSD was common.

According to Murdoch, there were regional variations among those who received VA benefits. The region in which veterans lived in either facilitated or complicated their chances of getting VA benefits or how long it would take for them to get approved for the benefits (Murdoch et al., 2003).

*Racial and Regional Disparities in Veteran’s Affairs Service*

Survey research shows the existence of racial disparities in service connection. An article about racial disparities in VA service connection for PTSD shows that minorities, especially African Americans have struggled to receive benefits. When asked questions through a survey African Americans were more likely to have been classified by a more tight scrutiny in comparison to other Raices. Additionally they were among the people who were more likely to wait a longer period of time in order to receive benefits (Murdoch et al, 2003).

However, although previous research has found such an unfortunate difference there is much controversy about whether or not the difference can be concluded because of race. Many other factors can influence the process of benefit distribution. There is a strong emphasis on accessibility to VA centers in order to get a classification of service connection. It is common for people of a minority to be at a disadvantage when accessing VA center and the benefits they offer. Unfortunately based on current research lower accessibility to VA centers and benefits is highly correlated with being of African American descent. However, it is extremely importance to stray away from generalizations when determining if race influenced the duration of the service connected benefits process.

Acknowledging that such differences exist is extremely important in order to improve the services the Department of Veterans Affairs offers returning veterans. Murdoch and colleagues (2003) have also found that in African American veterans and the general veteran population, those who were not classified as service connected yet still showed similar or more severe symptoms than service connected veterans were more likely to be homeless or financially unstable in comparison to veterans who had a documented disability. Additionally, veterans who did not have access to the health benefits provided through the Department of Veterans Affairs were more likely to suffer from other diseases and misfortunes.

*Gender Disparities*

Murdoch, again outlining such differences among war veteran benefits also considers gender to be a predictor of how benefits were distributed. According to Murdoch’s article *Gender differences in Service Connection for PTSD*; women were less likely to be labeled as Service connected to PTSD in comparison to men. This was commonly the case because men usually suffered from PTSD due to combat exposure which could be proven, on the other hand women usually report PTSD associated with sexual abuse during combat which was harder to proof and such cases were usually dismissed. This caused a disparity among genders because it put women at a great disadvantage when collecting VA benefits they were entitled to.

In addition to racial, gender and regional disparities there was also an age disparity among war veterans. According to Ashton’s *Changes in the VA Hospital use* there has been a drop in the amount of VA users due to age difference. There has been a drop in usage among older veterans and an increase of usage among younger veterans. The likelihood of this change is probably due to the many barriers to access non-VA care. Veterans are not able to get the proper help though a private hospital. Additionally these changes can be due to the fact that the pioneers of PTSD (Vietnam War veterans) are no longer in need of VA benefits due to old age or death. On the other hand with the recent wars occurring younger, newly pronounced veterans are coming home with PTSD symptoms.

All these disparities caused great delays to veterans who were in need of VA benefits related to PTSD. In my opinion this caused the severity of their symptoms to worsen which led them to be malfunctioned to society. In addition, due to the strict requirements to be diagnosed with PTSD, veterans were unable to be classified as having PTSD and were hence unable to get treatment. A person who suffers from PTSD highly benefits from treatment because it helps them adjust to society after being through such a horrific trauma. A lack of treatment caused many veterans to become unemployed, lose their families, and made it almost impossible for them to live a normal life.

**Dealing with Post-Traumatic Stress Disorder**

Over the years Post-traumatic disorder has been studied among a great number of returning war veterans. Although some psychological questions are still left unanswered, it is without a doubt that medical science and society has come a long way since PTSD was first introduced in the DSM-III back in the 1980’s. Despite many setbacks and failures, there have been many people who have successfully recovered from PTSD and were able to continue living a normal life as they were prior to combat exposure. In many cases, veterans who were diagnosed with PTSD underwent psychological treatment until they were able to finally take control over their lives once again. In more extreme cases, some veterans were placed in psychiatric facilities for a period of time until they were well again. Psychiatrists also prescribed medications to those who continued to have chemical imbalances and were unable to recover with psychological treatment alone.

The main reason why some veterans didn’t get appropriate help was because for many years doctors did not know exactly how to classify and treat PTSD. With such variation of symptoms and levels of severity the medical world was unsure of what to do. Unfortunately due to the lack of knowledge about mental disorders such as PTSD, there was a definite setback in identifying it and treating it. Medical professionals have hypothesized that mental disorders such as Post-traumatic stress disorder have affected people long before it was an actual labeled disability. However, since science was not quite as advanced as it has come to be today, many people were wrongly diagnosed and labeled as having multiple personalities because of the symptoms that result from PTSD.

According to Boone, “U.S Courts of Appeals for the Ninth Circuit declared that the VA’s “unchecked incompetence” in meeting the psychological needs of the soldiers violated their constitutional right to due process and mandated that the department completely overhaul its mental health care system.” However it is hard to address something that was built on an unstable foundation as is PTSD. During combat exposure soldiers displaying symptoms that required psychotherapy were discharged. PTSD is very complex, the treatment therefore cannot possibly be made for a “one size fits all” (Boone, 2011).

Although the government has improved the types of treatments that war veterans suffering PTSD receive they have yet to get over the hurdle of fairly distributing benefits to those who need them. In the VA’s defense it can be hard to be able to provide a solid solution to a problem that is different from case to case. Additionally PTSD suddenly became so prevalent among soldiers after the Vietnam War and no one expected the severity of it. I believe that physicians as well as the Department of Veterans Affair should aim to better the system and should try to do a better job at making diagnosis in those who have PTSD.

**Bibliography**

Sowmya D. Joisa, et al. "Abuse Of War Zone Detainees: Veterans' Perceptions Of Acceptability." *Military Medicine* 172.2 (2007): 175-181. *Academic Search Premier*. Web. 26 Sept. 2013.

Andreasen, Nancy C. "Posttraumatic Stress Disorder: A History And A Critique Andreasen PTSD History." *Annals Of The New York Academy Of Sciences* 1208.1(2010): 67-71. *Academic Search Premier*. Web. 28 Sept. 2013.

Cotton, Christopher, and John W. Ridings. "Getting Out/Getting In: The DSM, Political Activism, And The Social Construction Of Mental Disorders." *Social Work In Mental Health* 9.3 (2011): 181-205. *Academic Search Premier*. Web. 26 Sept. 2013.

Maureen Murdoch, James Hodges, Carolyn Hunt, Diane Cowper, Nancy Kressin and Nancy O'Brien *Medical Care* , Vol. 41, No. 8 (Aug., 2003), pp. 950-961

Carol A. Kidron *Ethos* , Vol. 31, No. 4 (Dec., 2003), pp. 513-544

Katherine N. Boone. *The Wilson Quarterly (1976-)* , Vol. 35, No. 4 (AUTUMN 2011), pp. 18-22

Wilbur J. Scott *Social Problems* , Vol. 37, No. 3 (Aug., 1990), pp. 294-310

Lembcke, Jerry. "The "Right Stuff" Gone Wrong: Vietnam Veterans And The Social Construction Of Post-Traumatic Stress Disorder." *Critical Sociology (Brill Academic Publishers)* 24.1/2 (1998): 37-64. *Academic Search Premier*. Web. 29 Sept. 2013. The Journal of American History , Vol. 93, No. 2 (Sep., 2006), pp. 452-490

Richard J. McNally, Richard A. Bryant and Anke Ehlers *Psychological Science in the Public Interest* , Vol. 4, No. 2 (Nov., 2003), pp. 45-79

Home from the war: Vietnam veterans: Neither victims nor executioners. Lifton, Robert J. Oxford, England: Simon & Schuster. (1973). 478 pp.

A behavioral formulation of posttraumatic stress disorder in Vietnam veterans. Keane, Terence M.; Zimering, Rose T.; Caddell, Juesta M. the Behavior Therapist, Vol 8(1), Jan 1985, 9-12.

Social support in Vietnam veterans with posttraumatic stress disorder: A comparative analysis. Keane, Terence M.; Scott, W. Owen; Chavoya, Gary A.; Lamparski, Danuta M.; Fairbank, John A. Journal of Consulting and Clinical Psychology, Vol 53(1), Feb 1985, 95-102. doi: [10.1037/0022-006X.53.1.95](http://psycnet.apa.org/doi/10.1037/0022-006X.53.1.95)

William J. Koch, Melanie O'Neill and Kevin S. Douglas. *Law and Human Behavior* , Vol. 29, No. 1, The Empirical Limits of Forensic Mental Health Assessment (Feb., 2005), pp. 121-149

Constance L. Shehan. *Family Relations* , Vol. 36, No. 1 (Jan., 1987), Spouse Support and Vietnam Veterans' Adjustment to Post-Traumatic Stress Disorder pp. 55-60

Charles C. Hendrix and Lisa M. Anelli. *Family Relations* , Vol. 42, No. 1 (Jan., 1993), Impact of Vietnam War Service on Veterans' Perceptions of Family Life pp. 87-92

Tyler C. Smith, Deborah L. Wingard, Margaret A.K. Ryan, Donna Kritz-Silverstein, Donald J. Slymen and James F. Sallis. *Public Health Reports (1974-)* , Vol. 124, No. 1 (JANUARY/FEBRUARY 2009), pp. 90-102

Bruce P. Dohrenwend, J. Blake Turner, Nicholas A. Turse, Ben G. Adams, Karestan C. Koenen and Randall Marshall. *Science* , New Series, Vol. 313, No. 5789 (Aug. 18, 2006), pp. 979-982

Gregory C. Gray and Han K. Kang. *Philosophical Transactions: Biological Sciences* , Vol. 361, No. 1468, The Health of Gulf War Veterans (Apr. 29, 2006), pp. 553-569

Maureen Murdoch, James Hodges, Diane Cowper and Nina Sayer. *Medical Care* , Vol. 43, No. 2 (Feb., 2005), Regional Variation and Other Correlates of Department of Veterans Affairs Disability Awards for Patients with Posttraumatic Stress Disorder pp. 112-121

Emily J. Ozer and Daniel S. Weiss. *Current Directions in Psychological Science* , Vol. 13, No. 4 (Aug., 2004), Who Develops Posttraumatic Stress Disorder pp. 169-172

Stuart I. Forman and Stephen Havas. *Public Health Reports (1974-)* , Vol. 105, No. 2 (Mar. Apr., 1990), Massachusetts' Post-Traumatic Stress Disorder Program: A Public Health Treatment Model for Vietnam Veterans pp. 172-179

Carol M. Ashton, Thomas W. Weiss, Nancy J. Petersen, Nelda P. Wray, Terri J. Menke and Robin C. Sickles. *Medical Care* , Vol. 32, No. 5 (May, 1994), Changes in VA Hospital Use 1980-1990 pp. 447-458

Maureen Murdoch, James Hodges, Diane Cowper, Larry Fortier and Michelle van Ryn. *Medical Care* , Vol. 41, No. 4 (Apr., 2003), Racial Disparities in VA Service Connection for Posttraumatic Stress Disorder Disability pp. 536-549

Childhood Physical Abuse and Combat-related Posttraumatic Stress Disorder in Vietnam Veterans. *The American Journal of Psychiatry*, Vol. 150, No. 2 (1993); pp.235-239

Terrance M. Keane, John A. Fairbank, Juesta M. Caddell, Rose T. Zimering. *Behavior Therapy*, Vol. 20, No.2 (1989), Implosive flooding therapy reduces symptoms of PTSD in Vietnam Combat Veterans pp.245-260

J. Douglas Bremner, MD., Steven M. Southwick, MD., Adam Darnell, MD., & Dennis S. Charney, MD. *The American Journal of Psychiatry*, Vol 153, No. 3 (Mar., 1996); Chronic PTSD in Vietnam Combat Veterans: Course of Illness and Substance pp369 375