

A CENTURY OF MISUNDERSTANDING: THE HISTORY OF THE
DEVELOPMENT OF POST TRAUMATIC STRESS DISORDER
UNDERSTANDING IN THE UNITED STATES MILITARY

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Military History

by

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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other governmental agency. (References to this study should include the foregoing statement.)

ABSTRACT

A CENTURY OF MISUNDERSTANDING: THE HISTORY OF THE DEVELOPMENT OF POST TRAUMATIC STRESS DISORDER UNDERSTANDING IN THE UNITED STATES MILITARY, by Major Charles S. Lawrence, 62 pages.

This thesis examines the development of Post-Traumatic Stress Disorder (PTSD) understanding within the United States Military. The study follows the progression of PTSD from its roots as the concept of WWI shell-shock, through WWII, Korea, Vietnam, and finally the Global War on Terror (GWOT) to its current definition. Additionally, this study examines the impact of the home-front environment to which servicemen and women return to after combat, the development of treatment for servicemen and women suffering from PTSD, and the treatment methods unique to WWII, Korea, Vietnam, and the GWOT eras. In short, the research highlights the development of the disorder, its historical impact on servicemen and women, and its development over a period of nearly a century. More to the point, the study aims to provide a historical context for PTSD, and to help show the improvements in its understanding and management throughout the course of American military history.

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CHAPTER 1

INTRODUCTION

O, my good lord, why are you thus alone?
For what offence have I this fortnight been
A banish'd woman from my Harry's bed?
Tell me, sweet lord, what is't that takes from thee
Thy stomach, pleasure and thy golden sleep?
Why dost thou bend thine eyes upon the earth,
And start so often when thou sit'st alone?
Why hast thou lost the fresh blood in thy cheeks;
And given my treasures and my rights of thee
To thick-eyed musing and cursed melancholy?
In thy faint slumbers I by thee have watch'd,
And heard thee murmur tales of iron wars;
Speak terms of manage to thy bounding steed;
Cry 'Courage! to the field!' And thou hast talk'd
Of sallies and retires, of trenches, tents,
Of palisadoes, frontiers, parapets,
Of basilisks, of cannon, culverin,
Of prisoners' ransom and of soldiers slain,
And all the currents of a heady fight.
Thy spirit within thee hath been so at war

And thus hath so bestirr'd thee in thy sleep,
That beads of sweat have stood upon thy brow
Like bubbles in a late-disturbed stream;
And in thy face strange motions have appear'd,
Such as we see when men restrain their breath
On some great sudden hest. O, what portents are these?
Some heavy business hath my lord in hand,
And I must know it, else he loves me not.

— William Shakespeare, *Henry IV, Act II, Scene 3*

Throughout the history of warfare, soldiers have experienced the debilitating effects of post-traumatic stress disorder, or PTSD. From the time of the hoplites of ancient Greece to the present-day soldier, the effects of waging war on individual

combatants remains, for the most part, the same.¹ The effect on military forces of PTSD traces its roots back to the mid 1600s, when doctors began identifying commonalities among men who fought in the mercenary armies of the Thirty Years War.² While the name of the disorder has changed over time, the diagnostic criteria have remained relatively similar: a person is exposed to an extreme external stressor that can lead to constant symptoms of sleeplessness, anger, agitation, hyper-vigilance, and an inability to concentrate on even the simplest of tasks.³

Throughout the course of American history, soldiers have followed a similar pattern in regards to fighting the nation's wars. Soldiers train, deploy, conduct operations, redeploy, and reintegrate into society. While the format of combat deployments remains the same, the manner in which soldiers reintegrate into garrison life and society has changed. During WWII, soldiers returning home from the European and Pacific theaters spent weeks at sea on troop carriers, passing time by reading, sleeping, and discussing their experiences with their fellow comrades. Upon their return, most American servicemen returned to their families and civilian lives. In order to maintain the bond they experienced as soldiers, many joined veterans support organizations such as the

¹ Iona Meagher, *Moving a Nation to Care : Post-Traumatic Stress Disorder and America's Returning Troops* (Brooklyn, NY: Ig Publishing, 2007), 13. Herodotus noted that during the battle of Termopylae, King Leonidas of Sparta ordered troops who appeared weakened from the battle to remove themselves from the fighting.

² Ibid., 14. Dr Johannes Hofer originally coined the disorder as "nostalgia" and noted that soldiers showed signs very similar to the current clinical diagnostic criteria noted in the DSM-V.

³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington, DC: American Psychiatric Publishing, 2013), 463-468. Original names of the disorder: Nostalgia (1600-1900), Shell-Shock (WWI), Battle fatigue (WWII).

American Legion or the Veterans of Foreign Wars.⁴ The Vietnam War was the first time in our nation's history where soldiers did not have an extended redeployment cycle. Soldiers boarded an aircraft in one country and within a period of a few days were back in the United States, with little or no decompression time. Another critical difference was the manner in which soldiers who fought in Vietnam were received upon their return. In stark contrast to the victory parades and photo-ops during the return of service-members from WWII, those who returned from Vietnam were welcomed back with disgust, disrespect, and hatred.⁵ While this is not the case for service-members during the Global War on Terrorism (GWOT) era, the limited decompression and reintegration timeline remains.

Over the past 70 years, the Army has dramatically changed the way that soldiers train, deploy, fight, and redeploy from a theater of war. While the individual soldier experiences vary from conflict to conflict, the prevalence of PTSD among soldiers remains constant. Over the course of time, the Army began to acknowledge the effects that PTSD has on the force, and implemented programs and procedures, medicinal and psychological, in order to help soldiers manage the disorder. While these programs and

⁴ The American Legion, "History," accessed November 30, 2014, <http://www.legion.org/history>; The Veterans of Foreign Wars, "About Us," accessed November 30, 2014, <http://www.vfw.org/Common/About-Us/>. These two websites give a very brief history of both veterans' social support groups. It is of note that membership in these organizations boomed after WWII, Korea, and Vietnam, while showing a very limited growth during the conduct of the Global War on Terror.

⁵ Slate. "Drooling on the Vietnam Vets," accessed May 2, 2015, http://www.slate.com/articles/news_and_politics/press_box/2000/05/drooling_on_the_vietnam_vets.html. Direct quote from Mr. Terry Baker of the Vietnam Veterans Association: "When the WWII guys came back," Baker adds, "they were able to talk about the war. With Vietnam, vets had to change their clothes in the bus station because people would spit on them."

procedures continue to evolve, the cycle remains constant: train, deploy, fight, and redeploy. What happens during each of these periods has an effect on the individual soldier's ability to cope with, overcome, or manage any post-traumatic stressor experienced during their deployment.

This thesis focuses on the study of one primary and six secondary research questions. The primary research question is: how did PTSD understanding and treatment change from WWII until the Global War on Terror? This led to six secondary research questions: What are the major differences between WWII, Korea, and Vietnam in regards PTSD understanding and development? What similarities exist between WWII and the Korean War? What similarities exist between Vietnam and the Global War on Terror? What types of medical and psychiatric support did WWII, Korea, and Vietnam era soldiers utilize to combat symptoms of PTSD? What social support mechanisms did soldiers of these past eras utilize, and were those mechanisms effective? How did military treatment methods for PTSD change over the course of the Global War on Terror, and were these changes effective? The intent of this study is to provide an overview of the development of PTSD across four major periods of war. This study will encompass an individual analysis of PTSD treatment methods for the average individual during WWII, Korea, Vietnam, and the Global War on Terror. Chapter 2 of this study will examine the similarities and differences in handling soldier PTSD during WWII and the Korean War. This chapter will examine the development of the understanding of the disorder, and the successes and failures made in regards to treating it. Chapter 3 of this study will examine the similarities and differences in handling soldier PTSD during Vietnam and the Global War on Terror. It will compare commonalities and differences across each of these

periods in terms of PTSD treatment, as well as compare the differences between treating the disorder with and without an available diagnosis. Chapter 4 of this study will discuss the current state of affairs in regards to the military's treatment of PTSD, and any working developments in regards to soldier PTSD care.

There is a great deal of literature that describes the psychological effects of war on the men and women who serve. One of the first books to examine the belief that psychological issues that stemmed from exposure to war were injuries and not flaws in character was *The Anatomy of Courage* by Lord Moran.⁶ Lord Moran, a medical officer with the First Battalion, Royal Fusiliers, provided his own take on the effect of shell-shock on the soldiers serving on the western front. He postulated that shell-shock was not an indicator of cowardice, but rather the way to define something more sinister; the effect of major trauma on the mind.⁷ His views were more progressive than the military leaders of the time, and were highly critical of Great Britain's War Office investigation *Report of the War Office Committee of Enquiry into "Shell-Shock,"* published in 1921.

The historical development of PTSD from its shell-shock roots to its modern definition is critical to understanding the difficulties that existed in treating those who suffer from the disorder's effects. *The Diagnostic and Statistical Manual for Mental Disorders* has been published in various versions: 1952, 1968, 1980, 1987, 1994, 2000, and the current version in 2013. A study of all available versions of the manual shows the

⁶ Lord Moran, *The Anatomy of Courage: The Classic WWI Study of the Psychological Effects of War* (New York: Carroll and Graf Berkeley, 2007).

⁷ *Ibid.*, 112. Lord Moran's views are seen as the precursor to the first definition of PTSD in the 1950s edition of the *Diagnostic and Statistical Manual for Mental Disorders*.

change in view of PTSD over a 60 year period. Each manual presents the symptoms of PTSD differently, with the exception of Version II, which eliminated the symptoms of PTSD from the manual completely. Even with the progress made by modern psychological study, there are still some concerns with the reliability and accuracy of the *Diagnostic and Statistical Manual*. Stuart Kirk and Herb Kutchins authored *The Myth of the Reliability of the DSM*, one of the more comprehensive studies on the utility of the *Diagnostic and Statistical Manual*.

A great deal of literature covers PTSD and the military. While most information focuses on comparisons between Vietnam and the Global War on Terror, there are some works that focus on the veterans of WWII and the Korean War. Hans Pols' book *War Neurosis, Adjustment Problems and an Ill Nation: The Disciplinary Project of American Psychiatry During and After WWII* covers the management and care of veterans suffering from symptoms of wartime post-traumatic stress. *Courage and Air Warfare: The Allied Aircrew Experience in the Second World War*, published in 1995 provides a view of the 1940s contemporary belief that PTSD symptoms were not an injury, but a flaw in character. One of the single-most comprehensive studies of the effects of wartime strain was Colonel Albert Glass' 1952 white paper entitled "Current Problems in Military Psychiatry." This paper listed the major failures of military psychiatry during WW II, and provided the guidelines for forward psychiatric treatment during the Korean War and the beginning of the Vietnam War.

Most of the literature focusing on PTSD and the military covers the Vietnam War, its aftermath, and similarities that existed during the Global War on Terror. Two major studies, written by Raymond M. Scurfield provide a detailed analysis of the effects of

PTSD on Veterans of the Vietnam War. The first, *Vietnam Trilogy, Volume I: Veterans and Post-Traumatic Stress*, published in 2004 provides a detailed view of how veterans of the Vietnam War were treated for PTSD symptoms. The author also highlights the major changes in modern psychology that stemmed from the study of Vietnam veterans. The second book, *War Trauma: Lessons Unlearned, From Vietnam to Iraq* published in 2006 highlights some of the major failures in military psychiatric treatment for veterans of Iraq and Afghanistan, particularly in PTSD cases.

While these works cover specific periods of history, none compare treatment and understanding of wartime stress across all large-scale wars the United States has fought. Each study compares one war to another, or looks at a war through a single lens without identifying common trends from the past. The major purpose of this study is to view PTSD understanding and treatment over the past 70 years and to identify any common trends or method that exist among WWII, Korea, Vietnam, and Global War on Terror veterans.

CHAPTER 2

PTSD IN WWII AND THE KOREAN WAR

In the years following WW I, military leaders, scholars, and medical professionals alike tried to understand the newly emerged concept of shell-shock suffered by soldiers who fought in the trenches of the western front. As early as 1919, the British established the War Office Committee of Enquiry into “Shell-Shock” to examine the effects and effects of shell-shock among soldiers. The committee published its findings in 1922, and determined that while shell-shock symptoms could manifest as a result of sustained combat with the enemy, these symptoms could be easily managed by a short period of rest and relaxation in a rear area.⁸ The report also included testimony from multiple commanders and leaders who witnessed the effects of shell-shock firsthand. Many of these leaders spoke of shell-shock as an act of cowardice not normally seen in good or effective front-line units.⁹ A minority of leaders supported the idea that soldiers suffering from shell-shock were in fact not cowards, but simply damaged and unable to cope with the memories and stress of the traumatic events of the war. The committee’s report was accepted by British leaders and led to the outlawing of the term shell-shock in the years prior to WW II. Instead, British physicians replaced the term with the more commonly

⁸ Great Britain War Office Committee of Enquiry into Shell-shock and Anthony Richards, *Report of the War Office Committee of Enquiry Into “Shell-Shock” (cmd. 1734): Featuring a New Historical Essay on Shell Shock* (Imperial War Museum, 2004), 190-194.

⁹ *Ibid.*, 12-91. The testimony given by a majority of leaders mirrors the beliefs held by Lord Gort, commander of the Grenadier Guards.

accepted diagnosis of post-concussion syndrome, a disorder typically associated with sport or accidental injuries.¹⁰

Surprisingly, the understanding of PTSD did not come along until well after the completion of WW II. The belief that PTSD symptoms were merely the manifestation of cowardice still rang true in the minds of many military leaders. George S. Patton, regarded as one of the greatest general officers in modern military history, was admonished for assaulting two soldiers during the Sicily campaign. Both soldiers claimed to be suffering from battle fatigue, the WWII name for the manifestation of PTSD. It is assumed in some circles that Patton's aggressive reaction was due to his own struggle with battle fatigue.¹¹ The first edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published in 1952, brought the diagnosis of gross stress reaction into the lexicon of psychiatrists and psychologists. While exceptionally short, this disorder states, "under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear."¹²

Treatment methods for PTSD symptoms differed among WWII, Korea, Vietnam, and GWOT veterans. In WW I, the U.S. Army developed a treatment program that assigned military psychiatrists to forward deployed units. This system, developed by

¹⁰ Mayo Clinic, "Post-Concussion Syndrome," accessed January 28, 2015, <http://www.mayoclinic.org/diseases-conditions/post-concussion-syndrome/basics/definition/con-20032705>.

¹¹ Meagher, *Moving a Nation to Care*, 12-13.

¹² American Psychiatric Association, *DSM I: Diagnostic and Statistical Manual Mental Disorders* (Washington, DC: American Psychiatric Association, 1952), 40.

Thomas Salmon, focused on treating soldiers suffering from the effects of shell-shock and combat stress by utilizing four key principles:

1. Close proximity of treatment in relation to the battle area
2. Immediacy of treatment
3. Simplicity of treatment
4. Expectancy of soldier's speedy return to the fight.¹³

This concept of forward treatment, while effective, continued to foster the belief that weak-spirited soldiers were the only ones who could potentially suffer from shell-shock or combat stress, and some medical professionals postulated that a screening process could separate soldiers likely to develop combat stress from those who would not.¹⁴ This concept was the only one carried over into WW II, which although it provided a screening method for initial entry recruits, it failed to identify treatment methods for troops engaged in persistent combat. For soldiers who developed symptoms of combat stress, or battle fatigue as it was known during WW II, treatment methods ranged from a small amount of rest near the forward lines, to psychotherapy and sodium pentothal injections aimed at calming soldiers and returning their minds to a state of normalcy.¹⁵ These methods, while moderately effective in rapidly returning soldiers back to the front

¹³ Meagher, *Moving a Nation to Care*, 16-17.

¹⁴ *Ibid.*, 17.

¹⁵ Hans Pols, "War Neurosis, Adjustment Problems in Veterans, and an Ill Nation: The Disciplinary Project of American Psychiatry during and after World War II," *Osiris* 22, no. 1 (January 1, 2007): 77-78, focused on soldiers fighting in the Tunisian campaign in North Africa. They were the first to postulate that all soldiers had a breaking point, which varied from 100 days to a full year of constant battle exposure.

lines, were ultimately unsuccessful in helping soldiers develop long-term coping strategies for combat stress.

Upon the completion of WW II, the military began the daunting task of redeploying millions of soldiers from the European and Pacific theaters of operation. In late 1944, with the end of the war in sight, American leaders began implementing procedures for an orderly demobilization of overseas forces. This initial program involved awarding soldiers points based off varying aspects of military service, from time in theater to awards, even to the fact that they were parents to young children.¹⁶ When Nazi Germany surrendered in the early summer of 1945, the American people cried out for the return of their sons and daughters from the European theater. While military leaders warned against too rapid of a drawdown, the pressure on political leaders to bring service members home was staggering, and their warnings went unheeded. By June of 1945, Operation Magic Carpet, the code-name for the massive sea redeployment of millions of American service members, was underway. Within six months the Army had reduced its wartime strength by over 50 percent, and by the summer of 1946, only 700,000 soldiers remained on active duty.¹⁷

The massive scale of Magic Carpet made the redeployment process a long and daunting task for the individual soldier. Soldiers first moved to makeshift camps near ports in England, France, and Germany to await cargo vessels. As the cargo vessels were

¹⁶ Office of the Chief Historian, European Command, *Redeployment: Occupation Forces in Europe Series, 1945-1946*, World War II Operational Documents, Combined Arms Research Digital Library, 13, accessed February 21, 2015, <http://cgsc.cdmhost.com/cdm/ref/collection/p4013coll8/id/2952>.

¹⁷ Owen Gault, "OPERATION Magic Carpet," *Sea Classics* (September 2005): 61.

emptied, they were almost immediately filled with soldiers in makeshift living areas in the vessels' cargo holds. Cramped and seasick, the soldiers endured the Spartan living conditions without complaint. Jerry Martino, a combat infantryman from New Jersey, described life aboard one of the returning cargo vessels:

We were packed aboard like sardines; hundreds of us berthed in the holds. The air was putrid; the never ending stench of vomit was nauseating with so many of us seasick most of the way. We had to queue up for everything from taking a pee to getting our chow. . . . Everyone was anxious, wondering what it would be like when we got back . . . if we could adjust to civilian life again. . . . There wasn't much else to do unless to do except read and talk, sleep and dream about the future. . . . We couldn't wait until we saw the Statue of Liberty again. And when we did, you could hear a pin drop on the deck. Home at last! God that felt good.¹⁸

Upon their return, WWII veterans found an America galvanized by patriotism and pride. From the largest cities to the smallest hamlets, parades and patriotic celebrations welcomed home the men and women of the Greatest Generation all across the country.¹⁹ Along with this feeling of euphoria and national pride, Congress passed a bill called The Serviceman's Readjustment Act of 1944, or more colloquially known as the GI Bill of Rights. This bill served as a method to provide a gateway to education benefits as well as loans for new homes and small businesses.²⁰ An incredibly successful program, the GI Bill is credited with stimulating a long period of American economic growth, and in

¹⁸ Ibid.

¹⁹ Tom Brokaw originally coined the moniker "The Greatest Generation" in his 1998 book of the same name.

²⁰ Hans Pols, "War Neurosis, Adjustment Problems in Veterans, and an Ill Nation: The Disciplinary Project of American Psychiatry during and after World War II," *Osiris* 22, no. 1 (January 2007): 82.

conjunction with the Baby Boom of the late 1940s, is seen as the predecessor to today's middle-class society.²¹

The PTSD symptoms during WWII were originally seen as the manifestation of cowardice rather than a mental disorder. The Eighth Air Force during the combined bomber campaign, found itself subjected to the Royal Air Force's concept of "Lack of Moral Fibre." The term, as viewed by American military psychiatrists in regards to combat neurosis was described in the following manner:

Lack of moral fibre comes closest to describing the reaction. Yet 'moral fibre' is not a good term, since it implies a philosophical or ethical value in an attitude which for most soldiers is simply based on identification with a group. Whether the group is right, whether its aims or purposes are ethical, whether giving one's devotion to it show 'moral fibre', must be left to history to decide.²²

American psychiatrists went on to describe the condition of Lack of Moral Fibre as an individual soldier's stress reaction related to the rigors of combat. Soldiers saw the term differently. They viewed the Lack of Moral Fibre moniker as analogous to cowardice, and that they were not fit or capable of properly serving in the military.²³ While American soldiers were never subjected to the same level of mismanagement the RAF was in regards to the Lack of Moral Fibre moniker, they still faced some of the same stigmas as their British counterparts.²⁴ A 29 year-old lieutenant, wounded on his

²¹ Joan E Collier, "Iraq and Afghanistan-What Happens When Our Soldiers Come Home?," *Florida Underwriter*, September 2007, 1, accessed November 1, 2014, <https://lumen.cgsccarl.com/login?url=http://search.proquest.com/docview/853698753?accountid=28992>.

²² Mark K. Wells, *Courage and Air Warfare: The Allied Aircrew Experience in the Second World War* (Portland, OR: Routledge, 1995), 164.

²³ *Ibid.*, 165.

²⁴ *Ibid.*, 167.

fifth mission as a bomber navigator, developed multiple signs and symptoms of PTSD. Classified as a Lack of Moral Fibre case, the lieutenant was sent before a medical board, where he subsequently received an “other than honorable” discharge from the service. An accomplished B-17 captain with nearly 2,300 flight hours claimed that he was “scared to death” and could no longer function as a pilot. To save face and avoid a court-martial for his sudden change in mental state, he resigned his commission and left the European theater of operations.²⁵ As early as 1943, the perception existed that mental illness was a sign of weakness within service members.

While the way soldiers with PTSD were perceived during the WWII era caused some concern, the way in which some were actually treated by medical professionals is even more astounding. Prior to the advent of a combined psychiatric approach of drugs and counseling, service members were subjected to experimental techniques and surgeries designed to help remove the mental symptoms that resulted from PTSD.²⁶ The most common experimental techniques in use at the time were electroshock therapy, the use of water jets spraying alternating cold and hot water, or insulin-induced comas. While many experimental treatments existed, none was more controversial and permanently damaging as the lobotomy.²⁷ Between 1947 and 1953, approximately 2,000 service

²⁵ Ibid., 177–179.

²⁶ Wall Street Journal, “The Lobotomy Files: Forgotten Documents Reveal Government Lobotomy of U.S. Troops,” WSJ.com, accessed April 9, 2015, <http://projects.wsj.com/lobotomyfiles/?ch=one&mg=inert-wsj>.

²⁷ Walter Freeman and James W. Watts, “Prefrontal Lobotomy,” *Bulletin of the New York Academy of Medicine* 18, no. 12 (December 1942): 794–800. Dr. Martin Freeman developed two forms of lobotomies. The first was the prefrontal lobotomy, which required the opening of the skull and the surgical removal of a portion of the frontal lobe of the brain. The second method, also developed by Dr. Freeman, was coined

members from the WWII era received lobotomies from Veterans Affairs hospitals across the nation. Roman Tritz, a pilot with the 782nd Squadron of the 452nd Bombardment Group, returned home from the war with multiple symptoms of PTSD. By 1949, his symptoms had worsened to the point that his parents decided to have him committed to a mental institution. For three years, Mr. Tritz endured electroshock therapy, water jet treatments, and insulin-induced comas, all in an attempt to cure him of his mental illness. In 1952, the Veterans Affairs hospital where Mr. Tritz was receiving treatment performed a prefrontal lobotomy on the WWII veteran. In the years that followed, Roman Tritz struggled to find work, and developed new psychoses exponentially worse than his PTSD symptoms.²⁸ The singular lack of understanding by medical and psychiatric professionals during the period immediately following WWII led to the mismanagement and improper treatment of veterans suffering from PTSD.

As service-members returned home, they found themselves under the scrutiny of the psychiatric community that was concerned with the massive influx of battle-hardened warriors into American society. While many veterans refused to acknowledge that they could potentially have psychological problems, the medical community saw the return of combat veterans from a different point of view. How could men, many of whom left

the ‘transorbital’ lobotomy. This method involved using a small ice-pick and a hammer to break through the thin bone of the eye socket, and then lateral and vertical cuts were made by the surgeon manipulating the pick.

²⁸ Wall Street Journal, “The Lobotomy Files: Forgotten Documents Reveal Government Lobotomy of U.S. Troops,” WSJ.com, accessed April 9, 2015, <http://projects.wsj.com/lobotomyfiles/?ch=one&mg=inert-wsj>. In recent years, Roman Tritz has become certain he served in the Secret Service, the Vietnam War, and that he has met Osama Bin Laden. While he acknowledges that some of his beliefs may be the result of his lobotomy, his inability to distinguish between fantasy and reality prevents him from leading a truly normal life.

home at the age of 18 to fight, be weaned off the military mannerisms of gruffness and violence and return to being functional members of society? In preparation for the mass return of veterans from the war, spouses were provided with books and articles informing them of how to observe and care for their returning veteran, and to watch for their “strengths and weaknesses.”²⁹ Many veterans were appalled at the manner in which the psychiatric community portrayed them, and denied that psychological issues had anything to do with their problems readjusting to society. Most, if not all veterans admitted that war had changed them, and that they did not want to return to their old lives or routines upon their return. Many veterans had held leadership positions during the war, and were reluctant to return to jobs they saw as inadequate or pointless. They missed their old comrades in arms, and regularly sought out other veterans to share drinks and war stories in order to cope with and manage their difficulties in returning to civilian life. While psychiatrists believed that only through therapy and medical treatment would veterans be able to fully reintegrate into society, veterans saw a different path to reintegration. As the character of Al Stephenson stated in the film *The Best Years of Our Lives*, “All I want’s a good job, a mild future, a little house big enough for me and my wife. Give me that and I’m rehabilitated [snaps his fingers] like that.”³⁰

By the time the U.S. entered the Korean War, the military began utilizing an evacuation method for treating soldiers suffering from combat stress. Not surprisingly the combat stress casualty rates were nearly three times higher than those of WW II in the early years of the war. Colonel Albert J. Glass, an army psychiatrist during WW II

²⁹ Pols, “War Neurosis, Adjustment Problems in Veterans, and an Ill Nation,” 84.

³⁰ William Wyler, *The Best Years of Our Lives* (MGM (Video and DVD), 2000).

realized that the necessity to refocus the treatment method to a concept similar to WW I. As a result of Glass' reforms, psychiatric casualties were again treated forward on the battlefield, and the concept of force rotation was added to limit soldiers' exposure to combat.³¹ This rotational force concept, along with mid-tour breaks referred to as rest and recreation (R&R), became the model the Army would follow for the next 60 years, including the Vietnam War, and the wars in Iraq and Afghanistan.

The ineffective WWII treatment methods for service members continued during the early stages of the Korean War. During the first year of the war, service members suffering the effects of combat stress or exhibiting PTSD symptoms were removed from the front lines and evacuated from the theater of operations. These evacuations effected front-line troops in two ways: first, by creating a sense of despair that their comrades were not returning; and second, that medical evacuation could potentially be the only way out of the war alive.³² Evacuation syndrome, as this concept became known, was defined as "a set of symptoms that can provide a means of getting evacuated from combat."³³ The truly desperate would become victims of accidental gunshot wounds, or would disregard safety protocols simply to become injured enough to be evacuated from theater. While psychological trauma provides a relatively low number of Korean War evacuations (approximately 6 percent), evacuation for preventable or non-battle injuries is relatively

³¹ Meagher, *Moving a Nation to Care*, 18; AJ Glass, "Current Problems in Military Psychiatry," *Journal of the American Medical Association* 150, no. 1 (September 1952): 6-7.

³² Barry R. Schaller, *Veterans on Trial: The Coming Court Battles over PTSD* (Washington, DC: Potomac Books, 2012), 71.

³³ *Ibid.*, 72.

high (approximately 25 percent).³⁴ The sense of despair was addressed during the latter part of the war when Glass implemented his policy of forward treatment of psychological casualties. While this forward treatment method did wonders for the front line troops fighting against the North Korean military, it prevented military psychiatrists and leaders from identifying a growing issue: the garrison casualty phenomenon.³⁵ During the stalemate years of 1952 and 1953, garrison or support troops outnumbered front-line troops by nearly five to one. These rear-echelon soldiers experienced boredom, homesickness, and feelings of low self-worth due to not being involved in actual combat. As a result, these soldiers turned to alcohol, drugs, and Korean brothels to pass time and keep their minds engaged.³⁶ These soldiers and their psychological issues were largely ignored, primarily due to the fact that they were not actively engaged in combat. Keeping fighting men in combat, or returning them to combat was the primary goal for psychological treatment throughout the Korean War. While this concept would have limited effects on Korean War service members, it would have major effects on those serving in the Vietnam War.³⁷

Similar to their WWII counterparts, Korean War veterans initially enjoyed the benefits of residual patriotism that existed in America as they returned home. The first veterans to return from the Korean War were met with the same parades and packed

³⁴ US Army Medical Department, Office of Medical History, "Battle Casualties and Medical Statistics," accessed April 9, 2015, <http://history.amedd.army.mil/booksdocs/korea/reister/ch5.html>.

³⁵ Meagher, *Moving a Nation to Care*; Schaller, *Veterans on Trial*.

³⁶ Schaller, *Veterans on Trial*, 72.

³⁷ *Ibid.*, 73.

docks that soldiers returning from Europe in 1945 and 1946 had seen.³⁸ That initial euphoria would change as American perceptions of Korean War veterans soured. Popular newspapers spearheaded this change in the America's view of returning servicemen by publishing articles claiming that the veterans returning from the Korean War were not as brave or disciplined as their WWII counterparts.³⁹ The press also released erroneous reports that Korean War veterans were the victims of communist brainwashing, particularly returning American prisoners of war. With the distrust of communism already gaining traction with the American population, the belief that service members could be closet communists was appalling. The most detrimental belief propagated by the press was that Korean War veterans were dishonorable and weak-willed due to their capacity for mental breakdowns.⁴⁰ These beliefs, along with declining popular opinion of Korean War veterans led to Congress providing an updated GI Bill of Rights that provided only three-fourths of the benefits given to WWII veterans.⁴¹ Just like the "Forgotten War" they fought in, Korean War veterans faded into obscurity upon their return from combat.

³⁸ Andrew J. Huebner, *Warrior Image: Soldiers in American Culture from the Second World War to the Vietnam Era* (Chapel Hill, NC: University of North Carolina Press, 2008), 104, accessed December 4, 2014, <http://site.ebrary.com/lib/carl/docDetail.action?docID=10524367>.

³⁹ *Ibid.*, 106.

⁴⁰ Stanley Sandler, ed., *The Korean War: An Encyclopedia* (New York: Taylor and Francis, 1995), 347.

⁴¹ *Ibid.*, 344-48. Example: the Korean War GI Bill of Rights removed the allocation of supplemental education funding.

CHAPTER 3
PTSD IN THE VIETNAM WAR AND
THE GLOBAL WAR ON TERROR

Although gross stress reaction was codified in the *Diagnostic and Statistical Manual-1* in early 1952, there was very limited research or study done on veterans until the late 1970s.⁴² The primary reason for this lack of study was the elimination of the gross stress reaction diagnosis from the 1968 *Diagnostic and Statistical Manual-II*. Published during the most active period of the Vietnam War, the *Diagnostic and Statistical Manual-II* fell prey to the common beliefs that labels and diagnoses simply served as a manner in which society could control intangible or ambiguous behaviors.⁴³ During this period, psychiatrists and physicians were working to understand the difficulties veterans of the Vietnam War were continuing to have adjusting to post-war life. Coined as “post-Vietnam syndrome” in 1970 by Dr. Robert Lifton, the suffering and distress of Vietnam veterans came to light as a result of a massive influx of patients in Veterans Affairs clinics, desperately seeking support for their symptoms.⁴⁴ Finally in 1983, after being largely ignored for nearly 14 years, the concept of gross stress reaction was again included in the *Diagnostic and Statistical Manual*, this time under the name

⁴² Meagher, *Moving a Nation to Care*, 19.

⁴³ Stuart Kirk and Herb Kutchins, “The Myth of the Reliability of DSM,” accessed January 28, 2015, <http://www.academyanalyticarts.org/kirk&kutchins.htm>.

⁴⁴ Meagher, *Moving a Nation to Care*, 19-20.

post-traumatic stress disorder.⁴⁵ This new disorder identified the major symptoms common across sufferers of traumatic events, and it finally gave psychiatrists and psychologists a framework to understand and potentially treat combat veterans. The definition, symptoms, and treatment methods of PTSD remained the same for nearly 22 years, until a new generation of veterans suffering from PTSD forced the American Psychiatric Association to revise and update the *Diagnostic and Statistical Manual*. The *Diagnostic and Statistical Manual-V*, published in 2013, defines the primary element of PTSD as, “the development of characteristic symptoms following exposure to one or more traumatic events.” These characteristic symptoms provided the framework for psychiatrists and psychologists to not only diagnose PTSD, but to provide the proper treatment method.⁴⁶

Treatment for combat stress during the Vietnam War bore many similarities to the WW I methods of Thomas Salmon, with some caveats. Salmon’s concepts were utilized in a way that was not necessarily concerned with helping a soldier recover, but to prevent a soldier from being evacuated from theater. Key principles for treating soldiers with combat stress or other psychiatric issues were:

1. Proximity: treat soldiers as close to their duty stations, camps, front lines as possible.
2. Immediacy: treat soldiers immediately upon the manifestation of symptoms.

⁴⁵ American Psychiatric Association, *DSM-III: Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. (Washington, DC: American Psychiatric Association, 1980), 247-251. The first true definition of PTSD, this manual gives clearly designed diagnostic criteria, persistent and characteristic symptoms of the disorder.

⁴⁶ American Psychiatric Association, *DMS 5: Diagnostic and Statistical Manual of Mental Disorders*, 274.

3. Centralization: a new concept designed to restrict medical evacuation authority to a select few medical professionals.
4. Expectancy: convince the casualty that his current problems were only temporary and that recovery was imminent.
5. Simplicity: provide a short respite from the battle and provide simple, basic services to soldiers suffering from combat stress.⁴⁷

Each of these concepts makes sense logically, but the reasoning behind their utilization, specifically the concepts of centralization, expectancy, and simplicity during the Vietnam War is much more practical. The concept of centralization was designed to limit the number of soldiers evacuated out of Vietnam. Commanders and leaders were graded on their proficiency reports based off of how many soldiers they lost to medical evacuation. The more soldiers who remained in theater, the better the report.⁴⁸ The principle of expectancy returned to the concept of the “stiff-upper lip” made so important by British leaders during WW I. This method took soldiers suffering from traumatic events, and almost immediately returned them to the source of their trauma, with little to no actual treatment for their problems.⁴⁹ The concept of simplicity existed due to the lack of resources provided to psychiatric teams during the Vietnam War. Soldiers suffering from combat stress were provided with a cot and three hot meals, some medications, and a good deal of sleep. Soldiers spend a few days in one of these locations, and were then

⁴⁷ Raymond M. Scurfield, *Vietnam Trilogy*, vol. 1, *Veterans and Post Traumatic Stress* (New York, NY: Algora Publishing, 2004), 1:40–41, accessed February 1, 2015, <http://site.ebrary.com/lib/car1/docDetail.action?docID=10476800>.

⁴⁸ *Ibid.*, 1:39.

⁴⁹ *Ibid.*, 1:40.

quickly returned to their duty station, be it desk or foxhole. In the words of Raymond Monsour Scurfield, “what doesn’t break you makes you stronger—and if it does break you, too bad.”⁵⁰ Not surprisingly, the aftermath of the Vietnam War saw large numbers of veterans turning to medical treatment facilities, particularly the Veteran’s Affairs for assistance. This large influx of veterans claiming to suffer from psychiatric issues led to the coining of the term Post-Vietnam Syndrome. Coined by Dr. Robert Lifton, the definition of Post-Vietnam Syndrome became the pivotal event in the development of understanding of PTSD. Dr. Lifton, along with a team of psychiatrists, met with veterans of the war and in 1980, successfully lobbied the American Psychiatric Association to include the diagnostic criteria and presenting symptoms for Post-Traumatic Stress Disorder in the Diagnostic and Statistical Manual.⁵¹ Finally, nearly 70 years after Lord Moran provided his testimony to the British government on the impacts of shell-shock, the disorder had a name.

The Vietnam War brought on a new concept of rapid deployment into a combat zone. Unlike their WWII or Korean War counterparts, servicemen deploying to the Vietnam War traveled primarily by air transport, which dramatically reduced the travel time between the continental U.S. and an active theater of war. Likewise, this new concept provided an expedited method of return for soldiers once their Date of Expected Return from Overseas (DEROS) arrived. Instead of a lengthy decompression period following conflict, soldiers left foxholes in Vietnam and found themselves at their

⁵⁰ Ibid., 1:41.

⁵¹ Meagher, *Moving a Nation to Care*, 19-20; Scurfield, *Vietnam Trilogy*, 1:73.

mother's dinner table a few days later.⁵² Soldiers returning from Vietnam also found a nation weary of war and disenfranchised with the idea of the heroic returning veteran. The peace movement of the late 1960s created an atmosphere of anger and chaos directed at almost all government figures, from police officers to returning servicemen and women. Demonstrations of hundreds of thousands of anti-war protesters sprung up in Washington D.C., New York City, and college campuses across the country. While a majority of these demonstrations were peaceful, some turned quickly to violence and further drove a wedge between servicemen and the civilian population of the United States. The Kent State massacre in May of 1970 that resulted in the shooting deaths of four students by members of the Ohio National Guard galvanized the anti-war movement and helped to further reduce American support for the war, which from 1969 to 1971 dropped nearly 30 percent.⁵³

It was this vortex of unrest and discord into which the veterans of Vietnam returned. There were no ticker-tape parades, no masses of people welcoming them home at the airports. The soldiers of Vietnam felt unappreciated, abused, and victimized by their nation. The people ostracized servicemen who defended the actions in Vietnam; the government shunned veterans who spoke out against the war. The national media portrayed veterans of Vietnam as drug users, drunks, criminals, and murderers.⁵⁴ The national media's portrayal of the My Lai massacre propagated the belief that individual

⁵² Scurfield, *Vietnam Trilogy*, 1:44-45.

⁵³ Huebner, *Warrior Image*, 208-209.

⁵⁴ Raymond M. Scurfield, *War Trauma: Lessons Unlearned, From Vietnam to Iraq* (New York, NY: Algora Publishing, 2006), 14, accessed November 1, 2014, <http://site.ebrary.com/lib/car1/docDetail.action?docID=10476870>.

servicemen were the only responsible parties for the terrible atrocities of the war. To counter this, the Vietnam Veterans Against the War (VVAW), in a memorandum to the Nixon Administration prior to one of their demonstrations stated “Most Americans are shocked by the isolated reports of atrocities and blame only the individual soldiers involved. We believe, however, that true blame lies at this time with President Nixon, the Joint Chiefs, [defense secretary] Melvin Laird, [and] high ranking military officers.”⁵⁵

Veterans blamed the administration for turning young Americans who fought in Vietnam into men who only understood violence. The VVAW even used the image of the “baby killer” Vietnam veteran to further their rhetoric that the government was responsible for turning good American boys into “ruthless killers.”⁵⁶ Veterans of the Vietnam War returned home to a country that did not understand their sacrifices and did little in terms of assisting in their reintegration back into society. Poor conditions at Veteran’s Affairs Hospitals, a lackluster GI Bill of Rights similar to the one given to veterans of the Korean War, and a poor economy created a generation of angry and bitter veterans who blamed their suffering on the country they believed they had fought to protect. The mistrust of American veterans would continue to exist in the minds of many Americans until the turn of the century, when a terrorist strike on U.S. soil would galvanize the nation and bring about major changes in the way the country viewed its servicemen and veterans.

Where there is limited personal recollection of PTSD symptoms from the Korean War, the inverse is true for those who fought in the Vietnam War. Current psychiatric

⁵⁵ Huebner, *Warrior Image*, 221.

⁵⁶ *Ibid.*, 228.

diagnostic manuals no longer viewed combat stress or combat psychosis as a mental disorder, so for soldiers serving in the war, there was little to no help. Many soldiers in Vietnam turned to drugs and alcohol to help ease the symptoms of PTSD. Vietnam veteran Larry Heinemann described his coping strategy as such “We’d get up at five o’clock in the morning and smoke a joint by the time we finished breakfast, and we were good for the day. . . . That numbness became more and more cherished the further into your tour you got . . . and the further you got into your tour, the more you’re drinking, too. . . . The goal was to be numb.”⁵⁷

By 1971, medical evacuations from Vietnam resulting from drug use eclipsed evacuations for battle injuries. Upon returning from the war, Vietnam veterans found themselves immersed in American drug culture. Marijuana and heroin were the most popular drugs, and their rampant use by deployed soldiers and returning veterans served as a way to escape their symptoms of posttraumatic stress.⁵⁸

Largely ignored throughout the war, Vietnam veterans began to flood Veteran’s Affairs clinics in the mid to late 1970s, bringing with them mental symptoms that could not be explained by current psychiatric definitions.⁵⁹ In truth, many veterans did not realize they had a problem upon returning from the war. Veteran Philip Caputo provides a very clear description of the uncertainty of PTSD symptoms “It’s kind of like you’re not sick if you don’t know you are. I undoubtedly did [have PTSD]; I called it ‘combat

⁵⁷ Tobey C. Herzog, *Writing Vietnam, Writing Life: Caputo, Heinemann, O’Brien, Butler* (Iowa City, IA: University of Iowa Press, 2008), 70, accessed February 5, 2015, <http://site.ebrary.com/lib/carl/docDetail.action?docID=10354499>.

⁵⁸ Schaller, *Veterans on Trial*, 82.

⁵⁹ Scurfield, *War Trauma*, 13.

veteranitis,' the spells of black depression, then anger and rage. I undoubtedly experienced those symptoms, but I think that every war veteran does.”

Veteran’s Affairs hospitals struggled for years to help treat the veterans of the Vietnam War who exhibited the symptoms of PTSD. Psychotherapy combined with prescriptions of valium and lithium served as the Veteran’s Affairs’s go-to treatments for veterans suffering from the after-effects of combat trauma. In 1972, Dr. Chaim Shatan wrote an article for the *New York Times* entitled “Post-Vietnam Syndrome.” This article gave a rudimentary understanding of the disorder impacting Vietnam veterans, attempting to predict the timeline for the manifestation of symptoms, and the symptoms themselves.⁶⁰ This concept of Post-Vietnam Syndrome served as the precursor to PTSD, but it would take another eight years and major national attention to finally give the symptoms veterans were suffering from a proper definition.

One event that brought the issues returning veterans faced into the national spotlight involved the case of Sergeant Dwight “Skip” Johnson. Sergeant Johnson received the Medal of Honor for “conspicuous gallantry and intrepidity at the risk of his life and above the call of duty” when his tank was attacked by North Vietnamese military forces.⁶¹ Lauded as a hero, Johnson received a job with U.S. Army Public Relations, and then later with a local Veterans Affairs hospital. While working at the Veteran’s Affairs hospital, Johnson was diagnosed with depression related to his tour in Vietnam. In March of 1971, frustrated and depressed, Johnson walked out of the Veteran’s Affairs hospital

⁶⁰ Schaller, *Veterans on Trial*, 95-96.

⁶¹ US Army, Center of Military History, “Medal of Honor Recipients-Vietnam War,” accessed April 10, 2015, <http://www.history.army.mil/html/moh/vietnam-a-1.html#JOHNSONDH>.

and returned home to Detroit. Less than a month later, Dwight Johnson was dead, killed while attempting to rob a liquor store near his home.⁶²

Yet another incident that helped to spark the argument for a legitimate psychiatric diagnosis occurred in late 1969, and involved a social worker with the Boston Veteran's Affairs hospital. Social worker Sarah Haley, on her first day of work at the hospital, noted a new patient who displayed symptoms of agitation and anxiety. The reason behind this anxiety was the result of a recent newspaper report about the charges levied against Lieutenant William Calley for his actions during the My Lai massacre.⁶³ During her interview with the patient, who claimed to have been a member of Calley's platoon, Haley determined the man had potentially become unnerved due to the report and believed he was in danger. Many of Haley's colleagues subscribed to the belief that the recent influx of Vietnam veterans claiming mental issues was not related to combat, but to underlying or pre-existing mental conditions. By 1971, in order to ensure that Vietnam veterans were receiving the care they needed and not being brushed aside by psychiatrists who did not see their issues as related to combat, Haley began providing a list of therapists to the Vietnam Veterans Against the War (VVAW). This list told the VVAW which therapists considered the mental issues of Vietnam veterans as related to combat experiences or trauma, and which therapists would ignore or discount those issues.⁶⁴ With growing support by psychiatrists for a formal definition of PTSD, the National Vietnam Veterans Research Project (NVVRP) established a working group to begin

⁶² Schaller, *Veterans on Trial*, 96.

⁶³ *Ibid.*, 94.

⁶⁴ *Ibid.*, 94-96.

pushing for the disorder's inclusion in the Diagnostic and Statistical Manual.⁶⁵ From 1975 to 1980, the NVVRP group attempted to convince the Diagnostic and Statistical Manual committee that a formal disorder recognizing the impacts of combat trauma or psychosis warranted inclusion in the next Diagnostic and Statistical Manual revision. In 1980, the Diagnostic and Statistical Manual committee approved the inclusion of PTSD in the Diagnostic and Statistical Manual-III, with combat-based manifestation of symptoms included as a subcategory.⁶⁶ After nearly a decade of suffering, the veterans of the Vietnam War, as well as the veterans of Korea, and WWII had a name and possible treatment for their symptoms.

The wars in Iraq and Afghanistan mirrored the Vietnam War in terms of duration and rotation only. Deployed in support of Operation Iraqi Freedom and Operation Enduring Freedom, due to the non-traditional, non-linear battlefield, a majority of soldiers deployed in support of OEF and OIF spent nearly every single hour of every single day for a year or more in a combat zone.⁶⁷ Unlike WW II, Korea, or Vietnam, the military understood the necessity of properly treating and caring for soldiers suffering the debilitating effects of PTSD. The primary obstacles to treating PTSD during this period were two-fold. First, the Army simply did not have the medical personnel available to treat the large influx of soldiers suffering from the effects of PTSD.⁶⁸ The second

⁶⁵ Ibid., 96.

⁶⁶ Meagher, *Moving a Nation to Care*; Schaller, *Veterans on Trial*; American Psychiatric Association, *DSM-III, Diagnostic and Statistical Manual of Mental Disorders*.

⁶⁷ Meagher, *Moving a Nation to Care*, 91-93.

⁶⁸ Ibid., 22.

obstacle was the primarily social construct of soldiers considering those claiming mental health problems as weak.⁶⁹ Treatment methods during the GWOT period were much more advanced than those of the World Wars, Korea, and Vietnam. Psychiatrists utilized a combination of clinical counseling, generally in the form of cognitive behavior therapy, and medications, normally in the form of Prozac or Zoloft.⁷⁰ These treatment methods, along with the forced cultural change necessary to remove the stigma of receiving mental health support for PTSD and other psychiatric disorders, provided the current framework of mental healthcare for the newest generation of combat veterans.

The experiences of soldiers returning from Operation Iraqi Freedom and Operation Enduring Freedom mirror those of their WWII predecessors in many ways. The resurgence of American patriotism after the terrorist attacks on September 11th, 2001 bolstered American pride for the men and women in uniform. An overhaul of the GI Bill expanded benefits for veterans including full tuition cost at state-funded colleges, reduced tuition for private or foreign schools, a robust housing allowance and a generous book stipend.⁷¹ Like their Vietnam counterparts, soldiers returning from OIF and OEF experienced shortened redeployment timelines, moving from foxhole to dinner table in a matter of days. Unlike their predecessors, soldiers were welcomed home by cheering crowds, weeping spouses, and jubilant children. Signs posted outside the gates of military installations touted messages welcoming home the heroes who fought so valiantly against

⁶⁹ *Ibid.*, 137.

⁷⁰ Department of Veterans Affairs, "Treatment of PTSD," accessed January 30, 2015, <http://www.ptsd.va.gov/public/treatment/therapy-med/treatment-ptsd.asp>.

⁷¹ Department of Veterans Affairs, "Education and Training: Post-9/11 GI Bill," accessed February 22, 2015, http://www.benefits.va.gov/gibill/post911_gibill.asp.

the specter of terrorism half a world away. The stage was set for the smooth return and reintegration for veterans of the Global War on Terror, but with shortcomings in health care and a shared national understanding of the conflict, this generation would also feel the pain of reintegrating into society.

During WWII, the nation was united in its support of the forces fighting against the tyranny and oppression of the Axis Powers. Those on the home front felt just as involved in the war effort as those fighting overseas. This was not the case with the Global War on Terror. After the initial surge of patriotism following the September 11 attacks began to wane, the American people once again began to lose sight of the cost of fighting a war. The average American went on with his or her life with little thought of the war, with the exception of an occasional, “thank you for your service” to a passing veteran or by sporting a faded American flag bumper sticker on their minivan.⁷² In 2004, a columnist for the New York Times showed the lack of overall American involvement in the wars:

The message from the White House has been: ‘You all just go about your business of being Americans, pursuing happiness, spending your tax cuts, enjoying the Super Bowl Halftime Show, buying a new Hummer, and leave this war to our volunteer Army. No sacrifices required, no new taxes to pay for this long-term endeavor, and no need to reduce our gasoline consumption, even though doing so would help take money away from the forces of Islamist intolerance that are killing our soldiers. No, we are so rich and so strong and so right, we can win this war without anyone other than the armed forces paying any price or bearing any burden.’⁷³

With the massive influx of injured soldiers, military hospitals such as Walter Reed Medical Center and Veteran’s Affairs hospitals across the country struggled.

⁷² Meagher, *Moving a Nation to Care*, 49-50.

⁷³ Thomas L. Friedman, “The Home Team,” *New York Times*, February 8, 2004.

Advances in battlefield medicine were saving more lives than in previous wars, but causing a flood of trauma patients for which stateside hospitals were not prepared. In 2007, a scathing report on the conditions at the Walter Reed Medical Center brought veteran medical care into the national spotlight. Service members recovering at the Washington D.C. medical facility reported mismanagement of cases, lost paperwork, unsanitary living conditions, and neglect at the hands of their medical caretakers.⁷⁴ To the veterans recovering in Walter Reed and other veterans hospitals across the U.S., the lack of care and effort put into place for their recovery was a violation of the promises made when they pledged to serve their country.

Like the Korean War and the Vietnam War, the primary psychiatric goal for the earliest years of the Iraq and Afghanistan Wars was to conserve fighting strength and to keep soldiers in the fight.⁷⁵ Like the Korean and Vietnam Wars, front-line soldiers remained the focus, with only two options for treatment: forward treatment and return to the battle, or evacuation from the war-zone. Similarly to the Vietnam War, commanders were evaluated by their ability to keep psychiatric soldiers in country, rapidly treating and returning them to the front lines as quickly as possible.⁷⁶ Raymond Scurfield, an expert in the field of military PTSD and veteran of the Vietnam War, described the military's method of treating soldiers as follows:

⁷⁴ Washington Post, "Soldiers Face Neglect, Frustration At Army's Top Medical Facility," February 18, 2007, sec. Nation, accessed March 3, 2015, http://www.washingtonpost.com/wp-dyn/content/article/2007/02/17/AR2007021701172_4.html.

⁷⁵ Scurfield, *War Trauma*, 52.

⁷⁶ *Ibid.*, 55.

It appears to be a mental health Catch-22 of the war: conserve the fighting strength while dramatically increasing the risk of PTSD by returning psychiatric casualties back to duty, or medically evacuate out of country and avoid further exposure to combat trauma yet expose evacuees to the emotional trauma of the evacuation process and ‘deserting’ their comrades. Pick your poison.⁷⁷

There is some military utility in keeping fighting men and women with their units; soldiers who have trained together, deployed together, and know their jobs are generally preferred to fresh-faced replacements. Similarly to Korea and Vietnam, soldiers treated for psychiatric problems generally preferred to return to their units instead of be evacuated from theater. The primary concern with psychiatric treatment during the initial years of the Iraq and Afghanistan wars was focused on the health of the unit, and not on the health of the individual.⁷⁸ In July of 2006, the Army published Field Manual 4-02.51: *Combat and Operational Stress Control*. Rather than use PTSD to describe the symptoms of soldiers, the Army used a Department of Defense approved acronym known as COSR, or Combat-Operational Stress Reaction. From the Army’s manual, the reasoning for utilizing COSR in lieu of PTSD is as follows:

The Army uses the DOD-approved term/acronym COSR in official medical reports. This term can be applied to any stress reaction in the military unit environment. Many reactions look like symptoms of mental illness (such as panic, extreme anxiety, depression, hallucinations), but are only transient reactions to the traumatic stress of combat and the cumulative stresses of military operations. Some individuals may have behavioral disorders that existed prior to deployment or disorders that were first present during deployment, and need (behavioral health) intervention beyond the interventions for COSR.⁷⁹

⁷⁷ Ibid., 54.

⁷⁸ Ibid., 55.

⁷⁹ U.S. Army, Field Manual (FM) 4-02.51, *Combat and Operational Stress Control* (Washington, DC: Government Printing Office, 2006).

The concepts listed in this definition come as somewhat of a surprise, considering their similarities with the previously discussed beliefs of WWII, Korea, and Vietnam-era mental illness.⁸⁰ For soldiers, this caused a great deal of discord. Service members who made use of Combat Operational Stress Command (COSC) teams reported feeling pressure to get over their trauma and rapidly return to their unit. The book *Black Hearts: One Platoon's Descent into Madness*, describes the progressive mental degradation of a platoon in the 2nd Brigade Combat Team of the 101st Airborne Division. Sergeant Eric Lauzier compared the interventions conducted by COSC teams to a “mechanic who fixes a flat tire when it’s the engine he should be looking at.”⁸¹ Other soldiers complained that the COSC teams would do nothing more than “hand out Ambien”⁸² with the expectation that the service member would sleep off their stress and be refreshed enough to continue fighting the following day.⁸³ Another soldier stated: “People started having psychological problems. For pain, they gave you 800 milligrams of Motrin. But for psychological problems, they started handing out Prozac and Paxil. Their attitude was, suck it up. . . . People lose focus on the human component of being a soldier in harm’s way.”⁸⁴

⁸⁰ A full description of forward-focused treatment for psychiatric casualties is covered in chapter 2 of this thesis.

⁸¹ Jim Frederick, *Black Hearts: One Platoon's Descent into Madness in Iraq's Triangle of Death* (New York: Crown, 2010), 142.

⁸² Ambien is a prescription sleeping aid commonly issued to military personnel to assist in re-establishment of circadian rhythm, or to help them relax after an event that could potentially trigger PTSD symptoms.

⁸³ Frederick, *Black Hearts*, 143.

⁸⁴ Meagher, *Moving a Nation to Care*, 87.

Again, Field Manual 4-02.51 keeps the focus on pushing the service member back to the front line, rather than focusing on the treatment of the individual:

Initial rest and replenishment at COSC facilities located close to the Soldier's unit should last no more than 1 to 3 days (USMC and Navy is 3 to 4 days). Those requiring further treatment are moved to the next level of care. Since many require no further treatment, military commanders expect their Soldiers to RTD [return to duty] rapidly.⁸⁵

While forward treatment of soldiers during the first few years of the War on Terror was lacking in many ways, the support structure at home was worse. Installation and Veterans Affairs hospitals in the United States were not prepared for the massive influx of mental health patients.⁸⁶ During the early years of the wars in Iraq and Afghanistan, Veteran's Affairs hospitals were actively attempting to negate PTSD diagnoses. In 2005, the Veteran's Affairs began a campaign to challenge the official diagnosis for PTSD, reviewing over 72,000 cases of veterans already receiving benefits.⁸⁷ While this effort failed due to lack of public opinion, it showed that PTSD was still not viewed as a real disorder in the eyes of the government and the military. For actively serving veterans, the fear of coming forward with mental health issues mirrored the concerns of their counterparts from years past. At Fort Carson in 2006, an investigation into the complaints of a squad-sized element of soldiers claiming they were either being denied help or ridiculed for asking for help in regards to mental health problems. One of those soldiers stated that one of his leaders threatened to "make his life a living hell"

⁸⁵ U.S. Army, FM 4-02.51, *Combat and Operational Stress Control*.

⁸⁶ Meagher, *Moving a Nation to Care*, 61-62.

⁸⁷ *Ibid.*, 63.

should he try and get a disability for PTSD.⁸⁸ To avoid the stigma and difficulties inherent with seeking mental health treatment, many soldiers suffering the effects of PTSD turned to drugs and alcohol. According to a 2008 RAND Corporation study, approximately 40 percent of Iraq and Afghanistan veterans surveyed abused alcohol, and 3 percent turned to drug use to help ease the symptoms of PTSD.⁸⁹ This creates a problem, as drug and alcohol abuse is frowned upon in the military, with both requiring soldiers to attend substance abuse courses, and potentially leading to discharge from the service.⁹⁰ Service members discharged for substance abuse can be, and many times are, discharged with a characterization of service of other-than-honorable. An other-than-honorable characterization of service prevents soldiers from receiving Veteran's Affairs benefits, and therefore the care they need to help manage their symptoms of PTSD.⁹¹

For each period of conflict in the history of the United States, the treatment of mental health issues followed a similar pattern. During each period of war, the psychological strain of war was initially ignored, and then only treated enough to the

⁸⁸ Ibid., 65. *CNN News* conducted an interview with many of the soldiers involved in the complaint. Private Ryan Lockwood, the soldier quoted in the paragraph, stated that he felt cast aside by his unit. Private Lockwood was "chaptered" out of the military in 2006, with no mention of his PTSD in his discharge paperwork.

⁸⁹ Terri L. Tanielian, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND, 2008); Susan V. Eisen et al., "Mental and Physical Health Status and Alcohol and Drug Use Following Return From Deployment to Iraq or Afghanistan," *American Journal of Public Health* 102, no. Suppl 1 (March 2012): S66-73, doi:10.2105/AJPH.2011.300609.

⁹⁰ Army Substance Abuse Program, "Home Page," accessed April 13, 2015, <https://acsap.army.mil/>.

⁹¹ Meagher, *Moving a Nation to Care*, 66.

point a service member was ready to return to the fight. The military's inability to learn the lessons of the past, specifically those from WWII, Korea, Vietnam, and the wars in Iraq and Afghanistan in terms of treating the mental health needs of soldiers is unsettling. The toll of the most recent wars in Iraq and Afghanistan: unyielding deployment cycle, increased suicide rates, drug and alcohol abuse, and high divorce rates would plague military leaders from the mid to late 2000s. Military leaders, unsure of what could be done to lessen these damaging statistics, looked to outside sources to help analyze the problems plaguing the military. One of the most critical studies was released by the RAND Corporation in 2008 and focused on the military's current efforts for mental health care, and recommendations for how to improve those efforts.⁹² Based off the results of this study, the U.S. military began to change the way it viewed its soldiers, their mental health, and PTSD in general.

As the United States continued to fight the wars in Iraq and Afghanistan, military and civilian leaders began to identify critical problems with the men and women returning from warzone deployments. Servicemen by this point in the wars had an average of two deployments, with some having as many as four. In order to meet the man-power and fiscal demands of fighting two wars simultaneously, military leaders enacted policies that kept servicemen in the fight longer, and in some cases past their contracted enlistment periods.⁹³ The stop-loss program and increased deployment lengths

⁹² Tanielian, *Invisible Wounds of War*, 71.

⁹³ U.S. House, Office of the Law Revision Counsel Staff, *United States Code, 2006, V. 5, Title 10, Armed Forces, Section 2001 to End* (U.S. Government Printing Office, 2008), 10. Title 10 USC provides a means for the President to suspend promotion, retirement, and separation of a member of the military when he or she determines the suspension is essential to US national security.

were incredibly unpopular programs that placed a huge physical and emotional strain on the men and women in uniform. By 2008, approximately a year and a half into President Bush’s surge strategy in Iraq, statistics showed a large increase in the number of suicides, divorce rates, and general disciplinary problems in combat veterans.⁹⁴ The suicide statistics from 2001 to 2008 show a steady rise in suicide across the entire Department of Defense, with the Army and Marine Corps holding the highest rates of suicide. The sharp incline in suicides began in mid-2005, when the Iraq insurgency was beginning to gain momentum against U.S. operations.

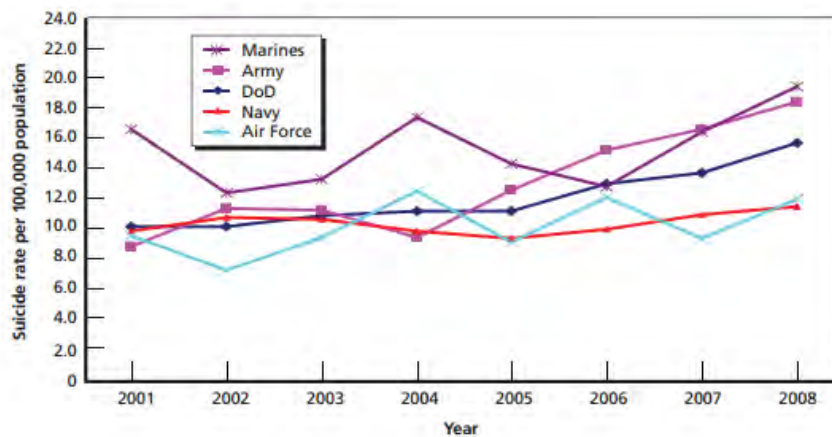


Figure 1. U.S. Department of Defense and Service Suicide Rates, 2001 to 2008

Source: Rajeev Ramchand et al., *The War Within: Preventing Suicide in the U.S. Military* (Santa Monica, CA: RAND Corporation, 2011).

⁹⁴ Scurfield, *War Trauma*, 39-41.

This increase in suicides mirrors a rise in cases of PTSD. From 2003 to 2008, reported cases of PTSD among men and women who served one or more deployments nearly quadrupled from 2,500 cases to over 15,000 cases.

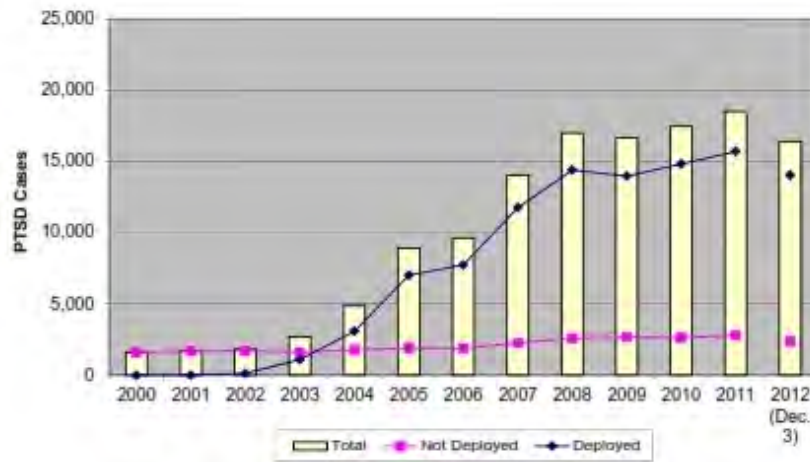


Figure 2. Annual Post-Traumatic Stress Disorder Diagnoses in all Services (as of December 7, 2012)

Source: Rajeev Ramchand et al., *The War Within: Preventing Suicide in the U.S. Military* (Santa Monica, CA: RAND Corporation, 2011).

At large, the military was not prepared for the massive influx of mental health and PTSD cases resulting from wartime experiences. Military and Veterans Affairs hospitals became overwhelmed with PTSD disability claims and unsure how to properly handle them denied or overturned previously approved claims.⁹⁵ Far too often, military commanders and mental health professionals would label servicemen and women claiming PTSD symptoms as malingerers, abusing the medical system to avoid work or deployments. In 2012, the commander of Madigan Army Medical Center at Joint Base

⁹⁵ Meagher, *Moving a Nation to Care*, 54.

Lewis-McChord, Washington came under fire for PTSD mismanagement. An Army Medical Command investigation found that over 40 percent of PTSD cases handled by the Madigan psychiatry team were either overturned or denied. As a result of the investigation, the military reinstated overturned PTSD disability ratings for multiple Joint Base Lewis-McChord soldiers.⁹⁶ Apart from the malingering argument, investigators found that psychiatrists and leaders at Madigan were denying claims based off the potential monetary cost to the U.S. Government. Under the current Veteran's Affairs disability system, a veteran with a 100 percent disability rating for PTSD warrants a monthly disability payment of \$2,769 per month. Madigan leaders argued that those payments, spread out over the course of a veteran's lifetime, would cost the government over \$1.5 million per PTSD case.⁹⁷ The issues at Madigan led to reevaluations of forensic psychology programs across the Army, but the damage to the military's treatment of PTSD sufferers was done. Even as late as 2012, leaders and medical professionals continued to view PTSD not as an injury, but as something temporary that could be easily conquered.

While medical professionals continued to struggle with properly caring for PTSD sufferers, military leaders began a focused campaign to stem the problems that PTSD caused within the force. In 2006, the Department of Defense launched the Military Pathways program, one of the first military focused screening programs for mental health

⁹⁶ Hal Berton, "Madigan Memo on PTSD Costs Sparked Army Review," *Veterans Today*, posted February 8, 2012, accessed May 11, 2015, <http://www.veteranstoday.com/2012/02/08/madigan-memo-on-ptsd-costs-sparked-army-review/>.

⁹⁷ *Ibid.*

issues.⁹⁸ Military Pathways was developed as a free program to help support Active, Guard, and Reserve servicemen and women and their families through free in-person screening and family resiliency training. The core of the program is the web-based self-assessment tool. This tool is designed as an automated program that takes answers to a self-assessment survey and determines the type and level of care provided.⁹⁹ While this program provides a venue for military members and their families to seek help in a confidential manner, it does so without individual interaction with a mental health care provider. One of the most astounding elements of the program is the Video Doctor program. The Video Doctor simulates a conversation between a service member and a doctor, guiding the user through self-care techniques and providing lists of mental health resources.¹⁰⁰ By removing individually tailored care for soldiers, the program fails to truly focus on the primary goal of assisting those suffering from PTSD in getting the help they need.

In 2009, the Army began implementing its Ready and Resilient Campaign to help train and aid its war strained forces in providing training and mitigation strategies for PTSD, divorce, sexual assault and suicide prevention. At its core, the Ready and Resilient campaign is:

A collection of comprehensive and far reaching programs designed to guide the Army's efforts to build physical, emotional, and psychological resilience in our Soldiers, families, and civilians, and directly enhance personal and unit readiness.

⁹⁸ Screening for Mental Health, "Our Programs," accessed May 13, 2015, <http://mentalhealthscreening.org>; U.S. Army, "Ready and Resilient: Medical Readiness," accessed May 13, 2015, <http://www.army.mil/readyandresilient/medical>.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

To ensure the health and well-being of the entire team, the Army's goal is to invest in and improve the performance of every individual on the team.¹⁰¹

While unit readiness remains an end state goal for the Ready and Resilient program, the primary method to ensuring unit readiness is through focusing on the individual. One of the major reforms in psychological treatment is in the addition of Embedded Behavioral Health Teams into all deployable Army formations. These teams are designed as a more robust alternative to the undermanned and poorly focused Combat and Operational Stress Control teams. The intended goals and missions of Embedded Behavioral Health Teams are:

Improving access to behavioral health care for active-duty Soldiers, increasing the mission readiness of operational units, identifying Soldiers with behavioral health challenges as early as possible, increasing and improving communication between behavioral health professionals and operational unit leaders, and serving as a clinical platform for quality care delivery.

Embedded Behavioral Health teams (EBHTs) are located within walking distance of the Soldiers' place of duty. The teams are composed of 13 people to include licensed clinical social workers (LCSWs), psychologists, a psychiatrist or psychiatric nurse practitioner, a case manager, an licensed practical nurse (LPN), two psychological assistants and two front desk personnel. When fully staffed there is one behavioral health provider point of contact for each battalion in a combat brigade. Brigade health officers assigned to operational units perform 20 hours a week of clinical care as part of the EBHT supporting their brigade.¹⁰²

Currently, 45 Embedded Behavioral Health Teams are established and operating in the United States and Europe on active Army installations. The Army's end state for the program is to have all teams in place and operating by the end of fiscal year 2016.

¹⁰¹ U.S. Army, "Ready and Resilient Campaign," accessed May 13, 2015, http://www.army.mil/standto/archive_2013-03-13/.

¹⁰² U.S. Army, "Ready and Resilient Campaign: Embedded Behavioral Health," accessed May 11, 2015, http://www.army.mil/standto/archive_2013-08-13/.

The military failed to take the historical lessons of WWII, Korea and Vietnam into account during the initial stages of the Global War on Terror. What makes the Global War on Terror different than any other war is the decision to make changes and reforms while the war was still being fought. While many of these changes lacked focus and did not have the initial desired impact, the fact that the changes were attempted is laudable. When one change failed to produce the desired effects, such as the Combat and Operational Stress Control methodology, reforms were made and a new program was implemented. Changes are still necessary, but the military is making active progress towards properly treating and caring for the men and women suffering the effects of PTSD.

CHAPTER 4

CONCLUSION

While it is essential to understand the historical development of PTSD and the general environment to which redeploying servicemen and women return to, understanding the impact of PTSD and its effect on individuals is even more important. Since the dawn of civilization, warriors have suffered the debilitating effects of combat stress and PTSD. The writings of Herodotus of Greece detail the actions of King Leonidas and the three hundred Spartans during the 480 B.C. Battle of Thermopylae Pass. During the course of the battle, King Leonidas noted the mental exhaustion his men were suffering as a result of constant attacks by Persian forces and the loss of their comrades. Eschewing the Spartan archetype, King Leonidas ordered any men suffering from mental fatigue to retire to the rear area of the battle for rest and recovery.¹⁰³ While acknowledgement of the impacts of combat trauma exist in history, research of specific periods of conflict show a common pattern in regards to acknowledging and treating those who suffer from PTSD. Research suggests that each period of conflict in American military history appears to follow a pattern of dismissing or ignoring the problems of soldiers, attempting to provide a quick fix to the problem, finally acknowledging the problems, and finally developing solutions to attempt to manage the problem.

The general understanding of post-traumatic stress disorder has evolved greatly over the past century. The primary goal of this thesis was to explore the development of PTSD from a military perspective from its WWI shell-shock roots to its definition today,

¹⁰³ Meagher, *Moving a Nation to Care*, 13.

to identify any trends across major periods of war, and to investigate whether what, if any lessons were learned over the course of history. Through this study, a common pattern for PTSD treatment and understanding emerged. In each major war the United States has taken part in, treatment initially focused on rapidly returning psychological casualties to the fight, allowing the problem to compound to the point where it was unmanageable by mental health providers, and then attempting to fix the problem after the war or conflict ended. Further compounding the issues with this pattern is the common stigma that seeking psychological care was a sign of weakness, and that those who did were unworthy of serving their nation.

The development of the Diagnostic and Statistical Manual's definition of PTSD is a direct result of the efforts to understand and treat psychological trauma in war veterans. The initial definition of gross stress reaction in 1952 came as a result of studying the psychological trauma patients of WWII. The establishment of the diagnostic criteria and definition of PTSD was due to the massive number of psychiatric patients from the Vietnam War. Dr. Robert Lifton's efforts to treat what he coined as Post-Vietnam Syndrome were instrumental to the acknowledgement of PTSD as a true mental disorder, and not just a flaw in character.¹⁰⁴

In the initial stages of each major war, soldiers suffering the effects of PTSD symptoms were treated in a similar manner. Service members claiming psychological trauma or operational stress were removed from the front lines, given a brief respite from action, and then expected to return to their units. Those who continued to exhibit symptoms were branded as cowards and in many cases sent home in shame. This belief

¹⁰⁴ Meagher, *Moving a Nation to Care*, 19.

was predicated on the concept that those who could not recover from psychological trauma suffered from a flaw in character, rather than from an injury. Much of this belief stemmed from the common expectations of soldiers during the era in which their war was fought. During WWII and Korea, men were expected to hide their emotions and deal with problems on their own. One of the areas where the Department of Defense and the Veterans Affairs administration continue to struggle is in the belief that a single method or program will work for anyone suffering from PTSD. The treatment a veteran of the Vietnam War requires is not necessarily the same as a veteran of the Global War on Terror. War trauma is normally viewed within the confines of the small unit; shared experiences can sometimes yield shared struggles.¹⁰⁵

There are multiple opportunities for further research into PTSD and its history. Very little information exists on the treatment of or for veterans of the Korean War. In 1952, *The Diagnostic and Statistical Manual-I* published the first definition of gross stress reaction that covered some of the symptoms of PTSD. The disorder was not removed until 1968, during the early stages of the Vietnam War. Potential research into if Korean War veterans sought psychiatric help or the effects of PTSD symptoms on their reintegration into society could be useful in further establishing the trends outlined in this thesis. Additionally, an in depth study of the utilization and efficacy of Embedded Behavioral Health Teams could provide a platform for highlighting the major improvements the military has made in terms of PTSD treatment and management.

The value of studying the history of psychological war trauma and PTSD understanding cannot be understated. By viewing the mistakes of the past, the U.S.

¹⁰⁵ Scurfield, *War Trauma*, 169.

military has an opportunity to prevent those mistakes in the future. The current focus on resiliency and the emerging view that PTSD is not a flaw in character but instead a legitimate injury that requires treatment, shows a great leap forward for the U.S. Military. Military leaders and mental health providers must continue to study and analyze the effects of PTSD on the force, and ensure that the next war does not follow the pattern of allowing the problem to compound until it is unmanageable. By providing the proper care and treatment to the men and women who suffer from PTSD's debilitating effects, the U.S. Military can prove that it values its most valuable resource, the individual soldier.

APPENDIX A

HISTORICAL LIST OF TERMS FOR PTSD

Ilona Meager's book, *Moving a Nation to Care: Post-Traumatic Stress Disorder and America's returning Troops* provides a detailed list of historical names for the disorder now known as PTSD. This list of names shows not only the complexity of the disorder, but the lengths to which psychiatrists and medical professionals have worked to understand and properly diagnose it. This list is in no particular order:

- 1) Soldier's Heart
- 2) Exhausted Heart
- 3) Irritable Heart
- 4) Da Costa's Syndrome
- 5) Swiss Disease
- 6) Railway Spine
- 7) Railway Shock
- 8) Railway Brain
- 9) Fear Neurosis
- 10) Erichsen's Disease
- 11) Hysteria
- 12) Exhaustion
- 13) Disorderly Action of the Heart
- 14) Heimweh (German term for homesickness)
- 15) War Hysteria
- 16) Traumatic Hysteria

- 17) Traumatic Neurasthenia
- 18) Shell Shock
- 19) Battle Shock
- 20) Battle Reaction
- 21) Battle Fatigue
- 22) Battle Neurosis
- 23) Battle Exhaustion
- 24) Combat Fatigue
- 25) Combat Stress Reaction
- 26) Combat-Operational Stress Reaction
- 27) War Neurosis
- 28) Wary Syndrome
- 29) Traumatic Neurosis of War
- 30) Nostalgia
- 31) Mind Sickness
- 32) Combat Trauma
- 33) Combat Exhaustion
- 34) Nerves
- 35) Maladie du pays (French for sickness of the country)
- 36) Psychoneurosis
- 37) Post War Disorder
- 38) Acute Stress Disorder
- 39) Acute Stress reaction

- 40) Gross Stress Reaction (first defined in DSM-I)
- 41) Post-Vietnam Syndrome (precursor to PTSD)
- 42) Post-combat Disorder
- 43) Catastrophic Stress Disorder
- 44) Mental Collapse
- 45) In-country Effect
- 46) Psychological Injury
- 47) Mental Trauma
- 48) Old Sergeant Syndrome
- 49) Acute Combat Reaction
- 50) Acute Combat Stress Reaction
- 51) Neurocirculatory Asthenia
- 52) Effort Syndrome
- 53) Lack of Moral Fibre (Royal Air Force term, used in WWII)
- 54) Estar Roto (Spanish for “to be broken)
- 55) Delayed Stress Syndrome
- 56) Psycho-neurosis
- 57) Psychiatric Collapse
- 58) Vietnam Disease (precursor to PVS)
- 59) Nervous Disease
- 60) Nervous Shock
- 61) Physical Shock
- 62) Neurasthenia following Shock and Accident

- 63) Accident Neurosis
- 64) Post Traumatic Shock
- 65) Veteran's Chronic Stress Syndrome
- 66) Explosion Blow
- 67) Cerebro-medullary Shock
- 68) Emotional Disturbance
- 69) Simple Continued Fever
- 70) Cardiac Muscular Exhaustion
- 71) Cerebro Spinal Shock
- 72) Wind Contusions
- 73) Post Traumatic Illness
- 74) Chronic Multisymptom Illness
- 75) Disordered Action of the Heart
- 76) Post-Combat Stress Reaction (used as recently as 2007)
- 77) Vietnam Veteran Syndrome
- 78) Buck Fever
- 79) Re-Entry Syndrome
- 80) Post-Vietnam Psychiatric Syndrome¹⁰⁶

¹⁰⁶ Meagher, *Moving a Nation to Care*, 162.

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