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Same Story, Different Name: A Survey of the Causes and Effects of the Medicalization of Post-Traumatic Stress Disorder

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Same Story, Different Name:
A Survey of the Causes and Effects of the
Medicalization of Posttraumatic Stress Disorder

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Thesis Summary

Particularly in light of recent shootings by those who have served in the military and subsequently admit to suffering from post-traumatic stress disorder (PTSD), there has been an increase in coverage and conversation regarding this mental health condition. For soldiers, this disorder is typically the result of experiencing some sort of trauma while serving in combat during a deployment. However, PTSD has not always been recognized as a mental health condition. My intent of this thesis is to trace the sociocultural history of PTSD among our servicemen, thus linking it to its medicalization in 1980 when it was added to the DSM-III.

After approaching its introduction as a mental health condition, I then plan on delving deeper into the current sociocultural and individual effects resulting from the medicalization of PTSD. When medicalization occurs, there are several latent affects that follow. For PTSD, society saw a shift in understanding of the mental health condition, discussion of its role in the lives of our soldiers and veterans, an increase in coverage by the media and popular culture, and the introduction of community support efforts for those affected. By gathering this information, I hope to assess three things: (1) report successes and limitations of modern day treatment methods as it pertains to all affected (2) future potential treatment methods that are regarded as experimentally effective and (3) use a sociological lens to analyze its potential cultural uniqueness to the United States.

Sometimes, if one is not personally affected by something it can be overlooked. As an individual who cares about our military, my thesis is not only meant to inform but to familiarize readers with a very pressing problem within the Armed Forces. From a sociological standpoint, it is important to analyze PTSD because it has not always been a medicalized part of society. By

seeking to understand why this came about and how it altered society can translate into many areas of life. Additionally, the medicalization of PTSD can help explain a development in cultural values over time. It is crucial to use other disciplines in my analysis because no part of society occurs independently of others. Therefore, the research presented should then provide myself and the reader with an understanding of two things: (1) how to effectively treat and/or interact with those members of the Armed Forces that experience life in ways that is different from our own and (2) how medicalization catalyzes a series of sociocultural changes.

Abstract

As society sees a rise in the addition of medical issues to the DSM that were previously deemed non-medical conditions, there is reason for a multi-variate analysis to take place. Post-traumatic Stress Disorder was added to the DSM-III in 1980 and has seen change both in the DSM-IV and DSM V. To understand these transitions, we start with a historical analysis of the mental health condition to legitimize its need for medicalization. This will then be followed by an analysis of the medicalization process in order to understand the progress that has been made as a mental health condition that requires medical and/or psychological treatment. Its medicalization encompasses empirical data, modern diagnostic and theoretical measures employed, treatment methods, both current and prospective. By understanding the process of its medicalization we can then understand its subsequent sociocultural implications.

Keywords: medicalization, mental health, post-traumatic stress disorder, United States, veterans

Introduction

For centuries, those who served our country in the armed forces have done so while millions of civilians remain unaware of the inhumane and, often times, life altering circumstances they face. Using the words of a former marine that returned to civilian life, “in the traumatic universe the basic laws of matter are suspended: ceiling fans can be helicopters, car exhaust can be mustard gas” (Morris, 2015). For individuals with no trauma experience, it is impossible to easily understand those that have experienced it. For former Marine David J. Morris, post-traumatic stress disorder (PTSD) was not only disruptive, but completely reoriented his life as a civilian. Particularly with psychological ailments, there is a long history of underrepresentation, misunderstanding, and sometimes complete ignorance towards the recognition and treatment on a societal level. Nevertheless, PTSD had a process of legitimization in which the causes, symptoms, and treatments were validated. This validation occurred by way of medicalization, or the process in which a human condition becomes defined as a medical condition that can be studied, diagnosed, and offered treatment or prevention (Charvat, 2010). For post-traumatic stress disorder, medicalization was initiated in 1980 when it was added to the DSM-III. This addition made the previously non-medical stress from a traumatic catalyst a medical issue, thereby legitimizing its experience. This timing is exceptionally important because PTSD became increasingly well-known after the Vietnam War ended in 1975; research finds that up to 30% of Vietnam veterans suffered from PTSD, the highest of any war in American history (Kessler, et al 2005). It is important to understand that medicalization is not a medically autonomous trajectory, commonly overlaps with other areas of life. Because it is very common for a mental health condition to be medicalized long after its acknowledged existence

by the community, it is necessary to understand and evaluate the medicalization of PTSD, thereby placing it within the socio-cultural context in which it evolved. Although there are numerous types of traumas that could cause one to develop PTSD, its recorded history is predominantly found in soldiers who served in combat roles (Bentley, 2005). For as long as recorded history, the enduring effects of trauma have been recognized by the people. For the purposes of tracing the medicalization of post-traumatic stress disorder, it is crucial to start with a historical analysis so that the four pronged process of medicalization encompassing empirical study, ability to diagnose, proposed prevention, and treatment options can be understood as a dynamic process within today's medical field.

Understanding the process of medicalization of PTSD is extremely important to the second component of its influence: how medicalization effects the individuals that are diagnosed, its reception by their community, and its representation in the public sphere. After a mental health condition is medically codified, there are several secondary outcomes that follow. As previously mentioned, when something becomes an addition to the DSM, it inevitably influences a variety of disciplines, and has both benefits and limitations whether intended, unintended, or latent. With post-traumatic stress disorder, medicalization becomes the starting point by which we can assess its psychosocial implications, political presence, and representation in pop culture. By directing the discussion towards the individual, community, and large-scale sentiments surrounding post-traumatic stress disorder, we gain an appreciation for the process of medicalization, and how it changes the climate of a mental health condition in virtually every aspect.

Finally, I intend to include a counterargument that outlines the negative effects of medicalizing PTSD. There are many that argue that since its medicalization, many people are

diagnosed with this mental health condition without actually having it (Muldoon & Lowe, 2012). Whether by the individual, psychologist, or sensationalism by media portrayal, the medicalization of post-traumatic stress disorder has brought with it a host of negative drawbacks that not only need to be addressed but given viable solutions.

Defining PTSD

For many of us, we do not have a tangible idea of what post-traumatic stress disorder looks like. Before delving into its history, it is necessary that we understand what an individual will experience as a result of clinical post-traumatic stress. PTSD is an anxiety disorder that causes an individual to experience symptoms like hypervigilance and arousal, stimulus aversion, and recurring thoughts of the trauma (Riggs, 2016). Additionally, one can also experience a variety of other symptoms including but not limited to anxiety attacks, depression, substance abuse, interpersonal problems and physiological symptoms like stomach aches or chronic pain (Riggs, 2016). These symptoms manifest in an individuals' life by making them "on guard" very frequently, causing difficulty sleeping, or having intense reactions to loud or sudden noises; this inevitably fosters a sense of mistrust in their surroundings which adds additional anxiety and stress (Ryan & Weimberg, 2008). While these symptoms are not exclusive to those in the military, the symptoms are commonly triggered by stimuli in the environment that are similar to prior combat experiences (Ryan, Weimberg, 2008). As is evident by symptomology alone, PTSD is a disorder that does not align entirely with depression as once believed.

History

For thousands of years, post-traumatic stress has been referenced under several other names such as irritable heart, shellshock, or combat stress reaction – just to name a few. The idea

of post-traumatic effects is so embedded in cultural history that it is discussed in literature such as the Bible, Greek historical texts, and Shakespeare plays. With its well documented nature, the real question becomes why it took so long for post-traumatic stress to be included in the canon of medically researched and treated disorders. A lot of this can be accredited to its primarily psychological manifestation (Bentley, 2005). When someone is missing a limb, the need for medical attention is evident but, when they are experiencing psychological trauma, the ease of identification is removed. In the past, it has been quite common for soldiers that any stress derived from a traumatic incident was filed under battle fatigue and written off. Many believed that this stress would dissipate over time, therefore making it a non-medical issue (Charvat, 2010). The problem with classifying stress following a trauma as a non-medical phenomenon is that all potential enduring psychological or physiological repercussions are altogether ignored. In addition to this belief that post-traumatic stress was fleeting, there are three other major sociocultural norms throughout history that ultimately impeded the medicalization of PTSD. Until the late 19th century, there was not a field in academia or the government that focused its efforts on improving, or even studying, the mental wellness of members in society until modern psychology was initiated by G. Stanley Hall with the founding of the American Psychological Association in 1892 (APA, 2016). In addition to this lack of concern, there was a great focus on hard work and productivity due to the introduction of capitalism in many developing and developed nations. Because of this, any trauma that was experienced by workers was neglected because worker's rights were not important (APA, 2016). Last, before World War I, wars and conflicts were more simplistic in nature and did not yield as many traumatic circumstances (Tick, 2005). With the advent of "total war" came better guns, more explosions and an extreme hike in the prevalence of post-traumatic stress (Scott, 1990). With the introduction of modern

psychology, advanced warfare, and a more vocal population concerned with their mental health there was a perfect storm created that helped usher post-traumatic stress into its medicalization.

Case Study: Vietnam War

Considered the first “television war”, the Vietnam War forced the American public to become painfully aware of the abysmal conditions our soldiers were facing every day. Unfortunately, this media exposure caused the homecoming of Vietnam veterans to be very unwelcoming (Scott, 2004). This “anti-war” culture that surrounded the soldiers as they came home not only invalidated them as war heroes but hindered their ability to re-integrate into society (Bentley, 2005). To make matters worse, Vietnam veterans were displaying symptoms of what is now known as PTSD but was then called gross stress reaction – deemed a “transient situational disorder” (Scott, 2004). Due to this categorization, gross stress reaction was seen as a disorder that would fade away, thus making veterans ineligible for medical treatment by the government (Scott, 2004). However, as the symptoms persisted beyond what was considered a normal adjustment period after returning home, the American Psychological Association began studying this condition among veterans and Holocaust survivors (Croomie, 2008). The results of these studies then led the APA to changing gross stress reaction to post-traumatic stress disorder and added it to the DSM-III in 1980. Despite the socio-political climate of the time that inevitably made understanding PTSD more difficult, its presence pre-dated the Vietnam War by several centuries.

Early Approaches to PTSD

The earliest accounts of PTSD, under a different name, go back thousands of years (Bentley, 2005). In early Egyptian history, around three thousand years ago, a veteran described

his post-combat experience with intense emotional and even spiritual language; PTSD according to his accounts was seeing his “soul lie in your hand” (Bentley, 2005). Another example of an early explanation for PTSD can be seen in Ancient Greek times, where Herodotus wrote that Leonidas of Sparta saw the “effects of war” in his soldiers and gave them reprieve from the Battle of Thermopylae (Charvat, 2010). Often times, old accounts of post-traumatic stress were understood as fatigue from combat, not psychological trauma. This notion inevitably led people to believe that the cure was rest – an easy fix (Bentley, 2005). Not only was this a conventional treatment method, it frequently eclipsed the important psychological suffering that one was experiencing by leaving it untreated.

Despite this common misunderstanding, there were several important strides made by individuals in more modern history. By the early 18th century Frenchman Dominique Jean Larrey, deemed the first modern military surgeon, identified three stages of what we now call PTSD: (1) heightened excitement and imagination, (2) period of fever and gastrointestinal problems, and (3) frustration and depression (Charvat, 2010). Prior to these three stages delivered by Larrey, many societies described post-traumatic stress disorder as being broken or experiencing homesickness. A century and a half later, activist Dorothea Dix created a tidal wave of efforts regarding treatment of the mentally ill in the United States and abroad. Her efforts led to an increased awareness and attentiveness given to the soldiers’ mental and physical wellbeing during the Civil War (Gollaher, 1995). Cardiologist, Jacob Mendez Da Costa, did work on the physiological effects of war on Civil War soldiers which indicated higher blood pressures and heart rates (Charvat, 2010). Because of these effects, Da Costa termed this condition “soldier’s heart” but is now more commonly referred to Da Costa’s Syndrome (Charvat, 2010). Even today, the etiology of this disorder is extremely controversial and should not be interpreted as a

19th century explanation of post-traumatic stress, rather, it serves as an example that shows the increase in attention being given to soldiers and the effects war had on them.

Before the introduction of PTSD in the DSM-III, there were several precursory disorders in the previous two that offered an explanation for the trauma that soldiers were experiencing. The first DSM, written in 1952, was compiled largely in part to statistical data from psychiatric hospitals and from manuals used by the United States Army (American Psychiatric Association, 2016). In the DSM-I there was “Gross Stress Reaction” which was defined as a “transient” reaction to military trauma (McGraw-Hill Dictionary, 2016). This disorder listed in the DSM-I was largely influenced by those who served in the Vietnam War, which began in 1946. While this was a step in the right direction for those who suffer from post-traumatic stress, it still undermined the tenacity of the disorder. An enduring belief during this time was that only emotionally weak and/or intellectually inferior soldiers were subject to this “battle fatigue”; coupled with these two ideas was the notion that soldiers with big egos were even more susceptible to post-traumatic stress (Brewin & Holmes 2003). These assertions were based on the assumption that susceptibility to PTSD increased if an individual was not masculine enough. Because these predispositions were simply assumed, they led to an inevitably flawed, yet still somewhat helpful, path of early empirical approaches by researchers. There was a popular theory of post-traumatic stress developed in 1976 by Dr. Milton J. Horowitz called *Stress Response Theory*. This theory posited the idea that post-traumatic stress occurred in individuals who could not comprehend or categorize what was happening to them and, as a consequence, they experienced terrifying flashbacks. This early theory prompted the development of several more theories that are widely accepted in today’s medical and psychological community.

Critical Approaches to Medicalization

The most common critical approach to the medicalization of posttraumatic stress disorder is that we “created” a psychiatric disorder by making a normal human condition a medical issue. According to political psychologists Orla T. Muldoon and Robert D. Lowe, post-traumatic stress disorder is less of a psychiatric disorder and more of a condition that results from varying social and political structures (260). These sociopolitical structures include Westernized views of trauma that are deemed irregular, political justifications for peace over war, and validation for suffering veterans seeking compensation after their return home (Muldoon, Lowe, 2012). Because of the inextricable relationship between politics, war, and posttraumatic stress disorder, critics often discredit the legitimacy of its pathology because it is viewed as a social construct and not a legitimate mental health condition. In addition to the sociopolitical factors that create an environment conducive to posttraumatic stress disorder, Muldoon and Lowe argue that the condition has been developed predominantly in western literature that focuses on the individual and not society; by dedicating a large part of our focus on the individual, we exacerbate the stress and anxiety caused by war and undervalue social cohesion (2012). As the argument continues, Muldoon and Lowe reveal that the plight towards universal trauma prevention should not be a primary concern of the people when faced with equally terrible physiological disparities (2012). Those who argue against the timelessness of posttraumatic stress disorder say that our modern interpretation of the condition causes us to view recorded examples of posttraumatic stress throughout history with an unnecessary and overtly harmful bias (Muldoon and Lowe 2012). While the argument presented by Muldoon and Lowe are sometimes relevant in the medicalization of other conditions, the military has taken a stance on this issue by validating the symptoms of soldiers and veterans with PTSD.

Military Response to Critical Approach

As of August 2012, all branches of the military have standardized their approach to and treatment of PTSD. This effort was made in order to provide a sense of equality among the branches so that all of those affected can feel validated and trust others with their condition. More specifically, the Army deemed this standardization a “patient-centered approach” that will actively try to fight against the stigma associated with PTSD so that all men and women in service can receive the treatment they need and deserve (Department of Defense, 2012). The evolution of an anti-war culture following the Vietnam War shows a concerted effort by the military to make it known that their alliance lies with the soldiers and their family members (Department of Defense, 2012). In addition to this standardization by the military for active duty soldiers, the U.S. Department of Veterans’ Affairs has facilitated a comprehensive guide for clinicians and veterans on the options afforded to ex-service men and women that suffer from PTSD (2016). This recent information provided shows that the VA is serious about re-directing the trend of veteran suicide in the United States by highlighting every opportunity available to those that are in need (2004). As we continue to see efforts being made by the government to release pertinent information to our mental health professionals and veterans regarding their stance on PTSD, we also see its inextricable relationship with the development of more modern diagnostic criteria of this mental health condition.

Modern Diagnosis

Following a long history of misinformation and misdiagnoses, the modern diagnosis and theory of post-traumatic stress disorder continues to make great strides as the body of information regarding its toll on individuals continues to grow. Due to the nature of this mental

health condition, prevention is not only difficult but relatively impossible. Because there is no way to ensure that traumatic events will not occur or to control how one will respond to it, PTSD becomes a mental health condition that varies by the individual. Despite these nuances, it is crucial to seek out help as soon as possible after symptoms are recognized. By addressing them at their onset, the sustained or persisted development of the symptoms of post-traumatic stress disorder can be thwarted (Wessely et al., 2008).

Now that the DSM-IV has evolved into the DSM-V, the criteria for PTSD has expanded to eight criteria of diagnosis labeled criterion A-H. These eight criteria include: (A) a stressor, (B) intrusive symptoms, (C) avoidance, (D) negative alterations in cognitions and mood, (E) alterations in arousal and reactivity, (F) duration, (G) lasting longer than a month, and (H) exclusion (DSM-V). For criterion A, the stressor can be qualified as a direct or indirect exposure to actual or threatened death, serious injury or sexual violence that occurs once or multiple times (DSM-V). This is different from the DSM-IV because it explicitly includes sexual violence as a stressor in criterion A (DSM-IV, 2000). The intrusive symptoms for criterion B include memories, nightmares, or flashbacks that are recurrent and involuntary. These symptoms are typically related to the avoidance behaviors of criterion C, where individuals will actively avoid any internal or external reminders of the trauma. Criterion D includes a negative perception of self and world that generally results in anger, mistrust, and self-imposed inadequacy; in addition to these negative cognitions, someone with PTSD will typically feel alienated from their peers and unable to experience positive emotion. These symptoms generally lead to those displayed in criterion E which can be explained by irritability and aggression, heightened startle responses, and hypervigilance (DSM-V, 2013). For example, if a combat veteran that has been diagnosed with PTSD hears a car door clam s/he may immediately revert to a mental and physiological

state of combat preparedness (Tick, 2005). The last three criteria require that an individual be experiencing these symptoms for longer than a month, at a detrimental and impairing rate, without being caused by medications, substance abuse, or other unrelated illnesses (DSM-V, 2013).

From the DSM-IV to the DSM-V there were three major changes in the diagnostic criterion. The first major change for posttraumatic stress disorder was its re-categorization from an anxiety disorder to a trauma- and stress-related disorder. This change occurred because, unlike an anxiety disorder, a stressful or traumatic event is a necessary prerequisite to the mental health condition. This was a significant change because it acknowledged that anxiety can be indicative of PTSD but not the deciding factor (Beall, 2016). Additionally, this change reflects a shift in how the affects of war and combat was approached by mental health professionals (Beall, 2016). The second major change was in criterion A where they removed the emotional language of “intense fear, helplessness, or horror” that was a requirement for an individual’s response to the trauma in order to legitimize their diagnosis (American Psychiatric Association, 2013). This first change initiated a shift in focus from the original response to the trauma to the corresponding symptoms that followed. This difference also contributed to the third major change which was an expansion of symptomatic diagnostic criteria from three to four. The addition of criterion D to the DSM-V focuses on the “negative alterations in cognitions and mood associated with the traumatic event(s) beginning or worsening after the traumatic event(s) occurred”, which has been acknowledged as distinctly separate from Criterion B in the DSM-IV which included “recurrent and intrusive recollections of the event” (DSM-V 271-72, DSM-IV 467-68).

Modern Theory

Although their developments were temporally homologous, the introduction of modern theories behind the development of post-traumatic stress disorder have been received and supported on a larger scale than the earlier approaches. The first of the three theoretical approaches is Emotional Processing Theory (Foa & Kozak 1986). This theory emphasizes the antecedent state of a soldier before they experience trauma and how that affects their subsequent internalization of their circumstances. For example, if a soldier sees a stimulus that is frequently associated with an intense physiological or behavioral response, it is hypothesized that because of pathological fear structures, an individual inappropriately generalizes their experience with the trauma to an untrustworthy world and incompetent self (Foa & Kozak 1986). This is because as opposed to typical fear structures, pathological fear structures encourage “excessive response elements and resistance to modification” (p. 21). Although these invasive thoughts are not true, the sufferer maintains them until they are modified.

The second, Dual Representation Theory developed by Brewin, Dalgleish, and Joseph in 1990, is a cognitive theory that states that there are two memory systems within the brain, with one encoding traumatic memories in a different manner than normal ones (Brewin, Dalgleish, & Joseph). These two memory systems are called verbally accessible memory (VAM) and situationally accessible memory (SAM) and can be discriminated by one’s ability to intentionally include it in their autobiographical knowledge (Brewin, Dalgleish, & Joseph, 1990). When an experience is encoded as SAM, the individual is unable to modify the memory but, instead, elicit visceral responses to stimuli in their environments. The intent of this theory is to explain the recurring flashbacks and corresponding physiological responses that individuals have because of their surroundings after they have experienced a stressful or traumatic event.

The third theory is not intended to explain the acquisition of posttraumatic stress disorder but rather the maintenance of it. Ehler and Clark's cognitive model states that victims that are unable to substantially encode concrete aspects of their surroundings and experiences during a stressful or traumatic event are at a greater risk of maintaining post-traumatic stress (2000). Ehler and Clark proposed a two-fold model that theorized that an individual's understanding of their external or environmental surroundings was atypical to those that did not acquire PTSD and, secondly, that the memory of the stressful or traumatic event itself is recalled differently by the individual with PTSD (Ehler & Clark, 2000). For those that recover from a stressful or traumatic event without symptoms of PTSD, the event is typically viewed as an isolated event that has no bearing on their abilities or the goodness of the world they live in. However, those that do experience the symptoms of PTSD view the event as more pervasive than their counterparts; this usually leads the individual to limiting their exposure to stimuli they deem similar (Ehler & Clark 2000). In addition to this harmful behavior, the Ehler and Clark model states that an individual with PTSD will sometimes suppress their negative cognitions following the stressful or traumatic event which inevitably worsens their condition (2000). The latter half of this model presents the question of why individuals with posttraumatic stress struggle with the deliberate recollection of the event but frequently experience involuntary and intrusive flashbacks of the event; when actively trying to recall the event, individuals often report fragmented or incomplete accounts while flashbacks are typically more inclusive (Ehler & Clark, 2000). While the theories proposed are still being tested, the medicalization of PTSD has prompted the empirical testing needed to understand this medical health condition further.

All three of these theories overlap in regards to their central focus on the codification of memories and why some individuals encode them in ways that lead to pathological symptoms

while others recover without any trace of psychological damage. This theme becomes important when research questions and treatment methods are proposed and developed. Additionally, these theories focus on the topic of thought suppression and its counterproductive yet common practice by those that are suffering from posttraumatic stress. As modern theory develops into practical application, we can see the significant progress that researchers, clinicians, and patients have made.

Prevalence, Treatment, and Sociocultural Presence of PTSD

Although the first step towards of medicalization is empirical research, the studies used to gain this empirical knowledge are guided by pressing research questions. Now that more modern theories have been proposed, there are three subsequent research questions that I find particularly relevant: (1) how prevalent is posttraumatic stress disorder now that it has been medicalized, (2) what are the most promising treatment methods that lead to rehabilitation and (3) how has its medicalization affected its sociocultural reception. With the first question being quantitative in nature, it should reveal that the medicalization of PTSD has influenced societal perceptions and acceptance of this mental health condition. Not only do I want to focus on overall prevalence, I seek to reveal any differences among race, gender, branch of service or military occupational specialty (MOS). While the second research question could be gauged quantitatively, my primary focus will be on the qualitative nature of the treatment received by affected individuals. Because PTSD is extremely detrimental to one's psyche, treatment methods should be geared not only towards symptom alleviation but towards holistic treatment by attempting to modify thought processes and empower the individual as well. Last, I seek to understand and explain how PTSD as a diagnosable mental health condition has been received on a sociocultural level by politicians, the media, and the public. When a mental health condition becomes a diagnosable

addition to the DSM, there are several events that follow like the spread of awareness to the public or inclusion in non-medical areas of society like film or politics. For PTSD, we see its medicalization affecting legislative efforts, popular culture, nonprofits, and reception from an individual to societal level.

Prevalence

As a direct result of its medicalization, there has been the introduction of a wealth of research and data concerning post-traumatic stress disorder, particularly after the Vietnam War. As previously mentioned, its current prevalence and treatment methods will be discussed as products of its addition to the DSM. For a majority of people, a traumatic episode will be experienced or witnessed at least once. However, only around 7.8% of those individuals will develop post-traumatic stress disorder; variation by gender, suggests that the prevalence of PTSD in women is roughly two times that of men at 10.4% (National Comorbidity Survey, 2005). A cross-sectional study done by a group of researchers for the Millennium Cohort Study Team did an analysis of rates of PTSD among 75,156 members of the US military. Factors taken into consideration were gender, birth year, education, marital status, race/ethnicity, military rank, service component, branch of service, and occupational category (Sallis et al., 2009). Additional information gathered that was taken into consideration in a secondary analysis were smoking and drinking habits.

Results revealed several things about the nature of our service men and women's behavior with regards to PTSD. Not surprisingly, women were more likely to seek treatment for posttraumatic stress than men even though men were typically more susceptible due to their occupational category during deployment (Sallis et al., 2009). Additionally, it was found that

active duty soldiers were less likely to report symptoms of PTSD than National Guardsmen, even though active duty servicemen were more likely to display symptoms than their counterparts (Sallis et al., 2009). Their findings revealed the following profile: a middle aged, white male with a high school diploma, that was married, in the army, and was a current smoker had the highest rates of PTSD (Sallis et al., 2009). While Sallis and team could not provide causation for why this profile was at such high-risk, it does prove useful when providing preliminary psychoeducation to soldiers (Sallis et al., 2009). When PTSD prevalence was assessed among those that were deployed in the Gulf War, Bosnia/Kosovo/South West Asia or to both locations, rates of PTSD were consistent with deployment to both locations and just the Gulf War. However, rates of PTSD in troops with sole deployment to Bosnia/Kosovo/South West Asia was the highest (Sallis et al., 2009). These increased rates of PTSD in Bosnia/Kosovo/South West Asia were explained by more brutal combat conditions over longer periods of time (Sallis et al., 2009). Not only can this explanation attribute to higher prevalence rates during these wars, but it is used to explain high rates of PTSD during other times of war as well.

According to a meta-analysis done on the prevalence of PTSD during wartimes since Vietnam conducted by the Medical University of South Carolina by researchers Magruder and Yeager in 2009, the prevalence of PTSD among United States veterans in the Vietnam War was roughly 8.5 to 19.3% while rates with Iraq War veterans at 4.7 to 19.9% and Persian Gulf War veterans at 1.9 to 24% (783). Despite the variation in these rates, the odds ratios for acquiring PTSD were significantly worse in the Vietnam War than in the Persian Gulf War (PGW) or Operation Iraqi Freedom (OIF) (Magruder & Yeager 2009). To add to this discrepancy, PGW and OIF studies were done within a two- to three-year time frame while Vietnam War studies were done more than a decade later; because of this, it is hypothesized that the numbers would

have been even worse if done in the same time frame (Sallis et al, 2009). The explanation for these dismal rates of posttraumatic stress disorder during the Vietnam War are in part due to exposure during deployment and a lack of appropriate homecoming when returning from the war (Sallis et al., 2009). While there are many studies done to explain the prevalence of posttraumatic stress in the United States, there have also been comparable studies that look at rates in the US versus those in other nations.

Surprisingly, among United Kingdom veterans of the Iraq War, prevalence of PTSD is only around 3-6%. A similar trend held true in other non-US western countries (Richardson et al., 2011). This is an extremely significant difference that is probably rooted in several factors that lead back to one primary difference: its medicalization. While the United States uses the DSM to diagnose medical disorders, European countries use the International Classification of Diseases or the ICD to diagnose their patients. This difference may be due in part because PTSD was not added to the ICD until 1992, more than a decade after its inclusion to the DSM-III (American Psychological Association). This delay can most adequately be described as a product of the overall UK's perception and treatment of mental health, which is so malignant that it has been described as a form of "structural violence" towards its citizens (Kelly, 2013). So while the initial reaction to the extreme gap in prevalence of PTSD in the US vs the UK seemed like an over-medicalization by the US it may actually be a product of gross negligence by the UK. By knowing that the United States has significantly more combat veterans with PTSD than most other countries, efficacious treatment methods are of the utmost importance.

Treatment Methods

As with most mental health conditions, treatment is a layered process that requires full participation from mental health providers, affected individual, and their support network. Typically, treatment for posttraumatic stress disorder will start with psychoeducation in order to provide comprehensive information on what the patient will experience and should expect throughout the treatment process. Psychoeducation can include videos, word-of-mouth, or written pamphlets; these sources will typically describe stress and how the body can react to stressful situations (Wessely et al., 2008). By starting with psychoeducation about the treatment process, the patient becomes better equipped to understand their symptoms and respond to treatment methods. However, there is little information on the efficacy of psychoeducation as a tool of recovery by itself, therefore, it should only be used as an introduction to other treatment methods. After psychoeducation has been delivered to the patient and potentially their support network, the next layers of treatment include pharmaceutical drugs and behavioral therapy.

It is very common for patients with posttraumatic stress disorder to use a combination of medications and therapy to yield the most effective results during treatment (Wessely et al., 2008). Although it is not a depressive condition, PTSD can often be comorbid with depression. Because of this, there are two antidepressant selective serotonin uptake inhibitors (SSRI) that are approved by the Federal Drug Administration for PTSD – Zoloft and Paxil (FDA). These SSRIs will help mitigate any symptoms relating to depression, lapses in concentration, and deteriorating sleeping or eating habits (Wessely et al., 2008). In addition to SSRI medications, those with PTSD can take anxiolytics to inhibit excessive anxiety and prazosin to help them sleep if nightmares significantly disrupt their sleeping habits (FDA). It is important to note that pharmaceutical drugs are used to alleviate the severity of symptoms, but will not go so far as cognition of behavior modification.

When discussing modern therapy methods for post-traumatic stress disorder, there are two categories to be considered. The first is a group of treatment methods that have been empirically tested and validated; while the second is a group of treatments that have been acknowledged as efficacious by those with PTSD, but are not yet grounded in substantial empirical research. Essentially, all of the empirically grounded treatment methods are a variation of cognitive behavioral therapy – which seeks to change or modify one’s negative cognitions that result in productive perceptions and behaviors (DeAngelis, 2008). There are four competing treatment methods that are primarily used for patients with posttraumatic stress disorder. The first two, cognitive processing therapy and stress-inoculation training are commonly integrated with the “gold-standard” treatment method called prolonged exposure therapy which leaves the fourth treatment method being eye movement desensitization and reprocessing therapy as its competition.

Cognitive Processing Therapy is a form of cognitive therapy that seeks to help patients with PTSD get past their “stuck points” and re-categorize their experience(s) with trauma into one separate from their actual competence and capabilities. “Stuck points” can be defined as negative cognitions that are not actually true yet still lead the patient to limiting their thoughts and behaviors (Monson et al., 2006). For example, many veterans believe that the trauma they experienced was a result of their own inadequacies due to a prior held belief that they are able to protect themselves in all dangerous situations. Cognitive Processing Therapy seeks to change this mentality by providing information to the patient that invalidates this belief, allows them to understand that not all dangerous situations can be escaped, and then empowers them to accept their past and move beyond seeing it as a personal failure (Monson et al., 2006).

As previously mentioned, stress inoculation training is very commonly used in conjunction with prolonged exposure therapy. It was even said by Dr. Edna Foa that stress inoculation training and prolonged exposure (SITPE) used together is the most efficacious treatment available for veterans with posttraumatic stress disorder (Lee et al., 2002). Stress inoculation training is typically composed of three to four phases that can take anywhere from six to fifteen sessions to complete. An example of SIT therapy was done by Christopher Lee and team where the phases were integrated into seven therapy sessions. Session one was used for assessment and instruction on how to exercise controlled breathing that would be utilized in the remaining sessions. The second session was primarily used to explain their rationale and method of treatment for sessions 3-7; included in session two was training on “progressive muscular relaxation” that would be assigned as homework nightly until the next session. Starting with session three, the patient is asked to re-experience a traumatic memory by narrating it in a present-day account while being recorded so that they can listen to it nightly until session four. Sessions 4-7 were then dedicated to teaching the coping skills outlined by Dr. Foa to the patient with a theory-application approach that enabled the patient to not only learn the coping skills but how to use them for their experiences. Following suit, the patient was instructed to do nightly homework on these practices in between sessions (Lee et al., 2002).

For researchers Foa and Kozak of Emotional Processing Theory, exposure therapy was their clinical recommendation. The most common form of exposure therapy utilized is prolonged exposure therapy. During prolonged exposure therapy sessions, therapists instruct their clients to recollect the traumatic event in a controlled environment so that they can maintain more control over their emotions and cognitions regarding what happened to them (Lee et al., 2002). The most effective component to PE therapy is the process of gradual yet repeated exposure; this can occur

both in the patient's imagination and in vivo (Foa & Kozak, 62). For example, if a veteran with PTSD is averse to helicopters, a therapist might start by getting s/he to imagine a helicopter then over time reach the point where s/he can be near one in person. For Foa and Kozak, prolonged exposure therapy was the optimal treatment for modifying the pathological fear structures that caused the initial extreme reactions to stressful or traumatic events; additionally, they also stressed that the fear structure was not to be "under-engaged" or "over-engaged" in order to achieve the most ideal results (62). In order to facilitate optimal engagement, the patient needs to recall their memories with their emotional responses in-tact while also not rushing the process. By doing this, the patient can successfully avoid dissociating from their negative cognitions or inducing counterproductive anxiety attacks. When done properly, this treatment method inevitably helps the patient modify their thoughts regarding their views on the world around them and themselves as competent members of society.

The final empirically tested treatment commonly utilized for posttraumatic stress disorder is called eye movement desensitization and reprocessing (EMDR). For EMDR therapy, there is a standardized eight phase methodology of treatment employed for each patient. As provided by the Mental Research Institute, Dr. Francine Shapiro released a description of the standardized eight-phase process in 2001. Phase one can be completed in one or two sessions and is used to gather the history of the patient so that an individualized treatment plan can be designed. Phase 2, which can take anywhere from one to four sessions, is considered a preparation phase in which trust is established between therapist and patient. Additionally, fundamental techniques to deal with anxiety or other emotional irregularities are taught so that they can be readily utilized at the need of the patient. Phase 3, the assessment phase, is one in which several scales are used to determine the patient's cognitions and level of disturbance by those cognitions. In addition to

cognition and disturbance scales, the therapist will also assess any negative emotions and physiological reactions to the patient's memories of the trauma. Phase four, the desensitization phase, is when the therapist guides the patient in "sets of eye movement with appropriate shifts and changes of focus" until they reach a lower level on the disturbance scale that was outlined in phase three. Phase five is the installation phase because this is where positive cognitions are introduced to the patient to take place of the previously held negative ones. Phase 6, the body scan phase, is a phase in which old trigger memories are recalled by the patient in order to see if they still elicit a physiological response. This is done because even though the installation phase is used to remove negative cognitions, it does not always alleviate the memories held by the body. At the end of every session, the seventh phase of closure, is used to return the patient to a state of control if it was not gained throughout the session so that they can function outside of the session. The final and eighth phase, reevaluation, occurs at the beginning of each new session to gauge where the patient is in regards to the previous session so that the therapist knows where to begin (Shapiro, 2001). While the four previously outlined treatment methods are all empirically validated, there are other common methods of treatment that are employed by veterans that yield successful results despite their lack of empirical basis.

A very common form of therapy for those with PTSD is companion therapy, which is most commonly a dog. It has been stated by the Department of Veteran Affairs that there is not enough research to confirm the legitimacy of using canine companions to treat the symptoms of PTSD, but the immense popularity and personal accounts given by those with the service canines have aided to a strong reputation of success (Department of Veteran Affairs, 2014). Regardless of its ability to be empirically tested, dogs provide the veteran with PTSD with an extremely reliable form of connection, which is critical in alleviating some symptoms that might be

experienced. The second treatment method that is still in the early phases of development is the use of therapeutic cannabis to treat the symptoms of PTSD. According to Dr. Mechoulam, a medicinal chemist in Israel, cannabinoids play an important role in memory extinction, which would obviously prove to be extremely useful when trying to eradicate traumatic memories. Despite a wealth of compelling evidence that supports this theory, the FDA will not conduct research of their own on the use of cannabis for treatment.

As is evident, treatment for posttraumatic stress disorder has the primary focus of helping the patient change the harmful thoughts they have towards themselves, their surroundings, and for their futures. Despite the controversy surrounding which method of treatment is the most effective, all four methods have their merits and have shown consistent improvement among those treated. Additionally, the latter two popular treatment methods are generally complementary to the four primary methods of treatment, but still prove to be efficacious. The redeeming quality of all modern day treatment methods is that posttraumatic stress disorder is no longer ignored or misunderstood like it was before its medicalization. As a product of its inclusion in medicine and academia, we can also see its unparalleled representation in every level of society. From law and politics, to grassroots community support efforts, to popular culture and attention in the media, posttraumatic stress disorder has initiated several sociocultural changes.

Legislative Efforts

One of the most significant changes in society that results from the medicalization of a mental health condition, particularly one so entrenched in military and veteran affairs, is its inevitable introduction to the political and legislative arena. Before a mental health condition is

medicalized, it is very difficult to establish it as a cause for concern in legislation because there is no definitive way to become informed on or appropriately discuss the issue, ascertain its role in society, or gauge public opinion (Parens, 2011). Once it has been researched and delivered to the public by the scientific or academic community, it can then exist within the scope of politics. In both the United States House of Representatives and Senate, there are standing committees that exist solely to gauge the state of veterans' affairs and address any pertinent situations that may arise relating to such. Even during a time of congressional polarization, the state of our service men and women both currently serving and retired has the ability to remain a relatively agreeable topic of discussion for both republicans and democrats.

A recent example of the successful legislative efforts regarding posttraumatic stress disorder is H.R. 203 – the Clay Hunt Suicide Prevention Bill to Aid Veterans. Introduced to the House committee on Veterans' Affairs on January 7th 2015 by Democratic Representative Timothy J. Walz, H.R. 203 was approved 430-0 in the House and 99-0 in the Senate which was then followed by President Obama signing it into law on February 12th. This overwhelming support at such a quick pace from our Congress is not only rare, but clearly demonstrates a shift in congressional focus to supporting the millions of veterans we have previously failed. The bill was inspired by the suicide of Marine Corps Veteran Clay Hunt when he returned to the states after being deployed in both Iraq and Afghanistan. As a veteran, he tried to seek help from a psychiatrist but his disability approval was not delivered until over a month after he took his own life. Keeping in mind that 22 veterans take their own life every day, Clay Hunt's suicide sparked unprecedented national attention because it occurred during a time of "massive overhaul" of the Department of Veterans Affairs because of extremely inadequate health care measures that have come to light in the past several years (Leonard, 2015).

Even more recently, a bipartisan group of lawmakers met at the beginning of March 2016 to discuss the pressing issue of service men and women that have wrongfully received less-than-honorable discharges from service because of behaviors caused by posttraumatic stress disorder or traumatic brain injuries. Once a soldier is given a discharge that is less-than-honorable they are unable to utilize the necessary resources to deal with their mental health issues. This discussion has arisen in congress because it continues to show the “red tape” surrounding the treatment of mental health in our military. According to veteran and conservative house member Representative Mike Coffman, an omnibus bill surrounding this topic will be delivered in the next several weeks (Shane, 2016). When living in a democratic republic, the voice of the people should be the basis of legislative efforts brought about by our elected representatives. While veterans’ affairs would hopefully receive attention independent of additional societal influences, the sociocultural addition of community support networks for veterans suffering from posttraumatic stress disorder establishes the need for attention from our politicians in addition to their many other positive benefits.

Community Support Efforts

As mentioned when discussing the prevalence of posttraumatic stress, proper military homecomings are important to soldiers because it helps validate the loyalty provided to their country and aids them in re-integrating themselves into civilian life. After PTSD’s medicalization, homecomings grew beyond its traditional meaning by developing into community support efforts such as non-profit organizations that support disabled veterans, online forums and blogs or in person gatherings where soldiers can meet others with PTSD, or engagement initiatives that encourage soldiers to get involved in their communities. Both on a national and community level, organizations such as the Wounded Warrior Project, Real

Warriors Campaign, and Vietnam Veterans of America have been founded to raise awareness, promote change, and provide assistance to the silently suffering veterans of the United States. To highlight one non-profit in particular, the Real Warriors Campaign uses the slogan “resilience, recovery, reintegration” as a platform for their efforts to help soldiers and veterans that are suffering in silence. Their website not only contains information for active duty and national guard/reserve soldiers and veterans, but for family members and mental health professionals as well. Their multimedia approach to psychoeducation enables soldiers and veterans to watch videos, read the personal accounts of other servicemen and women, listen to podcasts, and get email updates on information relating to posttraumatic stress disorder and traumatic brain injuries. Just like individuals with other mental health conditions, it is important to know that isolation is not a necessary reaction to your diagnosis because you are not alone in your suffering. By providing these community support networks, a dialogue is created among veterans and activists that can lead to real change. In addition to the introduction of resources for veterans, society has also seen the creation of support networks and resources for spouses, children, and other family members and friends that know someone affected by PTSD. These resources provide information on how they can help their loved ones and others in their community. Despite the overwhelming support provided by these community organizations, there are still some aspects of society that do a less-than-appropriate job at displaying posttraumatic stress disorder in a positive light.

Popular Culture

Following the Vietnam War, there were several movies that attempted to illustrate the psychological toll combat took on the soldiers. Three years after Vietnam, a movie entitled *The Deer Hunter* was released that told the story of three Pennsylvania farmers that joined the

military to fight against the Vietcong (1978). Due to the timing of its release, neither the movie nor the synopsis identifies posttraumatic stress as the root of their psychological suffering after the war, but it is now understood almost four decades later. In 1989, another movie titled *Jackknife* told the story of a Vietnam veteran struggling from “post-Vietnam stress syndrome” which hinders his ability to reintegrate into society. Even after posttraumatic stress disorder was added to the DSM in 1980, we can still see that diagnosing those affected by PTSD was still an issue as by its misrepresentation in popular culture. More recently, the public has seen films such as *American Sniper* and *Max* that display how posttraumatic stress disorder can manifest. While *American Sniper* ends in a shooting committed by a soldier with PTSD, the story of the service dog with PTSD, *Max*, is one of the only popular culture portrayals of the struggle towards recovery that ends positively (2015). In light of this increase in attention by popular culture, it is of concern to be conscientious about how those with posttraumatic stress disorder are represented. The archetypal veteran suffering from PTSD in film usually assumes a “crazy”, uncontrollable, and often times destructive or lethal set of behaviors which further reinforces a negative stigma for consumers. Despite this common inaccurate portrayal of PTSD in film, there are some instances when this mental health condition is delivered the way it should. One of the best examples of the accurate representation of PTSD is given by the song *A Soldier's Memoir* by Joe Bachman. In the opening lines, Bachman aptly explains PTSD as a war within your own mind by singing “I’m not sure how I got here / Or how I’m gonna get out / My Mama says I look the same as I did before I left / But if she could see inside of me / It would scare her to death” (2013). Throughout the rest of the song, Bachman sings of a soldier unable to get the war out of him because he feels like it is a daily battle to fight for his life. In comparison to how PTSD is portrayed in film, Joe Bachman’s song illustrates how devastating this mental health condition

truly is – it is not crazy, dangerous, or lethal. It is a soldier desperately trying to regain a sense of normalcy in a world he no longer knows (2013). These competing stereotypes of accurate versus inaccurate continue to manifest in the information delivered by major media outlets.

Attention in the Media

As Jon Stewart said best, “the bias of the mainstream media is toward sensationalism, conflict, and laziness” (2011). This becomes particularly relevant when discussing how posttraumatic stress disorder is delivered to the public by major media outlets. For example, in the past decade, the two deadliest shootings at the Washington Navy Yard and Fort Hood military base have been carried out by those who have served. When stories were delivered by major media outlets, both shootings were linked but not definitively explained by PTSD. Additionally, when stories of both shootings were released by the media they actively downplayed the possibility that the shooter was suffering from a mental health condition by inserting trivial quotes about their typically “calm” or “good” behavior patterns. To automatically categorize a soldier or veteran suffering from PTSD outside of the realm of “good” simply because of their mental health condition we not only continue to invalidate their need for help but we place our own uninformed interpretations of the condition on their behavior. During a Fox News interview, a statement delivered by one soldier suffering from PTSD helps shed some light on his struggles living with PTSD by admitting, “everyone deals with it in their own way. I try to hide it. I try not to think about it because I have to stay 100% - I have to keep a good example.” (PEEROnline, 2013). To complement this statement, the newscaster closed the story by announcing “The War in Iraq is over. The war in Afghanistan is winding down yet the troops returning home still fight battles of their own and – too often – on their own” (PEEROnline, 2013). This dual-edged representation

of PTSD by both a soldier and a civilian are important because it shows how conflicted those with PTSD truly are.

Limitations

Despite the many necessary changes facilitated by the medicalization of posttraumatic stress disorder, there are also several limitations that need to be addressed. There are three predominant problems of medicalization in general that are particularly applicable in the case of PTSD. The first, and most economical limitation, is that medicalizing a disorder increases the cost of health care (Parens, 2011). This is not always inherently a bad thing, however, the extra funding for health care costs usually comes from tax payers. Fortunately for posttraumatic stress disorder, a majority of public opinion supports efforts being made to take care of our veterans which ultimately legitimizes this mental health condition for the public. To this day, advocates and victims of PTSD spread awareness that the mental health condition is not a political ploy but a genuine psychological ailment that requires medical and psychological attention. The second limitation to the medicalization of post-traumatic stress is the constraints created on the subjectivity of human emotions as perceived by medical professionals (Parens, 2011). This is a dangerous limitation because it has the potential to dehumanize those suffering from posttraumatic stress and treat them as a checklist of symptoms as opposed to a human being experiencing a significant amount of stress, anxiety, and a host of other negative cognitions. However, this limitation can be kept in check through open communication between patient and clinician by employing the holistic treatment methods that have been discussed. The last press limitation of posttraumatic stress disorder as a medical issue is the emasculating effect it sometimes has for males that have been diagnosed. As mentioned at the onset, post-traumatic stress disorder is a life altering mental health disorder that is experienced by 13 million veterans

and rising (PEEROnline, 2013). By medicalizing PTSD, we have given those that suffer an opportunity to obtain explanations, treatment and social connections with other victims and members of their community. As a consequence, we have given those with PTSD the power to understand that what they are experiencing is not a fault of their own and does not dictate their entire future. By acknowledging such a significant part of our society, we can empower them and help facilitate them on their road to recovery, thus strengthening the fabric of American community. As can be seen, with all things positive there are some limitations that to keep it from being an overwhelming success. However, with the medicalization of PTSD, its limitations do not invalidate its necessity. Although it is hard to look at a mental health condition like posttraumatic stress disorder and argue against it being a medical issue, there are still arguments that attempt to make this case.

Conclusion & Call to Action

The medicalization of posttraumatic stress disorder as a mental health condition that had been previously considered a “non-medical” issue is an extremely controversial course of action. However, when the voices of those that suffer and their caretakers unite, their merit cannot be ignored for long by the medical healthcare professionals and academics alike. After its medicalization, we have been able to produce more effective treatment methods than ever before due to a development of better modern theory, protect and provide for those who serve and have served through legislative efforts, and witness a shift in society from ignoring this mental health condition to making significant strides towards representation, awareness, and a hope for future progress. For posttraumatic stress disorder, the benefits of medicalization far outweigh the proposed limitations and counterarguments offered. As we continue to see great strides made in a field oriented at removing the debilitating level of anxiety, stress, and other pathological

symptoms of this mental health condition from our veteran's lives, we continue to do our part by serving those that have served us.

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