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MEMORANDUM FOR Commandant, USASMA, Fort Bliss, TX 79918-8002


1. Thesis Statement. Post Traumatic Stress Disorder (PTSD) can occur in veterans, regardless of exposure to various combat environments.

2. Discussion. Veterans throughout the history of U.S. warfare display the symptoms and characteristics of Post Traumatic Stress Disorders. Prior to 1980, victims of this disorder suffered from various types of combat stress. Studies focusing on Vietnam and Persian Gulf War veterans provides the basis for current findings.

3. Conclusion. Throughout our history, PTSD evolved from complete dismissal to a significant problem. The effects of combat is the overwhelming cause of PTSD. Veterans suffer the life-long effects associated with the manifestation of PTSD symptoms following service. Post Traumatic Stress Disorder can occur in veterans, regardless of exposure to various combat environments.

4. Haines Award. I do not request that the Haines Award Selection Board consider this paper for the General Haines Award for Excellence in research. Writing Research Papers, Seventh Edition by James D. Lester, is the guide used in the preparation of this paper.

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Stress: A Study of Post Traumatic Stress Disorder in the Military

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Outline

Thesis: Post Traumatic Stress Disorder (PTSD) can occur in veterans, regardless of exposure to various combat environments.

I. Overview of Post Traumatic Stress Disorder
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Stress: A study of Post-Traumatic Stress Disorder in the Military

Post-Traumatic Stress Disorder (PTSD) can occur in veterans, regardless of exposure to various combat environments. This study shows how prevalent Post-Traumatic Stress Disorder is among veterans, using examples from World War I, World War II, Korean conflict, Vietnam War, and the Persian Gulf War. For better understanding, one must explore the evolution, symptoms, characteristic, and the classifications of Post-Traumatic Stress Disorder.

Some researchers in the psychiatric field do not agree that soldiers can contract Post-Traumatic Stress Disorder from exposure to traumatic events. Some researchers argue that predisposition, in which a soldier possesses existing psychological conditions prior to the traumatic exposure contributes to contracting Post-Traumatic Stress Disorder.

Robert and Dana Saparstein point out, "America and its service members once again adjust to a period of peace following the rigors and pains of war. It would do all well to purposely plan to accommodate the almost certain appearance of, what is called Post-Traumatic Stress Disorder" (54).

"The common perception during the Civil War era," as Robert and Dana Saparstein say, "is to expose the unfit soldier to a good dose of battle" (55). They also state in their article, which explains the characteristics of Post-Traumatic Stress
Disorder, that “during the Civil War years, British and Russian medical scholars classified Post-Traumatic Stress Disorder as a disease of the soul” (55). “Soldiers unable to perform their duties because of exposure to a traumatic event were shot for cowardice” (55). Soldiers who did not fit the “criteria of a hero became outcasts, not victims” (55). They also classified neurasthenia (nervous breakdown) and war neurosis (nervous disorder) for Post-Traumatic Stress Disorder (56).

British and American medical scholars classified Post-Traumatic Stress Disorder during World War I. Wilber Scott states: “The classification used for Post-Traumatic Stress disorder was shell shock to denote the dazed, disoriented state many soldiers experienced in combat, attributing this condition to physiological damage caused by exploding artillery shells” (596).

During World War II, military authorities conducted pre-induction psychiatric screening. The program attempted to reduce the amount of possible psychological casualties. The program failed because the military screened out more men than those drafted into the military. Some of the men (combat veterans) who passed the screening test already suffered from Post-Traumatic Stress Disorder. T. A. Rennie said, "This is especially important when one considers that in 1943-44 about 45 percent of all medical discharges (or 9,000 of 20,000 men a month) were for neuro-psychiatric reasons" (31). World War II brought about new
concepts and ideas. Robert and Dana Saparstein state: "The psychiatric community classified Post-Traumatic Stress Disorder as *Battle Stress, Battle Fatigue, Combat Exhaustion,* and *Acute Combat Reaction* as the official titles for war-induced stress disorders" (56).

In 1952, the American Psychiatric Association published the first Diagnostic and Statistical Manual of Mental Disorders (DSM I), which classified and defined Post-Traumatic Stress Disorder as *Gross Stress Reaction.* Charles Figley states that the *Diagnostic and Statistical Manual of Mental Disorders I* defines this as "situations in which the individual ...had...been exposed to severe physical demands or extreme emotional stress including combat situations" (xvii). The military officially adopted the classification system in the *Diagnostic and Statistical Manual of Mental Disorders I.*

The Korean conflict brought about new attempts at combating Post-Traumatic Stress Disorder. First, the Army initiated a rotation system where soldiers would rotate into the combat zone; then leave after accumulating a set number of points, thus limiting the exposure to combat. Second, military psychiatrists received assignments to forward treatment facilities where they could return the soldier to duty soon after treatment. Although this was a program designed to reduce the effects of this disorder; it turned out to be the forbearer of the combat stress control program used in the military today. Nancy Howell-Koehler
states: "A breakdown in combat effectiveness was dealt with in a situational manner" (17).

Charles Figley found that "the Diagnostic and Statistical Manual of Mental Disorders II published in 1968 dropped the Gross Stress Reaction title and replaced it with Adult Adjustment Reaction which means fear associated with military combat manifested by trembling, running, and hiding" (xvii). There was no scientific basis for this change as there was no war between the release of the Diagnostic and Statistical Manual of Mental Disorders I and the Diagnostic and Statistical Manual of Mental Disorders II. The amount of research conducted during this time did not support the change.

Because of the Vietnam conflict and problems experienced by veterans, the American Association of Psychiatry, in 1980, published the Diagnostic and Statistical Manual of Mental Disorders III. This edition adopted the term Post-Traumatic Stress Disorder as the official title.

Throughout our military history, Post-Traumatic Stress Disorder evolved from complete dismissal to a significant problem for veterans. To understand the concept and the significance of this problem we must recognize the characteristics and symptoms of Post-Traumatic Stress Disorder. Delores Kuenning advocates, "It should be remembered that it is not a mental illness; it is a reaction to the extreme stress" (49). "Veterans do not contract PTSD by pre-disposition," says Mathew Friedman, "or individual
weakness" (1). Friedman argues that "Post-Traumatic Stress Disorder is contracted from the exposure to a traumatic event, which is outside the range of usual human experience" (1).

Robert and Dana Saparstein explain that a "trigger or stressor event is one that is markedly distressing to almost anyone and is usually experienced with intense fear, terror, and helplessness" (57). They also found that "symptoms are self-perpetuating and the victim spirals through a pattern of intensifying symptoms; physical pain, emotional discomfort which trigger visual images (flashbacks)" (58). People who experience these symptoms release feelings associated with the original event. When the person experiences the original event, the whole event and associated emotions start into motion. All of these characteristics occur after the soldier leaves the combat zone. Not all soldiers experience Post-Traumatic Stress Disorder. Friedman states: "The capacity to cope with catastrophic stress can vary between individuals because of individual traits" (1).

One distinct characteristic of Post-Traumatic Stress Disorder; soldiers, while in combat, do not allow themselves to grieve until leaving the combat zone, or they push their emotions to the back of their minds and ignore them. Soldiers automatically created this habit while in the combat zone. The soldiers carried this habit to a non-combat area and eventually home. Robert and Dana Saparstein state: "Once the intense external pressure to survive is removed, it may be some time
before the door to the mind's dark closet cracks open under the internal pressure of all the suppressed emotion related to the war trauma" (59). The delayed part of Post-Traumatic Stress Disorder comes into play when this happens.

United States Army Field Manual 22-51 does not use the label Post-Traumatic Stress Disorder while the soldier is in the combat zone because Post-Traumatic Stress Disorder is a delayed reaction to the traumatic stressor.

What do we look for when we deal with Post-Traumatic Stress Disorder? Robert and Dana Saparstein place symptoms into three clusters: First, is the "reliving of the event manifested by nightmares, flashback episodes, intrusive or vivid images, recollections, and intense emotional distress when exposed to situations that symbolize the trauma"; the second cluster is "characterized by a numbed emotional state, a generalized detachment, an extreme avoidance of activities, and thought associated with the shock"; the final cluster is "characterized by what is called hyper-arousal, which includes difficulty sleeping, irritability and hostility, difficulty concentrating and hyper-psychological (paranoia) response when exposed to events that symbolize aspects of the trauma" (58).

The Diagnostic and Statistical Manual of Mental Disorders IV, published in 1994, agrees with these symptoms and dictates diagnostic criterion for Post-Traumatic Stress Disorder. Furthermore, the manual "classifies Post-Traumatic Stress
Disorder as acute if duration of symptoms are less than three months, chronic if duration of symptoms is three months or more, and delayed onset if onset of symptoms is at least six months after the stressor" (429).

We covered to this point, the evolution, symptoms, characteristics, classification, and conceptual knowledge needed in understanding Post-Traumatic Stress Disorder. Now we must ask, how prevalent is Post-Traumatic Stress Disorder in veterans?

In previous combat environments, soldiers deployed and redeployed as units, which provided for cohesion and mutual emotional support. Soldiers, according to Nancy Howell-Koehler, "reworked the especially traumatic episodes" (20), or vented their grief, which brought about closure. The Vietnam soldier deployed alone and returned alone; without the emotional support of comrades. The transition from the combat zone to the non-combat zone was 36 hours or less. Discharge from the military occurred within days. The soldier had little time for readjustment from combat. The World War II soldier had weeks with unit members during the transition.

In 1990 the Veterans Administration conducted a National Vietnam Veterans Readjustment Study which revealed that Post-Traumatic Stress Disorder affected a larger percentage of Vietnam veterans than most other combat veterans in history. The results show that 15 percent of the 3.1 million men and women involved in Vietnam now have Post-Traumatic Stress Disorder. A stunning
107,000 veterans effected by Post-Traumatic Stress Disorder live in the western United States. These numbers include those receiving treatment for Post-Traumatic Stress Disorder.

Herbert Hendin and Ann Haas conducted extensive research and state:

Vietnam veterans experienced trauma to a degree unparalleled in our earlier wars. Combat in Vietnam involved the killing of women, children, and the elderly: some of whom were armed fighters, some of whom were killed inadvertently, and some of whom were killed in retaliation for deaths caused by their countrymen. The Vietnam conflict caused more soldiers to suffer from Post-Traumatic Stress Disorder due to the nature of the combat. Post-Traumatic Stress Disorder is likely to be frequent among soldiers exposed to combat in any war. The psychological consequences of a war fought where number killed, rather than territory won was the prime objective is enormous. (4)

Margaret Benshoof-Holler states: "The average age for those who went to Vietnam was 19.2 years" (18). Dr. Francis Abueg, a research clinical psychologist at the National Center for Post-Traumatic Stress Disorder says, "It was the youngest war ever fought" (18). World War II soldiers averaged 26 years old. For a young man to cope with seeing his buddy, whom he developed a close relation with, get his head traumatically amputated or his
torso cut in half by enemy fire can be extremely traumatic. Although, what soldiers experienced in Vietnam happened to soldiers in other wars, the overall psychological affects were much greater because of the average age. The minds of young people are not fully developed. Young people are still evaluating values and beliefs, evaluating the world around them, and deciding on a course or path to follow. The harshness and horrors of war catch them unprepared. War is hell, but the horrors of the Vietnam War compounded the psychological effects because of the nature of this type combat; a type of combat where women, children, and old men suffer worse than the enemy soldier. This type of combat creates extreme feelings of guilt which young soldiers could not deal with. This guilt may carry through life. Combat causes many young men, 18-20 years old, to grow up fast and exposes them to the type of brutality existing in a persons worst nightmare. For a lot of young men fresh out of high school, Vietnam was their first trip away from home. Soldiers adopted methods of coping to deal with the atrocities and death. They dismissed reality and labeled death in a way that they could relate to. Benshoof-Holler quoted Edward "Robbie" Robinson referring to dying as, "Blown up,...blown away,...get smoked,...get waxed,...get dinged,...get danged. Nobody ever died in Vietnam. That's how we coped" (30).

Vietnam veterans talked about incidents that contributed to their contracting Post-Traumatic Stress Disorder. Margaret
Benshoof-Holler published one such account in her article. She recalls the words Robinson heard while leaning over a 19 year-old kid with a chest wound received in combat near the Demilitarized Zone (DMZ); "Don't let me die! I want my mom!," the young man cried (7). Robinson, of the third Division, 9th Marines, knew that there was nothing he could do. So he cradled him in his arms, gently murmuring, "It's okay. Mom's here" (7). "When the boy died," says Robinson, "the best part of me died with him" (7). "To this day, I tell my wife, and she understands it, that I can never be close to her in an act of love the way I was holding that kid in my arms" (7). For many veterans like Robbie, they can tell the same story time and time again. Recalling the brutalities, Robinson remembers "a buddy blown to pieces by a booby trap can stir up flashbacks so real that you can smell the gun powder, the death, the decaying bodies, the jungle" (7). For these veterans, the war is not over. Post-Traumatic Stress Disorder helps it linger without end.

During the interview, Robinson digressed to January 1969. He is actually reliving the war in his mind. Benshoof-Holler relates the experience, "Artillery...you can hear it way up in the mountains, B-o-o-m! B-o-o-m!, then you start looking because you have got maybe three, four seconds to run before it lands" (12).
Benshoof-Holler tells a story of memories recalled by Robinson:

On a reconnaissance mission, walking through the jungle in the steamy heat; suddenly, the guy 50 or 60 yards ahead steps on a booby trap. You get his brains and his body matter sprayed onto your shirt. You spend a half-hour making out a casualty report and trying to put what’s left of his pieces of flesh into a sandwich bag. In thirty minutes, the chopper is going to come. The troop is going to move out again. Maybe next time, you will walk into an ambush, you just never know. All these things are going through your head, but the consistent thought is, I’ve got to stay alive because I am no good to myself dead, and I am certainly no use to my friends if I crack under pressure. (12)

Traumatic experience in combat holds the memory in a state of arousal. Natural protective mechanisms that normally occur during sleep repress these memories; however, its failure will trigger the trauma and bring out the memories of the traumatic experience. The veteran begins to ask the question of whether or not he is responsible for his buddies’ injury or death.

Unlike the Vietnam War, Persian Gulf veterans did not experience the multitude of horrors or traumatic stressors; nevertheless, the symptoms of PTSD our personnel suffer from are numerous. Our country sent 697,000 troops to the Persian Gulf
during a 5-month build-up period in August 1990. This period preceded a 39-day air war and a 4-day ground war in February 1991. Additionally, hundreds of thousands of forces spread around the world stood ready for deployment.

The United States and its allies won the Persian Gulf War with relative ease and far fewer casualties than expected. We sent our forces to a hot and bleak desert environment where initial superiority belonged to the Iraqi Army. Despite a "4-day war" our troops spent months isolated in the desert, under constant stress, with no idea of when they would return home. Steven Hobfall affirms that negative psychological effects may develop in individuals because of the stress of war, family disruption, and financial difficulty (852). A Robert Stretch article identifies the most prevalent non-combat stressors: waiting for deployment, operating in desert climates, long duty days, physical workload, crowding in base camps, and lack of sleep (409). He cites the most critical combat stressors associated with PTSD symptoms as follows: threat of terrorist or scud missile attacks, exposure to dead or decomposed bodies, threat of enemy chemical weapons, artillery fire, and exposure to American soldiers killed or wounded (410). The PTSD rate for members of deployed reserve units show significant increases due to other factors. Stretch specifies that lack of psychological preparation for deployment, greater exposure to life trauma in
general, and first time deployment of reserve forces since the Korean conflict served as compounding negative stressors (409).

The effects of prior war experience also increases the risk of PTSD and its symptoms. James McCarroll determines that the Vietnam veteran serving in the Persian Gulf era has a statistically greater ratio (1 in 4) of suffering from PTSD than any other veteran (682). He finds that Vietnam veterans comprise 35 percent of all medically retired soldiers for PTSD between October 1990 and July 1994 (683). McCarroll also notes that one-half of these veterans developed PTSD symptoms prior to deployment to the gulf region (684).

One source reveals that 19 peer-reviewed scientific journals completed studies on PTSD in Gulf War veterans; but the overall number of studies conducted is extensive (Haley 696). A number of the most accurately accepted diagnostic tests served as the measures. These tests include a variety of population or unit based samples, various comparison groups, number of participants, and PTSD defining methods. In an overview, Robert Haley shows that Post-Traumatic Stress Disorder rates may vary from 0 to 36 percent (695). His discussion indicates high rates of PTSD and higher PTSD-related symptom scores in “deployed” versus “non-deployed” veterans (699). Haley specifies that veterans exposed to stressful war-zone experiences, such as combat, have higher PTSD rates (699). He also believes that a large number of
veterans are at great risk from suffering or unknowingly suffering from PTSD symptoms (699).

Lieutenant Colonel Robert Stretch is responsible for one of the largest studies. He assesses over 16,000 active duty and reserve personnel from all branches of service who reside in the states of Pennsylvania and Hawaii (407). He applies the same general demographic data to two groups and classifies them as "deployers" and "non-deployers" (408). The average age is 30, with 98 percent having a high school education, 87 percent enlisted, and 51 percent married (408). This study indicates PTSD symptom diagnosis for active duty "deployers" at 8 percent and 1.3 percent for "non-deployers" (409). His findings for reserve personnel are 9.2 percent for "deployers" and 2.1 percent for "non-deployers" (409). Two study groups used for comparison consist of approximately 5,000 active duty soldiers from the XVIIIth Airborne Corps and 6,000 from the VIIth Corps. He reports PTSD prevalence rates among "deployers" as 15.5 percent and 12.9 percent, respectively (409). He reports a "non-deployer" rate for the same units as 6.6 percent and 3.6 percent, respectively (409). This study identifies that the majority of the "deployers" from Pennsylvania and Hawaii are support personnel, and those from the XVIIIth and VIIth Corps are combat arms personnel (409).

Another of the more recent studies conducted by the Iowa Persian Gulf Study Group evaluates approximately 29,000 veterans
from the state of Iowa. This test affirms the prevalence of PTSD symptoms with statistics of 19 percent for deployed personnel and 11 percent for non-deployed personnel (243). The study also indicates a larger difference favoring active duty personnel and affirms that "all" deployed personnel experienced an increase in the presence of PTSD symptoms (245).

A review of numerous studies on reserve units with smaller personnel numbers deployed than non-deployed reveal similar but reduced statistics. In one study, David Holmes finds "elevated Post-Traumatic Stress Disorder rates in 6.8 percent of those deployed and 1.7 percent of those non-deployed" (172). He states that these numbers dropped "due to lower levels of combat stressors, perceived public support, and strong family base" (173).

Multiple sources and numerous studies point to personnel assigned graves registration duty as the greatest PTSD at-risk group. McCarroll determines in a study of "116 who did" and "118 who did not" handle human remains that the variance in symptoms is negligible (1876). He also specifies that those inexperienced at handling remains, whether they did or not, experienced more symptoms (1876). He examines those exposed and non-exposed to war and indicates a wider variance in symptoms; however, this difference does not significantly reduce the number of personnel at-risk (1877). In a similar study, Patricia Sutker finds that 48 percent of mortuary workers who deployed met criterion for
PTSD and show a lifetime prevalence rate of 65 percent (165). Her studies state: "The psychological aftermath of war-zone participation involving the gruesome task of handling human remains is profound" (169).

In a 1996 study, Hyams states: "Clinical evaluations of more than 80,000 Persian Gulf veterans identifies symptoms of PTSD in 15 percent of the population" (401). This may not seem alarming; however, the delayed manifestations of symptoms that appear later in life cause concern. Three separate studies show an increase in Post-Traumatic Stress Disorder rates during post-war follow-ups. Labbate and Snow affirm that members of a mechanized infantry company that sustained four friendly fire deaths have PTSD symptom rates which increased from 24 percent to 39 percent since the war (832). Southwick indicates that deployed reservists exposed and non-exposed to combat experienced increases in PTSD levels, with hyperarousal being the most elevated (1526). His two-year follow-up conducted in 1995 proves continuation of this trend and shows no decline of symptoms in those already diagnosed (1528). Sutker cites in a study of 215 reservists that between 16 to 24 percent exhibit increased levels of PTSD since their return (46). In a 1997 study of combat-exposed veterans, Dewleen Baker states: "Not only have we failed to find a decrease in the level of PTSD symptoms, we found an overall increase of reported symptoms linked to combat exposure"
Baker also cites, "Of concern is that once symptoms are present, they do not appear to readily resolve" (2077).

Is the Gulf War Syndrome (GWS) a physiological or psychological disorder? That question remains unanswered at the present time. Recent studies indicate a connection between somatic symptoms associated with previous war-related psychological disorders and GWS symptoms. Hyams specifies that "GWS symptoms match 9 of 13 common stress-related symptoms associated with other diagnosed war-time stress disorders" (399). Although debate rages on, the importance of this connection is the potential diagnosis of PTSD in a greater number of veterans.

Whether the number of Persian Gulf veterans at risk for the development of PTSD increases or decreases remains with the passage of time. Robert Stretch states: "That with current military downsizing, higher tempos of operational deployments, numerous peace-keeping missions, and constant stress of preparing for war-time contingencies we must prepare to handle the potential increase of PTSD in the lives of our veterans" (409).

In life, we face stress every day. These stresses can come from sitting in a traffic jam when late to work, a family dispute, or many other occurrences that cause us to change our thoughts and actions. These daily minor encounters will not cause us to develop Post-Traumatic Stress Disorder. Post-Traumatic Stress Disorder grows from events that have caused very severe stress.
Certain occupations expose its employees to acts of violence and trauma. Some of the most common jobs or professions are: military forces, police, firefighters, physicians, and other emergency response personnel.

Ellen Gerrity Ph.D., of the National Institute of Mental Health, explains this by saying, "Although PTSD was first brought to public attention by war veterans, it can result from many kinds of traumatic incidents. Millions of other Americans who have experienced natural and human-caused disasters, child or spouse abuse, rape, or other dangerous crimes, as well as people who witness such trauma to a loved one, also suffer from this condition" (10-11).

Not everyone that has one of these experiences will develop PTSD. However, they do fit the category of a person that has been predisposed to a severe trauma. This theory of predisposition means that a person is more inclined to suffer from PTSD after another serious event, such as military combat. Many health professionals continue to research this theory.

David V. Baldwin, Ph.D., conducted several studies in the area of PTSD. His research indicated that people who have experienced a traumatic event earlier in life are at more risk in developing PTSD. He states: "There is also evidence that early traumatic experiences (i.e., during childhood), especially if these are prolonged or repeated, may increase the risk of developing PTSD after traumatic exposure as an adult" (2).
Baldwin attributes this to "the way younger people deal with stressful occurrences or situations" (2).

Another study conducted by a team of researchers found that victims of PTSD also had a high rate of truancy, vandalism, alcohol use, and running away from home before the age of 15. They termed this as antisocial behavior and linked this with childhood problems (Helzer, Robins, and McEvoy 1632).

At this time, there are no screening methods to test for predisposed trauma in any new military applicants. This has been the case for many years. This debate has been going on since at least World War II. The book Stress Disorders among Vietnam Veterans gives a quote from a report (Neuropsychiatry in World War II) in which the Inspector General's office states: "If screening is to weed out all those likely to develop a psychiatric disorder, all should be weeded out" (12).

If the military reinstates the draft, this screening process could result in disqualifying persons from being accepted for military service. The added cost for a psychological evaluation for each applicant would greatly increase the overall cost for screening military applicants.

There is another side of this argument. We addressed how veterans of previous conflicts and wars suffered even more from PTSD. In this area, the military should conduct thorough research. The results could uncover a wealth of information concerning PTSD.
What are the chances of a person developing PTSD? The National Mental Health Association published a fact sheet with this information:

The chances of developing PTSD are as random as the chances of experiencing a disaster. The illness can develop in anyone... Different people will experience the same traumas differently. One person may develop PTSD after surviving a tornado, while his or her neighbor has no problem with the disaster. This also seems to be the case with some veterans of recent wars or conflicts. (7)

There are many studies ongoing to hopefully answer this and other questions about Post-Traumatic Stress Disorder. A study conducted by Herbert Hendin and Ann Pollinger Haas concluded that persons who have experienced traumatic events of war, but did not develop the symptoms of PTSD, share some of the same personality traits" (203-31). They all seem to have "strong leadership skills, the ability to function calmly under pressure, strong understanding and judgment, acceptance of fear in themselves and others, lack of excessive violence, and absence of guilt" (203-231). When closely examined, these traits lead to leadership skills that the Army tries to instill in every soldier.

David Baldwin is conducting a study on personality traits that may lead to new information about PTSD. He suggests that "persons who are introverted or shy may have stronger emotional
reactions and therefore are unable to deal with traumatic stresses" (2). This theory does not explain why every soldier with these traits does not develop PTSD and may only add to the controversy that surrounds this disorder. Current research seems to focus on treatment after the fact versus the pre-determination of persons who are more prone to developing PTSD.

The last area to address is why PTSD and other psychological disorders are not only hard to define, but sometimes the diagnosis for PTSD crosses over into areas that share common symptoms. Orsillo says, "Part of the difficulty here is that the diagnostic criteria for depression and PTSD are very close. Both are characterized by loss of interest, reduced concentration, and difficulty in sleeping. This makes it difficult to tell whether PTSD really leads to depression or whether PTSD patients are just more likely to test positive in an interview designed to diagnose depression" (2). Orsillo goes further by indicating "that a wide range of psychiatric problems with different names all share similar criteria for diagnosis" (2).

The New England Journal of Medicine published an article in 1987 that says, "Eighty percent of people with PTSD had other psychiatric disorders as well" (Helzer, Robins, and McEvoy 1630). This article also supports the pre-disposition theory. Overall, PTSD is a severe anxiety disorder. It can cause psychological and physiological disruption to the individual and their families. As with many psychological disorders, there are many
theories that contradict each other and show no concrete guidelines for diagnosis or prevention. Health care professionals must complete and agree upon research findings or this dilemma will continue.

The real dilemma is; it took almost two-thirds of a century to recognize that “shell shock” is a psychological, rather than a physiological, condition now known as PTSD. The psychiatric community officially recognizes this disorder. A major reason for the delay is the argument for pre-disposition; however, research suggests it is the nature of the trauma (much like war), its immediate impact on the victim, and subsequent psychological effects on the victim that over-rides such theories.

War is a unique experience with psychological effects on those engaged in combat and those threatened by possible combat. Many professionals question the research methods used and claim differences in measuring procedures, sample composition, or timing of assessments alter the outcome of such studies. Several conclusions from Jessica Wolfe of the National Center for PTSD are important. She states: “Even brief or circumscribed war-time deployment is associated with increases in general distress and PTSD symptoms” (2). Also cited is the “intensity of exposure (combat exposure or preparedness) with psychological outcomes” (2). Third, is the failure of PTSD symptoms to diminish, especially when the “exposure is intense, gruesome, or lengthened by time” (2). Finally, she points that “there appears to be a
layering of risk factors, whereby more inexperienced personnel and tasks involving involuntary exposure are strongly associated with event severity" (2).

The United States Armed Forces initiated prevention measures for managing operational tempo and monitoring deployed forces in Bosnia, and around the world, in an effort to battle PTSD and minimize its effects. Their actions recognize military downsizing, reserve deployments, and operations other than war as precursors to the full-blown display of stress-related disorders. As a nation we must recognize that Post-Traumatic Stress Disorder can occur in veterans regardless of exposure to various combat environments, and we must prepare military and veteran resources to handle the increase of this disorder.
Works Cited


