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The Social Progression of Post-Traumatic Stress Disorder: Post Vietnam and September 11th Attacks

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The Social Progression of Post-Traumatic Stress Disorder: Post Vietnam and September 11th Attacks

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Graduation Spring 2017
The Social Progression of Post-Traumatic Stress Disorder: Post Vietnam and September 11th Attacks

Ellie McDonald
California State University Monterey Bay
Dedicated to Bub for teaching me what honor, courage, and commitment means, all the service members who have bravely fought the good fight, pray you all find your peace. To my amazingly awesome daughter, who continuously encourages and inspires me to be the best version of myself. My loving husband who would never let me quit on my dreams and my family for their constant support. The SBS department and all their professors who continuously go above and beyond for their students, every one of you are appreciated and I am proud to have studied under your teachings.

THANK YOU.
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ABSTRACT

The Social Progression of Post-Traumatic Stress Disorder Post-Vietnam and September 11th Attacks is an examination on the infrastructure of the U.S. Department of Veterans Affairs’ and of the Department of Defense’s lack of clarity and misinformation of the challenges and effects of mental illness within military ranks. Post-traumatic stress disorder (PTSD) made the Diagnostic Statistical Manual (DSM) after Vietnam. Since then, PTSD has been reevaluated numerous times, to properly define it. This research is a comparative analysis of the misconceptions of PTSD as experienced by Vietnam veterans and the first responders of the September 11th tragedy. My research charts the social progression and breakdown of the negative attitudes and concerns of PTSD pre-, during, and post-deployment statuses and how stigma acts as a deterrent to mental recovery. This research was conducted with as sample population of 324 randomly-selected participants, ranging in age, background, location, and race. The research data analysis indicates a dramatic shift in modern social acceptance of PTSD in comparison to the Vietnam era, indicating that the symptoms of the condition have not changed, but that societal conceptions and expectations surrounding it have. This research will specifically analyze American culture has created social constructs around the symptoms of PTSD, enabling the disorder to worsen for many people, and even supporting discrimination and stigma for this sub-community. This research suggests that PTSD has socially progressed, but remains consistent biologically as a mental condition.
“He who did well in war just, earns the right to begin doing well in peace.”

-Robert Browning, Luria

**INTRODUCTION**

This is a comparative study of the historical impacts that Vietnam had on the American schools of psychology and psychiatric medicine. This study is analyzing the social conflicts of the returning combatants, who would come to experience and publicize the most common form of mental illness found in the military, Post-traumatic stress disorder, (PTSD) and Traumatic Brain Injury (TBI). Furthering current research on how Vietnam is still manifesting psychiatric casualties within military culture today, and what impacts this may have on the current state of war, post-September 11th attacks. Proactively sifting through the cause and effects of stigma of PTSD, specifically, pre-, during, and post-deployment. Tracking the social progression of PTSD post-Vietnam and September 11th. This study was guided by a series of overarching questions:

- **Prevalence:** How did Vietnam change the parameters of PTSD and to what extent were the effects post-September 11th for the mental health of combatants and their re-integration to civilian life?

- **Effects:** What was the social progression and change in social constructs surrounding PTSD since the Vietnam War, and what does this mean for our combatants?

- **Causation:** What charges the social constructs of PTSD, what is the diverting root of stigma of PTSD?

As defined in the Diagnostic and Statistical Manual of Mental Disorders, post-traumatic stress disorder is “a reaction to a psychologically traumatic event outside the range of normal experience” (Grossman, 2009). Manifesting PTSD symptoms include recurrent, involuntary, and intrusive memories, traumatic nightmares, dissociative reactions (flashbacks) and even complete loss of consciousness, intense or prolonged distress after exposure to traumatic reminders, and marked physiologic reactivity after exposure to trauma-related stimulus (Grossman, 2009).
When looking at repercussions of PTSD primarily within the military, there is a consistent and well-known difficulty for soldiers to adjust back into civilian life, especially when managing a disorder. This inability to find stability leads to increasing military unemployment and divorces rates, promoting issues of alcoholism, domestic violence, social withdrawal, and homelessness. Amongst these variables, there is also a public stigma, with a negative perception of moral or mental weakness. Stigma towards mental health is still very relevant in the whole of modern Western culture, but this research is specifically targeting the effects within the United States military. Almost half of active military personnel are functioning with a mental illness, and the most common is PTS, and PTSD (Grossman, 2009).

Post-traumatic stress and Post-traumatic stress disorder in military individuals, as it is typically characterized, is the repercussion of time spent in war. Studies have shown that less than half of service members sought out help for their illness when they returned to civilian life, which can ultimately cause concern for operational effectiveness (Jankovic, et. Al, 2005). With stigma, there are three main concepts. The first is the public stigma that exists on mental health issues, which entails the ideas, beliefs and expectations that an individual believes another person holds about mental illness. The second is the attitude of service members towards receiving mental health professional care, treatment and services. Lastly is organizational stigma that causes a lack of trust and confidence in mental health providers, and the expectations to meet specific behaviors (Psychiatric Services: Vol 61, No 6).

_The bravest are surely those who have the clearest vision of what is before them, glory and danger alike, and yet notwithstanding, go out to meet it._”

_-Thucydides_
LITERATURE REVIEW

The Vietnam War impacted thousands of individuals, not only on the literal battlefield, but also psychiatric warfare. For many sufferers of PTSD the mental ramifications of trauma lasted for decades, and new discoveries regarding war trauma are still being made. The nonfiction book *40 Lessons Unlearned About War and its Impact from Vietnam to Iraq* by Raymond Scurfield introduces research regarding how a “lifetime” of psychiatric and psychological disorders and damage impact veterans on a daily basis, and how this war trauma has grown significantly, instead of decreasing. However, Scurfield’s research notes that the true impacts of both wars remain the same. When comparing 1954-1975 warfare to Iraq and Afghanistan warfare, physiological and physiological psychiatric Casualties experienced both generations of combatants line up perfectly (Scurfield, 2006). However the public perception, or defined “societal concepts” do not prove to be as timeless. There are multiple myths and realities that are misunderstood and misinterpreted about war and its lasting impacts. These myths are decades of compounded challenges that military personnel and their families endure. Some of these myths include: “time heals all wounds,” “I must be crazy or weak to still be bothered by war after all this time,” “I can’t move on from war, so I can’t move on with my life,” and “coming home will fix everything.” In addition, Scurfield states that modern government policies dealing with veteran’s affairs and finances could use serious improvement. When budgeting is constricted, it is the veteran medical and health benefits that are some of the first to be cut. Furthermore, there is an underlining financial rewards system of power in place that actually profits from veterans having psychiatric illnesses. This system will ultimately cut veterans off
from government funded income supplements, if they psychologically improve.

Sculfield continues: for Vietnam veterans to first qualify for financial and health benefits, they must prove they are not psychologically sound. Essentially, the system encourages the significant increase in veteran’s mental health, and forces them to cope and maintain their PTSD diagnosis, rather than successfully overcoming it (Scurfield, 2006). Some veterans chose to misuse the benefits and services by claiming a factitious case of PTSD. *The Invisible Wound of War a diagnostic Psychological and Cognitive Injuries, Their consequences, and Services to Assist Recovery* discusses these cases (Tanielian & Jaycox, 2008). Many individuals that walk into the Veterans Affairs seeking services and health benefits, may in fact have some form of PTS, PTSD, or experienced TBI. However, the question raised is, does the Veteran Affairs conduct psychometric testing on every individual who claims to experience some form of depressive anxiety disorder? The reality is more times than not, the Veteran Affairs do not conduct efficient testing, making it possible for someone to memorize the stressors and triggers of PTSD and play the part during the screenings.

Cases of fraud have led to the assumption amongst mental health professionals that displaying consistent textbook symptoms of PTSD is a red-flag of a factitious case of PTSD. The growth of Veteran Affairs PTSD cases has grown fivefold within the last thirteen years. The incentive for being a veteran with a PTSD diagnosis is the compensation of $1200 - $3000 a month in income. A psychologist from the study stated that “it’s become very apparent that a large proportion of the VA’s clients are malingering.” The issue lies within the difficulty that mental health professionals face in assessing PTSD cases; the symptoms vary depending on each individual and PTSD is constantly changing. Some may report crippling depression and anxiety
where others have high episodes of energy or aggression. Some preventative measurements taken for malingering individuals is a three course test that is structured to detect highly unlikely response patterns. This response pattern will determine if the patient was exaggerating symptoms (Tanielian & Jaycox, 2008). However the flaw to this test is the high occurrence of PTS. Post–Traumatic Stress is very similar to Post-Traumatic Stress Disorder; both include heightened alertness, reoccurring flashbacks, and inability to concentrate.

However PTS is not a mental illness, and is very common and typically cycles for only a few days. PTSD symptoms are more severe, cause social withdrawal, and can last up to a few years, in extreme cases. Currently, the Veteran Affairs is doing all that it can to differentiate between factitious and actual accounts of PTSD. However there will always be those who abuse the system (Tanielian & Jaycox, 2008).

In the academic analysis of PTSD, Vietnam veterans are unique cases; they were first of their kind. These veterans have fought in a war unlike any other war in American history. This was largely because it was not mainly a war between armies. The major enemy for the United States was a guerrilla organization that did not fight traditional battles. The United States was fighting in a friendly country, trying to destroy an insurgency. In addition to this, the Vietnam War was protested by a large population of Americans. Upon returning home, the soldiers were not welcomed and were labeled “baby killers,” “murders,” “monsters,” and so forth. The loss of life among civilians in Vietnam is estimated to be from 2.4 to over 3 million—and at least 300,000 are still unaccounted for (Marmar, Schlenger, Henn-Haase, Qian, Purchia, Li M, Corry, Williams, Ho, Horesh, Karstoft, Shaley, Kulka, 2015). Lastly, long-term studies on Vietnam veterans found that PTSD symptoms did not decrease over their
lifespans, but significantly increased and worsened. Their symptoms seemed to be provoked and worsened by loss of employment or retirement benefits, health problems, family and friends aging or dying, lack of finding meaning in life, and substance abuse (Marmar, Schlenger, Henn-Haase, Qian, Purchia, Li M, Corry, Williams, Ho, Horesh, Karstoft, Shaley, Kulka, 2015).

What makes the Vietnam troops unique in comparison to current troops is the startling age difference upon deployment. Vietnam troops were significantly younger upon their war-deliverance than any other war in American history (Grossman, 2009). The average age of a soldier was eighteen years old, whereas, today the average age of a soldier deployed is between twenty-five to thirty-five years old. It is now rare for an eighteen year old American to see combat. However, in Vietnam, young boys saw immediate combat upon entry into the country; this was America’s first “teenage war.” These soldiers lacked wartime experience, psychological development, and maturity. Developmental and cognitive psychologists have concluded that the age of fifteen to eighteen is a crucial period for stabilizing one’s personality structure, and sense of self. These boys were delivered into a foreign and hostile environment with little to no mentors to guide them through warfare. Many of the officers present were not seasoned war vets, in comparison to today’s platoon leaders. Rather, immediate graduates from (OCS) Officer Candidate School, with only a few months more training than their fellow comrades, These soldiers were teenagers. They were teens leading teens into an endless catastrophic, horrendous war (Grossman, 2009).

“My God, what happened in Vietnam? Why do between 400,000 and 1.5 million vets suffer from PTSD as a result of that tragic war? Just what have we done to our soldiers?”

-Dave Palmer, Summons of the Trumpet
Effects of stigma:

The American Legion released an article discussing that there are thousands of service members arriving home from (OEF) Operation Enduring Freedom, and (OIF) Operation Iraqi Freedom with PTSD, PTS (Post-Traumatic Stress), and TBI (Traumatic Brain Injury). These mental conditions are standard and expected from exposure to combat; they are considered “signature wounds of warfare.” When analyzing the “signature wounds” of Vietnam and current veterans who have seen combat, research has shown that the symptoms and disorders of exiting servicemen are parallel despite the thirty to forty year gap between wars. This discovery implies that PTSD has not progressed in terms of its psychological, biological, and psychiatric damages (American Legion, 2013). Despite the increasing and staggering number of veterans functioning with TBI, PTS, and PTSD, there has not been an increase in adequate services to help alleviate symptoms and side effects. Since September-11th, there have been approximately 2.2 million service members deployed, with only 1.3 million returning (American Legion, 2013). Among the surviving servicemen and women, roughly half have enrolled for additional VA health care treatment. A debriefing and psychological screening upon their return home is required for all service members. However, these interactions only lightly screen for TBI, PTS and PTSD, and remain dependent on the honesty of the individual. The problem here is obvious: many are reluctant to fully disclose their mental conditions in the face of stigma, as well as anxiety to reunite with family and friends (The American Legion, 2013).

Stigma has grown tremendously within military communities. The causes of stigma are direct repercussions of stereotypes towards mental health. Doctors Gibbons, Miglior, Convoy, Greiner, Chiros, and DeLeon conducted a qualitative study to question the way
that stigma can prevent individuals from seeking mental health treatment by the fear of illuminating ones disability. Stigma has grown so large that many individuals have begun embracing it and accepting that they have an untreated mental illness. Gibbons, Miglior, Convoy, Greiner, Chiros, and DeLeon furthered their research primarily within the veteran’s community, analyzing and testing the ways that veterans are suffering mentally. Their interviews in 2014 showed that the amount of time it takes for the average veteran to seek professional help for PTSD can vary from between one year to several decades, the group of doctors had also began establishing precautionary steps and changes needed to be made by the medical community to adjust to this growing epidemic in order to make a more sound impact (Gibbons, Miglior, Convoy, Greiner, DeLeon 2014).

Aside from the stigma that remains commonplace within the world of medicine, there is also stigma that is affecting individuals within their own communities. This stigma affects the way mental disorders are viewed and perceived as well as the way the public and families embrace the ideas and stereotypes on mental health disorders. With these factors, it has created a large and strong barrier to individuals feeling safe and secure when seeking help (Britt, Greene-Shortridge, Castro 2007). In 2007, authors Britt, Greene-Shortridge and Castro went into depth on studying the effects stigma has on families, and those involved in military society (Britt, Greene-Shortridge, Castro 2007). What their studies showed is that stigma plays another role; alongside its typical behaviors, it also affects time spent overseas. Britt, Greene-Shortridge and Castro had found that stigma fluctuates depending on one’s deployment cycle (Britt, Greene-Shortridge, Castro 2007).

*Military Medicine* analyzed this finding more in depth. To do so, they began conducting individual studies on United States combat Marines. Marines were examined one month prior to
a seven month deployment to Afghanistan. The selected Marines were then examined again at one month, then at five months while overseas, then finally examined at their eighth month post-deployment. Post-traumatic stress disorder was also examined of the course of stigma, specifically analyzing the severity of the disorder before, during and after their deployment. What the study had found was that the perception of the stigma was stable throughout their deployment. However, it increased after they returned home. This method of looking at stigma as an assessed group provided a different understanding to the cause and effect of stigma, and how it carries over on deployment (Steenkamp, Boasso, Nash, Litz 2014). These results indicate that once the combatant is removed from the security of their unit, societal pressures and stigma impale them, and significantly increase the course of stigma (Steenkamp, Boasso, Nash, Litz 2014).

There is another large contributor to stigma that is found in the framework of military mental health treatment. It’s the effect it has on the individual. Stigma from within the military affects veterans; they feel much more stress and even a sense of constant anxiety or fear of losing their position or their job, if they admit they have a disability. Warner, Appenzeller, Grieger, Belenkiy, Breitbach, Parker, Warner, and Hoge analyzed the periods when individuals were debriefed or screened after deployment and found that the individual was only screened for symptoms of PTSD. Warner, ET. Al discuss how this assessment is extremely flawed because it’s dependent variable is one’s honesty of admittance and acceptance of the problem as well as the individuals only being tested for symptoms of PTSD and nothing else. The team decided to alter the assessments by applying the theory of creating a safe, anonymous environment in hopes that with anonymity, the combatant would feel comfortable enough to seek help. The results had a significant increase, concluding that an individual place into an anonymous environment is
more likely to comply with testing (Warner, Appenzeller, Grieger, Belenky, Breitbach, Parker, Warner, Hoge, 2011).

In contrast to previous methods, Di Leone, Wang, Sayer, and Pineles decided to analyze stigma’s affects in group and individual approaches, with a development and psychometric evaluation of the anticipated stigma inventory. Di Leone, Wang, Sayer, and Pineles concentrated on a new program that was created to serve multiple types of dimensions of stigma related beliefs on mental health, in the military and among veterans. Primarily, the individuals who had served in Operation Enduring Freedom and Operation Iraqi Freedom, which was the first set of American troops deployed to Afghanistan and Iraq after the September 11th attacks, were analyzed. In addition to examining the projected stigma, this study comparatively looked at discrimination against veterans, and the process of discrimination acting as a barrier for these individuals to obtaining help, even when some sought it out. Discrimination acted as a preventative measure, which was charged by fear of identifying under the umbrella of mental illness (Vogt, Di Leone, Wang, Sayer, Pineles, 2014).

“No event in American history is more misunderstood than the Vietnam War.

It was misreported then, and it’s misremembered now.”

-Richard Nixon

Methods of treatment:

An additional study was conducted with 6 male combat veterans with a positive PTSD diagnosis as well as their partners. PTSD symptoms not only affect those who have been diagnosed, but also those with whom they reside, most notably their spouse. This study reports the results on 6 heterosexual couples who have undergone cognitive-behavioral therapy in order to lessen the symptoms of PTSD and lessen the stress and anxiety associated with the
disorder. This study discusses the nature of cognitive-behavioral therapy and its association with positive relationship outcomes for those that are diagnosed with PTSD and undergo this type of therapy. Soldiers who have undergone this type of therapy have also reported a desire to include their families in their treatment. This inclusion may help to overcome the community-oriented stigma associated with PTSD treatment and the masculine behavioral norms that most commonly lead to an under-utilization of treatment options available to soldiers (Chard, K., Fredman, S., Monson, C., Schumm, J, 2013).

Durham, Holloway, Lee, Luxton, D., Reger, Tarantino discuss the different side effects and reactions to medication that is commonly used to treat PTSD. Some of these side effects can be sexual in nature depending on the prescribed drug. Although treatment for PTSD is available in pill form, due to the nature of work that soldiers are involved in, this method of treatment is not always preferred. Exposure-based treatment, also commonly referred to as cognitive therapy is preferred when it is available, especially in a deployed setting. During the study which this article discusses, soldiers were given three differing types of treatment; one of them being pharmaceutical. Soldiers responded much more favorably to treatment that did not involve medications and reported that they would be more willing to recommend treatment to others if they did not involve medications. One of the reasons for this is due to the side effects associated with medications used for PTSD treatment (Durham, T., Holloway, K., Lee, J., Luxton, D., Reger, G., Tarantino, K ,2013).

Blevins, Corrigan, Curran, Drummon, Mittal, Sullivan had conducted a study with 16 treatment-seeking combat veterans and the stigma associated with PTSD. Most veterans who do not utilize available treatment options do so due to the stigma associated with those who have been diagnosed with PTSD both in the public, as whole, and by their peers. Although veterans who receive treatment report lower incidents of self-stigmatization, most reported that treatment was initially not utilized due to feelings of being seen as “crazy” or
“violent”. These feelings of being “crazy” and/or “violent” can also have depressive side effects that can affect the health and functionality of soldiers that have self-identified as having PTSD or who have been diagnosed but refuse treatment (Blevins, D., Corrigan, P., Curran, G., Drummond, K., Mittal, D., Sullivan, G, 2013).

“We were so close that if one of us was cut, we all bled, we are brothers that were born in war.”

-Anonymous

Diagnostic Terminology:

A study was done evaluating shell shock and war neurosis to post-traumatic stress disorder, and the history of psych traumatology. *Dialogues in Clinical Neuroscience.* Had stated that during the Vietnam War, the protocol of treating psychiatric casualties were highly successful, this success was due to the lower levels of psychiatric casualties, than in comparison to post September 11th. Another contributor to lower levels of psychiatric causalities during Vietnam, as opposed to current warfare, is the higher incidence of alcoholism and drug abuse. This caused a delayed effect from combat exposure and PTSD (Crocq, Crocq 2000). Currently, there is a rough estimate of 700,000 Vietnam veterans, which totals near a quarter of all deployed soldiers to Vietnam from 1964-1973, that require psychological and psychiatric help. The prevalent and increasing number of PTSD among Vietnam Veterans is alarming, despite the preventative measures taken. The Vietnam War was a rude awakening in regards to PTSD and TBI. The United States had an overwhelming amount of returning soldiers that were psychologically ill and the American people were not adequately prepared to cope with them. This new paradox required a new evaluation and more research to understand the depth of severities of PTSD, that currently are not yet fully understood. Despite the United States’ alarming ignorance of returning soldiers’ mental state, the post-Vietnam era had led to the diagnosis of veterans and the adoption of PTSD as a respectable category in the Diagnostic Statistical Manual – II (DSM-II) (Crocq M-A, Crocq L, 2000).

However, throughout time, the concept and terminology has immensely changed
regarding PTSD. Zoellner, Gilligan, Marks, and Garcia discuss how PTSD has shifted from being viewed as an anxiety disorder to a more traumatic and stress-related disorder. This shift has caused the terminology to change as well, as how the disorder itself is being publicly and medically viewed. The structures of the symptoms carry persistent negative beliefs and have created expectations about the individual. Trauma-related emotions, specific behaviors, and attitudes are all classified as symptoms of PTSD. This is all reviewed and analyzed, looking at specific changes on the perspectives and attitudes towards PTSD and how the diagnosis and treatment of the disorder is evolving, along with society. Indicating that PTSD symptoms are ever-changing, as society evolves. That the symptoms of PTSD are peer-based and formulated based on general beliefs and assumptions of the disorder, which is then embodied by the individual who is suffering and projected back onto society. An evolved variation of the symptoms (Zoellner, Bedard-Gilligan, Jun, Marks, Garcia, 2013).

In 2017, the terminology of PTSD is being re-constructed. Various attempts to de-stigmatize the disorder have been made. The Department of Defense and The American Psychological Association is in the process of renaming PTSD as PTSI (Post-Traumatic Stress Injury), removing the term “disorder” altogether in hopes that it will lessen the weight of the label and remove a lot of the societal burden that comes with it (Vermetten, Bremner, Skelton, Spiegel, Kilpatrick, D., Buckley, Marshall, 2007). The following arguments against a name change from members of the Diagnostic and Statistical Manual-5 committee has been made: changing the name will make little to no difference, there are better ways to handle the stigma, The U.S. Department of Defense is subject to using any name they wish when it comes to labeling PTSD and not APA. Lastly, PTSD has biological and psychological changing elements, which is far more than a physical injury, giving it the right to claim a spot in the DSM-5 (Vermetten, Bremner, Skelton, Spiegel, Kilpatrick, Buckley, Marshall, 2007).

Recently, the new language towards the label has been receiving endorsements, such as
veterans who are advocating for the change and the need to better represent a traumatized population, and are asking the APA to push for the change, believing that this would alter the assumptions, and attitudes towards those who carry this burden (Zoellner, Beadred-Gilligan, Jun, Marks, Garcia, 2013).

“Killing is the worst thing that one man can do to another man...

*It’s the last thing that should happen anywhere.*”

- Israeli Lieutenant

**APPLIED THEORY**

When analyzing the effects of stigma projected on an individual, it is important to understand the historical background and the fundamental basis of the theory. Erving Goffman is the creator of the theory of stigma. This theory was presented in Goffman’s *The Presentation of Self in Everyday Life*. Here stigma is analyzed as how a person feels about themselves and their relationship to society and what is considered “normal” or “deviant behaviors.” Stigma is a social construct that creates pressures, attitudes, and beliefs about specific behaviors or individual attributes. Stigma comes in two forms: the stigmatized and those who control the stigma. The stigmatized are the individuals, such as sufferers of PTSD, being labeled as having a “deviant behavior,” those who control stigma and enforce deviant behaviors in society and culture, specifically targeting military culture (Goffman, 1959). This targeted population allows the analyzation of the social progression of the perception of post-traumatic stress disorder (PTSD). how these individuals function in both their civilian and military societies and how this affects them during their everyday lives. As well as how they are viewed, and treated both emotionally and physically. Additionally, evaluating the course changes and effects of stigma
pre-, during, and post-deployment cycles. This theory raises the question of whether attitudes of the mental state of military individuals have changed since the Vietnam war and post-September 11th attacks.

To further the breakdown of stigma’s effects on combatants, and the social progression of PTSD since Vietnam, we can utilize the theory of structuration by Anthony Giddens. The theory of structuration explains that social life is more than random acts of individuals not controlled by social forces. In fact, human life and social forces have a relationship with one another, mirroring that of stigma and society. What enforces the social forces is not the force itself, but the reputation of the acts of the individuals that endorse the structure. There are social structures that exist today, such as traditions, institutions, morals and ethics. These are all established methods of performing social acts. However, this theory proves that the structure can be changed when the masses start to ignore them, replace them or reproduce them differently (Salnero, 2004). When applying both of these theories towards combatants with PTSD and stigma, it’s apparent that structuration and stigma are strong social forces within this sub-community. Overall, the reputation of mental illness hasn’t changed since its predecessors: largely, people still fear it, which is what forms the social force and enables stigma to exist and thrive (Salnero, 2004). Fear is the fundamental component of the general public’s perception of PTSD.

“When violence does happen to you, it devastates you. It shatters you so when someone does try to kill us, it is simply not right and, if we are not careful it will destroy you.”

RESEARCH METHODS

This research was done with quantitative research methods. The methods were designed to create a broadly representative sample of the general public’s attitude towards PTSD, and the underlying cause and effects to what provokes specific attitudes toward PTSD. The sample was large and consisted of various geographical locations throughout the United States, as well as a large demographic sample size. The sample size of 324 randomly-selected respondents had the average age of 28 and 55 and over, 260 are females, and 64 are males. 273 indicated they have not served in the military, the remaining 51 indicated they have served, with the age term of service being 8 – 12 years. The survey was conducted on a series of 20 questions, all measured on the use of the Likert Scale with the response options of: strongly agree, Agree, neutral, disagree, and strongly disagree, yes and no responses and with two open-ended questions. The questions were created to gather general perspectives on perceived notions and biases towards PTSD. The survey was created in March of 2017 on Survey Monkey, and was distributed through social media, primarily Facebook and Instagram. Facebook accumulated 271 respondents, and Instagram accumulated 53 respondents. Cross-tabulation was conducted on 8 of the questions, creating 4 comparative analysis results, as well as chi-square analysis to further conclude the research hypothesis. The data was generated into charts and graphs to demonstrate the results in their sub-categories and illuminate the presence of stigma behind PTSD.

“Tell me then...what do you call the men that enter the darkness while the rest run from it? the men that enter the fires of hell...the men that stare death in the face and embrace it?

They are called warriors, and their souls will never die.”

-Anonymous
DATA ANALYSIS RESULTS

Cross-Tabulation Figure 1:

Question 5 and question 9 were measure by the use of the Likert Scale giving the following options for responses: strongly agree, agree, neutral, disagree, and strongly disagree.

QUESTION 5: Have you lived on or near a military base or community?  
QUESTION 9: All active and non-active military personnel have PTSD of some form?

Hypothesis: Living on or near a military base or community will increase assumption that all military individuals have PTSD of some form.

Conducting a cross-tabulation analysis on question 5, “have you lived on or near a military base or community?” and question 9, “All active and non-active military personnel have PTSD of some form?” will show if there is a relation between attitudes and assumptions of PTSD diagnosis and one’s geographical location to a military base or community, he statistics initially show that of those who indicated they have lived on or near a military base, 8% strongly agreed with that “all active and non-active military personnel have PTSD of some form.” 19% agreed, 38% were neutral on the statement. The highest response of 28% that live on or near a military base or community disagreed, and a low 6% strongly disagreed. Of those who indicated they have not lived on or near a military base or community, 10% strongly agreed with the statement, 28% agreed that “all military personnel have PTSD of some form.” 38% remained neutral, 21% disagreed, and a low 3% strongly disagreed. An additional chi-square test was conducted to further see if there is a level of significance towards one’s geographical location to a military base or community, and assumptions or attitudes in regards to PTSD diagnosis. What the results of the chi-square test shows is that there is not enough evidence to conclude that living on or near a military base can change or influence one’s assumption or attitudes towards PTSD. Although despite the statistical results initially found, showing that, those who have lived on or near a military base or community scored heavier on
disagreeing with the statement, than those who have not lived on or near a military base or community. Those who have not lived on or near a base or community scored higher in agreement with the statement that “all military personnel have PTSD of some form,” indicating a correlation to exposure to this sub-community. However, the results of the chi-square test were higher than the level of significance resulting in rejecting the hypothesis that there is no relationship between attitudes on PTSD diagnosis’ and one’s geographical location to a military base or community.

<table>
<thead>
<tr>
<th>Have you ever lived on/ near military base/comm.</th>
<th>STRONGLY AGREE</th>
<th>AGREE</th>
<th>NEURTAL</th>
<th>DISAGREE</th>
<th>STRONGLY DISAGREE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>8%</td>
<td>19%</td>
<td>38%</td>
<td>28%</td>
<td>6%</td>
<td>180</td>
</tr>
<tr>
<td>NO</td>
<td>10%</td>
<td>28%</td>
<td>38%</td>
<td>21%</td>
<td>3%</td>
<td>144</td>
</tr>
</tbody>
</table>

Have you ever lived on or near a military base and/or community?

![Chart showing the percentage of responses to the question of whether or not respondents have lived on or near a military base or community. The chart shows the distribution of responses for those who agree, disagree, and strongly disagree.]
Cross-Tabulation Figure 2:

Question 10 was measured by the use of the Likert Scale giving the following options for responses: strongly agree, agree, neutral, disagree, and strongly disagree. Question 11 was measured with a series of responses: School/educational background, Hollywood war movies, T.V., Social media, Books, and Personal experiences of PTSD.

**QUESTION 10: Do you have knowledge about the symptoms of the disorder?**

**QUESTION 11: Where does your knowledge of PTSD come from?**

**Hypothesis:** Average accumulation of the general public’s knowledge on PTSD is from Hollywood war movies, social media, and TV.

Conducting a cross-tabulation analysis on question 10, “Do you have knowledge about the symptoms of PTSD?” and question 11, “Where does your knowledge of PTSD come from?” will determine the source of knowledge of the general population pertaining to the symptoms and behaviors of PTSD for military individuals. The hypothesis for this cross-tabulation analysis is that: the standard accumulation of the general public’s knowledge on PTSD is sourced from Hollywoodized war movies, social media outlets, and T.V. A selection of knowledge outlets for question 11: School and/or educational background, Hollywood war movies, T.V, social media outlets, Books, Personal experience, and no knowledge on PTSD. The statistical analysis initially shows that individuals that indicated they strongly agree they have knowledge of PTSD symptoms 55.91% said their knowledge was from personal experience, 41.94% stated it was from school and/or educational background. Whereas 0% said it was from Hollywoodized war movies, and books, or have no knowledge on PTSD, lastly exactly 1.08% said it was from T.V, and social media. Of Individuals that stated they agree to have knowledge of PTSD symptoms, 36.09% stated it came from school and educational background. 34.91% from personal experience, 9.47% from T.V., 8.28% from books, 6.51% from social media, 4.73% from
Hollywoodized war movies, and 0% stated they have no knowledge. Those who remained neutral on the level of knowledge indicated that 24% came from school and educational background as well as personal experience. 16% stated T.V., and social media. 6% stated Hollywood war movies, and books, and 8% indicated they have no knowledge on the symptoms. Individuals who disagreed with the statement of “having knowledge on PTSD symptoms,” 30% indicated it was from Hollywood war movies, 20% stated it was from T.V, or they have no knowledge on symptoms. 10% stated it was from social media, books, and personal experience. Lastly, 0% said it was from school or educational background. Those who strongly disagreed with the statement of having knowledge on PTSD symptoms indicated that 50% was from T.V., and 50% said they have no knowledge on the symptoms. School and/ or educational backgrounds, Hollywood war movies, social media, books, and personal experiences were all 0%. These results indicate that of the individuals who strongly agree, or agree, have obtained knowledge on the symptoms of PTSD from personal experiences or through education. Those on the opposing side, that strongly disagreed, or disagree on having some form of knowledge on the symptoms of PTSD, mostly obtained their knowledge from Hollywoodized war movies, and T.V. With these results we do not reject the null hypothesis that the standard accumulation for the general public’s knowledge on PTSD symptoms is sourced from Hollywoodized war movies, social media, and T.V.
Cross-Tabulation Figure 3:

Question 3 and question 16 were measure by the use of the Likert Scale giving the following options for responses: strongly agree, agree, neutral, disagree, and strongly disagree and a yes or no response.

QUESTION 3: Do you know anyone that is currently or has served in the military?

QUESTION 16: There is stigma and discrimination for having or had PTSD

Hypothesis: The affiliation with an individual, who currently is or has served in the military, increases the likelihood for stigma or discrimination of PTSD.
Conducting a cross-tabulation on question 3, “Do you know anyone that currently is or has served in the military?” and question 16, “There is stigma or discrimination for having or had PTSD,” the null hypothesis for this data analysis is that the affiliation with an individual who currently is or has served in the military increases the likelihood of spreading stigma or discrimination of individuals with PTSD. Of those who answered “yes” to question 3: knowing someone in the military, 31% strongly agreed that there is stigma and discrimination for having or had PTSD, while 43% agreed. 17% remained neutral towards the statement, 8% disagreed, and 0% strongly disagreed. For those who answered “no” to question 3: knowing someone in the military. 18% strongly agreed there is stigma or discrimination. 41% agreed, 35% remained neutral, 6% disagreed, and 0% strongly disagreed with the statement. To further the likelihood of the probability of the hypothesis, and to determine any statistical significance, a chi-square test was conducted. The results of the chi-square test were 3.67, with the chi-square critical at 5.99. This result indicated that there is a significant relation between the two variables: affiliation with a military individual and the likelihood of stigma and discrimination for having PTSD. This concludes the failure to reject the null hypothesis, that the affiliation with an individual who currently is or has served in the military does increase the likelihood for stigma or discrimination for having PTSD.

<table>
<thead>
<tr>
<th>Do you know anyone that is/has served?</th>
<th>There is stigma or discrimination for having/had PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
</tr>
<tr>
<td>Yes</td>
<td>31%</td>
</tr>
<tr>
<td>No</td>
<td>18%</td>
</tr>
</tbody>
</table>
Cross-Tabulation Figure 4:

Question 1 and question 15 were measured by the use of the Likert Scale giving the following options for responses: strongly agree, agree, neutral, disagree, and strongly disagree and a yes, unsure, and no response.

**QUESTION 1:** Do you know anyone that has combat PTSD?

**QUESTION 15:** Have you ever felt threatened by being around an active duty or veteran individual with combat PTSD?

**Hypothesis:** The fear of individuals with combat PTSD decreases by exposure through relationships with an active or in-active individual, who has combat PTSD.

Conducting a cross-tabulation on question 1 “Do you know anyone that has combat PTSD?” and question 15, “Have you ever felt threatened by being around an active duty or in-active individual with combat PTSD?” With the null hypothesis for this data analysis stating that the fear of individuals with combat PTSD decreases by exposure through relationships with an active or in-active individual who has combat PTSD. For the individuals that selected “yes, I know someone who has combat PTSD” 86% strongly agreed that they have felt threatened by being around an active or in-active individual with PTSD, 75% agreed, 47% remained neutral. 59% disagreed with the statement, and 60% strongly disagreed. Of those who answered, “yes, I
have PTSD,” 0% strongly agreed with feeling threatened by an individual with PTSD. 6% agreed, 8% were neutral, 12% disagreed, and 11% strongly disagreed. The respondents that answered “unsure if they know someone with PTSD,” 0% strongly agreed with the statement of question 15. 13% agreed, 14% were neutral, 8% disagreed, and 13% strongly disagreed. The respondents that answered “no” to question 1, they did not know someone with PTSD. 14% strongly agreed, 6% agreed, 32% were neutral, 21% disagreed, and 16% strongly disagreed. With these results, the null hypotheses stating that; the fear of individuals with combat PTSD decreases by exposure though relationships with active or in-active individuals with combat PTSD, is rejected. This data shows that the highest response for feeling threatened by being around an individual with PTSD, were, in fact, individuals that know someone with PTSD. Question 15 was open-ended question, allowing the participants to describe their reasoning for fear or lack thereof, of an individual with PTSD. A text analysis was conducted to calculate the top 25 reoccurring themes from the 324 open-ended responses, the most common words used were: **drunks, triggered, stressed, alcohol, unpredictable, flashbacks, angry, violent, inconsolable, ruined, rage, assholes, bad tempers, mood swings, abuser, hitting, uncontrollable, jerks, arrogant, ridiculous, explosive, excuse, aggressive, crazy, dangerous.** This cohort of adjectives descriptively visualizes the stigma and disconnection to the community of individuals with PTSD.

<table>
<thead>
<tr>
<th>Have you ever felt threatened by being around an active duty/ veteran with PTSD?</th>
<th>Do you know someone who has combat PTSD?</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Has PTSD, but unsure if it’s combat related</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>86%</td>
<td>0%</td>
</tr>
<tr>
<td>Agree</td>
<td>75%</td>
<td>6%</td>
</tr>
<tr>
<td>Neutral</td>
<td>47%</td>
<td>8%</td>
</tr>
<tr>
<td>Disagree</td>
<td>59%</td>
<td>12%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>60%</td>
<td>11%</td>
</tr>
</tbody>
</table>
"Though the question always remains: What is worth defending? What is worth dying for?

What is worth living for?"

- William J. Bennett, United States Naval Academy

CONCLUSION

Addressing combatant PTSD, PTS, and TBI for all military individuals should be a national priority, despite if the conditions surfaced pre-, during, or post- deployment. There is a large underserved population that is mentally ill and is drastically increasing in psychiatric casualties. As conflicts increase, so does the manifestation of psychological wounds for our troops. Although significant changes in available services for this sub-community have been made, many gaps still remain unattended. It is up to the general public to fill these gaps holistically. We the people, as a nation, have our own duty to serve, and it is to those that have fought the horrors of war. We must educate and spread awareness regarding PTSD, PTS, and TBI in an attempt to alleviate the damages of stigma that is so prevalent in this
community. As troops come home, many of them will return psychologically sound. For those less fortunate, they will begin the cycle of horrors that is PTSD. This causes significant concerns for spouses, family members, and friends. However, significant concerns should affect the general public as well, for it is our veterans that end up homeless, and fall to the lures of substance abuse. Setting the goals of providing more accessible, quality care for these service members requires policy changes, however the most influential changes start within communities, slowly attempting to change the social forces that are the structures of our society, and understanding that PTSD is not something to fear and seeing these service members as a person with an illness, rather than an illness as a person.

“War is the evil that we must stand vigilant against. It is like a virus, starting from deep inside us, eating its way out until we are devoured by, and become its madness.”

-Richard Heckler, In Search of the Warrior Spirit

RECOMMENDATIONS

In anticipation of alleviating the detrimental impacts of stigma, there are a few pathways to consider. The most influential course of action would be more conclusive assessment testing of a potential subject. As stated throughout the study, this is an aspect that falls short to the human nature to deceive in the hope of receiving a reward. These screenings are most effective when conducted under proper conditions, such as the previously stated anonymity environments. Implementing anonymity as a standard condition for assessments would be most beneficial for honest outcomes. Holding the VA and the DOD accountable for their lack of information releasing on PTSD is another course of action in fighting stigma. The VA and DOD are the policy makers, and have the power to implement more social change, as well as harsher
requirements for returning combatants on obtaining psychological help. Finally, the course of action for social change and community involvement with hope for creating more integrated communities of military and civilians. More integration of both sub-communities will alleviate the underlying fear of the individuals of this community, which would diffuse the fundamental source that fuels stigma, and that is fear. Eliminating fear will then create a holistic and well-rounded community and way of life for everyone.

“What we say about mental illness reveals what we value and what we fear.”

-Juli McGruder
BIBLIOGRAPHY


Stigma, Barriers to Care, and Use of Mental Health Services Among Active Duty and National Guard Soldiers After Combat (: Psychiatric Services: Vol 61, No 6)


Appendix A:

Service Learning Capstone

As part of the course curriculum for major learning outcome IV, as well as undergrad requirements is service learning. Service learning was designed to engage and generate social justice and integration between community members and CSUMB students, faculty and staff members of all Monterey County. With my capstone focus being on military communities and services, I found placement at the Veterans Transition Center of Monterey County (VTCMC). This facility acted as an all-encompassing place for a veteran to find the resources and services they need, specifically targeting homeless veterans. VTCMC primarily focused on homeless veterans and their transitions to a sustainable, independent, and healthy life. My time spent at VTCMC mostly consisted with the food drive and donations, however during my time with the in taking of the food I was able to interact and get to know the members of this community, as many of them volunteered their time within the facility.

CSUMB service learning had created five questions required for consideration for community engagement, through service learning. The first question is: How have you used social and behavioral sciences principles and practices in "real world" contents? When applying social and behavioral sciences principles and practices towards service learning, I was able to obtain a certain perspective prior to engagement with the individuals. Throughout my time as a SBS student, I have been exposed to an array of social theories. These theories have expanded my expectations and perceptions on how individuals and sub-communities interact. Through social theory and understanding multiple ways one can self-identify and exhibit their self, allowed me to lose all bias and have an open mind.
The second question for consideration is: Describe the social, economic, and historical dimensions that have contributed to the problem addressed by these applications. Historically there has been a social and economic divide between civilians and military communities. Primarily those who suffer from PTSD, this sub community have undergone discrimination, and stigma regarding their mental health since post-Vietnam. When specifically looking at what that has done to current individuals today, there is noticeably large gap in communities that leaves many of these individuals on their own and left in solitude with their illness. Stigma thrives off social dominance and the separation of individuals. Social dominance in this regard, is labeling PTSD as something to “fear” or is a “common occurrence from time spent overseas.” When using this knowledge towards my service learning, it became apparent that many of these individuals carried this stigma with, especially the Vietnam veterans. These veterans, above all, have truly felt the course of stigma. Many of them exuded bitterness, aggression, and a disregard to others.

The third question for consideration is: How have you integrated learning derived from service with the subject matter outcomes? Integrating the learning obtained from my time spent as a service learner, has come in the form of better understanding this community and what is the driving force to certain behaviors. I have learned through my capstone service learning that this community is generally misinterpreted. This misinterpretation is projected onto the individuals in the form of stigma and preconceived notions regarding their expected behaviors and contributions to society. Currently western culture has created social constructs of the symptoms of PTSD and is enabling the disorder to grow, thus creating discrimination and stigma for this sub-community, which is ultimately furthering the divide between communities.

The fourth question for consideration is: What theories and methods of data collection have you applied? One of the theories chosen to better understand and evaluate this community
is Erving Goffman’s theory of stigma. This theory was presented in Goffman’s *The Presentation of Self in Everyday Life*. Where stigma is analyzed as how a person feels about oneself and their relationship to society and what is considered “normal” or “deviant behaviors.” Stigma is a form of social constructs that create pressure, attitudes, and beliefs about specific behaviors or individuals. Stigma comes in two forms: the stigmatized and those who control the stigma. The stigmatized are the individuals being labeled as having a “deviant behavior.” When specifically looking at military individuals, the deviant behaviors are the combatants with PTSD. On the other side of this spectrum, are the ones controlling the stigma and enforcing deviant behaviors in society and culture, specifically targeting military culture. (Goffman, 1959). This targeted population allows the analysis of the social progression of the perception of post-traumatic stress disorder. The second theory of choice is the theory of structuration by Anthony Giddens. The theory explains that social life is more than random acts of individuals, that’s not controlled by social forces. But in fact, human life and social forces have a relationship with one another, just like stigma and society. What enforces the social forces is not the force itself, but the reputation of the acts of the individuals that endorse the structure. These are all an established method of performing social acts. However, this theory proves that the structure can be changed when the masses start to ignore them, replace them or reproduce them differently (Salnero, 2004). When applying both of these theories towards combatants with PTSD and stigma, it’s apparent that structuration and stigma are strong social forces within this sub-community. Overall, the reputation of mental illness hasn’t changed since its predecessors, largely people still fear it, which is what forms the social force and enables stigma to exist and thrive (Salnero, 2004). Fear is the fundamental component of the general public’s perception on PTSD.
This research was done with quantitative research methods. The methods were designed to create a broadly representative sample of the general public’s attitude towards PTSD, and the underlying cause and effects to what causes specific attitudes to PTSD. The sampling strategy was large and consisted of various geographical locations throughout the United States, as well as a large demographic sample size. The sample size of 324 randomly selected respondents had the average age of 28 and 55 and over, 260 are females, and 64 are males. 273 indicated they have not served in the military, the remaining 51 indicated they have served, with the age term of service being 8 – 12 years. The survey was conducted on a series of 20 questions, all measured on the use of the Likert Scale with the response options of: Strongly agree, Agree, Neutral, Disagree, and strongly disagree, yes and no responses and with two open-ended questions. The questions were created to gather general perspectives on perceived notions and bias towards PTSD. The survey was created in March of 2017 on survey monkey, and was distributed through social media primarily Facebook and Instagram. Facebook accumulated 271 respondents, and Instagram accumulated 53 respondents. Cross-tabulation was conduct on 8 of the questions, creating 4 comparative analysis results, as well as chi-square analysis to further conclude the research hypothesis. The data was generated into charts and graphs to demonstrate the results in their sub-categories and illuminate the presence of stigma behind PTSD.

The fifth question for consideration is: Elaborate upon the relationship between the problem(s) studied and a multi-disciplinary approach in the social and behavioral sciences. When addressing combatant PTSD in veteran communities in a multi-disciplinary approach for social sciences, it’s important to always consider the social constructs that are in place that enforce these expected behaviors from military individuals. These expectations can be very detrimental for their mental health. As a social scientist it is also important to be aware of our
societal influences, for as conflicts increase overseas, so does the manifestation of psychological wounds for our troops.