



Article

War Trauma, Politics of Recognition and Purple Heart: PTSD or PTSI?

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Abstract: This paper discusses the exclusion of veterans with combat PTSD (CPTSD) from eligibility for the Purple Heart (PH). The main argument is that this exclusion is unjustified and that it strengthens the stigma attached to the traumatized veterans, with detrimental implications to their wellbeing. In the context of the politics of recognition, the history of the term PTSD, and with support evidence from brain studies, the paper contends that in the case of combat veterans, posttraumatic stress should be termed PTSI (posttraumatic stress injury) rather than PTSD (posttraumatic stress disorder). The proposed alteration in terminology may enable eligibility of posttraumatic combat veterans' for the Purple Heart, and consequently mitigate the stigma of their wounds, help to deconstruct their misrecognition as inferior to physiologically wounded, increase their willingness to seek aid, and improve their chances to heal.

Keywords: politics of recognition; social justice; PTSD; PTSI; Purple Heart; war trauma; stigma

1. Introduction

A stigma has always been attached to traumatized veterans [1], and they are still discriminated against compared to physiologically wounded veterans. A salient example for this discrimination is their exclusion from eligibility to receiving the Purple Heart (PH) medal. The American military has been decorating combatants for their sacrifice in battle since 1782, when General George Washington first established a chevron for meritorious acts. One hundred and fifty years later, on the occasion of the 200th anniversary of Washington's birth, General Douglas MacArthur re-instituted the decoration [2] and renamed it the Purple Heart medal, awarded to killed and injured US military personnel. Eligibility for the PH award was modified on several occasions and currently includes any member of the U.S Armed Forces who was wounded or died from bleeding wounds sustained in action against an enemy [3]. Since combat PTSD (CPTSD) is not a bleeding wound, veterans afflicted with it are not eligible for a PH medal. In recent years, this distinction between wound types has garnered growing attention of the American public, and has been a cause for bitter debates. This was the case in 2008, when Secretary of Defense Robert Gates stated, in a response to a question, that awarding the PH to combat veterans afflicted with PTSD was "clearly something that needs to be looked at" (as cited in [4], para. 1). Despite the high rate of psychologically injured soldiers among American veterans, current and former military personnel bitterly objected to Gates' cautious statement, and some said they would be ashamed to wear the PH medal if it is awarded to veterans with CPTSD, and that it would insult those veterans who suffered a "real injury" ([4], italics in source). In spite of growing support among some mental health and military advocates to award the Purple Heart medal to veterans with CPTSD,

the Pentagon continues to refuse to do so, with the firm support of the Military Order of the Purple Heart (MOPH), a congressionally-chartered veteran service organization [5]. Refusal to granting PH to traumatized veterans is spread also among those who acknowledge PTSD, who still fear that doing so would diminish the medal's prestige [6]. In other words, CPTSD still suffers from misrecognition by the dominant cultural norms of the military.

Explaining the Pentagon's decision of 6 January 2009, Defense Department (DoD) spokeswoman Eileen Lainez said that "PTSD is an anxiety disorder caused by witnessing or experiencing a traumatic event; it is not a wound intentionally caused by the enemy from outside force or agent" [7]. The two parts of this statement are perplexing. The second part is discussed below, and suffice to say here that 36 years after recognizing trauma as caused by an outside force, such a statement is puzzling. As for the first part, one should note, that although the DSM-V removed the syndrome from the classification of *anxiety disorders*, there has not yet been any change in the Pentagon's decision [8].

In an official statement (cited in [5]), MOPH added that PTSD is a disease, and a treatable one, unlike the loss of a limb or any other combat wound, which they contend, is a permanent loss. It is important, therefore, to emphasize that although current evidence does not indicate that PTSD is necessarily chronic, it has been shown to be a relatively persistent condition, which does not readily respond to psychotherapy or drug therapy [9]. This is especially true among war veterans, "which show less reduction in symptom severity following pharmacotherapy than other patient groups" ([10], p. 1095). Robjant and Fazel (2010) show that a combination of medication and psychotherapy may result in a clinically significant improvement [11]. However, they qualify their results by mentioning that studies involving Vietnam War veterans showed "less favorable outcomes" ([11], p. 1031). In addition, a twenty-year longitudinal study [12] found that a substantial portion of veterans that were diagnosed with PTSD shortly after combat, still suffered from PTSD 17 years later. Similar conclusions can also be drawn from the findings of Bradley et al. [13], demonstrating that the majority of patients continue to suffer—post-treatment—from residual symptoms. Schlenger et al. found prevalence of PTSD among 15.2% of men and 8.5% of women who served in Vietnam, 15 or more years after deployment [14]. Lifetime prevalence of PTSD among Vietnam veterans was found to be even higher—30% among male veterans and 25% among female veterans [15]. In a survey conducted in 1995–1997, Kang et al. (2003) found PTSD prevalence of 12.1% among veterans of the 30,000 veterans of the Gulf War vs. 4.3% among Non-Gulf veterans, a ratio of 3.1 [16]. Tanielian and Jaycox (2008), found 14% of their sample of the 1.64 million US troops who were deployed in Iraq and Afghanistan since October 2001 [17]. The implication of these findings to the topic at hand is that PTSD is hardly treatable, and most of those afflicted with it are injured for the rest of their lives. At the same time, regarding the PH medal, one should remember that some physiological injuries are also treatable and, yet, their bearers are nevertheless eligible for receiving it.

The MOPH also contends that one "can hardly find anyone who has served in combat and especially those who have been wounded in combat, that doesn't return with some form of PTSD" (Official Statement of the MOPH as cited in [5], para. 8). This view is shared by military personnel in diverse countries. For example, speaking at a government committee assigned to study the eligibility criteria for assistance granted by the Israeli Ministry of Defense in 2010, Israeli war hero Brigadier General Avigdor Kahalani expressed the view that PTSD is not an injury nor a disorder, but rather an expected outcome of combat: "Every soldier who has fought on the battlefield has PTSD [...] Show me one combatant who doesn't have PTSD" ([18], p. 18).

Views such as those stated by the MOPH and Kahalani reflect a misunderstanding of the severity of PTSD and also cast doubts on the casualties' integrity. According to the MOPH, "some may feign illness in order to receive medical treatment at the VA," but cannot fake a physical wound (Official statement of the MOPH as cited in [5], para. 8). Kahalani shares the same suspicion: "It's hard to make the distinction, and we see there are people who are able to get mileage out of it since they don't have to show a bleeding arm" ([18], p. 18). The similarity of views is not a coincidence: it reflects the fact that, despite tremendous progress in understanding and legitimizing PTSD, many still deny that

war trauma is an injury just like a bleeding physiological wound. Even when PTSD is not altogether denied as a psychological phenomenon with recognized symptoms, denial now extends to suspicions that the afflicted are faking symptoms. This attitude stands in complete contrast to both Israeli and American data, which clearly obviate the need for suspicion and indicate a low rate of exaggeration and dissimulation. Holowka et al. (2014) found 79.4% concordance between electronic medical records and structured clinical interviews for the DSM-IV for lifetime PTSD and 72.3% for current PTSD of American veterans serving in Iraq and Afghanistan [19]. Of those without concordance, there were varying proportions of false positives and false negatives. Aiming to verify combat exposure history of Vietnam veterans seeking treatment for combat-related PTSD, Frueh et al. (2005) [20], found objective documentation of Vietnam war-zone service for 93% of their sample, with average length of service of 6.54 years. Although only 41% of their sample had objective evidence of specific combat exposure documented in their military records, one cannot ignore the overall impact of serving in the Vietnam war-zone, as well as the difficulty of finding objective evidence three decades after the events. The Israeli data prove that those Israel Defense Forces (IDF) veterans afflicted with combat stress reaction (CSR) and PTSD who seek compensation generally do so only in the absence of any alternative [21]. Moreover, in a longitudinal research of 20 years, Solomon and Mikulincer (2006) tracked fluctuations in the psychological condition of all soldiers identified as having suffered Combat Stress Reaction (CSR) during the First Lebanon War (1982) over a 20-year period [12]. The study also tracked the condition of a control group, veterans of the same war with a similar health profile, who were exposed to the same risk situations of CSR, but had not been classified as such. The study found that 39% of the control group—who had never sought recognition or compensation from the Israeli Defense Ministry for any psychological disability—had suffered from PTSD at various times since the war. Surely, most of the suspicion is raised during compensation discussions and not throughout the diagnosis of PTSD. On the other hand, the trained experts who conduct the diagnosis and later treatment of individuals with PTSD are part of society, and as Dasberg (1987) showed, they, too, are influenced by social views [22]. It is, therefore, vital to revoke all stigma surrounding veterans with PTSD. Notwithstanding, secondary gain is still an issue among some veterans, who are looking for therapy as a pathway to such gain [23]. On the other hand, as McGuire (2015) found in a study among combat veterans who served in Afghanistan and Iraq, the most common primary motivation to seek care was symptom reduction, while the primary motivation of secondary gain was associated with the lowest level of PTSD symptoms [24]. Moreover, McGuire (2015) also found that most participants would not have sought care for their PTSD symptoms if not for the influence of others, a finding that strengthens the importance of reducing the stigma of PTSD [24]. This does not lessen the need for the development of evidence based diagnosis [25], as the current diagnostic tools cannot rule out cases of malingering [26].

In 2012, towards the publication of the DSM-V, scholars tried to convince the APA task force to accept the injury terminology, and change the name PTSD to PTSI [27]. In a detailed letter to the APA task force, Frank Ochberg and Jonathan Shay, two prominent scholars in trauma research, expressed their view that in trauma “*brain physiology* has been injured by exposure to some external force” ([28], italics added). They also emphasized their conviction that “The time has come to listen to the labeled and to do what we can do to lessen the stigma and shame that inhibits our patients from receiving our help”. This paper follows these arguments.

The main argument of this paper is that the scientific community should explore the possibility of replacing the term *disorder* (PTSD) with *injury* (PTSI), thus helping to deconstruct the term, which maintains the stigma [29] of CPTSD. This change may remove the stigma and may also facilitate the eligibility of traumatized veterans for PH, thereby enhancing the recognition of their sacrifice by society. Such a development might be significant for improving the recovery and resilience of war-traumatized soldiers and veterans all over the world [27]. One should note that the DSM-V (2013) removed the syndrome from the classification of *anxiety disorders*, but it has retained its label as a disorder under its new classification, *trauma and stressor related disorders* [8]. It is, therefore, important

to continue the discussion of the terminology. The following discussion focuses exclusively on war trauma (CPTSD) because of its unique nature as an injury that occurred on behalf of the nation [9]. A similar discussion should be held concerning PTSD among victims of other stressor-related trauma such as rape, road accidents, natural disasters, and crime. This paper focuses only on diagnosed PTSD individuals. Additional phenomena that may appear following traumatic experience such as depression, alcoholism, and substance abuse, are beyond the scope of this paper, and require a separate investigation.

After discussing the roots of the term *psychological trauma* and its defining triggers (Criterion A), Section 2 presents evidence from the field of brain research suggesting that PTSD may leave physiological marks in the brain. This evidence, the paper contends, supports the notion that using the *injury* terminology has merit. Section 3 discusses the concept of recognition and clarifies the implications of misrecognition of war trauma. The paper concludes with a discussion of the significance of the term *injury* and the PH eligibility for combatants, and suggests to further explore the possibility of adopting the *injury* terminology for the recuperation and resilience of veterans with CPTSD.

2. Trauma and Its Triggers: Roots and Controversy

When Sigmund Freud borrowed the term *trauma* from its original use, which referred to an injury to the body's tissues caused by an external factor, he did so to emphasize the intensity of the psychological injuries he observed in his patients. Through the analogy to physical injury, Freud emphasized the penetration of the traumatic event through the "mental skin" designed to protect the soul [30]. *Injury* is already inherent in the term post-traumatic stress disorder, as *trauma* in medical Latin and in Greek refers to physical wound. This fact strengthens the argument that renaming the syndrome has merit, while on the other hand one may argue that it is an unnecessary duplication. It is, therefore, important to stress that the suggestion to consider changing the term into PTSI is based on the importance of formal recognition of the *injury* quality of PTSD explicitly, and not implicitly, since the general public is not familiar with the Latin origin of the term *trauma*. Like his contemporaries, Freud assumed that the roots of psychological trauma are internal, and that its source is embedded in the individual's personality. While his choice of the term *trauma*, in fact, alludes to his understanding that mental trauma, like physical trauma, originates from an external injury, this understanding had not ripened to the point of triggering a change in the accepted paradigm at the time.

In a related manner, it is especially interesting to note the term *shell shock*, which was used to explain the mental reactions of WWI soldiers during or following battle, which occasionally included physical manifestations, such as blindness or deafness. Ostensibly, this term seems to illustrate the paradigm that an external source (shock waves from exploding shells) causes physical (brain) injuries. However, the use of this term represented enormous progress, as it heralded subsequent understanding that psychological injuries could be caused by external factors and not only by personality disorders. This understanding grew from observations that the consequences of the shock were not exclusively physiological, and similar effects were observed among soldiers who participated in combat far from the shells' explosions.

Official recognition of PTSD in the DSM-III [31] did not end the debate on the syndrome and its terminology. One of the facets of this debate, which is directly related to the topic discussed here, is Criterion A, the trigger event or the threshold criterion for diagnosing trauma. Criterion A has been modified several times over the years in the different versions of the DSM, probably due to the heavily supported argument that its definition was overly broad and included exposure to life events that, while challenging, are within the range of normal everyday life [32]. However, it is important to note that according to all editions of the DSM, the trigger event is defined in external, violent terms (except for the temporary recognition in the DSM-IV of receipt of notice of the natural death of a close family member or friend as a trauma event, which has since been eliminated, and its discussion is beyond the scope of this paper). It also seems that there is a consensus among the APA task forces for the definition of PTSD in the DSM, that trauma is a blow to the structures of the mind, just as physiological trauma is

a blow to the tissues of the body [33]. The DoD spokeswoman announcement, cited above, that PTSD “is not a wound intentionally caused by the enemy from outside force or agent” [7], takes the trauma debate years back, and reflects a continuous, dual denial: it ignores the agreement among scientists that trauma is caused by an outside force, and it denies the fact that the trigger event of war trauma is clear-cut: extreme, organized violence designed to strike on the other side a fatal blow—death or injury—whether the injuries are visible or concealed.

3. Psychological Trauma in Brain Research and Evidence of Injury

Findings emerging in recent years from new brain studies support the adoption of a new perspective of trauma as an injury, to replace the trauma-as-disorder paradigm. A meta-analysis of brain scan studies of individuals suffering from anxiety disorders found that a drop in activity of the vmPFC (the part of the brain involved in processing fear and danger, regulating emotions, and decision-making) is unique to post-traumatic syndrome and is not systematically observed in other anxiety disorders [34]. In recent years, trauma has also been explored through neuroimaging studies based on diffusion tensor imaging (DTI), which presents a three-dimensional picture of the brain’s white matter [35]. Fani et al., as cited in Stevens et al. [36], documented that such scans of PTSD-diagnosed individuals had shown white matter compromise in the part of the brain that serves as a major pathway between the vmPFC/ACC (Anterior Cingulate Cortex, a sub-area of vmPFC, which is involved particularly in decision-making) and the amygdala (part of the limbic system of the brain involved in fear, aggression, and identifying dangers). Additional recent studies found a drop in functional connectivity between the vmPFC/ACC and the amygdala [36] as well as the hippocampus [37]. Taken together, these findings help explain the strong unregulated (vmPFC/ACC) emotions of fear and panic (amygdala), post-traumatic people exhibit while facing ordinary signs of threat (thunderstorm, door slamming, etc.). In other words, PTSD casualties suffer from a “short-circuit” in their brains, and an impairment to different areas of the brain that should regulate emotions and resulted conduct in stress situations. This may explain extreme behavior of self-defense even in the absence of genuine threats.

Researchers have not yet succeeded, however, in clarifying the precise physiological source of this impairment of neural transmissions in the brain. It is nevertheless relevant for this paper that current hypotheses posit that the source is either some irreversible neural damage, or attribute the impairment to a different physiological cause that may reverse over time (such as a temporal impairment of receptors), or even the two causes combined. The assumption that both sources may exist (in different situations) could clarify why some posttraumatic people heal (at least in part) while others remain seriously hurt for the rest of their lives. For the issue discussed here, the most meaningful conclusion is that both possibilities may result from *physiological* damage to one’s neural transmission, which can sometimes be reversible and sometimes not.

It should also be noted, that while accumulating evidence such as those mentioned above clearly demonstrate the existence of neurophysiological abnormalities associated with PTSD [38], the question whether these abnormalities represent predisposing biomarkers of stress vulnerability or a consequential damage caused by the traumatic event, is still debated [39]. A major example may be the finding of reduced hippocampal volume among diagnosed PTSD patients, which was initially considered as an indication for a brain abnormality caused by the traumatic exposure. Later studies testing monozygotic twins (identical twins, developed from the same ovule), one of whom developed PTSD after exposure to trauma, concluded that lower hippocampal volume should be regarded more as a predisposing risk factor than a consequential abnormality [40]. Therefore, one might argue that PTSD should not be considered an injury, since the observed physiological abnormalities had preceded the traumatic exposure, and did not develop as its result. In contrast, however, a causal model accounting for neural abnormalities in PTSD argues that while genetic and neurobiological risk factors definitely exist, other brain abnormalities may be the *result* of the traumatic exposure and not a preexisting risk factor [41]. For example, in a prospective study among a priori healthy Israeli soldiers,

Admon et al. (2013) demonstrated that reduced vmPFC-hippocampus connectivity, both structural and functional, was observed among PTSD diagnosed soldiers only after and not before the exposure to trauma [37]. This study further demonstrated that following traumatic exposure, PTSD patients exhibited a lower nucleus accumbens (a main brain area related to reward mechanism) response to rewarding outcome, which may explain why PTSD casualties avoid social connection and lose interest in previously-satisfying activities [42]. In another prospective study [43], PTSD symptoms severity was shown to correspond with acquired (i.e., not preexisting) gray matter density loss in the orbitofrontal cortex (a frontal area involved in fear regulation and suppression of traumatic memories).

One might also argue that the statistical differences discussed above notwithstanding, there is currently no standard benchmark to indicate when these differences reach a pathological threshold. Developing such a normative standard indeed pose a great challenge to the scientific community and requires a combination of vast data gathering and careful meta-analysis studies [44]. Furthermore, studies that will incorporate longitudinal follow-up could examine whether recovery from PTSD is related to mitigation of the brain's abnormality, adding an important aspect to this debate.

Nevertheless, the existing empirical evidence collected by prospectively examining a priori healthy individuals, before and after trauma, clearly demonstrate the detrimental effects that external stress may have on the brain's function and structure, an observation also supported by animal studies [45]. Taken together, these findings support the view of post-traumatic symptoms as resulting, at least in some, from a compromise to the brain's structural and functional integrity.

4. Misrecognition and the Debate Surrounding Recognition of War Trauma

Charles Taylor (1997) argues for a strong link between recognition and identity [46]. According to Taylor, an individual's identity is defined by the horizon of his/her obligations and identifications, within which she/he can determine what is good and valuable, what action should be taken, what the individual supports or rejects [46]. Due to this link, self-identity is formed partially by recognition by others, or the lack thereof, and occasionally by others' misrecognition. The damage and distortions caused to an individual or a group by the attribution of a narrow, humiliating, or disparaging identity by surrounding society are deep and palpable: "Nonrecognition or misrecognition can inflict harm, can be a form of oppression, imprisoning someone in a false, distorted, and reduced mode of being" ([46], p. 98). Moreover, as Fanon (1967) showed, the damage resulting from misrecognition frequently seeps inward, causing the individual or group to internalize the distorted and disparaging image attributed to them, and they begin to believe in it themselves [47]. Nancy Fraser (2009) expresses such lack of recognition as a category of social injustice that reflects social patterns of representation, interpretation, and communication [29]. While Fraser was mainly referring to cultural, gender, ethnic, and sexual misrecognition, the term "recognition injustice" currently features in any debate on stigmatization and exclusion of distinct groups.

Inclusion of trauma in the DSM in 1980 signaled the rectification of the old, deep-seated misrecognition of war trauma casualties. The injustice, however, has been only partially corrected to date, and it persists even in the case of war heroes. Misrecognition of war-traumatized individuals nowadays takes place on two levels. The first level, of the barriers evolved from cultural construction [48], and of doubts and mistrust in the injury itself [9,49–51], has been discussed extensively. As evident from the MOPH's statements brought above concerning the Pentagon's refusal to recognize combat PTSD as eligible for the PH, it still exists. The second level of misrecognition is the conceptualization of CPTSD as a disorder or an illness rather than an injury. This concept flags CPTSD as a weakness resulting from the soldier's personality, and marks her/his inadequacy and distinction from their brothers in arms, the heroes who returned from combat with visible wounds.

Finley (2011) brings troubling testimonies of this stigma and misrecognition even by the families of American soldiers coming home from Iraq and Afghanistan: "One mother spoke of her son, who had been diagnosed with PTSD: 'I got the idiot here in the house now. He's afraid to come out.' A young wife, asked about her husband, responded, 'Oh yeah, that dude's a no-good mama's boy—won't

come out” ([1], p. 78). Strikingly, as often happens to victims of misrecognition [47], veterans with CPTSD internalize their false inferior image. One example is a combat veteran with PTSD who wrote a letter to a local newspaper, arguing that it is necessary to “protect” the PH medal from demeaning it by awarding it to PTSD afflicted veterans like himself [4]. Murray (2007), a lieutenant colonel in the US army who was diagnosed with CPTSD after serving in Operation Iraqi Freedom I, testifies that he saw himself as “damaged goods” ([52], p. 3), and was appalled and perplexed by the fact that it happened to him, despite all his training. Veterans with CPTSD experience an oppressive sense of failure and guilt for the death of others [53], for failing to meet their own expectations during the critical moments of battle, or for failing, after the battle, to conform to what they believe are the proper standards of conduct [52]. One of the harming consequences of stigma is refraining from seeking treatment and mental help. There is an overwhelming evidence for correlation between stigma and avoiding health care engagement and treatment by veterans with PTSD. This evidence can be gleaned from studies by: [1,17,54–61] (although some studies such as [62] conclude the opposite). Moreover, research specifically dedicated to stigma and treatment seeking among veterans with CPTSD, clearly show that not only stigma “is formidable” ([61], p. 57), it is internalized and, therefore, “creates an unconscious predisposition against seeking care” ([61], p. 55). Similar conclusions are also reached by Mittal et al. (2013) who found in their study that “most participants reported avoiding treatment early on to circumvent a label of mental illness” ([59], p. 86); by Hoge et al. (2004) [55] and by Kim et al. (2010) [58] who found that stigma and fear of harming a military career prevent members of armed forces to seek help; Sharp et al. (2015) [63] sums it all up by arguing that “across military studies, one of the most frequently reported barriers to help-seeking for mental health problems is concerns about stigma” ([63], p. 1). A report of the US army in 2003 revealed that 59% of the soldiers surveyed worried that seeking mental health care would result in their being seen as weak [1], and a large-scale study by the Rand Corporation, found an enormous lack of utilization of treatment, grounded not only in logistical considerations but also in veterans’ concerns of stigmatization [17]. The latter found profound cultural and social barriers to seeking help among soldiers, deep-seated stigma concerning mental health issues in general, and concerning CPTSD in particular. Approximately half of the service members who screened positive for mental disorder in a survey from the Office of the Surgeon General’s Mental Health Advisory Team, in 2003 and 2005 (cited in: [17]) expressed fears of appearing weak and losing the confidence of their comrades as barriers to getting mental care.

In Taylor’s terms, such stigmatic views lock the individual into a depressing, false existence [46]. When combined with suspected malingering to avoid combat, these views are especially grave: military combat is considered the supreme act of sacrifice for one’s country, and those suspected of evading it by masquerading as psychologically wounded experience shame as such aspersions portray them as unpatriotic.

Perhaps the most alarming evidence for the damage of locking veterans with CPTSD in a depressing and false existence is found in the findings of Kimbrell et al. (2011) [64]. According to their study, the mortality rate among Vietnam veterans with CPTSD who did not receive a PH are twice as high as that of Vietnam veterans with CPTSD who received a PH for their physiological wounds. The researchers note that CPTSD is consistently associated in research reports with early mortality by all causes—internal and external (homicide, accidents, overdose, etc.), even decades after the triggering combat event. Since physiological wounds may definitely be associated with greater physiological vulnerability in their later life, it is reasonable to assume that veterans with a combination of the two injuries, that is, both physiological injuries and CPTSD, would have the highest mortality rate. In their research, however, Kimbrell et al. (2011) found the opposite [64]. Not only did veterans with CPTSD who were awarded a PH live significantly longer than those without a PH, but also in the group of veterans who received a PH (were physiologically injured), there was almost no difference in mortality rates between those afflicted with CPTSD and those who were not. These striking findings echo observations by Taylor (1997) [46] and Fraser (2009) [29] that misrecognition imprisons the individual in a false and depressive existence, which may, in turn, decrease his/her resilience.

5. Discussion and Conclusions

In a recent paper, Solomon et al. (2015) show that loneliness is not limited to the actual experience on the battlefield, and continues to trouble the lives of traumatized veterans in later years [65]. Loneliness may aggravate other psychopathologic developments and is difficult to endure because it is “close to feeling lost” ([66], p. 308). Solomon et al. (2015) show a tight connection between feelings of loneliness and lack of social support among traumatized veterans, and emphasize the importance of social support to ease the feelings of loneliness [65]. Social support may be available from personal social networks but, in war trauma, the fact that an individual’s war injury stems from belonging to the nation [9] makes it critical for veterans to receive social support not only from their families and friends, but from their nation as well, as part of their healing process. When the nation gives them a cold shoulder, by either suspecting their integrity or denying them recognition as war heroes on par with their physiological wounded brethren, their loneliness deepens and their vulnerability increases. This may result in harsh consequences, some of which may explain findings such as the high mortality rate among veterans with CPTSD who did not receive a PH compared to veterans with CPTSD who were also physiologically injured and, therefore, awarded a PH [64].

The opposite of loneliness is belonging [66]. However, American veterans with CPTSD do not feel that they belong. They are excluded from the nation’s embrace that they crave, as they are denied the eligibility for the PH, a symbol of the nation’s ultimate recognition of the veteran’s sacrifice and heroism, and a formal act of social support. When veterans with CPTSD return to their communities, with their invisible wounds bleeding copiously, they do not have a PH medal on their chest to shield them from skeptics in their environment. Often, others see them as they see themselves: undeserving of the nation’s gratitude and recognition, weak people who were unable to face up to their duty, in battle and in its aftermath.

In other countries, which do not award a corresponding medal for injury in battle, nonrecognition is expressed in other ways, and veterans with CPTSD suffer similar feelings of alienation and deep loneliness [65]. Even war heroes are not immune. Sargent major Uri Lerner, an Israeli reservist in the Combat Engineering Corps, was decorated for extracting seven wounded soldiers under heavy fire during the battle of Marj Ayun, Lebanon in 2006, returning several times until he brought all of them to safety. His extraordinary act of heroism, however, did not stand to his credit when his hidden wounds emerged [67]. Lerner was not physiologically injured, but his case is similar to that of American veterans who receive a PH for their physical wounds but not for their CPTSD. Lerner was awarded a distinguished service medal for his heroism, but the stigma of his CPTSD was more powerful than the prestige of his act of heroism.

Evidence from brain research brought above take us back to Ochberg and Shay’s (2012) initial claim that a core component of PTSD is a change in the brain’s pattern of memory, and not just “remembering something terrible” [28]. Reviewing current neuroscience literature provides empirical support to this essential and comprehensive argument by showing an impaired plasticity of the brain’s memory function [37,41,42,45] appearing post and not pre-exposure to trauma. Beyond the correlation vs. causality debate, it is necessary to keep in mind that whether there are predisposed factors to PTSD or not, the outcome of the exposure to the traumatic event clearly shows physiological marks in the brain. Similarly, the outcome of a broken bone is an injury whether or not the wounded person suffered from a predisposed low bone density. In other words, when a person is physiologically injured, her wounds are considered an injury regardless of any undocumented predisposed risk factors that may have existed. Similarly, when discussing the issue of trauma as a disorder vs. trauma as an injury, the question should be what is the result of the exposure to the traumatic event, rather than the vulnerability to be its victim.

From a social justice perspective, such a change is a major way to overcome the stigma attached to CPTSD that obstructs these veterans’ process of healing. In Fraser’s terms (2009) [29], without changing the terminology, empathy and efforts to de-stigmatize veterans with CPTSD remain merely affirmative remedies that deal with the symptoms, but not with the roots of the phenomena; merely a painkiller

where antibiotics are needed. In order to deconstruct the false recognition and build a just one, it is necessary to address the root cause. While there is no doubt that the scientific community should continue exploring the reasons and outcome of combat related trauma, the evidence brought from brain research indicate that there is, to say the least, no reason *not* to name CPTSD an injury. On the background of the above discussion, one may wonder why a “short-circuit” in the brain that prevents CPTSD casualties from properly controlling their mental behavior should be treated differently—for recognition purposes—from physiological wounds that prevent the injured from properly control their physiological organs.

Adopting the term PTSI is essential for helping to de-stigmatize veterans who carry this wound, “justify” their social conduct and suffering in the eyes of their communities, and help them in their healing process. In the US, such recognition would pave the way to include CPTSI in the eligibility criteria for the Purple Heart, convincing the PH committee that, although the eligibility criteria to PH requires bleeding wounds [3], bleeding has more than one form.

Destroying stigma is a difficult process, but it is achievable by enhancing the unjustly devalued identity and by deconstructing the very terms that created the misrecognition in the first place [29]. It seems that replacing the term *disorder* with the term *injury* is an essential step toward full acceptance of war trauma as a genuine injury by the psychiatric and military community, and by the public.

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