

Blurring the Boundaries of War: PTSD in American Foreign Policy Discourse

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Though psychic trauma may be an essential part of the human condition, in recent decades its interpretation as PTSD has had important political consequences. I examine both the political roots of the PTSD diagnosis and the disorder's subsequent impacts on American foreign policy discourse. I draw on a mixed-methods approach, including historical analysis of PTSD's development and quantitative and qualitative analysis of presidential papers, presidential debates, and the *Congressional Record* from the last fifty years. My chief findings are twofold. First, even though PTSD was added to the DSM in 1980, American leaders only began commonly referencing the disorder around the 2008 presidential cycle, more than half a decade into the War on Terror. Second, critical discourse analysis reveals that increased attention to PTSD has contributed to a blurring of important spatiotemporal lines around the concept of war, extending its consequences into an unknown future and outside the war zone. This erosion has profound normative consequences, considering how it similarly blurs the pivotal ethical distinction between victim and perpetrator. These findings not only elucidate an evolution that has taken place in American foreign policy, but also speak to the more general conceptual challenges posed by war trauma.

In 1988, two conflicting reports revealed an emerging issue for the U.S. military and, indeed, a developing trend in U.S. public discourse at large. In the first, the Centers for Disease Control (CDC) found that only 2.2% of Vietnam veterans were experiencing post-traumatic stress disorder (PTSD)—surprisingly low rates, analogous to those found in the general public (Centers for Disease Control 1988). However, the second, the National Vietnam Veterans Readjustment Study (NVVRS), commissioned by the U.S. Senate, offered a far bleaker outlook. More than fifteen years after the war's heaviest combat had ended, the NVVRS found that more than 15% of veterans *still* had PTSD. The report further estimated 30.9% had developed the disorder at some point since deploying and another 22.5% experiencing partial symptoms (McNally 2007). These figures seemed improbable on their face, as

only 15% of military personnel during the Vietnam War had been assigned to combat. But the NVVRS anticipated detractors and dedicated multiple pages to outlining how its methods were in line with the American Psychiatric Association's (APA) 1987 revision of the Diagnostic and Statistical Manual of Mental Disorders' (DSM) third edition (Kulka et al. 1988). These updated criteria had significantly broadened the original formulation of PTSD in 1980's DSM-III by adding in the possibility that those not exposed to a violent event could suffer PTSD vicariously after "learning about a serious threat or harm to a close friend or relative" (Committee on Nomenclature and Statistics 1987). In testimony to the U.S. Senate on their report, the NVVRS authors argued that their methods were "both more comprehensive as well as more complex" than the CDC's, whose report they claimed reflected outdated criteria (U.S. Senate Committee on Veterans' Affairs 1988).

In retrospect, the NVVRS proved the more influential of the two reports and, in the decades since, its diagnostic approach has become the norm in military and civilian psychiatry (Horwitz 2018, 152). Beyond reflecting evolving psychiatric standards, the NVVRS found a sympathetic audience in American political culture, resonating with the Vietnam War's immense long-term unpopularity and growing social acceptance of war's psychic consequences as soldiers returned from combat and struggled to reintegrate (McNally 2007, 193). Since its publication, the number of former soldiers receiving Veterans' Administration (VA) disability benefits for PTSD skyrocketed from under 35,000 in 1990 to approximately 650,000 in

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2013 (Zaremba 2014). These numbers included veterans of all twentieth- and twenty-first-century wars, including nearly 350,000 Vietnam veterans and 250,000 from the Persian Gulf War and the Global War on Terror (GWOT). But even the large numbers on the VA rolls likely understate many more veterans diagnosed by private physicians or suffering without professional care. For example, VA researchers drawing on a meta-analysis of other studies estimated in 2015 that approximately 23% of veterans of the U.S. wars in Iraq and Afghanistan would experience PTSD (Fulton et al. 2015). Though extrapolating from averages across multiple studies can be problematic, if similar rates hold true across the 2.77 million American military personnel that served between September 11, 2001 and 2015, over 600,000 veterans of the GWOT alone would be eligible for the diagnosis.

This massive increase in diagnoses has transformed PTSD into a “powerful cultural script,” with numerous downstream impacts on American public discourse and beyond (DeGloma 2011, 59). First and foremost, it has led to a parallel increase in diagnoses among civilians, stemming in part from landmark feminist scholarship that has problematized masculine warrior mythology and identified gender violence and sexual abuse as leading causes of psychic trauma (see, for example, Herman 1992). This scholarship has extended to female veterans suffering from trauma due to military sexual assault, further intertwining public perceptions of the military and PTSD (Kelly et al. 2011). Second and relatedly, increased attention to and research on PTSD in the psy disciplines has buoyed the interdisciplinary trauma studies field in Western humanities and social science, expanding research to investigate trauma’s representational and social impacts beyond the psyche (Stuber 2002). The PTSD diagnosis has even been stretched to a variety of other non-clinical contexts, infusing, for example, global humanitarian discourses and leading to what Vanessa Pupavac (2001, 2002) has identified as a “pathologizing” of post-conflict populations in the developing world. As Fassin and Rechtman write, in the decades since PTSD’s codification, trauma has become “one of the dominant modes of representing our relationship with the past,” applied in varied ways across cultural contexts and historical periods. Yet even as trauma research has extended far beyond the confines of the initial Vietnam-era DSM diagnosis, in American political culture PTSD remains the dominant interpretation of trauma and it is most commonly associated with combat veterans struggling to reintegrate (Chamberlin 2012). During his time in the Senate and into tenure as President, Barack Obama came to refer to PTSD as a “signature wound” of the GWOT—a distinction that has since caught on across the American political spectrum (Kieran 2019).

While much interdisciplinary scholarship has critically examined PTSD’s politicized history and spread,¹ far less has focused on the disorder’s subsequent productive

power—its ability to shape discursive meanings and relationships that constitute common knowledge—in pivotal foreign policy debates on military intervention (Barnett and Duvall 2005). This is a notable gap. Contrary to traditional masculinized warrior mythology, recent decades have seen a surge in public discourse on war’s emotional and psychological tolls, raising questions about PTSD’s political impacts. What role does psychic trauma play in debates about war’s consequences? Already, numerous International Relations (IR) scholars have theorized the immense impacts of trauma, broadly defined, on shaping political communities and grievances (Edkins 2003; Fierke 2004; Hutchison 2016; Lerner 2019c, 2019b, 2019a). But this literature has largely reflected understandings of trauma developed in the humanities and social theory, rather than the medicalized PTSD diagnosis, which has become the dominant means of interpreting trauma in the United States. Alternatively, Alison Howell (2012) has examined how, since approximately 2010, U.S. military psychiatry has pushed back against PTSD’s expansion and begun a slow effort to shift its governance of soldiers’ mental health to either neurobiological or resilience-based approaches. But, by this point, the PTSD diagnosis had spread out far beyond clinical contexts and become a prominent idiom for mainstream political discourse. How has PTSD impacted American foreign policy debates about war and military intervention in the twenty-first century? To be sure, U.S. foreign policy debates only make up a portion of the larger international political discourses that shape understandings of war and PTSD is only a single, medicalized interpretation of trauma. But because of the United States’ disproportionate role in relevant international political discourses on armed conflict and because the PTSD diagnosis has spread across the globe, answering these questions can help orient theoretical reflection. Indeed, because PTSD was both developed within American psychiatry and has been applied widely to American soldiers in the twenty-first century, the U.S. GWOT proves a potent critical case for examining trauma’s impact on key international political imaginaries.

In this article, I examine how PTSD’s politicized emergence as a signature wound of modern conflict has become intertwined with pivotal foreign policy debates. In the next section, I consider relevant literature on the concepts of war and trauma, outlining how the latter can uniquely problematize traditional conceptualizations of the former, as well as the normative challenges of this interaction. Then, in the following section, I draw on diverse primary and secondary sources to briefly sketch out PTSD’s political history, including both its politicized emergence and political responses to this knowledge production. This section distills from the historical record an iterative model of psychosocial governance and diagnostic categories’ productive power, justifying my subsequent empirical focus.

The subsequent two sections turn to a mixed-methods analysis suited to the interdisciplinary nature of the research. I employ what Paul Baker and his collaborators (2008) have described a “useful methodological synergy” between quantitative content analysis and qualitative critical discourse analysis (CDA) of invocations of PTSD (see also Baker 2006; Fairclough 2013), trauma and their cognates in 49,667 American presidential papers and 128 presidential debates (both primary and general election) since the Nixon administration (Woolley and Peters 2019). First, I analyze frequencies and colocations to determine the periods of highest relevance (confirming these findings’ robustness with similar analysis of 630,266 documents from the *Congressional Record*, 1995–2019) and then, in the following section, I employ a CDA of PTSD’s meaning in context. Ultimately, I demonstrate how PTSD’s inclusion in GWOT debates has contributed to recent decades’ blurring of the concept of war in American foreign policy discourse. Once absent from presidential discourse, PTSD has become increasingly commonplace in presidential discourse since the 2008 election cycle among politicians of both major parties. Its presence in these debates, I demonstrate, has furthered a subtle erosion of war’s spatiotemporal limitations, as well as the pivotal, related normative distinction between victim and perpetrator.

Trauma’s Challenge to the Concept of War

War is a central political science concept, implicit in almost all paradigmatic grand theories of the international system and key theoretical dynamics like the security dilemma, the balance of power, and deterrence. Yet, despite war’s omnipresence in the IR discipline, traditional understandings in both academia and the general public have long contained problematic assumptions (Barkawi 2016), including about war’s containment in both time and space. Mary Dudziak (2010, 2012), for example, has argued that even though popular conceptions of wartime conceive of it as a distinct period, wartime’s legal and political state of exception is often distinct from the time in which fighting occurs, problematizing any neat delineation of war’s beginnings and ends. David Keen (2000, 1–2), in a similar vein, has argued that mainstream understandings of war reflect a problematic “sporting model” of military conflict taking place in a specific geographic arena, with a beginning and end, and even “goodies and baddies.” Though Keen’s terminology may seem risibly simplistic, it rhymes with operationalized definitions used in contemporary quantitative empirical scholarship that define war as spatiotemporally delimited. Numerous widely cited datasets classify wars based on duration and location, limiting them to specific battlefields or war zones, as well as delineated periods of wartime (Gleditsch et al. 2002; Raleigh et al. 2010; Sarkees and Wayman 2010).

Despite the appealing parsimony of such a contained definition, numerous scholars, including Dudziak and Keen, have challenged its spatiotemporal assumptions from multiple disciplinary perspectives. For example, scholars of religion have pointed out how various theological traditions have long understood war as an earthly manifestation of divine prophecy, endowing localized conflicts with mythic timescales and transcendent purposes (Silverman 2002). Likewise, ample critical military scholarship has examined how technological changes undermine the contained arena implicit in “sporting” models (Brenner and Clarke 2010; Lubell and Derejko 2013), while landmark feminist work has similarly criticized the gendered implications of divisions between the home front and the war zone (Sjoberg 2013; Sjoberg and Gentry 2007; Sylvester 2013). Helen Kinsella (2011), alternatively, has critically dissected the oftentimes problematic lines drawn between civilian and combatant that ground ideas about war. Outside of IR, global histories have offered specific critical re-examinations of the spatio-temporal boundaries of past wars, revealing how, for example, World War I wasn’t truly resolved in 1918 (Gerwarth 2017) or how the Second Sino-Japanese War, World War II’s Pacific Theater, and the Chinese Civil War can best be understood as “nested” together—a multi-decade period of intertwined conflicts (Paine 2014). This work all suggests that war oftentimes has murky spatio-temporal boundaries and can perhaps best be understood as a sensitizing concept, subject to continual evolutions in meaning across time and space due to cultural, technological, and normative changes.

Trauma, in its varied forms, poses a unique challenge to war’s spatiotemporal boundaries, blurring oftentimes overlooked psychic distinctions in addition to physical, temporal and conceptual ones. In individuals, war’s violence is typically understood as traumatic to the degree that it shocks the psyche, disrupting linear timing and preventing immediate understanding (Hacking 1998). For this reason, a common trauma-related symptom, documented across generations, is delayed, involuntary, and vivid flashbacks to precipitating violence after leaving the dangerous context (Horwitz 2018). According to such thinking, what makes an experience traumatic is not so much its immediate contents, but rather the way it intrusively reasserts itself after a latency period. Notably, this process of “acting out” trauma is not simply a form of remembering, which involves engaging with past events from a distance. Rather, it is a form of *re-experiencing*, oftentimes in vivid dreams or flashbacks that cannot easily be relegated to the past. In this sense, trauma makes violence an ongoing psychic threat to victims, even after they return to physical safety on the home front in peacetime (LaCapra 2001; LaCapra and Goldberg 1998). Trauma survivors bring violence home with them and, when their suffering continues and inhibits reintegration, it ripples out through

their families and communities. As they bear witness to their experiences in military conflicts and struggle to reintegrate to domestic life, their trauma can become a pressing socio-political concern even after the battles in which they fought have ended. Indeed, as traumatized veterans' ongoing suffering extends war's consequences across their communities at home and into an uncertain, undefined future, it seeps into the foreign policy discourses that define the subjects and objects of international politics (Hansen 2006).

The distinct contribution of trauma to war's spatiotemporal erosion entails similarly unique, yet profound normative implications, especially in delineating victim from perpetrator in a quest for retributive justice. As Hom (2018, 70) has written, subjective interpretations of time are framed by "social agents establish[ing] meaningful relationships between processes of change so that they unfold in ways conducive to orientation, direction, and control." An especially ethically-charged example of these meaningful relationships is cause and effect—understood here via common social attribution rather than underlying mechanism. Due to the complexities inherent in social life, actors often interpret otherwise opaque causality from how events follow one another in time. An action is understood to lead to a subsequent reaction, whether or not a firm causal link can be established. But as trauma disrupts linear timing, it can similarly disrupt implicit understandings of cause and effect, as well as the politicized narrations of blame such understandings inspire. When veterans suffer from trauma long after leaving the war zone or after combat operations have ceased, the cause of their psychic pain is a contentious subject, that can be narrated in multiple politicized ways. In this way, trauma's ability to confuse causality complicates blame's attribution in political discourse—a dynamic magnified by veterans oftentimes sympathetic portrayal in media reports. In recent years numerous soldiers dishonourably discharged from the military or facing criminal charges for violent behaviour have even appealed rulings by invoking PTSD (Hattenstone and Allison 2014; Rowan 2016).

Indeed, the socially-constructed categories of victim and perpetrator are not simply descriptive of implied causality—they are "in variable ways . . . social, political, and *ethical*," employed in normative discourses to absolve certain actors and assign blame to others (LaCapra 2001, 79). Though initial media accounts and political narratives may describe a battle as having distinct groups of survivors and victims, psychic trauma can reconfigure these discursive relationships. When otherwise physically unscathed soldiers receive PTSD diagnoses, they are often labelled a new category of war's victims—a shift with enormous political consequences. Though these same soldiers may have instigated unjust violence or, as some may argue, participated in a larger unjust military intervention, a PTSD diagnosis—in lieu of the more nuanced distinction

of moral injury—often facilitates their reception of limited public sympathies.² And, as my later empirical analysis will demonstrate, because of the immediacy of traumatized veterans' suffering as they return to the home front and reintegrate, political leaders often prioritize their needs over the legacy of those whose suffering has been discursively relegated to the past or a distant foreign war zone. Indeed, this is especially the case when those potential victims are foreign citizens. Trauma is a powerful discursive resource for eliciting empathy and motivating political action, but its relativizing nature leads to ethical quandaries over who deserves limited public sympathies and who deserves blame for instigating violence.

PTSD's Political Roots

Trauma-related symptoms have likely always been a part of the human condition. In the American context, recognition of post-traumatic "war syndromes" dates back to Jacob da Costa's diagnosis of "irritable heart syndrome" among Civil War veterans experiencing numbness, shortness of breath and rapid pulse after leaving the battlefield (Hyams, Wignall, and Roswell 1996). Yet, even as loosely defined ideas about related disorders like "railway spine" and "florid hysteria" developed throughout the nineteenth and early twentieth centuries (Horwitz 2018, 35–39; Micale 2010), the codification of the PTSD diagnosis would require an iterative process of psychosocial governance and productive power. Modern wars created constituencies of trauma survivors and military psychiatry responded by creating diagnostic categories. In turn, these diagnostic categories seeped into public discourse, influencing political debates.

The first major war of the twentieth century—World War I—was thus a turning point for still inchoate ideas about psychic trauma circulating among doctors and psychoanalysts (Jones and Wessely 2005, 1–16). Approximately 800,000 British, 800,000 French, and 100,000 American soldiers displayed war trauma symptoms both during the war and after. Initially, most physicians labelled soldiers' symptoms "shell shock," believing they stemmed from nearby explosions' physical impacts, but this theory broke down upon scrutiny. As the medical field debated, Sigmund Freud revised his previous, gendered "seduction theory" of hysteria stemming from repressed childhood sexual fantasies and offered what became a widely-influential alternative (Horwitz 2018, 53–58). In a conceptualization resonant with later criteria for PTSD, Freud theorized psychic trauma as the result of violent, shocking encounters, which disrupted the linear timing that guided soldiers' psychic lives. "Fixation to the traumatic accident lives at their root," Freud (1966, 274–75) wrote. "It is as though these patients had not yet finished with the traumatic situation." As psychoanalysis' influence expanded in the coming decades, Freud's post-World War I explanation for shell shock—later commonly

referred to as “war neurosis” or “battle fatigue”—proved increasingly influential.

Yet trauma-related symptoms continued to elicit suspicion from many political and military leaders, who often assumed traumatized soldiers were malingering. Even Charles Myers, the British physician credited with coining the term shell shock, later questioned his brainchild’s potential for abuse. Having heard numerous officers complain about soldiers feigning symptoms to earn a pension and “wound stripe”, Myers wrote that “it had proved impossible to legislate for the bad, without doing injustice to the good” (Shephard 2000, 29). While some traumatized soldiers received what then constituted advanced medical care and military pensions, lingering suspicion led others to be dismissed as “insane” by doctors or simply rebuked by commanders under threats of execution. As the war progressed, the British, American, and French militaries attempted to bypass trauma’s long-term impacts by instituting “forward psychiatry” according to the PIE acronym—treating shell shock victims *proximate* to battle, *immediately*, with the *expectation* that they would return to combat. In theory, this normalized wartime psychiatric care, but, in practice, it served what Freud later called “a role somewhat like that of a machine gun behind the front line, that of driving back those who fled” (Jones and Wessely 2005, 17).

The interwar period in the United States saw a major increase in veterans’ political influence, buoyed by groups like the American Legion, which formed in 1919 and attracted approximately 850,000 members within its first year. This provided an enormous impetus for the 1921 creation of the Veterans Bureau, the forerunner of the modern Veterans Administration (VA), which quickly became the U.S. government’s largest department, allocating approximately \$1 billion to veterans with psychic impairments during the interwar period (Cox 2001). Yet these benefits continued to provoke backlash among critics who maintained masculinized disregard for trauma or believed they created perverse incentives that worsened traumatized veterans’ reintegration. World War I veteran and professor Willard Waller (1944, 168, 267), for example, warned that benefits would do “positive harm to the psychoneurotic” and “create ill-feeling” towards veterans. “Fakers” and “chisellers,” he wrote, ended up with “the benefits for which others are too proud to apply.”

As World War II again necessitated mass conscription, the U.S. military attempted to preempt future issues with policy changes intended to screen out potential malingerers and those prone to psychic trauma. The Selective Service System contracted psychoanalyst Harry Stack Sullivan to filter out “undesirables,” whom the military deemed potential trauma sufferers. From 1941–1944, Sullivan’s methods removed 12% of eligible recruits, six times the rate during World War I (Pols and Oak 2007). Nevertheless, these interventions failed to prevent more than a million American military personnel (over 5% of all servicemen) from

requiring psychiatric treatment (Horwitz 2018, 69–70). As the war progressed, military psychiatry’s skepticism of psychic trauma waned, and many policymakers began to accept that “normal” soldiers could equally succumb to trauma. After World War II, psychiatric patients constituted 60% of those treated by the VA, with approximately 500,000 receiving pensions, forming an enormous and visible bloc in American society (Horwitz 2018, 75). During the Korean War, the U.S. military readily employed PIE principles that available evidence suggest were largely successful in minimizing trauma’s impact (Shephard 2000, 341–43).

In this context, in 1952 the APA published its first DSM, including the diagnosis of “Gross Stress Reaction” (GSR) clearly inspired by military psychiatry. GSR described soldiers’ psychiatric impairments as serious, but also temporary and eminently curable (Committee on Nomenclature and Statistics 1952, 40). Yet the more than decade-long period of peace and prosperity from the early 1950s to the beginning of the Vietnam War resulted in a waning of psychic trauma in public discourse, leading the APA to overlook the psychic consequences of combat as it drafted the DSM’s second edition. Published in 1968, the revision removed the GSR diagnosis, housing post-combat symptoms instead under the ostensibly less severe diagnosis of “Adjustment Reaction of Adult Life.” This diagnosis grouped together diverse examples like an “unwanted pregnancy,” and a soldier merely experiencing “fear” due to combat as different types of “transient situational disturbances” (Committee on Nomenclature and Statistics 1968, 48–49). This diagnostic category downplayed the gravity of soldiers’ suffering and effectively prevented long-term treatment (Wilson 1994).

The U.S. intervention in the Vietnam War and resulting anti-war movement revived these dormant debates, again revealing trauma’s conceptual dependence on international politics. During the war’s early years, rates of reported psychic casualties were strikingly low—less than one-third of the Korean War and one-tenth of World War II. These initial figures were unsurprising considering that 85% of Vietnam-era soldiers saw no combat and drafted soldiers’ mandatory service lasted only one year. Yet the decline in public popularity of the war’s mission fueled young soldiers’ increasing social discomfort with their experiences (Horwitz 2018, 85–86). Vietnam Veterans Against the War (VVAW), founded in 1967, became a leading force in a public campaign to distinguish policymakers’ unpopular motivations from the plight of conscripted soldiers. VVAW organized “rap groups” in which veterans would talk about their experiences, creating a therapeutic environment outside the VA, which was constrained by the limitations of DSM-II’s diagnoses (Lembcke 1998). Two psychiatrists—Chaim Shatan and Robert Jay Lifton—who participated in rap groups became leading figures in the movement to pathologize

veterans' struggles returning home. Shatan (1972) coined the term "post-Vietnam syndrome" in a New York *Times* editorial criticizing DSM-II era treatments, while Lifton's influential *Home from the War* (1974) outlined the medical consequences of survivor's guilt. Lifton testified to the U.S. Senate in January 1970 that such guilt could predispose veterans to "distrust of the civilian environment" that might inspire "outlets for a pattern of violence to which they have become habituated," creating a patina of fear around the public's complex feelings on returning troops (Lembcke 1998, 49–50). Over time, anti-war groups' portrayal of Vietnam veterans' difficulties readjusting provided a potent cultural script, inspiring numerous popular media accounts.

The VA's inability to compete with the VVAW's "street-corner psychiatry" posed a challenge for mainstream American military psychiatry (Lembcke 1998, 44). At the time, the APA was overhauling the DSM, purging previous editions' psychoanalytically inspired diagnoses and replacing them with empirically-supported diagnostic criteria that alluded to disorders' root biological causes (Decker 2013). Vietnam veterans posed a problem for this agenda. The idea that veterans suffered not only from their experiences on the battlefield, but also from their social reception upon returning to a polarized home front, conflicted sharply with the idea that mental disorders should be thought of primarily biologically. Nonetheless, veterans' lobbying forced Robert Spitzer, Chairman of the APA's Task Force on Nomenclature and Statistics, and his colleagues to reconsider. Lifton and Shatan, as well as former marine Jack Smith, convinced Spitzer to include them on the relevant drafting sub-committee and they helped shape a diagnosis relevant to the symptoms and social struggles of combat veterans. DSM-III, published in 1980, included the compromise PTSD diagnosis, utterly dissimilar to most of the manual's other classifications (Scott 1990). The diagnosis portrayed trauma as socially-mediated, but, in keeping with Spitzer and the APA's efforts at imposing rigor, it mandated that patients express at least four symptoms from three clusters (twelve total)—a threshold that, to this day, inspires much confusion (Committee on Nomenclature and Statistics 1980, 238).

In the decades since PTSD's inclusion in DSM-III, new editions have largely preserved its overall approach, though they have slowly expanded its applicability. The DSM-III-R (1987) included for the first time vicarious traumatization—"learning about a serious threat or harm to a close friend or relative" (Committee on Nomenclature and Statistics 1987, 248). This greatly increased the pool of potential victims, especially among veterans who did not experience combat. Overall, increased public attention to PTSD has reverberated back to the veterans' community, as the number of veterans seeking VA treatment and benefits from 1990–2010 increased over fifteen times (Zarembo 2014). The latest edition, DSM-V (2013), added more

specificity to the diagnostic criteria, but thus far has not resulted in a meaningful decrease in VA diagnoses.

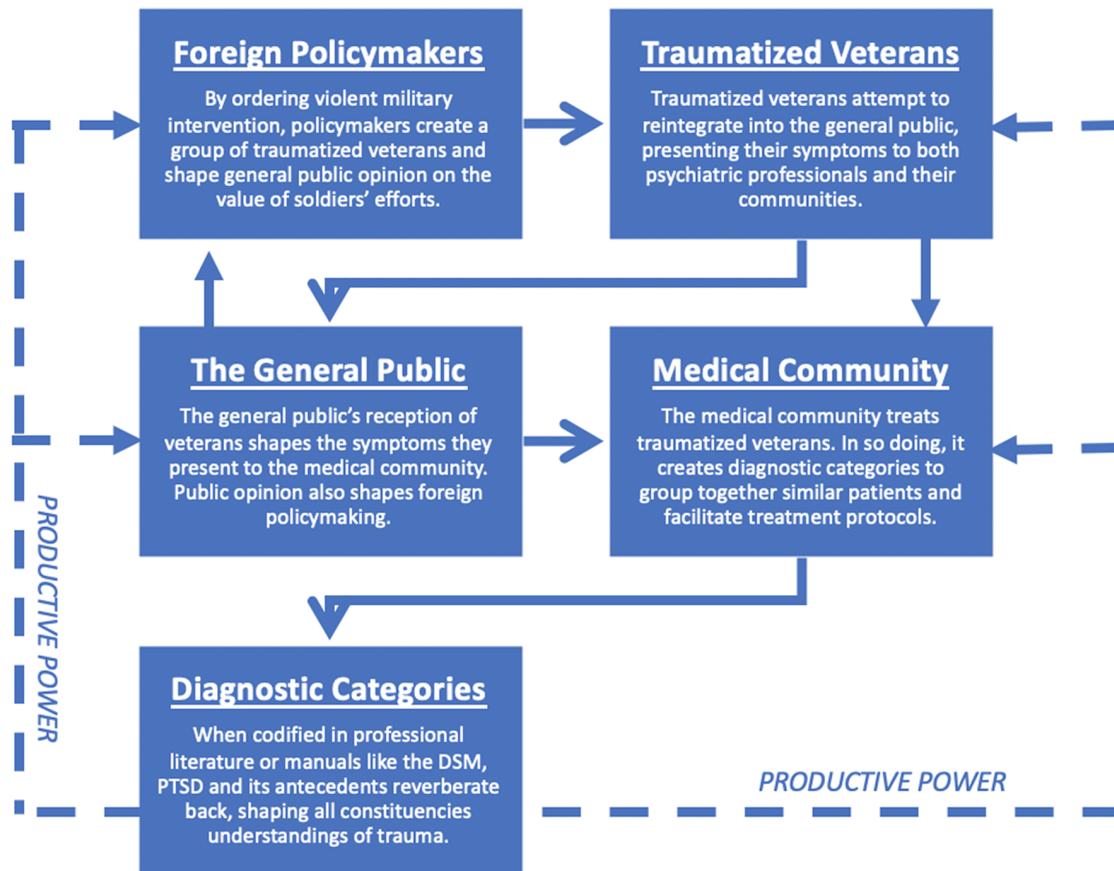
This historical examination of PTSD's politicized development and mainstreaming in twentieth-century American public discourse reveals an iterative process of knowledge production, outlined in figure 1. This process begins with the foreign policy decision to go to war, which creates constituencies of traumatized veterans. As they encounter difficulties both continuing in their service and reintegrating into the general public, they consult medical professionals. Presented with veterans' diverse trauma-related symptoms, the medical community codifies diagnoses that frame treatment protocols and shape supposedly universalistic medical knowledge. Finally, as this medical knowledge spreads into general public discourse, including foreign policy discourse, it exerts productive power on key debates. Due to institutionalized medicine's prestige and authority in American culture, new understandings shape not only which patients seek diagnosis and treatment, but also how all groups *interpret* traumatic events and their relationship to international politics. Though the model is specific to PTSD, it is potentially adaptable to multiple other institutionalized knowledge production processes.

In the next two sections, I turn more explicitly to the "productive power" of PTSD's seepage into general public discourse. But before continuing, it is worth briefly mentioning how another faction of the general public—academia—has adapted knowledge of trauma, creating a further avenue of knowledge production. Since PTSD's codification, academic research on trauma has branched out into the interdisciplinary field of trauma studies. Pioneered by theorists like Cathy Caruth (1996), Dominick LaCapra (2001), and others, trauma studies scholarship has sought to explore trauma's impacts *beyond* the mind, including on the social world and its representation in literature and history. Though, as I demonstrate, PTSD has been trauma's most important interpretation in American foreign policy discourses, undoubtedly this additional form of productive power has had overlapping effects, buoying interest in trauma in both media and numerous humanities and social science disciplines.

PTSD in American Foreign Policy Discourse

Since the U.S. involvement in the Vietnam War and the subsequent codification of PTSD in 1980, general American public discourse on PTSD has increased substantially, indicating that the initial knowledge production of American psychosocial governance has spread sufficiently to facilitate the productive power outlined in the schema. Chekroud and his coauthors (2018), for example, outline not only an evolution in terminology used to describe trauma-related symptoms among veterans in 14 million articles from three leading American news outlets

Figure 1
The iterative process of American psychosocial governance



(*New York Times*, Reuters, Associated Press) that tracks with the previous section's historical analysis, but also how the relative amount of press attention paid to trauma-related symptoms increased substantially from World War I to the post-Iraq War era. Their analysis finds that the peak years of discussion of Vietnam War- and Iraq War-related psychic trauma (approximately 1989–1991 and 2009–2012 respectively) witnessed more than three times as high a proportion of articles employing the era's leading diagnostic term than during the World War I-era's peak (1918–1921) and more than double the World War II-era peak (1944–1946). Likewise, results from Google Ngram, which queries a database of approximately 5 million English-language books from 1500–2008, demonstrates that rates of PTSD's invocation more than doubled from 1990–2000 and then doubled again from 2000–2010 (Michel et al. 2011). These indicators rhyme with scholarship on trauma studies' historical emergence around a decade after the DSM's codification of PTSD in 1980—another potential result of the disorder's productive power.

PTSD's codification in 1980's DSM-II resulted from the process outlined in figure 1 and began exerting productive power on non-medical discourses. But twenty-first-century U.S. foreign policy decisions have continued this iterative process, increasing the disorder's urgency in foreign policy discourses about war and its consequences for multiple reasons. First, the GWOT's military interventions began a significant period after PTSD's codification and the advent of trauma studies scholarship increased awareness of war trauma in American culture. By the early twenty-first century, more so than even in the late 1980s and early 1990s, "the psychologically damaged Vietnam veteran had penetrated cultural expectations," leading veterans of the GWOT to associate their difficulty reintegrating with the disorder and the public at-large to sympathize with them as PTSD victims, rather than viewing them with suspicion (Horwitz 2018, 151). Second, unlike the Vietnam War, which government officials articulated as an effort to contain communism in North Vietnam (though combat operations reached across Southeast Asia), the GWOT was articulated at its outset as *global*,

with vague goals to be achieved over an uncertain time-frame. It began with the September 11, 2001 attacks in the United States and has continued in some capacity for the past two decades, including military interventions in Afghanistan and Iraq, subsequent al-Qaeda attacks and plots in North America, Europe, and Asia, and military and police actions peppered across the globe. With soldiers called upon to serve multiple, lengthened tours of duty and widespread fear of continual threats against the United States, the PTSD diagnosis became a prominent idiom for grappling with the spatiotemporally ill-defined GWOT's psychic impacts and explaining soldiers' plight in such an uncertain conflict to the American public at-large (Howell 2011). Third, unlike during the Vietnam era, when veterans were often polarizing figures in American society (Scott 1993), the GWOT era all-volunteer U.S. forces has remained a prestigious and influential political demographic, courted by both major political parties (Bishin and Incantalupo 2008). Thus, drawing attention to veterans' plight has become a favored political tactic across the American political spectrum.

To determine how precisely this productive power has impacted elite foreign policy discourses about war and its consequences, I turn now to a dataset of presidential papers from 1969–2016 and presidential debates from the last five election cycles (Woolley and Peters 2019). Because the American president is the leading foreign policy official in the United States and Commander-in-Chief of the Armed Forces, presidential documents (including speeches, statements, transcribed interviews, and press conferences) and the election debates in which candidates audition for the job constitute a representative public-facing dataset of the official articulations of conceptualizations of war in American foreign policy discourse that prove most decisive in policymaking. And though perhaps biased by the unavailability of still-confidential sources, because this dataset includes both Democratic and Republican administrations, as well as an array of prominent presidential aspirants, I argue that it approximates some of the diversity of the larger American foreign policy discourses in question. To demonstrate the robustness of these findings, I have conducted similar analysis of the Congressional Record (2020). Though less public-facing and, arguably, less representative of the elite foreign policy discourse that shapes military interventions, these findings substantially complement with those from presidential papers and debates.

Evidence for a Discursive Shift

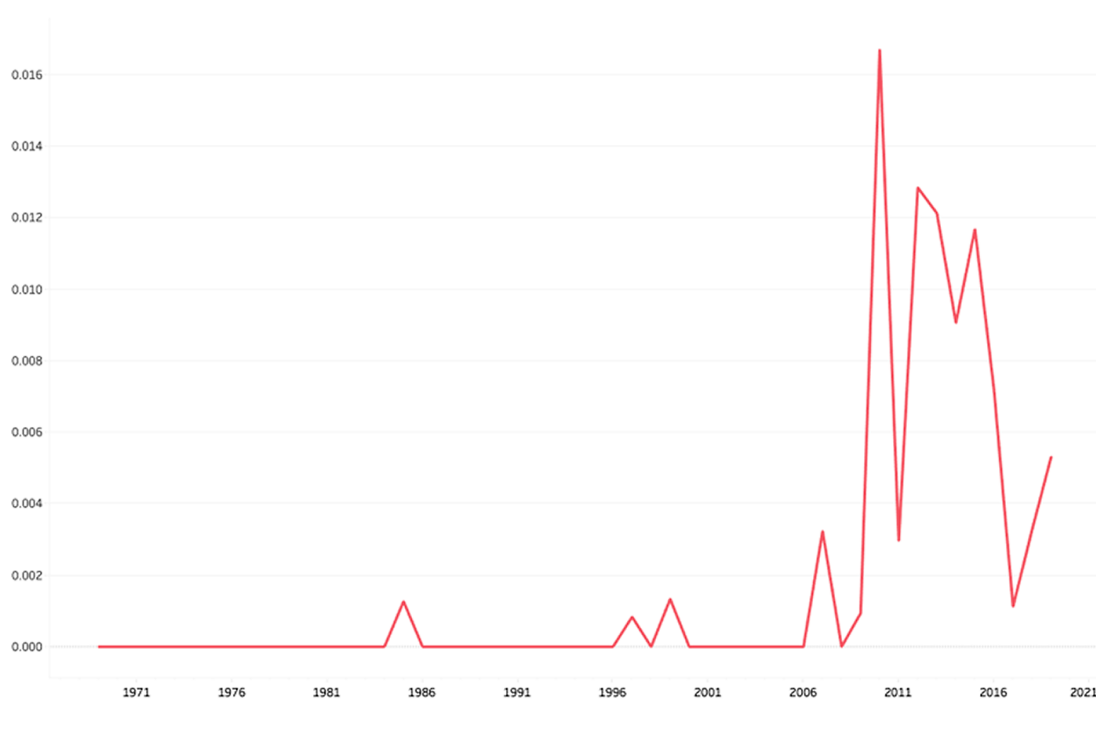
Initial examination of presidential papers (see Figure 2) and the *Congressional Record* (see Figure 3) reveals a deviation from trends in broader public discourse.³ While invocations of PTSD in both newspaper articles and

published books increased substantially throughout this period, all of the elite political databases under examination exhibit a significant delay before following suit. Not until the mid-2000s did presidents and presidential candidates begin mentioning PTSD and antecedent diagnostic terms.⁴ This delayed response is somewhat surprising—for twenty-five years following PTSD's insertion into the DSM (1980–2005), as the number of veterans receiving benefits for the disorder quintupled, presidents mentioned PTSD and its cognates only four times in 25,558 total documents (Ronald Reagan once and Clinton three times). Further, only one of these four invocations referenced combat even obliquely—Reagan (1984) spoke of teachers facing school violence experiencing “symptoms identical to those of World War I shell shock victims.”

This changed after the 2004 election cycle and accelerated even more so after President Barack Obama's inauguration. From 2005–2016, rates of invocations of PTSD and cognates rose from 0.16 to 7.36 per year. Though Obama invoked PTSD and cognates more than any other president, the term was not limited to his Democratic administration. Republican George W. Bush mentioned it three times late in his presidency and Republican Donald Trump used it eight times in the first three years of his presidency—the final years under analysis (2017–2019). Data from the Congressional Record, including speakers from both major parties, mirrors this significant upward trajectory, buoyed by a similar spike during 2007–2008's 110th Congress.

Data from presidential campaign debates held between 2000–2016 (five presidential cycles) complements this data and provides further examples of PTSD's spread from the Democratic party across the political spectrum (see Figure 4). During the 2000 and 2004 presidential cycles, PTSD and cognate diagnostic terms were not mentioned once during the primary or general election, presidential debates. This is perhaps unsurprising for the 2000 cycle, as the United States had not yet experienced the September 11 attacks and had not been involved in a major war since the first Iraq invasion almost a decade prior. Yet by the 2004 cycle, veterans had begun returning from the wars in Afghanistan and Iraq, begun in 2001 and 2003 respectively, and terrorism and the Iraq war polled as top issues for Americans (Gallup, Inc. 2003). Further, a spate of nineteen soldier suicides during the summer before the election led to headlines on military mental health across the country (Kieran 2019, 76). Still, during the election cycle these wars remained broadly popular and returning veterans encountered a more positive social climate, obscuring the plight of those developing long-term PTSD symptoms. Further, each candidate had a specific, personal incentive to neglect the issue of combat trauma. While President George W. Bush was championing the invasion as a triumphant victory, the Democratic candidate, John Kerry, faced longstanding unfounded attacks from groups

Figure 2
Proportion of presidential papers referencing PTSD and antecedent diagnostic terms (1970–2019)



like Swift Boat Veterans for Truth that his record as a Naval officer during the Vietnam War was exaggerated or faked.

By the 2008 presidential cycle, however, this dynamic changed sharply on the Democratic side, as the Iraq war's unpopularity was a top campaign issue. Candidates mentioned PTSD explicitly eleven times in nineteen Democratic primary debates. It was again mentioned three times in the 2012 cycle's debates—this time by Republican Michelle Bachmann and then-President Barack Obama—and then again five times in 2016 debates by even numbers of Democrats and Republicans.

The relative increase outlined in these corpuses is noteworthy considering both the breadth of issues under discussion at such debates and how these trends resonate with the recent history of American foreign policy. And though sporadic references to PTSD and antecedent terms during the decades before the 2008 presidential cycle did not consistently invoke the disorder with reference to any particular set of policy issues, the disorder's rise in prominence during the late 2000s is noteworthy due to its invocation in *foreign* policy discourse. During the 2008 presidential cycle, for example, PTSD was invoked exclusively with reference to veterans returning from combat in Iraq and Afghanistan, rather than as a broad disorder which could afflict victims of numerous types of

experiences. Indeed, *every* reference to the disorder except for one at presidential debates during the 2008, 2012, and 2016 cycles referred to veterans of recent wars and a large majority of these invocations related the disorder to both veterans' health care *and* American national security. Though less uniform, references to PTSD in presidential papers and the Congressional Record during this period also typically occurred, implicitly or explicitly, with reference to America's twenty-first-century wars, demonstrating the necessary intertwining of veterans' issues with those of foreign policy and national security. When considered alongside the massive increase in American public discourse on trauma generally and PTSD more specifically, beginning the two decades before these invocations, these figures support the conclusion that, after a delay, diagnostic terminology not only *reached* the most elite levels of American foreign policy discourse, but also that its productive power was applied most specifically in relation to the GWOT.

Blurring War's Spatiotemporal and Ethical Boundaries

By the 2008 presidential cycle, Democratic candidates realized that deploying PTSD would facilitate criticism of the consequences of Bush administration hawkishness,

Figure 3
Proportion of Congressional Record from 104th–116th Congress referencing PTSD and antecedent diagnostic terms (1995–2019)

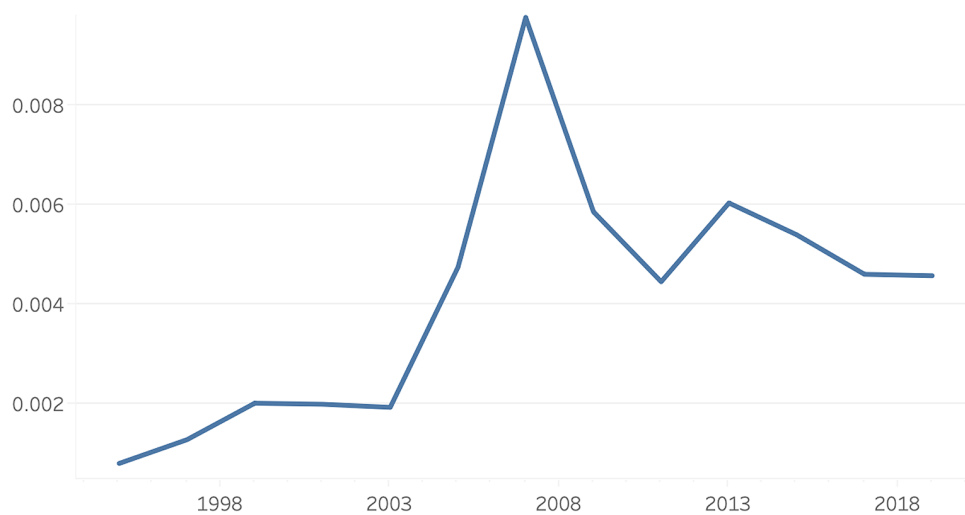


Figure 4
PTSD and antecedent diagnostic terms at presidential debates (2000–2016)

Presidential Cycle	Total Number of Debates	Proportion of Debates in which PTSD Is Referenced (Total Number)	Invocations by Individual Candidates (Party Affiliation, Total Number)
2000	26	0 % (0)	N/A
2004	6	0 % (0)	N/A
2008	39	20.5 % (8)	Bill Richardson (D, 7) John Edwards (D, 2) Barack Obama (D, 1) Questioner (1)
2012	24	8.33 % (2)	Michelle Bachmann (R, 2) Barack Obama (D, 1)
2016	33	12.12 % (4)	Bernie Sanders (D, 1) Martin O'Malley (D, 1) Rick Santorum (R, 1) Jim Gilmore (R, 1) Questioner (1)

while also avoiding charges that dovish liberal alternatives were unconcerned with the plight of soldiers and their families—politically influential demographics that have traditionally leaned slightly rightward (Bishin and Incantalupo 2008). Over time, as Republicans distanced themselves from the unpopular foreign policy of the Bush administration, they too realized the utility of invoking

PTSD as a means of demonstrating loyalty to troops while also criticizing unpopular past decisions. Yet PTSD's introduction cannot be dismissed as simply a strategic tool used to criticize specific aspects of Bush administration foreign policy. Because the PTSD diagnosis has become a dominant idiom for interpreting war's psychic consequences, it has exerted productive power in the elite

foreign policy discourses it has entered, contributing to critiques of endless conflict and neglect of American military intervention's foreign victims by blurring important spatiotemporal and ethical boundaries. And while these rhetorical shifts stemmed from Bush-era debates on U.S. wars in Afghanistan and Iraq, they are not solely of historical interest—taken together, they allude to the larger malleability of war in the face of trauma, as well as the potential normative consequences therein.

The first aspect of PTSD's contribution to war's conceptual blurring relates to the distinction between assumedly spatiotemporally delimited wartime and the more amorphous timing of trauma. Indeed, presidents and presidential candidates frequently drew on PTSD to extend wars' impact to the home front, even after violence had subsided and most troops had returned home. This trend began most forcefully during the 2008 presidential cycle, as Democratic presidential candidates sought to prevent hawkish Republicans from portraying America's wars as contained in faraway regions or the near past and thus used trauma to extend the Iraq War's consequences, making it and the related War in Afghanistan more immediate and proximate to voters. The strategic context of the Democratic primaries helped motivate this tactic—despite the Iraq War's unpopularity over the long term, the primary campaign took place in late 2007 and early 2008, as U.S. military fatalities in Iraq declined precipitously during the “surge” of troops overseen by General David Petraeus (Biddle, Friedman, and Shapiro 2012; Rosentiel 2008). Further, the United States had not experienced a major domestic attack since 2001, allowing the Bush administration and its most ardent Republican supporters to claim they had effectively contained terrorism outside the United States.

In this context, PTSD became a potent means for Democrats to amplify the Iraq War's costs, insinuating that casualties were higher than those reported and that PTSD's prevalence among veterans meant that the GWOT had not contained violence abroad, but rather facilitated its spread to the home front. For example, in a debate on November 15, 2017, a moderator asked New Mexico Governor Bill Richardson whether he would acknowledge that the surge's success, to which he responded by contesting a narrow definition of casualties, saying “we shouldn't be talking about body counts.” He continued on to say that increased troop presence might lead to future issues and noted that, in addition to past deaths, the United States had suffered from “60,000 wounded, casualties, mainly mental trauma,” a low estimate that would increase over the course of the campaign (American Presidency Project 2007b). In a debate the next month, Richardson similarly referred to PTSD in an answer to explain how “the Iraq war has drained our military,” without referencing any material costs or losses in personnel, manpower, or equipment. “Our veterans

coming back with mental health problems, with trauma,” he added (American Presidency Project 2007c). Richardson, who raised the issue of PTSD in debates more than any other candidate that cycle, frequently drew upon the trope of soldiers returning with PTSD to blur the war's consequences beyond the relatively small numbers of Americans killed in action compared to prior conflicts. He argued that the Bush administration's neglect of soldiers' mental health had undermined national security. In one campaign speech Richardson even suggested that the Bush administration's lack of attention to “mental trauma” demonstrated that the president was keeping the costs of war “hidden away,” having “traded in our troops' health care for tax cuts” (Richardson 2007). By conflating state-level military might with the mental health of veterans who had completed their service, Richardson established a direct linkage between the negative—yet difficult to quantify—impacts of PTSD on soldiers and larger collective issues relating to the costs of hawkish military interventions.

The election's future winner, Barack Obama, echoed Richardson's invocations of PTSD at multiple points on the campaign trail that cycle. In one primary debate, for example, he defended his proposal to increase the U.S. military budget and add 100,000 troops by sidestepping the financial costs or potential casualties associated with continued foreign wars. He explained the increased budgetary outlays as “treating [veterans] with the honor and dignity that they deserve” by funding treatment and benefits for those with “post-traumatic stress disorder” (American Presidency Project 2007a). Here, again, PTSD's ability to blur the spatial lines between home front and war zone, including the realms of foreign and domestic policy, allowed Obama to conflate largely separate budget allocations for defense and veterans' health benefits to support his expansionist proposal. Likewise, in a general election debate, Obama drew on this trope by calling the Bush administration's inadequate funding of veterans' benefits for post-traumatic stress disorder a “national security issue,” as it would auger America's “econom[ic] decline” over the long term by leaving veterans jobless (American Presidency Project 2008). On multiple occasions on the campaign trail, Obama (2008a) even drew on this blurring to argue for an expedited withdrawal from Iraq. “We can't keep spending \$10 billion a month in Iraq at a time when we've got enormous pressing needs here in the United States of America, including, by the way, taking care of veterans who are coming home with post-traumatic stress disorder.” In another speech he referenced the disorder as part of the “heavy price” the United States pays for “opened” engagement in Iraq (Obama 2008b). While PTSD appeared in many Democratic candidates' discussion of veterans' health care and criticisms of the Iraq War, rarely did they specify the exact policy measures they would

employ to improve veterans' mental health and contain their suffering—instead, Democrats' invocations of PTSD served primarily to amplify the negative consequences of the Bush administration's foreign policy, extending them temporally into the future and spatially into the domestic political arena.

While PTSD may have been introduced into the 2008 presidential election by Democrats, Republican candidates could hardly neglect trauma's potency over the long term, especially considering its increasing prevalence in news reports on the wars in Iraq and Afghanistan. Former Arkansas Governor Mike Huckabee was the only Republican candidate during the 2008 cycle to obliquely mention PTSD at a debate, citing Bush's general lack of attention to veterans' "mental health" to subtly distance himself from an unpopular president's costly war without specifically mentioning the Iraq invasion that he had supported (The American Presidency Project 2007d). But as Republican nominee John McCain (2008a, 2008b, 2008c) turned to the general campaign and attempted to appeal beyond his party's base, he cited his authorship of "the first major legislative initiative to address post-traumatic stress disorder" in multiple speeches on his plans to achieve "victory in Iraq," insinuating that containing PTSD was vital to containing the war itself. In light of Democratic criticisms, McCain sought to reclaim authority over the disorder's consequences to bolster his image as an expert on military and foreign policy issues.

As these politicians introduced PTSD into foreign policy debates during the 2008 campaign cycle, trauma's blurring potential met with and contributed to a larger erosion of war's spatiotemporal boundaries already well under way in the GWOT era. During the first years of the Bush presidency (approximately 2001–2005) administration officials had similarly invoked ideas of a sprawling, amorphous worldwide effort to justify their expanded power. Bush (2003, 2004), for example, frequently referred to the conflict as a "global war against a scattered network of killers," in which "American service men and women [were] deployed across the world." The 2001 Authorization to Use Military Force passed by Congress the week after September 11 at the Bush administration's behest was not limited to a particular theater, but rather spread to any "nations, organizations, or persons he determines planned, authorized, committed, or aided the terrorist attacks" (107th Congress 2001). Yet these early post-9/11 invocations of a global war were distinct from those related to PTSD. They focused primarily on terror groups' sprawling ambitions and called for global military action to contain them, rather than suggesting the GWOT's negative consequences for Americans would spread out across time and space. Indeed, in the case of the 2003 invasion of Iraq, Bush justified expanding the GWOT to Saddam Hussein's regime precisely for the purposes of containment and preventing further suffering

at home, in the future. Later criticisms of the GWOT involving PTSD, however, insinuated that this containment was ineffective, and that Americans were suffering beyond the war zone and even the temporal end of combat operations.

Indeed, continued invocations of PTSD by politicians from both parties even after the Bush administration suggest that the disorder's strategic purpose evolved over time, reflecting trauma's unique challenge to traditional conceptualizations of war. Indeed, PTSD remained prevalent in foreign policy discourse even after the Republican party largely disavowed its Iraq-era interventionism and downplayed unpopular ideas of a sprawling global war effort. For example, during the 2012 primary campaign, former Republican Senator Rick Santorum (2012) distanced himself from his prior championing of the Iraq war by invoking PTSD. As president, he said, he'd ensure "we don't create the situation that creates a lot of this PTSD—repetitive tours of duty; five, six, seven, eight tours of duty is way too much to ask." That summer, the Republican Party's platform recognized PTSD's extension of war's consequences, stating that "The nature of the fighting in Iraq and Afghanistan has resulted in an unprecedented incidence of ... post-traumatic stress disorder" (Republican Party 2012).

This thinking continued into the 2016 cycle, even after U.S. involvement in Iraq ended, as both major parties included in their platforms the idea that PTSD in the United States was a direct and ongoing consequence of the GWOT (Democratic Party 2016; Republican Party 2016). Indeed, in a 2016 Democratic primary debate, Vermont Senator Bernie Sanders, who had chaired the Senate Veterans' Affairs committee, adapted this criticism to highlight his longstanding opposition to unpopular military interventions. Sanders used an inflated figure for veterans continuing to suffer from PTSD during a Democratic primary debate to criticize the more hawkish foreign policy of his opponent, Hillary Clinton, and what he labelled its "long-term consequences," continuing on into the present (American Presidency Project 2015). Though Clinton had acknowledged regret over her past decision, she remained scarred by her 2003 vote in favor of the Iraq invasion and the continued impact of PTSD on the home front allowed Sanders to extend her vote's consequences beyond the United States' withdrawal in 2011. In these ways, elite foreign policy discourse adapted PTSD beyond specific individuals or the timeline of specific military interventions as a continually relevant criticism of the ongoing GWOT.

While many of these campaign invocations referred to the ongoing consequences of past decisions to initiate wars in Iraq and Afghanistan, PTSD has also been projected forward, deployed in debates on salient foreign and domestic policy issues. On multiple occasions during his presidency Obama referred to PTSD without specific reference to Iraq or Afghanistan, advocating instead a proposed future veterans policy initiative or criticizing

perceived Republican hawkishness. He repeated on multiple occasions the aphorism “for many of today’s troops and their families, the war doesn’t end when they come home” (Obama 2010b, 2010c; Terkel 2008). Indeed, Obama (2010a) came to refer to PTSD and traumatic brain injury “the signature wounds of today’s wars,” portraying psychological suffering as an inevitable long-term consequence of contemporary warfare beyond the GWOT, sufficiently commonplace that it would extend conflicts’ consequences beyond traditional accounting. These continued invocations of PTSD as representing the intangible, amorphous consequences of war supported a longer-term theme of Obama’s presidency—his overwhelming caution in deploying American soldiers abroad. Even as he justified missile strikes in retaliation for Syrian President Bashar al-Assad’s use of chemical weapons in a 2013 speech, Obama (2013) reassured that he would not put “boots on the ground,” quoting a veteran: “This nation is sick and tired of war.” Indeed, critics of military intervention came to see PTSD as not only an inevitable consequence of war, but also a symbolic trope to denote recognition of military conflict’s spatiotemporal blurring beyond the tangible and quantifiable.

PTSD’s post-Iraq salience in foreign policy debates has not been limited to the Democratic Party. Donald Trump, for example, has spearheaded an anti-interventionist shift in the Republican Party, drawing on PTSD at times to emphasize the potential long-term negative consequences of military intervention beyond the GWOT. For example, following a 2018 mass shooting by a veteran, Trump speculated that PTSD might have caused the shooter to commit his crimes. “People come back—that’s why it’s a horrible thing—they come back, they’re never the same,” Trump said, drawing on PTSD’s amorphousness to portray the incident as a negative extended consequence of military intervention, as well as to stymie inevitable gun-related explanations from critics (Sonne 2018). On World Suicide Prevention Day Trump (2017) likewise released a statement that “more servicemembers have died by suicide than from combat in recent years.” This juxtaposition of statistics again served to blur the boundaries between violence in the war zone and suicidal violence at home, typically considered distinct arenas, suggesting the need for warlike urgency regarding a domestic mental health issue. Indeed, Trump has drawn on PTSD on multiple occasions to demonstrate his fealty to the armed forces. Since 2017, Trump has become the first president to release statements annually on June 27, PTSD Awareness Day. In 2019, his Vice President Mike Pence, who had previously supported the Iraq War as a member of the U.S. House of Representatives, travelled to Walter Reed National Military Medical Center for the occasion and told a crowd that PTSD had forced a shift in collective thinking about the consequences of U.S. military action. “Ten years ago . . . we failed to recognize [PTSD’s]

challenges,” Pence (2019) told the crowd, “we’re recognizing that as a nation.” These comments from Pence, who had supported the Iraq War while in Congress, demonstrate not only his party’s recognition of PTSD, but also the disorder’s integration into the cultural consciousness as a long-term crisis that continues even after soldiers return to safety.

Taken together, this analysis demonstrates the productive power PTSD has taken on in elite-level foreign policy debates about war and its consequences, adapting over time to new issue areas and new criticisms. Political leaders have incorporated PTSD into critiques of the GWOT’s sprawling nature, insinuating that a spatiotemporally ill-defined war necessarily entails spatiotemporally ill-defined costs. In this sense, the so-called invisible wounds of twenty-first-century wars have become their signature ones precisely because they have adapted strategically to multiple different political contexts and debates. PTSD has thus been a key long-term contributor to ideas about the costs of endless war that have continued past the end of the Iraq war into recent years’ debates (Van Buren 2017; Keen 2006).

Yet this account of PTSD’s expansion in American foreign policy discourse would be incomplete if it offered solely analysis of the disorder’s strategic malleability and productive power. By further disrupting the linear temporality implicit in ideas about war and its costs, PTSD has also had profound normative effects, contributing to a blurring of vital ethical distinctions like that between victim and perpetrator. This dimension of PTSD’s effects is best understood in the data via discursive absence. *None* of the invocations of PTSD in the prior section’s content analysis, for example, referred to Iraqi or Afghani civilians’ potential psychic traumatization, nor did any refer to trauma resulting from soldiers’ moral injury, an alternative interpretation of violence’s aftermath that provides a more nuanced portrait of soldiers both committing and suffering from violence (see Subotic and Steele 2018). PTSD’s presence in these discourses has frequently been invoked to portray veterans as the primary victims of American interventions spearheaded by political leaders—on the rare occasions when Iraqi and Afghani civilian casualties have been mentioned in official discourse, these victims almost always lack names, personalized anecdotes or even specific locations of death. Instead, they are primarily referred to in abstract groups by their citizenship with no precise casualty counts or emotional consideration.

During the Bush administration, senior officials often constructed “Iraqi civilians” and “Afghan civilians” into either adversaries to be tamed with Western ideas or abstract, helpless categories in need of protection from Saddam Hussein’s regime, insurgents or the Taliban. In an exemplary joint statement, Bush and UK Prime Minister Tony Blair (2003) contrasted American troops with their Iraqi counterparts, stating that while “coalition forces take great care to avoid civilian casualties the Iraqi regime has

done the opposite. It has deliberately put Iraqi civilians in harm's way and used women and children as human shields." Following this logic, the unquantified number of Iraqi civilian deaths stemming from the invasion were the fault of Saddam Hussein's government and not the coalition forces that launched the strikes that killed them. While American soldiers were to be lionized for their voluntary sacrifice to the war's just cause, they also could not be held responsible for their participation's negative consequences on foreign lives. Their actions had been ordered by the military hierarchy and these actions' negative consequences were attributable primarily to the enemy's unsavory tactics.

Even as Obama shifted Bush era foreign policy and sought to transfer combat operations to the Iraqi government, his administration similarly avoided empathizing with Iraqis by outlining their victimization due to American soldiers' violence. Instead, in his speech announcing the "End of Combat Operations in Iraq," Obama praised the "resilience" of the "proud" Iraqi people as they took "responsibility for their own security"—characterizations that downplayed their hardship (2010a). He did not acknowledge the trauma they had endured or how the material devastation inflicted by U.S. military force might have exacerbated it (Lerner 2019c). He similarly neglected to adapt his trope about the war continuing for Iraqis after American soldiers returned home. Instead, Obama's (2010a) speech declared victory despite a lack of "surrender ceremonies," portraying the clearest victims of the war as the American soldiers who "stared into the darkest of human creations—war—and helped the Iraqi people seek the light of peace." Whether Iraqis or U.S. coalition partners also stared into this abyss alongside American forces remained unaddressed.

Recognizing American soldiers' traumatization fulfilling a mission they did not order while also understanding their agency in inflicting violence and traumatization raises ethical questions too complex to unpack fully here. Nevertheless, I highlight these issues to demonstrate that PTSD's spatiotemporal blurring is not simply a benign strategic, political tool. PTSD's ability to victimize both those involved in supporting violence and those inflicting it erodes intuitive lines between victim and perpetrator that structure narratives of conflict. Though oftentimes multifaceted and opaque, such lines are vital to achieving normative goals oftentimes embedded in both foreign policy and psychosocial governance. If PTSD continues to appear in American foreign policy debates about intervention, similar quandaries are liable to fester, problematizing easy assumptions that undergird so many foreign policy debates.

Conclusion

So long as human beings are capable of committing violence, they necessarily must wrestle with its long-term

psychic consequences. But, as this article has demonstrated, PTSD cannot be regarded as solely a medical innovation—its emergence has been shaped by and subsequently shaped politics. Its formulation was contingent on political mediation and it has, in turn, played a politicized role in foreign policy debates. To understand this process, I outlined a model of psychosocial governance that deliberately draws attention to the productive power of prominent diagnostic categories as they spread beyond the medical profession into public discourse. I then turned to presidential documents and debates, analyzing how PTSD's deployment has contributed to a blurring of the spatiotemporal and ethical lines that frame the concept of war.

Outside of my more specific examination, this analysis' insights are suggestive of potential future shifts that warrant further investigation. First, the bulk of this analysis has focused exclusively on the presidency and presidential campaigns. Future work could expand the data under consideration, examining how mass media representations or other levels of foreign policy discourse reflect or contrast with these trends. If, as Alison Howell (2012) has suggested, psychosocial governance of PTSD has undergone a shift in the United States over the past decade towards resilience and neurobiological frameworks, will this shift eventually shape elite foreign policy discourses? If so, how? A second avenue for further research would extend these questions beyond the American context, which has proven uniquely attuned to PTSD during the GWOT era. Future comparative analysis might explore whether the American experience parallels or contrasts with those of other countries. What other contextual factors encourage politicized invocations of trauma, especially in foreign policy discourses?

By extending my analytical lens across time and space, future scholarship will also contribute to a final important extension of this analysis into normative inquiry. As outlined in the prior section, PTSD's spatiotemporal blurring raises profound ethical issues. Indeed, trauma's subjective dimensions make it a uniquely complex issue, as trauma lends itself to a problematic relativism that encourages flexible lines between right and wrong. As research continues to interrogate PTSD's roots, normative scholarship can wrestle with the difficulties it poses for promoting justice in violence's wake, guiding policymaking into the future.

Notes

- 1 See Lembcke 2013; Shephard 2000; Young 1997.
- 2 This controversy played out publicly in 2019 following President Trump's pardoning of two former soldiers accused of war crimes. See Editorial Board 2019.
- 3 I have excluded seventeen references in the corpus to "Vietnam syndrome" from analysis (compared to 2,655 to PTSD and cognates), as they did not refer primarily

to a medical diagnosis, but rather an abstract sense of American foreign policymaking's condition after the Vietnam War.

4 For this analysis, I queried all twenty-six diagnostic terms, derivatives, and alternative spellings from Chekroud et al.'s 2018 initial study, as well as alternative spellings and formulations of PTSD.

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