In the concluding paragraph of *The Origin of Species*, Darwin urged his readers to contemplate a tangled bank, clothed with many plants of many kinds, with birds singing on the bushes, with various insects flitting about, and with worms crawling through the damp earth, and to reflect that these elaborately constructed forms, so different from each other, and dependent upon each other in so complex a manner, have all been produced by laws acting around us. . . . Thus, from the war of nature, from famine and death, the most exalted object which we are capable of conceiving, namely, the production of the higher animals, directly follows. There is grandeur in this view of life, with its several powers, having been originally breathed . . . into a few forms or into one; and that, whilst this planet has gone cycling on according to the fixed law of gravity, from so simple a beginning endless forms most beautiful and most wonderful have been, and are being evolved.

The fixed laws of physics, chemistry, and biology have yielded this chapter, this textbook, this paper, these computers, these words, and these readers. What comes next is unpredictable and potentially creative, the exercise of yet another presumed outcome of natural selection: Namely, free will.

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SUGGESTED CROSS-REFERENCES

Readers should consult the section on neural development and neurogenesis (Section 1.3), psychiatric genomics (Section 1.11), population genetics (Section 1.18), genetic linkage analysis of psychiatric disorders (Section 1.19), animal research and its relevance to psychiatry (Section 5.4), the genetics of schizophrenia (Section 12.4), genetics of mood disorders (Section 13.3), psychiatry and reproductive medicine (Section 28.1), pervasive developmental disorders (Chapter 39), and ethical issues (Section 52.5c).

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▲ 4.3 Sociopolitical Aspects of Psychiatry

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No field of inquiry or practice exists within a social vacuum. The domain of mental health is no exception, and within its realm resides one of the most hotly debated areas: Traumatology—the study of human stress responses and the treatment of patients with posttraumatic stress disorder (PTSD). It is no surprise that traumatology is a magnet for controversy, after all, the study of PTSD is the study of victims—how to define them, how to treat them, and how to determine what they are owed when the ordeal endured was caused or exacerbated by man. Thus, traumatology is a field to which appeals are routinely made—by advocates and sometimes even clinicians and researchers themselves—about whom to designate as a victim, what kinds of questions researchers should be encouraged to pursue, and the implications of research findings.

This chapter focuses on three areas that have been caught in the intersection between clinical necessity and political expedience. The first is the origin of PTSD as a formal diagnosis. This episode within the history of psychiatry highlights the role of social forces in shaping nosology. The second is the growth of disability claims among Vietnam veterans and the interpretation of that trend. The approach taken by traumatology experts shows how alternative explanations can be overlooked when their implications are at odds with a prevailing ideological agenda. And the third is the estimation of PTSD prevalence among Vietnam veterans. This underscores how methods that yield unpopular findings can be discounted.

Although much of the material in this chapter is derived from the study of Vietnam veterans, it contains important implications for the care of soldiers now returning from Iraq and Afghanistan and also, more broadly, for the understanding, study, and treatment of trauma victims.

On April 15, 2005, Joe Baumann, a 20-year-old sergeant serving with the California National Guard in Baghdad, was shot in the abdomen by a sniper. Two years after being wounded, he still suffered from weak flank muscles and back pain. But what troubled him most were phobias, anger, and problems with concentration. Diagnosed with an anxiety disorder, Sgt. Baumann told a radio reporter that he could not "function" because he had to "keep [his] distance" from people and crowds. Convinced that he was psychiatrically disabled, Sgt. Baumann sought early retirement and permanent disability status for PTSD from the Department of Veterans Affairs (VA) but was having difficulty obtaining those benefits.

The news story highlighted the intransigence of the VA bureaucracy, but Sgt. Baumann's situation is notable for another reason. It raises important questions about the fate of young soldiers barely into their 20s who return from overseas deployment to a society bombarded with news reports of psychiatrically impaired veterans? How will this affect their perception of themselves and their futures? How many will seek permanent VA disability for psychological wounds at an early stage of their postcombat lives? And among those who do, what percentage will drop out of the workforce permanently and become chronic psychiatric patients? What are the perverse consequences of rushing to judgment about the rehabilitative prospects of veterans? What if disability entitlements work to the detriment of the patients by keeping them from meaningful work and by creating a perverse incentive for them to embrace invalidism?

Doubtless, most mental health professionals who work at VA medical centers, must have pondered these questions at one time or another. Much experience has accumulated from treating patients who are part of the Vietnam era, and the lessons learned in doing so should be heeded as professionals now turn their attention to young men and women returning from the Middle East. Before exploring these lessons, a review of the origins of PTSD as a diagnosis is in order.

HISTORICAL AND CONTEXTUAL FACTORS OF PTSD

In the waning days of the Vietnam War, a band of psychiatrists set about formulating a new diagnosis to describe the psychological wounds veterans sustained in the war. Two New York City psychiatrists spearheaded the effort, both fervently opposed to the war: Robert Jay Lifton, well known for his work on the psychological impact of Hiroshima on the Japanese, and Chaim Shatan.

They organized "rap" groups for veterans who felt socially and spiritually dislocated. These men, the psychiatrists warned, were the tip of an iceberg; hundreds of thousands, perhaps millions, of other traumatized veterans across the country suffered out of sight and in silence. Lifton and Shatan became their voice. "Out of kinship with the veterans [we] have moved beyond therapy alone and toward advocacy; we have entered actively into public affairs," Shatan said. He described his goal as [giving] . . . the widest possible publicity to the unique emotional experiences of these men. To do so, we go—together with the veterans—wherever we will be heard, conventions, war crimes hearings, churches, Congress, even abroad."

Along with a handful of colleagues, Lifton and Shatan would shape the image of the Vietnam veteran as haunted and damaged beyond repair, subsequently immortalized by Hollywood in powerful antiwar films like *Taxi Driver*, *Coming Home*, *The Deer Hunter*, and *Rambo: First Blood.* (More recent examples of the genre, such as *Jarhead* and *In the Valley of Elah*, have featured soldiers returning home from the Iraq War.) In 1972 Shatan unveiled the "post-Vietnam syndrome."He described it in a *New York Times* op-ed as a condition marked by self-punishment, rage at being "duped and manipulated by society," and alienation from one's feelings. Shatan acknowledged that veterans of other wars wrestled with depression, alienation, and nightmares, but the Vietnam veterans suffered uniquely because the military discouraged them from grieving for their lost friends. A hostile homecoming magnified feelings of guilt—over having killed and over having survived—and made it almost impossible for them to mourn.

The result, as Shatan described it, was a "delayed massive trauma" response that could manifest as family discord, unemployment, and addiction months or years later. "He returns as a tainted intruder in our own society," Lifton testified before the Senate in 1970, with some "likely to seek continuing outlets for a pattern of violence to which they have become habituated."

Jerry Lembcke, a former member of Vietnam Veterans Against the War and now a sociologist at Holy Cross College, considers the May 6, 1972, publication of Shatan's *Times* op-ed a turning point in the campaign to publicize the plight of the returning soldier. Lembcke described the scene at the Republican Convention 3 months later: On the very day the Republican Convention opened in Miami with over a thousand protesting veterans in the streets, the *Times* ran a major front page story on "post-Vietnam syndrome." Titled "Postwar Shock Is Found to Beset Veterans Returning From the War in Vietnam," the article alleged that 50 percent of Vietnam veterans needed "professional help to readjust." The association with mental illness was deepened in the text of the story that contained a liberal sprinkling of phrases like "psychiatric casualty," "emotionally disturbed," "mental breakdowns," and "men with damaged brains." The story provided no data to support the image of the dysfunctional veterans, Lembcke said; what it did provide "was a mode of discourse within which America's memory of the war and the veterans' coming-home experience would be constructed."

This mode of discourse set the Vietnam veteran apart from soldiers who came before him. It bore the "suggestion or outright assertion that Vietnam veterans have been unique in American history for their psychiatric problems," writes historian Eric Dean, Jr. Civil War soldiers also succumbed to mental breakdown, but because the Union soldiers' war is today perceived as a righteous crusade to save the Union and end slavery, it elicits images of heroes and prompts battle reenactments. World War II was a fight to protect our values against a foreign threat; soldiers' stories were those of courage and noble sacrifice. Only an unjust conflict like Vietnam, Dean argued, could prime the cultural imagination to accept the idea of soldiers as psychiatric victims, misfits, and tormented souls.

In 1974 the American Psychiatric Association began planning a third edition of the *Diagnostic and Statistical Manual*. As the image of the psychologically disabled veteran took root in the national consciousness, the psychiatric profession debated the wisdom of giving him his own diagnosis. Soon, Lifton and Shatan—along with other activist clinicians, antiwar veterans, and religious groups—were lobbying the manual task force of the association to adopt the title "post-Vietnam syndrome." The task force rejected the syndrome as vague and unscientific and turned its attention to a more systematic diagnosis called PTSD.

As a taxonomic category, PTSD was indeed more refined than "post-Vietnam syndrome." It focused on specific symptoms, not social attitudes, and it applied to a wide variety of frightening or horrifying events, such as natural disasters, severe accidents, or confinement in a concentration camp. The women's movement greeted PTSD enthusiastically because it created a diagnostic niche for victims of rape, domestic violence, child abuse, and sexual assault. Even so, some members of the task force remained doubtful about the wisdom of adopting PTSD. Symptoms such as recurrent images, avoidance, guilt, jumpiness, and irritability, they argued, were not distinctive and could be subsumed under variants of existing disorders such as depression or anxiety.

PTSD: Part Politics, Part Pathology

In the end, PTSD became part of the psychiatric nomenclature in 1980 with the publication of the third edition of the diagnostic manual. And regardless of one's political opinion on Vietnam, its inclusion was

certainly defensible. It could help avert serious diagnostic errors—the kind reported in damning accounts from veterans' hospitals, where Vietnam veterans with "flashbacks" (vivid, lifelike replays of terrifying scenes) were mistaken for schizophrenic patients and wrongly treated with potent antipsychotic medications. Clearer nomenclature made research more objective and replicable. In addition, the PTSD designation was helpful to patients who sought federal disability benefits for chronic war stress, as the government required a way to classify them as a psychiatric casualty of war.

Combat veteran and sociologist Wilbur Scott chronicles the roots of PTSD in his detailed 1993 account *The Politics of Readjustment: Vietnam Veterans Since the War.* "The placement of post-traumatic stress disorder in [the *Diagnostic and Statistical Manual*] allows us to see the politics of diagnosis and disease in an especially clear light," he writes. "PTSD is in [the manual] . . . because a core of psychiatrists and Vietnam veterans worked conscientiously and deliberately for years to put it there. . . . at issue was the question of what constitutes a normal reaction or experience of soldiers to combat."

Psychiatrists like Robert Jay Lifton clearly saw PTSD as the normal response. And, normal or not, veterans with the condition were indeed a boon to the antiwar agenda, touted as living proof that military aggression destroys minds and annihilates souls. Thus, by the time PTSD was incorporated into the official psychiatric lexicon, it bore a hybrid legacy—part political artifact of the antiwar movement, part legitimate diagnosis. Moreover, PTSD was now assumed to be a normal and natural process of adaptation to extreme stress likely to occur in anyone as a result of exposure to an extreme event. Thus, writes British war historian Ben Shephard, "Vietnam helped to create a new consciousness of trauma in Western society." It was a consciousness that saw the traumatic incident itself as the sole determinant of whether a victim developed PTSD.

But if the pendulum swung too far, obliterating the role of an individual's own characteristics in the development of the condition, it served a political purpose. As British psychiatrist Derek Summerfield put it, the newly minted PTSD "was meant to shift the focus of attention from the details of a soldier's background and psyche to the fundamentally traumatogenic nature of war." Today, more than two decades after ratification of the PTSD diagnosis, it is known that the condition is neither normal nor inevitable in the wake of catastrophe. Although otherwise healthy people can develop PTSD, the risk is considerably greater for those with preexisting psychological vulnerabilities, such as depression, anxiety, or personality disorders, and conduct problems in childhood.

Temperament and intelligence also influence an individual's response to extreme events. Moreover, they play a part in whether individuals are exposed to those events in the first place. Intelligence, on the other hand, has been shown to be a protective factor. After all, cognitive competence enables one to evaluate and adapt to new information and experiences. People who are sensation seeking, impulsive, or poor at predicting the consequences of their actions are more likely to get in harm's way.

Psychologist Marilyn Bowman of Simon Fraser University has remarked upon the reluctance of some of her colleagues to acknowledge that a traumatic event alone is not sufficient to produce PTSD. She notes in her book *Individual Differences in Posttraumatic Response* that "clinical practice is based on an exaggerated idea of the power of life events, and a correspondingly significant inattention to preexisting factors." Attention to those factors, in fact, should be a key aspect of treatment. If the clinician can help a patient modulate his or her baseline anxiety, depression, or impulsivity, chances are he or she will be less vulnerable to disruptive events in the future.

Not surprisingly, to ask what a person was like before he or she encountered catastrophe is to invite charges of insensitivity. Yet acknowledging what a person was like before exposure to trauma is hardly blaming the victim. "Discovering risk factors is essential for understanding PTSD just as it is for understanding heart disease," Richard McNally asserts. "The alternative is ignorance, and ignorance is an unreliable basis for treatment and prevention of any disorder, including PTSD." Being charged with blaming the victim, however, can be an occupational hazard for those who question the prevailing wisdom.

DECIPHERING TRENDS IN PTSD DISABILITY CLAIMS

All veterans with documented medical or psychiatric disabilities related to military service are eligible for disability payments from the Department of Veterans' Affairs. This policy has been in effect since World War II. Combat-related PTSD represents one of the largest categories of disability payment within the VA system, and recent administrative trends show a striking acceleration. The number of veterans receiving VA disability payments for PTSD has climbed steadily since the early 1990s, increasing 79.5 percent from 1999 to 2004. Notably, other disabilities combined increased only 12.2 percent during that same period of time. According to the inspector general's report, PTSD disability payments during this period rose 148.8 percent (to $4.3 billion annually), while payments in all other disability categories combined increased rose by only 41.7 percent.

Within this trend, several features stood out. First, the inspector general found that fully one quarter of recent disability award files lacked compelling evidence of combat exposure. In fiscal terms, this means *potential* fraud of $19.8 billion over the lifetime of veterans with current PTSD disability. Second, the report documented that most veterans' self-reported symptoms of PTSD become steadily worse over time until they reached the 100 percent disability level, at which point there is an 82 percent drop in use of VA mental health services (but no change in VA medical health service use). In other words, disability claimants reporting their worst level of psychiatric impairment are meanwhile using the lowest level of clinical mental health services. This is notable: If the system were helping veterans recover, why were they dropping out of treatment at the same point in time they claim to be the most disabled?

The third feature of the surge in PTSD claims was its composition. Mostly Vietnam veterans in their 50s and 60s, not young soldiers returning from Iraq and Afghanistan, were the beneficiaries. That Vietnam veterans were only now claiming to be psychologically crippled by their service of decades ago prompts a question: Can it really take up to 40 years after a trauma before someone realizes they can no longer cope with the demands of civilian life? There is good reason to be skeptical—after all, it can be very difficult to know if wartime exposure that took place decades ago is the true cause of incapacitating psychopathology experienced today.

Explanations for VA Administrative Trends Regarding PTSD Disability

Among claimants who seek entitlement so many years after a presumed precipitating event, several subgroups likely exist. These are applicants who can be helped with short-term psychiatric care, those who are seeking a "free ride" or attempting to cope with financial hardship, and those who are largely resistant to treatment and truly merit the diagnosis of chronic PTSD. Below is a rough typology.

Chronically Ill Veterans Who Never Sought Timely Care. Some percentage of the claimants will almost surely be applicants who have "never been right," as their spouses often say, since their discharge from the military. They never regained their civilian footing and drifted further away from their families and communities. By the time they come to a veterans' hospital, they are suffering from "malignant PTSD," that is, severe symptoms of PTSD complicated by drug and alcohol abuse and other mental problems like depression. They are notoriously challenging to treat.

Reactivated Symptoms. The literature contains case reports of World War II and Korean and Holocaust survivors developing PTSD decades after their wartime ordeals. Generally, these patients suffered stress reactions in the immediate aftermath of service, then led productive lives for decades before their clinical status deteriorated in their 60s or 70s. Most likely these cases represent reactivation of earlier traumatic symptoms due to subsequent crises or personal disruptions, such as retirement or illness in old age.

Today, the average age of Vietnam veterans is about 60, which means any new compensation awards coincide with the retirement years. Retirement itself, even for people with no latent store of wartime horrors, often leads to feelings of profound dislocation. This is not surprising. After all, retirement can signify impending frailty and threats to one's identity, which in our culture is largely defined by occupation. It may also denote a loss of purpose, foreclose an important social outlet, or dissolve comforting daily routines. Physical illness and the loss of a spouse may also hit hard at this phase of life. The significance of symptom reactivation is that it by no means foreshadows permanent disability. The good news, though, is that when individuals encountering these difficulties seek care, clinicians report that they tend to do well and are able to find relief through new kinds of activity and revised perspectives on aging and other existential dilemmas. For those who led rockier lives and long attributed their drinking or concentration and sleep problems to job-related stress, the clinical challenge is greater, although not necessarily insurmountable.

In 2006 the *Washington Post* ran an article suggesting that the current war in Iraq is responsible for the increase in disability compensation among veterans' ranks. The headline read "Iraq War May Add Stress for Past Vets; Trauma Disorder Claims at New High." This is possible but unlikely, in the authors' opinion, to be a major factor in claims seeking. Consider September 11, 2001. In the immediate aftermath Veterans Administration medical centers in the New York area and even across the country had braced themselves for an influx of Vietnam and Persian Gulf veterans with reactivated PTSD. Yet researchers from the Department of Veterans Affairs Connecticut Healthcare System at West Haven, writing in the *American Journal of Psychiatry* in 2003, found no increase in the use of inpatient or outpatient mental health services at VA centers among veterans with a diagnosis of PTSD or any other mental illness in New York City or elsewhere in the United States in the 6 months after September 11. Another research team at the Bronx VA Medical Center did detect a rise but could not establish that it was actually due to the attack on the World Trade Center. In yet another analysis, the West Haven team reported in 2003 in *Psychiatric Services* that "VA patients with preexisting PTSD were, unexpectedly, less symptomatic at admission [to hospital] after September 11 than veterans admitted before September 11, and patients who had follow-up assessments after September 11 showed more improvement."

Delayed Onset. Another explanation for the rise in newly identified cases is that they represent "delayed onset" PTSD. According to the fourth edition text revised *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), this form of PTSD manifests 6 months or more after an individual has sustained trauma, although skeptics have questioned whether symptoms can appear de novo after such a hiatus.

A recent review of delayed onset PTSD concluded there is "no consensus emerging as to its prevalence." Studies demonstrating delayed onset PTSD in the absence of *prior* symptoms are extremely rare, but when delayed onset is defined as an exacerbation of a subthreshold syndrome or as reactivation of prior symptoms that had once resolved, the phenomenon becomes relatively common (e.g., 38.2 percent of military and 15.3 percent of civilian cases of PTSD). Two large-scale epidemiological studies have reported zero or extremely low rates of delayed onset PTSD (0 to 1 percent of all cases of identified PTSD) in civilians, while a smaller study of former prisoners of war found only 1.4 percent of all PTSD cases were classified as delayed onset. Interestingly, there is some evidence of higher rates of delayed onset PTSD in civilians than veterans. A number of other smaller studies have reported a wide range (as high as 60 percent or greater) of delayed onset PTSD in civilians and veterans. Most studies examine respondents' PTSD rates 1 or 2 years after the index traumatic event, which sheds little light on onset that may occur 20 or 30 years later.

In order to clarify the diagnostic picture, Robert Spitzer and colleagues have proposed revising PTSD diagnostic criteria for *DSM-V*. They suggest changing the onset criterion (Criterion E) to read as either "the symptoms develop within a week of the event" or "if delayed onset, the onset of symptoms is associated with an event that is thematically related to the trauma itself (e.g., onset of symptoms in a rape survivor when initiating a sexual relationship)." The *DSM-V* task force will be considering this proposal for the next edition, which is planned for 2012, but from a public policy standpoint, it is clear that the recent jump in numbers of Vietnam veteran claimants cannot easily be explained as the result of a growing number of "delayed onset" cases of PTSD.

Attribution Bias. Is it possible that some claimants genuinely believe they are suffering PTSD, although the cause of their distress lies elsewhere? Some veterans have significant life problems such as alcohol abuse. They are erratically employed and commit domestic violence. But is traumatic exposure during war the actual cause of their dysfunction? Not necessarily, yet many VA mental health workers simply assume that whatever problem a veteran is having is a product of war experience. It is not only clinicians who have imbibed this narrative—and suggest it to vulnerable patients—the veterans and their families have too. The medicalized storyline for many unhappy, but not necessarily traumatized, veterans is an attractive, orderly, and face-saving explanation for what went wrong. They invoke PTSD as part of an "effort at meaning"—a poignant term used by British psychologist Frederic C. Bartlett to signify humans' longing to make sense of feelings and circumstances. Such effort is as strenuous as it is unwitting. Researchers have documented, for example, that people tend naturally to reconstruct the past in terms of their present circumstances, exaggerating the degree of earlier misfortune and trauma if they are currently feeling bad, minimizing it if they are feeling good.

Symptom Exaggeration, Malingering, or Misrepresentation. Some veterans misrepresent clinical symptoms and descriptions of combat. This reality is as old as war itself, yet it is an uncomfortable truth for some who champion veterans' rights because they fear it will sow doubt among politicians and the public upon whose goodwill financial support for veterans' aid depends. Evidence dating back to the early 1980s reveals that veterans seeking

PTSD treatment in VA clinics often present a confusing clinical picture. Symptom reports may seem unrealistic or inconsistent, and psychological test scores and structured forensic interviews may point to malingering. This pattern is accentuated among veterans who are seeking disability. In addition, some veterans' reports of combat exposure change over time and also as a function of reported PTSD symptom severity. In extreme cases of misrepresentation, some claim combat exposure or war-zone deployment that cannot be corroborated by military records.

It should come as no surprise, then, that many experienced VA clinicians find themselves skeptical of the veracity of self-reports at some time or another, suspecting that the veteran's participation in treatment is primarily intended to help him or her obtain or maintain disability payments. Evidence indicates that mental health clinicians have a more negative view of the "treatment engagement" of veterans who are seeking disability compensation than they do for veterans who are not seeking disability. And when the new applicants are filing just when they are reaching retirement age, one must wonder about the simple economic motivation that some claimants have for embracing disability. These observations do not mean that most treatment-seeking veterans are malingering. They do suggest, however, that the potential for disability compensation can influence clinical presentation, as the inspector general had speculated. Not only that, the promise of compensation surely has an affect on treatment planning insofar as it had an effect on the patient's clinical presentation.

Lack of Treatment Efficacy in Veterans with PTSD

Another important consideration in the disability controversy is veterans' response to psychiatric treatment. According to the literature and VA administrative data, veterans with putative PTSD appear to benefit far less from mental health care than other populations of traumatized persons. Randomized controlled clinical trials indicate that psychosocial interventions are quite effective in treating civilian PTSD, and there is evidence for the efficacy of sertraline (Zoloft) and paroxetine (Paxil), which are U.S. Food and Drug Administration (FDA)-approved for the treatment of PTSD. Yet, there is little corresponding evidence of efficacy for these therapies in combat veterans with PTSD, even in large VA cooperative studies of cognitive-behavioral therapy and antidepressant medications. Why would this be? It is easy to see why some of the reasons for patients' poor treatment response could prove unwelcome, if not embarrassing, to clinical leadership at VA medical centers. For example, maybe the quality of VA clinical services are substandard; perhaps severe PTSD is simply untreatable (and therefore treatment services should be reduced or cut); or possibly some of these patients are not actually afflicted with PTSD in the first place but are instead manipulating the system to obtain disability payments or something else.

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Weak motivation on the part of the patient may also account for part of the picture. Not all veterans who seek disability entitlement want treatment; but virtually all who seek treatment also desire disability. Up to 94 percent of claimants seeking treatment for the first time are also applying for PTSD disability benefits, suggesting that they did not even give treatment a chance before judging themselves to be beyond help. Looking at those applying for disability, only half are receiving psychiatric care at the time of their application, suggesting several interpretations, namely, they felt they were not benefiting from care and therefore stopped visiting the clinic; they had little interest in treatment because they assumed they were untreatable; they had little interest in changing their lifestyle.

This is consistent with other data suggesting that disability benefits often have detrimental effects that discourage full participation in vocational rehabilitation and result in significantly worse rehabilitation outcomes. The profound words of physician Nortin Hadler who has written widely about disability-seeking patients with all kinds of medical conditions apply here as well: "If you have to prove you are ill, you can't get well." Given what we know about the impact of contingencies on human behavior, it is not at all surprising that veterans often fail to benefit from mental health treatment.

Few question the good intentions behind care of veterans in the post-Vietnam era. Yet, evaluation of various treatment strategies has shown them to be ineffective. Inpatient and residential programs once emphasized abreactivelike activities, such as group therapy and art or drama therapy, which encouraged them to relive their war experiences. In many VA hospitals, a cohort of about 20 or fewer veterans were admitted to hospitals and stayed together, platoonlike, for up to 4 months. This practice took them out of their communities and away from their families, and may have served paradoxically to help entrench an identity as a psychologically damaged warrior. Some of the veterans returned home with new war-themed tattoos and combat fatigues. Instead of enabling such regression, clinicians should have emphasized resolution of everyday problems in living, such as family chaos, employment difficulties, and substance abuse.

The PTSD ward seemed to serve more as an echo chamber for pathology than a readjustment facility. The psychologist in charge of the unit was fully aware of these problems. He noted soberly that "long-term intensive inpatient treatment is not effective, and other forms of treatment should be considered after rigorous study." In response, he developed a "second generation" program that focused on repair of family relations, rehabilitation, and adjustment to the community by performing volunteer work or taking a vocational course, for example. Another "helpful strategy" for social adaptation was "not allowing everything [negative] to be attributed to PTSD."

Most of the first-generation inpatient and residential programs are now shuttered. As a result of this, as well as a general shift away from Freudian methods, many VA clinicians are now spending less time eliciting war narratives from patients and urging cathartic re-enactment of war trauma. What remains a lingering threat, however, is clinicians who are too quick to interpret any psychological distress or problems in social relationships as tantamount to incurable PTSD. This is a critical juncture; it is often the point at which a patient's vision of his or her future is forged: Will the patient surmount his or her psychological duress with the help of clinicians or will he or she be overpowered by distress and demoralization?

Clearly, some patients will remain deeply and irretrievably damaged by their war experience. Yet so many others have the capacity to resume work, greater family participation, and engagement in their community. The problem is that once patients receive a monthly check because they are diagnosed with psychiatric illness, their motivation to hold a job can diminish. They may assume—often incorrectly—that they are no longer able to work, and then, the longer unemployed, the more their confidence in their ability to work erodes and the skills atrophy. At home while on disability, a "sick role" is adopted, that ends up depriving him or her of the estimable therapeutic value of work. Lost are the sense of purpose work gives (or at least the distraction from depressive rumination it provides), the daily structure it affords, and the opportunity for socializing it creates. That work serves as a prophylactic against psychological distress is especially evident among veteran retirees.

Lamentably, current VA policies and services, developed in the post–World War II era, are not in line with modern psychiatric rehabilitation principles. This deficit was explicitly noted in the 2007 review conducted by the Government Accountability Office, which recommended the VA consider "reexamining program design such as

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updating the disability criteria to reflect the current state of science, medicine, technology, and labor market conditions."

CONTROVERSY REGARDING PTSD PREVALENCE

For a vivid case study in the sociopolitics of combat PTSD the discussion turns to the current debate over the accuracy of a congressionally mandated study called the National Vietnam Veterans Readjustment Study (NVVRS). Published in 1990, the NVVRS examined the prevalence of PTSD in 260 Vietnam veterans and found that 15.2 percent of all men who had served in Vietnam continued to suffer from PTSD at the time the study was conducted in the mid-1980s—well more than a decade after they had come home from the war. The NVVRS had long been considered the landmark analysis on the prevalence of PTSD among Vietnam veterans.

AU: specific to men or where there women too?

In 2006 Columbia researchers reanalyzed the original data collected by the NVVRS team and determined a more plausible estimate of PTSD to be 9.1 percent—an impressive reduction of 40 percent. Their findings appeared in *Science* and received significant media attention. "We can quibble about the numbers but the point is that it's a lot of people," said the executive director of the National Center for Post-Traumatic Stress Disorder for the Department of Veterans Affairs to the *New York Times*. Others went so far as to imply bad faith on the part of the Columbia researchers. "[It] seems the NVVRS estimates have withstood this most recent assault," wrote one psychiatrist affiliated with a VA hospital. And the *Psychotherapy Networker*, a popular newsletter for therapists, said that the Columbia study "cast[s] doubt on the whole diagnosis of PTSD." And furthermore, that "one can't help wonder if that wasn't, perhaps, the intention."

AU: Columbia University?

Several months after the Columbia study appeared, Richard McNally, a professor of psychology at Harvard University and an expert in anxiety disorders, took the Columbia reanalysis a step further. At a symposium called "Controversies Surrounding the Psychological Risks of Vietnam for U.S. Veterans: Multiple Perspectives on New Evidence," at the 2006 annual meeting of the International Society of Traumatic Stress Studies, McNally (in an invited, prerecorded audiovisual presentation) walked the audience through his own analysis of the proportion of Vietnam veterans afflicted with PTSD.

McNally's main contention was that the Columbia team used a definition of "clinically significant impairment" in its reanalysis that set the bar too low for making the diagnosis. By recalibrating the definition of impairment (which was based on the Global Assessment of Functioning scale), McNally found the prevalence of PTSD to be 5.4 percent among men who served in Vietnam. Although neither author was present at the symposium, eyewitness accounts and the authors' review of an audiotape revealed a startling reaction to his presentation by the audience and some of the other invited speakers on the panel.

Did you ever actually hear the tape? I did not, so we need be careful before we include this!

The substance of McNally's argument—the downward revision of PTSD prevalence—was not addressed by the commentators on the panel. They did, however, charge him with putting a "spin" on his "misleading" and "immoderate" presentation and issued impassioned pleas for "accurate" and "responsible" research, clearly implying that McNally's was neither. During these commentaries there were ripples of approving laughter from the audience. At least one panel participant, however, found the atmosphere so unsettling that he asked aloud, "Is Rich McNally the Anti-Christ?" Ad hominem remarks aside, the panelists barely mentioned McNally's methodology. This was remarkable because McNally's reworking of the data was the centerpiece of his presentation. The proportion of veterans afflicted was the sole policy-relevant aspect of the NVVRS; it was the very reason Congress mandated the study in the first place.

Curiously, too, none of the panelists directed any criticism toward the Columbia team. In fact, they praised its work lavishly. Why assail only McNally when the Columbia analysis also resulted in a significant drop in estimated PTSD? One possible reason is that McNally was already in their cross-hairs for being a member of a vocal cadre of psychologists and historians of military psychiatry who insisted that the original estimate made by the NVVRS—namely, that 15 percent of troops had chronic PTSD—was too high. How, they asked, could the prevalence be equal to the percentage of men assigned to combat, also 15 percent?

The McNally affair at the annual meeting of the International Society for Traumatic Stress Studies was nothing less than a set piece in the sociology of science, a backdrop against which heated reaction to unpopular inquiry exposes the troubled state of a health care and academic enterprise. The hostility toward a colleague and the failure to engage the novel and data-driven assertion he has made—indeed, the only truly new finding presented during the entire panel—reveal the intensity of high-profile sociopolitical aspects of modern psychiatry. This is neither new nor secret, of course. The controversy over repressed memories of child abuse—which reached a fever pitch in the mid-1980s and 1990s—gave the field a self-inflicted black eye. That scandal ruined the lives of many patients and their families. The current tension over the NVVRS numbers is perhaps less sensational than "recovered memory therapy." But the tempest swirling around the NVVRS is a striking example in its own right, destructive to the conduct and culture of scientific inquiry. It shows, as McNally has put it, how vigorously "the advocacy tail can wag the scientific dog" in the world of trauma research.

FUTURE DIRECTIONS

In December 2005 the *Washington Post* ran an article titled "A Political Debate on Stress Disorder." It quoted a VA official who summed up the dilemma facing policy makers. "If we [find] that PTSD is prevalent and severe, that becomes one more little reason we should stop waging war. If, on the other hand, PTSD rates are low . . . that is convenient for the Bush administration." This statement captured the way a psychiatric diagnosis can become a political pawn. And it echoed, unmistakably, the sentiments of antiwar psychiatrists in the 1970s who, by their own admission, sought to discredit the Vietnam War by emphasizing its psychological ravages.

Despite their personal agenda, however, these psychiatrists cared deeply about veterans and were sincere in advocating what they believed was best for them. Their commitment to the well-being of veterans came at a time—the early 1970s and 1980s—when traumatology was a fledgling field and stress-related psychopathology was often underrecognized. Over the decades trauma specialists have succeeded in bringing the plight of survivors into the national spotlight. Yet they remain vigilant. They seem to fear, for example, that the NVVRS, which readjusts the prevalence of PTSD downward, or investigations into misreporting of wartime exposure, or perspectives that regard traumatic responses as time limited and treatable, may end up reversing their hard-won gains. After all, if the problem is smaller in scope or less likely to become chronic with good treatment, this might result in a reduction in funding for services and research. And as the visibility of a problem recedes, so can the prestige of a field.

It is doubtful that awareness of PTSD or funding for treatment is under threat. The media are highly attuned to the psychological problems of soldiers returning from Iraq and Afghanistan, and Congress is very sympathetic. In order to provide state-of-the-art cognitive-behavioral treatment many new clinicians need to be trained, and prodigious amounts of money should be aimed at treating young

veterans early, not many years after coming home, as was the case with so many Vietnam veterans.

Although healthy funding of veterans' services is likely to continue, there is good reason for concern about the professional health of the field of traumatology itself. Its intellectual integrity has been compromised in several ways. First, there is growing recognition among researchers that VA disability policy has inadvertently distorted the integrity of the PTSD knowledge base. After all, if clinicians and researchers do not have confidence in their diagnoses, it is almost impossible to correlate research findings and treatment outcomes with psychopathology. Powerful acknowledgment of this fact came from an expert consensus panel of PTSD researchers who recommended excluding compensation-seeking veterans for this very problem of diagnostic validity. The recommendation to exclude disability seekers has been largely ignored, however, perhaps because there are so many treatment-seeking veterans who apply for financial compensation that excluding them would decimate the potential population of research subjects.

Indeed some unfortunate veterans will be too sick to resume work and thus need and deserve disability compensation from the VA. Sgt. Joe Baumann, who was mentioned at the start of this chapter, may end up being one of them, though one hopes not. Clinicians can keep this subgroup as small as possible by heeding the lessons of Vietnam. In brief: Do not suggest, do not regress, and do not offer disability benefits too quickly. It is prudent to think of PTSD as a treatable and time-limited affliction and—key—to treat it early when symptoms are most responsive to intervention with cognitive behavioral therapy and, if needed, medication. Treatment will be most effective when it focuses on practical issues and rehabilitation programs and strategies that have been proven effective, and when it capitalizes on the well-established finding that prognosis after trauma greatly depends on what happens to the individual "postevent"—factors such as marital discord, poor physical health, financial stress, and his or her expectation of lasting impairment.

It is always wise to learn from the past, as the Columbia researchers who did the reanalysis sought to do. By revising the number of PTSD cases downward, they have in no way diminished the suffering of veterans who were and still are afflicted. At the same time, the downward estimate is a healthy reminder of the importance of not exaggerating the widespread nature of the disabling impact of trauma. For the new generation of Iraq War veterans, it is imperative that proper concern over the scope of the care they need is paired with serious consideration of the philosophy guiding that care.

AU: correct wording, or do you mean health professionals?

The Vietnam experience does not merely indicate that some veterans will be afflicted with mental illness. It also implies that the problem can be made worse by overpathologizing the psychic pain of war. There is a risk of instilling the defeatist and self-fulfilling expectation that war-zone deployment itself will inevitably leave veterans psychiatrically scarred and incapacitated. Such a dire message may serve political ends, but it will do so at the expense of patients.

SUGGESTED CROSS-REFERENCES

AU: pls add a section and list mentions of other chapters in this book that are relevant

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AU: can this be updated?

▲ 4.4 Transcultural Psychiatry

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THE CULTURAL ASSESSMENT OF THE PATIENT

Culture is defined as a set of meanings, norms, beliefs, values, and behavior patterns shared by a group of people. These values include social relationships, language, nonverbal expression of thoughts and emotions, moral and religious beliefs, rituals, technology, and economic beliefs and practices, among other items. Culture has six essential components: (1) Culture is learned. (2) Culture can be passed on from one generation to the next. (3) Culture involves a set of