

Progress and Controversy
in the Study
of Posttraumatic Stress Disorder

Richard J. McNally
Harvard University

- The “controversies” in traumatology are important and interesting scientific (and historical) issues

- To ignore them will imperil the credibility of our field

National Vietnam Veterans Readjustment Study (NVVRS)

- PTSD = 30.9%
- Partial PTSD = 22.5%
- Combined = 53.4%



Ben Shephard

*Soldiers and
Psychiatrists in the
Twentieth Century*

A War of Nerves

Why are the historians puzzled?

- Because there were very few combat stress reactions in Vietnam itself.

- Only 3.5% of psychiatric casualties in country were diagnosed with “combat exhaustion”

- Delayed onset
- Different from shell shock and battle fatigue in World War I & II
- Psychiatric trauma-induced illness usually began in the war zone

- And the percentage of men assigned to combat units was only...

15%

- Twice as many developed PTSD as were in combat units???

How Do We Explain the Puzzling NVVRS findings?

STOLEN VALOR



How the Vietnam Generation Was Robbed
of its Heroes and its History

B.G. BURKETT
GLENN WHITLEY

- Burkett's thesis:
- Skepticism about the accuracy of reports of trauma, of symptoms, or both
- (No clear motive for fabrication in an epidemiologic study.)

- Oversampling from combat units?
 - 1,632 Vietnam vets (100 with service-connected disabilities)

- Not all those exposed to trauma were in combat units
- (e.g., medical corpsmen, truck drivers)

- Deployment to war zone itself as a qualifying traumatic stressor?

- Interviewers biased to avoid false negatives?

- No criterion F (impairment)?

- Retrospective reappraisal?
- Reinterpreting diverse problems (or symptoms) through the lens of the war?
- Imposing a trauma narrative on one's life?
- Attributing them to military service?

Studying Archival Data

(Or, how the methods of historians
can supplement those of
psychiatrists and psychologists)

- Burkett & Whitley (1998) Stolen Valor
 - Using the Freedom of Information Act, Burkett checked files of 2,000 vets
 - 75% were “pretenders”
 - But not an epidemiologic sample

- Frueh et al. (2005) British Journal of Psychiatry
 - 100 patients reporting war trauma (94% with PTSD diagnosis)
 - Frueh obtained military personnel records to attempt to verify trauma history
 -

- **Verified combat trauma** = **41%**
- Served in Vietnam, but no record of combat medals = 20%
- No combat exposure (e.g., clerk) = 32%
- Never in Vietnam or in the military = 7%

- 59% of the cases had no convincing evidence of trauma exposure in their personnel files

What's going on?

- Was there fabrication of trauma histories in a subset of the 59%?

- Or were there gaps in the archival data?
- Were traumatic events missed by the record?

- Reported witnessing or participating in battlefield atrocities:
 - 12% of the combat group
 - 28% of the no combat group

DVA Office of Inspector General Study

- Randomly selected 2,100 PTSD compensation cases (at least 50%)
- From seven VA hospitals
- Mean age = 56 years old
- Discharge to PTSD rating = 24 years

- No evidence of trauma = 25.1%
- No evidence: Oregon = 40.7%
- No evidence: Maine = 11.0%

- BUT lack of evidence of Criterion A exposure in clinical files does NOT confirm fraud
- Perhaps an overworked assessor just didn't do his homework

Weird Facts

- Patients continued to make mental health visits until they achieved 100% disability compensation
- Then they either ceased therapy or drastically reduced their visits -- by 82% on average
- Other medical visits did not decline

What's going on?

- Burkett's Hypothesis: Patients exaggerate (or even fabricate) trauma history and symptoms to secure compensation payments
 - “Part of the problem is that the compensation program has a built-in disincentive to get well when veterans are reapplying to get their disability ratings increased” (OIG, 2005)

- Toxicity Hypothesis: Extant treatments actually make patients worse

- Deteriorating-Disease-Course-and-Inert Treatment Hypothesis: Extant treatments are inert, and are helpless to reverse a relentlessly deteriorating disease course

Conclusion

- We need to triangulate trauma with multiple, independent -- albeit, fallible -- sources of data
- Self-report, archival, physiologic

Original Concept of Trauma

- DSM-III
 - Traumatic stressors were distinguished from ordinary stressors
 - Outside the bounds of everyday experience
 - Provoke distress in almost everyone
 - Canonical stressors
 - Combat
 - Rape
 - Confinement to a concentration camp

Conceptual Bracket Creep in the Definition of *Trauma*

- The concept of *traumatic stressor* has broadened greatly
- Noncanonical stressors from within the bounds of everyday life now qualify (e.g., learning about the death of a loved one)
- Increasingly more of modern life counts as *trauma*

Some recent PTSD stressors

- Being exposed to crude sexual jokes in the workplace
- 21 million dollar settlement in Michigan case

- Giving birth to a healthy baby following an uncomplicated delivery

- Birth-caused PTSD constitutes “a serious mental health problem” (Olde et al., 2006, *Clinical Psychology Review*)
- 3,000 new cases each year (est.) in the Netherlands

- Does this make birth control a primary prevention method for reducing the incidence of PTSD?

Breslau's epidemiologic research

- Nearly 90% of American adults now qualify as trauma survivors

- But does bracket creep *really* matter?

- Suppose someone has the symptoms of PTSD following exposure to a noncanonical stressor?

- Should the person be denied the diagnosis?

- Surely we cannot “legislate” the person’s symptoms out of existence!

- Indeed, if the concept of *psychic* trauma denotes an event that is traumatic in virtue of its *meaning* to the person, then why should we care about bracket creep?

- Even with an extremely broad definition of traumatic stressor a person *still* must meet *symptomatic* criteria for PTSD

Why we should worry about bracket creep

- First, broadening the definition of trauma threatens to undermine any chance we might have of elucidating the psychobiological mechanisms underlying PTSD.

- A survivor of a fender bender is unlikely to have much in common with a survivor of the Holocaust.

- Second, the more we broaden the concept of traumatic stressor, the less credibly we can assign causal significance to the stressor itself, and the more we must emphasize preexisting vulnerability factors.

- Shifting the causal burden away from the stressor undercuts the very rationale for having a diagnosis of PTSD in the first place.

- That is, it produces background-foreground inversion
- The stressor recedes into the background as vulnerability factors dominate the causal foreground

- Third, if anything can now qualify as a traumatic event, then *trauma* becomes an all-purpose idiom of distress -- a trope for misfortune in contemporary life

- By diluting the concept of *trauma*, bracket creep blurs the distinction between traumatic stressors and ordinary stressors.

- It medicalizes more of human experience while trivializing genuinely traumatic events.

- And this may shape our culture in ways that will undermine our capacity for resilience in the face of adversity