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IOM

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Purpose today is to show why PTSD poses diagnostic dilemmas. This will be a conceptual talk. I can get references for you where data have been collected but my main agenda is to stimulate skepticism about the validity of delayed presentation PTSD when it so profoundly influenced by expectation and secondary gain within the context of a veterans' healthcare system.

In my view, the problems with PTSD as a valid and reliable diagnosis are a result of at least two intrinsic aspects of the diagnosis:

Only DSM dx with an etiology
Politicized history

1. obvious: there is no PTSD without an event (define: fear reaction not extinguish) Not true of schizophrenia. May or may not be true of depression. We do have post partum depression, but, still, dep is a collection of symptoms.
2. why important – bec PTSD depends on as trauma as a cause and sometimes that linkage between cause (trauma) and effect (symptoms/function) is not straightforward
 - a. when the cause and sequelae are temporally closely linked: we do not have a problem. For example: man goes to Starbucks. Is in car accident on way there. 31 days later still troubled by re-experiencing/arousal/avoidance.
 - Classic PTSD: fear reaction that has not extinguished despite removal of stimulus.
 - He understands his problem, accurately, as stemming from the accident. --No accident – no PTSD.
 - Treatment avail.
 - Good prognosis.
 - b. but here are two examples that are not easy to understand.
 - i. 30 year old woman presents with some bad dreams, recollections of mistreatment as a child (NOT talking “repressed”). Says she is drinking; unhappy with relationships with men; suicidal thinking. She says that her current problems are due to mistreatment as a child. Her therapist calls it PTSD from her childhood.
 - ii. or consider scenario from a VA hospital
53 year old comes in. Trouble with marriage; using a little heroin; anxious. Dreams of Vietnam experience, tense-jumpy. Ruminating over decisions made in combat situation. Staff calls this PTSD – they assume the problems are traceable to the war experience.

Keep these scenarios in mind. I would argue that it nearly impossible to know that the diagnosis of PTSD is correct bec it is nearly impossible to determine that the events emphasized by the patients are the “cause” of their symptoms

Now, I want to take some time to tell this little bit of history, because it sets the stage for the complications inherent in PTSD diagnosis.

The story of PTSD starts with the Vietnam veteran. In the late 1960s, a band of self-described antiwar psychiatrists--spearheaded by Robert Jay Lifton, **SLIDE** who was well known for his work on the psychological damage wrought by Hiroshima--formulated a new diagnostic concept to describe the psychological wounds that the veteran sustained in the war.

In 1972 they proposed "Post-Vietnam Syndrome,"but rejected as too specific

The efforts of Lifton and his group would shape the dramatic image of the Vietnam veteran as the kind of "walking time bomb" immortalized in films such as *Taxi Driver* and *Rambo*. (**SLIDE**)

This mode of discourse set the Vietnam veteran apart from soldiers that came before him. "The suggestion or outright assertion was that Vietnam veterans have been unique in American history for their psychiatric problems.

In 1980, the American Psychiatric Association adopted post-traumatic stress disorder as an official diagnosis.

More generic than Post-Vietnam Syndrome, a diagnosis of PTSD was applicable to those who suffered other kinds of traumatizing conditions, such as natural disasters, accidents, or sexual assault.

Prior to the introduction of PTSD, there were other designations for traumatic reactions--in World War I and World War II, combat reactions were called shell shock or battle fatigue--but otherwise well-adjusted individuals were believed to be at small risk of suffering more than a transient stress reaction once they were removed from the front.

The diagnosis of PTSD changed all this. According to the British psychiatrist **Derek Summerfield**, 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."

No longer were prolonged traumatic reactions viewed as a reflection of constitutional vulnerability; they became instead a natural process of adaptation to extreme stress --subtext: the extreme stress being a politically unpopular war; one that destroys minds and annihilates souls.

More generally, a traumatic event was thus defined as one that would cause significant distress to anyone anywhere.

Considered a normative reaction. (9-11 hysteria)

For those of you who remember VA hospitals from the late 70s and 80's, the narrative was rarely questioned. No matter what problems a veteran had -- ETOH, erratic employment, domestic violence -- BY DEFINITION they were a product of war experience. A distinct therapeutic culture coalesced around the idea that combat was the root of all anguish. In such a milieu, a troubled, middle-aged veteran who only had minor complaints of nightmares or occ disturbing thoughts of Vietnam could find himself dx'd with PTSD.

So now here is one big problem with PTSD: Too much has been paid to claims making aspect of PTSD. It is a diagnosis that invites people to speculate on what has traumatized them. Or, better yet, invites their advocates to speculate on what has traumatized them. And this is strongly influenced by their political views. In order to demonstrate that one has been wronged, there must be pathology...and conversely: IF ONE DID NOT GET PTSD FROM AN ORDEAL? HOW BAD COULD IT HAVE BEEN?

And YES! Sometimes there IS pathology but in the absence of straightforward Event A, Reaction B scenario, we are often left to rely on a script and speculation.

Keep in mind also, that when you have a diagnosis with the cause built-into it, you provide traction for litigation (blame) and compensation (sense of entitlement).

You also have a very logical story line for your life...great human appeal

This is now a backdrop against which to discuss something topical about the VA. All read in the Washington Post in Dec that the funds for PTSD disability payments went up 150% between 1999 and 2005...for Vietnam veterans. (SLIDE)

What can this mean? Grossly, it means that over 100,000 new veterans who were involved in a war over 30 years ago are now presenting with PTSD.

Five possibilities:

- a) delayed manifestation
- b) reactivation
- c) misattribution
- d) chronic PTSD
- e) rational economic choice

Delayed: this is a concept that was introduced in 1980 as part of the DSM III definition of PTSD. Technically, it refers to onset of symptoms six months or more after event.

Point of clarification: delayed presentation vs. delayed onset. The former much more often the case. Rare that individual is asymptomatic and then wakes up one day. Possibility: smoldering symptoms and balance tipped over.

Literature review shows that most subjects who ultimately develop PTSD, were afflicted quite soon after the event. Most important, in cases of delayed in lit, the patients responded to treatment.

b) this brings us to reactivation – documented in WWI, WWII, Holocaust survivors, Korea vets

Clinically, it is typically a context of life alteration. Retirement; death of spouse; developmental stage of adulthood. Ok. So it is an adjustment problem to be treated in that context, one of a discontinuity. Not obvious that it results, except very rarely, in long-term disability.

Here my question is: ok, so we have instances of reactivated PTSD: under what circumstances does it become a chronic disability?

c) now we get to the complicated possibility: misattribution.

i. cultural narrative: A well-advertised syndrome like PTSD could have provided a medicalized explanation for many unhappy, but not necessarily traumatized, veterans who had been trying to make sense of their experience. Such “effort at meaning” is a deeply human – and well-documented phenomenon.

When a person suffers great inner turmoil, she could easily, and unconsciously, latch onto an attractive illness narrative and transform her distress into a recognized mental disorder. Such a psychic strategy--which may be imbibed from the media and from self-help books--directs

which sensations she should pay attention to and which she should ignore – these dreams, not those; these memories, not others.

Therapists contribute to the process by declaring some sensations more important than others, or by reward, or the emotional gratifications of the sick role.

It is easy to see why some individuals find the PTSD diagnosis attractive – it bolsters one’s self-image as a wounded warrior, helps them make sense of failures and allows them to attach meaning to pervasive feelings of demoralization, apathy, and irritability. In this way, therapists and patients may unwittingly negotiate a "mental disease."

D. “true chronics,”

Surely some of these applicants have “never been right,” as their wives often say, since their discharge from the military. They lost their civilian footing and over the years drifted further away from their families and communities. By the time they came to the VA for treatment, these veterans had so-called “malignant PTSD” – that is, severe symptoms of PTSD complicated by drugs and alcohol problems and other mental conditions such as depression and personality disorders. Unemployment, domestic discord, and criminal activity are common.

Not surprising, patients bearing so many layers of maladaptive behaviors are notoriously hard to treat. Had they received help within a year or two of returning from the service, however, they might have done well. At that time they would have more in common with civilian PTSD – that is, cases of assault or motor vehicle accidents – which is known to respond quite well to care.

E Financial incentives. Facing retirement. Rational economic choice.

WE CANNOT DISTINGUISH HOW MANY ARE A,B,C,D, or E

Now, I am sure many of my remarks made some people uncomfortable. After all, I am saying that when individuals present themselves with symptoms (R-A-A) many years after an event, it is nearly impossible to determine whether a set of symptoms was caused by the event especially when there have been many interceding years of functioning.

There is a positive note on which to end, however.

- a) First, simply because we cannot be confident of the etiology of distress and dysfunction does not mean we cannot treat it. Depression, anxiety, drug abuse, marital problems. So, we treat people according to the set of problems they present.
- b) ideally treat SOON! We know civilian PTSD responds well to treatment, so we should encourage care early after exposure. The longer someone waits, more they build up layers of dysfunction

This means we should create conditions that vets get treated when they are most like civilian PTSD: ACUTELY!

Think of PTSD as treatable and time-limited, like civilian PTSD. And treat it early, when it is most responsive, like civilian PTSD. This is our best hope because making diagnosis years later is almost impossible.

The dynamics I have mentioned today are among the “issues and controversies” associated with PTSD. They are what introduce confusion into the diagnosis. My major questions have to do with the

ability to make a diagnosis when presentation is significantly delayed and the idea that by conceptualizing PTSD as a commonly chronic problem that we create the conditions – expectations and disability payments especially, that make it so. This is a condition that results from an interaction between physiology and environment (expectations, the meaning of symptoms, and incentives). And these phenomena make the diagnostic sands shift – it is not a straightforward disease.

We have good treatments when we intervene early, and that is where our focus should be and how we should be thinking about PTSD: as a condition that is, in most instances, time-limited.

IF TIME, MENTION THIS: We can do things to help the problem remain a time-limited one.

I worked as a psychiatrist at a Veterans Affairs hospital in Connecticut for five years in the late '80s and early '90s. Unsettling as this sounds, I believe a sizable number of the roughly 224,000 veterans that the VA counts today as being disabled by post-traumatic stress disorder could have been rehabilitated.

This resulted from a confluence of unfortunate practices. **First**, VA mental health workers commonly believed -- and many still do -- that participation in war results, de facto, in post-traumatic stress disorder. In communicating this mistaken notion to veterans, they set up expectations of illness. **Second**, treatments themselves inadvertently contributed to problems. **Third**, generous VA disability payments may act as a disincentive to recovery.

How can the VA avoid creating a "new generation" of chronically ill vets? **It can start by carefully interpreting psychological states.** Many soldiers returning from war will feel confused, sad. They may have trouble sleeping, be easily distracted, and some will be bitter, even hostile. Whether this is psychopathology depends on how impaired they are and the persistence of the problem. It is vital to remember, however, that people in a fragile state can be susceptible to the suggestion that they are ill, and latch on to that idea.

Conversely, when otherwise healthy men and women are told they are experiencing natural and time-limited reentry difficulties, they will generally adopt that outlook.

Smoothly adjusting to family and community life depends largely on a veteran's economic security, family stability and physical health. Rehabilitation and social services are key. Such support can also help veterans regard their service as a worthy sacrifice or put their regret or guilt into perspective. They will suffer less than those who remain isolated and demoralized.

Another lesson is to keep **treatment practical.** Standard care for Vietnam War vets entailed months-long inpatient stays in special units. That increased identification with invalidism and made readjustment to civilian life harder. Therapy often consisted of repeatedly telling war stories to release anger and sadness. For many this exacerbated their problems. As the VA now recognizes, hospitalization should be reserved for those who can't function in another environment.

Finally, the disability trap: In most circumstances, psychiatric conditions will be temporary. Moreover, generous disability payments provide an economic incentive to remain ill. In fact, work is often good therapy, providing structure, a sense of purpose and social opportunities.