

# The Paradox of PTSD

*Thousands of soldiers are returning from Iraq and Afghanistan with deep psychological scars. Posttraumatic stress disorder is a common diagnosis—but is it the right one?*

BY KATHERINE N. BOONE

WHEN STAFF SERGEANT KYLE JEWART RETURNED to his hometown of Savannah, Georgia, from Iraq in 2008, he had trouble sleeping. During his 15-month tour with the U.S. Army's Sixty-Fourth Armor Regiment, six men in his company were killed in combat, and many more were wounded. He thought about those guys a lot. As a part of the Army's civilian reintegration process, he filled out a standard questionnaire: Did you kill anyone? Did you lose anyone close to you? Do you feel tense? Do you think about harming yourself?

"There must have been something in my answers," Jewart says, "because they told me I had PTSD." The Army offered him counseling, the military's most common treatment for posttraumatic stress disorder (PTSD), but after a session or two, Jewart stopped going. "I guess according to the definition I had PTSD, but I just didn't feel like I did."

Jewart neither was having flashbacks nor was seriously impaired by his symptoms. He wasn't suicidal. To keep his mind occupied, he went back to school to finish his bachelor's degree, and he sought support from his friends, family, and fiancée. Over time, he began to feel better and to sleep more easily. Today, he says he's doing fine. So had Jewart really suffered from PTSD? Any medical diagnosis, of course, must

be made by a licensed clinician, but Jewart's story raises a larger question: How is a person *supposed* to react to trauma?

For the past decade, legions of soldiers have returned from Afghanistan and Iraq bearing wounds both physical and psychological. As a country, the United States is struggling to understand, support, and treat these veterans. But for all its advances in finding ways to repair their bodies, the medical establishment is still grappling with how to treat their minds.

How many soldiers suffer from PTSD? There is no clear answer. The Department of Veterans Affairs (VA) says that more than 177,000 Iraq and Afghan war veterans have received a provisional diagnosis of PTSD, though this number does not take into account soldiers who are still serving or veterans who seek care outside of the VA system. What's more certain is that the VA has struggled with the diagnosis and treatment of those affected. In May, the U.S. Court of Appeals for the Ninth Circuit declared that the VA's "unchecked incompetence" in meeting the psychological needs of soldiers violated their constitutional right to due process, and mandated that the department completely overhaul its mental health care system. Indeed, bureaucratic delays, case backlogs, a shortage of qualified medical personnel, and stringent documentation

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Showing the strains of the fighting in Afghanistan's bitterly contested Korengal Valley in 2007, a U.S. infantryman takes refuge near a bunker.

requirements delay or block disability compensation and treatment in many instances—and what sufferers do receive is often inadequate. Treatments vary widely, from medication to intensive one-on-one therapy, and depend on whether the servicemember is still on active duty—the VA's treatment is often different from the Army's.

Perhaps one of the reasons the system has become so complex and dysfunctional is that the conceptual foundation on which it is based is fundamentally unstable. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the bible of the psychiatric profession, Staff Sergeant Jewart should indeed have been afflicted by PTSD. The DSM's definition of the disorder is somewhat mechanistic: Input a sufficient degree of stress, and you get disorder. And therein lies the illness's paradox: If you

react normally to trauma, you have a disorder; if you react abnormally, you don't. As Nancy Andreasen, a neuroscientist and psychiatrist at the University of Iowa, aptly observed in *The American Journal of Psychiatry* in 1995, PTSD is the only disorder that patients want to have; unlike all other psychiatric conditions, which imply defects of some kind, a diagnosis of PTSD confirms the patient's normality.

The creation of PTSD as a diagnostic category emerged as much from politics as from medicine. The disorder was first included in the DSM's third edition, published in 1980, in large part because activists, many of them Vietnam War veterans, had lobbied for a formal diagnosis that not only validated the experience of delayed and prolonged psychic pain but also relieved sufferers of the shame and stigma associated with mental illness. At the same time, clinicians who

studied other traumatic events as varied as rape and the Holocaust supported the idea that symptoms could appear months or even years after exposure to the stressor—one of the criteria the DSM incorporated.

The recognition of PTSD was not the first time the military had grappled with war's psychological effects on combatants. During World War I, psychiatrists thought that the spate of unusual psychological symptoms afflicting soldiers was the result of concussions caused by the new high explosives used in battle—hence the term “shell shock.” Though the theory was quickly discredited, the term lingers. The problem was put into bold relief when, in 1943, the Veterans Administration calculated that the government had spent over a billion dollars on the long-term care of World War I psychiatric casualties, who constituted more than half of the Veterans Administration's patients. In the early years of World War II, psychiatric casualties were diagnosed with “war neurosis,” a condition already existent in the individual because of inherent weakness or defective parenting and ag-

**DURING WORLD WAR I, doctors believed soldiers' psychological ills were caused by the concussions of high explosives—shell shock.**

gravated by armed conflict. The U.S. military, unable to provide the months, if not years, of psychotherapy that war neurosis required, discharged soldiers displaying psychiatric distress of any kind.

Midway through the war, a manpower crisis forced the military to re-evaluate its policy of summary dismissal. Escalating casualties and a dwindling pool from which to draft meant that the armed services could no longer afford to discharge men who were physically fit, if psychically shattered. In response to the problem, a group of Army psychiatrists in North Africa developed the theory of “combat fatigue,” also known as “combat stress” or, simply, “exhaustion.” If the “war neurosis” label implied a deep-seated pathology, combat fatigue suggested exactly the opposite. Ac-

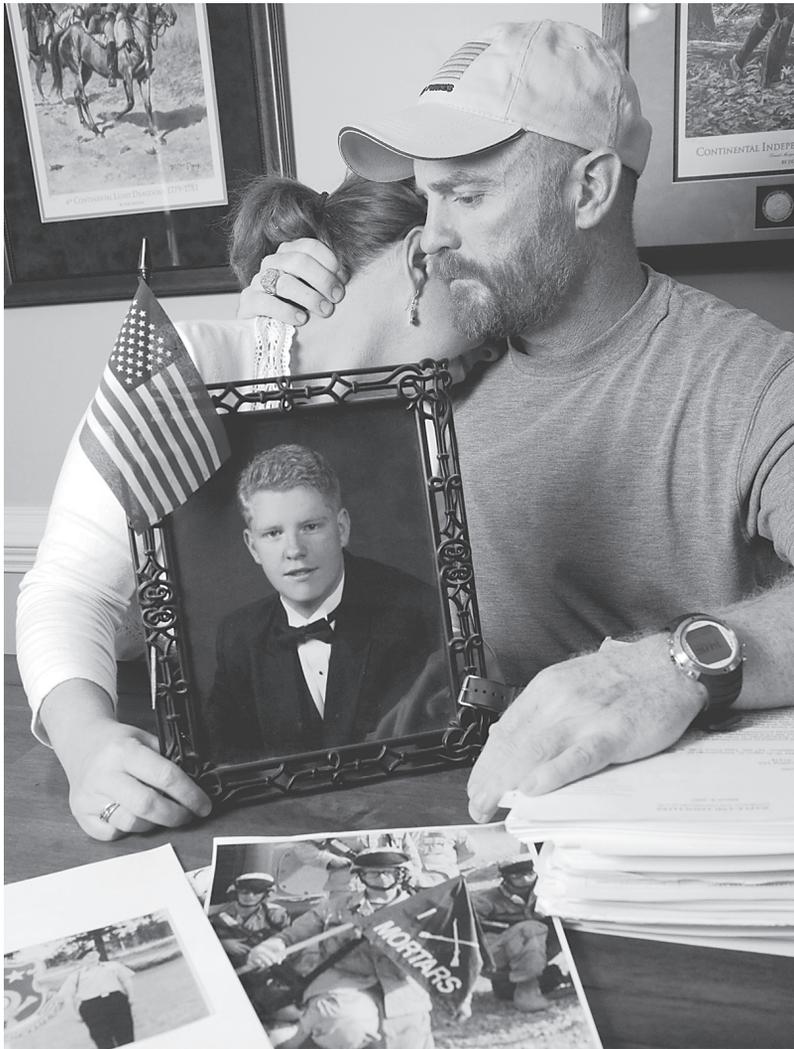
ording to this new theory, it was not a latent neurosis that caused psychiatric symptoms among soldiers but natural emotional and physical fatigue that was highly treatable. Because the condition was not pathological, Army psychiatrists theorized that rest, emotional support, and encouragement not to think of themselves as sick or abnormal could re-fortify most men, who consequently would not need to be automatically discharged. Much to the military's relief, many of them could return to duty—often quickly.

By making psychiatric symptoms normal, the combat fatigue diagnosis freed soldiers from the stigma of neurosis. The flip side of this reclassification, however, was that it risked minimizing soldiers' very real psychic pain. Whatever its strengths and flaws, combat fatigue was the dominant paradigm in 20th-century military psychiatry until the advent of PTSD.

Though the diagnosis of combat fatigue was commonly used by military psychiatrists, it had no widely accepted analogue in civilian psychiatry. Thus, when the first DSM was published in 1952, the category

of “gross stress reaction” was included to formally acknowledge reactions to traumatic stress in civilian life. That diagnosis was eliminated, however, from the second edition, published in 1968. The absence of gross stress reaction left psychiatrists

without a concept for understanding and treating those exposed to extreme stress. A new diagnosis was thus necessary both to capture the new understanding of how stress worked and to accord victims the treatment they needed. The 1980 edition made clear that PTSD was precipitated by a single external event and not anything in the victim's nature. Thus, while all other psychiatric diagnoses eschew assigning causes, which are invariably manifold, the definition of PTSD requires a specific etiologic event: exposure to an identifiable traumatic stressor. Without such exposure, known in the DSM as “Criterion A,” a patient cannot be diagnosed with the disorder, no matter how closely his or her other symptoms seem to fit. But Criterion A has undergone major alterations in all subsequent



**The Pentagon and the Department of Veterans Affairs have come under fire for mishandling PTSD cases such as that of Private Jason Scheuerman, whose parents mourn his 2006 suicide.**

revisions of the DSM precisely because it has been so difficult to specify what constitutes traumatic stress.

The 1980 edition of the manual defined traumatic stress as “a recognizable stressor that would evoke significant symptoms of distress in almost everyone;” qualifying events fell “generally outside the range of usual human experience.” In PTSD’s original configuration, the only reaction for almost everyone—i.e., normal people—to sufficiently abnormal events was to develop PTSD. Inherent in this wording were assumptions about what a normal person is and does and what events constitute a normal life—assumptions that proved somewhat simplistic and shallow. After all,

sticky question of what the usual human experience is and how normal people ought to react to it.

Nevertheless, the concept of normality originally so necessary to the project is still implicit in the construct of PTSD. The symptoms of the disorder include flashbacks, avoidance, numbing, and the state of heightened tension known as hyper-arousal. However, Harvard psychiatrist J. Alexander Bodkin has found that people experience these symptoms after events that fail to reach the threshold of Criterion A, such as divorce, the collapse of adoption arrangements, and financial insolvency. Similarly, a study by psychologists at Temple University found that when a set of

people survive—and even find meaning in—suffering, and the definition of normal life as being free of traumatic events obscures the difficult and often tragic aspects of human experience.

The definition had technical problems as well. As it was written, Criterion A failed to distinguish the types of traumatic stressors it intended—such as combat, rape, and natural disasters—from “everyday” stressors, such as divorce or the death of a loved one. Moreover, other PTSD-precipitating events—car accidents and assaults, for example—are an unfortunate but hardly unusual part of everyday life.

In response to such criticisms, in the DSM’s 1994 revision the language defining Criterion A was changed to read that “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.” In excising all language of normalcy, psychiatrists hoped to disentangle PTSD from the

otherwise normal undergraduates were asked to think about the most troubling aspect of their lives, they reported PTSD symptoms at equal and sometimes higher rates than did students who had been exposed to Criterion A stressors.

If a normal event can precipitate the symptoms of PTSD in normal people, it would seem that the description of the clinical syndrome in the DSM fails to distinguish between normal and abnormal reactions. It's a catch-22: The only way not to be called crazy is not to be bothered by trauma, but in some ways you'd have to be crazy *not* to be. As Bodkin and others have argued, the problem with the DSM's symptoms is that they are broad phenomena—sleep disruption, anxiety, depression—that are common to many forms of psychic distress, and that those criteria lack adequate means of distinguishing symptoms of genuine disorder from their normal analogues. As many critics have pointed out, the confusion of ordinary unhappiness with actual illness troubles all fields of psychiatry. The profound, implacable suffering of those with true PTSD ought not to be cheapened by being conflated with everyday distress.

Compare how we think about trauma to how we think about bereavement. Grief is understood as a normal, painful part of life through which a person eventually passes, thanks to a combination of time, soul-searching, and the compassion of others. It is normal human pain. The DSM reflects the commonality of this process with an official diagnosis for normal grief, indicating that there exists a non-pathological condition for which a person might seek professional help. Diagnoses of clinical depression, a recognized pathology, apply only to those whose sadness becomes chronic. Yet there is no designation for a normal reaction to traumatic events.

In recent years, we've learned that not everyone exposed to a traumatic stressor gets PTSD. In the wake of 9/11, predictions that there would be an epidemic of PTSD among New Yorkers weren't borne out (though more than 10,000 firefighters, police officers, and civilians present at the site of the attack did at some point suffer from the disorder.) Important research on risk factors, vulnerability, resilience, and even "posttraumatic growth" both complicates and illuminates the relationship between PTSD and nor-

malty without reverting to the pre-PTSD tendency to blame the victims for their condition. Much has been written on the factors that might predispose any given individual to PTSD: race, gender, ethnicity, coping mechanisms, support networks, and education level, to name several.

According to the National Center for Posttraumatic Stress Disorder, approximately eight percent of American adults will experience PTSD in their lifetimes; the VA estimates that among the more than two million soldiers who have served in Iraq or Afghanistan, the proportion will be between 11 and 20 percent. Other researchers, looking just at Iraq vets, project rates of up to 35 percent. To be sure, a much greater proportion of both soldiers and civilians have been exposed to a traumatic stressor as defined by the manual than suffer from the syndrome. Still, little is known about why some people exposed to extreme stressors experience PTSD while others don't. The next version of the DSM, to be published in 2013, provides an opportunity to modify the definition and criteria to reflect new research.

A number of psychiatrists, among them Robert L. Spitzer, who coauthored the original PTSD diagnosis in 1980, have been vociferous in their criticism of the current definition of the disorder, and many are skeptical that whatever changes are implemented in the next DSM will resolve the conceptual problems. While Spitzer and others have advocated a tightening of the diagnosis, there is concern that the definition might even be broadened, which would further blur the line between normality and disorder. Besides diminishing the significance of the disorder for both the sufferer and society at large, this "conceptual bracket creep," as Harvard psychologist Richard J. McNally has called it, would have real consequences for the military. Treating soldiers such as Staff Sergeant Jewart strains already-scarce resources and diverts them from the ones who need more intensive care. As Jewart says, "We were shot at and we were hit with IEDs throughout the whole deployment. I guess I really should have gotten PTSD. Everybody in my platoon *should* have." A one-size-fits-all diagnosis begs for a one-size-fits-all treatment, but treating those with milder symptoms the same way as those who are incapacitated does justice to none. ■