



PTSD in the U.S. military, and the politics of prevalence



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ABSTRACT

Despite the long-standing codification of posttraumatic stress disorder (PTSD) as a mental disorder, the diagnosis is a controversial one whose legitimacy is at times disputed, particularly in U.S. military contexts (e.g., McNally and Frueh 2013; McNally, 2003, 2007). These disputes often manifest in a struggle over prevalence rates. Utilizing data from in-depth interviews and relying on situational analysis methodology (Clarke, 2005), I highlight this struggle in the wake of a decade of U.S.-led war in Afghanistan and Iraq. I focus on the objects of contestation employed by public officials, veterans' advocates, and researchers to make or refute claims about PTSD prevalence. These objects of contestation include the diagnostic category and criteria; screening tools, procedures, or systems; and the individuals who express symptoms of the disorder. Based on these claims, I make two key interrelated assertions. First, PTSD is viewed by some public officials as an overly generalized or invalid diagnostic category that is often induced in or falsified by veterans or servicemembers. As such, PTSD is perceived by these stakeholders to be *over-diagnosed*. Compounding these perceptions are beliefs that PTSD is costly and negatively impacts military duty performance, and thus overall manpower. Second, there exist perceptions, largely on the part of veterans' advocates but also some public officials, that many servicemembers and veterans are not seeking treatment (and thus, a diagnosis) when they experience symptoms of PTSD. Thus, PTSD is perceived by these stakeholders to be *under-diagnosed*. Paradoxically, some public officials make both claims: that PTSD is *over-diagnosed* and *under-diagnosed*. I conclude by exploring the implications of these findings.

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1. Introduction

Posttraumatic stress disorder (PTSD) has been a recognized disorder in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (DSM) for more than thirty years. However, it remains a controversial disorder whose legitimacy is at times disputed, particularly in U.S. military contexts (e.g., McNally and Frueh, 2013; McNally, 2003, 2007). This paper highlights the mechanisms by which PTSD is disputed in the wake of a decade of U.S.-led war in Afghanistan and Iraq. These disputes manifest not in questions about whether PTSD exists, but often in queries and statements about how many individuals are, or should be, diagnosed with PTSD; the struggle is over prevalence rates. As such, these disputes target many facets of the disorder, including the diagnostic category and criteria; screening tools, procedures, or systems; and the individual servicemembers or veterans who express symptoms of the disorder.

PTSD is a trauma- and stressor-related disorder defined by criteria listed in the fifth edition DSM, the DSM-5. The diagnostic criteria for PTSD include past exposure to a traumatic event (that is, actual or threatened death, serious injury, or sexual violence), "intrusion" symptoms such as recurrent distressing memories, avoidance of stimuli associated with the trauma, negative alterations in cognition or mood associated with the traumatic event, and marked alterations in arousal and reactivity associated with the traumatic event (American Psychiatric Association, 2013). Symptoms must persist for one month following the trauma, cause significant functional impairment, and not be related to the physiological effects of a substance or another medical condition.

Researchers approximate that the prevalence of PTSD among returning U.S. military servicemembers is between 5 and 20 percent, although some assert that the most reliable estimates to fall between 10 and 14 percent (Ramchand et al., 2010; Schell and Marshall, 2008). These Afghanistan- and Iraq-era estimates follow a long-standing debate over the prevalence of PTSD among U.S. military populations. In the late 1980s, researchers from the National Vietnam Veterans Readjustment Study estimated the lifetime prevalence of PTSD among Vietnam War veterans to be 30.9% and

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the prevalence at the time to be 15.2% (Kulka, 1990). However, these rates have been perceived by some to be imprecise (McNally, 2007). Although social scientists have at least partially explained discrepancies in estimates, the exact rate of PTSD among veterans of Vietnam or other wars remains a topic of debate.

Comparing prevalence rates across war eras implicitly raises questions about whether PTSD is a static construct over time. Although PTSD was incorporated into the third edition of the DSM in 1980, its roots lie in centuries past (Dean, 1997; Finley, 2011; Scott, 1990, 2004; Shepard, 2001; Young, 1995). Mental health practitioners and researchers often frame PTSD as a manifestation of these earlier phenomena—that is, as a fixed biopsychiatric construct that has been discovered and refined over time. However, some scholars assert that responses to traumatic stress do not constitute a singular entity but are instead products of the social, institutional, and technological environments within which they exist and through which they are understood (Young, 1995; see also Conrad and Schneider, 1992).

I approach this study assuming that both of these interpretations may prove true, at least to a degree. That is, in accordance with the social constructionist framework of Brown (1995) that draws on the work of Freidson (1970), I postulate that biopsychiatric realities, identified through biomedical knowledge structures, could underlie the PTSD construct while the disorder is also acted upon and shaped by a range of individuals and institutions. I place particular emphasis on the cultural meanings—most notably, perceptions of prevalence—attached to PTSD via the actions of claims-makers and interested parties who influence and construct the disorder (Conrad and Barker, 2010). The manner in which the disorder is constructed and the cultural meanings it carries may in turn affect who is (or is not) diagnosed. Stated differently, I view PTSD through a “social diagnosis” framework, wherein social actors are presumed to contribute to the creation of a diagnosis which is interconnected with political, economic, cultural, and social factors (Brown et al., 2011).

2. Methods

This paper is part of a larger project focused on U.S. military and veterans' PTSD policy between 2001 and 2012, the decade following the start of the U.S. led war in Afghanistan. The multi-pronged goal of the study was to investigate changes in military and veterans' PTSD policy during this period, how social actors such as veterans' advocates have shaped PTSD policy, and how individuals involved in PTSD policy making understand and frame issues related to PTSD diagnosis and disability compensation. This research utilized situational analysis methodology (Clarke, 2005), which involves qualitative fieldwork, and augments grounded theory's analytical tools (Glaser and Strauss, 1967; Strauss and Corbin, 1998). Data sources for the overarching project included semi-structured interviews, document analysis, and participant observation. Human subjects protection approval for this study was granted by the University of California, San Francisco's Committee on Human Research.

The findings presented here stem from analysis of semi-structured interviews conducted between June 2011 and December 2012. I conducted interviews with a purposive sample of 26 individuals involved in military or veterans' mental health policy making. Potential interviewees were identified via publicly available documents and snowball sampling. As the study progressed, theoretical sampling (Glaser and Strauss, 1967; Strauss and Corbin, 1998) was used to ensure that selected interviewees contributed to a rich understanding of the emerging foci of the study, and that a diverse sample, and thus a wide range of perspectives, was represented. I described the research to potential interviewees as a

social-historical study of PTSD policy in the U.S. military context, and obtained verbal consent prior to interviews. The interviews ranged from 30 min to 3 h in duration. With interviewee permission, I digitally audio-recorded the interviews and then transcribed and supplemented them with field notes.

Overall, the sample comprised 16 current or former public officials employed by the Department of Veterans Affairs (VA), the Department of Defense (DoD), or Congress; 8 veterans' advocates; and 2 university-based researchers. Of these 26 individuals, five had been trained as mental health care providers and 5 as health care providers. All interviewees possessed a bachelor's degree, and one-half the sample had earned a doctoral or professional degree. Fourteen interviewees had served in the U.S. military previously or were currently serving.

Data were coded and analyzed in accordance with the principles of grounded theory (Glaser and Strauss, 1967; Strauss and Corbin, 1998) and situational analysis (Clarke, 2005). I first analyzed words, phrases, and sentences to generate codes. Interviews were comprehensively reviewed and coded, whereas media articles and government documents were selectively coded for relevant themes that emerged as the study progressed. All coded data were uploaded into ATLAS.ti software, which enabled the further elaboration of codes and the clustering of related codes into categories. I utilized constant comparative analysis to move back and forth among the data to refine codes and categories. Data were further analyzed using positional maps, a tool of situational analysis (Clarke, 2005). Positional maps are useful for simplifying and visually plotting discourses that are articulated (or not articulated) in the data.

3. Findings

These findings center on a positional map (Clarke, 2005) used to analyze claims concerning PTSD's prevalence conveyed by interviewees (see Fig. 1). These claims fell into three categories (listed on the *x*-axis), each concerning an object of contestation utilized by stakeholders to make or refute claims about PTSD prevalence: the diagnostic category and criteria; the screening tools, procedures, or systems; and the individual servicemembers or veterans who express symptoms of the disorder. These claims were utilized by interviewees to make statements about the “true” prevalence of PTSD—that is, whether too many or too few servicemembers or veterans are being diagnosed—or to express *uncertainty* about the prevalence of PTSD (listed on the *y*-axis). The positional map shown in Fig. 1 guides the themes discussed in the sections below.

3.1. Perceiving over-diagnosis: categorical and behavioral

Several interviewees, particularly public officials, claimed that PTSD is over-diagnosed among servicemembers and veterans. They attributed the high number of diagnoses either to a flawed diagnostic category (categorical over-diagnosis) or to diagnosis-seeking behavior of individual servicemembers (behavioral over-diagnosis). These claims are represented in the upper row of Fig. 1.

3.2. Categorical over-diagnosis

Interviewees focusing on the *diagnostic category* as a means to claim that too many cases of PTSD have been diagnosed articulated one of two arguments about categorical over-diagnosis shown in Fig. 1: (1) PTSD is a sociopolitical, not clinical, construct created by the psychiatric community and veterans' advocates, and is therefore not a valid clinical diagnosis; or (2) PTSD is a “catch-all,” “wastebasket,” or “garbage can” diagnosis. For the most part, these were mutually exclusive positions.

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