The Post-Traumatic Stress Trap

A growing number of experts insist that the concept of post-traumatic stress disorder is itself disordered and that soldiers are suffering as a result

By David Dobbs

KEY CONCEPTS

- The syndrome of post-traumatic stress disorder (PTSD) is under fire because its defining criteria are too broad, leading to rampant overdiagnosis.
- The flawed PTSD concept may mistake soldiers' natural process of adjustment to civilian life for dysfunction.
- Misdiagnosed soldiers receive the wrong treatments and risk becoming mired in a Veterans Administration system that encourages chronic disability.

—*The Editors*

In 2006, soon after returning from military service in Ramadi, Iraq, during the bloodiest period of the war, Captain Matt Stevens of the Vermont National Guard began to have a problem with PTSD, or post-traumatic stress disorder. Stevens's problem was not that he had PTSD. It was that he began to have doubts about PTSD: the condition was real enough, but as a diagnosis he saw it being wildly, even dangerously, overextended.

Stevens led the medics tending an armored brigade of 800 soldiers, and his team patched together GIs and Iraqi citizens almost every day. He saw horrific things. Once home, he said he had his share of "nights where I'd wake up and it would be clear I wasn't going to sleep again."

He was not surprised: "I would *expect* people to have nightmares for a while when they came back." But as he kept track of his unit in the U.S., he saw troops greeted by both a larger culture and a medical culture—especially in the Veterans Administration (VA)—that seemed reflexively to view bad memories, nightmares and any other sign of distress as an indicator of PTSD.

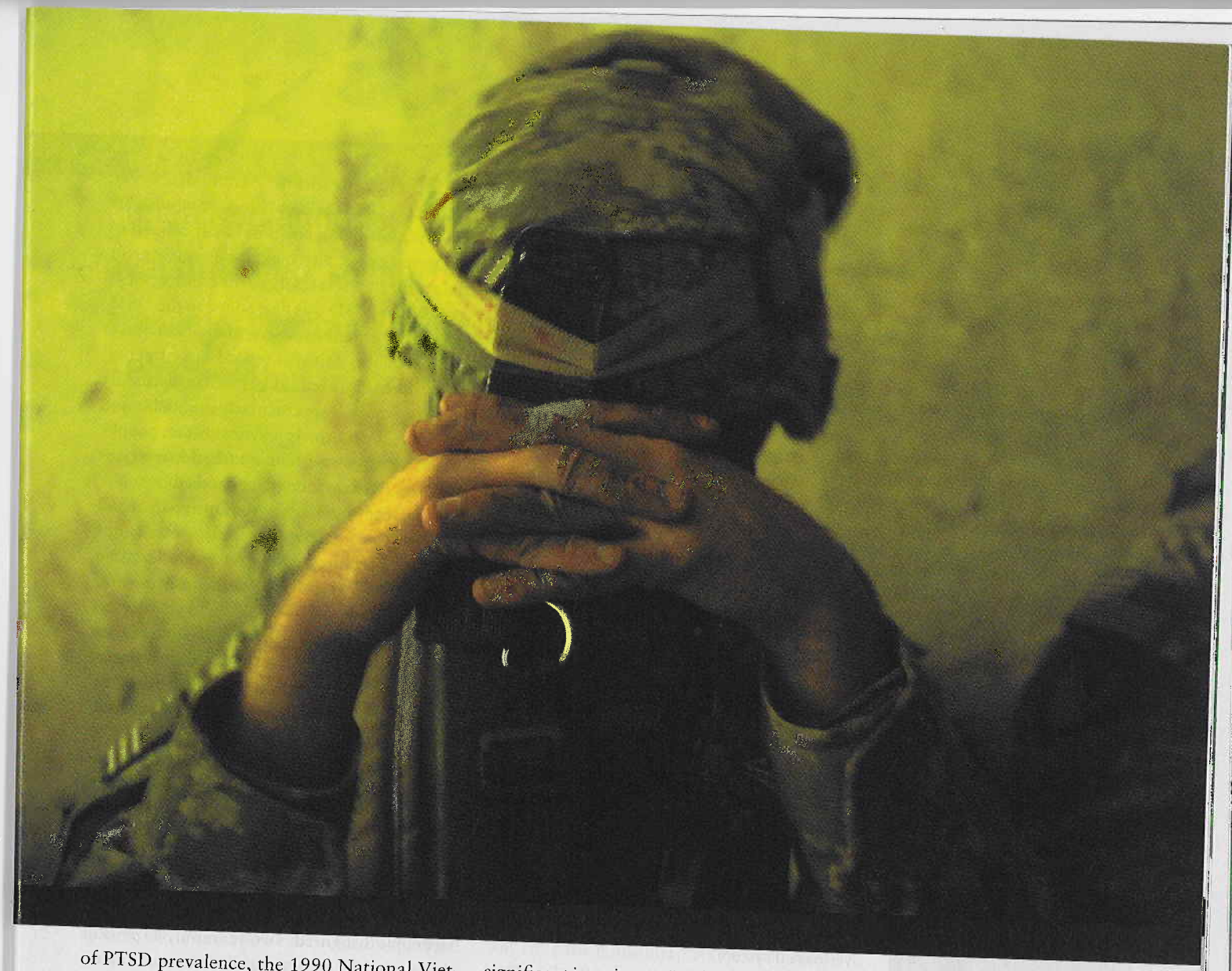
"Clinicians aren't separating the few who really have PTSD from those who are experiencing things like depression or anxiety or social and reintegration problems or who are just taking some time getting over it," Stevens says. He worries that many of these men and women are being pulled into a treatment and disability regime that will mire them in a self-fulfilling vision of a brain rewired, a psyche permanently haunted.

Stevens, now a major and still on reserve duty while he works as a physician's assistant, is far from alone in worrying about the reach of PTSD. Over the past five years or so, a long-simmering academic debate over PTSD's conceptual basis and incidence has begun to boil over. It is now splitting the practice of trauma psychology and roiling military culture. Critiques originally raised by military historians and a few psychologists are now advanced by a broad array of experts—indeed, giants of psychology, psychiatry and epidemiology. They include Columbia University's Robert L. Spitzer and Michael B. First, who oversaw the last two editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* the *DSM-III* and *DSM-IV;* Paul McHugh, former chair of Johns Hopkins University's psychiatry department; Michigan State University epidemiologist Naomi Breslau; and Harvard University psychologist Richard J. McNally, a leading authority in the dynamics of memory and trauma and perhaps the most forceful of the critics. The diagnostic criteria for PTSD, they assert, represent a faulty, outdated construct that has been badly overstretched so that it routinely mistakes depression, anxiety or even normal adjustment for a unique and especially stubborn ailment.

This quest to scale back the definition of PTSD and its application stands to affect the expenditure of billions of dollars, the diagnostic framework of psychiatry, the effectiveness of a huge treatment and disability infrastructure, and, most important, the mental health and future lives of hundreds of thousands of U.S. combat veterans and other PTSD patients. Standing in the way of reform is conventional wisdom, deep cultural resistance and foundational concepts of trauma psychology. Nevertheless, it is time, as Spitzer recently argued, to "save PTSD from itself."

Casting a Wide Net

The overdiagnosis of PTSD, critics say, shows in the numbers, starting with the seminal study



TYLER HICKS New York Times

DISTRESS CAN BE A NORMAL response to pain and loss or a sign of a psychic wound that is failing to heal. Critics of PTSD diagnostic criteria, including many soldiers, feel that returning veterans' natural process of adjustment is often mislabeled as a dysfunctional state.

of PTSD prevalence, the 1990 National Vietnam Veterans Readjustment Survey (NVVRS). The NVVRS covered more than 1,000 male Vietnam vets in 1988 and reported that 15.4 percent of them had PTSD at the time and that 31 percent had suffered it at some point since the war. That 31 percent has been the standard estimate of PTSD incidence among veterans ever since.

In 2006, however, Columbia epidemiologist Bruce P. Dohrenwend, hoping to resolve nagging questions about the study, reworked the numbers. When he had culled the poorly documented diagnoses, he found that the 1988 rate was 9 percent and the lifetime rate 18 percent.

McNally shares the general admiration for Dohrenwend's careful work. Soon after it was published, however, McNally asserted that Dohrenwend's numbers were still too high because he counted as PTSD cases those veterans with only mild, subdiagnostic symptoms, people rated as "generally functioning pretty well." If you included only those suffering "clinically significant impairment"—the level generally required for diagnosis and insurance compensation in most mental illness—the rates fell yet further, to 5.4 percent at the time of the survey and 11 percent lifetime. It was not one in three veterans who eventually developed PTSD, but one in nine—and only one in 18 had it at any given time. The NVVRS, in other words, appears to have overstated PTSD rates in Vietnam vets by almost 300 percent.

"PTSD is a real thing, without a doubt," McNally says. "But as a diagnosis, PTSD has become so flabby and overstretched, so much a part of the culture, that we are almost certainly mistaking other problems for PTSD and thus mistreating them."

The idea that PTSD is overdiagnosed seems to contradict reports of resistance in the military and the VA to recognizing PTSD—denials of PTSD diagnoses and disability benefits, military clinicians discharging soldiers instead of treating them, and a disturbing increase in suicides among veterans of the Middle East wars. Yet the

PTSD: A Problem Defined by Its Cause

In the current American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*), the first diagnostic criterion for post-traumatic stress disorder (PTSD) is having experienced trauma:

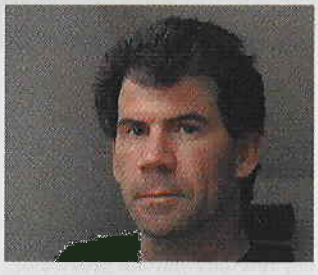
"The person has been exposed to a traumatic event in which both of the following have been present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) the person's response involved intense fear, helplessness, or horror."

The presence of three clusters of symptoms—reexperiencing the event, for example, via nightmares or flashbacks; numbing or withdrawal; and hyperarousal, evident in irritability, insomnia, aggression or poor concentration—for more than a month and to the extent that they cause "clinically significant distress or impairment in social, occupational or other important areas of functioning" completes the syndrome's definition.

Critics of this diagnostic construct argue that the symptoms themselves can be characteristic of a wide array of other disorders and may appear together in people who have not experienced trauma.

PTSD was first defined in the *DSM-III*, published in 1980, in response to anti–Vietnam War psychiatrists and veterans who sought a diagnosis to recognize what they saw as the unique suffering of Vietnam vets. —*D.D.*

[THE AUTHOR]



David Dobbs is a contributing editor of *Scientific American Mind* and was the founding editor of the Mind Matters blog on www.SciAmMind.com. He also regularly writes on medicine, nature, education and culture for the *New York Times Magazine*, Slate.com and *Audubon*. Dobbs has published three books: *Reef Madness: Charles Darwin, Alexander Agassiz and the Meaning of Coral* (Pantheon, 2005); *The Great Gulf: Fishermen, Scientists and the Struggle to Revive the World's Greatest Fishery* (Island Press, 2000); and *The Northern Forest*, with Richard Ober (Chelsea Green, 1995). His Neuron Culture blog is at http://scienceblogs.com/neuronculture

two trends are consistent. The VA's PTSD caseload has more than doubled since 2000, mostly because of newly diagnosed Vietnam veterans. The poor and erratic response to current soldiers and recent vets, with some being pulled quickly into PTSD treatments and others discouraged or denied, may be the panicked stumbling of an overloaded system.

Overhauling both the diagnosis and the VA's care system, critics say, will ensure better care for genuine PTSD patients as well as those being misdiagnosed. But the would-be reformers face fierce opposition. "This argument," McNally notes, "tends to really piss some people off." Veterans send him threatening e-mails. Colleagues accuse him of dishonoring veterans, dismissing suffering, discounting the costs of war. Dean G. Kilpatrick, a University of South Carolina traumatologist and former president of the International Society for Traumatic Stress Studies (ISTSS), once essentially called McNally a liar.

A Problematic Diagnosis

The *DSM-IV*, the most recent edition (published in 1994), defines PTSD as the presence of three symptom clusters—reexperiencing via nightmares or flashbacks; avoidance by numbing or withdrawal; and hyperarousal, evident in irritability, insomnia, aggression or poor concentration—that arise in response to a life-threatening event [*see box above*].

The construction of this definition is suspect. To start with, the link to a traumatic event, which makes PTSD almost unique among complex psychiatric diagnoses in being defined by an external cause, also makes it uniquely problematic, for the tie is really to the memory of an event. When PTSD was first added to the *DSM-III* in 1980, traumatic memories were considered reasonably faithful recordings of actual events. But as research since then has repeatedly shown, memory is spectacularly unreliable and malleable. We routinely add or subtract people, details, settings and actions to and from our memories. We conflate, invent and edit.

In one study by Washington University memory researcher Elizabeth F. Loftus, one out of four adults who were told they were lost in a shopping mall as children came to believe it. Some insisted the event happened even after the ruse was exposed. Subsequently, bounteous research has confirmed that such false memories are common [see "Creating False Memories," by Elizabeth F. Loftus; SCIENTIFIC AMERICAN, September 1997].

Soldiers enjoy no immunity from this tendency. A 1990s study at the New Haven, Conn., VA hospital asked 59 Gulf War veterans about their experiences a month after their return and again two years later. The researchers asked about 19 specific types of potentially traumatic events, such as witnessing deaths, losing friends and seeing people disfigured. Two years out, 70 percent of the veterans reported at least one traumatic event they had not mentioned a month after returning, and 24 percent reported at least three such events for the first time. And the veterans recounting the most "new memories" also reported the most PTSD symptoms.

To McNally, such results suggest that some veterans experiencing "late-onset" PTSD may be attributing symptoms of depression, anxiety or other subtle disorders to a memory that has been elaborated and given new significance—or even unconsciously fabricated.

"This has nothing to do with gaming or working the system or consciously looking for sympathy," McNally says. "We all do this: we cast our lives in terms of narratives that help us understand them. A vet who's having a difficult life may remember a trauma, which may or may not have actually traumatized him, and everything makes sense."

To make the diagnosis of PTSD more rigorous, some have suggested that blood chemistry, brain imaging or other tests might be able to de-

COURTESY OF DAVID DOBBS

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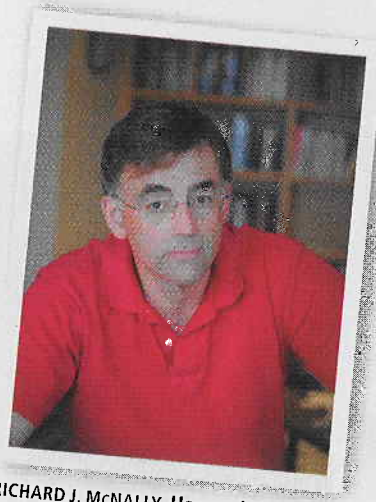


RICHARD J. McNALLY, Harvard University

tect physiological signatures of the disorder. Some studies of stress hormones in groups of PTSD patients show differences from normal subjects, but the overlap between the normal and the PTSD groups is huge, making individual profiles useless for diagnostics. Brain imaging has similar limitations, with the abnormal dynamics in PTSD heavily overlapping those of depression and anxiety.

With memory unreliable and biological markers elusive, diagnosis depends on clinical symptoms. But as a study in 2007 starkly showed, the symptom profile for PTSD is as slippery as the would-be biomarkers. J. Alexander Bodkin, a psychiatrist at Harvard's McLean Hospital, screened 90 clinically depressed patients separately for PTSD symptoms and for trauma, then compared the results. First he and a colleague used a standardized screening interview to assess symptoms. Then two other PTSD diagnosticians, ignorant of the symptom reports, used another standard interview to see which patients had ever experienced trauma fitting *DSM-IV* criteria.

If PTSD arose from trauma, the patients with PTSD symptoms should have histories of trauma, and those with trauma should show more PTSD. It was not so. Although the symptom screens rated 70 of the 90 patients positive for PTSD, the trauma screens found only 54 who had suffered trauma: the diagnosed PTSD "cases" outnumbered those who had experienced traumatic events. Things got worse when Bodkin compared the diagnoses one on one. If PTSD required trauma, then the 54 trauma-exposed patients should account for most of the 70 PTSD-positive patients. But the PTSD-symptomatic patients were equally distributed among the trauma-positive and the trauma-negative groups. The PTSD rate had zero relation to the trauma rate. It was, Bodkin observed, "a scientifically unacceptable situation."

More practically, as McNally points out, "To give the best treatment, you have to have the right diagnosis."

The most effective treatment for patients whose symptoms arise from trauma is exposure-based cognitive-behavioral therapy (CBT), which concentrates on altering the response to a specific traumatic memory by repeated, controlled exposure to it. "And it works," McNally says. "If someone with genuine PTSD goes to the people who do this really well, they have a good chance of getting better." CBT for depression, in contrast, teaches the patient to recognize dysfunctional loops of thought and emotion and develop new responses to normal, present-day events. "If a depressed person takes on a PTSD interpretation of their troubles and gets exposure-based CBT, you're going to miss the boat," McNally says. "You're going to spend your time chasing this memory down instead of dealing with the way the patient misinterprets present events."

To complicate matters, recent studies showing that traumatic brain injuries from bomb blasts, common among soldiers in Iraq, produce symptoms almost indistinguishable from PTSD. One more overlapping symptom set.

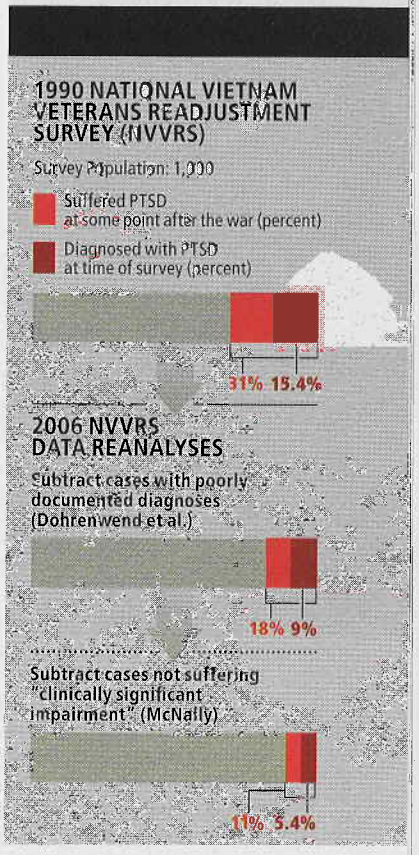
"The overlap issue worries me tremendously," says Gerald M. Rosen, a University of Washington psychiatrist who has worked extensively with PTSD patients. "We have to ask how we got here. We have to ask ourselves, 'What do we gain by having this diagnosis?' "

Disabling Conditions

Rosen is thinking of clinicians when he asks about gain. But what does a veteran gain with a PTSD diagnosis? One would hope, of course, that it grants access to effective treatment and support. This is not happening. In civilian populations, two thirds of PTSD patients respond to treatment. But as psychologist Christopher Frueh, who researched and treated PTSD for the VA from the early 1990s until 2006, notes, "In the two largest VA studies of combat veterans,

DISCREPANCIES IN DIAGNOSES

Estimates of PTSD incidence among soldiers are often inflated for several reasons, including the condition's vague diagnostic criteria. Assessment survey questions—and answers—are also highly subject to interpretation. Stricter analyses of the 1990 National Vietnam Veterans Readjustment Survey data, for instance, reduced PTSD incidence to one third of the original results.



JUSTIN IDE *Harvard News Office (McNally)*; JEN CHRISTIANSEN; SOURCES: "FINDINGS FROM THE NATIONAL VIETNAM VETERANS READJUSTMENT STUDY," BY J. L. PRICE. NATIONAL CENTER FOR POSTTRAUMATIC STRESS DISORDER: "THE PSYCHOLOGICAL RISKS OF VIETNAM FOR U.S. VETERANS: A REVISIT WITH NEW DATA AND METHODS," BY B. DOHRENWEND ET AL., IN *SCIENCE*, VOL. 313, AUGUST 18, 2006; "PSYCHIATRIC CASUALTIES OF WAR," BY R. J. McNALLY, IN *SCIENCE*; *IBID.* (graphs)