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# Perspectives on Veterans' Health and Care

## Abstract

The study of military veterans has been largely overlooked by the field of sociology, despite the magnitude of social relevance and sociological insight this population has to offer. This dissertation is comprised of three substantive chapters relating to veterans' health and care. The first chapter grapples with theoretical issues including the role of media in the emergence of social problems, and the impact of scandals on their trajectories. Through content analysis of New York Times articles (2000-2010), I studied veterans' healthcare, the roles of scandal and social externalities, in shifts in volume and content of coverage. Analyses revealed that changes in reporting began before the outbreak of scandal, but that scandal acted as an amplifier, increasing overall coverage. Furthermore, scandals can travel across domains and heighten public attention to problems beyond their initial target. The second and third chapters stem from a year of ethnographic fieldwork in a social services program for veterans. The vast majority of participants were low-income and/or disabled, and their lives were intimately tied to the Department of Veterans Affairs. The second chapter investigates the social process of Vietnam War veterans coming to terms with Posttraumatic Stress Disorder. Through analysis of fieldnotes and formal interviews, I built upon Erving Goffman's moral career framework, and developed a model explicating various pathways on a journey beginning before diagnosis, through treatment, and beyond. The chapter contributes to the medicalization literature by exploring the impact of medicalization on people who lived for extended periods before their conditions were legitimated by the medical profession. The final chapter examines problems bureaucratic human services agencies face in handling elusive conditions. Through research based primarily on government reports, Congressional testimony, and existing published reports, I demonstrated that Posttraumatic Stress Disorder is a complex condition requiring subjective judgments from diagnosis through the determination of magnitude of disability, making it a particularly problematic condition for organizations reliant upon rationality, measurement, rules, and standards. Overall, this dissertation reflects a fact glaringly evident in my fieldwork - a complex relationship exists between the veteran as individual and the broader social structure.

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PERSPECTIVES ON VETERANS' HEALTH AND CARE

Mollie Kate Rubin

A DISSERTATION

in

Sociology

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Philosophy

2012

Supervisor of Dissertation

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Mollie Kate Rubin

## **DEDICATION**

In memory of Kate Jeans-Gail and Jennifer Kelley.

Your journeys were cut far too short, yet your impact shall be with me forever.

## ACKNOWLEDGMENTS

Writing this dissertation has been a long and arduous process, and were it not for the support of so many people, it may never have come to fruition. First, and foremost, this project would not have been possible without the access granted to me by the program director, the staff, and the participants of the site where I conducted my fieldwork. I owe so many thanks to the veterans who opened up to me, and let me into their lives. Throughout my fieldwork, I heard time and time again, that there are some things only a veteran can understand, and certain things veterans will only discuss, if ever, amongst other veterans. Still, for some reason, some veterans shared their stories – stories that were never meant to be spoken. Because of this, I have learned to understand their silence, and have developed an even greater appreciation of the sacrifices certain men and women have made for their country. I only hope that these individuals can someday find peace.

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# ABSTRACT

## PERSPECTIVES ON VETERANS' HEALTH AND CARE

Mollie Kate Rubin

Charles L. Bosk

The study of military veterans has been largely overlooked by the field of sociology, despite the magnitude of social relevance and sociological insight this population has to offer. This dissertation is comprised of three substantive chapters relating to veterans' health and care. The first chapter grapples with theoretical issues including the role of media in the emergence of social problems, and the impact of scandals on their trajectories. Through content analysis of *New York Times* articles (2000-2010), I studied veterans' healthcare, the roles of scandal and social externalities, in shifts in volume and content of coverage. Analyses revealed that changes in reporting began before the outbreak of scandal, but that scandal acted as an amplifier, increasing overall coverage. Furthermore, scandals can travel across domains and heighten public attention to problems beyond their initial target. The second and third chapters stem from a year of ethnographic fieldwork in a social services program for veterans. The vast majority of participants were low-income and/or disabled, and their lives were intimately tied to the Department of Veterans Affairs. The second chapter investigates the social process of Vietnam War veterans coming to terms with Posttraumatic Stress Disorder. Through analysis of fieldnotes and formal interviews, I built upon Erving Goffman's moral career framework, and developed a model explicating various pathways on a journey beginning before diagnosis, through treatment, and beyond. The chapter contributes to the



medicalization literature by exploring the impact of medicalization on people who lived for extended periods before their conditions were legitimated by the medical profession. The final chapter examines problems bureaucratic human services agencies face in handling elusive conditions. Through research based primarily on government reports, Congressional testimony, and existing published reports, I demonstrated that Posttraumatic Stress Disorder is a complex condition requiring subjective judgments from diagnosis through the determination of magnitude of disability, making it a particularly problematic condition for organizations reliant upon rationality, measurement, rules, and standards. Overall, this dissertation reflects a fact glaringly evident in my fieldwork - a complex relationship exists between the veteran as individual and the broader social structure.

## TABLE OF CONTENTS

<b>ACKNOWLEDGMENTS</b> .....	<b>IV</b>
<b>ABSTRACT</b> .....	<b>VI</b>
<b>TABLE OF CONTENTS</b> .....	<b>VIII</b>
<b>LIST OF TABLES</b> .....	<b>IX</b>
<b>LIST OF ILLUSTRATIONS</b> .....	<b>X</b>
<b>CHAPTER 1. INTRODUCTION</b> .....	<b>1</b>
<b>CHAPTER 2. FROM PROBLEM TO SOCIAL PROBLEM TO SCANDAL: VETERANS’ HEALTHCARE IN THE NEWS, 2000-2010</b> .....	<b>6</b>
<b>CHAPTER 3. MORAL CAREER PATHS OF VETERANS WITH POSTTRAUMATIC STRESS DISORDER</b> .....	<b>35</b>
<b>CHAPTER 4. BUREAUCRACY AND CLASSIFICATION SYSTEMS: AN ORGANIZATIONAL ANALYSIS OF DISABILITY CLAIMS PROCESSING FOR POSTTRAUMATIC STRESS DISORDER</b> .....	<b>96</b>
<b>BIBLIOGRAPHY</b> .....	<b>127</b>

## LIST OF TABLES

Table 1.1: Definitions of Each Main Topic	30
Table 1.2: Number of Articles for Each Theme by Year	31
Table 1.3: Veterans Living by Period of Service and Age (in thousands, as of July 1, 2001)	32
Table 1.4: Number of Articles Focused on Veterans Mentioning PTSD, TBI, Suicide	33
Table 1.5: Number of Articles Focused on Veterans that Refer to Individual Veterans, Include Direct Quotes of Veterans, Direct Quotes of Family Members	33
Table 3.1: Most Prevalent Service-Connected Disabilities for Veterans Receiving Compensation at the End of Fiscal Year 2011	124

## LIST OF ILLUSTRATIONS

Figure 1.1: Noteworthy Dates	34
Figure 1.2: Search Terms Used to Compile Articles from <i>Lexis/Nexis</i>	34
Figure 2.1: Diagnostic Criteria for Posttraumatic Stress Disorder in Adults	94
Figure 2.2: Path of Posttraumatic Stress Disorder	95
Figure 3.1: Diagnostic Criteria for Posttraumatic Stress Disorder in Adults	125
Figure 3.2: General Rating Formula for Mental Disorders	126

## **Chapter 1. Introduction**

This dissertation, entitled *Perspectives on Veterans' Health and Care*, developed from a year of fieldwork with an organization that bridges the transition for economically disadvantaged veterans to post-secondary education. It may be surprising that the chapters in the dissertation are not about education, despite the setting of the fieldwork. Rather, the dissertation is comprised of three papers that relate to the health and care of veterans. How did a dissertation focused on education transform into papers on veterans' health care? The most succinct answer to this question is that my time spent with the program for veterans revealed a complex relationship among veterans as individuals and the opportunity structure of the larger society. In this particular case, the vast majority of the program's participants were low-income and/or disabled. Once the veterans became cases managed within classificatory confines, their lives were intimately tied to the veterans' social welfare system. In the United States, the welfare system for veterans is administered by the Department of Veterans Affairs (VA).

Some of the program participants used the program specifically for its stated purpose – to prepare veterans to enter, be successful, and graduate from college. For many others, it was yet another program through which they passed on a journey through life as a disadvantaged American veteran. Many subjects in my study utilized other social service programs in addition to the education program. And many did not enter the program for reasons that aligned with the stated mission of the program, but rather at the recommendation from a counselor at a drug treatment program, transitional housing

coordinator, a computer skills program director, or another veteran who found it to be a positive distraction from the regular, daily grind. This does not imply that the program was a failure, a waste of time, or money, but rather its benefits for such veterans were broader than those a program limited to education provides. In fact, the program itself often played a very important, positive role in the lives of the veterans who had struggled most, as it gave them a socially respectable activity in which they could immerse themselves. But for these veterans, what was most prevalent in the individual stories they shared with me, and the barriers I watched them attempt to traverse, encompassed segments of shattered lives, and the process of overcoming exposure to the trauma of combat.

As a result, my attention turned to some of the most persistent themes for these individuals, including problems of physical and mental health, struggles with drug and alcohol dependence, healthcare, and the disability compensation system. These topics are key pieces to the dissertation, as they were in fact the most pressing elements in the lives of so many people within the program. The common thread in each of the chapters that follow is an investigation of the social and structural obstacles faced by military veterans. Each piece demanded different approaches for the array of topics, from which emerged a mosaic of the individual, group, institutional, and organizational factors at play.

The first chapter wrestles with the emergence of veterans' healthcare as a social problem. It returns to a question fundamental to the study of social problems – what makes something a social problem? In line with the social interactionist tradition, I argue that problems only become *social problems* through a process of collective recognition

and definition. I analyze the roles of scandal, the news media, and social externalities in this process. The particular scandal of focus in this work was exposed by the *Washington Post* in 2007. It exposed sordid conditions at the most celebrated and iconic military medical facility, Walter Reed Medical Center. Stories by the *Post* and then other news outlets documented problems extending beyond Walter Reed. These problems affected care of wounded soldiers and veterans. The chapter focuses on veterans' healthcare, defining it as an arena with longstanding problems that regularly went unrecognized by the general public. Content analysis of *New York Times* articles published between 2000 and 2010 uncovers major themes that defined the framing of veterans' healthcare, some of which were consistent across time, and others that shifted overtime, and situates the Walter Reed scandal within these patterns. This chapter also explores the role of scandals in general, and Walter Reed in particular, in relation to problems and social problems, and their role in fostering change. Moreover, this piece deciphers macro-level societal shifts that allowed ongoing, systemic shortcomings to rise to the level of public concern worthy of consistent media attention.

The next chapter moves from macro level exploration to the individual level, focusing on the moral career paths of veterans with Posttraumatic Stress Disorder (PTSD). One of the largest challenges of my work was that the persons I sought to connect with were not always willing to connect. This is certainly a common experience in qualitative inquiry. But, by the nature of the project, every member of the group had a high likelihood of having a condition that could prevent him/her from interacting. In fact, avoidance at all costs was the name of the game for some. PTSD is the third most

common and the fastest growing disability for which veterans are compensated by the VA. Many veterans with the disorder endure its effects without diagnosis, often attributing their struggles to other factors. In my own study, I encountered numerous veterans with this experience. This chapter is primarily about the social experience of PTSD. It describes life experiences before diagnosis, and identifies different pathways to diagnosis and treatment, variability in veterans' contextualization and mobilization of diagnosis, and different responses to treatment as well. I organize these experiences within a conceptual framework that summarizes different stages and typical variations amongst subjects. The discussion employs and extends Erving Goffman's moral career framework and perspectives on medicalization to organize and analyze these trajectories.

In the fourth chapter, I move from a mapping of common experiences shared by veterans with PTSD, to an organizational level exploration of PTSD. The VA has been widely criticized for failures to anticipate, assess, diagnose, treat, and financially compensate veterans with PTSD. I use the VA's struggles with PTSD as an example of the problems faced by bureaucratically organized human services agencies that deal with complex, dynamic, amorphous problems. Using Weber's classical work on bureaucratic structures, along with more current work on classification and categorization, I offer a sociologically based way to understand systemic breakdowns. I explore the struggles of the Veterans Benefits Administration to assess and compensate veterans. Through the synthesis of literature from multiple disciplines, documentary research, government reports, and Congressional testimony, the chapter demonstrates how complexities of conditions like PTSD, which involve subjective judgments from diagnosis through the



determination of degree of disability, are particularly problematic within bureaucratic structures reliant upon rationality, measurement, rules, and standards to coordinate work. Rather than creating more standards, rules, and stringent guidelines, I argue that flexibility and a willingness to incorporate space for vagueness is essential if bureaucratic organizations dealing with these types of problems are going to succeed.

Although the dissertation transformed into an investigation of health rather than secondary-education of veterans, ultimately it is a work of education. Like much work in the field of sociology, part of it challenges current discourse, and other parts lend new lenses to understanding the complexities in the health of veterans. The *Oxford Advanced Learner's Dictionary* defines education as “a process of training and instruction...which is designed to give knowledge and develop skills.” My experiences with the veterans who allowed me into their classrooms, and sometimes their lives, and the product of those experiences - this dissertation - certainly constitute what we deem and value as education. It is my hope that the knowledge and skills I have developed can help to further an understanding of veterans' in general, the complex web of structural arrangements by which they are bound, the legacy of war some carry forever, and the ways in which public attention to their circumstances ebbs and flows over time.

## **Chapter 2. From Problem to Social Problem to Scandal: Veterans' Healthcare in the News, 2000-2010**

### **Introduction**

The social interactionist tradition sees social problems as the product of collective definition, rather than as mirror reflections of all the troublesome conditions in existence (Blumer 1971; Spector and Kitsuse 1973). This perspective holds that there are many problems in society that go unrecognized, and only through a process of collective recognition and definition do they gain public attention and concern. In line with this tradition, Hilgartner and Bosk (1988) note that it is not how overtly harmful or problematic a situation is that attracts attention. Hilgartner and Bosk provide an ecological analysis, asking how and what kind of problems are elevated to, and remain on the public agenda, given the limited carrying capacity of a society to manage problems. They ask what makes some problems more important than others, and emphasize the importance of dramatic appeal for attracting and sustaining attention towards specific problems in the public arena.

The media, in particular, also has a limited carrying capacity. Only so much news can be covered. The news media both influences, and is influenced by, public opinion (Gamson and Modigliani 1989; Dearing and Rogers 1996; Uscinski 2009). One factor of the ability of any issue to gain and maintain media and public attention is cultural resonance (Gamson and Modigliani 1989). Gamson and Modigliani find that not all images and symbols are equally potent. Certain topics garner more attention than others

because their ideas resonate with broader cultural themes. Audiences identify with certain issues and stories because they feel “natural and familiar” (1989:5).

Stories that report transgressions can lead to media scandals, yet not all do. Adut (2005) develops a theory of scandal that attempts to delineate the necessary conditions for transgressions to become full blown scandals. He identifies two major traditions in the conceptualization of scandal in the social sciences. The first approach is “objectivist,” and “focuses on the conditions and characteristics of significant (exceptionally costly or offensive) transgressions that elicit (or should elicit) reaction once publicized. The privileged object of study is the abuse of public trust through political or corporate corruption” (216). The problem with this perspective is that it gives “short shrift to, or [is] simply uninterested in, the dynamics that are set in action when transgressions are publicized, as well as ignoring the autonomous logic of the ensuing legal and/or social norm enforcement process” (216).

The other perspective on scandal is “constructivist”. Like the social interactionist approach more generally, this approach emphasizes that reactions to transgressions are based upon additional factors beyond the scope of the transgression itself. Adut criticizes this perspective as having “difficulty explaining the variations in the public reactions to deviance” (2005:217). Adut’s contribution, is to show that externalities beyond the issue itself influence whether, or not, transgressions become scandals. “For a transgression to give rise to a genuine scandal... its publicity has to generate negative and disruptive effects on parties other than the offender or immediate victim of the transgression” (219). According to his formulation of scandal, publicity is also an essential factor in the

elevation of normative transgressions into full-blown scandals, and “the authoritativeness of the source of communication augments the probability and power of publicity” (218).

While incorporating this point about the media’s integral role in the exposure, and subsequent amplification of transgressions, this paper addresses Adut’s criticism of the “constructivist” perspective on scandal. I demonstrate how media coverage can lay the groundwork for scandals to erupt, and remain on the media and public agendas. My approach asserts, that scandals, like social problems, are also the product of collective recognition and definition. They are most successful when they are dramatic and have cultural resonance.

I also incorporate insights from the work of Dixon-Woods, Yeung, and Bosk (2011) who build on Adut’s (2005) formulation of scandal in their investigation of why certain scandals bring about strong regulatory responses and others do not, and call attention to the role of contextual externalities such as historical, political, and social conditions. In the case of the dismantling of self-regulation of medicine in the United Kingdom, they conclude that “[C]onfronted with highly organised and deeply wounded families and patients, relentless media pressure, and a multiplicity of voices demanding action, the state seized control” (1457). My own work suggests contextual externalities lead to increased media attention for a given issue, and ultimately the outbreak of scandal.

According to Lull and Hinnerman,

Scandal serves as a term to delineate a breach in moral conduct and authority. *A media scandal occurs when private acts*

*that disgrace or offend the idealized, dominant morality of a social community are made public and narrativized by the media, producing a range of effects from ideological and cultural retrenchment to disruption and change* (1997:3, emphasis in original)

Through content analysis of 11 years of *New York Times* coverage on veterans' healthcare this paper investigates the relationship between media coverage, scandal, and the rise of social problems onto the public agenda. The analysis reveals a clear shift in reporting over the period of investigation that I link to contextual externalities, as well as the influx of young men and women just home from war into the veteran population. These factors imbued long existing issues in the veterans' healthcare system with previously lacking cultural resonance. I also demonstrate that this shift occurred prior to the emergence of a series of scandals, the most prominent of which exposed deplorable conditions at Walter Reed Medical Center. Finally, I demonstrate the ability of scandals to expand beyond their initial domain, as was the case in the Walter Reed scandal, which grew from exposing problems at a military hospital run by the Department of Defense (DoD), to encircle the veterans healthcare system as well. This resulted in an increase in the publication of stories focused on systemic, egregious, long-standing failures of the Department of Veterans Affairs (VA).

To lay out these arguments, I address the following empirical questions:

1. How was veterans' healthcare portrayed in the *New York Times*?
2. Did the representation of veterans' healthcare change over time?
3. How are veterans portrayed in the *New York Times*?
4. Did the portrayal of veterans change over time?
5. What was the relationship between news coverage and scandal(s)?

## Data and Methods

### Overview

The study used content analysis to analyze 276 newspaper articles published in the *New York Times* between January 1, 2000 and December 31, 2010. The eleven-year time frame begins almost two full years before the September 11, 2001 attacks - the catalyst for the wars in Afghanistan (Operation Enduring Freedom/OEF) and Iraq (Operation Iraqi Freedom/OIF). Stories from this time provide a snapshot of media coverage prior to the wars, and the associated mass mobilization of troops. In addition, the time frame captures the beginning of the war in Afghanistan, which initially had broad support amongst the American public, the lead up to, and invasion of Iraq, and the decline in support for both wars, especially the Iraq war. It also captures a scandal that sent shockwaves through the world of military and veterans' healthcare in February 2007. Finally, the frame captures the period after that particular scandal, and allows for assessment of the content of reporting and the salience of veterans healthcare as a social problem. Figure 1.1 shows noteworthy dates during the timeframe of the study.

The *New York Times* was chosen as the source for articles for three major reasons: first, numerous studies have demonstrated its agenda-setting effect on news outlets across the nation. Dearing and Rogers (1996) note that the *New York Times* has a particularly important role in setting the media agenda.

When the *New York Times* indicates that an issue is newsworthy, other U.S. news organizations take note. When producers and editors at

television stations, radio stations, newspapers, and, to a lesser degree, newsmagazines sit down to decide which stories will receive the most time, the best placement, and the biggest headlines that day, they often have checked first to see what decisions editors at the *Times* have made about the same issues. The *New York Times* news service conveys the next day's front-page stories to thousands of other newspapers, broadcasting stations, and other media institutions late each day, thus influencing the next morning's headlines and news priorities. (Dearing and Rogers 1996:32)

Second, its news coverage is local, national, and international in scope; and third, the *Times* is consistently ranked third in circulation in daily newspapers, behind the *Wall Street Journal* and *USA Today*, and it has the largest Sunday circulation.

Broadly, content analysis is a systematic method of analyzing mass media from written content to visual media, such as television programs, news broadcasts, or advertisement content, to visual imagery as well (see Krippendorff 2004; Altheide 1996; Hodson 2005; Weber 1990; Neuendorf 2002). In addition to being systematic, it aims to be objective; results should be replicable by multiple researchers who use the same criteria. Overall, it is a method of organizing large amounts of data into categories, allowing for comparison and extraction of meaningful information in a condensed format. The process used for this paper is a hybrid of qualitative and quantitative approaches to content analysis. The analysis is primarily based on intensive coding associated with the methodology of grounded theory (Glaser and Strauss 1967; Strauss and Corbin 1998), but I also make use of word frequencies and descriptive statistics in the analysis and reporting of my findings.

### Coding Process

The articles were gathered using *Lexis/Nexis*. With the goal of capturing articles focused on healthcare for veterans, I developed a list of search terms, testing and refining them until I was able to gather a collection of articles that would be suitable for this analysis (see Figure 1.2 for specific search terms). Obituaries, as well as articles from the Society desk and the Styles desk were omitted. The initial search yielded 534 articles.

The initial coding process honed in on articles relevant to the analysis. Gathering a robust database of articles pertaining to issues of healthcare for veterans meant including certain search terms that allowed numerous articles into the sample that had little or nothing to do with the specific topic of interest. The driving question to determine whether an article was included in the final sample was: “Does the article specifically mention veterans’ healthcare?” The greatest number of articles removed during this process referenced the results of medical research conducted by physicians affiliated with the Department of Veterans Affairs. Such articles were included only if the results were directly related to veterans, or resulted in changes in protocol, procedural guidelines, or standard of care practices. Additionally, articles reporting research findings based on programs implemented at a VA facility, such as new procedures for stopping the spread of infection, were included. This type of research themed article was kept because the findings were directly related to the quality of patient care or services for veterans. Also removed from the database were all articles that included one of the search terms, but had nothing substantively to do with healthcare of veterans or the Veterans Health Administration (VHA). For example, if an article reported that an employee of a VHA medical center won the lottery, or an employee of the VHA was



getting married, the article was removed from the database. This reduced the total to 303 articles. Finally, I removed all letters to the editor. The final sample contained 276 articles. All 276 articles were assigned themes using open-coding, and brief summaries of each were recorded as well.

After finalizing the set of articles, I conducted a second round of coding using *Atlas.ti*. The themes assigned to each article in the first round were condensed into ten main topics. Each article was assigned a main topic, though some were assigned more than one, as shown in Table 1.1. For instance, if an article was about fighting amongst members of Congress on ideological grounds about spending, and it was holding up the federal budget, and the article mentioned funding for veterans' healthcare, the article received two main topics – Budget and Politics – and then the specific reference to veterans' healthcare was coded as “funding”. Table 1.2 provides frequencies of the main topics by year, and also the total number of stories in each year. I also coded for the presence of quotes, especially when veterans and veterans' family members were quoted, as well as the mention of individual veterans, paying special attention to when they were used as exemplars of larger problems. Other codes captured references to problems, and whether they were portrayed as systemic or individual in nature. Finally, I analyzed the prevalence of certain keywords over time, such as Posttraumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), suicide, and homelessness.

## **Results**

The four most prevalent main topics were Veterans, VA/VHA, Budget, and Politics. The results here are based on findings from articles with the main topics

“Veterans” and “VA/VHA”. Both of these categories followed a similar pattern of development over time. The articles can be broken into two distinct eras. The first encompasses the years 2000 through 2004 and the second 2006 through 2010; 2005 is briefly addressed, though not included in either period, because no articles fell under these categories in that year. Articles published in 2005 almost exclusively focused on general battles over the federal budget. Veterans and the VA were mentioned repeatedly in passing in these articles, because it was one of the few spending bills Congress eventually passed. The stories of veterans, the care they were receiving, and the state of the VA were completely absent.

#### 2000-2004

In the initial era OEF/OIF veterans were rarely mentioned. These articles were focused on the VA of old and the traditional veterans population. Before these latest wars, the veteran population was predominately comprised of veterans from the World War II, Korea War, and Vietnam War eras. It was an aging population, decreasing in size, and predominately male. Table 1.3 provides the composition of the living population by period of service and age as of 2001.

Nine of the fifty-four articles assigned a main topic of Veterans, and twenty-two of the fifty-four articles about the VA/VHA were published during this period. Articles from this period were primarily about an aging population and its problems, and an aging infrastructure and its problems. For example, “Saluting the Fourth: The Veterans; In a U.S. Hospital, Lonely Ex-Soldiers Get No Bands and Few Visitors” (Leduff 2000), co-

assigned to the categories of Veterans and VA/VHA contrasted celebrations surrounding the day with the stories of a group of terminally ill veterans confined to a veterans hospital in New York City. As New Yorkers celebrated a grand armada passing under the Verrazano-Narrows Bridge, lonely, destitute veterans

sat silently in the beds and halls and doorways of the Veterans Affairs hospital, unable to see the flotilla from their windows... These men passed the morning inhaling the smell of antiseptic and the stench of bedpans, listening to the mumblings of the dying, lying in bed watching the beautiful boats on their televisions.

Articles that spoke of veterans focused on those of these earlier wars. Whether a story of a formerly homeless 58 year-old veteran with mental health problems (Gonzalez 2004), or an article published for Veterans' Day recounting the life of a World War II veteran, and the ways in which war had forever changed him (Berger 2004), the image of the veteran was consistently that of an older man struggling with the vestiges of war.

Articles specifically focused on the VA/VHA were dominated by talk of hospital reorganizations and closures. With changes in medical practice as well as a shrinking veteran population, thousands of hospital beds laid empty throughout the country. This problem was most severe in the Northeast and Midwest, as the veteran population had become increasingly concentrated in the South and Southwest in the years since World War II when the greatest number of VA facilities were built. This left the VA with the burden of maintaining aging, underutilized facilities. Efforts to increase economic efficiency led to calls for the closing of facilities, but such closures were consistently unpopular with veterans, advocacy groups representing them, and politicians wanting to

protect their constituents access to care as well as jobs. In addition to articles focused on infrastructure and reorganization and closings of facilities, other articles of this time highlighted moves by the VA to modernize, whether it be changes in standards of care, the move away from requiring inpatient stays for procedures that could be handled on an outpatient basis, revisions in scheduling so the neediest veterans would have priority in scheduling appointments, and the adoption of a no-penalty reporting system of medical errors. Only three articles assigned a main topic of VA/VHA mentioned the future cohort of veterans that would be entering the system. Two were in stories protesting the closings of New York area VA facilities. The first, an Associated Press story (2003) reported an announcement by the VA to close some facilities and open others in an effort to realign services with future demands. To this Senator Charles Schumer responded, “At a time when many troops are overseas and will need these services when they come home, you want to bolster our veterans’ health care, not gut it.” In “Talk of Closing Manhattan VA Hospital Prompts Campaign to Save It” (von Zielbauer 2003) Senator Hillary Clinton protests.

“The Manhattan V.A. should be kept open,” Senator Hillary Rodham Clinton said in a telephone interview yesterday. She accused the administration of seeking to cut money for veterans’ health care when “the long-term care needs of aging veterans is still an unmet obligation.”

“Veterans are living longer, and we’re making more veterans every day,” she added, “with our operations in Iraq and Afghanistan and elsewhere.”

The main topics of Veterans and VA/VHA in the first period concluded with an article assigned to both categories. In a sign of things to come, “A Deluge of Troubled Soldiers Is in the Offing, Experts Predict” (Shane 2004), was the first detailed article in the sample

to warn about the pending influx of returning soldiers who would rely upon the VA system in the years to come. Veterans' advocates and military doctors discussed problems likely to affect a large percentage of those returning from war. In response to these warnings, the article reported,

Military and Department of Veterans Affairs officials say most military personnel will survive the war without serious mental issues and note that the one million troops include many who have not participated in ground combat, including sailors on ships. By comparison with troops in Vietnam, the officials said, soldiers in Iraq get far more mental health support and are likely to return to a more understanding public.

Articles from this period addressed two important problems that continued to menace the VA during the second period, but they were framed quite differently in this first period. In a January 2001 address to the media, President-elect Bush and his choice for secretary of veterans affairs, Anthony J. Principi highlighted systemic problems within the V.A including long delays in the processing of disability claims. On this issue, Principi proclaimed,

It may be necessary for V.A. to declare its own war on claims processing...I am not interested in abstract theories of veterans benefits...I want hands-on practical solutions. I will not want to hear that problems are intractable because of the language of the law (Associated Press 2001).

In the same appearance, the President-elect also called for modernization of the veterans' healthcare system and improvement in the quality of care veterans received. Other articles focused on the strain faced by the VA such as "V.A. Health Care Strained By Big Wave of Enrollees" (Freudenheim 2002). The article reported

Elderly veterans struggling to cope with rapidly rising drug costs are pouring into the health care system of the federal Veterans Affairs

Department, so severely straining its resources that in some parts of the country, thousands of them are waiting years to see a V.A. doctor.

Another article (New York Times 2002) attributed the backlog to a 1996 policy that allowed non-combat wounded soldiers to enroll in the VA. In that article, secretary of veterans affairs Principi said, “We need to get back to our core mission: the service-disabled and the poor.” The article noted “More than 300,000 veterans cannot get appointments within six months of their requests, and thousands cannot get appointments at all, according to the department.”

In sum, articles that focused on veterans and the VA/VHA primarily portrayed veterans as older people who struggled not only in life, but also in their efforts to obtain quality care from the system that was obligated to provide for them. The VA was a struggling organization, trying to maintain costs and introduce efficiencies, primarily through the controversial closings of outdated and underutilized facilities. Problems such as long waits for appointments and a backlog in the processing of disability claims were well established and acknowledged by both President George W. Bush and his secretary of veterans affairs. At the same time, warnings that a new influx of veterans posed additional stress were downplayed by the VA.

2005

In 2005 not a single article focused specifically on veterans, nor the VA/VHA. Instead, 2005 was a year where veterans’ healthcare was primarily reported on in the context of stories about the federal budget and political fights that had little to do with

veterans at all. Rather, veterans were invoked by politicians from both parties as a way of demonstrating their own patriotism and demonizing the other side. In the yearlong battle over spending allocations and cutbacks, spending on veterans healthcare became a way to prove how American, or un-American, members attached to each ideological stance really were. Veterans were symbols - political fodder - in ideological battles that went far beyond their care and wellbeing.

#### 2006-2010

In early 2006 everything changed. This second period was characterized by a dramatic shift in the focus and content of the reporting. The number of articles increased (45 articles were about veterans and 32 about the VA/VHA), and the content changed as well. The image of the veteran was no longer that of a troubled, often lonely older man. Rather, the focus shifted to the new generation of veterans and the struggles they were facing. For example, “When Soldiers Come Marching Home, Trauma Often Sets In” (Gettleman 2006) focused exclusively on the experiences of members of a National Guard Battalion who had just returned from Iraq. The only deviations from their personal stories came when the author provided estimates of potential long-term costs of treating the wounded, and the reporting of experts’ opinions about the prevalence of psychological injuries of war. Such predictions became common in the articles that followed.

Another feature which differed greatly from the earlier articles was the reliance on

the words of veterans themselves in retelling their stories both at war and upon returning home. The stories spoke of the stresses of life in a combat zone as well as those faced once home; PTSD, nightmares, troubled readjusting to home life, conflict with spouses, emotional distancing from children, struggles to find work, and suicide became typical features of the articles. Readers were introduced to individuals suffering from Traumatic Brain Injuries (TBI), and complex Polytrauma, and reporters recounted their daily routines, therapy regimens, and the stories of their family members who dropped everything to be by their side and act as their advocates. The stories are written in a manner that easily evoked empathy from the reader. This approach continued throughout the timeframe covered by the analysis. Table 1.4 shows the number of articles that mentioned PTSD, TBI, and suicide. All three of these issues emerged as serious problems for returning veterans and this was reflected in the newspaper coverage. Coverage of these factors was almost non-existent in the first period, but dominated the reporting in the second.

Rather than distant reporting, these stories delved into the lives of people going through the experiences of adjusting to civilian life, depending on the VA system for healthcare and disability benefits, and trying to make peace with their experiences of war. The use of direct quotes made these stories especially powerful. Table 1.5 shows the increase in articles about veterans that featured references to specific veterans, told their personal stories often in their own words, and at times even included the perspectives of family members.

In July 2006, an article appeared entitled “Clinton Seeks More Help For Veterans”



(Confessore and Schweber 2006). There were quotes from the Senator, but also commentary provided by two Iraq War veterans dependent on the VA

‘The problem in the New York area is that so many soldiers returned at the same time, and they're all seeking care at the same V.A. hospital,’ said Capt. Christopher Daniels, 39, of Centerport, N.Y., who was wounded in Iraq. Captain Daniels said his local Veterans Affairs hospital was ‘just not equipped to provide these services.’

Michael Zacchea, 38, of Hicksville, N.Y., said he trained Iraqi soldiers in Iraq for a year and was wounded in a firefight. He now has problems with his memory, he said. ‘The V.A. is underfunded,’ he said, ‘which means that veterans are waiting beyond the critical first six months for benefits and critical health care that will help them readjust to living a civilian life.’

In addition to reflecting the style of reporting that developed in the second period, which incorporated the voices of veterans, these descriptions of problems and the veterans’ explanations of them reflected a shift in the framing of systemic problems within the VA. As early as 2000, President Bush and his secretary of veterans affairs had promised to remedy the backlog in claims for disability benefits and the long waiting periods for medical care appointments. The problems at the time were blamed on changes in policy in 1996. Now, however, the backlogs and long delays were understood to be the byproduct of a mass influx of new veterans into the system. In addition, issues about access to care and the quality of care remained, but the framing also shifted between periods. In the first period, these matters usually arose in the context of potential VA closures. In the second, however, quality of care and access to care were predominantly about the VA’s inability to provide quality treatment for PTSD, other mental health

problems, TBI, and polytrauma. Access was usually about the difference in care available at specialty facilities versus local facilities, and general lack of access for veterans in rural areas.

The increased attention to veterans healthcare became even greater following the publication of a story entitled “Soldiers Face Neglect, Frustration At Army's Top Medical Facility” in February 2007 by the *Washington Post* (Priest and Hull 2007). The article destroyed the image of Walter Reed, the “crown jewel” of the military medical establishment where presidents and other powerful politicians sought their own healthcare. The 4,592-word article documented deplorable conditions, including mold covered walls, crumbling ceilings, and rodent infestation. Walter Reed was depicted as a place where wounded soldiers were rotting and forgotten. This was a glaring contrast to Walter Reed as a place where politicians paraded in front of cameras to show off their patriotism and the excellent care the nation was providing for the young men and women who had risked their lives for their country.

An additional nine articles were published through 2007, and the series later won the 2008 Pulitzer Prize in Public Service. The initial article ignited a full-blown scandal. It evoked public outcry, increased media attention by other outlets (The Pew Research Center’s Project for Excellence in Journalism 2007b, 2007c, 2007a), motivated condemnation of the reported conditions by politicians, and was the catalyst for Congressional hearings, and the formation of a presidential commission. Interestingly, **the initial Walter Reed story was not about veterans**; it was focused on an Army facility, and soldiers who had been wounded in Iraq and Afghanistan. In the aftermath of the

initial publication however, the story spread to encompass veterans' hospitals across the country in addition to the treatment of wounded soldiers. Often, in fact, the two were conflated even though the Department of Defense (DoD) oversees healthcare for soldiers, while the Department of Veterans Affairs is in charge of veterans' hospitals.

Reports had already emerged about substandard care for returning soldiers and veterans before the *Washington Post* series. The articles did not expose an invisible problem to politicians or the general public. Yet the in-depth, graphic reporting served to further amplify attention paid to problems with veterans' healthcare. The attention garnered by these particular pieces set in motion a series of events that again shifted the discussion on veterans' healthcare. The political and public outcry spurred by the series led directly the firing of top brass within the Army and VA, Congressional hearings, the formation of a presidential commission, and eventually policy changes, though many of the problems remained long beyond the scope of this study. Veterans' healthcare became a prominent issue on the media, public, and political agendas.

Following the scandal the *Times* continued to report on problems at VA hospitals around the country. There was the closing of a psychiatric ward in Texas pending an investigation after at least five veterans committed suicide there (Associated Press 2008), multiple stories about the exposure of veterans to H.I.V. because of improperly cleaned equipment in Tennessee, Florida and Georgia (Cave 2009; Associated Press 2009), a "rogue" cancer unit at the Philadelphia VA (Bogdanich 2009, 2010), and the potential exposure to H.I.V., hepatitis B, and hepatitis C at the St. Louis VA due to unsanitary conditions, including improperly cleaned dental equipment (Gay 2010). The article also

noted that the same facility had been cited the previous year in a report by the Office of the Inspector General of the VA that “identified ‘ongoing’ problems with contaminated endoscopes at the hospital, noting that inspectors found that ‘rags and disposable gloves were strewn about’ and that there were no ‘defined clean and dirty areas’ in the hospital's sterilization section.” While these problems were ongoing, they were not topics deemed worthy of national news coverage prior to the heightened attention brought on by the Walter Reed debacle.

The scandal at Walter Reed did not cause the shift in reporting. The change occurred well before the explosion. Problems regarding access to quality care were explicitly articulated by veterans, veterans’ advocates, and politicians, and documented in the national press by early 2006. However, the Walter Reed scandal did serve to further intensify the frequency of coverage. The type of coverage that developed in the second period is likely to have reflected *and* fed changing sentiments writ large, and may have laid the groundwork for a scandal like Walter Reed to emerge and have such power. In the wake of the Walter Reed scandal other potentially scandalous conditions at local VA facilities around the country became worthy of national news coverage.

## **Discussion**

In this analysis, discourse and style of reporting on veterans’ healthcare fell into two distinct periods. During the first period, the image of the veteran was an older, often destitute man, and the healthcare system itself was seen as outdated. Reporting focused

on infrastructure, especially the closing of regional VA hospitals. In the second period, there was an increase in the overall number of articles, and a shift in their focus as well. Stories that focused on veterans shifted to the cohort returning from Iraq and Afghanistan. Human interest stories about young men and women, and the problems they encountered, both in terms of adjusting to civilian life, and their struggles to access quality healthcare, became the norm. The healthcare system was criticized for its lack of preparation to care for the influx of new veterans. The second period included the materialization of a scandal about healthcare for wounded soldiers that expanded to envelop veterans' healthcare as well.

Increased coverage of veterans' healthcare in the year prior to the Walter Reed scandal likely exposed the public to the problems, which were further magnified by the extreme nature of the conditions reported in the *Washington Post* pieces. Following the scandal, even more articles were published. They continued to speak about the experiences of veterans, but also focused increasingly on problems within the VHA that had long existed, but had not previously been deemed important enough to be covered in the *New York Times*. This general shift in reporting marked the transition of long existing problems that rarely appeared in the media, into collectively recognized and defined social problems that deserved media scrutiny, and required government intervention.

This shift over time, and its intensification following the outcry by the public and politicians, provides support for the social interactionist tradition that sees social problems through the process of collective definition, rather than as reflections of abject conditions. Longstanding problems went largely unreported until shifts much larger than the problems themselves led to recognition and sustained attention by the media and the

public. The 2004 presidential campaign focused heavily on veterans. In addition, ideological battles over the federal budget in 2005 evoked the plight of veterans, with members of both the Democratic and Republican parties trying to prove their allegiance to the troops, and the others party's abandonment of them. By 2006, additional social and political forces beyond the scope of veterans' healthcare likely came into play. The war in Iraq had grown unpopular, the President's approval ratings were dismal, and public opinion polls showed little faith in Congress.<sup>1</sup>

Furthermore, the trajectories of reporting on each of these categories sheds light on the factors that contribute to the amplification of stories to the level of full-blown scandal. Investigative reporting often brings attention to problems that have gone largely unrecognized, but not all stories develop into scandals. The conditions at Walter Reed had in fact been reported on Salon.com (Benjamin 2005) two years before the publication of the *Washington Post* series, yet failed to garner traction in the media, evoke the public ire of politicians, or outrage the broader public. By looking at 11 years worth of newspaper articles on veterans' healthcare, we see that changes in reporting occurred prior to the publication of the *Washington Post* series and the scandal which ensued. The changes in reporting, and the increased attention to the plight of veterans and wounded soldiers, may have in fact, laid the groundwork for the escalation of the problems onto the public and policy agendas, and the continued proliferation of reporting in the media.

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<sup>1</sup> See the following Gallup websites for concise poll data summaries:

- Iraq: <http://www.gallup.com/poll/1633/Iraq.aspx>
- Presidential Approval: <http://www.gallup.com/poll/116500/Presidential-Approval-Ratings-George-Bush.aspx#1>
- Congress's handling of its job: <http://www.gallup.com/poll/1600/Congress-Public.aspx>

<sup>2</sup> All-veterans approval ratings were dismal. Some polls showed 65% Presidential Approval Ratings were

- Congress's handling of its job: <http://www.gallup.com/poll/1600/Congress-Public.aspx>

Additionally, the Walter Reed scandal tells us something else about scandals and the power they possess. The Walter Reed scandal provides an example of domain expansion. Originally about healthcare at a DoD facility, the scandal grew to encompass the Department of Veterans Affairs. The focus expanded, and the VA was swept into the frenzy as well. The VA, and the care it provides, have never been entirely absent from the media, nor the political agenda. Quality healthcare for veterans, the system that provides it, and its funding, consistently graced the political agenda on campaign trails and in annual budget melees long predating the scope of this study. Those who suffered from the problems were different, however, from the veterans who entered the system after serving in Iraq and Afghanistan. Before the wars in Afghanistan and Iraq, the VHA serviced a population that was aging and decreasing in size; the majority of its constituents were veterans of World War II and the Vietnam War. Enrollment requirements led to a population that was disproportionately poor, disabled, or elderly.

OEF/OIF veterans were very different. They fueled a growth in the overall veteran population, and increased the number of people served by the VA and VHA. In addition, this new cohort of veterans required services that differed greatly from the existing population because of their relative youth. Their problems had the dramatic appeal to garner public and political attention. Chronic, systemic problems had burdened the veterans' healthcare system for years, but they lacked cultural resonance and emotional appeal to maintain the attention needed to elevate the problems to the public arena, and stimulate their collective definition as social problems (Gamson and Modigliani 1989). The stories of these young veterans were emotionally compelling.

They evoked empathy amongst readers. They had the dramaturgic appeal noted by Hilgartner and Bosk (1988) and Adut (2005), which elevates and maintains issues to the public arena, and contributes to their ability to develop into full-fledged scandals. Once veterans' healthcare became newsworthy, awareness amongst the general public increased as well. By the time the incendiary reporting in the *Washington Post* appeared, the nation was primed for a scandal. "Scandals are ubiquitous social phenomena with unique salience and singular dramatic intensity. They can mobilize much emotional energy, at times with momentous consequences. Scandals in effect trigger a great deal of the normative solidification and transformation in society" (Adut 2005:213).

The scandal, a product of investigative journalism, solidified collective indignation. Pross et al. (1991) refer to investigative journalism the journalism of outrage.

More than a news-gathering process, the journalism of outrage is a form of storytelling that probes the boundaries of America's civic conscience. Published allegations of wrongdoing-political corruption, government inefficiency, corporate abuses-help define public morality in the United States. Journalistic exposés that trigger outrage from the public or policy makers affirm society's standards of misconduct (5).

The plight of veterans became a story of moral failure. A nation sent its youth to war, and news media coverage exposed the public to the numerous barriers soldiers and veterans were facing upon returning home. A nation that was still reckoning with its treatment of veterans after the Vietnam War, made sure to always stand behind the troops. A common anti-war slogan that emerged before the invasion of Afghanistan said, "I support the troops, but not the war." This firm commitment to the troops, even amongst opponents of the wars, created a situation where the neglect they faced upon



their return became anti-patriotic. The opportunity for media scandal arises “when the public believes that the dominant morality of the day has been violated...” (Lull and Hinerman 1997:3). Failure to help veterans became a failure in the fulfillment of an obligation to help those who had voluntarily sacrificed for the nation and its citizens. In this process, care for veterans was collectively defined as important. It was elevated from an oft-ignored problem to a social problem, worthy of media coverage and political attention. The emergence of veterans’ healthcare was further strengthened through an instance of domain expansion in which problems in one agency flooded another. Once the VA was entangled in scandal, there was further amplification by the media of problems within the agency. In line with the social interactionist tradition, problems were collectively recognized and defined as social problems. This laid the groundwork for the emergence of a full-blown scandal. Transgressions became an affront not just to a minority of destitute veterans, but young heroes, the general public, and the nation’s ideals. This work adds to the social interactionist tradition of the study of social problems by linking the emergence of social problems with social externalities, illustrating the role of extant media coverage in aiding the emergence of scandals, and demonstrating the ability of scandals to expand across domains.

Table 1.1: Definitions of Each Main Topic

<b>Main Topic</b>	<b>Criteria for Assignment</b>
<b>Veterans</b>	Assigned when veterans were the main focus of the article
<b>V.A./V.H.A.</b>	Assigned when the V.A. or V.H.A. was the main topic of the article
<b>Budget</b>	Assigned when the main topic was about the Federal Budget or other spending bills
<b>Politics</b>	Assigned when an article focused on politicians, campaign activities, and political fighting between parties (at times this was coded alongside Budget as in Times when Democrats were fighting with Republicans over the Federal budget and the main contentions were ideological in nature)
<b>Investigation</b>	Assigned when the article focused specifically on an investigation (this was coded with V.A./V.H.A. code when the investigation specifically focused on an investigation of an incident at a V.A. facility)
<b>Patient Safety</b>	Most of these articles were about patient safety in general, rather than pertaining specifically to treatment at V.A. facilities. They were included because the articles references V.A. facilities or procedures, or patient outcomes.
<b>Healthcare Innovation</b>	These articles were primarily focused on innovative practices and technologies in the healthcare field. They were typically included in the sample because they referenced innovations at V.A. facilities such as the use of electronic medical records, innovative therapies, and programs to reduce medical error.
<b>Healthcare Reform</b>	These articles were focused on the issue of National healthcare reform and referred to the V.A. system as an exemplar (in either a positive or negative way) of government run healthcare.
<b>Research</b>	This was assigned only when research about veterans or research affecting protocols of care within the V.A. was the focus. The initial search terms yielded numerous articles about research that were not included because they involved V.A. affiliated researchers, but did not study issues pertaining to veterans' healthcare, nor did they use veterans as their research subjects.
<b>Other</b>	All articles with main topics that did not fall under the previous nine were labeled as other.

Table 1.2: Number of Articles for Each Theme by Year\*

	Year										
	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
<b>Total Articles*</b>	<b>18</b>	<b>12</b>	<b>16</b>	<b>23</b>	<b>27</b>	<b>21</b>	<b>30</b>	<b>55</b>	<b>27</b>	<b>31</b>	<b>16</b>
Veterans	1	1	0	3	4	0	6	15	12	9	3
V.A./V.H.A.	4	2	7	7	2	0	6	11	4	6	5
Budget	1	3	0	4	5	9	5	7	4	2	0
Politics	5	2	2	3	19	6	7	5	3	2	1
Investigation	0	0	1	1	1	0	0	6	0	3	1
Patient Safety	3	0	4	2	0	2	1	3	1	7	4
Healthcare Innovation	3	0	0	1	0	1	1	4	1	1	2
Healthcare Reform	0	0	0	0	0	0	2	3	1	5	0
Research	0	2	3	5	0	2	1	2	1	0	1
Other	6	5	2	4	3	5	6	4	5	5	4

\*Note: An article can have more than one main theme.

Table 1.3: Veterans Living by Period of Service and Age (in thousands, as of July 1, 2001)<sup>a</sup>

	Period of Service						
	Total Veterans <sup>b</sup>	Wartime Veterans <sup>c</sup>	Persian Gulf War	Vietnam era	Korean Conflict	World War II	World War I
<b>Total</b>	<b>25,348</b>	<b>19,120</b>	<b>2,723</b>	<b>7,718</b>	<b>3,064</b>	<b>5,039</b>	<b>1</b>
Age							
Under 35	2,105	1,833	1,833	-	-	-	-
35-39	1,444	432	432	-	-	-	-
40-44	1,808	331	295	35	-	-	-
45-49	2,028	1,487	128	1,249	-	-	-
50-54	3,049	2,962	26	2,810	-	-	-
55-59	3,098	2,722	6	2,667	-	-	-
60-64	2,263	882	2	789	69	-	-
65+	9,553	8,470	1	169	2,994	5,039	1

“-” represents or rounds to zero. (a) Based on 1980 Census of Population data, extended to later years on the basis of estimates of veteran interstate migration, separations from the Armed Forces, and mortality; not directly comparable with earlier estimates previously published by the V.A.. Excludes 602,000 veterans whose only active duty military service of less than 2 years occurred since Sept. 30, 1980, and who failed to satisfy the minimum service requirement. Also excludes a small number of National Guard personnel or reservists who incurred service-connected disabilities while on an initial tour of active duty for training only. (b) Excludes reservists (c) Veterans who served in more than one wartime period are counted only once in the total.

Source: United States Census Bureau, Statistical Abstract of the United States: 2002, p. 335, Table 506.

Table 1.4: Number of Articles Focused on Veterans Mentioning PTSD, TBI, Suicide

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
PTSD	0	0	0	1	1	0	5	10	8	6	2
TBI	0	0	0	0	0	0	1	9	6	3	0
Suicide	0	0	0	0	1	0	2	3	6	5	3

Table 1.5: Number of Articles Focused on Veterans that Refer to Individual Veterans, Include Direct Quotes of Veterans, Direct Quotes of Family Members

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Individual Veterans	1	0	0	3	4	0	3	10	11	6	2
Veteran's Voice	1	0	0	3	3	0	4	8	5	6	2
Family's Voice	0	0	0	0	0	0	1	4	3	2	1

Figure 1.1: Noteworthy Dates

January 1, 2000 – first day in sample
September 11, 2001 – Terrorist attacks
October 7, 2001 – Invasion of Afghanistan
October 16, 2002 – U.S. Congress joint resolution (Authorization for Use of Military Force Against Iraq Resolution of 2002) signed into law by President George W. Bush
March 18, 2003 – Coalition forces begin bombing Iraq
February 18, 2005 – Salon.com publishes “Behind the walls of Ward 54” ( <i>By Mark Benjamin</i> )
February 18, 2007 – “Soldiers Face Neglect, Frustration At Army's Top Medical Facility” ( <i>By Dana Priest and Anne Hull</i> ) is published in the <i>Washington Post</i>
December 31, 2010 – Last day in sample

Figure 1.2: Search Terms Used to Compile Articles from *Lexis/Nexis*<sup>a</sup>

V.A. Medical Center; veterans medical center; veteran healthcare; veterans' healthcare; veteran health care; veterans health care; V.A. health care; veteran health administration; veterans health administration
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<sup>a</sup> If any of these terms appeared in the body of the article, they were included in the initial sample.

## **Chapter 3. Moral Career Paths of Veterans with Posttraumatic Stress Disorder**

### **Introduction**

Medicalization is the process by which phenomena experienced by people become formally recognized as medical conditions, problems, or pathologies. Through medicalization, behaviors that deviate from the social norm become indicators or symptoms of formalized pathologies. Medical sociologists study the implications of medicalization, especially social ones, as well as the consequences on patient care, and the lived experiences of people with such conditions. This paper contributes to the medicalization literature by examining the experiences of a group of Vietnam-era combat veterans who returned from war with what eventually became known as Posttraumatic Stress Disorder (PTSD).<sup>2</sup> It suggests that failure to formally recognize medical conditions can exacerbate their ill effects by delaying or denying appropriate treatment, and in the case of conditions that result in socially deviant behaviors, damage social ties that are important for recovery.

Before 1980 PTSD did not exist. That is not to say it was discovered or fabricated. Rather, it was not until 1980 that the medical profession formally recognized PTSD. As a result, for many veterans who served during the Vietnam War era and before, it took years before their ongoing psychic wounds of war were formally recognized as a disabling condition. As a result, these veterans lived years without diagnosis and

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<sup>2</sup> All veterans in this study were enlisted soldiers. Some joined the military voluntarily, while others were drafted.

treatment. Social scientists often distinguish between *disease* and *illness*; the first concerns etiology, diagnostic criteria, pathological markers, etc., while the second focuses on the experiences of individuals affected by a condition. Analysis of PTSD as a medical condition (equivalent to disease in this framework), and as an illness, illustrates its complexities. Though officially classified as a psychiatric condition, PTSD is a multi-faceted condition; its manifestations are biological, psychological, and social.<sup>3</sup> This paper aims to broaden the lens through which we frame PTSD by incorporating the social context through which inappropriate behaviors, disturbing thoughts, and out-of-control feelings are reinterpreted as ‘normal’ signs and symptoms of a legitimate psychiatric disorder that is catalogued in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and possesses its own *International Classification of Diseases* code (ICDN code).

The analysis also builds upon and extends the framework developed by Erving Goffman in his essay “The Moral Career of the Mental Patient” (1961). Goffman wrote that the career of the mental patient fell into three phases – prepatient, inpatient, and ex-patient – but only examined the first two of these. I organize the experiences of the veterans in this study into three similar phases, but examine all three. Analysis of data collected through participant observation, informal conversations, and formal interviews with veterans has guided the development of a conceptual model that summarizes the process veterans with protracted, undiagnosed PTSD traverse if they eventually are treated for the disorder. The model summarizes the process, dividing it into three distinct

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<sup>3</sup> There is some emerging support that there are differences in brain function between adults who have PTSD and the general population. This work is still developing and no definitive marker yet exists (see Georgopoulos et al. 2010 for an example of this type of work).



phases: pre-treatment, treatment, and post-treatment, and identifies typical characteristics and experiences within each stage (see Figure 2.2). The model incorporates experiential insights provided by veterans. Unlike Goffman's model, which depicted a singular career path, the model developed here demonstrates variability present within each phase as well.

By combining the moral career framework with theories of medicalization, I examine the implications of non-recognition and non-diagnosis of people's problems. The model, however, is not only useful for looking backwards. Despite formal recognition of PTSD as a medical condition and its effects, many veterans who served after 1980 also have undiagnosed, or untreated PTSD. Furthermore, the medical community continues to identify treatments, but all remain inconsistent insofar as their effectiveness for any particular individual. As we shall see, diagnosis does not always mean recovery.

This paper begins with a review of Goffman's moral career framework and theories of medicalization. I then provide a brief history of the medicalization of PTSD. I also offer a formal look at PTSD as a medical disorder, providing current diagnostic criteria. A description of the methods of data collection and analysis follows. Then, in the results section, I provide an in-depth look at the three phases which comprise the conceptual framework I have developed to describe the process individuals go through as they go from a state of living with undiagnosed PTSD, to treatment, and then outcomes following treatment. I focus on the experiences of veterans living with PTSD, with special attention given to the implications of suffering from an unrecognized medical

condition. I identify common pathways by which veterans learned that they had PTSD after 1980. I examine the ways that veterans mobilized the diagnosis as a means of providing context for their struggles following their military service. I show ways that the medicalization of PTSD has affected trajectories of veterans living with the condition. Throughout this process I highlight “latent consequences” of the medicalization of deviance (Conrad and Schneider 1980) as a mechanism for understanding implications of the recognition of PTSD for veterans. I conclude with a discussion that summarizes the model, and offer some key insights that emerged from the research. I also discuss the relevance of the model in an era where PTSD is a recognized condition, offering evidence that medicalization may effect trajectories in some ways, but that the problems of earlier generations are likely to continue in younger veterans because of barriers to care and lack of effective treatments for the condition.

### Moral Careers

Erving Goffman introduced the concept of moral careers in his essay “The Moral Career of the Mental Patient” (1961). While the term career usually invokes images of work and occupational trajectories, Goffman broadened the notion to mean “any social strand of any person’s course though life” (127). People falling into the same social categories share certain experiences and changes over time that are common amongst members of the group. While common amongst members, they happen independently amongst individuals. Less interested in unique outcomes, this perspective is focused on similarities shared in the process of living one’s life as a member of a special social category that differentiates individuals, making them members of a subgroup within

society as whole. Goffman wrote about mental patients; I build a model of the moral career the military veteran.<sup>4</sup>

What does it mean to focus on the moral career specifically? The moral element of the career is “the regular sequence of changes that career entails in the person’s self and in his framework of imagery for judging himself and others” (128). At once then this perspective of moral career allows for the exploration and linking of the external social world, social relations, personal identity and self-image. The use of the moral career framework therefore “allows one to move back and forth between the personal and the public, between the self and its significant society, without having to rely overly for data upon what the person says he thinks he imagines himself to be” (127).

At the most basic level, all veterans have certain things in common. They all had lives as civilians before they entered the military. Of course variability exists between individuals in civilian life. For instance one’s social class, race, ethnicity, gender, family, friendship networks, and education all shape the individual’s identity and his position within the social structure. All veterans also share the experience of serving in the military. Variability exists here as well. The greatest differentiation for individuals within the military social structure is one’s status as officer or an enlisted soldier, for this defines all social relations within the military institution. Other major differences include period of service, exposure to the theater of war, and actual combat exposure. Furthermore, some people flourish in the military, while others describe it as the worst times of their lives.

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<sup>4</sup> This work is specifically concentrated on veterans who served during times of war.

Veterans' lives are an amalgamation of their experiences prior to, and during, military service, as well as their trajectories after they return to civilian life. Identities and experiences after military service are, at least to some degree, influenced by people's situations in the two previous life-states of civilian and soldier. The transition from soldier to veteran is smooth for some, but not for others. Being wounded during service is an obvious hurdle to reintegration, and when these wounds are psychic in nature they can be especially problematic because they often go unrecognized. Furthermore, there is no consensus among members of the medical profession about how to best treat them. In addition, stigma provides a disincentive to seek out support and help. This paper focuses specifically on veterans who after extended periods of time, entered treatment for Posttraumatic Stress Disorder, the phases through which they passed, and the commonalities they experienced.

### Medicalization and its Implications

Through medicalization problems fall under the jurisdiction of health professionals, who act as agents of social control by providing or denying access to treatments, disability benefits, and other statutory entitlements (Conrad 1975; Conrad and Schneider 1980).<sup>5</sup> For sociologists, the foundations of this line of study are normally attributed to Parsons (1951), who wrote of the "sick role" and its transformation of deviant behavior away from a threat to the social order where everyone must participate in their appropriate "role". The sick person is supposed to behave in certain ways, and by

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<sup>5</sup> PTSD is a condition affecting survivors of many forms of trauma, not only veterans. It is commonly diagnosed amongst survivors of other forms of trauma such as childhood molestation, sexual assault, natural disasters, and refugees that have fled their homes due to hostilities. This paper, however, is specifically concerned with the case of veterans with PTSD.

doing so is allowed to deviate from socially mandated activities and behaviors. The proliferation of studies on medicalization began in the 1970s, and was primarily linked to issues of deviance and social control (Zola 1972; P. Conrad 1975). Others wrote of medicalization as a means by which the medical profession expanded its reach; anything defined as sickness, disease, illness, etc. fell under the purview of doctors' expert knowledge (Freidson 1970a, 1970b). Over time the focus expanded to examine historical, technological, social, and political factors leading to medicalization, demedicalization, and even remedicalization of specific phenomena.

Just as conditions are medicalized and fall under the purview of medical jurisdiction, there is a countervailing force of demedicalization as well. Conditions can fall in and out of the medical box. A well documented example of medicalization, demedicalization, and remedicalization is homosexuality (Conrad and Schneider 1980; Conrad and Angell 2004). Also some conditions have mixed jurisdiction—alcoholism is a medical problem—drunk driving is a legal one (J.W. Schneider 1978; Gusfield 1993). Normally, being in the sick role excuses one from blame. But the alcoholic driver is subject to legal sanctions. When PTSD explains and excuses behavior, and when it does not, is an issue that points to what we might call 'incomplete or limited medicalization.'

Studies also explored the medicalization of society more broadly (Fox 1977; Conrad and Schneider 1980; Conrad 2007). The literature is clear that medicalization is not a neutral act. Medicalization is a political act that is the outcome of moral entrepreneurship. The Americans With Disabilities Act prohibits discrimination, affords legal protections, and requires accommodations for people with disabilities. So long as

PTSD is a recognized medical condition, veterans with PTSD fall under these protections (U.S. Department of Justice, Civil Rights Division, Disability Rights Section 2010) and are entitled to additional benefits from the VA as well.

Sociologists emphasize that medicalization is the byproduct of action. This approach is in line with a constructionist perspective, rather than a perspective that treats medical conditions as emerging from the objective discovery of new phenomena. For example, medicalization of conditions is also driven by social, political, and economic factors. The constructionist approach demonstrates that scientific knowledge is not neutral, and medicalization is not a process free from moral judgments, or motives of actors.

In the same way that actions lead to medicalization, the medicalization of phenomena typically has consequences as well. Conrad (1975, 1992) theorized about positive and negative ramifications of medicalizing deviance. These were refined and further developed by Conrad and Schneider (1980) in their seminal work on medicalization. Some consequences affect individuals who become defined as having medical problems, while others operate at the societal level. These social consequences are outcomes that are separate from the validity of medical definitions, or whether interventions help. In the words of Conrad and Schneider, “These variously ‘latent’ consequences inhere in medicalization itself and occur *regardless* of how efficacious the particular medical treatment or social control mechanism” (1980:246, emphasis in original). My work incorporates these past works on medicalization, but also adds to the literature on the implications of non-recognition of medical conditions on the lives of

individuals. And while acknowledging the many positive consequences of medicalization, this work also questions the implications of medicalization when there is no known etiology, no proven treatment, and therefore no guarantee of alleviation from symptoms, or cure.

#### Origins of PTSD – The Modern Medicalization of War Trauma

Despite the status of PTSD as a relatively new condition, there is a long history of recognizing trauma as leading to social and medical problems. From the Civil War on, we have accounts of conditions among veterans of war similar to what today is called PTSD. Over time such conditions have been assigned labels such as shell shock, battle fatigue, war-neuroses, and psychic degeneration (Young 1997; Dean 1997; Shephard 2001). World War One soldiers were often labeled malingerers, and their conditions were blamed on weakness or deviance – an attempt to shirk military duty to avoid returning to battle.<sup>6</sup> Veterans of the Vietnam War were actively involved in lobbying the American Psychiatric Association (APA) to include PTSD as a unique disorder in the *Diagnostic and Statistical Manual of Mental Disorders, 3<sup>rd</sup> Edition* (1980).

Young (1997) offers a comprehensive history of the various ways trauma has been understood to affect individuals. PTSD, in this sense, is but the latest construct of many that have attempted to formalize and categorize the sequelae of experiencing trauma. PTSD is a bio-psychosocial condition that has been, and continues to be, shaped

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<sup>6</sup> See Allan Young's *The Harmony of Illusions*, Section One (1997) for a thorough account of the evolution of conditions associated with trauma/traumatic memory in the field of psychiatry. Also the anthropologist, neurologist, psychiatrist W.H.R. Rivers wrote many account of his groundbreaking work with combat traumatized WWI soldiers and veterans. See for example "The Repression of War Experience" (1918). The conditions described by Rivers and Young align closely with what is today known as PTSD.

by political, cultural, and historical understandings of trauma and its particular effects on the body. Furthermore, the manifestations of trauma are related specifically to the cultural and social milieu in which they exist. The context in which the veteran experiences PTSD is very likely to affect the way the condition manifests within the individual, as well as the ways the diagnosis is perceived by both the person who has it, the people in their social world, and society in general. PTSD is a disorder with a history intimately linked with wars and its effects on those who have fought them.<sup>7 8</sup>

Wilbur Scott (1992) offers a thorough telling of the process by which the actions of people, primarily veterans of the Vietnam War, alongside mental health professionals, led to recognition of PTSD by the APA. Medicalization is often a contested process, and the acceptance of PTSD within the medical community is still not universal. Since its initial inclusion in the DSM-III, the definition of PTSD has changed more than almost any other condition with the subsequent editions of the DSM (Moreau and Zisook 2002). Diagnostic criteria for PTSD have been revised in each new edition since its original formulation in the DSM-III.<sup>9</sup>

### The Formal Definition of Posttraumatic Stress Disorder

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<sup>7</sup> After the APA recognized PTSD, the condition expanded to include other groups who suffered ongoing effects resulting from trauma. These groups include survivors of rape, sexual molestation, Holocaust concentration camps, and refugees coming from war torn regions.

<sup>8</sup> The fiction of World War One is particularly good on PTSD. Pat Barker's *Regeneration Trilogy* (1991, 1994, 1996), or Jacqueline Winspear's *Maisie Dobbs* mystery series (2004 for example) are recent examples. Another work of fiction is Bobbie Ann Mason's *In Country* (1985), which retells the story of a Vietnam War veteran struggling with PTSD.

<sup>9</sup> There have been three subsequent revisions of the DSM since the third edition. They are the DSM-III-R (1987), the DSM-IV (1994) and DSM-IV-TR (2000).



According to the DSM-IV-TR (2000), PTSD is an anxiety disorder brought on by a *specific* traumatic event.<sup>10</sup> Diagnosis requires an individual to exhibit multiple symptoms along six different axes (See Figure 2.1 for specific criteria as defined by the DSM-IV-TR). In sum, however, diagnosis of PTSD is dependent upon an individual experiencing some, or all of the following, after exposure to a traumatic event: the re-experiencing of the trauma through intrusive thoughts, flashbacks, dreams, and/or hallucinations, feelings of reliving the trauma each time they think or speak about it, and avoidance of situations and people who are directly connected to the specific trauma. Sleeping problems are common, as are numbing of emotions, and feelings of doom, such as the end of life being near. Furthermore, individuals commonly exhibit hyper-vigilance, a heightened startle response, irritability, outbursts of anger, and difficulty concentrating. These symptoms often interfere with personal relationships, social interactions more generally, and the individual's ability to function in the workplace.

PTSD may be an acute condition if lasting less than three months, or classified as a chronic condition if symptoms persist for more than three months. Diagnosis is complicated by the fact that the onset of PTSD may not occur immediately after the experience of trauma. The condition is classified as *with delayed onset* when the symptoms present at least six months after the initial trauma. PTSD may also subside and then reappear after many years of latency, often triggered by exposure to an event similar to the initial trauma. For example, former Georgia Senator Max Cleland, who

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<sup>10</sup> Combat soldiers are very likely to be exposed to multiple traumatic incidents. Furthermore, life in the theater of combat entails extended periods of time where traumatic events could occur at any moment. Soldiers are therefore required to be on heightened alert at all times.

lost both legs and an arm during Army service in Vietnam, sought treatment for PTSD in 2006, citing problems including hyper-vigilance, fear for his safety, sleep problems, general depression, and social withdrawal, that he attributed to a deep sense of sadness and connection with injured soldiers of the Iraq War (Cleland 2009).

PTSD is a condition whose diagnosis can always be challenged because it lacks an objective marker. It cannot be seen.<sup>11</sup> There is no scan, no laboratory test, nor obvious physical alteration to the body. This invisibility poses problems of measurement and validation. Furthermore, PTSD does not present as a single shared experience or manifestation; it can best be understood as a *spectrum disorder*. Spectrum disorders are conditions that are experienced differently by different people. There is no singular manifestation of the condition, both in terms of particular symptoms and their magnitude. Further compounding this issue, as seen in prevalence rates, not everyone exposed to trauma develops PTSD, making etiology of the condition unclear. Moreover, the degree of debilitation varies not only between individuals, but may vary within the individual over time. As a chronic condition, it can ebb and flow, sometimes with a clear-cut logic, as in the case of flaring up on the anniversary of a trauma, or when hearing stories similar to one's own trauma; or it may reemerge seemingly at random for no particular reason at all.

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<sup>11</sup> This is a problem regarding other *hidden injuries of war* common amongst those who have served in Iraq and Afghanistan. While major Traumatic Brain Injury (TBI) is visible with scans such as CT-scans and MRIs, minor-TBI is often undetectable with modern imaging technology.

In her study of Atherosclerosis, Annemarie Mol (2002) demonstrated how the disease takes on different forms and meanings with different consequences for various actors. She refers to these varying forms as the disease's *multiple enactments*. In the case of PTSD, psychiatrists and neurologists may focus upon chemical changes in the brain as a result of trauma, and have pharmacologically driven treatment approaches. PTSD treatment led by a psychologist or social worker, however, may center on various therapies and counseling approaches such as cognitive-behavioral therapy or eye movement desensitization reprocessing (EMDR). Further complicating things, medical providers may have different beliefs about how to best treat the patient as well. There is no standard of care for the treatment of PTSD. While medicalization has made PTSD a legitimate focus for medical professionals, it has failed to result in the development of treatments proven to be consistently effective. So while medicalization has provided legitimacy, it has also opened the door for the contestation of the condition's legitimacy as well.

## **Methods of Data Collection and Analysis**

### **Research Setting**

All of the veterans in this study were either low-income, or would represent the first generation in their families to obtain college level education. They were participants in a program aimed at this special group of veterans, which aimed to help them access post secondary education. To paraphrase the program's mission statement, the aim was to

prepare veterans to enter, be successful, and graduate from college.<sup>12</sup> The actual model is built upon a subset of program participants who served during Vietnam and identified themselves to me as having PTSD.

The program operates three fourteen-week sessions each year and aims to enroll 60 students per session. Classes and activities were held during the late afternoons and evenings on a college campus that rented space to the program. Because students typically took at least two semesters of classes while enrolled, there was an overlap between the sessions. The target enrollment was approximately 120 individual students per year. During the first session, half of the approximately 60 students who attended the orientation did not complete the session. In the second and third sessions new students were admitted to replace the ones moving out of the program (either due to attrition, or completion of the courses). This research targeted all participants of the program during the three sessions of the 2007-2008 school year. During the course of that year there were a total of 104 individuals who cycled through the program, though some lasted only a matter of days, and others were present for all three sessions. Twenty-seven students graduated at the end of the 2007-2008 school year.

### Program Participants

The students could be divided into two main groups. The first group was made up of people who moved through the program quickly and with little trouble. They usually arrived minutes before class time, coming directly from work, and had clear plans to

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<sup>12</sup> In order to protect the privacy of program participants and ensure that the promise of confidentiality is maintained, the names of the program, its employees, and all program participants have been changed or withheld.

enroll in a college, or other post-secondary education program, once completing the program. The second group was very different and was comprised of people I shall refer to as the strugglers. Strugglers typically struggled not only with the academic load, but were also battling other difficulties in their lives. Many of them were unemployed, often because of disabilities. Though they typically encountered more problems academically, they spent far more time on the campus, hanging around the buildings where classes were held, or in the administrative offices. For them, the program gave them something to do with their lives. It broke up monotonous days, kept them out of trouble, and provided a social setting where they could interact with other veterans in similar situations as their own. These are the people with whom I spent the vast majority of my time.

For many members of this second group, PTSD had affected every aspect of their personal lives. I heard stories of lives “derailed” by PTSD and other problems strongly associated with the condition, such as major depression, alcoholism, and drug abuse. For veterans, the genesis of their PTSD is typically located in experiences undertaken on behalf of an entire society, but the condition has an isolating effect, often leading to family conflict and dissolution, loss of friendships, and chronic unemployment; all of these are alienating, increase social isolation, and often manifest as problems understood as rooted within individuals.

#### Primary Data Collection

My approach to data collection was inductive, and it employed multiple methods. Heavily reliant upon participant observation and informal interactions with the members

of the program, I also conducted in-depth conversational interviews (Weiss 1995) and collected information about veterans' backgrounds via questionnaires. I also attended staff meetings, talked to instructors and the program director throughout the course of the project.

Overall, my time spent at the research site proved the most valuable source of data. It allowed me to get to know my subjects, build rapport, gain trust, and to begin understanding the different forces impacting their lives. My primary role in this approach was as a participant observer. I spent time going to classes and tutoring. I also spent time with the veterans before and after classes, and this provided a setting in which I got to know them through discussions that occurred when I hung out with them. There were certain individuals who would sit and speak to me for hours. At the same time, many of the veterans were reluctant or refused to participate in recorded interviews, or to fill out questionnaires, despite assurances of confidentiality or anonymity. This was reflective of a great distrust many of these veterans had towards the world in general. As one veteran told me

I'll never put my name on anything, but I'll answer any questions you ever have. I trust you, but I don't trust my name on anything. I'll help you... You won't learn anything from all those books you're reading. I'll tell you the truth about what really happened...[Paul]

Eventually, however, I was able to conduct 14 recorded interviews and another 4 which were not recorded. For the unrecorded interviews I took as many notes as possible during the interviews, and also recoded notes immediately afterwards where I tried to

record as many details as possible. Thirty-one students completed the questionnaire, including all 14 of the students who sat for recorded interviews.

I spent three to four afternoons and evenings each week at the program. Afternoons were divided between informal periods before and between classes spent hanging around with and talking to the veterans about everything and anything imaginable, tutoring both individuals and small groups of students, and attending special programs organized by program staff. Most evenings were spent observing classes. Following each day, I recorded detailed, descriptive fieldnotes, documenting my experiences, observations, reflections, and emergent questions (Emerson, Fretz, and Shaw 1995).

My focus expanded beyond educational experiences to include subjects relevant to the lives of the people with whom I worked. Unlike many college students, their lives were not defined by their roles as students. To understand the lived experiences of my subjects I needed to learn about a variety of other topics well. Such areas included disability benefits and healthcare, issues of physical and mental health, homelessness, addiction, and incarceration. Many of the veterans were involved not only in transitioning into the world of higher education, but in numerous other transitions as well. Many were living in transitional group homes after bouts of homelessness, hospitalization, or incarceration. Furthermore, many decided to return to school after losing their jobs, often due to disabilities. As I got to know the students, it occurred to me that many of them were still trying to put their lives back together, even the students who were veterans of the Vietnam War era.

## Methods of Analysis

Fieldnotes and interviews were coded with the assistance of *Atlas.ti*, a computerized qualitative analysis program. Coding was an inductive process. The initial round involved open coding; codes were not predetermined, but rather emerged from the content of the data (see Glaser and Strauss 1967; Strauss and Corbin 1998). Then in an iterative process involving re-reading the data along with the codes, the coding scheme was revised and improved to allow for more systematic analysis of the data. The process led to a significant amount of material that came to comprise the data upon which this particular work was built. Codes included discussion of life with PTSD, feelings about the VA and treatment, commentary on applying for and receiving disability benefits, and general struggles with topics such as alcoholism, drug addiction, recovery, homelessness, group housing, and interactions with social service agencies. I also included commentary about family conflict, (un)employment, and social networks. Homecoming stories, and stories about how and why individuals enrolled in the program also became important components as I worked to build a conceptual framework of the process/stages that veterans struggling with PTSD traverse. The process of building such a model involved three main steps: identify key concepts for inclusion, showing linkages amongst them, and testing to see if the model fit the cases. Such models are reductions of complex realities and are meant to help both researcher and reader better understand the complexities involved in any process (Bernard and Ryan 2009).

## Key Informants



My model was constructed based on the experiences of many veterans who at some point opened up to me about their PTSD, but I primarily depend upon the accounts of three individuals to describe the three stages of the conceptual model I have developed. The very nature of PTSD makes it difficult for people to speak about their experiences. Therefore obtaining cases like these, where the veterans were willing to speak to me at great length, repeatedly, was a rarity. These three individuals were people I interacted with almost daily over the course of the year. I also add examples from others where it seems fit, but these three cases provide clear examples of distinct experiences and trajectories I have identified through the analysis of my data. All three men shared the common experience of returning from war with what we today call PTSD. They all struggled for many years as they tried to move beyond the war and (re)build their lives, and all eventually entered treatment for PTSD. There are similarities in the struggles they encountered before diagnosis and treatment, yet their paths to diagnosis and treatment varied, as did the implications and outcomes of diagnosis and treatment.

Brief biographical sketches of the three men follow.

**Kahlil** was taking classes at a local community college when he found out his girlfriend was pregnant. His father, enraged by the news, immediately withdrew his financial support. The following semester, unable to pay for college on his own, he left school, got married, and began working to support his new family. Almost immediately he was drafted into the Army. It was 1968, and he was 18 years old. After basic and advanced training, Kahlil was sent directly to Vietnam where he spent the remainder of his two-year enlistment. He was a combat soldier, and the horrors of war became the

reality of his daily life. Kahlil left the army for a short time once his initial two-year enlistment ended, though he eventually reenlisted and served a total of six years.

**James** is another Vietnam War veteran. He voluntarily enlisted in the Marine Corps in 1967, and went right from boot camp to Vietnam, where he spent the next three years. When he entered the Marine Corps he dreamed of serving for the full 20 years and making a career of it. James left the Corps after his first enlistment ended. As an African American man he experienced racism, especially from his commanding officers, and this soured him on military life. Though he dreamed of serving his country, his experiences, both in combat fighting the Vietnamese, and with his comrades, eroded his commitment to the fight and the military. He returned from war as a Purple Heart recipient. To this day there is still shrapnel in his body.

**Paul**, like James and Kahlil, came from what he described as a rough neighborhood. He dropped out of high school in 9<sup>th</sup> grade. “That’s what you did when you were from there. You dropped out, went to work, and waited for your number to be called.” Paul opted to enlist in the Army because he knew his “number was going to come up,” and he “wanted to try and avoid infantry.” He ended up in an infantry unit anyway as a radio operator. Paul spent nine months in Vietnam. He “got shot, has PTSD, you name it.” Paul was given an honorable discharge after being wounded in combat; he was shot in the leg. He was also exposed to Agent Orange, which caused numerous health problems, including reoccurring cancerous lesions throughout his body.

## **Results**

Within the disease/illness framework, illness is concerned with the lived experiences of people who are affected by medical conditions. Mol's (2002) concept of multiple enactments can be expanded beyond the arena of disease to include the subjective experiences of individuals as well. For instance, a diagnosis of PTSD may be, though not limited to, any of the following: a way to contextualize feelings and struggles, confirmation and legitimization, a mark of disability that might carry the added weight of stigma, a negative label, an affront to the masculine warrior persona, a sign of weakness, or instability. All of these enactments are evident in the respondents' accounts.

Deployed soldiers often count down the days until they return home. Stresses that await them are often cloaked by the excitement of an idealized return to normal life. Homecoming, and the euphoria that surrounds, it is similarly noted by Goffman (1961) in his analysis of mental patients who dream about their release from the mental institution (1961, 1963). Veterans are similar to mental patients insofar as they have experienced life within the confines of a total institution; they have gone from soldiers with lives entirely ordered by the military, and have then been released from the total institution back into civil society. In this way, veterans with PTSD have two overlapping moral careers. The first, common to all veterans, is that of the transition to civilian life. The second, which is the primary concern of this work, is the social experience of life with PTSD, and the stages of recognition and dealing with the diagnosis and the disorder itself.

Reintegrating into family life, readjusting to civilian routines, and (re)joining the civilian workforce are all part of fitting back into a world that has gone on without them. Such stress is often compounded by the fact that soldiers' unit members, the backbone of

survival during deployment, are often scattered; unit members are dispersed across the country, while others remain deployed. The recently demobilized soldier is pulled in many directions and faces a complex process of adjustment and (re)integration to civilian life after the return from war, with no formal period of decompression, and no formal preparation for what stress of return might be like. For many, the initial euphoria of returning home obscures vestiges of combat trauma, and alleviates the immediate stress of life in the civilian world. At the same time, family and friends are initially likely to make allowances for a period of adjustment. Reintegration and readjustment pose steep hurdles, even for soldiers who return healthy in mind and body with a strong social support networks waiting for them.

While a certain amount of stress is normal and a period of readjustment should be expected, some soldiers/veterans ultimately fail to (re)build their lives. PTSD is a common way that this inability to reintegrate or readjust to civilian life has been medicalized. This analysis of veterans with PTSD is fashioned upon, and extends, Goffman's moral career framework. Goffman divided the moral career of the mental patient into three distinct phases: prepatient, inpatient, and ex-patient, but focused exclusively on the first two (Goffman 1961:130). Here the moral career of the Vietnam veteran with PTSD is divided three ways as well: Pre-Treatment, Treatment, and Post-Treatment. All three stages are examined (see Figure 2.2). Goffman's work examined only those people suffering from mental problems that landed them in the hospital, even though far more people with such problems eluded such institutionalization. Similarly, I focus on a specific type of veteran with PTSD, because these are the veterans to whom I

was exposed. They are in sum, Vietnam era veterans, with low social capital, who went years before receiving diagnosis and treatment for PTSD, and all of them spent time in inpatient facilities operated by the VA.

I examine the types of experiences, interpretations, reflections, and realizations that occur within each stage. I also show the possible outcomes of these processes as a way of leading to the next stage in the progression. The Pre-treatment phase adds to the medicalization literature by examining the experiences and implications of having a condition that has not been formally recognized or legitimated by the medical community. Many of the veterans with whom I spoke spent more than a decade before they learned that there was something clinically wrong with them, and that it could be attributed to their war experiences. Examination of the Treatment phase reflects both latent and manifest consequences of medicalization. These consequences carry into the Post-Treatment phase. My examination of the Post-Treatment phase highlights variability in outcomes, and extends Goffman's moral career framework by examining life after treatment. It also evokes questions about the implications of diagnosis, and medicalization in general, when treatment fails to alleviate suffering, or bring other benefits to the person afflicted with the condition.

#### Stage One – Pre-Treatment

People within the Pre-Treatment phase may have different degrees of awareness that something is amiss. At one extreme, they may be completely unaware of problems, though this is usually a short-term state of being. More likely, they may recognize that

their behaviors or feelings are strange, or that they do not feel well. Similarly, they may be aware that they are different from other people. There are also people who are acutely aware that something is wrong, but they do not know what it is; they do not have a label for it, or they label it as something other than what truly lies at the root of their problem. This is especially true given the high rate of comorbidities with PTSD, such as drug and alcohol dependence, depression, and anxiety. It is common to experience a number of these states. For veterans who served before 1980, PTSD was not even a diagnosable condition.<sup>13</sup> But people with PTSD have certain symptoms; these are the symptoms that comprise the diagnostic criteria (see Figure 2.1).

A veteran with undiagnosed or unaddressed PTSD is very likely to experience social isolation and distancing, strained social relationships with old friends and family, and a high degree of conflict. This is often exacerbated by drug and alcohol use that the veteran turns to as a form of self-medicating. The following veterans' accounts of their homecomings, and the time before being diagnosed with, or going for treatment for PTSD, reflect the diagnostic criteria used by medical professionals to diagnose the disorder, but put them in the context of lived experiences.

This first account is a reflection on the time soon after returning from war. The veteran was asked whether he thought that something was wrong at the time he first returned home, and if he had problems.

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<sup>13</sup> OEF/OIF veterans may receive a diagnosis of PTSD before separation from the military because of recent regulations requiring post-deployment screenings for mental health disorders. That does not, however, mean that they enter treatment once they return home. In fact, they may dismiss the diagnosis all together (a point to which I shall return). These veterans would also fall into this category for some amount of time before seeking out help.

I didn't think it affected me at all. I had no idea that I was any different than anybody else... coming straight out of the boonies, out of the jungle, you know, back to the United States after seeing all the carnage and the killing and all the kind of gory stuff there... I found myself doing a lot of little strange things that [people back home who had never been to Vietnam] just weren't used to. And even though I grew up in a neighborhood where everybody was kind of tough, I think I was a little tougher because I did things that were so unexpected, that they just thought that I was out of my mind. [Kahlil]

In retrospect Kahlil is able to recognize that certain behaviors were not normal. He was “doing a lot of strange little things.” But at the time he felt there was nothing wrong with him. As we sat years later, and he recounted these facts to me, he was quick to identify these behaviors as vestiges of his experiences in Vietnam. And in comparison to the realities he saw in Vietnam his behaviors were perhaps “little things” even if they included rigging booby traps. Perhaps they also seemed rather insignificant to him because other veterans he knew also had similar “little things” they did too.

...a lot of these [other veterans] were having problems way before I was having problems, but they just thought they were normal too... But it was obvious that – I didn't know it, but it was obvious to other people that I was different. I had changed and I wasn't the same guy. But it didn't dawn on me until after I got out of the service [years later] that something was wrong. [Kahlil]

Kahlil tried to return to the life he left behind when he was drafted into the military.

I even tried to go back to school... because it was, my goal was that I wanted to go to law school. And I tried to go back to school, and it just, I just was doing too many dysfunctional things that just didn't allow me to function. That's where I was at then.

No matter how determined Kahlil was, things got in the way. In his words he was always being “derailed” but he didn’t understand why. A host of “dysfunctional things” got in his way. Even in our discussions, Kahlil could not articulate the dysfunctional things getting in his way. But something was there, and it was a giant roadblock.

Here another veteran discusses his return home and some of the immediate problems he experienced.

I went in the military at a very young age and came out real disenchanted. You know disappointed... When we came home there wasn’t like no indoctrination - reindoctrination - to fit you back in the society. You was in Vietnam one night, and two nights, three nights later you were walking up and down the streets of [your old neighborhood], just like nothing happened. Nobody checked you – the effects it had on you. We were kids! Eighteen, 19 year-old children, and most of us had never been outside [our neighborhoods], never the less outside the city... [James]

James was injured in Vietnam and when he returned to the U.S. he went to the local office where veterans were evaluated for combat-related injuries. Here he speaks briefly about that experience.

...When I got out of the service in 1970, I was a Purple Heart recipient. And I had got wounded. I had shrapnel throughout my hand. And um one of the things they did when I was in Vietnam when they did the surgery, see if you lose a joint you got automatically paid. So what the doctor did because the finger was split down, he took and pulled it over and saved the joint. So when I came out the service...and I learned all this stuff years later...and at the time you thinking these people are looking out for your best interest, you know because we fighting a war you know what I mean...So when I came home at that time [disability evaluation office] was where you went at for evaluation for disability, and I went up and I saw the doctor and he looked at me and shooed me right on off. So I left under



the illusion that I wasn't entitled to anything and they don't give you no information that the VA supposed to...

James's belief that there was nothing really wrong with him was strengthened by his interactions with the VA doctor. He left this appointment under the impression that he was not entitled to any compensatory remuneration for the wounds he received while in Vietnam. Furthermore, despite clear signs that he had a full-fledged drug addiction at the time, and as we shall see, he was experiencing what are today recognized a textbook symptoms of PTSD, he was never offered any services. There was no mental health examination. He was examined by a doctor who "shooed him right on off." Despite his clean bill of health from the VA doctor, things were not okay.

...when I came home I had problems dealing with car backfires and things of that nature because like I said there was no debriefing. I'm in a war ducking bombs. You on high alert. You walk around on high alert all day. So when you come back, a car backfires, you hitting the dirt, you know? I had a problem with seeing trash bags in the rain because it's a lot of body bags, it's a lot of monsoons - so they kind of correlate together. So you walking down the street in the rain and you see the trash bags and you thinking about body bags. You medicate yourself.

James's account poignantly identifies the contrast between experiencing mental health problems versus the experience of physical injury. According to James, doctors in Vietnam did everything they could to save the digit of his finger. When he showed me his finger the top piece was missing, but in fact, the joint itself was there. But in the case of war related trauma, and many mental health issues more generally, there is no biological alteration or marker. PTSD is invisible. It is not a joint. There is no definitive

test. It cannot be easily slotted into a formula and assigned a numerical compensatory value. Of course, at the time James went for his medical examination, PTSD was not a recognized condition, and even if military or VA doctors wanted to diagnose his condition, neither the medical language, nor formal bureaucratically recognized language for diagnosis and compensation of PTSD existed.

#### Social Isolation, Conflict, Misattribution of Locus of Problems

As a result of his toughness and strange behaviors people avoided Kahlil, especially when he was drinking, which he explained was most of the time. He had a short fuse and would fight at the drop of a hat.

...somebody would do something, I said all right, I'll be back in 10 minutes, you know, clear the corner. That kind of stuff. [I would] get drunk and always would want to fight. All kinds of stuff. My brother wouldn't even kinda hardly mess with me. We're only like 2 years apart.

Here we see classic signs of PTSD: the quickness to fight, irritability, and lack of predictability in his actions. Such behaviors isolated Kahlil from the people in his pre-war social network, even his brother. He spent increasing amounts of time with other veterans who understood what he had experienced. Other veterans made him feel more normal and less out of place. These veterans understood each other and the experiences that people who had not been to war could not comprehend. With this group of veterans he would numb his pain through alcohol and drug use, both of which are now recognized as having high rates of incidence among people with PTSD, especially combat veterans.

When I asked James if he had problems when he returned back to his old community he told me

Well, nobody fooled with me. I came back and I was already strung out on drugs...I went back to my neighborhood, most of the guys who I came up with was getting high. Plus a lot of guys from Vietnam had shipped drugs home. And a lot of them came home with the same problems I had. So it was kinda here when I got here, so I kinda like fell right in.

James “fell right back” to a life of drug use and nobody “fooled” with him because they were scared of how he might react. He had a short fuse, was irritable, and prone to outbursts. The easiest thing for him to do once he returned was to continue to feed his drug addiction because it was the only way he fit into the world around him.

Conflict was a theme that ran through many of the interviews and conversations I had with struggling veterans. In the previous two cases we see the proclivity to fight, but these problems are also common within families as well. Paul returned to the United States after he was wounded in combat, and was given an honorable discharge. Once his leg healed, he felt he had to get out of the country for a while. He was “messed up in the head,” and left for Europe to connect with members of his father’s family. He was hoping to restart life abroad, at least until he could find some inner peace. War had “shattered” his belief in the United States. The war he had excitedly signed up for had become a symbol of American hypocrisy to him. And so he set off for Europe with his new wife, a woman with whom he had grown up, and married right after he got out of the Army.

But Europe was no escape from his problems. He initially lived with his family members, but fought with them constantly. Shortly after arriving he moved out of their

home and lived on his own with his wife. After about two years he and his wife decided to return to the United States. They had their first child while overseas, she was 17 months old, and Paul wanted to find steady work. Despite his intentions, the return home did not go smoothly. He constantly fought with his wife, and the fighting often deteriorated into physical altercations, especially when he had been drinking. Despite the problems at home, he and his wife had three more children.

Unlike the two previous men, Paul was able to hold down a job, despite his heavy drinking. He was hired by the railroad and did track maintenance, but he fought with co-workers, especially supervisors. Still, he was good at his job, and eventually became a foreman on his work crew. He explained that the railroad brought with it a heavy drinking culture, so his alcoholism was not a problem most of the time. But the conflicts with management and superiors became more frequent. He started working the third shift because there were fewer people to deal with and he hardly ever slept anyway (something he later learned was attributable to his PTSD). Eventually, however, despite the drinking culture of the railroad, his drinking became too much. His company came to him and offered him help, but he refused.

I was like fuck you, you don't know me. My attitude was, this place can't make it without me. You'll see it's all going to fall down when I leave. But I was wrong, because once I was gone things kept on going the way they always did.

His refusal to get help led to his termination. From there life began to further unravel. He left home, wound up in a shelter, was forbidden from having contact with his wife after she got a restraining order against him, and fell out of contact with his children.

Paul attributed this all to his drinking and eventually went into an alcohol treatment program, stopped drinking, and stayed sober for the next nine years. His sponsor was another veteran who he felt understood him, as only another veteran could. But his problems did not all go away despite his sobriety. He was still stormy, isolated himself socially, and was now unable to find work. He spent a lot of time “just being angry at the world.” Like James, he blamed his problems on his alcoholism, his alcoholism on an inherent weakness, and no matter what he did, he could not escape the emptiness he felt.

All of these men were extremely troubled by their war experiences. Leaving the theater of war did not eliminate their inner battles, and conflicts with other people in their lives became a common feature. Their volatility drove others away, but none of them said they initially attributed these problems to the experiences they had at war. Furthermore, because their struggles began prior to the medicalization of PTSD, there was no outreach by the military or the VA to identify and help these individuals. Neither, Kahlil, James, nor Paul were able to accurately identify the source of their struggles.

#### Pathways to Diagnosis and Treatment

The accounts thus far are pictures of lives marked by the legacy of war when the veterans were still non-medicalized individuals. Eventually these veterans received formal help. Amongst the veterans who shared their stories with me there were three pathways that led them to treatment, and they always involved the intervention of an

outside party. The most common force was the urging of a relative, the second was through the urging of another veteran, and the third, judicial coercion.

Though Kahlil had isolated himself from most of his friends and family, especially his younger brother with whom he was so close before going to war, his mother remained an important part of his life, even if their relations were often strained. Kahlil struggled for 12 years before he entered treatment.

It took my mom to tell me, 'listen you know, you don't realize that you've had some whatever experiences.' And she said, 'I can't tell you what they were. But you've had some because you're my child. I know you went one way and you came back another way. And perhaps you need some help, you need to talk to somebody.' I said, 'I don't need to do that, I don't need to do that. All I need to do is get me another bottle of wine, you know, couple joints and whatever else and try to forget about it. But you wake the next morning and it's still there. I finally went and that was...January...of 1986.

Goffman (1961:136) noted a similar phenomenon. Most patients had one particular family member who remained a trusted confidant despite the problems resulting from the patient's mental state. They were often the ones who defended the patient's behaviors to others, ignored or dismissed the behaviors altogether, or were willing to forgive them repeatedly. This person was most often the person who lead the patient to be admitted into inpatient treatment.

The second pathway is one which highlights a very real bond between veterans through which information often flows. Such networks are especially important for veterans who feel alienated or uncomfortable in dealing with bureaucratic structures like the VA. As recorded earlier, James was a veteran who

clearly struggled upon his return from war, but he was also under the impression for many years that in the eyes of the VA there was nothing wrong with him, and that he was not entitled to care or disability compensation. In fact, the VA represented the interests of the government, not those of veterans in his mind.

In 1980, ten years after he was discharged from the military, things began to change for James.

The Posttraumatic Stress was vibing on. I didn't have a clue of what that was. Wasn't no fliers, or nothing going around. You start finding out - basically what happens, you start getting your information from other veterans, you understand, that are successful in their endeavor in trying to get help. They tell you what worked for them. How you go about it. I applied twice at [the residential treatment facility]. Twice they told be I was Posttraumatic Stress. I had a disorder and it was chronic (*sic*). What the word chronic means is that it don't get better it just gets worse.

Through this network of veterans, James realized that he was not the only one with problems, and that his problems might run deeper than drug and alcohol dependence. I heard from many veterans of this network between veterans for the transfer of information. It was a mechanism by which many learned how to access resources. As one veteran named David explained, "See the information kinda passes around through the vets. Because the vets kinda got a little code amongst themselves. There's nothing spoken, but vets kinda look out for vets." The information James received from other veterans who had successfully navigated the VA, been diagnosed with PTSD, and received treatment led him to enter the same program.

The third pathway is that of judicial coercion. In the example that follows, judicial diversion away from jail to treatment was at the whim of a judge in a standard court. Paul went nine years without a drink, but then for reasons he could not or would not, recount he started drinking again. As he shared this with me he proclaimed, "I even made the local news one night." Here is the story as he told it to me.

One night I was drinking gin. That is what I drank in Vietnam. I snapped or something and went into a different mode. I thought I was back in Vietnam. I locked and loaded, while walking up and down [a major city street]. The police did not know what to do with me. They talked me down. 302'ed (involuntary committed) me. They could have shot me right there. I was [confined to the psychiatric unit] for a while, and they said I needed to go to an alcohol treatment program and PTSD school.

He said he would go, but once he was released from the hospital he never went. It was not over though; because of the incident he had to appear before a judge. On his way into the courthouse he saw a van from the VA, but it never occurred to him that it was there for him.

The judge told me I could do 90 days in county jail, or 90 days in a treatment program. I was so disgusted - felt no one could help me. I enthusiastically said, 'County jail, Judge!' The judge said, 'Wrong answer! You are going to treatment!' And that was it.

Conrad and Schneider (1980) note that one implication of medicalizing deviance is that it allows for flexibility in the forms of social control we use to regulate people's behaviors. In Paul's adjudication this is clearly the case. The judge made a decision to send Paul to treatment, rather than jail. Judicial coercion is a pathway to diagnosis and treatment we might expect to become more common due to the recent advent of veterans courts, which



seek to divert veterans away from the regular criminal justice system, keep them out of jails and prisons, and address underlying problems that have led them into contact with the judicial system (Russell 2009). The medicalization of deviant behavior, and the increased belief it is the byproduct of trauma, is increasingly allowing judges to force veterans into treatment programs to address PTSD and other conditions caused or aggravated by military experiences.

### Stage Two: Treatment

As we have seen thus far, some people enter treatment voluntarily, even if it is the result of years of coaxing by family members or friends. We should figure that not all people who enter as a result of family pressure are doing so by choice, but rather as a result of an ultimatum. Still others are literally forced into treatment. Regardless of the pathway, it is common to resist entering a treatment facility because of the stigma associated with mental health problems and mental health care, especially when it is inpatient in nature. This is compounded by cultural images of masculinity and the persona of the tough, stoic soldier.

I didn't want to go because I thought people would think that I was crazy.  
[Kahlil]

You now what they say? All gave some, some gave all. Why should I be complaining? At least I got to come home. Some of my buddies weren't so lucky. [Adam]

Alcohol is my problem. I can face my past. I just need to control the drinking. Nobody messes with me. I can handle myself. [Paul]

Upon entering treatment there is variability in experiences as well. In Goffman's discussion of the initial transition to inpatient status he notes that confinement, even when initially resisted by the individual, is a relief for some people, but for others it makes things worse. This is similar for veterans with PTSD. On the one hand, there can be instant relief for the patient because they no longer have to engage in the act of seeming okay to the rest of the world. They are able to let their guard down that they have used to hide strange behaviors. On the other hand, confinement can be interpreted as an affront – an assault on one's autonomy. For instance, Paul felt as if he had been “sold-out” by the judge. To him, this was just another insult in a long line of insults he had incurred which began with his service in Vietnam.

#### Diagnosis and Treatment

All the veterans featured in this analysis spent time at the same VA facility. Unlike large VA hospitals, this facility was especially designed to treat mental health problems, alcoholism, and drug addiction. After the VA officially recognized PTSD in October 1980, this facility quickly became, and remains, a recognized leader in the treatment of PTSD. While some veterans had already received an initial diagnosis of PTSD before entering the facility, others received the diagnosis after evaluation once there. PTSD treatment at this facility takes a holistic approach, aimed at treating not only PTSD, but the other problems veterans often have such as addiction. Just as some people are

resistant to entering a treatment program while others go voluntarily, there is variation in people's acceptance of both diagnosis and treatment. For some people diagnosis alone is a tremendous relief. Others resist the diagnosis of PTSD and therapy as well.

Kahlil's account offers a well developed example of a person who embraces the diagnosis, and who benefits from the realization that there was a name for what he has been experiencing. By the time Kahlil finally entered treatment he was convinced he was suffering from psychosis and spending a tremendous amount of energy to hide it from the rest of the world.

I had to come to the realization that I had some emotional imbalances; that they weren't just truly psychotic. You know I found out that they're not psychotic. You've just got some emotional stuff going on as a result of the experience you had and the exposure that you had.

[That facility] gave me an opportunity you know... They opened some doors. They told me I could get past this. And again, there were some sensitive people up there. There were some people who were really interested in assisting vets in that program... the hospital itself is just, just, in my opinion, and a lot of other guys will say the same things that I've met over the years, that [that particular facility] is just different.

For many people the treatment program was an opportunity to make things right in their lives. It took them out of the negative environments they were stuck in and also gave them hope that they could get better. Diagnosis and treatment can open a door that leads to an understanding of what has been happening in their lives. That knowledge can allow people to begin the process of moving forward. A medical framing of problems often imbues a sense of hope; the medical perspective extends a belief to the individual (and

others) that treatment can lead to recovery and healing ( Conrad and Schneider 1980).

Overall, Kahlil was a driven and determined man with lofty aspirations, but the scars from his time in the military halted the pursuit of his dreams. Before being diagnosed with PTSD he had come to see himself as a persistent failure and as psychotic. His fear that people would think he was crazy for seeking treatment inhibited him from doing so. His dependence on drugs and alcohol, his lack of concentration that led to failing classes and dropping out of college, his inability to hold down a job for more than six months, were all barriers to moving forward in life. Diagnosis meant that all of these dysfunctional behaviors became framed as manifestations of his PTSD. Ultimately, for Kahlil, learning he had PTSD allowed him to contextualize his behaviors, to understand why he acted and felt the ways he did, and to stop labeling himself as weak or a failure. He began the process of understanding his medical condition. A tremendous weight was lifted from his shoulders.

And after kind of finding out what was going on, and why I wasn't focused, and why I didn't finish things and [things] were kind of topsy-turvy, the [PTSD treatment] program allowed me to put things into perspective – at least a greater perspective than what they had been...They're impacting experiences. So they treated that. Their whole system up at [that facility] is centered around your emotional balance and that was unique. Because, you know, even in Vietnam you got shot, you put a bandage on, and you kept on rolling. Guy got his leg blown off, you know, you tighten the tourniquet around his thing, you shot him up with some morphine, and blink, he'd be googly eyed, and you'd keep on going about your business. I mean people got killed; you wrapped them up in a poncho; you put them on the side; you piled them up.

In Vietnam, Kahlil piled up the bodies and pushed the experiences to the side, but these experiences also piled up in his mind and left their mark. Through treatment for PTSD, Kahlil learned that the problems he had been experiencing for years were related to the traumatic experiences of war, and he learned that they were “normal”. Forces such as stigma and the soldier’s ethos of carrying on in the face of horror – something essential to staying alive in combat – were barriers to seeking care. But the knowledge that he had a recognized condition called PTSD allowed him to begin to make peace with his past. He learned to understand the underlying reasons for so many of his behaviors. He learned why he was so easily angered and so impatient, even with his children.

I remember Dr. Gray saying...that anger issues for Vietnam vets as opposed to other people - where somebody would go from A maybe to C, or maybe from A to D in terms of their anger going up. or out of control - or maybe even from A to H. The Vietnam vet goes from A to X, like that [snapping fingers]. There’s no in between. You don’t think. You don’t rational – you’re totally irrational. And it’s because we make split decisions. In life and death that’s what you have to do. And when you do that for 3 years, you know everything’s [gestures to indicate something very large]. And I used to do that to my kids and my kids used to think I was nuts and my wife used to say, ‘what the hell is the matter with you? They’re 3 and 4!’ ‘Yeah but I want them to hurry up! Jump from the first step to this one! Now!’

In the passage above, Kahlil explains how therapy has helped him to make sense of his emotions and behaviors. In Vietnam, quick action and obedience kept people alive. Back at home, his adaptations were dysfunctional and harmful. Therapy opened his eyes to this. Rather than being a bad father and a mean husband, he was someone with an illness.

This was the first time he learned that he could work on these behaviors and try to adjust his reactions.

Not everyone embraces diagnosis, nor are they open to therapy. Paul always referred to the treatment program as PTSD school. He was angry that he was sent there instead of the county jail and he remained angry the entire time he was there.

I did my time there and was out. I didn't want anything to do with PTSD school. My problem is alcoholism. That's my disease. I know my inner *gook*. I know his culture, and his food, and I don't want to know anything else about him. I isolate. That's the problem...when it gets bad with the PTSD.

As in the excerpt above, Paul frequently rejected and embraced his diagnosis at almost the exact same time. In the previous excerpt, he says his problem is alcoholism, not PTSD, but then he continues to say that he knows exactly what PTSD does to him, and why it is a problem. Furthermore, his use of the word "gook" can be read as an indication that his war is still raging within, as this was the common prerogative term for the Vietnamese enemy. On another occasion when we discussed his news making incident, he directly attributed it to his PTSD; flashing back to Vietnam after drinking gin, and walking up and down the street with a loaded gun was caused by his PTSD "rearing its head". Paul asserts control over his own life in his statement. He rejects the medical diagnosis of PTSD, and attributes his problems to alcoholism instead. Alcoholism is a condition that Paul has managed in the past, aside from his slip-up that led to his news-making incident. But PTSD was something he felt he had no control over. To Paul there was no shame in alcoholism, even if it admittedly was unhealthy and

caused problems in his life. But PTSD was entirely different. It was an injury of war, unlike being shot in the leg, that he had been unable to defeat.

One complicated aspect of treating PTSD is that people with the disorder are forced to revisit their traumas, yet one of the telltale indicators of PTSD is the avoidance of the trauma and things that remind the person of the trauma. There is therefore a paradox of sorts built into getting help. One is essentially forced to confront what one systematically avoids. “PTSD school” made Paul come face to face with parts of his life that he worked very hard to avoid revisiting. When he did return to those memories he experienced them as if they were happening all over again. Furthermore, his deep sense of privacy, and the isolation that he attributed to his PTSD were challenged in the therapeutic setting. For some people, putting their demons on display to others is humiliating, rather than an act that bonds one to other members of a group. Kahlil explains what it is like when he is forced into revisiting the traumas he experienced during the war.

The impact of those kind of things [combat experiences], and they're so poignant right now - I mean like you know I'm sitting here right now and I could go into an emotional tizzy right now and start crying right now and it's hard, and I've learned to kind of control it sometimes, but it's just like you and I sitting here. I mean it's just as clear today as it was 40 years ago, so you don't realize that those kind of impacting statements are mentally ingrained in your mind. And you know that's what they talk about when you have flashbacks and intrusive thoughts. I can smell things sometimes, like burning; right away I gotta go somewhere. I gotta go sit down, or I gotta get away from that thing that's initiating those type of things.

Facing the memories then is a doubled edged sword; Treatment mandates it, but the experience causes the person to relive horrors they have tried to put behind them. It

makes sense then that some people avoid treatment of PTSD because it is just too painful. When treatment brings relief and instills coping strategies, the pain of revisiting the past is a necessary evil, but for those who continue to struggle after going through therapy, being forced to relive their traumatic memories only adds to their pain. It can be seen as just another insult of many. Just as researchers have been unable to determine why some people develop PTSD in the face of trauma and others do not, the same is true when it comes to treatment of the condition. For some people, treatment relieves symptoms of the disorder, but for others it does not.

Still for others there is a middle ground. They do not exactly embrace, nor resist treatment. For veterans who feel that the VA does not operate in their best interest, delayed diagnosis can provide more evidence to support that perspective. For James, diagnosis was additional evidence that the VA had “jerked him around” and “thrown him out” when they no longer needed him. He continues to believe that the military uses soldiers until they have used them up.

These kids coming from Iraq... They done jerked the ones who came home from Dessert Storm... there are people homeless. You got Vietnam veterans from 1970s living in the street. It's 2007. I think there's something wrong with that picture.

The distrust that many veterans have developed toward the VA is in itself a deterrent to seeking treatment from the VA and can color the experiences of any therapeutic course as well. In James's mind, the VA was responsible for many lost years in his life. He tried to get help when he first returned home, and later he tried to stop using drugs on his own



because he was unaware of resources available to him. When he finally learned from the only people he believed he could trust in the world, other veterans, that there might be a place where he could get better he listened, but he also had to submit himself to the organization he felt had worked against his best interest for years.

In this second phase then we see a variety of responses to diagnosis, as well as variability in the degree to which individuals embrace or reject treatment. In line with Conrad and Schneider's (1980) work, we see evidence that medicalization of problems extends a sense of hope for recovery, at least for some people. It can also lead to an understanding of one's circumstances. For James, finally being able to name his problem reinforced resentment towards the military establishment and the government. Despite this, it did afford him the knowledge that in order to overcome his drug addiction, he would have to address other underlying factors. Differing from Goffman, we see variability in responses to diagnosis and treatment. Reasons for this are expanded upon in the discussion.

### Stage Three: Post-Treatment

Goffman suggested an ex-patient stage, but did not examine it in his study. This section aims to recount different outcomes in the Post-Treatment phase. Variation in outcomes is the norm. Those who fare best are able to return to their lives and build on their time in treatment. This often involves finding work, using coping mechanisms to reduce stress and anxiety, and depending on the support of others around them when they need help. Some people do not have the good fortune of a support network waiting for

them upon their return. Unfortunately, it means they are often left to face the path of rebuilding their lives outside the treatment program on their own. This can be frustratingly similar to their extended efforts of rebuilding their lives after the military before they entered treatment.

Treatment can be life altering as Kahlil expresses here.

Last time I smoked a cigarette. Last time I used any narcotics. Last time I drank any alcohol. And that was it. It was over. I went there, like I said, I didn't go for 10 days I didn't for 20 days I went for 3 months and then even after that I stayed up [near the facility] for another 11 months in a therapeutic environment because, you know, by that time I was 35 years old and I just said, you know something's gotta give. You're getting a little older here. You know what I'm saying? I just – nothing was happening. I was just kind of making it by. Not grasping the essentials of life or something. I just didn't want to be like that.

Learning that he had PTSD allowed Kahlil to be more open about his problems, both with himself and the people in his life. Finally being able to label his condition helped Kahlil stop blaming himself and marked the beginning of his process toward a life of healthier living. Though his condition is chronic and he has returned to the same treatment facility multiple times, he has also made numerous positive changes in his life. Aside from abandoning drugs, alcohol, and cigarettes, he was able to keep a steady job, owned his own company for many years, and was able to complete the education program, where we met with academic honors. Since then, he has continued on to a four-year bachelor's program, where he has continued to flourish. His life was in shambles before diagnosis. But diagnosis and treatment set him on a path toward recovery. He began a healing process when he entered treatment in 1986, and the understanding that he

is dealing with a chronic condition means that when he is having trouble coping with the world, he has somewhere to turn. Kahlil is also fortunate to have a wife and children who have learned about his condition alongside him. This has provided him with an invaluable support system for facing the daily stresses of life, as well as the times when his PTSD has flared up and brought back the dark times in his life.

Unlike Kahlil, whose sobriety began the day he entered treatment, it took another 19 years for James to get “completely clean,” though there were periods of time during those years when he tried to stop using drugs. He stopped placing all the blame for his problems on his drug dependence and on himself as individual. He continued going to therapy off and on, and also began taking medications to help manage some of the symptoms associated with his PTSD. He also began to think about all the opportunities he had missed over the years since his return from Vietnam. Though it took him many years, his entry into the education program was an attempt to achieve something he long believed was out of his reach. Like Kahlil, he hit roadblocks; at one point he disappeared from the education program for two weeks before the staff could finally track him down and convince him to return. Ultimately he returned after he decided that failure only meant giving into the forces set in motion so many years earlier that he believed were meant to defeat him. His framing of the disorder differed from Kahlil’s. He felt that as a young, poor, Black man he was sent to war to die for a country that devalued his existence. PTSD was the legacy of that attempt. His motivation to stay off drugs and try to move forward with his life was an attempt to win that epic battle.

The most important impact of treatment for James, however, was that diagnosis made him eligible to claim remuneration from the VA, which he felt he deserved and had been unfairly denied for years. To him, formal recognition of his disability was at the very least a recognition that he made a sacrifice by going to war, a sacrifice that went beyond losing the tip of his finger. It also helped him to financially provide for himself and his family, which ultimately made him feel like a better man. Formal diagnosis of a service-connected disability allows veterans to begin the process of making claims to organizations like the Veterans Health Administration for healthcare services, and the Veterans Benefits Administration for disability payments. Medicalization has extended medical legitimacy to the psychic wounds of war and the government is therefore mandated by law to compensate them for their losses. This of course cannot solve everything, but it is something.

But for some veterans life does not get better after treatment. Whether this is because they refuse to adhere to the treatment, it does not work for them, or a combination of the two, these veterans are often left with an even deeper sense of despair than before. Having had hope of recovery waved in their face and then been denied the benefits, life can seem even more dire and hopeless. Some veterans' outcomes leave them in a similar state as before, but with a language of PTSD that they can use to explain their actions.

Paul never wanted to go to treatment, and he resisted therapy the entire time he was there. He had no interest in following up with therapy afterwards, but he did agree for some time to take medications prescribed to treat his PTSD, depression, and anxiety.

Eventually though he refused to take them. He dumped his pills because they made him feel “out of it, and not like myself.” One day he showed me where he threw them, and said, “look for something to start growing there any day now. I only take the meds before I go get my levels checked and then I take the full dose.” It is unlikely that the doctors were fooled by Paul’s scheme, but Paul thought they were. Paul felt more in control of his life when he was not taking the medications, even though he probably was not.

Additionally, for Paul, rejecting the medication was an act by which he affirmed his individual freedom even if it actually made him worse off. After learning that the cancer caused by Agent Orange exposure had returned, Paul claimed he was going out on his own terms – no more medications, no chemotherapy. This is further evidence of his refusal to submit to medical control; to accept the supremacy of medical knowledge was an act of abdication of his right to self-control; to him, it signified submission, compliance, and domination. Of course, it could also be seen as giving up on life.

While medicalization extends certain allowances to people who exhibit deviant behavior, this is not without limits (Fox 1977). The “sick role” (Parsons 1951) requires the individual to adopt the role of patient, accept the help of medical professionals, and actively work to get better. For instance, the sick person is supposed to cooperate with doctors, adhere to medication regimens, and actively participate in therapeutic treatments.

So long as he does not abandon himself to illness or eagerly embrace it, but works actively on his own and with medical professionals to improve his condition, he is considered to be responding appropriately, even admirably, to an unfortunate occurrence... (Fox 1977:15).

One can view Paul's story as both abandoning himself to illness and at times eagerly embracing it. He was clearly a non-compliant patient and went against doctors' orders as if it were a sport. But for Paul these actions were likely his only ways to maintain a modicum of control over his own existence, despite the fact that his actions were ultimately self-defeating.

After the doctors found lesions on many parts of his body, Paul agreed to undergo surgery to have them removed. As a result he was spending a lot of time at the VA hospital.

I feel sorry for the person who crosses me wrong now, because my PTSD is over the top. There's no real proven treatment for this cancer because it grows below the skin and it's not an area with a lot of blood flow so chemo isn't that effective and radiation doesn't work because there's no set spot where it is to aim at. And I'm done taking all that [psychiatric] medication they give me. I am going out on my own terms... When I was up visiting Roger (another veteran in the program who had just had surgery), I totally PTSD'ed out on the doctors, and they called the VA cops to the floor. Those cops couldn't handle me, but they are federal cops, so they weren't going to call the city. I was a raging bull.

Here again, we see Paul mobilizing his diagnosis of PTSD to explain his actions. A negative element of the medicalization of deviance is the "dislocation" of responsibility from the individual (Conrad and Schneider 1980). There is no doubt that Paul was angry, and understandably so, but his behaviors were unacceptable, and he attributed them to his PTSD. This is not only negative because it can be seen as an excuse for not behaving in an appropriate way, but also because it may be shifting the locus of anger away from where it should be aimed. Was Paul's anger caused by his PTSD, or was he angry because of something much deeper? When Paul learned that his cancer had returned, he

faced his own mortality in very real terms. Yelling and screaming at doctors and the refusal to leave the hospital were about more than his PTSD being out of control. In this way, PTSD was a mechanism of diversion and diffusion. Paul was angry because he was dying before he was ever able to recover from war.

A week after the surgery to remove the lesions, Paul and I sat down on our bench outside the library and I asked him how his recovery was going. He said he was doing “pretty well.” He was on campus the day after the surgery limping around the [program] office with a cane. He told me he was determined not to let people who have written him off be right. So he was back talking to the program director and using the computers that very next day, despite orders from his doctor to rest. “I’m recovering well from the surgery, but I’m not in a good place. I feel like I am slipping back into my hole,” he told me., Paul had stopped talking to the people in his life except for me and his Alcoholics Anonymous sponsor.

I am about to lose it. I was slipping before the surgery. I felt like this before then too. Greg, Roger and my sponsor Larry are all worried I am going to crack up and lose it. I feel myself slipping. One sign is I’ve been giving things away to my kids since I saw them a couple weeks ago. I’m not planning on offing myself, but when I feel like this I go back to certain tactics associated with my PTSD, like traveling light, and not ever getting weighed down with things since you never know when you’ll have to move on.

Then the conversation shifted.

Paul: Ever since I stepped off that plane from Vietnam I was a shattered person. Everything I believed in was shattered. I am so tired of being a fake person, and feeling like I don’t belong.

Me: What do you mean by fake?

Paul: You gotta fake it 'til you make it. Well I'm really tired of it. I don't want to die, but just want to feel normal – a part of this world. I have tried everything: forgiveness, understanding, alcohol, therapy - and none of it makes it right. I keep wondering how long it is going to take, and if it will ever happen.

Paul left the program only a few weeks after this conversation. He told me he was going away, going to disappear, going out on his own terms. About a week before he disappeared he told me he had gone to visit his family. “They really don't have any idea what's going on. They believe that the doctors can fix anything that goes wrong. They have no clue.” He said he told his sons about the cancer, but he could not bring himself to tell his daughters because it would get to him too much. “I had my boys tell my girls. One of the boys handled it pretty well but the other was really upset.”

The last time I ever saw Paul was a chance encounter at the library. I recorded this fieldnote later that night.

He came through the turnstile and I asked what was going on. He said this was it for him. He has moved out of the house where he was living. I asked him where he was going, but he didn't answer me. I told him to be careful. I was worried. He said he was planning on writing me one more email before he left and I said something like, “good, well we will be able to stay in touch that way.” He said, no, that he was shutting down the account, and I asked him why. He just said he wouldn't be needing it anymore.



None of the other veterans saw him again either, nor did the program director. I sent an email a month later that went without response. Paul had disappeared.

While Goffman did not examine what he referred to as the ex-patient phase, his idea that institutional arrangements and one's position in the social world mediated behaviors, identity, and self-image is evident in this section of the analysis as well. While all three men continued to struggle with their chronic PTSD after leaving treatment, they returned to different social situations. Kahlil, who embodies the most successful path, still struggled with his PTSD, but he had a strong social support network, and a religious community in which he immersed himself. By letting his family in, and having them learn about his problems they were able to support him. He was also able to minimize his "dysfunctional behaviors" and find work. Owning his own company gave meaning to his life as well. This structure helped Kahlil deal with his internal demons.

Perhaps the polar opposite outcome is that embodied by Paul: failed treatment, further alienation from family, unemployment, bouts of homelessness, and social isolation. These events, and the ever-present feeling of having lost everything only reinforced his despair. He was so detached from the social world that eventually he was literally able to disappear entirely.

#### Relevance of the Model in the Post-Vietnam, Post-Medicalization Era

Though this model was developed based on the accounts of Vietnam era veterans there is compelling evidence to believe that it may apply, perhaps in a modified form, to

veterans of the latest wars. Medicalization has led to an expansion in services available to soldiers and veterans. It means that some soldiers will seek help early on and receive accurate diagnosis. The hope is that medicalization will mean fewer people languish for years before their problems are addressed and their needs are met. But many of the experiences of dealing with PTSD remain constant across cohorts of veterans.

For example, Shawn served in the Marine Corps and spent more than two years in Iraq as a part of Operation Iraqi Freedom. I recorded this fieldnote excerpt after a lengthy discussion we had one afternoon. It offers a more current reflection of the soldier's return home. In contrast to Vietnam veterans who returned home before PTSD was a recognized medical condition, today all soldiers are screened for signs of mental health problems when they return from deployment. This excerpt, however, shows how many soldiers avoid revealing difficulties they might be having. Furthermore, it is quite possible that because PTSD often has a delayed onset, demobilizing soldiers will not immediately experience symptoms of PTSD.

I asked Shawn whether he received any transitional guidance, information, etc. when he got back to the United States from Iraq. His response was that he received a lot of paper work. When asked whether it was helpful, he replied "absolutely not." He explained that they threw all kinds of paperwork at him once he arrived back in the U.S., but all he was thinking about at that point was getting out and going home. He said his attitude was that he "would deal with it later, and didn't give a shit," because at that moment all he cared about was getting out.

We might ask, who of sound mind, following a lengthy deployment would voluntarily admit to having problems if it would result in being required to remain on a military base for extra time? Kahlil and James both spoke specifically of the rapid transition from war

to home. This remains a reality for modern soldiers. Shawn spoke of a honeymoon period, which was then followed by a period where the pressures of home such as looking for housing and work, the loss of camaraderie offered by other soldiers who understand what you have lived through, and facing the difficult realities of his time at war set in.

Like many veterans with PTSD, Shawn had trouble sleeping when he got home. He turned to alcohol as a sleep aid. He would “put away a six or a twelve [pack of beer], or maybe more in a night to be able to get some rest.” This seemingly destructive, counterproductive, irrational behavior might be seen as completely rational given Shawn’s circumstances. Up every night, unable to sleep, and alone, drinking was a way to escape and eventually pass out. It was his way to cope with the troubles of his untreated PTSD.

The following fieldnote exemplifies war inverting rational and irrational behaviors and reactions. Such inversions can lead to dysfunctional and taxing behaviors for the veteran in life following combat. The hyper-vigilance required in a war zone becomes a symptom of a disorder (PTSD) when the veteran is unable to stop having such reactions. Here we see how actions, responses, and behaviors are often in direct opposition to each other in civilian and military life. Skills and adaptations that are needed to stay alive in combat become dysfunctional when the soldier returns home. Rational behaviors in the theater of war are irrational in the civilian world.

Veterans are often overly aware of their surroundings. This was a survival technique in war, but seems like an overly paranoid awareness in the “normal” civilian world.

Shawn knows when he walks into a building how many people he passed along the way, where they were standing, etc. He hates driving. He checks every window he passes and hates stopping. Soldiers in Iraq are under constant threat of IED [improvised explosive device] attack and one of the most common ways for this to happen is on the road. He says when he drives he’s really anxious and there’s nothing he can really do to stop it.

We talked about living with the fact that you could die at any moment and the stress of that reality. When he was first in Iraq he was so busy that he never really had time to process what was going on. Then [his unit] moved to Fallujah and when he got there he looked around, took in the situation, and told himself, ‘I might die here. Okay, there are worse places to die.’ He said that and then just moved on. He detached himself from that reality, or rather made himself okay with it, in order to survive the reality in which he was operating.

In a war zone, life depends on hyper-vigilance. It is an essential skill. But when it carries over to life at home and cannot be turned off it is no longer a skill. In fact, it can become debilitating. Furthermore, the normalization that death might come at any moment changes the stakes of everything else for the returned soldier. To accept that you may die at any moment, and to cope by disassociating from reality is profound. It impacts the lens through which the individual perceives realities of everyday civilian life upon return. Emotional detachment is a survival mechanism in the war zone, but when it carries over to civilian life it is problematic. Things that seem extremely important in the civilian

world, like showing up to work, or getting to class on time, may suddenly be rendered meaningless and trivial; the mundane becomes inane in the face of the past. In many ways, Shawn's story is not all that different from those of the Vietnam era veterans.

In the current era, soldiers learn about PTSD before discharge. Mental health providers are issued clinical guidelines and receive training on recognizing and treating PTSD, treatment is available for individuals and their families, and compensation is available as well for people who are incapacitated by its effects. But this does not necessarily mean that soldiers and veterans will seek help, or even recognize the need for it within themselves. The barriers to care such as social stigma, an ethos amongst soldiers that discourages complaining and signs of weakness, and cultural constructions of masculinity remain. Furthermore, for many people, the symptoms of PTSD work as a deterrent to seeking treatment. The fact remains, as evidenced in the Treatment and the Post-Treatment phases, that responses to treatment and outcomes vary greatly.

Many veterans spend years struggling before they are aware that they are not alone and that what they are experiencing is not uncommon. Even if they have heard about PTSD, they do not necessarily make the connection that their "personal problems" are in fact more than just reflections of personal weaknesses and flaws. Furthermore, stigma surrounding mental health conditions, cultural notions of masculinity, and the persona of the soldier/veteran, all decrease the likelihood that veterans will enthusiastically, or even voluntarily seek out care. The forces that work against the proclivity to seek help call for reexamination of policies, procedures, and programs of the Department of Defense (DoD).

Great strides have been made since the medicalization of war trauma as PTSD. The wars in Iraq and Afghanistan have brought increased attention and awareness to the problems associated with the disorder. That the DoD now screens every soldier returning from deployment for signs of mental health problems is a significant step forward. Recent increases in VA funding for mental healthcare, especially PTSD treatment programs and research, is also needed and commendable. But it is clear that many cases still go unidentified. We must wonder how many veterans with undiagnosed and untreated cases of PTSD continue to struggle everyday. Could more cases be identified and addressed, or perhaps even avoided if the military were to incorporate some form of reverse boot camp into the standard enlistment cycle? Perhaps such measures would identify problems earlier, ease the path to treatment, and also destigmatize the need for help.

Viewed from a life course perspective (Elder 1985), diagnosis and the knowledge it provides the veteran, can be a *turning point* that has widespread influence on the direction of life. A *trajectory* is a long-term pathway through the life course. *Transitions*, on the other hand, are short-term developments, such as entering or exiting the military, starting a family, starting a new job, or accessing treatment for a medical condition. These transitions are embedded in trajectories, and may also lead to turning points, or shifts in the life-course (Elder 1985:17). Veterans with chronic, unidentified PTSD are on extended trajectories often marked by frustration, failure, and persistent struggle. Before diagnosis, even though they may recognize there is something wrong, they lack a way to identify the driving forces behind their struggles. Receiving a diagnosis and entering treatment is often a turning point that may shift trajectories. Regardless of how

veterans with PTSD use this new information, and whether or not it helps them to get better, they are able to label their struggles; they can begin to contextualize feelings, behaviors, and their overall life situations. At the very least they have knowledge that can lead to an understanding of their situation. For the individual whose condition has no legitimate name, they often blame their struggles on themselves, personal weaknesses, or have general fears of insanity. But the power of medicalization is that when an individual finally seeks help, there exists a diagnosis that reflects what they are experiencing.

Whether they served before PTSD became a recognized medical condition or after, there are veterans who spend their lives wondering why they are the way they are. As in the examples above, they demonstrate behaviors and conditions that are now understood as classic symptoms of PTSD such as isolation, avoidance of situations that remind them of their traumatic experiences, being easily angered, or experiencing general numbing toward life and the things they may have been passionate about before war. They may become estranged from their families, be unable to hold jobs, or fail out of school. All veterans who have spent time removed from the civilian population must slot back into civilian life. For many that means returning to friends, families, and possibly jobs they left when they were deployed. Some veterans are never able to fit into the social role that is generally expected: some cannot hold a job, violence destroys families, excessive drinking and drug use are more frequent than in the general population. Their problems make it nearly impossible to function in the socially prescribed way.

It is impossible to know if people like Paul could ever have lives marked by health and happiness. It is normal to question whether Paul was just a broken person long

before he shipped off to Vietnam. Yet one aspect of Paul's story should not be missed. After Paul healed physically he tried to heal psychically. He hoped that by leaving the country and connecting with distant relatives he would find the space to begin his life anew. Getting away was not enough however. It is quite possible that earlier diagnosis and treatment would not have made a difference, but perhaps it would have helped. We cannot know. Though we cannot draw any definitive conclusions, it is fair to postulate that identifying and treating soldiers and veterans earlier would not cause harm. Medicalization increases the opportunities and likelihood that someone seeking help will in fact be able to identify the source of their problems, and hopefully be exposed to a therapeutic method that alleviates their symptoms and gives them tools to manage their condition.

## **Conclusion**

Goffman's model of the moral career of the mental patient suggests a standard path through which patients traveled. He attributed this to the fact that all mental patients passed through the same asylum, and were therefore subjected to the same institutional arrangements. Identities and behaviors were altered because of the institutional structure into which patients entered and were forced to surrender. The model developed in this work is not so absolute. Yes, all subjects were confined to the same residential treatment program, and operated within the confines of the VA medical system. In this model, which incorporates Vietnam veterans, all with minimal social capital, there is greater variability. This does not necessarily contradict Goffman's model. Goffman's lack of variation may be, at least in part, attributed to the nature of the treatment environment



itself. The majority of Goffman's subjects were involuntarily committed to the asylum, and the only way out was to submit the self to the demands of the institution. As we saw in the case of Paul, though he was involuntarily committed to the treatment program, he still had the freedom to resist its offerings once inside. His release was based on serving a period of time, rather than following the program and making it through mandated steps that would lead to release. The mental asylum was a harsher, more rigid institution than the modern day treatment program through which these veterans passed.

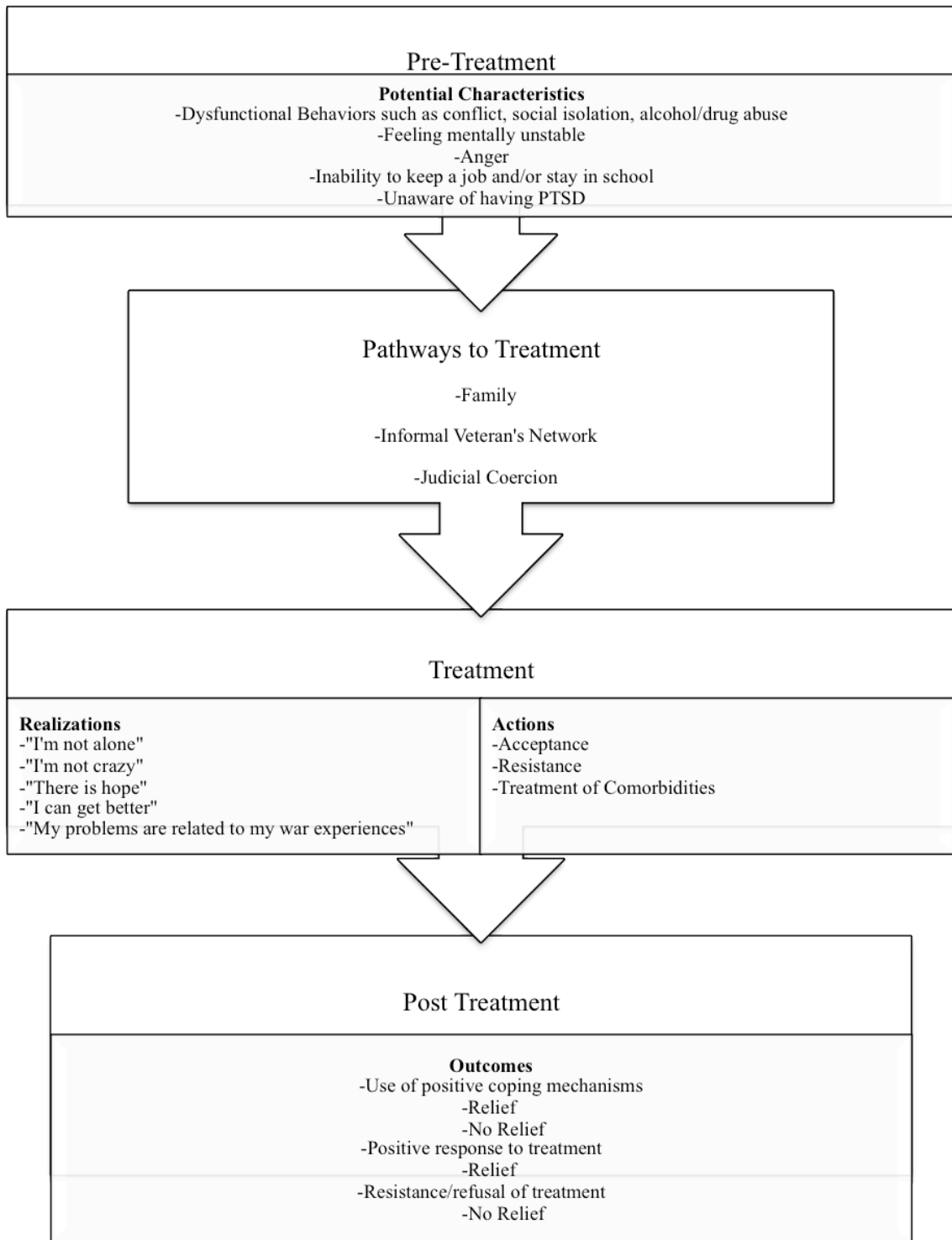
If identity and self-image are shaped in part by institutional arrangements and the broader social structure, then the variability present in the model created here should be expected. Furthermore, because this model incorporates the Post-Treatment phase, further room for variability is introduced, and this is reflected in the model. This is partly because treatment fails for some people altogether, and they are therefore not better off when they leave treatment. In fact, the disappointment of failure may place them in a worse state. Additionally, people often return to the same social worlds after treatment, as when they entered. Here then, we can expect outcomes to be in part influenced by the social arrangements of the individual on the outside. For people like Paul, who are alienated from their families and avoid social contacts and ties, there is less tethering them to the world that they would like to return to in order to "feel normal" again. But, for other people, with strong social networks, such as Kahlil, there are built in external supports for the individual as they work to move forward after treatment. Overall the lesson here is that treatment and outcomes are strongly affected by external factors in addition to individual, personal traits and dispositions.

Figure 2.1: Diagnostic Criteria for Posttraumatic Stress Disorder in Adults

- A. The person has been exposed to a traumatic event in which both of the following were 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.
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
  - 1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
  - 2. recurrent distressing dreams of the event.
  - 3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
  - 4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - 5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
  - 1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - 2. efforts to avoid activities, places, or people that arouse recollections of the trauma
  - 3. inability to recall an important aspect of the trauma
  - 4. markedly diminished interest or participation in significant activities
  - 5. feeling of detachment or estrangement from others
  - 6. restricted range of affect (e.g., unable to have loving feelings)
  - 7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
  - 1. difficulty falling or staying asleep
  - 2. irritability or outbursts of anger
  - 3. difficulty concentrating
  - 4. hypervigilance
  - 5. exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Source: Adapted from the DSM-IV-TR (American Psychiatric Association 2000)

Figure 2.2: Path of Posttraumatic Stress Disorder



## **Chapter 4. Bureaucracy and Classification Systems: An Organizational Analysis of Disability Claims Processing for Posttraumatic Stress Disorder**

### **Introduction**

This chapter addresses a problem faced by bureaucratic organizations whose primary function is to provide human services. Though bureaucracies have many advantages, especially when there is a need to standardize and execute large workloads, they have their weaknesses as well. In his description of the bureaucratic form, Max Weber (1978 [1922]) explained, “bureaucracy has a ‘rational’ character, with rules, means-ends calculus, and matter-of-factness predominating...” (p. 1002). To Weber, an advantage of bureaucracies was that the “‘objective’ discharge of business primarily means a discharge of business according to *calculable rules* and ‘without regard for persons’” (p. 975, emphasis in original). Today, bureaucracies remain the dominant administrative form, and are the ubiquitous model for government administration. While the ability of these organizations to function without regard for persons may ensure standardization of services rendered, there are times when bureaucracies do just the opposite. Rather than ensuring fairness, an advantage Weber praised in his comparison of bureaucracies to previous forms of administrative organizations, their weaknesses are at times injurious to the very people they are supposed to serve. In other words, when human needs comprise the business of the bureaucracy, and their problems are not objective, matter of fact, and clear-cut, but instead complicated, murky, and lack clear structure, bureaucracies struggle to efficiently and effectively carry out their duties. This paper demonstrates this weakness by examining the persistent problems the Department

of Veterans Affairs (VA) has in meeting the needs of veterans with Posttraumatic Stress Disorder (PTSD). By examining this particular case, I illustrate the ways that bureaucratic organizations that are in the business of meeting human needs are often strained by their own inherent weaknesses, which can lead to systematic failures and organizational breakdown.

Beyond its ability to demonstrate this particular limitation of bureaucratic human services agencies, PTSD is an important issue of investigation because it is one of the fastest growing diagnoses for which the VA is distributing disability compensation to former service members. Anyone who has received an other than dishonorable discharge from the military is eligible for disability benefits, if they can show that they have a disability that resulted from, or was aggravated by, their service. The Veterans Benefits Administration (VBA) is responsible for evaluating, processing, and administering all such claims. From 1999-2004 there was a 79.5% increase in the number of veterans receiving disability payments for PTSD (increasing from 120,265 cases to 215,871 cases), as compared to a 12.3% increase for all other disabilities during that time. During the same period, benefits *payments* for PTSD increased 148.8% from \$1.72 billion to \$4.28 billion. Compensation for all other disability categories increased by 41.7%. Veterans compensated for PTSD represented 8.7% of all claims, yet they received 20.5% of all compensation benefits (U.S. Department of Veterans Affairs, Office of Inspector General 2005). By March 2011, of the 3.27 million veterans receiving disability

compensation from the VA, 441,642 (13.5%) were receiving compensation for PTSD.<sup>14</sup> The rapidly expanding costs, as well as those not yet realized, require the VA to develop methods and procedures for accurately and efficiently anticipating, assessing, and remunerating PTSD claims.

Following a summary of Weber's work on bureaucracy, and an introduction to some basic ideas on classification and categorization, I provide information on PTSD, including diagnostic criteria, prevalence rates, common comorbidities, and VA approved methods of treatment. Next, I outline the process for submission and evaluation of disability claims. I then detail some of the specific problems the VBA has encountered in the handling of PTSD claims. The paper then moves to a detailed discussion of how bureaucratic human services agencies that rely heavily on tools of classification and categorization are at a disadvantage in effectively meeting the demands of their constituents. In particular, I demonstrate how the structure of the claims process, the broader procedural framework, and structure of the VA and VBA are problematic, which results in organizational strain, and constraints on the efficient and accurate handling of PTSD claims. This work is especially important because amongst disability claims to the VA, PTSD is the fastest growing in number and cost, and will continue to be, as veterans of the wars in Iraq and Afghanistan enter into the VA system.

The framework I use can be expanded to understand shortfalls in other areas of the VA, like the Veterans Health Administration (VHA), in dealing with PTSD. On a

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<sup>14</sup> Numbers current as of as of March 31, 2011. See VA Benefit and Healthcare Utilization table, available On-line at <http://www.va.gov/VETDATA/docs/Quickfacts/Spring2011.pdf>. Last accessed June 28, 2012.

broader level, the lens through which I examine particular problems surrounding PTSD disability claims can be expanded to other problems that have traditionally caused difficulties for the VA, especially minor Traumatic Brain Injury, which is another rapidly expanding disability category that the VA is struggling to manage. The constraints inherent in the bureaucratic organizational form, which are illustrated here, can be applied to understand struggles in bureaucratic organizations working to meet the needs of people with complicated, hard to classify problems. In sum, I argue the traditional responses of strengthening oversight, adding new rules and procedures, and attempts to standardize and regulate the claims process will not solve the problems. Such measures only introduce more of the same. Rather, to address problems that result from hard to define, loosely structured, amorphous conditions like PTSD there is need to create room for vagueness and flexibility instead of added stringencies.

## **Theoretical Framework**

### Bureaucracy

In his seminal work on bureaucracy, Max Weber (1978[1922]) wrote, “bureaucracy has a ‘rational’ character, with rules, means-ends calculus, and matter-of-factness predominating...” (p. 1002). Bureaucratic organizations are organized by the principle of fixed jurisdictional areas, ordered by rules, regular activities distributed in fixed ways, and authority attached to the position a person holds, which is generally granted to someone based on the possession of expert knowledge (p. 956). Furthermore, Weber writes, the management of the modern office is based upon written documents

(“the files”) (p. 957), and “precision, speed, unambiguity, knowledge of the files, continuity, discretion, unity, strict subordination, reduction of friction and of material and personal costs—these are raised to the optimum point in the strictly bureaucratic administration...” (p. 973). According to Weber, “bureaucratization offers above all the optimum possibility for carrying through the principle of specializing administrative functions according to purely objective conditions” (p. 975). Such “‘objective’ discharge of business primarily means a discharge of business according to *calculable rules* and ‘without regard for persons’” (p. 975, emphasis in original). The sheer size of the VA, its number of employees, national dispersion of personnel, offices, hospitals, outpatient centers, etc., the scope of its responsibilities, and the numbers of clients it serves, render it reliant on these organizational principles. Yet these characteristics, which generally permit such a large organization to function, do not come without weaknesses. The challenges PTSD poses to bureaucratic organizations and the weaknesses inherent in these systems that are exposed add to our understanding of how and why bureaucracies fail to effectively manage complicated, hard to classify conditions and situations..

### Classification and Categorization

To order the world around us we categorize and classify constantly. These practices can be informal or highly standardized, ranging from personal methods of organization, like sorting papers that accumulate on our desks, to multi-volume encyclopedias which classify knowledge in a standardized, ordered format. According to the *Concise Oxford English Dictionary* (2008), nosology is “the branch of medical science dealing with the classification of disease.” Medical reference directories like the



*International Statistical Classification of Diseases and Related Health Problems (ICD)* (World Health Organization 1992), or the *Diagnostic and Statistical Manual (DSM)* are used almost universally by medical professionals. Both are nosological classification schemas. The amorphous nature of PTSD poses difficult problems for these systems of classification.

Classification systems are not abject reflections of the world around us, however. Bowker and Star write that classification systems “embody moral and aesthetic choices that in turn craft people’s identities, aspirations, and dignity” (2000:4). In the case of nosology, medical conditions are defined and given legitimacy. Categories and classification schemas are often contested, but continue to be used and reified by professionals. As Andrew Young (1997) notes, psychiatrists often contest and criticize the DSM in their own practices, yet they also use its language amongst each other.<sup>15</sup> Though flawed, organizations could not coordinate their work without practices such as categorization and classification. Bureaucracies depend on classification and categorization to organize their work and coordinate duties across jurisdictional areas. When these systems breakdown they introduce additional problems for organizations. In certain cases, such as PTSD, classification schemas fail to create order and streamline work load. This is because such systems work to summarize and simplify, but as I show in the next section, PTSD is complex, amorphous, and multifaceted.

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<sup>15</sup> See Maser and Patterson (2002) for a description of the histories of the DSM and ICD classification schemas, as well as references to accounts of dissent and dissatisfaction evident in the psychiatric and psychological literatures.

In his examination of the effects of classification on clinical encounters, von Peter (2012) creates an analytical dichotomy in therapeutic approaches, the first of which he terms “classificatory” and the second “vague”. Based on ideas that classification in medicine homogenizes patient accounts and subsequent therapeutic paths (Conrad 1992) he argues that the need for “classification and regulatory power...” in institutional settings “might preclude open, creative and unconventional interventions and methods” (p. 153). To counterbalance the negative effects he introduces Schofield’s (2003) notion of “re-instating the vague”. Vagueness is the opposite of precision, but the two are not necessarily at odds. Instead they can be seen as dependent upon each other. To Schofield, the vague, while more complicated, provides space for dealing with stubborn, imprecise problems. This paper argues that Schofield’s call for “re-instating the vague” might be more fertile than instituting stricter rules and regulations and greater oversight not just in clinical practice, but in bureaucratic procedures as well.

## **Posttraumatic Stress Disorder: Diagnostic Criteria, Symptoms, Prevalence, Comorbidity, and Treatment**

### Diagnostic Criteria and Symptoms

PTSD is an anxiety disorder brought on by a *specific* traumatic event (American Psychiatric Association 1994, 2000). Individuals must exhibit multiple symptoms along six different criteria following exposure to trauma (See Figure 3.1 for specific criteria as defined by the DSM-IV-TR). Typical symptoms include the re-experiencing of the trauma through intrusive thoughts, flashbacks, dreams, and/or hallucinations, feelings of

reliving the trauma each time the person thinks or speaks about it, and avoidance of situations and people who are directly connected to the specific trauma. Insomnia, nightmares, numbing of emotions and feelings of doom, such as the end of life being near are also common. Individuals commonly exhibit hyper-vigilance, heightened startle responses, irritability, outbursts of anger, and difficulty concentrating. These symptoms often interfere with personal relationships, social interactions in general, and ability to function in the work place. PTSD is a *spectrum disorder*; there is no uniform experience or manifestation amongst people who have it. Symptoms and their magnitude vary within and between individuals. Though often a chronic condition, its symptoms can change in intensity over time.

PTSD is designated as an acute condition when it lasts less than three months, or a chronic condition if the symptoms persist for more than three months. Onset can be immediate, but can also occur months or years later. In cases where PTSD emerges after six months or more it is labeled as *delayed onset*; this is not uncommon. PTSD may also enter remission for lengthy periods of time only to reemerge years later. Research has shown that reemergence can be triggered by numerous factors including exposure to an event similar to the initial trauma, changes in stage of life such as retirement, declining health, or death of a loved one (Zahava Solomon and Mikulincer 2006; Markowitz 2007; Kaup, Ruskin, and Nyman 1994). Anniversary reactions to trauma have also been shown to trigger reemergence of PTSD (Morgan et al. 1999).

Prevalence, Comorbidity, and Treatment

People experience trauma at far higher rates than they develop PTSD; the specific etiology of PTSD is unknown.<sup>16</sup> Studies on prevalence of PTSD have failed to determine consistent estimates. Prevalence rates are comprised of two distinct measures. The first is *lifetime occurrence* of the condition; whether someone has ever experienced PTSD. The second, *current prevalence*, measures the proportion of the population currently experiencing PTSD. The National Comorbidity Survey (NCS) and the National Comorbidity Survey- Replication provide best estimates for prevalence of PTSD in the adult general population (Harvard School of Medicine 2005). These studies rely on methodologically rigorous design and a tested interview instrument, the Composite International Diagnostic Interview (CIDI), which allows lay-interviewers to perform accurate mental-health assessments. Diagnoses obtained from the CIDI correspond with official diagnoses obtained by mental health professionals. Despite high rates of trauma exposure in the general population, NCS/NCS-R places *lifetime prevalence* of PTSD amongst the general population at 6.8% overall (Harvard School of Medicine 2005). These data yield an estimate for *current prevalence* of 3.6%, just under half of lifetime rates. Research consistently finds that women experience PTSD at a higher rate than men.

PTSD prevalence amongst veterans differs from the general population.

Assessing prevalence rates of PTSD amongst veterans is more complicated because there is no comprehensive study like the NCS tracking the veteran population. Some studies,

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<sup>16</sup> Sixty-one percent of men and 51% of women have experienced at least one traumatic event in their lifetime, and 34% of men and 25% of women have experienced at least two or more (Kessler et al. 1995). In addition to combat exposure, the most typical forms of traumatic events include witnessing someone being injured or killed, being in a fire, flood or disaster, physical attacks, rape, sexual molestation, childhood neglect and/or physical abuse.

however, have begun to assess PTSD prevalence rates in Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (OEF/OIF) soldiers and veterans. The largest of these studies, the *Millennium Cohort Study*, is a Department of Defense (DoD) sponsored project being conducted to evaluate the long-term effects of military service. Launched in 2001 it has the advantage of following soldiers before, during, and after deployment. The study will run through 2022 and is comprised of four cohorts. The first from 2001 included over 77,000 soldiers, the second cohort (2004) included 31,000 soldiers, and the third and fourth cohorts were added in 2007 and 2011 adding over 103,000 additional study participants. Researchers have established baseline PTSD rates and compared them to PTSD prevalence in returning soldiers. At baseline 2.2% of men and 3.3% of women screened positive for PTSD (Riddle et al. 2007). Subsequent data revealed increased prevalence of PTSD amongst soldiers who *did not* test positive for PTSD at baseline: 3% of soldiers who had not deployed, 2.1% who had deployed but not experienced combat, and 8.7% of soldiers who had been deployed with combat (T. C. Smith et al. 2009).

A rise in rates for deployed soldiers who had seen combat is not surprising, but the rise in rates for those who deployed, but did not experience combat, and the rise amongst those who did not deploy at all are more curious. It is possible that at baseline some soldiers downplay psychological problems so as not to lose opportunities for advancement, or because of general fear of stigma. It is also possible that as enlistments come to an end, these initial fears would dissipate. Additionally, revealing problems at time of discharge can help soldiers officially document troubles, which may be helpful

later on for securing healthcare and disability compensation. Also, service members do not have to engage in combat to have traumatic experiences. Factors such as repeated exposure to the wounded and dead can lead to PTSD. Furthermore, Military Sexual Trauma (MST) is not uncommon. The authors of *PTSD Compensation and Military Service* (Institute of Medicine and National Research Council, Committee on Veterans' Compensation for Posttraumatic Stress Disorder 2007) reviewed studies on MST, and found consistent evidence that amongst service personnel MST was quite common, especially for women. Also common was the experience of sexual harassment.<sup>17</sup>

A 2008 study conducted by the RAND Corporation found PTSD prevalence amongst formerly deployed soldiers significantly higher than non-deployed soldiers (Tanielian 2008). Overall 13.8% of soldiers returning from deployment had PTSD. Rates are likely higher amongst the overall OEF/OIF population due to underreporting and the possibility of delayed onset. Even using the conservative estimate from the *Millennium Study* of an 8.7% prevalence rate, and given there are more than two million soldiers who have deployed during OEF/OIF, the increased incidence of PTSD is large. The influx of new cases into the VA has exacerbated problems already present in the system itself.

Unfortunately, comparing prevalence of PTSD across cohorts of veterans by era of service is difficult. Attempts must combine findings from many different studies. Often due to differences in study design, definitions and methods of assessing mental

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<sup>17</sup> For an in-depth discussion of research findings on MST and sexual harassment amongst service personnel, see *PTSD Compensation and Military Service* (Institute of Medicine and National Research Council, Committee on Veterans' Compensation for Posttraumatic Stress Disorder 2007:189–92)

health (interviews, assessment checklists, etc.) and other methodological issues the findings do not align in simple ways. In addition, cohorts vary greatly in terms of combat exposure, social and historical context, and the environments to which they returned. Furthermore there are no studies of prevalence of PTSD before 1980, when it first became a recognized medical condition. One result of this is there are no representative studies of Korean and World War II veterans and PTSD. This fact demonstrates the importance of standardization, classification, and definition, even in the research environment. PTSD is difficult for researchers in addition bureaucratic agencies.

Studies of Vietnam War veterans and Gulf War veterans demonstrate PTSD prevalence at rates higher than the general population. A representative sample of 3,061 Vietnam War era veterans interviewed for the National Vietnam Veterans Readjustment Survey (Kulka et al. 1990), conducted between November 1986 and February 1988, found a 30.9% lifetime prevalence rate of PTSD for men and 26.9% rate for women. Current prevalence rates amongst those veterans were 15.2% of men and 8.1% of women. Prevalence rates for Gulf War era veterans are closer to current estimates for OEF/OIF soldiers and veterans. Kang et al. (2003) surveyed 11,441 Gulf War era veterans between 1995 and 1997 using a PTSD assessment checklist and reported a current prevalence rate of 12.1%.<sup>18</sup>

Certain comorbidities are common amongst people with PTSD, especially psychological disorders and drug and alcohol dependence. Kulka et al. (1990) reported

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<sup>18</sup> Kang et al. (2003) used the PCL PTSD Assessment checklist. Further information on this method may be found in their report.

that 98.8% of Vietnam theater veterans with PTSD had a history of another disorder, as compared to 40.6% of those without PTSD. In studies of Vietnam era veterans with PTSD, social phobia, mood disorders, substance abuse disorders, and other anxiety disorders have been found to frequently co-occur with PTSD (e.g. Orsillo et al. 1996; Roszell, McFall, and Malas 1991). Other studies demonstrate high rates of major depression disorder and suicidality (Kramer et al. 1994; Campbell et al. 2007; Franklin and Zimmerman 2001; Ginzburg, Ein-Dor, and Z. Solomon 2010).

There is no standard of care for the treatment of PTSD, and no treatment that works on the majority of cases. In fact, treatment often involves trying different techniques with the hope that something will work (U.S. Department of Veterans Affairs and U.S. Department of Defense 2010b:97). Treatment is further complicated by the presence of co-occurring conditions. Clinical practice guidelines outline numerous psychotherapeutic, pharmacotherapeutic, and alternative interventions (such as acupuncture) for the treatment of PTSD.<sup>19</sup> For a system that depends on diagnostic codes and standardized procedures to execute its workload, this is especially problematic.

## **The Disability Compensation Claims Process**

Veterans seeking disability status begin by filing an *Application for Compensation* with the VA. The VA then writes the veteran and explains the necessary

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<sup>19</sup> For detailed information on the various treatments see *VA/DoD Clinical Practice Guideline for The Management of Post-Traumatic Stress, Guideline Summary, Version 2* (U.S. Department of Veterans Affairs and U.S. Department of Defense 2010a:42–50)



supporting documentation needed from the veteran for the claim to be evaluated. This includes granting releases to service-related medical records as well as records from private medical providers. The third step of the process involves a compensation and pension (C&P) evaluation by a VA physician. In the case of a PTSD claim, a VA psychiatrist or psychologist evaluates the veteran.<sup>20</sup> Following the C&P evaluation and completion of associated paperwork, the file is considered complete. A Ratings Veterans Service Representative at one of 57 VA Regional Offices (VAROs) then reviews the file and makes a decision about the validity of the claim. If they deem the claim(s) to be of merit, the Service Representative also assigns a disability rating that corresponds to the amount of monthly financial compensation the claimant will receive from the VA.

Disability evaluation is regulated by Section 4 of the Code of Federal Regulations Title 38: Pensions, Bonuses, and Veterans' Relief (38 C.F.R.). Services are dependent upon the severity of injury and related occupational and social incapacities. Disability review procedures, as well as guidance for specific injuries are defined in these provisions. PTSD falls under the section on the consideration of mental disorders.<sup>21</sup> Under this regulation, members of claims agencies are required to be familiar with the nomenclature of the DSM-IV as it serves as the basis of the rating schedule (38 C.F.R. § 4.130). While every medical condition is given its own code, unlike other types of injuries, mental disorders fall under a common rubric for assessing disability rating level,

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<sup>20</sup> For the worksheet for initial evaluation of PTSD, see *PTSD Compensation and Military Service* (Institute of Medicine and National Research Council, Committee on Veterans' Compensation for Posttraumatic Stress Disorder 2007:222–30)

<sup>21</sup> See 38 C.F.R. § 4.125 through § 4.130

the General Rating Formula for Mental Disorders (see Figure 3.2).<sup>22</sup> These generalized guidelines make no mention of the signature symptoms of PTSD such as intrusive thoughts, nightmares and flashbacks (Simonson 2008).

Following notification of the decision by the VA, the veteran has the legal right to appeal a denied claim, or the disability rating assigned to an approved claim. Such an appeal must be filed with the local VARO within one year of notification. Because the process is complicated, veterans are strongly encouraged to seek representation from Veterans Service Organizations (VSOs) throughout the process, and it has been shown that veterans who do so are more successful both in having initial claims approved and with the appeals process (Hunter et al. 2006).

### **Documented Problems**

The VA has come under scrutiny from Veterans Service Organizations, politicians, and the media for problems in its handling of disability claims for PTSD, such as errors in ratings and outright rejections of disability claims, even when veterans have been diagnosed by medical professionals as having PTSD. The VA Office of the Inspector General (OIG) carries out audits of VA programs, including evaluations of disability claims processing. There is a heavy emphasis on ensuring VAROs comply with procedure in adjudicating claims. Reports on these analyses often focus on whether

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<sup>22</sup> While the DSM IV is the standard by which symptoms are assessed and diagnoses are made, the VA has its own nosological nomenclature for classifying conditions called the Veterans Administration Schedule for Rating Disabilities (VASRD). The DSM IV code for PTSD is 309.81. Under the VASRD system it becomes disability code 9411 in the rating schedule.

VARO non-compliance is leading to overpayments or improper assignment of disability status altogether [for example see “Systemic Issues Reported During Inspections at VA Regional Offices” (U.S. Department of Veterans Affairs, Office of Inspector General 2011); “Review of VA’s Compliance with the Improper Payments Elimination and Recovery Act (U.S. Department of Veterans Affairs, Office of Inspector General 2012); “Review of State Variances in VA Disability Compensation Payments” (U.S. Department of Veterans Affairs, Office of Inspector General 2005)]. Most audits identify instances of overpayment, or times when raters have failed to accurately establish particular evidence of trauma.

The VA and some political actors express great concern that veterans may be defrauding the system. Malingering in the form of exaggeration or total fabrication of PTSD symptoms is a concern of the VA, and is a focus of C&P examinations. While great dishonor can come to all veterans with legitimate claims should non-deserving veterans dupe the system, even more insulting is the false accusation of malingering by the VA to a veteran with a legitimate claim. There is little evidence to substantiate the fear that malingering is in fact a serious problem (Institute of Medicine and National Research Council, Committee on Veterans’ Compensation for Posttraumatic Stress Disorder 2007). Overall, however, has led the VA to set the bar high for proving a legitimate claim.

On the other hand, individual veterans and VSOs have claimed that the VA is denying benefits to veterans with legitimate claims of PTSD. In a document submitted for a hearing before the House of Representatives, Subcommittee on Disability Assistance

and Memorial Affairs of the Committee on Veterans' Affairs, Paul Sullivan, Executive Director, Veterans for Common Sense (VCS) drew attention to the disparity in number of diagnoses of PTSD among OEF/OIF veterans and the number granted disability benefits for PTSD. He explained,

According to the most recent VA reports obtained exclusively by VCS using the Freedom of Information Act (FOIA), more than 105,000 Iraq and Afghanistan war veterans were diagnosed by VA with PTSD. However, only 51,000 Iraq and Afghanistan war veterans were granted disability benefits by VA for PTSD" (H. of R. U.S. Congress 2009:66).

Additionally, there have been accusations waged by VSOs, individual veterans, and VA employees of intentional malfeasance on the part of the VA/VBA. Whether or not the DoD and VA are actively trying to avoid diagnoses of PTSD is beyond the scope of this paper, but there is evidence that the problem exists, even if it is not occurring system-wide. One such incident that became the focus of a 2008 hearing before the Senate Committee on Veterans' Affairs, entitled the *Oversight Hearing on the Systemic Indifference to Invisible Wounds* centered on an email sent to staff members of a Texas VA facility, encouraging them to "refrain from giving a diagnosis of PTSD straight out" (U.S. Congress 2008). The testimony illuminates many of the complications of PTSD diagnosis. At the hearing, the author of this email along with leaders from the VA testified to clarify the meaning of the email in question and to address whether the VA was systematically depriving claimants of their lawful right to accurate evaluation and compensation. The author of the email, Norma J. Perez, Ph.D., a psychologist who served as the PTSD Coordinator of the PTSD Clinical Team at the Temple, Texas VA

Medical Facility testified that she was not trying to deny veterans the care and compensation which they were due. Perez testified that her intent was not malicious.

Combat stress is a normal reaction to abnormal events. It can occur immediately following an event or many years later, but in either situation, we stand ready to assist the veteran.

Combat stress can manifest itself in different clinical conditions, including PTSD and Adjustment Disorder...

All of our clinicians are trained to use the guidelines published within the Diagnostic Standards Manual-IV for clinical diagnosis of mental health conditions, including PTSD...

*Several veterans expressed to my staff their frustration after receiving a diagnosis of PTSD from a team member during an initial intake when they had not received that diagnosis during their compensation and pension examination. This situation was made all the more confusing and stressful when a team psychiatrist correctly told them, they were displaying symptoms of combat stress but did not meet criteria for the diagnosis of PTSD.*

Because veterans were receiving conflicting messages from the team, I thought it was necessary to provide further guidance. As an extension of ongoing discussions and to address the frustrations of veterans, I sent an email to my staff on March 20th emphasizing careful evaluation of a patient's symptoms to ensure consistent and accurate diagnosis... (U.S. Congress 2008:11-12, emphasis added).

Surely, this testimony could be written off as a VA official covering her tracks, but the content of the testimony itself illustrates some of the difficulties of PTSD. How can a clinician definitively prove or disprove the presence of PTSD? And with a condition where variability in severity of symptoms is the norm, could a person meet the diagnostic threshold for PTSD at one evaluation only to fall short of it at a later period in time? With certain illnesses this would be an indication of progress - that the patient was

getting better – healing. But with PTSD, the person could be even worse the day after the evaluation. PTSD is a moving target. Its inconsistency poses diagnostic challenges, which become particularly problematic when judgments regarding the assignment of long-term disability status and the allocation of financial compensation are at stake.

The case of Dr. Perez’s email was not an isolated event. Other cases have emerged alleging pressure being placed on clinicians by their superiors to refrain from diagnosing PTSD. For examples see the articles “I am under a lot of pressure not to diagnose PTSD” (De Yoanna and Benjamin 2009) and “Tale of the secret Army tape” (Benjamin and De Yoanna 2009). Furthermore, there are allegations that the military has been discharging soldiers and labeling them with preexisting psychological conditions to avoid assigning diagnoses of PTSD. Pre-existing conditions are not service-connected disabilities and therefore are not eligible for disability compensation (for example see “A Military Diagnosis, ‘Personality Disorder,’ Is Challenged” (Dao 2012).

## **Discussion**

Thus far, this paper has described problems the VA and VBA experience regarding the processing of PTSD disability claims, the specific nature of PTSD as a psychological disorder, and the specific process by which disability claims are adjudicated. Now that these problems and procedures have been described, we can contextualize them within their organizational environment and the nature of classification and categorization. Ultimately, we shall see that the nature of PTSD

exacerbates weaknesses inherent in bureaucratic organizations and classification systems. We shall leave the issue of intentional malfeasance until the end, and for now assume that these problems are the product of systemic failures instead. Afterwards, we shall briefly address possible motivations of organizational leaders, if in fact intentionality was at the root of these problems identified.

The Department of Veterans Affairs operates “the nation’s largest integrated health care system with more than 1,400 sites of care, including hospitals, community clinics, community living centers, domiciliary, readjustment counseling centers, and various other facilities” (Department of Veteran Affairs 2011:1). Furthermore, the VA conducts the largest education and training effort for health professionals in the country. In 2010, over 115,000 trainees received some or all of their clinical training at the VA. More than 65% of all physicians trained in the U.S. and 50% of U.S. psychologists have had VA training prior to employment.<sup>23</sup> Without mechanisms of classification, large bureaucracies could not coordinate their many activities. In such cases classifications serve as “objects of cooperation across social worlds” (Bowker and Star 2000:15), also referred to as *boundary objects* (Star and Griesemer 1989). As boundary objects, classifications travel between worlds while maintaining some constant characteristics which allow them to be mutually comprehensible. They are therefore both fixed and malleable. Categories and classifications can take on different meanings at different sites, all while creating a common language between different jurisdictions as well. The DSM is a boundary object within the VA bureaucracy. PTSD is a medical condition

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<sup>23</sup> Extensive information about the VA’s role in medical training of U.S. medical professionals available On-line at <http://www.va.gov/OAA/index.asp>

diagnosed by mental health professionals, an illness affecting individuals' lives, a classification demarcating disability, and a code which, if assigned by a VBA Rater, may entitle a veteran to financial compensation, medical services, and other benefits depending upon the degree of disability.

The malleable nature of classifications when serving as boundary objects means that they also lack concrete definition and therefore may be interpreted differently in different spaces. While the mental health profession sees the DSM as a guide, freely acknowledging its weaknesses (Young 1997), its diagnostic criteria may not be interpreted with such nuance in other arenas. In the case of disability rating assignment this is especially risky since the people tasked with assessing claims and assigning disability ratings are not medical professionals. At the same time then, these objects allow different groups, departments, organizations, etc. to work together and share a language, though specific interpretations and meanings and subsequent flexibility in adherence to definition may differ at each locale.

A fundamental weakness inherent to classification schemas is that they must simplify – erase nuance – in order to be all-inclusive. In *Seeing Like a State*, political scientist James Scott (1998) documents a variety of schemes meant to improve the human condition that failed because of their need to oversimplify. Scott illustrated instances where plans and classification schemas aimed to create order out of the disorder of everyday reality proved inflexible and ultimately failed. It is this sort of phenomenon we see in the failure of the military establishment to adequately handle PTSD, for PTSD is no simple disorder. Reliance on classification schemata like the DSM and the VBA's



General Rating Formula for Mental Disorders is mandated in the disability evaluation process, yet it is injurious at the same time.

There are numerous ways in which PTSD differs from other medical conditions. Table 3.1 shows the 10 most prevalent service-connected disabilities for which veterans received compensation in 2011 (U.S. Department of Veterans Affairs, Veterans Benefits Administration 2011). PTSD is the third most prevalent condition and differs from every other condition listed. It is the only condition that cannot be seen; there is no scan, no laboratory test, nor obvious physical alteration to the body (except perhaps some forms of Tinnitus).<sup>24</sup> Such invisibility poses problems of measurement and validation. These aspects allow the legitimacy of PTSD to be contested as a medical condition, generally, and as a specific diagnosis given to any patient, and also creates concerns for an organization like the VBA that patients might be exaggerating, or even fabricating their symptoms for financial gain.

Because there is no established biological marker, and no known etiology for PTSD, its existence, or conversely lack thereof, cannot be proven. Subjectivity is unavoidably built into the process of determining whether or not a person has PTSD. There is no absolute measure of the degree to which the condition impedes a person's social or occupational capabilities at any given time. Further complicating the problem is that PTSD is marked by high degrees of variability. Symptoms can ebb and return, yet

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<sup>24</sup> This is a problem regarding other *hidden injuries of war* common amongst those who have served in Iraq and Afghanistan. While major Traumatic Brain Injuries are visible with scans such as CT- scans and MRIs, minor-TBI is often undetectable with modern imaging technology. This paper does not allow for an in-depth discussion of this issue, but more information is widely available.

evaluations by physicians are done at discrete moments in time. Additionally, symptoms and limits on social and occupational functioning vary across individuals.

This variability is even evidenced in studies of prevalence rates. For example, one meta-analysis (Ramchand et al. 2010) reviewed 29 different published articles reporting prevalence estimates amongst OEF/OIF participants (deployed American and other Allied forces). Of these articles, 19 measured prevalence amongst nontreatment-seeking samples, and 10 articles examined treatment-seeking samples. Reported prevalence estimates for nontreatment-seeking samples ranged from a low of 1.4% to a high of 60%, while amongst treatment-seeking samples findings ranged from 5.2% to 50%. The authors attribute the enormous variance to numerous factors including, but not limited to, sampling method, composition of the sample (e.g. whether the service member faced combat during deployment), as well as sample size, the diagnostic tool used to assess presence of PTSD amongst individuals, the threshold determined to indicate PTSD when using such tools (e.g. how many symptoms must the person have to qualify as testing positively), and the amount of time that had passed since deployment. This problem is also evidenced by the difficulty in comparing prevalence rates across studies from other eras of service.

The consistent variability does not mesh well with systems dependent on uniformity, as is the case with the VBA in its assessment of disability compensation claims. The claims process itself is highly regimented. There is a standard order and strict procedural rules, dictated not only by VA policy, but also by federal law. While these regulations are meant to protect the veteran and ensure that claims are properly handled

in a uniform, fair manner, with conditions like PTSD this is at times harmful. A clear example of this is the VBA's reliance on the General Rating Formula for Mental Disorders (see Figure 3.2). In choosing to streamline all mental disorders for the sake of assigning disability ratings, the VBA is bound by a tool that often obfuscates rather than creates simplicity and clarity. Because none of the signature characteristics of PTSD is present in the General Rating Formula, raters are left to make choices, which are supposed to be determined by the very mechanism of a rating schedule. Combining a reliance on the DSM with the General Rating Formula only exacerbates the problems inherent in classification systems. While recent reviews of the VA's handling of disability claims have identified a need for raters to receive more training (Department of Veterans Affairs 2005; Hunter et al. 2006), it is unlikely this will completely resolve the problem. The fact remains that PTSD is an imprecise condition that does not behave well when held up to rigid classification systems.

The claims process poses additional problems as well for people with PTSD. Generally speaking, those veterans who are the most incapacitated by the condition will likely have the hardest time going through the process. The diagnostic criteria for PTSD (see Figure 3.1) can be seen as directly in conflict with the skills and perseverance needed to file a claim and see it through. The claims process requires veterans to build a docket demonstrating the presence of trauma. They must actively confront and present traumatic experiences, yet one major symptom of PTSD is the avoidance of thinking and speaking about events associated with the trauma. Additionally, a person with PTSD may be unable to recall aspects of the trauma, which could potentially damage the credibility of

their claim; difficulty concentrating, disinterest, emotional numbing, and intense psychological distress in recounting events all work against the veteran filing a claim. And for someone who goes through the initial process only to have their claim rejected, there may be intense feelings of being disrespected, insulted, and dishonored.

The disability assessment process poses challenges for clinicians as well. Making a determination of whether the claimant has PTSD and whether there is evidence the condition is linked to service-connected trauma is not their only job. C&P examiners must also assess comorbidities. In doing so they are required to determine whether veterans who present with drug and alcohol problems can attribute their dependence to service-connected disorders, or whether the drug and alcohol abuse would have been present regardless of the service-connected condition. Here then is another example of subjective judgments entering the process by which the determination of benefits is made.

VA is prohibited by statute, 38 U.S.C. 1110, from paying compensation for a disability that is a result of the veteran's own ALCOHOL OR DRUG ABUSE. However, when a veteran's alcohol or drug abuse disability is secondary to or is caused or aggravated by a primary service-connected disorder, the veteran may be entitled to compensation. See *Allen v. Principi*, 237 F.3d 1368, 1381 (Fed. Cir. 2001). Therefore, it is important to determine the relationship, if any, between a service-connected disorder and a disability resulting from the veteran's alcohol or drug abuse. Unless alcohol or drug abuse is secondary to or is caused or aggravated by another mental disorder, you should separate, to the extent possible, the effects of the alcohol or drug abuse from the effects of the other mental disorder(s). If it is not possible to separate the effects in such cases, please explain why (Institute of Medicine and National Research Council, Committee on Veterans' Compensation for Posttraumatic Stress Disorder 2007:234, emphasis in original).

Ultimately, subjectivity cannot be removed from the PTSD disability assessment process.

Intentionality?

Accusations of outright systemic malfeasance on the part of the VA/VBA are likely overstepping the reality of the situation. However, there is great incentive for people concerned with long term costs to try and limit the number of cases the VA/VBA deem worthy of disability compensation. Not only is PTSD the fastest growing disability for which veterans are being compensated, but it is also disproportionately expensive. The inability to derive accurate prevalence rates is not a problem confined to the jurisdiction of researchers. The VA depends on actuarial estimates for budget requests and funding allocations. There is also reason to believe that there are factors which lead to underestimates of the numbers of veterans with PTSD, even in studies credited with providing the most robust prevalence estimates. Aside from evidence that in some locations VA physicians have been discouraged from assigning PTSD diagnoses, it is also likely that many people with PTSD do not seek treatment, or disability compensation. Mental health conditions remain highly stigmatized in our society, and asking for help for such problems is in opposition to cultural constructions of masculinity and the brave soldier.

Even when acting in the best interest of veterans, the VA cannot ignore the looming, long-term costs associated with the rapid expansion of PTSD benefit payments. Granting PTSD claims is especially problematic, because it is a condition that is often

resistant to treatment. Furthermore, there is no protocol that the VA, VHA, and VBA can rely upon for treatment in hopes of curing PTSD sufferers and moving them off the disability rolls.

There are significant difficulties in categorizing the different evidence-based psychotherapies that have been found to be most effective for PTSD. There are a number of reasons for this difficulty, including the diversity of treatments available, a lack of a common terminology to describe the same treatment components, the specific ways in which similar components are manualized [*sic*] or packaged, and lack of consensus between proponents for specific treatments (U.S. Department of Veterans Affairs and U.S. Department of Defense 2010a:43).

Every step of the way, from diagnosis, through the disability claims process, to treatment, PTSD presents challenges to a system that relies on standard procedures and protocols. Classic characteristics of bureaucracies - precision, ‘unambiguity’, calculable rules, and ‘objective discharge of business’ - are all missing in the case of PTSD. The classification schemata the VA depends on to efficiently and consistently coordinate its responsibilities erase nuance and subjectivity in the face of a condition marked by vagueness, variability, and imprecision. Such factors complicate claims adjudication and expose constraints of the bureaucratic form. But organizations can incorporate ways of operating that step away from the need for precision if they are willing to embrace the potential of vagueness as well. As Schofield argues, the vague “constitutes a dynamic potential...[it] can entice and provoke – even compel – us to draw on its possibilities as a means of imagining alternative ways of organizing human affairs...the vague becomes a site of activity and novelty where alternative possibilities may be contemplated and tried out.” (Schofield 2003:329).

Why does Posttraumatic Stress Disorder continue to be an Achilles heel of the Department of Veterans Affairs? Despite celebrated improvements amongst other sectors of the VA system (Oliver 2007; F. L. Grover et al. 2001; Khuri et al. 1998), PTSD remains an area where the VA falls short (Burnam et al. 2009; Rosenheck and Fontana 1999). Even with increased attention, funding for research and programs, hiring of and training for employees, and increased oversight from organizational leaders and politicians, the VA continues to struggle to effectively treat and compensate veterans for the condition. PTSD differs from other common ailments amongst veterans.

Bureaucracies in their ideal form run best when human agency and subjectivity is removed. But dealing with a condition such as PTSD requires the ability to incorporate space for vagueness and human judgment. Though oversight, training, procedures, and regulations are important, they will not eliminate problems bureaucratic organizations face when their task is to deal with conditions that are not predictable. Such conditions shine light on an inherent weakness of bureaucracies and the introduction of added stringencies will not resolve this problem.

Table 3.1: Most Prevalent Service-Connected Disabilities for Veterans Receiving Compensation at the End of Fiscal Year 2011

Tinnitus	840,865
Hearing loss	701,760
Posttraumatic stress disorder	501,280
Scars	441,030
Diabetes mellitus	354,581
Lumbosacral or cervical strain	309,915
Limitation of motion of the knee	299,062
Hypertensive vascular disease	294,937
Traumatic arthritis	287,751
Impairment of the knee, general	268,320

Source: U.S. Department of Veterans Affairs, Veterans Benefits Administration (2011)



Figure 3.1: Diagnostic Criteria for Posttraumatic Stress Disorder in Adults

- G. The person has been exposed to a traumatic event in which both of the following were 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.
- H. The traumatic event is persistently reexperienced in one (or more) of the following ways:
  - 1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
  - 2. recurrent distressing dreams of the event.
  - 3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
  - 4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - 5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- I. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
  - 1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - 2. efforts to avoid activities, places, or people that arouse recollections of the trauma
  - 3. inability to recall an important aspect of the trauma
  - 4. markedly diminished interest or participation in significant activities
  - 5. feeling of detachment or estrangement from others
  - 6. restricted range of affect (e.g., unable to have loving feelings)
  - 7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- J. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
  - 1. difficulty falling or staying asleep
  - 2. irritability or outbursts of anger
  - 3. difficulty concentrating
  - 4. hypervigilance
  - 5. exaggerated startle response
- K. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- L. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Source: Adapted from the DSM-IV-TR (American Psychiatric Association 2000)

Figure 3.2: V.A. General Rating Formula for Mental Disorders

DEGREE OF IMPAIRMENT	RATING
Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships	70
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication	10
A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication	0

Source: Schedule for Rating for Mental Disorders, Code of Federal Regulations, Title 38: Pensions, Bonuses, and Veterans' Relief, Section 4. Available online at <http://ecfr.gpoaccess.gov/>.

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