

PTSD Is Not as Common in Vietnam Vets as Believed

BY ROBERT FINN
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A reinterpretation of data from a 1988 study of Vietnam veterans has determined that their lifetime occurrence of posttraumatic stress disorder is far lower than previously thought.

The reinterpreted analysis suggests that only 19% of those veterans had a lifetime occurrence of PTSD, and that 9% were suffering from the disorder at the time of the study, which was 11-12 years after the war. The original study, based on a representative sample of 1,200 veterans, calculated a lifetime occurrence of 31%, with 15% suffering from the disorder when they were interviewed.

The National Vietnam Veterans Readjustment Study (NVVRS) relied on self-reports by the veterans on whether they experienced traumatic events, and used the DSM-III-R definition of PTSD. The new study used DSM-IV criteria and estimated exposure to traumatic events by using independent sources, such as military personnel files, military archives, and newspaper and historical accounts (Science 2006;313:979-82).

Bruce P. Dohrenwend, Ph.D., of Columbia University, New York, and colleagues applied these new estimates of military exposure to 260 of the veterans who participated in the original study. As in the original study, the investigators found a strong dose-response relationship between combat exposure and the occurrence of PTSD.

They attributed the lower estimates of PTSD occurrence to two factors. First, they eliminated individuals in whom the index traumatic event occurred before or after their service in Vietnam. Second, whereas current DSM-IV criteria for PTSD require at least some degree of social impairment to establish a diagnosis, DSM-III-R criteria in the original study had no such requirement.

Critics of the original study charged that

the 31% lifetime occurrence of PTSD could not possibly be accurate, because only 15% of Vietnam veterans served in combat roles. And they said that the veterans' recall of their exposure to traumatic events could not be relied on, suggesting that access to veterans' benefits provided a motive for falsification.

The investigators involved in the reanalysis disputed both of those explanations. In comparing the self-reports of combat exposure with their objective measures, they found little evidence that the veterans falsified or exaggerated their experiences, they wrote.

For example, of the individuals judged to have low exposure to war zone stress by objective measures, 97% self-reported low exposure and only 3% reported high exposure. And of the individuals judged to have very high stress exposure by objective measures, 72% self-reported high exposure and 28% reported low exposure.

Furthermore, even though the conflict in Vietnam has been described as a "low-intensity" war for U.S. forces, it was not a conventional war with assurances of safety behind the front lines. Some military histories estimate that at least half of the veterans who served in Vietnam or its environs were involved in combat and could have been exposed to traumatic events.

"The message from the NVVRS has been that the Vietnam War took a severe psychological toll on U.S. veterans. Our results provide compelling reasons to take this message seriously," the authors wrote. Furthermore, they pointed out, similarities exist between the combat experience in Vietnam at that time and in Iraq now.

"Both have been wars without fronts, in which it is often difficult to tell peaceful civilians from enemy combatants," they wrote. "What has been, and can still be, learned about PTSD and Vietnam veterans should be applicable to understanding the psychological risks to U.S. veterans of the war in Iraq." ■

Early Poststressor Sleep Disturbances May Flag Later Posttraumatic Stress

SALT LAKE CITY — Sleep disturbances that occur in the weeks immediately after a stressor may predict later development of posttraumatic stress symptoms, data from a post-Sept. 11, 2001, survey suggest.

A total of 782 subjects from an ongoing Web-based research panel completed a measure of acute stress (the Stanford Acute Stress Reaction Questionnaire) 2 weeks after the Sept. 11 attacks, and also completed a posttraumatic stress questionnaire at 2 and 6 months after the attacks, Elaine T. Bailey, a graduate student in psychology at the University of Arizona, Tucson, reported at the annual meeting of the Associated Professional Sleep Societies.

Sleep disturbances, including trouble falling or staying asleep at 2 weeks after the attacks, had a small, but significant predictive value for development of posttraumatic stress symptoms at both 2 and 6 months after controlling for potential effects of preexisting anxiety, de-

pression, and insomnia. Data on these preexisting conditions were available for participants from their ongoing involvement on the Web-based research panel, for which they had completed a health questionnaire before Sept. 11.

However, after controlling for the effects of acute stress symptoms in the early period after the attacks, the findings remained significant only for development of PTS symptoms at 6 months, Ms. Bailey said. The average age of the group was 49 years. About half of the members were men. Demographic distribution of the group closely matches current U.S. census counts in terms of age, sex, race, and geographical region.

These findings raise the possibility that sleep disturbance in the period immediately after a stressor might exacerbate or contribute to the development of PTS symptoms, particularly in those who develop symptoms later in the posttrauma period, she said.

—Sharon Worcester

EXPERT COMMENTARY

Hindsight Is Not Always 20/20

Bruce P. Dohrenwend, Ph.D., and his colleagues claim in an article in Science magazine to have found that both the lifetime incidence and current prevalence of posttraumatic stress disorder in Vietnam veterans were lower than reported by the National Vietnam Veterans Readjustment Study (see story at left).

Dr. Dohrenwend and his colleagues arrived at their conclusion after a reanalysis of the NVVRS data reported by the Research Triangle Institute in 1988 (Science 2006;313:979-82). I was the main government official overseeing the implementation of the NVVRS as directed by Congress. It is clear to me that the authors' findings are flawed.

Three factors explain how they arrived at this conclusion: lack of understanding of the clinical course of posttraumatic stress disorder (PTSD), reliance on a weak measurement instrument, and misconceptions about the nature of military experience in Vietnam.

The authors begin their analysis of lifetime incidence and current prevalence (LI/CP) rates of PTSD by reducing the NVVRS estimates of 30.9/15.2 to 22.5/11.22 with neither explanation nor discussion in the article.

I have learned from an independent source that this came about because the authors arbitrarily excluded all those veterans whose PTSD was identified as having commenced before or after the war.

This ignores the fact that Congress by law required a determination of the extent of PTSD in Vietnam veterans, and that those thrown out by the authors had PTSD that might have needed treatment. This arbitrary exclusion also reflects a lack of understanding of the clinical course of PTSD and fails to take into account that war-related PTSD may be influenced by both prewar and postwar traumatic events and PTSD.

The authors further reduce the NVVRS estimates to 21/10.4 by excluding all those who showed a lower degree of impairment in functioning. Although they point out that level of impairment was not particularly addressed by the NVVRS, they make far too much of the one measure of impairment used by NVVRS, the Global Assessment of Functioning scale (GAF).

The GAF is a superficial scale designed for clinical, not research, use. As such, this scale is not suited for finding the degree of impairment in

war veterans with chronic PTSD; it fails to capture significant impairment. For example, some veterans with PTSD have marked impairment maintaining intimate relationships or, although they are able to hold a job, they may fail to thrive normally in work and career. Neither of those possibilities nor any other possible problems, such as nightmares, are grasped by the GAF.

Finally, the authors design an eight-factor formula that purports to "independently" document war zone trauma events reported by the veteran study subjects.

Eight of the subjects do not meet these criteria and are thus excluded, which lowers the PTSD estimates to 18.7/9.1. The nature of this formula and the way in which it is used by the authors demonstrate marked naïveté about the nature of military experience in Vietnam.

Their formula includes official combat service specialty, Purple Heart, Combat Infantry Badge, being in a company with one or more persons killed in action, Combat Medal, being in a high casualty division, being in Vietnam during the 1968 Tet Offensive, and being in an event reported in the New York Times or the Los Angeles Times.

The authors' naïveté is also shown by the fact that any veterans in the following categories with a significant likelihood of exposure to events causing PTSD might well not fit according to their formula: hospital medics; doctors and nurses in combat field hospitals; anyone serving in an installation that was shelled or even assaulted by enemy forces and where many were injured but no one was killed; troopers who served in a morgue handling dead bodies and body parts for as long as a year; and medics, surgeons, and nurses on hospital ships dealing with casualties for many months.

The eight subjects dropped by these authors probably had the traumatic experiences that they had reported. It would be interesting to personally interview them. Meanwhile, it seems the NVVRS estimates have withstood this most recent assault.

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