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We Owe Our Injured Military Veterans Good Treatment

It was with no small amount of distress and irritation that I read Sally Satel's piece on the recent loosening of military requirements for the diagnosis of post-traumatic stress disorder ("The Battle Over Battle Fatigue," Weekend Journal, July 17). Her writing comes very close to reinforcing the terrible practice within the military, among medical staff as well as service personnel, to see a PTSD claimant as weak, shiftless and flawed.

While the political in-fighting within the psychiatric community rages on, institutionally as well as ideologically, Dr. Satel's suggestions serve to highlight the great failure of the mental-health profession, veterans' agencies and the government in the diagnosis, treatment and management of the illnesses and conditions that our warriors suffer in defense of our nation.

With such failures in the provision of care of our veterans across both political parties, decade after decade, it is shameful that there is any pushback on expanding care for them. Since we have erred on the side of poor performance for several generations, what is the harm in moving the pendulum a bit to the good side of the equation? When it comes to PTSD, I'm willing to come down on the side of the warrior. It is a shame that Dr. Satel comes down on the political side of the equation.

Richard Bird

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In the 1970s, psychiatrist Chaim Shatan saw that traumatic war neurosis had been eliminated as a diagnosis by the American Psychiatric Association, that it hadn't been replaced by PTSD and that the psychological readjustment problems he saw among Vietnam veterans in rap groups were ignored by the Veterans Administration. In 1981 he told me that VA staffers considered his advocacy for post-Vietnam syndrome as "dishonoring the service" of Vietnam veterans.

By claiming that such advocacy leading to the diagnosis of PTSD was "part political artifact of the antiwar movement" and by arguing for treatment first, before application for disability compensation, Dr. Satel continues a decades-long tradition against U.S. financial compensation to veterans and their families who bear the mental costs of service.

Ron Bitzer

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From my experience as an Army psychiatrist in Vietnam from October 1972 to March 1973, as well as from my clinical experience treating veterans with PTSD for 16 years with the Veterans Administration, I came to the conclusion that just being in a war zone is often, though not inevitably, sufficient to produce PTSD symptoms, for in a combat zone there is always exposure.

For any of my colleagues who may doubt the authenticity of PTSD symptoms, I can assure them, from

personal experience, that they are real, involuntary, often intense and clearly have an impact on the social and occupational dimensions of life. I believe that the human body and psyche aren't made for war, so whether the psyche's responses are normal or not normal becomes a philosophical conundrum. PTSD from combat-zone experiences shouldn't be equated with PTSD from trauma events in civilian life, with the exception of PTSD in women subjected to rape. Daily life in a combat zone is different than a civilian event.

The real reason behind the objections to Veterans Affairs Secretary Eric Shinseki's decision is economic. The monetary cost of war extends long past the peace treaty, and how our nation deals with that economic cost is a measure of who we are as a people. We need to recognize the bravery and heroism that leads to the impacts on the body and psyche rather than seeing our servicemen and women as victims. The nation needs to remember why these condi tions occur, something stated most eloquently in the last words of the most famous of all addresses: ". . . so that government of the people, by the people, and for the people, shall not perish from this earth."

Dennis H. Grant, M.D., M.Div.

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The new regulations don't broaden the definition or criteria for PTSD but simply relax the evidence required for a veteran to establish combat-related stress. Instead of proving specific instances of trauma, physical or mental, the totality of combat-zone service may be considered. Veterans with Combat Infantryman Badges or Purple Hearts will no longer have to provide additional "buddy statements" or detailed descriptions of their stressors.

Unlike most civilian PTSD cases, which involve one specific incident, combat-related PTSD is often a matter of cumulative stress, including realistic, continuous anticipation of death or serious injury. In this regard, combat PTSD is the psychiatric equivalent of an orthopedic carpal tunnel syndrome due to repetitive trauma, rather than a broken wrist due to a single accident.

In the modern war zone, there are no safe areas or occupational specialties. Combat personnel are at highest risk, but everyone on base or in convoys is subject to rockets, mortars, snipers and roadside explosives. In Vietnam, helicopter mechanics routinely served as door gunners, and their successor mechanics and truck drivers have the same kind of duty on the ground today.

As a former Air Force flight surgeon and current VA psychiatric examiner, I think the new regulations are right on target.

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