

The “Trauma Pitch”: How Stigma Emerges for Iraq and Afghanistan Veterans
in the PTSD Disability Claims Process

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Posttraumatic stress disorder (PTSD) continues to be a highly stigmatized disorder for the veteran population and stigma continues to be identified as the main deterrent in treatment seeking. PTSD also remains the highest compensable mental health disorder in the Veterans Affairs disability system. Identifying how stigma emerges for veterans with PTSD may inform understanding of this phenomena and direct policy and procedure interventions. The author conducted a formative longitudinal qualitative study of Iraq and Afghanistan veterans, veterans’ disability claims officers and Veterans Affairs mental health providers to identify if and where stigma became a variable in the disability claims process and the effects of linking a PTSD diagnosis to compensation in relation to stigma. Data was gathered through semi-structured in-depth interviews and participant observation over 10 months. Stigma was identified in four inter-related areas: the structural level in the VA disability claims process, the individual level in interactions with VA service providers, and a social level in the public’s negative perceptions of mental illness diagnosis and government aid. Results based on veterans’ narratives suggest that the bureaucratic nature of the disability claims process requiring multiple repetitions of personal trauma, coupled with an institutional stigma of malingering, exacerbated PTSD symptoms. This influenced first time users of the VA by deterring treatment--seeking but was not found to affect veterans who had already initiated treatment. Ancillary to this, treatment seeking was negatively affected by public stigma surrounding new gun ownership laws that required background mental health checks. Despite the stigma experienced in everyday public life and at the VA veterans separated from military service still sought disability compensation. Veterans viewed this compensation as acknowledgment of their loss and validation of their sacrifice.

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Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that develops after life threatening events such as combat, crime, an accident or a natural disaster. People with PTSD may re-experience the event through intrusive memories, smells, sounds, flashbacks and nightmares, causing much suffering in their day-to-day life. Symptoms include avoidance of anything that reminds a person of their trauma, emotional numbing, difficulty concentrating, and physiological arousal such as hypervigilance and sleep disturbances (Institute of Medicine [IOM], 2012). These symptoms disrupt daily activities and influence ones ability to maintain relationships, learn new things, be gainfully employed, and feel purpose in life (Finley, 2011; Gutmann & Lutz, 2010).

After over a decade of military conflicts in Iraq and Afghanistan, the number of war veterans diagnosed with PTSD continues to rise. A recent military commissioned report (Army, 2010) showed that the number of newly diagnosed people increased from 2931 in 2004 to 10,137 in 2007, with only slightly more than half of them seeking treatment (IOM, 2012). Epidemiologic studies suggest that barriers to treatment involve a fear of being stigmatized as psychologically weak (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004; Greene-Shortridge, Britt, & Castro, 2007). To avoid stigmatization and status loss, many service members do not disclose mental health problems for fear of being perceived as incapable by leaders or unreliable by peers (Kim, Thomas, Wilk, Castro & Hoge, 2010). While this model of stigma for members in the military is well established, a model of veterans' experiences of stigma and PTSD in the civilian world is noticeably absent.

Veterans face different stigmas as they begin to reintegrate into a new social, economic and political context. This is a social context where disability ratings are often relied upon for support and survival in the same manner ones' squad and the military was relied upon at war. Recent qualitative studies in psychology (Caplan, 2011), sociology (Holyfield, 2011) and anthropology (Gutmann & Lutz 2010; Finley, 2011) illustrate that the PTSD label is necessary for veterans to claim benefits yet at the same time, this claiming of victimhood conflicts with the very values that military culture embraces (namely, physical and psychological strength and group loyalty).

The tragic irony is that the intent of the PTSD diagnostic label, created in the 1980s post-Vietnam political milieu, was to alleviate the suffering of veterans through providing public acknowledgement, granting financial compensation and reducing stigma (Young, 1995). 40 years later, in the midst of a military mental health crisis, the PTSD label remains a mark of stigma.

Stigma, as theorized by sociologist Erving Goffman (1963), is a process of stereotyping where negative labels (i.e. dangerous, crazy) are attached to a category (i.e. PTSD, veteran), thereby differentiating people as unusual or unacceptable. This "spoiling" of identity results in discrimination, loss of status and social exclusion. Stigmatization cannot occur without the social power necessary to transform stereotyping into negative consequences (Link & Phelan, 2006). In a health-related stigma context people often will hide their condition and forego treatment to resist these effects. This is especially true of conditions that are culturally perceived to have been caused by moral transgressions, are perceived as dangerous, and/or affect one's appearance (i.e. AIDS/HIV, substance misuse, leprosy, schizophrenia). Stigma can be so powerful that even when people want services and they are available, treatment is delayed, terminated or avoided. Not surprisingly, this exacerbates symptoms and transforms treatable and curable conditions into desperate cases and premature death (Keusch, Wilentz, & Kleinman, 2006).

Specific to mental illness, not only can stigmas exacerbate symptoms through treatment avoidance but they often create more suffering than the disease itself through a “cycle of stigmatization” (Sartorius & Schultz, 2005). This cycle involves a “marker” (behavior or label), which is loaded with negative content (from media, community members and personal experiences). The marker becomes the “stigma” and can lead to discrimination that leads to disadvantages in housing, employment, social networks, and healthcare. These setbacks can create a sense of social defeatism and damage a person’s self-worth. The added stress may intensify the person’s condition, leading to greater disability and thereby strengthen the marker, creating a cycle of stigma.

Disability benefits are one possible way of intervening in the stigma cycle. For example, Murdoch et al., (2011) found that veterans who received PTSD benefits had clinically meaningful reductions in symptoms and less poverty and homelessness than veterans who were denied benefits over the course of 10 years. These findings challenge previous studies suggesting that Veterans Affairs (VA) disability policies promote illness behavior and secondary gain (i.e. by exaggerating symptoms and participating in treatment to receive benefits or by staying ill to continue receiving benefits) (VA, 2005; Gold & Freuh, 1999). A recent review of research by the VA’s National Center for PTSD (Marx & Holowka, 2011) suggests that the balance of evidence implies these concerns are misguided and that disability compensation policy and practices may not promote secondary gain. Little is known however, about the role of stigma in this disability compensation (in VA terms, “claims”) process and the impact stigma has on VA compensation and pension (comp and pen) evaluation procedures. At the time of writing this report, only two studies were identified that provided links between the veteran population, stigma and/or disability compensation.

Sayer, Parker, Hintz & Rosenheck (2011), in their research on veterans’ reasons for seeking VA disability benefits for PTSD offer a glimpse into the connection between stigma and disability compensation. Their results showed that veterans who did seek disability benefits did so for tangible needs, to help clarify their health issue, as a form of recognition, and through the encouragement of trusted friends or professionals. Veterans who were deterred from applying for a service connection were concerned with negative public perceptions associated with disability and also with receiving government aid. This corroborates partly with earlier research done by Rank (1996) on welfare recipients from diverse ethnic backgrounds participating in various public assistance programs. He found that lack of privacy and social stigma associated with government aid partly drove recipients to exit from welfare.

A more recent qualitative study specifically focused on self-stigma (the internalizing of societal stereotypes) and treatment-seeking Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) combat veterans, reported that delayed treatment involved concern over being labeled mentally ill (and the negative consequences of that labeling) in addition to the public perception of being personally responsible for their illness (due to voluntarily joining military) (Mittal, Blevins, Corrigan, Drummond, Curran & Sullivan, 2013). Importantly, it was not self-stigma that deterred veterans but the perceived negative consequences that social stigma brought about. This study did not consider the links between pursuing a VA disability compensation and stigma.

In general there is scarcity of studies looking at stigma and the veteran population. Previous epidemiologic studies that address stigma as a barrier to treatment tend to focus on individual beliefs rather than external factors, such as the disability claims process. Recent qualitative studies, mentioned above, have provided rich narratives surrounding veterans’ experiences with posttraumatic stress and barriers to care yet none specifically focus on the impact of stigma or its relationship to claiming

disability benefits (in VA terms, “service connection”). This lack of research may contribute to overlooked opportunities for policy makers and interventionists to reduce PTSD disability among veterans. This formative qualitative study was conducted to help fill this gap through identifying how stigma unfolds for veterans and the consequences on disability. The primary objective was to: (1) identify if and where stigma became a factor for veterans in the disability claims process and (2) the effects of linking a diagnosis to compensation in relation to these stigma experiences.

METHODS

Context. The study took place in a Midwestern city at the local VA medical center, Veterans Benefits Administration offices, VA Domiciliary and three local veterans service organizations sites.

Methodology. A qualitative research design with a smaller sample was selected due to the preliminary and formative nature of the research. As a first phase in public health services research, qualitative findings can generate hypotheses that inform larger scale research studies such as population-based surveys. The advantage of qualitative methods at this phase in inquiry was the ability to identify where, when and how stigma experiences unfolded in relation to disability compensation. Additionally, it allowed for identification of the personal meanings of disability ratings for OIF/OEF veterans. Due to the lack of research in this area, these stigma processes could not have been postulated a priori.

An ethnographic approach was utilized to identify issues veterans encountered as they moved through the claims process. The benefit of this qualitative technique over others is that it takes place in the context of participants’ lives as they are engaged in service utilization. Ethnography combines participant observations (i.e. accompanying veterans to VA appointments), in-depth semi-structured interviews, and document analysis (i.e. VA screening tools/procedures). Collecting data at these three levels allows for establishment and confirmation of facts through constant comparison or triangulation. In studying sensitive topics, participant observation provides evidence that moves beyond the strictly psychological (what people say or forget to say) to the behavioral (what people do or do not do).

Participants. In order to accomplish the study objective, I carried out a prospective longitudinal study of Iraq (OIF) and Afghanistan (OEF) veterans (n=15, 10 men and 5 women) who were seeking or had a service connection for PTSD. One woman who was in the Army Reserves did not pursue a service connection because of her leadership status and fear of losing that status. Two other participant groups were interviewed during this time to gain a broader understanding of institutional practices and perspectives: claims officers and patient advocates (n=7) and VA health care providers (n=7).

Recruiting for veterans was accomplished through flyers at local veteran service organizations and through network sampling. Once the study had 10 participants a stratified purposeful sampling procedure was utilized to obtain more variability on categories of interest and to provide better representation of the OIF/OEF population. These categories included PTSD diagnosis and gender; underrepresented minority groups; military specialty (combat enlisted, combat officer, support enlisted, support officer) and; veterans’ military status (separated from military, enlisted in National Guard or Army Reserves). Recruitment continued until n=15 to account for dropout. Serendipitously, there was great variability in participants’ claims status including: PTSD service connection denied and claims being re-opened, claims granted, new claims pending, and old claims being re-evaluated for an increase in rating.

Four people dropped out of the study by not returning interview scheduling calls and one person died from drug withdrawal complications. Of these five participants who left the study, useful data was still

collected: two completed one interview and three completed two interviews. Of the remaining 10 participants (retrospective=6 and prospective=4), seven were men and all served in the infantry (combat) and three were women (technically “noncombat” although experienced combat). Of this sample one was a commissioned officer in the Marines and three were noncommissioned officers in the Army or Army Reserves; three were of ethnic minority status and; two participants were still working in the military (one in the Army Reserves and another in the National Guard).

Claims officers and veterans’ advocates were recruited through face-to-face meetings with leaders of veteran service organizations and through their network referrals. Four claims officers and three veterans’ advocates participated (n=7). Of these, seven out of eight were veterans themselves.

Recruitment of VA health care providers was accomplished through the generous support of VA clinical leaders. With this support I was able to conduct a presentation of the project at a staff meeting and recruited psychologists, a psychiatrist, a clinical psychiatric nurse, clinical nurse educator, clinical nurse social worker, and a chaplain (n=7). Over half the participants were veterans and all worked directly with OIF/OEF veterans.

Procedures. I conducted a series of semi-structured interviews focusing on the PTSD experience, diagnostic procedures and compensation process with all samples to identify variance in multiple perspectives. The claims officers/veteran advocates and VA providers took part in one interview lasting approximately 45 to 60 minutes (n=14). Each interview was transcribed verbatim and generated approximately 13 pages of single spaced text.

To identify how stigma surfaced for veterans throughout the claims process and the effect on their everyday life I conducted a series of three interviews that were administered over 10 months (n=30). The longitudinal study design allowed for capturing veterans’ experiences as the lengthy bureaucratic process ensued. On average these interviews occurred at two-month intervals. Interviews lasted anywhere between 30 minutes and two hours. The verbatim transcriptions generated on average 18 pages of single spaced text per interview.

Interviews focused on veterans’ thoughts surrounding their diagnosis, the experience of PTSD, the choice to pursue a disability claim and their experience in the process, and their experiences with treatment. The topics of stigma were addressed by *physical locations* (specifically healthcare settings), *sociological locations* (specifically in the interactions with service providers), and through the relationship of *diagnosis and compensation* (the claims process). To avoid leading the participants in their responses, questions broadly addressed these topics and probed for specifics through conversational strategies (i.e. “laddering” techniques where the interviewer consecutively asks “why” a person feels a particular way or “how” something is experienced through particular examples).

Interview guide questions were refined at certain intervals to include specific themes that were developing. When new questions were added, follow-up interviews included those questions for the participants who interviewed before those intervals. This ensured consistency across data collection. For example, as the new theme of ‘telling trauma stories to total strangers’ emerged I incorporated a set of questions on this topic midway through phase three of interviewing veterans. I included questions that focused on telling these stories, what veterans decided to disclose and why, and how this process made them feel. I then went back and had follow-up conversations with those participants who were not asked this specific set of questions. This refinement process also assisted in developing associations and testing emerging patterns in the data.

In a couple of instances, when a new theme developed early in the interview process (phase one) I elected to incorporate a new question in the next phase of interviews. For example, it was clear after the first interview with veterans that their worldview had significantly changed after being deployed to a warzone, affecting their perceptions of others and their reintegration into civilian life. As such, in the second interview I specifically addressed this change in worldview and asked veterans how this shaped their social interactions and general wellbeing. I then laddered these questions to drill down into specifics: for example, how did changes in worldview influence help-seeking and claiming disability? Interview questions were refined in every phase of veteran interviews (three times) and once in the provider interviews.

Interviews were accompanied by participant observation at the local VA medical center and service organizations where I engaged in informal interactions with veterans and providers. I was able to follow one woman through her claims process from beginning to end, accompanying her to her initial claims appointment and disability and compensation evaluation appointment. She also contacted me at every touch-point she had with the Veterans' Health Administration (VHA) and the Veterans' Benefits Administration (VBA). These observations and interactions were documented through field notes and processed on a computer. Approximately 80 pages of data were generated in these informal observations.

Through this combination of interviewing and participant observation I explored the radical shifts veterans made in their transition to civilian life and focused on the consequences of these shifts on their stigma experiences and their choice to pursue disability compensation. The entire project generated over 700 pages of data; however, for this study I focused specifically on those segments that addressed stigma and disability, the claims process, and the meaning of disability determination and ratings. I was able to narrow the scope of my data through filtering and isolating sets of data using qualitative software.

Analysis. Analysis began with a review of the data to create top-level codes. These codes described broad common themes in the data such as VA, PTSD experience, and social life. I then sub-coded excerpts of the data, under these broad themes, that related specifically to the claims process, stigma and disability. These sub-codes reflected participants' experiences. In comparing and contrasting these sub-coded categories across data sets I was able to identify patterns and the relationships between them (Denzin & Lincoln, 2005). The patterns that emerged were notated through analytical memos that were linked to the coded data. In using this constant comparative method and inductive and deductive analysis themes and variations of themes were discoverable (Glazer & Strauss, 1967). As interviewing, observations, and coding proceeded, new codes emerged and established codes went through revisions. The flexibility of this coding process allowed for new theories to develop (Hammersley & Atkinson, 1995). Coding and retrieval of excerpts was facilitated through Dedoose qualitative analytical software.

To ensure validity of data: 1) data was triangulated through comparing interviews, participant observation and official documents; 2) emerging theories were cross-checked with lead informants (veterans, claims officers and a psychologist) to confirm the representativeness in their experience and; 3) the most robust findings had to reflect categories identified in at least half of the participants in their respective samples.

FINDINGS

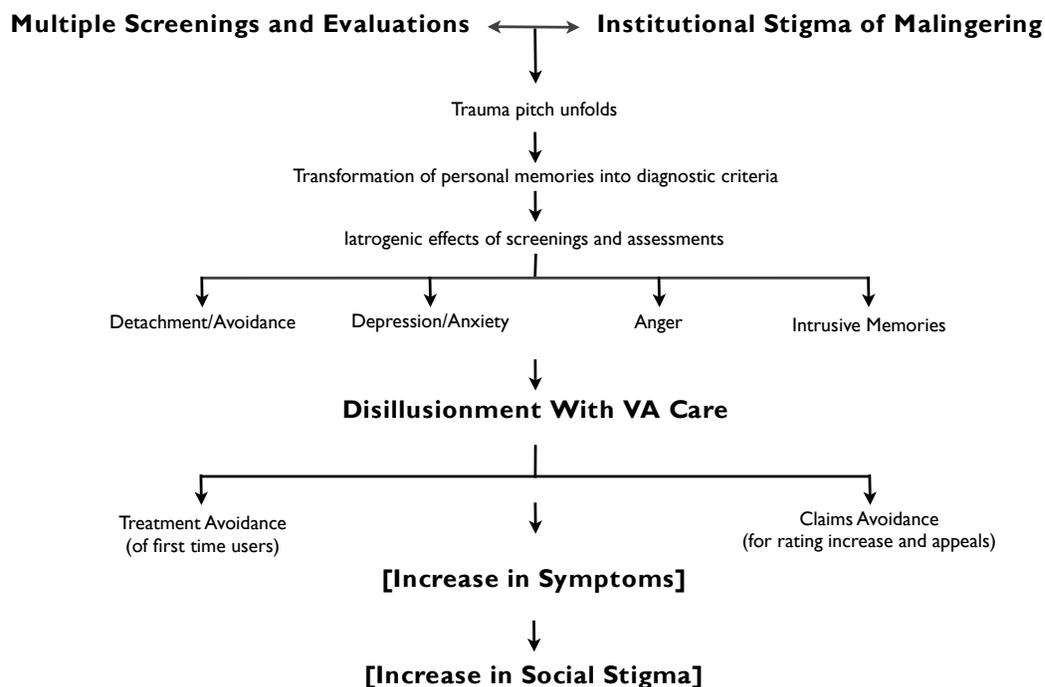
Stigma emerged for veterans with a disability rating or engaged in the disability claims process in two broad but distinct locations: bureaucratic Veterans Affairs (VA) life and everyday social life. I conceptualize VA life as the time spent at the local veterans medical center and navigating the Veterans Benefits Administration (VBA). This includes the many appointments veterans had to attend and related paperwork they were required to submit. The sheer amount of time that was spent in these activities, including waiting for responses and appointments, trying to assess what was needed in terms of paperwork (and collecting those items), initiating and undergoing treatment, understanding what was available to them in terms of services and benefits, and the emotional and physical energy these activities required, all make up “VA life.”

“Everyday social life” I define as the time veterans spent managing their persona in their social networks and in the civilian world. This included time spent with family and friends, going to school, hobbies, finding employment and housing, going to work and, in general, the process of reintegrating after military service. Social life and VA life interconnect and influence each other and will be discussed below. I also present the perspectives of claims officers and health care providers in support of, and as a counter-narrative to, veterans’ experiences.

In VA life, stigma occurred on a structural and individual level. An institutional stigma of malingering, coupled with bureaucratic process (structural level), was most notable and played out significantly in what I call the “trauma pitch.” This involved the multiple times veterans were required to retell their trauma (“stressors” in VA terms) during the claims process. Influencing and interrelated to the trauma pitch were the bureaucratic interactions veterans had with a variety of Veterans Health Administration (VHA) providers and Veterans Benefits Administration (VBA) compensation evaluators (stigma on individual level). I have provided a model, based entirely on veterans’ narratives, that illustrates how these interactions impact the stigma cycle through exacerbating symptoms (essentially, inadvertently creating more PTSD) (Diagram 1).

In everyday social life, stigma emerged in ways that were linked both to being labeled with PTSD and of being a recipient of disability compensation. This included the social stigma of being violent and unstable and of being a welfare recipient. (See Diagram 3.)

DIAGRAM 1: OIF/OEF Veterans' Perspective of Disability Determination Process and Effects



**VA Life: Systems Level
The Trauma Pitch**

“You’re being put on display having to talk about it every time. Basically you are being soul raped anytime you have to talk about it.” (Male, OIF veteran and claims officer)

To receive a service connection a veteran must have a diagnosis of PTSD. In this sample, veterans told recounted their trauma four to seven times in the disability claims process, depending on where they started. For example one veteran started at a Vet Center (a satellite of the VA) with a counselor and then was referred to the VA to ‘get into the system’ in order to file a claim and receive future services. Here he was connected with a service officer who helped him file for disability and medical appointments were set up. He told his story for the third time to a primary care provider who made an assessment and referred him for a traumatic brain injury (TBI) evaluation (with medical students observing). After the TBI evaluation he was referred to a psychologist for a diagnosis. Then, he saw a psychiatrist for medication. This veteran gave his trauma account six times to six different people. At minimum veterans see a primary care physician, a claims officer, a psychiatrist, a psychologist and finally a compensation and pension examiner (not necessarily in that order). A number of veterans also have clinical care coordinators or clinical social workers.

It is this process of retelling their story “multiple times to strangers” where veterans experienced a devaluation of their trauma that in turn undermined their relationship with treatment.

You just get sick and tired of telling your own story, it’s like a business pitch and you have to get it down... It’s like a performance. You act out everything except the event. I feel it detaches you from your memories. They lose meaning and you are a year fresh from it. And they’re

(providers) talking about it like it's out of a textbook and I'm still feeling the memories and experiencing the symptoms. (Male, OIF veteran)

Why would you want to talk to so many people about something that you are ashamed of to begin with? They don't know what it is like there so to them it is a diagnosis. To you it's your life. (Male, OIF/OEF veteran and claims officer)

The perceived moral judgment of medical providers and the shame veterans felt about their trauma made them hesitant to disclose the full details of their war experience. This was in spite of the understanding that ones disability percentage is "based on how messed up you are" (Male, OIF/OEF claims officer).

"I don't want to admit my most personal disabilities. I'm ashamed of what I did and especially ashamed of how it affected me to the point where I need help and then am labeled." (Male, OIF veteran)

I'm not going to tell a total fucking stranger the deep rooted feeling... how I lost guys... how I killed... that's part of who you are, you don't just tell these stories... you don't talk about traumatic stuff because it brings back bad thoughts and feelings. It's embarrassing to yourself." (Male, OIF veteran)

The process of having to tell strangers about their trauma created much discomfort for veterans and in their view, made their symptoms worse. After VHA/VBA appointments veterans expressed feelings of becoming "...withdrawn and want(ing) to be away from the world", of "...feeling bad about myself", and "retreating to the basement and not talking to my wife or daughter." One male veteran explained "... the evidence (of combat-related trauma) isn't there even though you have been going to the doctor there for HOW LONG?! It pisses you off and creates resentment. There is the anticipation of something bad (happening) again." As one female veteran put it, "The stress alone triggers my PTSD. I have to live it all over again... My blood pressure goes up, I start to sweat, I can't focus. I start thinking about that stuff. I can't sleep..." Another male veteran stated, "It would ruin my whole week, that one bad interaction. You feel vulnerable after that... I'd go back into my hole. That's why I don't go there (VA) anymore." These feelings that veterans experienced are consistent with the Diagnostic and Statistical Manual of Mental Disorders V [DSM-V] PTSD symptom criterion B4/5, C2, D2/6, E1/5/6 (VA, 2013):

- B4. Intense or prolonged distress after exposure to traumatic reminders
- B5. Marked physiologic reactivity after exposure to trauma-related stimuli
- C2. Avoidance of trauma-related external reminders
- D2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world
- D6. Feeling alienated from others (e.g., detachment or estrangement)
- E1. Irritable or aggressive behavior
- E5. Problems in concentration
- E6. Sleep disturbance

In addition to veterans' experience of symptom aggravation, the trauma pitch placed veterans' pride and identity at stake, making veterans "...clam up in the compensation and pension exam and as a result get a 10% rating when they deserve a 50% rating" (Male, OIF veteran and claims officer).

"...the stuff you see and do (at war) is not something you want others to see, people getting killed... you have a persona you have to keep. Pride is a big thing. Even if the person is a health

professional they are still human, they are still going to judge you.” (Male, OIF/OEF veteran and claims officer)

When I’m told to tell my story time and time again I try to downplay it. I won’t say how bad it was rather than tell all the details because I don’t feel like telling someone about the people that were killed, you know, dying moments. I don’t feel people deserve to know those moments. Those were my moments. I don’t want people to take that away from me, tell me how to think about it, how to feel about it. (Female, OIF/OEF veteran)

These “dying moments”, intense personal experiences of war, were not something veterans wanted to corrupt in any way. They hold significant meaning. Veterans cherished and took ownership of these experiences and although they lost loved ones they did not want to lose the fragments of their memories. And yet, these memories felt like they lost value upon every retelling: “Having to tell people over and over makes it fake, not real... it desensitizes you. I don’t want that to happen” (Female OIF/OEF Veteran). Altering the trauma memories in this way was a dehumanizing process that was experienced as insensitive care.

It’s a PERSONAL THING, it was terrible and it gets diluted when you keep having to tell people about it. And then it gets mangled by docs. They break it down into clinical terms and that takes away from the experience and the memories. You have honor and respect for people you get deployed with, then it gets turned into some med student project where they are matching up the symptoms with the diagram in their textbook. (Male, OIF veteran)

Memories particularly became corrupted in a technical manner through this transformation of personal experience into professional expertise (i.e. “checking boxes”). For veterans, this diagnostic process depersonalized traumatic events by turning them into quantifiable symptoms, scores, and statistics: “ I think they downgrade (scores) because they need positive evidence in light of the public criticism they are receiving... so now I’m a positive statistic” (Male veteran applying for an increase in PTSD disability rating and concerned about his score). One such scale, the Combat Exposure Scale includes questions like: “What percentage of the soldiers in your unit were killed (KIA), wounded or missing in action (MIA)?: (1) None; (2) 1-25%; (3) 26-50%; (4) 51-75%; (5) 76% or more” and “How often did you fire rounds at the enemy?” Depersonalizing experiences in this way contributed to the detachment that veterans already felt.

As experiences became “diluted” through every round of assessments, veterans unanimously expressed anger at the depersonalized bureaucratic process that was required for them to receive compensation. Veterans became angry both when they needed to tell everything in detail in order to get a high rating (with the assumption that the VA already had all this evidence in a medical file) and when the VA awarded them a lower rating than they thought they merited. 90% of veterans in this sample felt that the VA was not looking out for their interests, trying to “catch them in a lie” and “refuse them a service connection.” The claims process was described as “...very impersonal, I feel like they don’t care” (Male, OIF veteran). Another male veteran stated that when he went for his traumatic brain injury (TBI) test “...there were four med students in there, their trainer and my doctor. They were asking me questions and I felt like they were cross-examining me to see if my statement was the same (as my claim) and my story held up.” (TBI and PTSD have many of the same symptoms so often veterans will go through screening for both if they have had a head injury or were exposed to a concussive blast).

The continuous and multiple evaluations made veterans not only feel like they had to keep their story straight but more significantly, it made them feel like they had to defend their reactions to war:

I have to justify why I have an issue, why I feel the way I do. It makes you feel bad... I think they are looking for inconsistencies in the story... I go in one day and tell them I saw 5 IEDs (improvised explosive devices) and the next time they ask I say it was 3 IEDS... I betray my own convictions entering that building because I don't think the VA is in the business of helping veterans at the expense of these providers who are there to help... (Male, OIF veteran)

Providers struggled with the claims process as well, in particular, the need to generate diagnosis rather than treat symptoms. "The most painful experience of your life gets turned into a pain-scale and there is something really wrong and invalidating about that... they (veterans) know things about themselves we only know intellectually" (VA psychologist).

Some seasoned providers digressed from these screening tools to offer a more sensitive evaluation. The psychologists in particular felt that the parameters of these tools were very limiting:

...certainly I can check off boxes, I can record symptoms, but I feel like that, you know, by doing that you lose a lot of the qualitative richness of each persons experience... you lose some of these other contributing issues that are outside those check boxes like the guilt, the grief, the changes in identity and world view, and that I really, really, really, hate. (VA psychologist)

Veterans often expressed empathy for providers, viewing them as victims of the system. The impersonal nature of the VA was chalked up to "...people were overworked and just going through the motions." Despite this empathy for VHA mental health providers there was a general distrust and fear of incompetency on the part of VBA evaluators and the rating system in general. One particularly disparaging story sums up the anxiety and anger that the compensation process can generate:

She (physician doing the evaluation) wouldn't even look at me in the face and she was reading my file: "knocked out by IEDs, mortars." I had numerous concussions and she said there was not enough evidence. That's because I was infantry! Your corpsman (medic) would push out with 40 marines... that (incident) wasn't documented because I was not on base! We were getting shot at. She did not understand that. Then I almost had a panic attack because she did not know what an IED was. Here she is, totally ignorant of my injuries. The lady who is in charge of my disability has no idea what's going on!

Although VA policies have changed to liberalize the evidentiary standard (to establish the link between trauma and service) as of 2010, stories like this circulate through the "Joe Network" and are difficult for the VA to recover from. These comp and pen experiences made some veterans question the capability of VHA mental health providers and contributed to delaying or avoiding treatment, as well as reapplying for rating increase or appealing a denied claim.

VA Life: Individual Level Guilty until Proven Innocent

"The institutional perception of VA is that they (veterans) are coming to the treatment setting with ulterior motives." (VA psychologist)

Stigma unfolded on both a systematic and individual level in VA life (Diagram 2). Some veterans felt as if their evaluators automatically labeled them a fraud and experienced outright stigma in their claims process: "My comp and pen nurse made the comment 'Who is telling you what to say when coming in for your exam?' She's not following the 'benefit of the doubt' requirement in the 38 CFR (the VA Schedule for Rating Disabilities)" (OIF/OEF veteran and VA disability rater). However, many understood

the logic behind the system and condemned those veterans that were faking their symptoms for compensation.

He (comp and pen examiner) said “expect 10%, we’ll see you later.” (He thought I was) more or less just looking for a hand out and unfortunately there are a lot of people in the VA system looking for a hand out, which screws everything up for the people who actually need it. (Male, OIF/OEF veteran)

As one male veteran described those who are fraudulently gaming the system:

There’s a military name for them, Blue Falcons, they just care about themselves and don’t think about how their actions affect everyone else. They are the ones who sneak a candy bar in (during training) and the rest of us have to do push-ups while he eats it.

Built into the claims process is the need to produce evidence of trauma, or a “verifiable stressor.” Not surprisingly, all the veterans in this study felt they had to “prove” they experienced trauma to their individual assessors. In other words, there was a feeling of judgment before the process even started. As a result of having to produce this evidence repeatedly, veterans felt that the VA did not believe them, care about them, or, want to compensate them.

You feel like you are giving a testimony. I told you the story. It’s on record. It’s the same story. Why do I have to do that for level 3 and 4? It’s intruding. (Male, OIF veteran)

Their job is basically to deny you and so they don’t want to know you personally. (Male, OIF veteran)

It is your responsibility to prove why you deserve compensation. If you don’t get those records to them (even if they have them) they won’t compensate you. They don’t help you. They don’t want to pay... You get so frustrated you just give up. (Female veteran, Army Reserves)

This bureaucratic necessity of providing evidence of trauma created anxiety in 80% of participants:

It was very nerve-racking... because they ask you so many personal questions and it’s doctors you don’t deal with on a regular basis, it’s not YOUR doctors (the ones) that actually might care about you. It’s their job specifically to see random people everyday. Their decision is what the disability will be based on. Your percentage, and that’s a huge deal, and that like really scared me. (Male, OIF/OEF veteran)

This perspective of veterans is in stark contrast to the providers in this study: “Everyone I work with gives the vet the benefit of the doubt. We all hate the comp and pen process. We care about the vets and hate to put them through this” (VA psychologist). At this particular VA medical center, mental health providers were required to do a quota of compensation and pension exams per month. This dual role that crosses clinical and administrative services created conflict for many because it “muddies the water” of treatment as well as the therapeutic relationship. “Our lane is clinical. Our lane is not benefits. Do not cross out of that lane and begin to make statements, write letters, tell people ‘you need to be 100 percent certified’. Do not do that. If you do that you are not helping the veteran” (VA psychiatrist).

Many providers felt that, at some level, compensation hindered treatment through the possibility of incentivizing illness. As one VA psychiatrist explained it:

Here's our problem as VA providers... we are training as mental health providers to help someone who is distressed and sick. I want to help you get better, that's easy. The problem is we have people coming in with different motivations - they need to have me writing in their chart, in a certain way, that they have these symptoms and "it is affecting my life in this particular way because I am going to take that to regional office where I am now going... to convince them that I am sick so I can get my paycheck and you are a tool that is going to help me with that." And so VA providers, wanting to help out, we are helpers right, so you come and say "I need a letter." I need a letter from Dr. L telling me that I am really sick and I can't work anymore... that would be counter-therapeutic for me to do that... I have been used sometimes and it bothers me to this day... (VA psychiatrist, veteran)

Providers wanted what was best for their veterans but many felt conflicted in encouraging support through disability compensation. As one clinical nurse put it:

I will be really honest with you, that's (compensation) a huge struggle for me and for my team and for people who work in this area because there are those mixed messages. With all of my heart I want to get people into the system and I want to get them connected with every benefit they deserve, however... (you) have a 22 or 23 year old sitting in your chair and then you are kind of like giving them all these things (benefits)... up front the need is there, believe me, I have worked with plenty of people who come home broken, have a mortgage payment, they have a family, they can't get a job due to symptoms and... so of course we get them compensated to the highest level possible that we can to help them in that area, but yet then... where is the incentive to get them into a different mind set? Again, when I have people sitting there in my office and I am working with them and I develop that relationship, I always find myself asking them out loud you know, what were your dreams when you were a kid?

So while there was some provider resentment towards veterans who used them as a tool to game the system, it was intertwined with a genuine concern over the long-term effects of disability compensation on the future potential and livelihoods of young veterans. Yet, a number of veterans felt their injuries (physical more than mental) were not being taken seriously because their age and bodies did not reflect their pain.

I feel I get a little shafted when I go to the medical center because they look at me like a 25 year-old kid that should be healthy. And I will complain about "Oh my back is screwed up, this and that" and if an 80 year-old says that they are jumping through hoops trying to get braces trying to do this, this, and this, and when they hear someone like me bitch, I think they think "Oh yeah he is just being a whiner or a complainer, he is just trying to get money." No, no, no, I have really bad health problems because of what I have been through. So please give me the same amount of respect in treatment that I deserve because yes I am not that old but I have the body of a 45-50 year-old right now at 25 years old you know. (Male, OIF veteran)

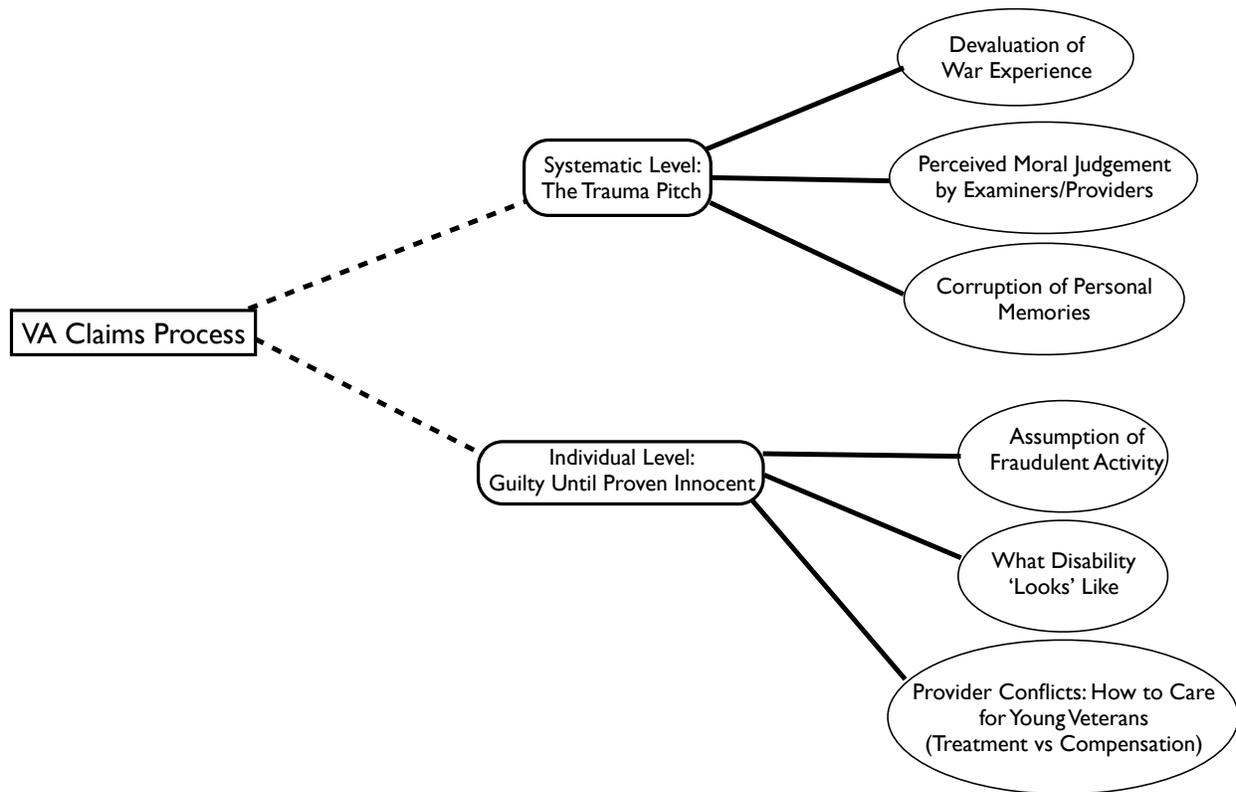
Even though veterans felt more stigmatized when it came to physical complaints, the interplay of bodily function and appearance was linked to PTSD symptoms. For most this played out in their symptoms of hypervigilance, anxiety and depression. So for example, if the body was "jacked" (slang for messed up) then hypervigilance was more difficult to manage, thereby creating more anxiety.

I went to the VA last week and they kept making comments of how much I work out because I am a bigger guy and I don't look like I'm overweight or something. Yeah, I try and take care of my body, I was marine infantry and that was pretty implemented into my life. But I am fucked

up, I am jacked. I mean this weekend I could not even turn my head. And it bothered me so much because I feel vulnerable. I feel like I am not 100% so anytime I do a crazy movement, and me being a “crazy veteran” and me always thinking in fighting mode, well... (Male, OIF/OEF Veteran)

When I go in they ask me how I am and I say fine, because I am polite, but they are putting that in the chart right away and they are looking at my appearance. I showered before my appointment, I take pride in my appearance, but that does not mean I’m feeling good inside. (Female, OIF veteran, National Guard)

DIAGRAM 2. How Stigma Processes Unfold in the Disability Determination Process



**Social life: Stigma of Diagnosis
Trained killers**

Veterans experienced two sources of stigma in their everyday social life: in particular, PTSD mental illness stigma and in general, war veteran status. All the veterans in this study publicly hid their PTSD status except for three: two male OIF/OEF veterans who worked in advocacy roles and one woman, a Sergeant in the Army Reserves, who shared her experiences with PTSD in counseling her soldiers. Corroborating with past research on barriers to care (i.e. Hoge et al., 2004), this woman refused to submit a claim for PTSD because she did not want it on her military record (afraid it would affect her rank). 70% of veterans did not disclose their status and were particularly concerned with public perceptions that the media had generated surrounding violence.

You know I get leery at telling people that I have a diagnosis. Like just recently... I was talking with my daughter's social worker at (her) school because (she) got an ADD diagnosis and well one day my daughter went to school, and my daughter is very dramatic, she said, "My mom tried to kill me" because I tried to put my hand over her mouth cause she was screaming. So the social worker calls me and goes "I am mandated to report you to CPS (child protective services) blah blah blah but you know I know you are a veteran and I know you are dealing with PTSD blah blah blah" and I am like, "Don't make this something it is not... you totally used that against me and tried to make that an issue because you see in the media PTSD means everybody is violent." (Female, OIF/OEF veteran, Army Reserves)

One male veteran was rejected for life insurance due to his PTSD and had to "...demonstrate no re-occurrences for three years, so basically that means I can't go to counseling for three years if I want to be covered." The notion that veterans are a dangerous liability was further illustrated in over half this sample in the concern over the new gun control laws. These laws limit gun and ammunition sales to persons with a mental disorder. Veterans felt that their disability rating or diagnosis would blacklist them from owning guns, going hunting or to the shooting range. Even being a veteran and owning a gun created judgment from others.

So there are these laws being implanted and people have this whole crazy thing "Oh, you like guns?" Even my friends and colleagues even say shit to me you know. And I carry to work very day because I have to go to the hood everyday and you don't know what these people are gonna do. (Male, OIF veteran)

What is more disconcerting is that the public and institutional stigma surrounding combat PTSD contributed to veterans discontinuing therapy or considering treatment exit.

One of the only things that makes me happy in this world is shooting (at a shooting range)... But I get really weary of the government because now I am like even scared to go to therapy because I, you know, I'm really worried about this mental back-ground check with guns and stuff... a bunch of my friends are like, I can tell you at least 10 vets I know, stopped going to therapy because of it. (Male, OIF veteran)

Despite hiding their PTSD status, veterans felt that even friends in their social network treated them as dangerous and damaged. Friends were described as expecting violent and unpredictable reactions in everyday social activities.

Like my friends out West, I went to visit her and she just straight up legitimately asked me, "Is it ok if you drink with us and stuff?" I was like "yeah." And she said "Well you are a big dude and you are like a veteran and I like don't know if you are going to go crazy" or like I was going to lose my mind and start pounding chicks or something like that... I was like, "Its fine, I can have a drink." (Male, OIF veteran)

What these findings suggest is that the stigma surrounding being a war veteran, or as some described themselves, "trained killers", is stronger than the mental illness stigma of PTSD alone. This is linked to their combat exposure and knowledge of weapons.

Social Life: Stigma of Compensation

A Touchy Subject

All veterans considered compensation a “touchy subject” and did not speak of it unless prompted. Importantly, even for those who shared their PTSD status with others, compensation was *not* something that was shared publicly: “I’d have to explain why I have that diagnosis and then I’d have to justify why it’s worth X amount of dollars per month” (Male, OIF veteran). Veterans did not want to be seen as “welfare queens” and felt that they deserved compensation for their service and sacrifice. Yet, veterans felt that an unsupportive public viewed their service as employment that they already had been compensated for and it was veterans’ own fault if they had issues, “They figure, you signed up for it, what did you expect?” (Male, OIF veteran). The general feeling from veterans was that compensation was something that was “earned.” Overall veterans felt that the public did not understand the gravity of their disabilities and the impact of injuries on their daily lives.

...it’s such a weird touchy topic with vets and civilians. Like I’ve had friends straight up tell me “That’s where our tax dollars go to? Giving people money to (makes gesture of disbelief)?” and they don’t know I receive disability but its like, whew, holy shit. I’m pretty jacked up compared to you and I sacrificed a lot of my time and like, my LIFE. And I’m never going to be normal I feel like. (Male, OIF veteran)

People don’t understand what I went through, what happened at war. The fact that I collect money from the government, they don’t truly understand (why) no matter how much I explain that. They look at me and automatically make the connection that you look fine. I don’t mention my compensation because I don’t want to have that fight. (Male, OIF veteran)

In addition to feeling that the public viewed them as undeserved of monetary compensation, some veterans felt judged even by the people they deployed with.

I don't tell anyone I get disability. There are only a few veterans that know... those Marines I served with... they are 70, 80, 90% disabled. I have two buddies who are vets who don't get disability for anything. They go to the VA for healthcare but don't get disability. They think they are not hurt. All of us I think suffer at some level. I mean they talk to us but they refuse to get disability because they think it's like a cop out or something. (Male, OIF/OEF veteran)

Some veterans spoke of friends who refused disability compensation completely because it conflicted with their sense of group loyalty and personal strength. This is in line with previous qualitative research (i.e. Finley, 2011) identifying barriers to treatment. One person, in the beginning of this study refused a disability rating because she did not feel deserving of it. (Although, over the course of this study, she decided the symptoms were affecting her enough that she would file a claim, but only if she were to be medically discharged from the Army Reserves for her asthma.)

It (PTSD) means that you have seen a lot of bad stuff you know and I feel like the things I have seen is [sic] not as bad as some peoples’ so why should I get that... like why should I take a disability for PTSD when there are guys who don't take disability for it who have way worse PTSD than I do? Why should I take it? I don't deserve, I haven't done anything to deserve that, so there are plenty of people out there who do deserve it. I don't. I can handle it.

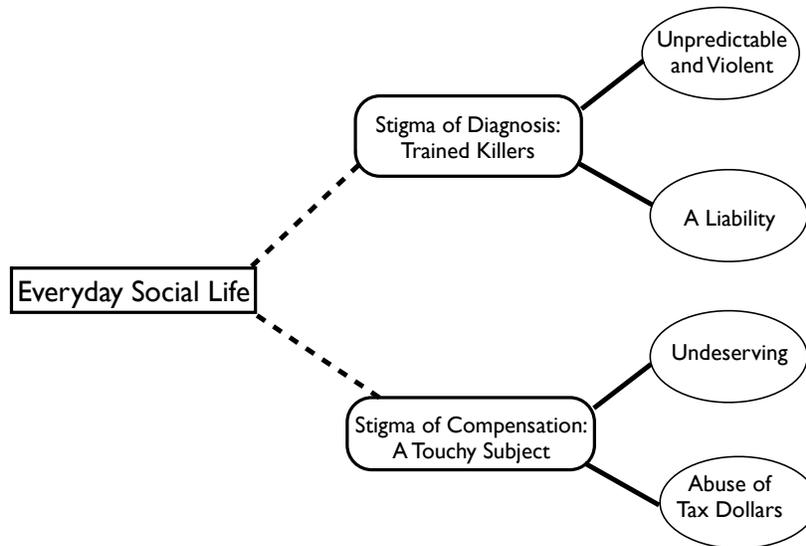
(Female, OIF/OEF veteran, Army Reserves)

I do have friends who are against it. I have (veteran) friends who are pretty fucked up and they refuse to get disability and they are like “I don't want to take anything more from the

government” or they think they would be stealing, they think it is an abuse of the government.
(Male, OIF veteran)

While social stigma did not deter participants in this study from pursuing a disability claim, it did have a potential impact on exiting treatment due to the threat of losing gun rights. Social stigma most definitely affected disclosure of disability compensation.

DIAGRAM 3: Stigma Experienced by OIF/OEF Veterans in Social Life



LIMITATIONS

This study has a number of limitations. It was conducted in a Midwest state in an urban area with a participant sample that was mostly white. A majority were combat veterans and one third were deployed for their first time at the beginning of the Iraq war. This means, for one third of this sample, their first contact with the VA was at a time when the VA was not quite prepared for a young cohort of veterans (with different needs than VA was accustomed to serving). A number of the veterans in this study had first contact with the VA before more lenient policy changes surrounding verifiable stressors was instituted. As such, these formative results are not generalizable to diverse veteran populations. Self-report biases may have been a limitation due to the nature of the topics explored, as well as the population of study, who tend to be proud and strong in presenting themselves. However, by including three phases of interviews over 10 months, this research design attempted to mitigate these biases. Recollection bias was a limitation in that memory loss itself is a symptom of PTSD. Lastly, while broad policy recommendations are difficult to make at this formative phase of research, results can inform wide scale surveys that can do so. Despite this particular constraint, I utilized a research approach that included participants in designing solutions to improve the claims process. These suggestions are included in the discussion below. Some of these participants had over 20 years of experience in the VHA and VBA and had important insights into how to advance VA disability policy and practice.

DISCUSSION

I have identified four interrelated areas where veterans experienced stigma in regards to PTSD disability and the VA claims process. Stigma occurred on a systematic and individual level in VA life and through negative public perceptions of diagnosis and compensation in everyday social life. In consideration of VA practice and disability determination policy recommendations this discussion will focus on the former.

To summarize, stigma emerged for veterans engaged in the claims process through the many appointments needed to ascertain disability status and the perpetual need to recite their trauma experiences to “strangers.” Coupled with an institutional stigma of malingering, veterans felt that their clinicians and evaluators did not believe their accounts. To make matters worse, the process made veterans feel they were being morally judged for their actions at war. From the veterans’ point of view, the result of multiple screenings was iatrogenic: an inadvertent exacerbation of the PTSD symptoms of anxiety, alienation, depression and anger. While these experiences, and most certainly the outcomes, were real to veterans, at the heart of this issue is an **unawareness of the bureaucratic process**.

First of all, the VHA is separate from the VBA, a split that most veterans are not cognizant of. Veterans thought they were “seeing all the same type of people”: physicians at a hospital. But in reality, veterans saw health care providers through the VHA for a diagnosis and claims officers and comp and pen evaluators through the VBA for their disability rating. To muddle things more, these comp and pen evaluators were also VHA providers, which in turn created conflict for their therapeutic practice (a separate problem, discussed below). These two settings, the clinical and the administrative, are co-mingled, and for obvious reasons, veterans thought all their appointments were part of one process, not two.

Confusion was compounded when veterans thought they were at the hospital for a therapy intake: 30% of the veterans in this sample did not even realize they were going through the disability claims process, having initiated contact with the VA to start treatment. As one provider put it, “At this point they want a listening ear and instead someone is typing away at their computer.” It is a failure of the system that the retelling of veterans’ trauma, an element of “exposure therapy”, is unintentionally initiated without any continuity of care (with the same mental health provider) or follow-up. Especially since, as veterans’ narratives have illustrated above, this disability rating process creates iatrogenic effects.

Moreover, these veterans who were treatment seeking were automatically “put into the system” which included application for a disability rating. One of the participants in this study received a “surprise” check of over \$3,000 in back pay for a claim he did not even know he started. This speaks to the findings of Sayer et al. (2011) who found that service connection cannot be understood without considering the vital role veteran service officers play in the disability claims process.

To contribute to the confusion (and anxiety) of this process, veterans did not understand why they had to go through all these appointments and what the appointments were for. For those who intentionally submitted a claim, they did not know what the status of their claim was for up to ten months. This was especially true for the retrospective participants in this study. For the prospective participants the VBA sent them letters every 30 days explaining that their claim was still being processed. Through my participation in following a veteran through the entire claims process, I observed a service officer explain the procedure and what to expect. However, it should be noted that this was in a veteran service organization independent of the VA where the officers have the time to advocate and educate.

This is in contrast to federal VA claims officers who are overburdened with a claims backlog and required to meet a weekly quota.

All claims personnel felt it was critical for veterans to have a service officer lead them through the disability claims process, "They should not attempt this bureaucratic process on their own." All VHA and VBA staff acknowledged difficulties in navigating the system, especially for those veterans with PTSD who are already contending with anxiety, anger, difficulties focusing and depression. The one veteran in this study who submitted a disability claim without assistance from a service officer expressed that the "wording was very confusing" and virtually impossible to get through. The paperwork itself was so overwhelming that he was not sure he did it right and was very frustrated with the "lawyer talk" in the application. A few veterans, in my informal conversations at community-based organizations, related that they had abandoned the process multiple times while attempting the process on their own. The need for a "navigator" to lead and support veterans through the claims process, especially for those with PTSD symptoms, cannot be overstated.

A significant difference was identified between first time users of the VA who were going through the claims process and veterans who were already in treatment and had established a relationship with a mental health provider. Those who were going through the claims process and interacting with the VA for the first time were more inclined to avoid future interactions with treatment. Those who were already in treatment were not deterred from continuing therapy. Another significant difference was noted between those veterans who sought services in 2008 and earlier, compared to those going to the VA in 2009 and later. Those seeking services in the later part of the war felt they had more help and direction in navigating the VA than earlier veterans. As one male OIF/OEF veteran, who was visiting the VA in 2009 for treatment, stated "It was a complete 180 compared to when I went after my first deployment in 2004." For all veterans, there was a disinclination and dread to reopen or appeal their claim. These three findings are especially important in consideration of the VA's new outreach initiatives. In these programs, VHA and VBA representatives are "waiting for veterans as they get off the plane" as one social worker put it, to assist them with care and benefits. Often times, through these initiatives, the claims process is the first contact that veterans have with the VA, especially since veterans may not be ready for treatment yet because they are busy reestablishing themselves in their work and family lives.

This issue of readiness to initiate treatment, understandably, was of concern for providers in the context of claiming a service connection. First, caring service officers (who felt they were assisting veterans with their PTSD) suggested their claimants seek treatment under the pretext of improving their chances of getting a rating. This was also the case for those veterans who received a low rating and desired to reapply for a higher service connection. Some providers on the other hand felt this was a "waste of everyone's time" since veterans, in these instances, were not seeking treatment nor ready to commit to a treatment plan. Future research should address whether veterans who are exposed to these new initiatives (2009-present) delay treatment due to negative experiences with the claims process *or* unpreparedness to initiate treatment.

In addition to lack of awareness of the bureaucratic process, there also existed a significant difference surrounding the **meaning of disability ratings** between veterans and service providers. It was this gap in veterans' personal understanding of ratings and broader institutional definitions where stigma emerged. For the veterans in this study, a disability rating was a validation of their war trauma and sacrifice. The rating provided a stamp of truth in a system, they believed, was designed to catch frauds.

Veterans felt that they were being rated for their experiences (i.e. how many deployments, how many times they were blown up, etc.). This is understandable considering the tools used to screen for PTSD such as the Combat Exposure Scale that quantify war experiences all the way down to a percentage. The institutional definition of a disability rating is not about war experiences but the *effects* of these experiences, or “occupational and social impairment.” This is what the VBA bases a rating off of (according to the VA General Rating Formula for Mental Disorders). Certainly, veterans talked about no longer being able to engage in certain activities but this was more in relation to physical injuries. When it came to mental injuries, a disability rating was an acknowledgment of “being messed up by war.”

Whereas a disability rating was validating for the veteran, from a provider perspective, “claims is not about validation, treatment is” and disability compensation is about “what you can and cannot do.” As a result of this difference in meaning, veterans went through the claims process feeling that their trauma had not been recognized, and often felt their ratings were unfair and inaccurate. Linked to this, on a systemic level, an ambiguity between the meanings of impairment and disability and their relationship to a rating emerged. The Post Traumatic Stress Disorder General Rating Formula for Mental Disorders used at the VBA rates for occupational and social impairment that affects the performance of *occupational tasks*. Certainly, someone can be severely impaired but not disabled: in other words, still able to work. This was evidenced by some veterans with 50-90% ratings (moderate to highly impaired) working full-time jobs. As one provider put it, “The reason for compensation got lost somewhere because the idea is that if you are 30% service connected, 30% of your earning potential has been eaten away.” Earning potential is ambiguous also. Theoretically it might be reduced through no longer being able to live out one’s dream of working as a physician, but as a result of war injuries, end up working as a full-time security guard. Importantly, *all* the employed veterans in this study with 50-90% ratings were working for other veterans or veteran organizations (i.e. the VA). This suggests a therapeutic relevance of work and purpose for disabled veterans, as well as the need to have employers who understand the nature of war’s effects.

To push the question of impairment and disability further, it was observed that reduced reliability and productivity could mainly lie in the social realm, with certain types of employment still manageable. In other words, work was possible but social lives were severely impaired. As a case in point, imagine the veteran who goes straight home from work everyday and closes all his blinds and locks himself in his house until work the next morning (a bit tired from waking up every few hours to check the perimeter of his home). This is what one veteran joked as “vets not wanting to give up their position.” I mention this because public misperceptions of this ambiguity between being disabled, but able to work, contribute to stigma surrounding veterans who are service connected. The implications for future research include a broader understanding of what disability is for OEF/OIF veterans with PTSD and how a disability rating might ameliorate or perpetuate impairment.

Finally, this study suggests that the screening tools used for PTSD have a negative impact on veterans through quantifying and devaluing their trauma. The fact that a majority of caring and seasoned providers in this study did not use these tools is indicative of the adverse effects they create. Clinicians felt the screening tools left out important layers of PTSD experience such as guilt and shame and that the diagnostic criteria were too limiting. The general consensus was that PTSD could present with only a few severe symptoms and in “splitting” experience into symptom criteria and “checking boxes”, the overall picture, and ironically, an official diagnosis, was often missed. A PTSD diagnosis was viewed as a “communication tool” but not a clinical tool. These findings, in part, corroborate with research by Jackson, et al., (2011) assessing the practices and attitudes of VA mental health providers and their use of disability assessments. These researchers found that 59% of clinicians rarely or never use screening tools with only 17% routinely using them. Less experienced providers used them more frequently. The

reasons why varied widely. In general, I found that VA mental health providers expressed much frustration over their role in the disability determination process, which in their professional view, conflicted with their training and therapeutic goals.

My conceptualization of the “trauma pitch” and the iatrogenic effects created by screening and assessments (Diagram 1) is based entirely on veterans’ narratives. Further research might test these effects through independent assessments of peoples’ symptom levels before, during and after their engagement with the VA claims process. While the results of this study suggest a combination of institutional perceptions of malingering and bureaucratic processes that create stigma, researchers need to examine which of these plays a stronger a role. This will be necessary to direct funding into appropriate channels to develop interventions. As a closing point, providers and veterans both acknowledged incidences of malingering and fraud, but the overwhelming opinion of VA staff was that veterans were honest in the presentation of their symptoms. If anything, as my findings imply, there is an underreporting of trauma and its effects on veterans lives.

POLICY RECOMMENDATIONS

This formative study has the potential to impact disability determination policy and VA practice in regards to PTSD screening tools and procedures. The cyclical model of stigma, presented in the beginning of this paper, implies that there are points of intervention in the claims process. The marker may not be able to be removed (i.e. “PTSD” or “veteran”) but there is an opportunity to reduce stigma-producing experiences at various touch-points.

Using a community based participatory research approach (Themba-Nixon, Winkler & Freudenberg, 2008) I engaged veterans and VA staff in discussions on how to improve the claims process. We generated suggestions on a systems level and individual level:

Individual Level Recommendations

1. *Peer Navigator Program.* To assist individuals with PTSD in the claims process, a “peer navigator program” could be developed. Peer navigators would be persons with PTSD who have a similar Military Operational Specialty (service background) as the veteran, and who have been through PTSD screening and the disability determination process. This would be a peer support person, not a VA social worker or patient advocate, who would be able to accommodate veterans to their appointments. To reduce the need to recount their trauma, a peer navigator could operate as a representative for the veteran in need and speak in their place.

2. *Trauma Statement.* To further reduce the iatrogenic effects of the trauma pitch for veterans with PTSD, the veteran (and peer navigator) could create a written statement that holds all the pertinent information regarding traumatic events and exposures. The veteran in need could provide this statement to VBA and VHA staff during appointments should verbalizing these details prove to be too difficult. This statement might also be used by the peer navigator as a reference.

3. *Veterans Grand Rounds.* To combat stigma at an individual level, VA could develop VBA training or VHA Grand Rounds that include a panel of veterans speaking about the impact of PTSD on their daily lives. The intention would be to dismantle notions of what PTSD looks like in younger veterans (this addresses the issue of being treated for one’s symptoms, not one’s age or appearance) and provide an understanding of how PTSD and physical injuries interact (the need for holistic care).

Systems Level Recommendations

1. *Claims Fact Sheet*. VBA could provide a letter or fact sheet, when a claim is initiated, that describes in detail what the institutional definition of a rating is, the process (who, what, where, why and approximately how long) and be clear that “these appointments are not a treatment initiation”.
2. *Claims Status Alerts*. VBA could provide letters explaining the status of a claim, specifically at what step in the process the claim is at (i.e. Veteran Service Officer [evidence collection], Rating Veteran Service Representative [rating] or Veteran Claims Examiner [authorization] – “...so they (claimants) could see the progression rather than always think they are ignored.”
3. *New Screening Protocol*. VA could eliminate the use of the Combat Exposure Scale and develop a screening protocol for PTSD, in addition to training in how to most effectively use it, that allows clinicians a maximum amount of flexibility in interviewing veterans while still providing some measure of PTSD
4. *Third-Party Evaluations*. Compensation and pension evaluations could be performed by a third party separate from the VA hospital and at a different location (concern was raised that contract staff “not working with combat vets all day” would be insensitive to war trauma and combat PTSD).
5. *Training*. VHA providers could provide training on combat PTSD to contracted VHA evaluators to ameliorate the lack of nuanced understanding of this population.
6. *Contact-based Training for Medical Students*. To combat stigma at the structural level (institutional) contact-based training and education for medical students is suggested and have proven to be effective.
7. *Trauma Informed Care*. Trauma informed care training has been successfully implemented in domestic violence and mental health service organizations to reduce retraumatizing clients in the intake process and care provision. VHA and VBA staff might benefit from basic training in these strategies.

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