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Values in the DSM—American Military Influence in PTSD Classification

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Posttraumatic stress disorder (PTSD) provides a vocabulary to describe the psychological toll all manner of traumatic events can take. However, although most PTSD is not combat related, over 90% of PTSD-related federal legislation introduced between 1989–2009 targeted military populations.[1] The U.S. Departments of Defense and Veterans Affairs (VA) are leading funders of PTSD research.[2] PTSD has been constructed as a predominantly military phenomenon.

Psychiatric researchers rarely publicly forswear military patronage in defense of scientific integrity, as some social scientists did during the Cold War. Following decades of increased attention to national security following the September 11 attacks, Americans have assimilated militarization into daily life.[3] Indeed, critical engagement with the politics of PTSD may seem to dishonor veterans and can thus be politically taboo. The consequences of military influence on both clinical and cultural understandings of PTSD nevertheless bear further scrutiny.

Close reading of *DSM-5* text surrounding Criterion A, which specifies types of events that can constitute PTSD-causing trauma, illustrates how American military values have shaped PTSD's classification. The *DSM-5* discussion of PTSD risk factors frames combat as inherently traumatic to *both* victims and perpetrators of war-related violence. This value-laden claim, although not directly incorporated into Criterion A, vastly expands the range of war-related events that can constitute trauma by including acts perpetrated by soldiers. But further, by specifying military personnel, this language withholds from civilian perpetrators the same classification and medical legitimization (panel). Under this interpretation, soldiers "killing the enemy" experience a potential Criterion A event. However, it is not clear whether a civilian who kills another civilian has met Criterion A.

Some contextual factors help explain the inclusion of military perpetration as a PTSD risk factor. First, this language mirrors American cultural acceptance of military violence; “killing the enemy” might be considered necessary, even heroic. However, some civilian professions can involve culturally sanctioned violence (e.g., prison guards, police officers), yet the *DSM-5* does not specify these—something more is at play. Additionally, combat veterans comprise a large proportion of American PTSD research subjects, and their Criterion A events often involve perpetrating violence. However, prior to *DSM-5*’s release, extant research demonstrated high prevalence of PTSD in civilian violent offenders,[5] yet the revisions did not reference this population. These factors both reflect the militarization of present-day medical understanding of PTSD.

The *DSM-5*’s classification of PTSD has significant implications for the treatment, study, public understanding, and subjective experience of PTSD in both military and civilian contexts. A PTSD diagnosis validates suffering, providing language to describe and normalize distress. For veterans, eligibility for VA disability benefits might rely on meeting *DSM-5* criteria for PTSD. Medicalization of the expected aftermath of war as PTSD legitimizes the societal need for government-funded healthcare and rehabilitation efforts to reintegrate veterans into civilian society. The breadth of resources dedicated to military psychiatry has enabled a nuanced and compassionate public understanding of military trauma, facilitating advocacy on behalf of military perpetrators of violence who require psychiatric services.

However, scrutinizing the military-centric classification of PTSD helps us to see that—and question why—political and cultural forgiveness toward violence perpetrated by military personnel does not culturally or diagnostically extend to civilian perpetrators who require

trauma-focused healthcare. A PTSD-like “post-incarceration syndrome” has been identified in former prisoners,[6] and lifetime PTSD prevalence is estimated to be 18% for male and 40% for female prison populations.[7] Nevertheless, this population receives significantly less research and trauma-focused care. One might argue that this disparity in resource allocation is a question of legality or responsibility, since military violence is often legally permissible or mandated. However, it is increasingly common to tailor military PTSD-specific research and treatment guidelines for veterans who participated in abusive violence toward civilians[8] or were otherwise personally culpable[9]; thus, this distinction cannot fully explain the military-centeredness of trauma-focused care for perpetrators.

Historians argue that “following the money”—investigating the power patronage exerts on the development of scientific knowledge—can elucidate the practical, political, and personal reasons fields of research unfold in the directions they do.[10] The case of PTSD is ripe for historical investigation, given the way it reveals direct integration of military-funded scientific knowledge with politics and human affairs. The disparity in trauma resources for prison populations, who have high rates of PTSD but are subjects of far less research than military populations, demonstrates how military experience has been privileged in research and clinical understandings of PTSD. Values underlie any research trends or methodological decisions, even (especially) when those values go unnamed. Unpacking those values historically embedded in our knowledge systems and research infrastructure yields insight into the ways patients’ access to population-specific resources can be directly affected by these underlying values. Rather than accepting these tacit values without question, we ought to name the values underlying research with intention, in hopes of mitigating the disparities that unintentional bias can cause.

Contributors

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