

PTSD's Diagnostic Trap

Military history is rich with tales of warriors who return from battle with the horrors of war still raging in their heads. One of the earliest examples was enshrined by Herodotus, who wrote of an Athenian warrior struck blind "without blow of sword or dart" when a soldier standing next to him was killed. The classic term--"shell shock"--dates to World War I; "battle fatigue," "combat exhaustion," and "war stress" were used in World War II.

Modern psychiatry calls these invisible wounds post-traumatic stress disorder (PTSD). And along with this diagnosis, which became widely known in the wake of the Vietnam War, has come a new sensitivity--among the public, the military, and mental health professionals--to the causes and consequences of being afflicted. The Department of Veterans Affairs is particularly attuned to the psychic welfare of the men and women who are returning from Operation Iraqi Freedom and Operation Enduring Freedom. Last July, retired Army General Eric K. Shinseki, secretary of Veterans Affairs, unveiled new procedures that make it easier for veterans who believe they are disabled by wartime stress to file benefit claims and receive compensation. "[Psychological] wounds," Shinseki declared, "can be as debilitating as any physical battlefield trauma."

This is true. But gauging mental injury in the wake of war is not as straightforward as assessing, say, a lost limb or other physical damage. For example, at what point do we say that normal, if painful, readjustment difficulties have become so troubling as to qualify as a mental illness? How can clinicians predict which patients will recover when a veteran's odds of recovery depend so greatly on nonmedical factors, including his own expectations for recovery; social support available to him; and the intimate meaning he makes of his distress? Inevitably, successful caregiving will turn on a clear understanding of post-traumatic stress disorder.

According to the Columbia reanalysis, the psychological cost of the war was 40 percent lower than the original NVVRS estimate. One of the most important and paradoxical lessons to emerge from these insights is that lowering the threshold for receipt of disability benefits is not always in the best interest of the veteran and his family. Without question, some veterans will remain so irretrievably damaged by their war experience that they cannot participate in the competitive workplace. These men and women clearly deserve the roughly \$2,300 monthly tax-free benefit (given for "total," or 100 percent, disability) and other resources the Veterans Administration offers. But what if disability entitlements actually work to the detriment of other patients by keeping them from meaningful work and by creating an incentive for them to embrace institutional dependence? And what if the system, well-intentioned though it surely is, does not adequately protect young veterans from a premature verdict of invalidism? Acknowledging and studying these effects of compensation can be politically delicate, yet doing so is essential to devising reentry programs of care for the nation's invisibly wounded warriors.

What Is PTSD

The most recent edition of the Diagnostic and Statistical Manual (DSM IV) of the American Psychiatric Association defines PTSD according to symptoms; their duration; and the nature of the "trauma" or event. Symptoms fall into three categories: re-experiencing (e.g., relentless nightmares; unbidden waking images; flashbacks); hyper-arousal (e.g., enhanced startle, anxiety, sleeplessness); and phobias (e.g., fear of driving after having been in a crash). These must persist for at least 30 days and impair function to some degree. Overwhelming calamity--or "stressor," as psychiatrists call it--of any kind, such as a natural disaster, rape, accident, or assault, can lead to PTSD.

Notably, not everyone who confronts horrific circumstances develops PTSD. Among the survivors of the Oklahoma City bombing, for example, 34 percent developed PTSD, according to a study by psychiatric epidemiologist Carol North. After a car accident or natural disaster, fewer than 10 percent of victims are affected, while among rape victims, well over half succumb. The reassuring news is that, as with grief and other emotional reactions to painful events, most sufferers get better with time, though periodic nightmares and easy startling may linger for additional months or even years.

In contrast to the sizeable literature on PTSD in civilian populations and in active-duty soldiers, data on veterans are harder to come by. To date, the congressionally mandated National Vietnam Veterans Readjustment Study (NVVRS) remains the landmark analysis. Data were collected during 1986 and 1987 and revealed that 15.2 percent of a random sample of veterans still met criteria for PTSD. Yet, a number of scholars found those estimates to be improbably high (e.g., if roughly one in six Vietnam veterans suffered from PTSD, as the NVVRS suggests, this would mean that virtually each and every soldier who served in combat--a ratio of 1 combatant to every 6 in support specialties--developed the condition). To help clarify the picture, a team of researchers from Columbia University undertook a reanalysis of the NVVRS. After their results appeared in *Science* in 2006, it became impossible for responsible researchers to consider the original findings of NVVRS as definitive.

According to the Columbia reanalysis, the psychological cost of the war was 40 percent lower than the original NVVRS estimate--that is, 9.1 percent were diagnosed with PTSD at the time of the study. The researchers arrived at this prevalence rate by considering information--collected by the original NVVRS investigators but not used--on veterans' functional impairment (i.e., their ability to hold a job, fulfill demands of family life, maintain friendships, etc). However, the Columbia team used a rather lenient definition of "impairment," stipulating that even veterans with "some difficulty" but who were "functioning pretty well" despite their symptoms had PTSD. This spurred yet another reanalysis. In a 2007 article in the *Journal of Traumatic Stress*, Harvard psychologist Richard McNally took the definition of impairment up a notch so that only veterans who had at least "moderate difficulty" in social or occupational functioning could qualify as having PTSD. In doing so, he further reduced the estimate of affliction to 5.4 percent. If nothing else, this analytic sequence--from the NVVRS, to the Columbia reevaluation, and to the McNally recalibration--serves as an object lesson in the definitional fluidity of psychiatric syndromes.

From the wars in Iraq and Afghanistan, researchers have collected data on thousands of active-duty servicemen, but very little on veterans of those conflicts. The most rigorous evaluation to date appeared in the *Archives of General Psychiatry* last summer. It was conducted by investigators at the Walter Reed Army Institute of Research who applied rigorous and uniform diagnostic standards. This distinguished their work from other studies on the current Gulf wars, which were deficient in one or more ways: failure to perform in-depth diagnostic assessments; use of broad sampling that did not distinguish combat from support personnel; or assessment by snapshot rather than longitudinal follow-up. The Walter Reed team assessed over 18,000 army soldiers in infantry brigade combat teams at three points: pre-deployment (to establish a baseline); three months after deployment; and at twelve months post-deployment. After three months the rate of PTSD (symptoms accompanied by "serious impairment") was 6.3 percent higher than the pre-deployment baseline. At a year, it was 7.3 percent higher.

The New VA Rule

On July 12, 2010, General Shinseki penned an op-ed in *USA Today* ("For Vets with PTSD, End of an Unfair Process") announcing a new Veterans Administration rule making it easier for veterans suffering from PTSD to file disability claims. Part of the rule was straightforward: The VA would no longer require that a veteran provide documentation of his exposure to combat trauma, seeing how such paperwork is often very difficult for veterans to obtain. Streamlining the lumbering claims bureaucracy is one thing, and welcome it is, but the new rule does not end there. It also establishes that noninfantry personnel can qualify for PTSD disability if they had good reason to fear danger, such as firefights or explosions, even if they did not actually experience it. "[If] a stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity, he is eligible for a PTSD benefits," according to the Federal Register. This is a strikingly novel amendment. The idea that one can sustain an enduring and disabling mental disorder based on anxious anticipation of a traumatic event that never materialized is a radical departure from the clinical--and common-sense--understanding that traumatic stress disorders are caused by events that actually do happen to people.[1] However, this is by no means the first time that controversy and ambiguity have swirled around the diagnosis of PTSD.

During the Civil War, some soldiers were said to suffer "irritable heart" or "Da Costa's Syndrome"--a condition marked by shortness of breath, chest discomfort, and pounding palpitations that doctors could not attribute to a medical cause. In World War I, the condition became known as "shell shock" and was characterized as a mental problem. The inability to cope was believed to reflect personal weakness--an underlying genetic or psychological vulnerability; combat itself, no matter how intense, was deemed little more than a precipitating factor. Otherwise well-adjusted individuals were believed to be at small risk of suffering more than a transient stress reaction once they were removed from the front.

In 1917, the British neuroanatomist Grafton Elliot Smith and the psychologist Tom Pear challenged this view. They attributed the cause more to the experiences of war and less to the character or fiber of soldiers themselves. "Psychoneurosis may be produced in almost anyone if only his environment be made 'difficult' enough for him," they wrote in their book, *Shell Shock and Its Lessons*. This triggered a feisty debate within British military psychiatry, and eventually the two sides came to agree that both the soldier's predisposition to stress and his exposure to hostilities contributed to breakdown. By World War II, then, military psychiatrists believed that even the bravest and fittest soldier could endure only so much. "Every man has his breaking point," the saying went.

The story of PTSD, as we know it today, starts with the Vietnam War. In the late 1960s, a band of self-described antiwar psychiatrists--led by Chaim Shatan and Robert Jay Lifton, who was well known for his work on the psychological damage wrought by Hiroshima--formulated a new diagnostic concept to describe the psychological wounds that the veterans sustained in the war. They called it "Post-Vietnam Syndrome," a disorder marked by "growing apathy, cynicism, alienation, depression, mistrust, and expectation of betrayal as well as an inability to concentrate, insomnia, nightmares, restlessness, uprootedness, and impatience with almost any job or course of study." Not uncommonly, the psychiatrists said, these symptoms did not emerge until months or years after the veterans returned home. Civilian contempt for veterans, according to Messrs. Shatan and Lifton, further entrenched their hostility and impeded their return.

This vision inspired portrayals of the Vietnam veteran as a kind of "walking time bomb," "living wreckage," or rampaging loner, images immortalized in films such as "Taxi Driver" and "Rambo." In the summer of 1972, the New York Times ran a front-page story on Post-Vietnam Syndrome. It reported that 50 percent of all Vietnam veterans--not just combat veterans--needed professional help to readjust, and contained phrases such as "psychiatric casualty," "emotionally disturbed," and "men with damaged brains." By contrast, veterans of World War II were heralded as heroes. They had fought in a popular war, a vital distinction for understanding how veterans and the public give meaning to their wartime hardships and sacrifice.

Historians and sociologists note that the high-profile involvement of civilian psychiatrists in the wake of the Vietnam War was another feature that set those returning soldiers apart. "The suggestion or outright assertion was that Vietnam veterans have been unique in American history for their psychiatric problems," writes the historian Eric T. Dean Jr. in *Shook over Hell: Post-Traumatic Stress, Vietnam, and the Civil War*. As the image of the psychologically injured veteran took root in the national conscience, the psychiatric profession debated the wisdom of giving him his own diagnosis.

PTSD Becomes Official

In 1980, the American Psychiatric Association adopted post-traumatic stress disorder (rather than the narrower post-Vietnam syndrome) as an official diagnosis in the third edition of its Diagnostic and Statistical Manual. A patient could be diagnosed with PTSD if he experienced a trauma or "stressor" that, as DSM described it, would "evoke significant symptoms of distress in almost everyone." Rape, combat, torture, and fires were those deemed to fall, as the DSM III required, "generally outside the range of usual human experience." Thus, while the stress was unusual, the development of PTSD in its wake was not.

No longer were prolonged traumatic reactions viewed as a reflection of an individual's constitutional vulnerability. Instead, stress-induced syndromes were a natural process of adapting to extreme stress. With the introduction of PTSD into the psychiatric manual, the single-minded emphasis on the importance of one's pre-morbid state in shaping response to crisis gave way to preoccupation with the trauma itself and its supposed leveling effect on human response. Surely, it was wrong of earlier psychiatrists to attribute war-related pathology solely to the combatant himself, but the DSM III definition embodied an equal but opposite error: It obliterated the role of an individual's own characteristics in the development of the condition. Not surprising, perhaps, this blunder served a political purpose. As British psychiatrist Derek Summerfield put it, the newly minted diagnosis of PTSD "was meant to shift the focus of attention from the details of a soldier's background and psyche to the fundamentally traumatic nature of war."

Shatan and Lifton clearly saw PTSD as a normal response. "The placement of post-traumatic stress disorder in [the DSM] allows us to see the policies of diagnosis and disease in an especially clear light," writes combat veteran and

sociologist Wilbur Scott in his detailed 1993 account *The Politics of Readjustment: Vietnam Veterans Since the War*. The diagnosis of PTSD is in the DSM, Mr. Scott writes, "because a core of psychiatrists and Vietnam veterans worked conscientiously and deliberately for years to put it there . . . at issue was the question of what constitutes a normal reaction or experience of soldiers to combat." Thus, by the time PTSD was incorporated into the official psychiatric lexicon, it bore a hybrid legacy--part political artifact of the antiwar movement, part legitimate diagnosis.

Over the years, the major symptoms of PTSD have remained fairly straightforward--re-experiencing, anxiety, and phobic avoidance--but what counted as a traumatic experience turned out to be a moving target in subsequent editions of the DSM. In 1987, the DSM III was revised to expand the definition of a traumatic experience. The concept of stressor now included witnessing harm to others, such as a horrific car accident in progress. In the fourth edition in 1994, the range of "traumatic" events was expanded further to include hearing about harm or threats to others, such as the unexpected death of a loved one or receiving a fatal diagnosis such as terminal cancer oneself. No longer did one need to experience a life-threatening situation directly or be a close witness to a ghastly accident or atrocity. As long as one experienced an "intense fear, helplessness, or horror" in response to a catastrophic event (e.g., after watching the September 11 terrorist attacks on television, or being in a minor car accident) he could conceivably qualify for a diagnosis of PTSD if symptoms of re-experiencing, arousal, and phobias persisted for a month.

There is pitched debate within the field of traumatology as to whether a stressor should be defined as whatever traumatizes a person. True, a person might feel "traumatized" by, say, a minor car accident--but to say that a fender-bender counts as trauma alongside such horrors as concentration camps, rape, or the Bataan Death March is to dilute the concept. "A great deal rides on how we define the concept of traumatic stressor," says Richard J. McNally. In the civilian realm, he says, "the more we broaden the category of traumatic stressors, the less credibly we can assign causal significance to a given stressor itself and the more weight we must place on personal vulnerability." In the context of war, too, while anticipatory fear of being thrust in harm's way could conceivably morph into a crippling stress reaction, this will almost surely be more likely among individuals who struggled with anxiety-related problems prior to deployment. Surely, their distress merits treatment from military psychiatrists, but the odds that such symptoms persist after separation from the military, let alone harden into a serious, lasting state of disablement, are probably very low.

The Troubled VA Disability System

Secretary Shinseki's move to reduce the bureaucratic hurdles to the VA disability system and broaden eligibility for PTSD will add to the already accelerating stream of veterans who are applying to enter it. Thus, it is imperative that the VA turn its attention to that system itself. Two overarching problems need remedies. The first is the culture of clinical diagnosis. Some disability evaluators now use a detailed interview checklist to gauge the degree to which daily function is impaired, but its implementation is uneven across medical centers. Thus, it is still easy for clinicians--especially those whose diagnostic skills were honed during the Vietnam era--to label problems such as anxiety, guilt over comrades who died, and chronic sleep disturbance mental illnesses. This is facile, of course, as symptoms splay out along a continuum ranging from normal, if painful, readjustment difficulties to chronic, debilitating pathology. Further, not all symptoms of distress in someone who has been to war reflexively signal the presence of PTSD, as some clinicians seem to think. Among veterans whose problems are indeed war-related, however, the distinction between reversible and lasting incapacitation matters greatly when the veteran is seeking disability status. And this brings us to the second matter: the inadvertent damage that disability benefits themselves can sometimes cause.

Imagine a young soldier wounded in Afghanistan. His physical injuries heal, but his mind remains tormented. Sudden noises make him jump out of his skin. He is flooded with memories of a bloody firefight, tormented by nightmares, can barely concentrate, and feels emotionally detached from everything and everybody. At 23 years old, the soldier is about to be discharged from the military. Fearing he'll never be able to hold a job or fully function in society he applies for "total" disability (the maximum designation, which provides roughly \$2,300 per month) compensation for PTSD from the VA. This soldier has resigned himself to a life of chronic mental illness. On its face, this seems only logical, and granting the benefits seems humane. But in reality it is probably the last thing the young soldier-turning-veteran needs--because compensation will confirm his fears that he is indeed beyond recovery.

While a sad verdict for anyone, it is especially tragic for someone only in his twenties. Injured soldiers can apply for and receive VA disability benefits even before they have been discharged from the military--and, remarkably, before they have even been given the psychiatric treatment that could help them considerably. Imagine telling someone with a spinal injury that he'll never walk again--before he has had surgery and physical therapy. A rush to judgment about the prognosis of psychic injuries carries serious long-term consequences insofar as a veteran who is unwittingly encouraged to see himself as beyond repair risks fulfilling that prophecy. Why should I bother with treatment? he might think. A terrible mistake, of course. The months before and after separation from the service are periods when mental wounds are fresh and thus most responsive to therapeutic intervention, including medication.

Told he is disabled, the veteran and his family may assume--often incorrectly--that he is no longer able to work. At home on disability, he risks adopting a "sick role" that ends up depriving him of the estimable therapeutic value of work. Lost are the sense of purpose work gives (or at least the distraction from depressive rumination it provides), the daily structure it affords, and the opportunity for socializing and cultivating friendships. The longer he is unemployed, the more his confidence in his ability and motivation to work erodes and his skills atrophy. Once a patient is caught in such a downward spiral of invalidism, it can be hard to throttle back out. What's more, compensation contingent upon being sick often creates a perverse incentive to remain sick. For example, even if a veteran wants very much to work, he understandably fears losing his financial safety net if he leaves the disability rolls to take a job that ends up proving too much for him. This is how full disability status can undermine the possibility of recovery.

What To Do: Treatment First

For many veterans, the transition between military and civilian life is a critical juncture marked by acute feelings of flux and dislocation. Recall the scene in *The Hurt Locker* (one of the few scenes, incidentally, that former soldiers have deemed realistic) in which Sergeant William James stares at the wall of cereal boxes in the supermarket, disoriented by the tranquil and often trivial nature of the civilian world. As Sebastian Junger wrote in his powerful book *War*, "Some of the men worry they'll never again be satisfied with a 'normal life' . . . They worry that they may have been ruined for anything else."

Returning from war is a major existential project. Imparting meaning to the wartime experience, reconfiguring personal identity, and reimagining one's future take time. Sometimes the emotional intensity can be overwhelming--especially when coupled with nightmares and high anxiety or depression--and even warrants professional help. When this happens, the veteran should receive a message of promise and hope. This means a prescription for quality treatment and rehabilitation--ideally before the patient is even permitted to apply for disability status. However, under the current system, when a veteran files a disability claim, a ratings examiner is assigned to determine the extent of incapacitation, irrespective of whether he has first received care.

As part of the assessment, the examiner requests a psychiatric evaluation with a psychiatrist or a psychologist to obtain a diagnosis. If the veteran is diagnosed with PTSD by the clinician, the ratings examiner then assigns a severity index to his disability. The Veterans Benefits Administration recognizes different levels of disability. As detailed in the Code of Federal Regulations, a ten percent severity rating for a mental illness denotes "mild or transient symptoms which [affect] occupational tasks only during periods of significant stress." A patient assigned 30 percent disability has "intermittent periods of inability to perform occupational tasks although generally functioning satisfactorily." A 50 percent rating begins to denote significant deficits including "difficulty in understanding complex commands" and reduced reliability and productivity. The most severe level, 100 percent, corresponds to "total occupational and social impairment."

Something is terribly wrong with this picture. To conclude that a veteran has dismal prospects for meaningful recovery before he or she has had a course of therapy and rehabilitation is premature in the extreme.[2] To be sure, the VA is trying hard to make treatment accessible, but administrators, raters, and clinicians cannot require patients to accept it as a condition of being considered for disability compensation. Absent a course of quality treatment and rehabilitation, evaluators simply do not have enough evidence to make a determination. Unwittingly, this policy has set in motion a growing dependence on the VA and disincentive to meaningful improvement. In 2008, former Senator Richard Burr of North Carolina, then the ranking member of the Senate Veterans Affairs Committee, sought a limited remedy. He introduced the Veterans Mental Health Treatment First Act. The purpose of this bill was to induce new veterans to embark upon a path to recovery. Any veteran diagnosed with major depression, post-

traumatic stress disorder, or other anxiety disorders stemming from military activity would be eligible for a financial incentive (which Burr called a "wellness stipend") to adhere to an individualized course of treatment and agree to a pause in claims action for at least a year or until completion of treatment, whichever ever came first. The bill died in committee.

Don't Fight the Same War Twice

Mental health experts have learned a lot about how not to treat veterans from our experience during the Vietnam era. I speak from my experience as a psychiatrist at the West Haven Veterans Affairs Medical Center in Connecticut from 1988 to 1992, a time of blossoming interest in PTSD within both the VA and the mental-health establishment. Good intentions were abundant, but, in retrospect, much of our treatment philosophy was misguided. For example, clinicians tended to view whatever problem beset a veteran as a product of his war experience. In addition, therapists spent too much time urging veterans to experience catharsis by reliving their war experiences in group therapy, individual therapy, art therapy, and theatre reenactments. Groups of twenty or so veterans were admitted to the hospital and stayed together, platoonlike, for four months. This practice took them out of their communities and away from their families. I remember some of the men coming back from a day's leave from the hospital ward with new war-themed tattoos and combat fatigues--not exactly readjustment! It is clear, in retrospect, that instead of fostering regression, we should have emphasized resolution of everyday problems of living, such as family chaos, employment difficulties, and substance abuse.

The good news is that most of these inpatient programs are now shuttered. Studies showed them to be largely ineffective. What followed over the years was a wholesale shift away from cathartic reenactment of war trauma and a growing emphasis on forward-looking rehabilitation and evidence-based treatments such as cognitive therapy, behavioral desensitization (some techniques involving virtual reality recreations of combat scenarios), and medication if needed. The VA does appear to be making serious efforts to ensure that all mental health clinics are equipped to offer state of the art treatment for PTSD.

Some clinicians, myself included, would even like to see the diagnosis of PTSD downplayed altogether in favor of trying to understand patients' symptoms in context. As Texas psychiatrist Martha Leatherman puts it, "behaviors such as easy startling, hypervigilance, and sleep disturbance that are common in combat situations are normal, survival mechanisms," she says. Unfortunately, when they return, veterans are told that these symptoms mean PTSD. "This stirs up visions of Vietnam veterans living under bridges," Leatherman says, "and then, in a panic, they apply for disability compensation for PTSD so that they won't end up homeless too." Regrettably, the legacy of Vietnam era PTSD haunts the current generation of veterans. "It has been very troubling to me to see OEF/OIF veterans who truly need mental health treatment refuse it because it would mean having an illness that is associated with Vietnam-era chronicity and thus is incurable." The clinicians' job, of course, is not to incite morbid preoccupations, but to dispel misconceptions about Vietnam veterans (the vast majority of whom went on to function well) and steer veterans, as early as possible, to healthier interpretations of their symptoms. Early intervention also leverages the well-established fact that prognosis after trauma greatly depends on what happens to the individual in its immediate wake. That is why serious attention must be paid to the everyday problems that beset many veterans during the readjustment period, such as financial stress, marital discord, parenting strains, occupational needs.[3]

Finally, the balkanization of the veteran's services complex demands attention. The federal Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA) tend to operate in separate universes. The VBA is geared toward helping veterans maximize benefits and gives little to no attention to improving their clinical situation. On the other hand, the VHA is focused on treatment, as it should be, but doesn't extend its expertise to helping veterans with the financial hardships they face. (These can be the kinds of problems that might lead a patient to turn to disability compensation--not because he is incapable of work but because the reliable check is a rational solution to his financial woes.) County-based Veterans Service Officers actively help veterans file for disability--not necessarily a bad thing at all, but because they are advocates, their job is to get a veteran what he wants, which is not necessarily in his best clinical interest. Lastly, the Veteran Service Organizations which, as a matter of principle, are driven to funnel largesse to their constituents, tend to be extremely suspicious of proposed reforms of the disability system, as they were of Senator Burr's proposal. With the missions of both agencies and the agendas of pressure groups all working at cross purposes, disability reform is a daunting challenge indeed.

Anyone who fights in a war is changed by it, but few are irreparably damaged. For those who never regain their civilian footing despite the best treatment, full and generous disability compensation is their due. Otherwise, it is reckless to allow a young veteran to surrender to his psychological wounds without first urging him to pursue recovery.

Over the last hundred years or so, psychiatry has taken very different perspectives on war stress: from an overly harsh, blame-the-soldier stance in World War I, to the healthy recognition in World War II that even the most psychologically healthy individual can develop war-related symptoms, to the misguided expectation in the wake of Vietnam that lasting PTSD was routine. The new VA rule, which expands PTSD disability eligibility to noncombatants who have experienced the dread of harm but have not had an actual encounter with it, alters the meaning yet again. What should have been a welcome bureaucratic reform by the VA--waiving documentation that might be difficult or impossible to obtain--ended up distorting the diagnosis. Add to this the practice of conferring disability status upon a veteran before his prospects for recovery are known, and the long journey home will now be harder than it already is.

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