



“Heroes’ invisible wounds of war:” constructions of posttraumatic stress disorder in the text of US federal legislation



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ABSTRACT

Public policies contribute to the social construction of mental health problems. In this study, I use social constructivist theories of policy design and the methodology of ethnographic content analysis to qualitatively explore how posttraumatic stress disorder (PTSD) has been constructed as a problem in US federal legislation. I analyzed the text of 166 bills introduced between 1989 and 2009 and found that PTSD has been constructed as a problem unique to combat exposures and military populations. These constructions were produced through combat-related language and imagery (e.g., wounds, war, heroism), narratives describing PTSD as a military-specific phenomenon, and reinforced by the absence of PTSD in trauma-focused legislation targeting civilians. These constructions do not reflect the epidemiology of PTSD—the vast majority of people who develop the disorder have not experienced combat and many non-combat traumas (e.g., sexual assault) carry higher PTSD risk—and might constrain public and political discourse about the disorder and reify sociocultural barriers to the access of mental health services.

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“Public policy is the primary tool through which government acts to exploit, inscribe, entrench, institutionalize, perpetuate, or change social constructions.” (Schneider and Ingram, 2005, p. 5)

The construction of posttraumatic stress disorder (PTSD) as a mental health problem has been the subject of extensive sociological scholarship. These analyses have focused on how social, political, and economic interests gave rise to the disorder’s place in psychiatric nomenclature (Bracken, 2001; Fassin and Rechtman, 2009; Lembcke, 1998; Scott, 1990, 1992; Stein et al., 2007; Young, 1997), debates about the validity of PTSD as a scientific construct and the types of experiences that constitute a “traumatic” exposure (Kienzler, 2008; McHugh and Treisman, 2007; McNally, 2003; Rosen, 2004; Summerfield, 2001), and historical accounts of its diagnostic lineage (Andreasen, 2010; Jones and Wessely, 2005; Scott, 1990; Trimble, 1985; Wilson, 1995). Although much as been written about PTSD, virtually no research has investigated what PTSD means in the public policy arena. From a social constructivist perspective, this knowledge gap warrants attention because public policies reflect and reinforce prevailing ideas about the reality of

social problems.

According to policy design theory, the content of public policies not only perform technical functions to address problems (e.g., distribute resources, regulate behavior), but also contribute to the social construction of problems by making public proclamations about their origins, who they affect, what should be done about them, and why (Ingram and Schneider, 2006, 2007; Schneider and Ingram, 1993, 2005, 2008; Schneider and Sidney, 2009). The ways in which problems are constructed in policy documents are important because they influence the range of policy solutions that will be considered to address problems in the future and shape, and often reinforce, shared understandings about problems in the present (Schneider and Ingram, 2005).

The purpose of this study was to explore how PTSD has been constructed as a problem in the text of legislation proposed in US Congress between 1989 and 2009 and examine the potential implications of these constructions. This qualitative study builds upon a quantitative content analysis of federal legislation introduced to address PTSD which found that over 90 percent of the legislative proposals targeted military populations (Purtle, 2014).

1. Epidemiology of PTSD

PTSD largely emerged out of a military context in the United

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States (Jones and Wessely, 2005; Scott, 1990, 1992), but combat is only one type of event that can cause the disorder. Although the lifetime prevalence of PTSD is higher in the combat-exposed military population than the civilian population as a whole (Kessler et al., 2005; US Department of Veterans Affairs [VA] 2014), the vast majority of PTSD cases in the United States result from exposure to non-combat traumas. Among US men ages 18 to 54, it is estimated that nearly 80 percent of past-year PTSD is attributable to non-combat traumas (Prigerson et al. 2002)—a percentage that is likely to be much higher for women (Tolin and Foa, 2006) and thus the US population as a whole. Given that the civilian population is markedly larger than the military population and the fact that the risk of PTSD is higher after exposure to many non-combat traumas than combat traumas (Beck and Coffey, 2007; Centers for Disease Control and Prevention [CDC] 2012, 2013; Kang et al., 2003; Kilpatrick and Acierno, 2003; Kristensen et al., 2012; Kulka et al., 1990; VA, 2014; Van Denderen et al., 2013), PTSD affects a considerably greater number of civilians than military personnel.

The National Vietnam Veterans' Readjustment Study found that 960,450 males (31 percent) who served in Vietnam had PTSD at some point in their lives as did 1936 females (27 percent) (Kulka et al., 1990). Among US military personnel deployed to the Persian Gulf region during Operation Desert Storm, approximately 70,000 (10 percent) developed PTSD (Kang et al., 2003). Among US soldiers returning from Operations Iraqi Freedom, New Dawn, and Enduring Freedom, 350,898 (20 percent) had received care for potential PTSD at a VA Center as of February 2014 (VA, 2014). In sum, approximately 1.4 million US military personnel who served in these armed conflicts were affected by PTSD.

In terms of civilians, an estimated 6.8 percent of adults (Kessler et al., 2005) and 4 percent of youth ages 13 to 18 (Merikangas et al., 2010) have had PTSD at some point in their lives. This translates into roughly 16.9 million civilians who have experienced the disorder. Research on the incidence of PTSD after non-combat events, coupled with data about their frequency, explains why the raw number of people affected by PTSD is so much higher among civilians than military personnel (Beck and Coffey, 2007; CDC, 2012, 2013; Kilpatrick and Acierno, 2003; Kristensen et al., 2012; Van Denderen et al., 2013).

Approximately 25 percent to 33 percent of motor vehicle accident survivors develop PTSD (Beck and Coffey, 2007) and 2.5 million nonfatal motor vehicle injuries were treated at US hospitals in 2013 (CDC, 2013). Violent crime is a major source of PTSD among civilians, with 30 percent to 80 percent of sexual assault survivors and 23 percent to 39 percent of nonsexual assault survivors developing PTSD (Kilpatrick and Acierno, 2003). There were 102,216 rapes and 1.1 million cases of aggravated assault reported to police in the United States in 2013. Sudden death caused by suicide, homicide, and accidents can lead to PTSD among friends and family of the deceased (Kristensen et al., 2012). Estimates of PTSD among homicide survivors range from 19 percent to 71 percent (Van Denderen et al., 2013). In 2012, there were 16,688 homicides and 40,600 suicides in the United States (CDC, 2012).

This study examines how the epidemiology of PTSD is, and is not, reflected in constructions of PTSD in legislated texts. Background about the tenets of policy design theory provides context about why the characteristics of different populations affected by PTSD might influence how the disorder is constructed in policy documents.

2. Theoretical framework

I used Anne Schneider and Helen Ingram's theories of policy design (Ingram and Schneider, 2006, 2007; Schneider and Ingram, 2005; Schneider and Sidney, 2009) and social construction of target

populations (Schneider and Ingram, 1993, 2005) as the analytic frames for this study. Schneider and Ingram approach the study of public policy from a social constructivist perspective. The central premise of social constructivism is that shared interpretations of the world create institutions, norms, identities, and individual and collective realities (Holstein and Gubrium, 2008). Accordingly, policy design theorists believe that the design (i.e., the content) of public policies cyclically produces and reproduces socially constructed meanings about the reality of problems.

A great deal of social constructivist policy research has focused on how constructions of problems and populations interact to influence policy design. According to the theory of the social construction of target populations (Schneider and Ingram, 1993, 2005), problems are likely to advance on policy agendas if they are seen as affecting populations that: a) are politically powerful, and/or b) embody positive attributes (e.g., altruism). Military veterans, for example, have been among the most politically powerful and positively constructed populations in the United States since the end of the Vietnam War (Schneider and Ingram, 1993). Alternatively, people who commit crimes have been viewed as politically undesirable and negatively constructed (Schneider and Ingram, 2005). Through these dynamics, the design of public policies strengthens, and occasionally alters, predominant constructions of problems and populations in a society (Schneider and Sidney, 2009).

3. US federal legislative process

A detailed description of the US federal legislative process is beyond the scope of this article and provided elsewhere (Oleszek, 2013), but an overview of the process through which bills are introduced is important to contextualize the study. Bills (i.e., proposed federal laws) can be introduced by any member of US Congress, which is comprised of 535 elected officials—100 Senators and 435 House Representatives. There is no limit to the number of bills that a Congressperson can introduce and thousands of bills are introduced annually. Every bill has a title that is provided by the Congressperson who introduces it. There is no requirement for a bill's title to accurately reflect its content and Congresspersons often play the "name game" (Oleszek, 2013, p. 105) and title bills in ways that will gain media attention and garner political support.

4. Method

I used the methodology of ethnographic content analysis (ECA) to structure my data collection and analysis. ECA is a qualitative methodology in which the reflexive analysis of textual documents is conceptualized as fieldwork (Altheide, 1987; Altheide and Schneider, 2012). Although observing and engaging in face-to-face social interaction typically constitutes fieldwork in ethnographic research, the artifacts of social interaction, such as legislative texts, can also be analyzed to elucidate meaning about a phenomenon (Altheide, 1987; Altheide and Schneider, 2012). ECA adapts analytic strategies from grounded theory (Glaser and Strauss, 1967) as it opens up meaning through the comparison of concepts across texts and purposeful sampling, but differs in that "Grounded theory stresses more the systematic coding of field notes, whereas ECA is more oriented to concept development, data collection, and emergent data analysis" (Altheide, 1987, p. 17).

4.1. Data collection

Congressional Research Service (CRS) staff assigned Legislative Indexing Vocabulary (LIV) terms to bills introduced in US Congress to classify them according to the topics that they addressed (CRS,

2013). The LIV term “Post-traumatic stress disorder (PTSD)” was first assigned to a bill on September 27, 1990 and then to all bills that mentioned the disorder until January 3, 2009 when CRS adopted a new indexing vocabulary (CRS, 2013). I used the Browse Bills and Resolutions, Subject Term search function in THOMAS—a comprehensive, publically available database maintained by the US Library of Congress (2015) that contains the full text of every bill introduced after January 3, 1989—to identify and access the full text of all bills assigned the LIV term PTSD.

To ensure that this search captured all bills that mentioned the disorder during the period in which the LIV term PTSD was assigned, I compared the results with those obtained through an alternative search strategy. I used the THOMAS Word/Phrase search function, with the Include Variants (plurals, etc.) option selected, and searched for bills containing the phrase “post-traumatic stress disorder.” Of the bills identified through this search, all were assigned the LIV term PTSD if introduced during the period when CRS staff used the LIV. I identified seven additional full text bills that mentioned the disorder but were introduced before the date when the LIV term PTSD was first assigned. I added these bills to my sample for a total of 166 PTSD bills introduced in the 20 year period between January 3, 1989 and January 3, 2009.

For each bill, I created a document in NVivo 10 (QSR International, 2012), a qualitative data management software program. I then imported the full text of the most recent version of each bill and its All Information (except text) page, which contained detail about the bill’s legislative history and attributes (e.g., title, bill number, date introduced).

4.2. Data analysis

First, I conducted word searches for “post-traumatic stress disorder,” “posttraumatic stress disorder,” “post traumatic stress disorder,” “PTSD,” and “P.T.S.D.” to identify and code sections of text that mentioned the disorder. As is recommended for content analyses (Krippendorff, 2012), I used naturally occurring units of text to establish the boundaries of these coding units—in this case the heading “Sec.” at the beginning of the section that mentioned PTSD and the heading “Sec.” of the subsequent section. I identified 382 sections of text that mentioned the disorder. This process reduced the data to that most relevant to my research question while retaining information about the contexts in which the disorder was mentioned.

I then used NVivo to electronically highlight these sections and display them within the bills in which they appeared, allowing me to view the sections of text preceding and proceeding them, and employed a broad brush coding strategy in which I assigned the sections of text to general categories (Bazeley and Jackson, 2013). The broad brush coding process categorized the data at a low level of abstraction, which aided the comparison of concepts across texts at the subsequent stages of analysis. Throughout this coding process, I was immersed in the data and wrote memos about my interpretations of the texts.

After broad brush coding was complete, I re-read the texts and used a categorical coding strategy in which I assigned the bill titles and sections of text mentioning PTSD to inductively generate categories (e.g., heroism, statistics, war imagery) that were grounded in the data. These categories were informed by my initial memos, which I continued to write throughout the coding process. I consolidated and refined categories through an iterative process as I interacted with the data through multiple readings and compared concepts across texts.

As recommended by Richards (2014, p.103), I considered what I found interesting in the data and asked myself “Why is that interesting?” and “Why am I interested in that?” This process of inquiry

spurred the development of analytic coding categories (e.g., worthiness, justification) that were more abstract and reflected latent messages embedded in the data (Kuckartz, 2014). Throughout the analysis process, I purposefully sampled bills that did not necessarily mention PTSD but served to shed light on emergent findings (Coyne, 1997). I generated coding matrixes, arranged quotes in tables, and created visual diagrams to develop core themes.

In addition to exploring themes that were present in the legislative texts, I noted those that were absent and contemplated the meanings of these omissions. As Krippendorff (2012) states, “content analysts are as interested in what is not said as they are in what is said—that is, they are interested in what texts reveal about a phenomenon not spoken of” (p. 360). I read the legislative texts through a lens informed by epidemiological research about the burden of PTSD among populations exposed to different types of trauma and considered the congruence between this research and constructions of PTSD.

In accordance with recommendations to establish validity in qualitative research conducted within a constructivist paradigm (Creswell and Miller, 2000), I sought negative cases, rival explanations, and evidence that disconfirmed my findings. I also provided a rich description of my findings by presenting quotes, the titles of bills and section headings, and references to the full text of bills.

5. Findings

5.1. PTSD as a “signature injury of war”

Throughout the legislative texts, constructions of PTSD were produced through language that explicitly defined PTSD’s membership in broader categories of problems. The words “other,” “such as,” and “including” were frequently used to link PTSD to intersecting categories related to military service and mental health. For example, a bill supported the “Identification of ‘best practices’ for treatment of post-deployment mental health problems including PTSD.” This type of language, which was abundant in the legislative texts, had the effect of implying that PTSD shares features with the other problems in these categories (e.g., “post-deployment mental health problems”) and singled out the disorder as an exemplar.

PTSD was frequently presented as a problem in military contexts. While the connection between PTSD and military service was implied by the fact that more than 90 percent of the legislation addressing PTSD targeted military populations (Purtle, 2014), it was also explicitly defined as a combat-related problem through language that circumscribed PTSD’s membership in categories related to war. For example, PTSD was named as one of many: “forms of combat stress,” “combat-related mental health conditions,” “post-deployment mental health problems,” “disorders that may be associated with service in the Armed Forces,” “mental health disorders commonly associated with deployment,” and “signature injuries of veterans of Operation Iraqi Freedom and Operation Enduring Freedom.”

In multiple instances, addressing PTSD was described as being in the “national interest”—a term typically used within the context of foreign affairs and military strategy (Trubowitz, 1998). The Military Construction and Veterans Affairs and Related Agencies Appropriations Act[s], for example, described it as being “in the national interest” for the VA to train psychologists to treat veterans with PTSD. This language of “national interest,” which was not present in bills introduced address PTSD among civilian populations, contributed to the militarization of PTSD.

5.2. Weaving “Psychological Kevlar” for heroes’ “invisible wounds”

The titles of PTSD bills targeting military populations contained combat-related imagery and built on concepts commonly associated with positive constructions of military populations, such as heroism. By providing the overarching frame for legislative discourse about PTSD to take place, the titles of the military-focused bills served as proclamations about why PTSD was a problem that should be addressed among military populations and contributed to the disorder's production as a problem exclusively related to military service.

Many of the bill titles referenced “wounds,” such as the “Dignified Treatment of Wounded Warriors Act” and the “Wounded Heroes’ Bill of Rights Act.” The “wound” frame contributed to military-specific constructions of PTSD by likening the disorder to physical injuries sustained in war. This analogy was more explicit in the “Healing the Invisible Wounds Act of 2006” in which PTSD was depicted as a less physically observable (i.e., psychological) casualty of war.

Consistent with the wound of war leitmotiv, the titles of the “Psychological Kevlar Act[s]” of 2006 and 2007—bills focused on preventing PTSD among military personnel—implied that PTSD could be avoided by adapting a military technology developed to prevent penetrating wounds. (Kevlar is a bullet-resistant fiber used in body armor). The “Psychological Kevlar” language also conveyed that PTSD could be prevented by increasing the mental toughness and strength of those at risk. Because toughness and strength are archetypal attributes of military personnel—the US Army's recruiting slogan is “Army Strong” (*The Washington Times* 2006)—these titles bolstered militarized constructions of PTSD.

War heroism was also a common theme in PTSD bill titles. Heroism is often viewed as an “apex of human behavior” (Franco et al., 2011, p. 1) and mentions of heroism in bill titles suggested that people with PTSD should possess heroic qualities in order for the problem to be considered worthy of a legislative response. The titles of “Heroes at Home Act of 2007,” “Healthier Heroes Act,” “Healing Our Nation's Heroes Act of 2008,” “Wounded Heroes’ Bill of Rights Act,” and “Homecoming Enhancement Research and Oversight (HERO) Act[s],” for example, communicated that legislation introduced to address PTSD was legitimate because the target population was suffering from the disorder as the result of performing heroic acts in war.

Discourses of heroism extended beyond bill titles and were present in the main sections of legislative texts. One bill, for example, proposed to establish an “Office for Wounded Heroes Advocates” within the Department of Defense to provide veterans with case management services and “Maintain regular contact between health care providers and Wounded Heroes for the identification of symptoms of post traumatic stress disorder.” Mentions of heroism were not present in bills aimed at addressing PTSD among civilians. As such, discussions about PTSD within the context of heroism had the effect of constructing the disorder as a problem reserved for heroes, particularly those who obtained this label in the context of war.

5.3. Facts and figures about PTSD

Many of the bills that targeted military populations began with Sense of Congress and Findings sections, legislative provisions in which Congresspersons express opinions and provide the rationale behind a bill (Davis, 2013). These sections had narrative structures as they told stories about the scope and origins of problems related to PTSD among military populations. Like the bill titles, these sections provided the context in which readers interpreted legislative text about PTSD. These sections contained less symbolic language

than bill titles, however, in exchange for statements presented as objective facts.

Statistics were frequently used in these sections to depict the burden PTSD places on military populations. Government records were often used to generate these statistics. For example: “Records [of the VA] show that 120,000 members of the Armed Forces who are no longer on active duty have been diagnosed with mental health problems, approximately half of whom suffer from post traumatic stress disorder” and “Between 2002 and 2005 almost 19,000 veterans of military service in Afghanistan and Iraq were treated for post-traumatic stress disorder (PTSD) through programs administered by the VA.” The availability of military records has been integral to validating political claims about PTSD among military personnel (Scott, 1990, 1992) and supported constructions of the disorder as a military-specific problem in legislative texts.

Military-specific constructions of PTSD were also strengthened by statements that provided information about the combat-related diagnostic antecedents of PTSD, but not those related to non-combat traumas. For example, two bills stated that: “A large body of evidence indicates that such psychological disorders related to combat stress, such as war neurosis, combat fatigue, and the disorder commonly known as ‘shell shock’ are analogous to PTSD.” The fact that the military-specific precursors to PTSD were named, but not those that were established among civilian populations who experienced non-combat traumas—such as hysteria (sexual assault) and railway spine (transportation accidents)—furthered PTSD's construction as a military-specific disorder.

5.4. The absence of PTSD in civilian contexts

I reviewed the bills that mentioned PTSD with prior knowledge of legislation that had been introduced to address traumatic stress among civilians in the United States. Using THOMAS, I purposefully sampled these bills, reviewed their text, and found that mentions of PTSD were absent—a finding inconsistent with the repeated mentions of PTSD in bills targeting military populations. Omissions of the disorder in civilian contexts bolstered the construction of PTSD as a problem unique to military personnel and combat exposures.

For example, the terrorist attacks of September 11, 2001 were collective traumas that had substantial impacts on the mental health of the US population (Resnick et al., 2004). A search in THOMAS revealed that eight bills were co-assigned the LIV terms “Stress (psychology)” and “September 11, 2001.” All of these bills contained language describing the need to address the effects of traumatic stress among civilians, but none included any mention of PTSD. For instance, “The Post Terrorism Mental Health Improvement Act” made no reference to PTSD despite being introduced with the stated intent to “provide assistance with respect to the mental health needs of individuals affected by the terrorist attacks of September 11, 2001.”

The section of legislative text that created the National Child Traumatic Stress Network (NCTSN) is another example of PTSD's absence from trauma-focused legislation targeting civilians. The Network is a federally-funded collaborative of more than 130 organizations that receives approximately \$50 million in Congressional appropriations annually (NCTSN, 2015). According to the Act's text, the Network was established with the:

Purpose of developing programs focusing on the behavioral and biological aspects of psychological trauma response and for developing knowledge with regard to evidence-based practices for treating psychiatric disorders of children and youth resulting from witnessing or experiencing a traumatic event.

PTSD is only one possible consequence of exposure to traumatic events and the broad legislative language gives administrative

agencies flexibility in implementing the Act and addressing a range of issues related to trauma among civilian youth. The fact that PTSD was not mentioned, however, is in sharp contrast to bills targeting military personnel where the disorder was explicitly named as consequence of combat exposure.

While constructions of PTSD as a military-specific problem were strengthened by the fact that the disorder was not mentioned in trauma-focused legislation targeting civilians, this problem definition was codified through the text of the resolution that designated June 27th National PTSD Awareness Day. Here mentions of PTSD were abundant, but mentions of civilians were absent. The resolution described the prevalence and consequences of PTSD among military personnel at length, but did not acknowledge that PTSD exists among civilians. The segment of text that described the Awareness Day's intended outcomes included war-related imagery similar to that which appeared throughout the sample of PTSD bills introduced between 1989 and 2009. The resolution stated:

Whereas the establishment of a National Post-Traumatic Stress Disorder Awareness Day will raise public awareness about issues related to PTSD, reduce the stigma associated with PTSD, and help ensure that those suffering from the invisible wounds of war receive proper treatment [emphasis added].

Within the context of the resolution's broad title and legislative narrative that did not acknowledge the reality of PTSD among civilians, the "invisible wounds of war" language implied that combat exposure was necessary for a person to develop PTSD. Awareness days designated by US Congress are symbolically powerful and can delineate the boundaries of problems through legislative text that describes why an issue is problematic and necessitates a collective response. The text of the PTSD Awareness Day resolution circumscribed PTSD as a problem specific to soldiers who have experienced combat.

6. Discussion

PTSD was constructed as a problem unique to combat exposures and military populations in the text of federal legislation between 1989 and 2009 (Fig. 1). These constructions were produced through war-related language and imagery, narratives describing PTSD as a war-specific phenomenon, and statistics about the burden of PTSD among military personnel. They were reinforced by the absence of the disorder's mention in trauma-focused bills targeting civilians. Constructions of PTSD in legislative texts are misaligned with epidemiological research about the burden of PTSD across the US population. Most people affected by PTSD have no history of combat exposure, the vast majority of cases of PTSD are attributable to non-combat traumas, and many non-combat traumas carry a higher risk for the disorder. It is important to consider the possible causes and potential consequences of these constructions.

Administrative structures and federal statutes related to the VA and military populations were likely causal factors that shaped the military-specific constructions of PTSD in legislative texts. One administrative arrangement of particular relevance is the relationship between the Veterans Health Administration (VHA) and US Congress. A component of the VA, the VHA is a federal agency that provides health care services exclusively to military veterans. It is the largest integrated health care system in the US—operating over 1,500 health care facilities and employing more than 53,000 licensed health care providers (VHA, 2015). Because the VHA is a federal agency that provides health care services to military personnel, Congress is capable of, with relative ease, legislating the provision of PTSD treatment to this population. Congress does not have such an ability to legislate the provision PTSD treatment to civilians because civilians are primarily served by health care providers in the private sector. In fact, as evidenced by federal

legislative efforts to mandate parity insurance coverage for mental health disorders, Congress' ability to affect the provision of mental health care services to civilians in the private sector is limited (Barry et al., 2010).

Federal statutes that were enacted through the Veterans' Health Care Act of 1984 (Public Law 98–528) are also likely to have contributed to the military-specific constructions of PTSD. Section 101 of the Act, entitled "Post-Traumatic-Stress Disorder," created numerous entities within the VA to address PTSD among military personnel (Younce, 2013). The National Center for PTSD, for example, was established within the VA to "promote the training of health care and related personnel in, and research into, the causes and diagnosis of PTSD and the treatment of veterans for PTSD." A Special Committee on PTSD was also created within the VA to "carry out a continuing assessment of, the capacity of the Veterans' Administration to provide diagnostic and treatment services for PTSD to veterans."

The relationship between Congress and the VA and the existence of federal entities created with an explicit mandate to address PTSD among military personnel provide an administrative architecture that enables Congress to legislate activities to address PTSD among military populations, and with much greater ease than civilian populations. These factors provide a partial explanation for the military-specific constructions of PTSD observed in this study. According to policy design theory, however, the production of PTSD as a military-specific construct in the text of federal legislation could have consequences that pervade beyond the legislative realm.

Reflecting on the significance of public policies from a social constructivist perspective, Schneider and Ingram (2005) stated that "Laws are not bundles of advantages and disadvantages, but are also messages about who matters and who does not" (p. 106). The finding that PTSD has been constructed as a military-specific phenomenon in the text of legislation might send policymakers, and the public, the message that the disorder is not a problem among civilians. More specifically, constructions of PTSD in the text of legislation could imply that it is primarily heroes of war who matter when it comes to PTSD.

'Heroes' are socially produced as they reflect and reinforce cultural norms and prevailing ideologies (Franco et al., 2011). There are two main criteria used to evaluate acts of heroism: risk to self and benefit to others (Rankin and Eagly, 2008). The soldier who risks physical peril for benefit of country is an archetypal hero in most contemporary societies (Dinter, 1985; Franco et al., 2011; Woodward, 2000). By establishing a connection between PTSD and acts of heroism in war, the legislative texts incorporate notions of altruism and personal sacrifice into constructions of PTSD. Congresspersons may have established these linkages to harness the moral weight that PTSD carriers among military populations and advance legislative agendas. The construction of PTSD as a 'hero's disorder' could potentially hinder the passage of targeted policies that address the disorder, and other sequelae of trauma, among trauma-exposed civilians who are not considered to possess the positive attributes of heroism.

For example, elevated rates of violent crime in low-income urban communities, primarily comprised of racial and ethnic minorities, place residents at increased risk for trauma exposure and PTSD (Breslau et al., 1991, 1998, 2004; Brewin et al., 2000; Goldmann et al., 2011; Lowe et al., 2014). In contrast to the celebrated qualities of war heroes, residents of these communities are often negatively portrayed in the media (Kang, 2005) and stereotyped as dangerous (Hurwitz and Peffley, 1997) and economically dependent (Bullock et al., 2001). According to the theory of the social construction of target populations (Schneider and Ingram, 1993, 2005), the findings of this study could potentially suggest

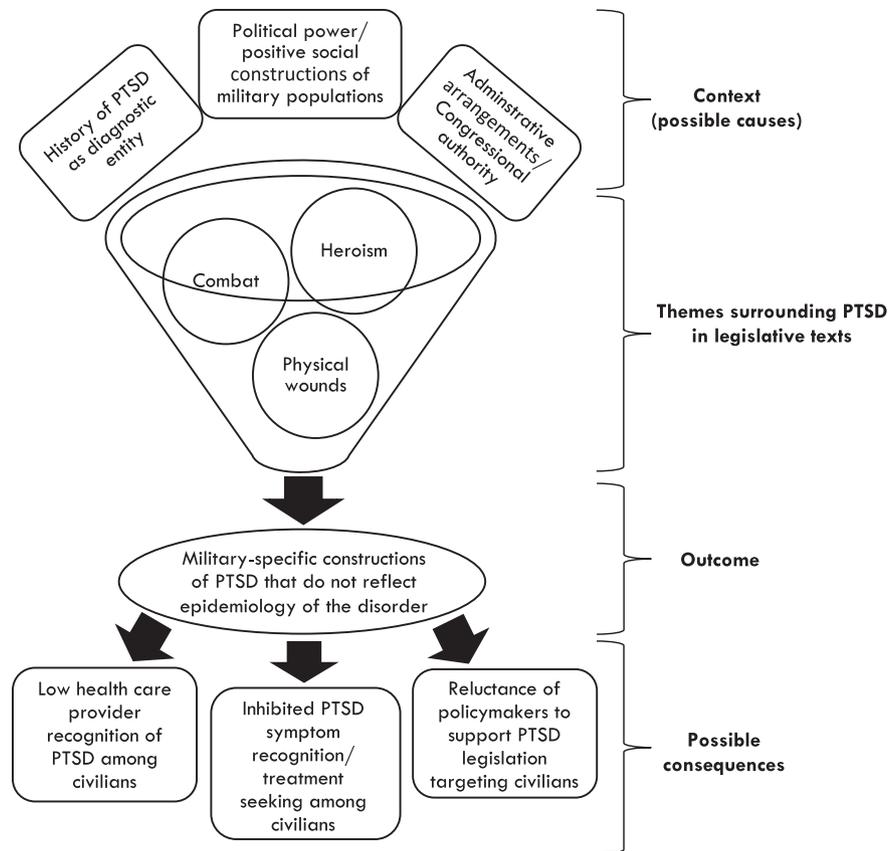


Fig. 1. Posttraumatic stress disorder (PTSD) in US federal legislative texts: Contexts, constructions, and consequences.

that policymakers might be reluctant to address PTSD among this segment of the civilian population, as well as others not considered to embody characteristics of heroism, because doing so could be viewed as disrespectful to military populations and infringing on the boundaries of a problem reserved for war heroes.

Although health insurance reform legislation that does not explicitly target PTSD benefits all civilian populations affected by the disorder, additional policy interventions are needed to sufficiently address the issue in low-income urban areas and eliminate racial disparities in PTSD (Alegria, Perez, and Williams, 2013; Kelly et al., 2010). Examples of such policy interventions include loan repayment programs that incentivize mental health service providers to practice in low-income urban areas, grants to develop culturally-tailored trauma-focused treatments, and support for point-of-care interventions for victims of violent crime.

The results of this study are consistent with research that has identified misconceptions about the incidence of PTSD after non-combat traumas. A vignette study found that PTSD was correctly identified as the problem significantly more often when a person had experienced combat (82.5 percent) as opposed to an accident (68.6 percent) or rape (49.4 percent) (Merritt et al., 2014). Lack of knowledge about events capable of causing PTSD, particularly sexual assault, has surfaced as a barrier to PTSD treatment seeking (Sayer et al., 2009; Schreiber et al., 2010). This is illustrated by a quote from a study of veterans who submitted PTSD-related disability claims to the VA: “one Vietnam veteran only recently conceptualized her posttrauma symptoms as possibly reflecting PTSD, because she believed that only combat could lead to PTSD: ‘I never thought of myself with PTSD because to me that was always people that were in a war; they had PTSD’” (Spoont et al., 2009, p. 1460).

Misconceptions about PTSD also appear to exist among health

care providers. A survey of emergency medicine physicians identified limited knowledge and inaccurate beliefs about the disorder (Ziegler et al., 2005). A vignette study found that primary care physicians were significantly less likely to correctly diagnose PTSD than depression (67.5 percent versus 94.4 percent) (Munro et al., 2004). Constructions of PTSD in legislative texts could propagate the false notion that combat exposure is a necessary criterion for the disorder. As a result, survivors of non-combat traumas might not seek treatment because they do not recognize posttraumatic stress symptoms as PTSD, and health care providers might not recognize the disorder or offer intervention.

Although military-specific constructions of PTSD could mask the epidemiology of the disorder, the amount of legislative attention the disorder has received can be seen as reflecting a culture that accepts PTSD as real. Fassin and Rechtman (2009) contend that the legitimization of PTSD has, in part, been made possible by a shift in moral climate where “[t]he way in which one’s suffering is viewed depend[s] on their status or their social usefulness” (p. 30). Military personnel hold a venerable status and serve important social functions—instrumentally as they provide national security and symbolically as they embody cultural values of patriotism and personal sacrifice. From this perspective, militarizing PTSD can be seen as a political strategy that leverages positive constructions of the disorder to bolster Congresspersons’ legislative proposals. This might have enhanced visibility of the disorder and enabled its acceptance as a diagnostic entity, but done so at the consequence of constructing the disorder as a military-specific phenomenon.

6.1. Limitations

This study was limited to bills introduced at the federal level in

the United States and its results are not generalizable to US state legislatures or other countries. Legislative text is only one artifact of law making processes at the federal level. Transcripts of committee meetings, expert testimonies, and reports also contribute to the construction of problems in the legislative arena. These documents could potentially contain alternative constructions of PTSD that did not surface in legislative texts because they were counter to prevailing constructions of the disorder as a military-specific problem. I did not investigate how constructions of PTSD differed according to the political party of the Congressperson who introduced a bill or if specific features (e.g., themes of heroism) were associated with a bill's passage into law.

This study focused on PTSD, not the broader concept of traumatic stress. PTSD is one of many disorders (e.g., substance misuse, depression) for which risk increases after exposure to a traumatic event. It should be emphasized that this study examined how PTSD has been constructed in legislative texts and did not aim to analyze the instrumental aspects of policy proposals or evaluate their potential to produce measurable benefits (e.g., prevent PTSD, increase receipt of evidence-based treatments).

This study was limited to bills that were introduced after January 3, 1989 and did not explore constructions of PTSD in legislative texts introduced prior to this date. I excluded bills introduced before this date because their full text is not publicly available on the Internet. Providing the reader with the opportunity to view the texts and co-construct their own meanings of PTSD is consistent with the study's constructivist approach. Furthermore, given that I was the sole coder and analyst of the study data—which can be viewed as a limitation from a post-positivist perspective (Madill et al. 2000)—the publically available nature of the texts enhances the replicability and credibility of the study (King, 1995).

There are general limitations associated with the use of LIV terms in social science research (Hillar, Purpura, and Wilkerson, 2008). Because LIV terms are assigned by CRS staff, they can be applied inconsistently as coding decisions are reflections of staffers' individual perceptions of the topics that a bill addresses. This is problematic for broad topics (e.g., civil rights) that are open to a wide range of interpretations. This is not necessarily a limitation of the current study because PTSD is a distinct diagnostic entity and a narrow topic and the LIV term was assigned consistently.

7. Conclusion

Public policies are social proclamations about the reality of problems. PTSD exists in the epidemiological literature as a problem universal to all populations, but has been constructed in the text of federal legislation as one specific to military personnel and combat exposures. As a consequence, legislative texts might constrain public and political discourse about PTSD and reify sociocultural barriers to the access of mental health services among populations that have experienced non-combat traumas. By elucidating what PTSD means in the legislative realm, this study can inform advocacy efforts to forge new constructions of PTSD and spur a societal response that promotes healing across the entire spectrum of populations affected by the disorder.

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