

RESEARCH ARTICLE

The “trauma pitch”: How stigma emerges for Iraq and Afghanistan veterans seeking disability compensation

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Abstract

Posttraumatic Stress Disorder continues to be a highly stigmatized disease for the veteran population and stigma, experienced as a mark of discredit or shame, continues to be identified as the main deterrent in treatment seeking. Little attention has been paid to how the process of obtaining service-connected disability status can amplify veterans' perceptions of being stigmatized. The following ethnographic study identified how combat veterans experienced stigma in processing through Veterans Affairs care and the effects of linking a Posttraumatic Stress Disorder diagnosis with disability compensation. Stigma was identified in two inter-related areas: 1) the structural level in the Veterans Affairs disability claims process and 2) the individual level in interactions with Veterans Affairs service providers. Findings based on veterans' narratives suggest that the disability claims process, requiring multiple repetitions of personal trauma, coupled with perceptions of institutional stigmas of malingering, created *bureaugenic effects*: a worsening of symptoms caused by bureaucratic protocols intended to help veterans. This process influenced first time treatment users of the Veterans Affairs by deterring treatment-seeking behavior but was not found to affect veterans who had already initiated treatment. Despite the experience of stigma and commodification of their suffering through disability and diagnostic screening, veterans still sought disability compensation. Veterans viewed this compensation as acknowledgment of their loss and validation of their sacrifice.

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Data Availability Statement: Data cannot be shared publicly for ethical reasons: the public sharing of identified data was not stipulated in the consent form signed by study participants. The minimal relevant data set is included in the paper via quotes supporting the thematic analysis. This is the standard operating procedure in reporting ethnographic research.

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Introduction

The convergent relationship between Posttraumatic Stress Disorder (PTSD), veterans' experiences with PTSD-related stigma, and the need to be diagnosed with PTSD to receive Veterans Benefits Administration (VBA) (Table 1) disability benefits remains under explored. The clear intent of the VBA is to ensure that veterans injured through combat or other military related events receive appropriate financial support, healthcare, and ancillary services to reduce the impact of these events. However, little attention has been paid to how the process of obtaining service-connected disability status can impact the veteran's perceptions of being stigmatized and their experience of PTSD.

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Table 1. Acronyms.

Title	Acronym
The United States Department of Veterans Affairs	VA
Veterans Benefits Administration	VBA
Veterans Health Administration	VHA
Posttraumatic Stress Disorder	PTSD
Traumatic Brain Injury	TBI

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After two decades of military conflicts in Iraq and Afghanistan, the number of war veterans diagnosed with PTSD continues to rise. A RAND study conducted in 2008 estimated PTSD prevalence for these veterans at 13.8% [1]. A recent meta-analysis of PTSD in Afghanistan and Iraq veterans found a much higher number, estimating prevalence at 23% [2]. Only slightly more than half of veterans with a PTSD diagnosis seek treatment [3]. According to a Department of Veterans Affairs (VA) study, barriers to care include mistrust of the medical establishment, difficulty finding a therapist, uncertainty that treatments will be successful, and stigma [4].

While treatment seeking for PTSD among veterans remains a serious public health issue, PTSD also remains the most prevalent compensable mental health disorder in the VBA's disability system. PTSD claims have more than tripled in the last decade. About 22% (1,118,041) of all veterans who receive disability compensation through the VBA (4,944,275) have these benefits because they suffer from PTSD [5]. In order to receive disability compensation, a veteran must first go through a series of appointments in the Veterans Health Administration (VHA, i.e., the "VA Hospital") to be diagnosed and provide evidence that their diagnosis or injury is specifically related to their military service. In the language of the VBA, veterans need to prove that their injury is "service connected". Some injuries are "conceded", and military decorations such as the Combat Infantry Badge and the Purple Heart can be considered as evidence of exposure to combat-related stressors. However, these policy changes did not occur until 2010, seven years after the Global Wars on Terror began.

A military service-connected disability is defined as a disability that is due to injury or illness sustained in or worsened by a veteran's military service. Within the VA system, it is known as a "service connection" and veterans refer to applying for a service connection as submitting a claim or "claims". There are eight steps involved in the claims process: 1) claim received; 2) claim under review; 3) gathering of evidence from veteran or medical professional (combined VBA/VHA); 4) review of evidence; 5) preparation for decision; 6) pending decisions for approval; 7) preparation for notification; and 8) completion and delivery of decision packet [6]. A claims officer assists the veteran in applying for a service connection and claims reviewers gather the evidence needed to access the claim.

The Iraq and Afghanistan veterans who are within five years of separating from the military have access to VA medical benefits. It is a tiered insurance system where veterans who have 30% or more service connection receive free healthcare. This percentage must be maintained to continue to receive these benefits and percentages are re-evaluated periodically. Veterans also receive monthly monetary compensation based on their disability rating. In 2021 a 10% disability rating for a veteran with no dependents provided a monthly compensation of \$152.64, 60% rating provided \$1214.03, and 100% rating provided \$3332.06 [7]. Not all veterans who go to VA medical centers for care claim a disability connection for reasons discussed later in the paper.

The VA's institutional definition of a disability rating is based on "occupational and social impairment" according to the VA General Rating Formula for Mental Disorders [8]. The VBA

bases a rating off a veteran's ability to work and function in their social world and ratings are made at 0, 10, 30, 50, 70, 90, and 100%. A 0% rating acknowledges there is an illness or injury connected to military service but does not warrant compensation at that point in time. Essentially, a rating is not related to war experience or military trauma but to the *effects* of these experiences.

Veterans seek disability compensation for PTSD for a variety of reasons, including material benefit, but also for symbolic reasons linked to acknowledgment for the sacrifices they made during their military service [9]. Disability claims may help the veteran clarify their health issue, offer a recognition of service, and often are undertaken with encouragement of trusted friends or professionals. Veterans deterred from applying for a service connection report concern with negative public perceptions associated with disability and receiving government aid [10]. Veterans who delay seeking VA treatment for their PTSD are also concerned about the stigma of being labeled mentally ill and being accountable for own their illness given that military service was voluntary [11].

In a health-related context, stigmatized people often hide their condition and go without treatment. Stigma, as theorized by Erving Goffman [12], is a process of stereotyping where negative labels (e.g., dangerous, crazy) are attached to a category (e.g., 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 [13]. This is especially true when conditions are culturally perceived to be caused by moral transgressions, dangerous, and/or affect one's appearance (e.g., AIDS/HIV, substance misuse, schizophrenia). Stigma can be so powerful that desired and available treatment is delayed, terminated, or avoided, exacerbating symptoms, and transforming treatable conditions into desperate cases that can result in premature death [14].

Several studies with military members suggest that an individual's fear of being stigmatized as psychologically weak is a barrier to mental health treatment [15–17]. This begins while in the service. To avoid stigmatization and status loss, many active duty service members do not disclose mental health problems for fear of being perceived as incapable by their officers (chain of command), declared unfit for active service, viewed as unreliable by peers or harming their career [18]. For Iraq and Afghanistan veterans with psychiatric diagnoses, stigma and barriers to care were most strongly associated with feelings of embarrassment, perceptions of being viewed as weak, lack of knowledge regarding where to go for treatment and scheduling difficulties [19].

Recent ethnographic studies in psychology [20], sociology [21], and anthropology [19, 22] illustrate that while a PTSD label might be necessary to receive disability benefits for the psychological injuries that military service incurs, the very act of claiming a PTSD diagnosis is often viewed by veterans as claiming individual victimhood, creating a form of moral tension and stigma. Claiming a PTSD diagnosis conflicts with the core values that military culture embraces, i.e., physical and psychological strength and group loyalty. Military service period may also play a role, Harris et al. [23] found that veterans of the Iraq and Afghanistan wars who received disability benefits had trouble overcoming self-stigma and alienation compared to other veterans.

These studies typically address stigma as a barrier to treatment and tend to focus on veterans' individual beliefs, rather than external or systemic factors, such as the VBA disability claims process itself. This ethnography helps fill this gap in knowledge by identifying how stigma unfolds for veterans as they process through these bureaucratic forms of care. Because of the ethnographic approach taken, this study frames the analysis from two main contexts: the systemic and the individual level. The perspectives of 1) veterans engaging in mental health

care at VA hospitals and applying for benefits at their local VBA benefits facilities, are compared with; 2) veteran healthcare providers and claims officers working in VA hospital and VBA bureaucracies.

The primary objectives of the study were to:

1. Identify if and where stigma became a factor for veterans in claiming disability for PTSD.
2. Identify the effects of linking a diagnosis to disability ratings and compensation.

Methods

Ethnographic approach

As a first phase in public health services research, qualitative findings can generate hypotheses that inform larger scale studies. Due to the lack of research in this area, stigma processes could not have been postulated *a priori* for hypothesis testing and an ethnographic approach allowed these processes to emerge throughout the data collection and analysis. This approach specifically seeks to understand the relationship between the micro-level experiences of individuals and macro-level cultural and social systems. Observing, documenting, and analyzing the relationships between these elements are conceptualized as ‘thick description’ [24], especially useful in problem assessment and intervention design in health promotion research and practice [25]. Ethnography further allowed for the identification of the personal meanings of disability ratings for Iraq and Afghanistan veterans [26].

This ethnography combined direct, *in situ* participant observations that veterans consented to (accompanying veterans to VHA (hospital) and VBA (benefits) appointments), in-depth semi-structured interviews (with veterans, disability claims reviewers and VHA mental health providers) and document analysis (VHA screening tools and VBA procedures). Document analysis [27] of participants’ “VA paperwork” including disability determination letters, applications, and disability rating schedules. Veterans shared these documents of their own accord within the context of VA appointments and interviews. Collecting data at these three levels of participant observation, interviews, and documents established confidence in the findings through constant comparison (triangulation) and as a part of theory generation [28]. The ethnography was designed and carried out by a trained qualitative researcher with seven years of experience and in fulfillment of a doctoral degree. The researcher is a civilian with no connection to the United States Military.

Context

The study took place in a Midwestern city in the United States at a VHA medical center, VBA offices, and three local veteran service organizations sites. Local service organizations assist veterans with accessing health care, housing, VA benefits and provide general social support through peer mentoring and programming.

Participants

Twenty-four participants from four distinct participant groups took part in this study (Table 2). 10 Iraq and Afghanistan veterans participated for 18 months while either seeking a VBA service connection for PTSD or having an approved claim. Three additional participant groups were interviewed during this time to gain a broader understanding of institutional practices and perspectives: claims officers (n = 4), VA patient advocates (n = 3), and VA mental healthcare clinicians including psychologists, psychiatrists, clinical psychiatric nurses,

Table 2. Participant characteristics.

Participant Group	Number	Veteran Status	Male Identified	Female Identified	Existing PTSD Diagnosis and Rating	Filing a PTSD Claim
Veterans	10	10	7	3	6	4
VA Benefits Claims Officers	4	4	4	0	n/a	n/a
VA Patient Advocates	3	2	2	1	n/a	n/a
VA Mental Health Clinicians	7	3	4	3	n/a	n/a
Total	24	19	17	7	6	4

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(n = 7). IRB approval was granted by the author's educational intuition and all participants signed a written consent.

Recruitment, sampling, and participant characteristics

Veteran recruitment was accomplished through flyers at local veteran service organizations and through snowball sampling [29]. Once the study had 10 participants a purposeful sampling procedure was utilized to obtain more variability on categories of interest and to provide better representation of the Afghanistan/Iraq population. Categories of interest included PTSD diagnosis and gender; racial and ethnic groups that are underrepresented in the military; military specialty (combat enlisted, combat officer, support enlisted, support officer) and veterans' military status (separated from military, enlisted in National Guard or Army Reserves). An attempt to mirror the overall demographics of the military in the sample was made. Recruitment continued until 15 participants were enrolled to account for dropout. In qualitative research, to reliably ensure consensus and adequate data collection at least ten interview participants are recommended [30]. Serendipitously, there was great variability in participants' claims status including: PTSD service connection denied, claims being re-opened, claims granted, new claims pending, and old claims being re-evaluated for an increase in rating.

Four veterans did not complete the study by not returning scheduling calls and one person died from drug withdrawal complications. Of the remaining 10 participants, six had a PTSD diagnosis and a disability rating, while four were in various stages of filing a disability claim. Seven were men and all served in the infantry (combat) and three were women. These women, technically "noncombat" still experienced combat through "beyond the wire" (outside the base) convoys, enemy attacks, and firefights. One veteran was a commissioned officer in the Marines and three were noncommissioned officers in the Army or Army Reserves. Three were of ethnic minority status. Two participants were still working in the military, one in the Army Reserves and another in the National Guard. One woman in the Army Reserves did not pursue a PTSD diagnosis or service connection because of her leadership status as a noncommissioned officer and fear of losing that status. Notably, a PTSD diagnosis renders soldiers undeployable and the Department of Defense can pull the electronic health records of VHA patients.

VA Claims Officers and Patient Advocates were recruited through face-to-face meetings with leaders of veteran service organizations and through their network referrals. Six of the seven were veterans. VA mental health clinicians who worked with Iraq and Afghanistan veterans were recruited through a project presentation provided at a staff meeting at the VA hospital. Three of the seven mental health clinicians who participated were veterans.

Interview procedures

A series of semi-structured interviews were conducted (n = 52), focusing on the PTSD experience, diagnostic procedures, and compensation process to identify variability in participants'

multiple perspectives. With each of the 10 veterans who finished the study, a series of three interviews administered over 18 months at three to five-month intervals was conducted. For the five veterans who did not complete the study, two completed one interview and three completed two interviews. A total of 38 veteran interviews were conducted. Interviews varied in length and focused on veterans' thoughts surrounding their diagnosis, their choice to pursue a disability claim and experience in this process, and their experiences with treatment. The 18-month study design allowed for capturing veterans' experiences as the lengthy bureaucratic process ensued. The VA claims officers, patient advocates and VA providers took part in one interview each, for a total of 14 interviews. All interviews were audio-recorded and transcribed.

In situ observations of the claims process

To augment the veteran interviews and gain deeper insight into the claims process, direct participant observation was conducted (and consented to) at the local VA medical center and service organizations where the author engaged in informal interactions with veterans and providers. The author was able to follow one woman through her claims process from beginning to end, accompanying her to her initial claims appointment to the final disability and compensation evaluation appointment. This veteran also contacted the author at every touchpoint with the VHA and VBA. In the ethnographic research process, participants sometimes do things we do not expect. Veterans often called or texted the author, providing updates after interactions with VHA and VBA staff. Other times the author received photos of squad reunions or links to news articles participants thought would be of interest. These observations and interactions were documented through field notes, processed on a computer, and analyzed in qualitative software. Approximately 80 pages of field note data were generated in these observations.

Analysis

The entire project generated over 700 pages of data; however, this study focused specifically on those segments that addressed stigma and disability, the claims process, and the personal meanings of disability determinations and ratings for research participants. The scope of data was narrowed through qualitative software Dedoose version 8.1.

Analysis began with a review of the data to create overarching codes. These codes described broad common themes in the data such as VA, PTSD experience, and social life. Excerpts of data were sub-coded, under these broad categories, 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 patterns and the relationships between them were identified [31]. 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 identified [32].

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 regarding veterans' experiences of stigma and disability compensation to develop [33]. Trustworthiness is how qualitative research attends to validity [34] and was addressed by: 1) triangulation of interview, observation, and document data; 2) cross-checking emerging theories with research participants, and; 3) reporting only the categories that were represented by at least half of participants.

Findings

The study findings are presented in the following thematic sections, with interpretations supported by raw data. The findings are organized into two broad categories: systems level stigma

and individual level stigma. The systems level is conceptualized as stigma resulting from bureaucratic processes and procedures. The individual level stigma relates to perceived personal bias, stereotyping and discrimination that is experienced as interpersonal.

Systems level stigma

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, Iraq veteran and claims officer

In this sample, veterans had recounted their trauma four to seven times in the disability claims process depending on what type of VA facility they started with (an outreach center, the VA hospital, or the VBA regional offices). For example, one veteran started at a Vet Center (a satellite of the VA) with a counselor (1) 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 (2) who helped him file for disability and set up medical appointments. He told his story again to a primary care provider (3) who made an assessment and referred him to a specialist (4) for a traumatic brain injury (TBI) evaluation (with medical students observing). After the evaluation he was referred to a psychologist (5) for a diagnosis. Then, he saw a psychiatrist (6) for medication. This veteran gave his trauma account six times to six different people, all of whom needed to know the details of his trauma in order to make an assessment. At minimum veterans see a primary care physician, a disability claims officer, a psychiatrist, a psychologist and finally a compensation and pension (C & P) examiner (not necessarily in that order) (Fig 1). 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 the veterans' 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, Iraq 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.

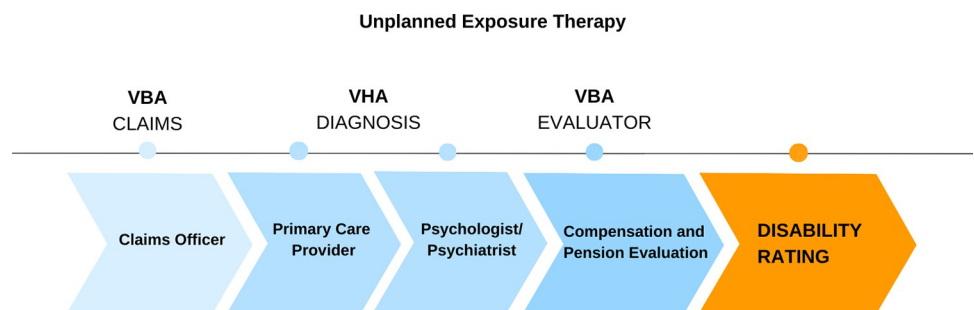


Fig 1. The recounting of trauma in the VA disability claims process.

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- Male, Iraq/Afghanistan veteran and claims officer

I conceptualize this repetitive retelling of intimate and emotionally laden memories as the "trauma pitch". In these bureaucracies of care (VHA and VBA) the trauma pitch was a necessary process to obtain benefits, whether it was healthcare or disability compensation. Objectifying memories through multiple tellings was painful because it alienated veterans from their service and those they served with. The trauma pitch, as an overarching practice and requirement to seeking a diagnosis and benefits, was experienced as stigmatizing because veterans felt that the VA was trying "catch" them in a lie, assuming they were malingerers and frauds trying to get a "free hand-out". The following themes extrapolate on the impact of the trauma pitch on PTSD symptoms and veterans' experience of stigma.

"Unplanned exposure therapy" and exacerbating symptoms. 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, Iraq 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, Iraq 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, Afghanistan 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 [35]. One male Iraq veteran summed the claims process up as "unplanned exposure therapy".

Individualizing trauma: Threatening collective and personal identity. 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, Iraq 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.

- Male, Afghanistan/Iraq 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. . . 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, Afghanistan/Iraq veteran

These “dying moments”, intense personal experiences of war, were not something veterans wanted to corrupt in any way. They hold significant meaning and putting them into words diminished them. 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, or what it meant “to be a veteran”. 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, Afghanistan/Iraq veteran

Altering the trauma memories in this way was a dehumanizing process that was experienced as insensitive care and having “to remember” in a non-reverent way felt shameful.

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, Iraq veteran

Quantifying sacrifice: Translating trauma into percentages. 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, Afghanistan 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 (they assumed that the VA already had all this evidence in a file) and when the VA awarded them a lower rating than they thought they merited.

The claims process was described as:

. . . very impersonal, I feel like they don't care.

- Male, Iraq veteran

Another male, Iraq veteran stated that when he went for his 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 (difficult and stressful because memory is affected by trauma) 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, Iraq veteran

Providers also struggled with the claims process and its quantification, 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 1

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 person's 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 2

Providers as victims of bureaucracy. 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, compensation, and pension (“comp and pen”) evaluators, and the rating system in general. Staff were sometimes perceived by veterans as under-trained in military culture, war work and its impacts. 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!

-Male, Afghanistan/Iraq veteran

Although VA policies have changed to relax the evidentiary standard that establishes the link between trauma and service, stories like this circulate through the "Joe Network" and are difficult for the VA to recover from. These compensation evaluation experiences made some veterans question the competence of VHA mental health providers and contributed to veterans delaying or avoiding treatment and deterring reapplication for rating increases or appealing a denied claim.

Individual level stigma

Blue Falcons and frauds.

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

- VA psychologist 2

Stigma also unfolded on an individual level in the claims process. 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" (this is the VA's Schedule for Rating Disabilities) (Afghanistan/Iraq 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 handout and unfortunately there are a lot of people in the VA system looking for a handout, which screws everything up for the people who actually need it.

- Male, Afghanistan/Iraq veteran

As one male, Afghanistan 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.

Proving yourself: Authenticating trauma. Built into the VA claims process is the need to produce evidence of trauma, or a "verifiable stressor." Not surprisingly, at the time of this study all the veteran participants 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, Iraq veteran

Their job is basically to deny you and so they don't want to know you personally.

- Male, Iraq 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, Iraq veteran

This bureaucratic necessity of providing evidence of trauma created anxiety in most participants.

It was very nerve-racking. . . because they ask you so many personal questions and its 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 every day. 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, Afghanistan/Iraq veteran

The percentage is a big deal because it translates directly to healthcare benefits and financial assistance.

This perspective of veterans, that the VA does not want to compensate them, 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 1). 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

Invisible injuries: "I'm a 25-year-old in 50-year-old body. 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."

- Male, Iraq veteran

Even though veterans felt more stigmatized when it came to physical complaints, the interplay of bodily function and physical appearance was linked to PTSD symptoms. For most this played out in their symptoms of hypervigilance, anxiety, and depression. 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, Afghanistan/Iraq veteran

Golden handcuffs: “Compensation as counter-therapeutic”. Many providers felt that, at some level, compensation hindered treatment through the possibility of incentivizing illness.

Here's our problem as VA providers. . . we are training as mental health providers to help someone who is distressed and sick. The problem is we have people coming in with different motivations—they need to have me writing in their chart. . . to convince them (VBA) that ‘I am sick so I can get my paycheck and you are a tool that is going to help me with that. . . 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, Afghanistan/Iraq veteran

Providers wanted what was best for their veterans, but many felt conflicted in encouraging disability compensation, also referred to as the “golden handcuffs.” As one psychiatric nurse put it:

I will be really honest with you, that's (compensation) a huge struggle for me. . . 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 mindset? 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?

Moral judgment. For a number of veterans, the perceived moral judgment of medical providers and the shame veterans felt about their trauma, made veterans hesitant to disclose the full details of their war experience. This was despite the understanding that one's disability percentage is “based on how messed up you are” (Male, Afghanistan/Iraq 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, Iraq 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, Iraq veteran

Even if the person is a health professional, they are still human, they are still going to judge you.

- Male, Afghanistan/Iraq veteran and claims officer

These nine interrelated themes identified above describe how stigma was experienced by one group of Iraq and Afghanistan veterans possessing or seeking a disability determination for their war-related psychological injuries. The stigma experiences that emerged during the VA claims process, from the perspectives of these veterans, were entangled in systemic bureaucratic processes but also in the individual personal interactions with VA providers (Fig 2).

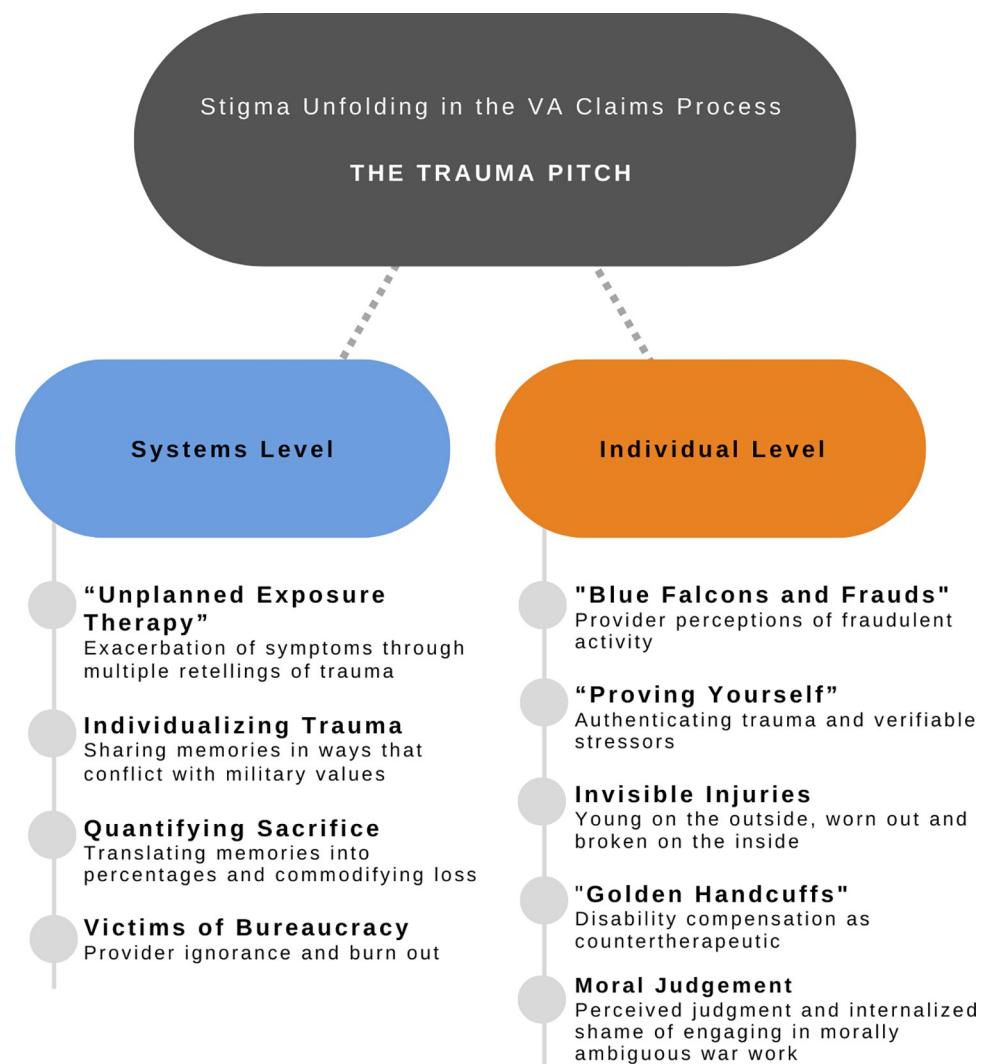


Fig 2. How stigma unfolds for veterans in the VA disability determination process. The "trauma pitch" impacted veterans via systemic processes and individual interactions.

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Analysis and discussion

This ethnography focused on two main research questions: How stigma was experienced by veterans claiming disability for PTSD and the effects of linking a diagnosis to disability ratings and compensation. I have identified nine interrelated areas that contributed to stigma experiences in the VA disability determination process from the veteran perspective (Fig 2). I argue that the *trauma pitch*, conceptualized as the repeated telling of intimate trauma experiences to “strangers” (VA bureaucrats and clinicians) is at the core of systemic level stigma processes. The trauma pitch involved the many appointments and screenings veterans were required to go through in seeking a disability rating. These multiple screenings led to an inadvertent exacerbation of the PTSD symptoms of anxiety, alienation, depression, and anger, and were brought on by bureaucratic processes.

In addition to symptom aggravation, the trauma pitch placed veterans’ pride and identity at stake. 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 a soldier’s squad and the military were relied upon at war. Ethnographic studies in psychology [20], sociology [21] and anthropology [22, 36] 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, selfless sacrifice and group loyalty). This conflict aligns with a major finding of this study illustrating that, beyond the PTSD label, the institutional processes that label veterans (diagnosis, treatment, and claims) can further root stigmas in ways that threaten collective military and personal identities.

To transform stigmatization into negative consequences social power is necessary [13]. For the veterans in this study that power laid in clinicians’ authority to diagnose and the compensation and pension evaluators authority to rate the service-connected disability. 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’ [37]. A label (e.g., malingerer) 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 label, creating a cycle of stigma. In contrast to treatment avoidance-related stigma, this study suggests that a cycle of stigma develops through engagement *with*, rather than avoidance of, the bureaucratic processes of diagnosis, treatment and disability claims and compensation.

Disability benefits are one possible way of intervening in the stigma cycle [38], but as this study illustrates, the unintended side effects of the disability determination process, a process designed to aid veterans, can end up causing more harm than good. I have termed this process, bureaugenic effects. Like iatrogenic effects in medicine, (the adverse outcomes that are the result of a medical treatment) bureaugenic effects are the adverse outcomes of bureaucratic processes intended to help veterans. The bureaugenic effects of the disability claims process increased PTSD symptoms and the experience of stigma in this study (Fig 3). Coupled with an institutional stigma of malingering, veterans felt that clinicians and evaluators did not believe their trauma pitch. Considering the details of veterans’ traumas that often involved perpetrating or witnessing morally injurious events, veterans felt they were being morally judged by VA staff. This could be interpreted as a form of internalized stigma, or self-stigma that relates to a person’s embarrassment or shame connected to their condition, and the expectation of being stigmatized by others keeps people from sharing their trauma and seeking help [39]. Critically,

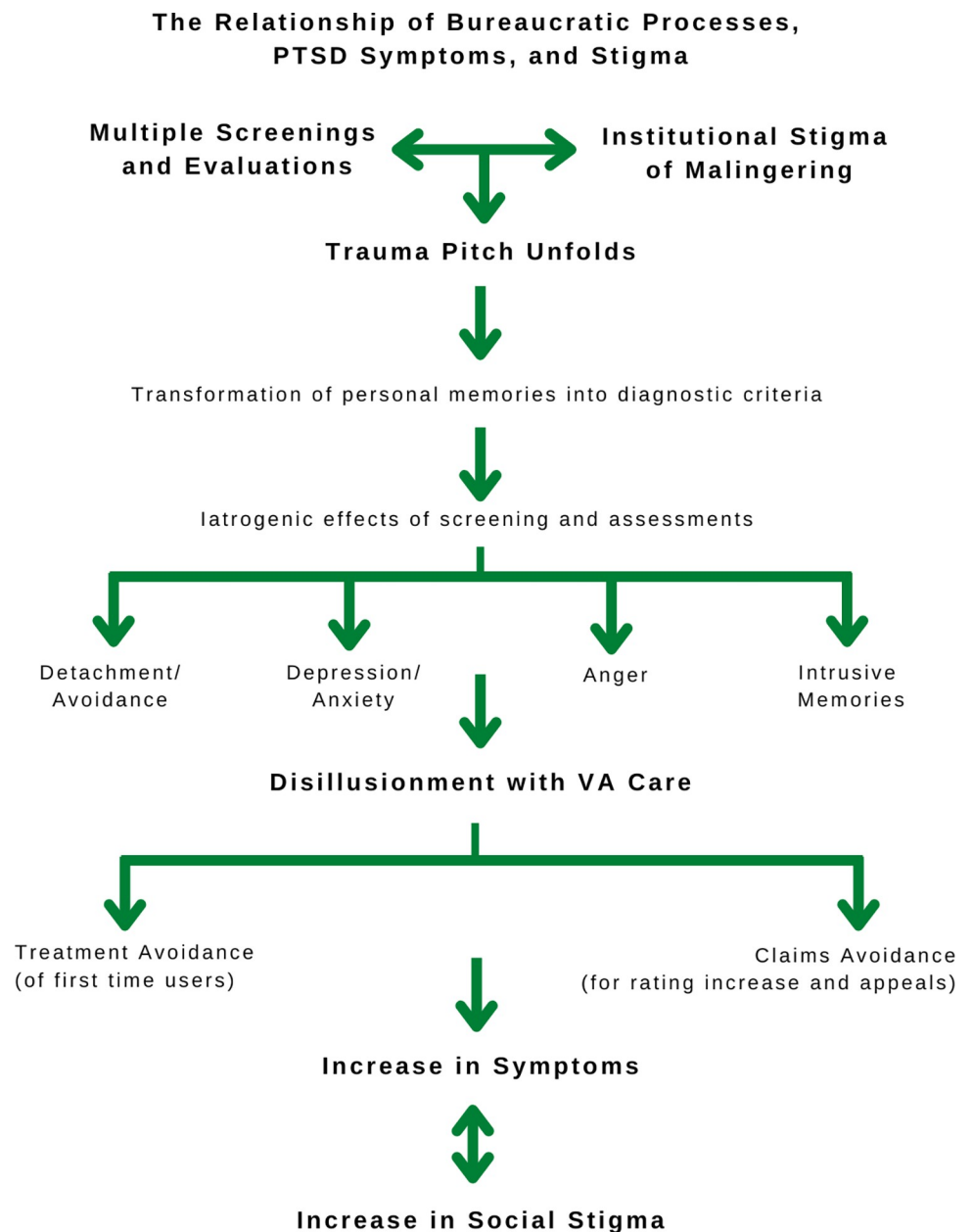


Fig 3. The bureaugenic effects: The relationship between bureaucratic processes, PTSD symptoms and mental health stigma in determining disability compensation for US military veterans.

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the trauma pitch and resulting bureaugenic effects deterred first time VA users from seeking treatment and filing disability claims.

While all these stigmas were tangible and part of veterans' lived experience (Fig 2), at the root was a lack of knowledge of bureaucratic process on the part of the veterans and an unawareness of the negative impact of these processes on the part of the VHA and VBA.

Bureaucracies of care

The VA is a Cabinet-level executive branch department of the United States federal government and a complex bureaucracy. The VHA is separate from the VBA, and surprisingly this

was a split that the veterans in this study were not aware of. Veterans saw health care providers through the VHA for a diagnosis and compensation evaluators through the VBA for their disability rating. To muddle things more, these compensation evaluators were also VHA providers, which created conflict for their therapeutic practice. These two settings, the clinical and the administrative, were co-mingled, and veterans thought all their appointments were part of one process. Confusion was compounded when veterans thought they were at the hospital for a therapy intake: three of the ten participants who finished the study did not even realize they were going through the disability claims process, having initiated contact with the VHA to start treatment. These veterans 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. As one provider put it, “At this point they want a listening ear and instead someone is typing away at their computer” to document the details for a claim.

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”. At the time of this study, veterans did not know what the status of their claim was for up to ten months. Improvements have been made since this study was completed as veterans can now track their claim electronically to see where it is in the process by registering for eBenefits at www.ebenefits.va.gov. At the time of this publication, the average time to process a claim was three to four months [40]. VHA and VBA staff acknowledged difficulties in navigating the system, especially for those veterans with PTSD who were already contending with anxiety, anger, difficulties focusing and depression. A few veterans related that they had abandoned the process multiple times. Notably, this bureaucratic burnout mirrors research on clinical providers. According to a study of VHA clinicians in PTSD focused clinics, participants identified organizational politics and bureaucracy as the main cause of burn-out, as opposed to hypothesized symptoms of secondary trauma related to providing PTSD therapy [41].

Meanings of disability ratings: Validation and acknowledgment

In addition to lack of awareness of bureaucratic process, there also existed a significant diversity in the meanings of disability ratings between veterans, service providers and VA. It was this gap in veterans’ personal understanding of ratings, in contrast to broader institutional definitions, where stigma emerged. For example, from the veteran point of view, a disability rating was often a validation of their war trauma. The rating provided a stamp of truth in a system, they believed, was designed to catch frauds. A disability rating was viewed as a form of acknowledgement for their suffering and something they “deserved” for their sacrifice. This echoes the quantitative research of Sayer et al. [9] who found that almost 75% of their veteran sample felt it was important to receive a disability rating and compensation for PTSD because it proved government acknowledgment of the impact of military service.

In contrast, from a clinician perspective, “claims is not about validation, treatment is” and disability compensation is about “what you can and cannot do” (related to functioning in society). 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. The perspective of clinicians in this study, that disability compensation can serve as “golden handcuffs” and be counter-therapeutic contrasts the epidemiological study by Murdoch et al. [38], who found that veterans who received compensation for PTSD had clinically meaningful reductions in symptoms and less poverty and homelessness than veterans who were denied benefits over the course of 10 years.

Veterans felt the meaning of their service was reduced to scores and percentages. They felt they were rated for their “experiences” (e.g., quantifying how many deployments they went on,

how many times they were “blown up”, killed, etc.) and not the impact of those experiences on their everyday lives. This is understandable considering the tools used to screen for PTSD such as the Combat Exposure Scale [42] that help clinicians assess wartime stressors through quantifying and translating war experiences into a diagnostic score. This PTSD score is later translated into a disability rating and then a monetary compensation. Lower scores would translate as lower levels of PTSD. While the institutional definition of a disability rating reflects the effects of war experiences on “occupational and social impairment” this is not what veterans experienced.

Linked to conflicts of meaning, on a systemic level, an ambiguity between the meanings of impairment and disability and their relationship to a rating emerged. The Posttraumatic Stress Disorder General Rating Formula for Mental Disorders used at the VBA rates for 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 who with 50–90% ratings (moderate to highly impaired) were able to hold down 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. For example, one veteran planned on becoming a physician, but because of traumatic brain war-related injuries, now works in low-level administration. To push the question of impairment and disability further, veterans could be seriously impaired in their social lives, with certain types of employment still manageable. Veterans’ perception of social impairment included inability to initiate and maintain relationships, engage in activities with friends and family and in general, have a “social life”.

Negative impact of screening tools

This study suggests that the screening tools used for PTSD can have a negative impact on veterans through quantifying and devaluing their trauma and service. 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 consensus was that PTSD could present with only a few severe symptoms and in “splitting” experience into symptom criteria and “checking boxes” a formal diagnosis was not established. A PTSD diagnosis was viewed as a “communication tool” but not a clinical tool. In other words, it was a way to communicate with the VBA or other care providers what was going on, but secondary to work therapeutically with specific symptoms and behaviors to improve quality of life. These findings are similar to those of Jackson, et al. [43], which found that 59% of clinicians rarely or never use screening tools with only 17% routinely using them, with less experienced providers using them more frequently. Overall, the providers in this study expressed much frustration over their role in the disability determination process, which in their professional view, conflicted with their training, professional ethos, and therapeutic goals.

Limitations

This study has several 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 VA was at a time when VA was not prepared for a young cohort of veterans with unique needs that the VA was unaccustomed to serving. Also, early Iraq war deployment generally equates to more trauma exposure, symptom severity, and discomfort interacting with providers and institutions. Several of the veterans in this study had

first contact with VA before more lenient policy changes surrounding PTSD claims and verifiable stressors was instituted (in 2010). As such, these formative results may not be generalizable to diverse or recent 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 in presenting themselves. However, by including three phases of interviews over 12 months, this research design attempted to mitigate these biases and build trust and comfort between the researcher and participants. Recollection bias was a limitation in that memory loss itself is a symptom of PTSD.

Conclusion

In this ethnographic study I have identified how bureaucratic forms of care created stigma and exacerbated PTSD symptoms for 10 combat veterans seeking treatment and disability compensation for PTSD. This study elucidated the multi layered process veterans navigated to qualify and receive compensation for their war-related psychological injuries. The VA disability claims process, entangled with treatment and diagnosis seeking, required multiple recounting of personal trauma, and was experienced by veterans as a "trauma pitch". This process not only worsened veterans' perception of being judged and stigmatized, but inadvertently exacerbated PTSD symptoms of anxiety, alienation, depression, and anger. The increase of these symptoms brought on by institutional processes are conceptualized in this study as *bureaugenic effects*. In addition to veterans' experience of symptom aggravation, the bureaugenic effects of the trauma pitch placed veterans' identity at stake: military values of group loyalty and honor were threatened through the objectification of their sacrifices. This threat to identity was further intensified through the screening tools that quantified traumas and calculated percentages of disability, placing a monetary value on loss. Paradoxically, veterans viewed this commodification of suffering via disability compensation as a validation of those losses and sacrifices.

All too often, we think of bureaucratic red tape as the daunting task of filling out paperwork, following excessive protocols, or the process of navigating various low-level rules that frustrate and anger us. For veterans and other populations that are in a vulnerable state, the impacts on mental health can be far more detrimental. This ethnographic study brings to light the need for institutions to be aware of how their bureaucratic processes impact the people they serve, and how stigma and ill-being are propagated through these institutional procedures. The veterans in this study engaged in the disability process to make meaning of their suffering. They pursued a service-connected disability rating to authenticate their trauma and validate their sacrifices. This is not the purpose of disability compensation. In many cultures and societies this acknowledgment, validation, and support, is the role of the communities the veterans come home to.

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