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# Inpatient Treatment of War-Related Posttraumatic Stress Disorder: A 20-Year Perspective

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*These papers show that long-stay inpatient PTSD programs provide treatment that is quite different from other programs but that they are neither as effective, from a psychometric perspective, nor as helpful, from the veterans' subjective perspective, as has been expected. VA treatment of PTSD is changing its focus and is being influenced by three distinct societal forces, in addition to data from studies like these: (1) the continuing effort of American society to come to terms with its Vietnam War experience; (2) the crisis of U.S. health care costs; and (3) the emergence of a movement to "re-invent" government and to increase public accountability through performance data.*

**KEY WORDS:** posttraumatic stress disorder; veterans; inpatient treatment; public policy.

The papers presented in this special section substantially contribute to our understanding of the processes and outcomes of the treatment of posttraumatic stress disorder (PTSD) in Department of Veteran Affairs (VA) Specialized Inpatient PTSD Units (SIPUs). They also present novel methods for examining treatment process and outcome that are readily applicable to other PTSD programs, and to the treatment of other disorders. But perhaps the principal importance of these papers is that they draw attention, at a time of major change, to the diverse and shifting contexts which have influenced the evolution of treatment for war-related PTSD during the past 20 years. The history which we describe here centers on

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the VA experience, but it is likely to have parallels in the experiences of other institutions, and in other countries. The academic and professional communities have traditionally taken it for granted that the delivery of health care services is guided by expert opinion and scientific data. While the recent evolution of PTSD treatment in VA reflects, to a large degree, an increasing commitment to scientific outcomes assessment as part of every day medical practice, it also illustrates the influence of other factors, originating far beyond the health care community, on the delivery of health care services.

Recent studies of specialized inpatient PTSD programs, like those in this special section, have presented results that would not have been expected two decades ago. It has long been asserted that Vietnam veterans with war-related readjustment problems find standard mental health services unsatisfactory (Lifton, 1973). Successful treatment is said to require specialized services in which treatment is conducted in the company of veteran peers, in programs that delve deeply into their warzone experiences (Chief Medical Director's Special Committee on PTSD, 1991). As demonstrated by the first of the papers presented here (Johnson, Rosenheck, & Fontana, 1997), during the 1980s the VA developed a large number of programs that met these specifications: (1) they treated a carefully selected population of motivated Vietnam combat veterans; (2) they were characterized by high morale, high patient satisfaction, and a sharp focus on the war and its consequences; and (3) they provided long-term intensive treatment, quite different from the norm in contemporary psychiatric inpatient units. Even though the trend to limit reliance on inpatient care was well underway nationally, PTSD experts insisted that long term inpatient treatment was needed to definitively address deeply rooted traumatic experiences.

The evidence presented in the other two papers in this section, however, suggests that intensive exploratory treatments *increase* short-term distress (Johnson, Lubin, James, & Hale, 1997) and, in the long-term are regarded as having been relatively *unhelpful* by veterans themselves (Johnson & Lubin, 1997). In addition to the studies presented here, several uncontrolled outcome studies have failed to find long-term benefit associated with this treatment (summarized in Johnson, et al., this issue; see also Johnson et al., 1996). Furthermore, a large multi-site cost-effectiveness study that compared SIPU treatment with treatment of PTSD in other VA inpatient programs found no evidence of additional clinical benefit from SIPU treatment, although it incurred considerable additional cost, estimated to be $18,000 more per patient per year (Fontana & Rosenheck, in press). Shorter term specialized programs emphasizing evaluation and brief

treatment, in contrast, were found to generate high levels of satisfaction and positive outcomes at far lower cost.

These findings have proved controversial, disappointing, and enlightening, and are now being used to reshape VA clinical programs. They reflect important progress in our understanding of the treatment of PTSD, and are consistent with results from non-VA programs. For example, a comprehensive review of PTSD treatment outcome studies recently concluded that once the disorder has been present for a significant period of time, treatment, while effective, results in limited improvement (Shalev, Bonne, & Eth, 1996). Recent VA experience draws our attention to the influence of three distinct societal contexts, in addition to these data, which have shaped PTSD treatment in VA, and perhaps elsewhere as well: (1) the continuing effort of American society to come to terms with its Vietnam War experience; (2) the crisis of US health care costs; and (3) the emergence of a movement to "re-invent" government in response to growing public disenchantment with the public sector. In this time of widespread change it is useful to take stock of these contexts, and to examine how treatment of PTSD, perhaps more than other disorders, has been shaped by social forces as well as by, and in combination with, scientific data.

## Coming to Terms With Vietnam: Patriotism, Guilt, and Reparation

Institutions are often influenced by the historical moment in which they are conceived (Powell & DiMaggio, 1991). The first specialized inpatient PTSD programs were developed in the late 1970s (Berman, Price, & Gusman, 1982), and many others were opened during the early 1980s, at a time of widely experienced national guilt over the Vietnam war, and concern over the neglect of Vietnam veterans following their return from Southeast Asia.

Public controversy over the Vietnam war and its effects on U.S. soldiers started before, and continued long after, the last U.S. combat troops left Vietnam in March 1973. The first Congressional hearings on the special readjustment difficulties of Vietnam veterans were held in 1970, well before the war ended, and Lifton's (1973) account of postwar psychological problems was published in 1973. Public concern about the effects of military service in Vietnam became even more widespread toward the end of the 1970s, when: (i) a group of Vietnam veterans filed a class action-lawsuit against the manufacturers of dioxin (Agent Orange) (January, 1979); (ii) the Vet Center program was established as an alternative to standard VA mental health treatment (November, 1979); and (iii) the national Vietnam

Veterans Memorial was dedicated (November 11, 1982). Above all, the surge of patriotic feeling stimulated by the release of the U.S. hostages held by Iran, in January 1981, triggered an outpouring of sympathy for the plight of Vietnam veterans and recognition of the need to "separate the warriors from the war" and welcome them home, at last (Scott, 1993).

The national urge to remember the war, to heal its wounds, and to compensate its veterans for the hardships they endured, when combined with the dominant psychodynamic clinical philosophy of the time, resulted in a clinical emphasis on in-depth exploration of war traumas and emotional catharsis of feelings of grief and rage in hospital settings (Young, 1993). The development of these programs was thus grounded in a distinctive historical moment when Americans were seeking to come to terms with the Vietnam war and to settle a deeply felt debt to the nation's Vietnam veterans. So strong was this impulse that one Congressman, in response to reports of extensive pre-admission waiting lists for VA inpatient programs, proposed that VA establish a Specialized Inpatient PTSD Unit at every VA medical center, a policy that would have cost almost $200 million and required a 15% increase in VA funding for its mental health budget.

## The Health Care Cost Crisis: Reducing Hospital Utilization

At the same time that the nation was addressing its debt to Vietnam veterans, another legacy of the 1960s, the exploding cost of health care, was also having a profound effect on the American economy and public policy. By 1982, when the Vietnam Veterans Memorial was dedicated, health care costs accounted for 10% of the Gross National Product, a 34% increase from 8% when the Vietnam war ended. Several efforts to control the growth of health care spending had already been tried and had failed (Starr, 1982).

Since the cost of inpatient care was the fastest growing part of the problem, increasing at a rate of 7% per year (Mischel & Bernstein, 1993), vigorous efforts were directed at reducing use of hospital services. In 1982, in a bold effort to reduce inpatient Medicare expenditures, the Congress adopted a prospective payment system based on Diagnosis Related Groups (DRGs) that created powerful financial incentives for shortening lengths of stay. A DRG-based budgeting system was also implemented by the Veterans Administration in 1984 and resulted in a 36% reduction in psychiatric lengths of stay from 1984 to 1988 and a 16% reduction in the total number of psychiatric beds (Rosenheck et al., 1991).

Thus, when the goal of establishing a SIPU at every VA medical center was proposed at a Congressional hearing in 1989, the thrust to expand inpatient services for PTSD and the drive to reduce hospital utilization and costs were brought face-to-face on a virtual collision course. The likelihood of collision was increased when balancing the Federal Budget had became a top national priority in 1985-6.

## Reinventing Government: The New Accountability

The election of Ronald Reagan in 1980 symbolized a third factor that eventually affected the shape of PTSD treatment in the VA—the increasing disillusionment with the performance of public agencies and the growing movement to "reinvent" government by infusing it with private sector strategies. The principal response to this distrust of government was not to reduce government services (although some reductions occurred), but rather to either privatize government services by contracting them out to the private sector, or to "re-engineer" them by importing private sector management methods (Smith & Lipsky, 1993). A major result of this movement has been a growth in public accountability and an insistence that government programs define a "bottom line" for themselves, and demonstrate their effectiveness with data.

In an effort to support and strengthen VA mental health programs it was decided that all new national initiatives would include an evaluation-monitoring component to assure that the programs maintain their intended clinical focus and to gauge their effectiveness. Anticipating that the emphasis on long-stay inpatient treatment for PTSD would eventually collide with a health care culture that was cutting back on inpatient treatment, a comprehensive plan for program development and evaluation of VA PTSD services was implemented. Outpatient and non-hospital based residential models that would serve as alternatives to long-stay inpatient PTSD treatment were designed and evaluated. The first study presented in this special section was originally the first part of that evaluation effort.

As a result of these studies, serious doubts have been raised about the value of intensive and prolonged psychotherapeutic exploration of war trauma in hospital settings (Fontana & Rosenheck, in press; Johnson, 1997). The Specialized Inpatient PTSD Units that were developed during the early 1980s, however, provided a unique, protective setting in which clinicians and veterans learned how to explore some of the darkest aspects of human experience. Few would doubt that effective treatment of PTSD begins with a basic understanding of the traumatic experiences and their potential sequelae. Although many VA medical centers are now re-organ-

izing their PTSD services in new directions as a result of the research findings and social developments reviewed here, they will continue to draw on lessons learned in these programs. As emphasized by Shalev et al. (1996), additional studies are now needed to identify effective approaches to the treatment of war-related PTSD in both outpatient clinics and in rehabilitation-oriented programs.

The emphasis on performance management, cost-effectiveness and public accountability will continue to transform the delivery of health care service delivery in the VA system and beyond it as well. The era when professional judgement was the prime shaper of health care systems will continue to recede as the concerns of government and corporate stake holders grow in influence. On the positive side, improvements in efficiency can allow greater numbers of patients to be treated in public health care systems. Furthermore, empirical identification of clinical programs and treatment methods with limited effectiveness will stimulate the search for new and better approaches. On the negative side, the continuing changes in the health care system are likely to impose strains on both patients and health care professionals who have become accustomed to traditional models of care and almost unquestioning respect for professional judgment. There is also a serious danger that the drive for efficiency and accountability will result in reduced overall funding for PTSD and other specialized treatment programs in health care systems like the VA, and that the quality of health care services will deteriorate and their accessibility will decline. In the treatment of PTSD in VA, and elsewhere in the health care system, a major challenge for both clinicians and administrators in the future will be to sustain the availability of the basic treatment elements of understanding and hopefulness in a vastly transformed health care system.

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