National Catastrophes and Striving for Objectivity

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From the safe, comfortable distance of a dry home with electricity, air conditioning, running water, and food, watching thousands of Gulf residents before and after Katrina was heart-rending. Disastrous consequences were not alleviated, and may have been made worse, by inadequacies of leadership. A natural human response for many of us was to wonder how we could help the countless victims, while becoming irritated when too little assistance aggravated misery reportedly on a scale unprecedented since the Civil War.

Some of this misery meant that thousands of Katrina's victims went days without toilet facilities, drinking water, food, and shelter from the South's summer sun, or that victims had "shelter" in a place where safety and the other necessities of living were not assured. And we saw communities of homes destroyed by Katrina's winds and inundated by flood waters, with the homes' contents often irretrievable—not only necessary contents such as clothing, food, and water, but also personal and family photos, and the myriad items that carry the memories of who we are. Then, there was the more serious trauma of separated young children and parents fearing for the lives of each other, and adult children fearing for the lives of their parent(s) left behind, and dead spouses and partners. Deaths of loved ones were expected on a scale of thousands, with 20,000 body bags obtained for the subsequent formidable task of gathering the deceased anticipated in these numbers.

The catastrophe's effects continued and worsened one day to the next, while we in safety had our comfortable night's sleep, then maybe breakfast with hot coffee, before again tuning in to the tragedy in the morning. While my imagination and heart were in the Gulf with the suffering victims and their helpers, my body never got closer. Although I was on standby and prepared to provide counseling at the shelter set up in Topeka to receive a few thousand victims, I never went there. Katrina's victims—repeatedly described as refugees, displaced persons, tsunami-like survivors, third-world residents—decided they did not want to be so far away from their homes in distant Kansas.

Not many days before the catastrophe, the Veterans Affairs Department announced that it would begin a review of 72,000 cases of veterans on disability with PTSD, most of these arising from the Vietnam War of decades earlier. Among concerns of the VA is that disability had been too often awarded without an adequate identification of the necessary stressor(s), and that some of the claims may have been fraudulent. The Vietnam War was another national catastrophe in which, from the comfort and security of our homes, we observed on television our fellow citizens being killed and otherwise traumatized. And while watching this war "brought into our living rooms," many of us had similarly decried the failures of leadership that contributed to this trauma. In an attempt to "do something," many of us became antiwar protesters.

As a treater or forensic psychiatric evaluator, one's heart easily goes out to people who are victims of the catastrophes in Vietnam or in our Gulf. And while we always want to be objective, whether as clinicians or forensic evaluators, our forensic psychiatric ethical obligation of "striving for objectivity"[1] can be difficult to achieve and maintain for many reasons. Basic human sympathy may have us wanting to reach out to help someone exposed to a very miserable situation over which he or she may have had little control.

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In other innumerable subtle and not so subtle ways, conscientious and honest objectivity can be distorted.

When treating or evaluating such patients or evaluees, we may too easily assume or accept exposure to aspects of the catastrophe that meet the criterion A threshold for a diagnosis of PTSD: "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and "the person's response involved intense fear, helplessness, or horror," with the additional qualification that in children this response "may be expressed instead by disorganized or agitated behavior" (Ref. 2, p 467). We may be hesitant to inquire in detail about the experience of the main trauma(s) in question and the responses to it, or to inquire about other trauma(s) that may have been occurring in the patient's/evaluee's life contemporaneously with the known trauma. We may consider it callous to inquire carefully about pretrauma baseline functioning against which to assess the new catastrophe's effects.

Clinically and forensically, objectivity can be less than ardent in many ways. Within the VA, residential and outpatient PTSD programs often provide most of the major clinical material used for PTSD-related disability applications, applications the VA has an affirmative duty to help the veterans complete. For the diagnosis of PTSD in which nightmares can be such an important part of the diagnostic criteria by satisfying criterion B ("recurrent distressing dreams of the event" Ref. 2, p 468) in the VA PTSD program that I have been most familiar with, the report of this symptom was routinely accepted from the patient, but systematic nocturnal clinical observations of veterans hospitalized for months at a time, let alone sleep studies, were essentially never done. (Clinical observations to record possible nightmares or other sleep disruption can be done, for example, with hourly documentation overnight for several days at a time by ward staff.) And this failure to attempt to verify objectively an important aspect of the diagnosis was the case even though the potential awarding of hundreds of thousands of dollars in disability benefits might hinge on such information.

Objectivity in PTSD diagnosis can also be distorted when the staff documenters in such PTSD programs owe the viability of their programs, and perhaps their jobs, to the identification of veterans who are PTSD-afflicted in large enough numbers to sustain the programs. Then, with post-combat-related trauma inherently associated with violence and guns, the potential for renewed violence from any cause is often not far from the conscious mind of the treater or evaluator. One of the most frightening threats that I have ever received in my forensic work came from a Vietnam veteran being evaluated for a worker's compensation case in which there was a claimed relationship between the work trauma and Vietnam trauma for which the veteran was receiving disability. And the violence may not only be perpetrated against the treater or evaluator, but may be turned against the veteran himself. This was the case with a Vietnam veteran who took his life by gunshot in his therapist's VA office. What therapist or evaluator would not struggle with his or her objectivity to help keep such a threatening or troubled veteran at bay or alive with whatever commiserations might be useful at the time?

All of these considerations about the diagnosis of Vietnam-related PTSD and its objectivity are still being made several decades after the Vietnam trauma. And they are considerations affecting many thousands of veterans and costing billions of dollars per year—money earned at a high price by the disabled, but not earned by some claimants. (The VA's proposed review met strong opposition and was subsequently canceled.)

As we consider the victims of our Katrina catastrophe, the first requirements are to provide the necessary life-saving and shelter-providing assistance and then to reunite families and other loved ones, all in a supportive environment that gives solace. Then, there is the need to confront grief and to help in myriad ways with other acute and subsequently persistent stress reactions.

Later, many of us will be donning our forensic psychiatric hats with a good number of the hundreds of thousands of Katrina's victims as we evaluate them for sundry forensic psychiatric claims related to the catastrophe. Some victims will have PTSD. As forensic psychiatrists we will be doing this work for decades to come. And we will be striving for objectivity without losing our humaneness. It is a tall order.

To do this work we should review the literature on natural catastrophes to try to understand expected reactions to disasters, including their degrees of severity and for what durations, and to examine the effects of receiving or not receiving support during

the catastrophes. But of course no natural disaster exactly duplicates another, and so the art of applying the science will always be present.

While doing such forensic evaluations, we will at times be reviewing clinical records of prior treaters. As we review these records we will be asking ourselves who provided the treatment, whether the treaters were essentially independent or were they persons whose fundings depended essentially on the presence of post-disaster symptoms, so that their objectivity may have been compromised.

We will also be considering countless other factors that can challenge objectivity as we do these forensic evaluations: our humane desire to be helpful to someone who has suffered great losses; our positive, and our negative biases for and against racial and ethnic groups and "the poor" ("They should have evacuated!"); the evaluee's symptoms, which may include being suicidal; considerations of who will provide any monies that may be awarded, whether they may be partly responsible for the trauma suffered, and their ability to pay; personal experience with parenting when that is relevant; personal experiences with floods, hurricanes, and other natural disasters; and personal experiences with other trauma and with losses, especially recent ones; and so many other potential biases to objectivity.

But almost all of us will start our forensic work in these Katrina cases, as it was with the Vietnam War, from the comfort of our homes and the daily heart-rending observations of the victims of the disaster. From such beginnings, we must do our best to strive to be objective, at times a difficult ethics standard to satisfy indeed. Yes, we can envy attorneys' easier burden of "zeal in advocacy on the client's behalf" (Ref. 3, Rule 1.3 Commentary).

References

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2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
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