Regarding a recent Journal article by Larson et al. (1), we agree with the authors about the importance of assessing the psychological costs of current military operations in Iraq and Afghanistan and about the need for psychometrically rigorous diagnostic methods for establishing incidence and estimating past history of disorder. Unfortunately, their study falls short of this measurement standard when it relies on diagnoses of unknown reliability derived from TRICARE medical records of military personnel. The results they obtain show lower overall incidence rates of all disorders in a cohort of US Marines deployed for combat in Iraq than in nondeployed Marines and other comparison samples. The incidence of only posttraumatic stress disorder (PTSD) is elevated in the deployed cohort regardless of whether those with predeployment disorders are included or excluded. However, the incidence rate is 1.6% (1.5% when prior PTSD is excluded), far lower than rates of “probable PTSD” estimated in previous research of troops serving in Iraq and Afghanistan that has relied on symptom screening scales (2).

Larson et al. (1) argue that whatever cases are missed or misclassified by their case-finding procedures, the losses are not differential for the cohorts being compared. This assumption needs to be checked. It is possible, for example, that individuals selected for and involved in combat are especially sensitive to stigma that might compromise their warrior status in the eyes of their fellow Marines; if so, we would expect these individuals to be less likely to disclose...
their symptoms or seek treatment for them than individuals in the comparison samples of nondeployed troops. To make
their case that the presence of PTSD and other disorders is
equally likely to be missed in the cohorts being compared,
Larson et al. need to pay much more attention to the role of
stigma when seeking treatment in military settings (2).
Larson et al. (1) present evidence for substantial rates of
early separation from the military that, as they point out,
may selectively screen for health as demonstrated by sur-
viving the rigors of basic training. It would be useful to
pursue this hypothesis by examining the actual role of psy-
chiatric problems in relation to other possible factors in
those affected by early separation compared with those
who are deployed and serve in combat.
We hope that Larson et al. (1) will build, in several im-
portant ways, on their previously presented work. It would
be especially important for them to conduct diagnoses in-
dependent of treatment status in combat deployed and com-
parison samples with special attention to selective factors
that determine who does and does not enter treatment set-
tings and, once there, who is and who is not accurately
diagnosed with PTSD and other psychiatric disorders.

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REFERENCES
1. Larson GE, Highfill-McRoy RM, Booth-Kewley S. Psychiatric
diagnoses in historic and contemporary military cohorts:
combat deployment and the healthy warrior effect. Am J
and Afghanistan, mental health problems, and barriers to care.
3. Toomey R. Invited commentary: how healthy is the “healthy

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