bad character, than to biological or genetic causes (2). Our work (3) and the work of social psychologists like Bernard Weiner (4) also suggests that people are less likely to help those whom they view as responsible for their problems.

Consistent with Weiner's attributional model of helping behavior, the committee states, "The degree to which we as psychiatrists view our patients with addictions as responsible is central to our approach to them." What does this mean for providers and programs? Providers may expend less energy to help patients with substance use disorders if they believe that these patients are responsible for the onset and progression of the disorder and their recovery from it. Administrators and policy makers may be less willing to allocate resources to serve people whom they believe are responsible for their disorders, and they may decide to allocate resources to more coercive services based in the criminal justice system (5).

However, the belief that persons with substance use disorders are not responsible has a down side. If we view clients as not in control of some aspects of their disorder, we may fail to deliver services in a way that empowers them to recover.

The committee has provided an insightful review of several perspectives on responsibility for substance use and abuse. Clearly, what is needed now is research that examines how beliefs about responsibility for onset, progression, and recovery influence clinical practice and policy.

Amy C. Watson, Ph.D.
Patrick W. Corrigan, Psy.D.

Dr. Watson is project director of the Chicago Consortium for Stigma Research, and Dr. Corrigan is professor of psychiatry and executive director of the University of Chicago Center for Psychiatric Rehabilitation.

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3. Corrigan PW, Rowan D, Green A, et al: Challenging two mental illness stigmas: Personal responsibility and dangerousness. Schizophrenia Bulletin, in press

4. Weiner B: Judgments of Responsibility: A Foundation for a Theory of Social Conduct. New York, Guilford, 1995

5. Corrigan PW, Watson A: What factors explain how policy makers distribute resources to mental health services? Psychiatric Services, in press

In Reply: The members of the Committee on Addictions of the Group for the Advancement of Psychiatry (GAP) thank Drs. Peyser, Watson, and Corrigan for their insightful and relevant comments on our paper on individual responsibility in the genesis and treatment of substance use disorders.

Drs. Watson and Corrigan address one of the seminal issues in the areas of both policy making and treatment. We agree with the contention that research on the impact of how beliefs about responsibility influence clinical practice, policy, and funding for both treatment and research is long overdue and very much needed.

Ambiguities bedevil the field in this context. On one hand we frequently address the issue of "readiness for treatment" (1), an approach that strongly implies a volitional component in the addictive process. On the other hand, substantial information points in the direction of the reasonable efficacy of imposing treatment on individuals whose motivation may be low or lacking (2), an approach that presupposes a relative lack of individual control and responsibility. How are we to reconcile these essentially diametrically opposed views?

The answers will probably emerge less from a dialectic approach than from a research one. At this time we have little hard data on how to differentiate individuals who are capable of making a reasoned decision about whether to engage in treatment from those who cannot make such a decision but might nevertheless benefit from imposed treatment.

Dr. Peyser's erudite delineation of the legal attitude toward responsibility further highlights the issue. The confused concept of "free will" assists us in our clinical work but also complicates our interventions. With some frequency we as clinicians and as citizens encounter the individual who drinks excessively or who uses illegal drugs but who has little or no awareness of his or her problem, or who has no intention of dealing with it.

The result is that each of us—and society—continues to struggle with the ambiguities and contradictions related to personal responsibility in our attempts to find the level of persuasion or coercion appropriate to each individual patient and prospective patient. The challenge is to avoid the procrustean approaches that have so often been an impediment for us in the treatment of addictions.

Richard T. Suchinsky, M.D.

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Military Records and Veterans' Claims of Combat Exposure

To the Editor: In a letter in the March 2002 issue, McGrath and Frueh (1) described fraudulent claims for compensation for posttraumatic stress disorder (PTSD) in the Department of Veterans Affairs (VA). During the 14 years I have spent in the mental health clinic of the VA Medical Center in Gainesville, Florida, I have seen the opposite problem on a number of occasions.

We routinely check military records to verify claims of combat exposure. In the case of individuals who served in covert activities, the records are frequently falsified to conceal those activities. As a result, deserving individuals have spent years without needed compensation until a mem-

ber of Congress has finally unearthed the verification of their claims.

It would be of great help to us in dealing with these individuals in therapy if the military would at least provide a "yes" or a "no" to the question that is essential for determining eligibility for compensation for PTSD: Was the individual exposed to an unusually stressful or dangerous situation? We don't really care what the situation might have been; in therapy we are much more interested in how the individual experienced it.

Memories of traumatic events are notoriously unreliable. I even knew a World War II veteran who returned from a 50-year reunion surprised that his friends had hailed him as a hero for some act of bravery of which he had absolutely no memory!

C. Brooks Henderson, M.D.

Dr. Henderson, now retired, was in private practice in Ocala, Florida.

Reference

1. McGrath JM, Frueh BC: Fraudulent claims of combat status in the VA? Psychiatric Services 53:345, 2002

In Reply: In his response to our letter describing the problem of fraudulent claims of combat status, Dr. Henderson raises concern about the opposite problem. He reports that he has treated individuals at a Veterans Affairs (VA) medical center who served in covert activities and whose military records have subsequently been falsified to conceal these activities, thus cheating deserving veterans of recognition and eligibility for PTSD disability compensation. With respect, we wonder how Dr. Henderson knew that the records were falsified and that the individuals' claims of covert combat were true. In our experience, the scenario he describes is extremely unlikely.

In the course of extensive research using military personnel records that spanned the past 15 years and covered thousands of individuals (1), the first author (BGB) has never known of a military personnel record falsified by the government to conceal covert or any other activities. That is not how covert activities are handled in individual veterans' military personnel records. Even though some operations during the Vietnam War were classified, the documentation for those operations was thorough and is included in personnel records as "Top Secret." No military personnel would risk their career undertaking an operation with no supporting documents. Furthermore, virtually all such records were declassified years ago.

Information related to an individual's military training, duty assignments, and so forth is never classified. Although personnel files would not describe a specific secret mission in which military personnel participated, personal data would not be changed to hide the general character of the military duty—for example as a fighter pilot, Green Beret, or Force Recon. In addition, all personal decorations indicating participation in combat, such as the Silver Star, Combat Action Ribbon, and Purple Heart, would be listed in an individual's record. The record of a man who was a Green Beret assigned to 5th Special Forces in Vietnam would never be doctored to show he was a cook.

For example, Fred Zabitosky, a Green Beret, was awarded a Medal of Honor for a secret mission in Laos. His Special Forces training and combat decorations were clearly documented in his personnel record. The Medal of Honor citation did not mention Laos, but "Southeast Asia." Years later, after declassification, he had his record officially changed to show "Laos." At no time did his personnel records show anything false.

Many phony combat heroes depend on gullible and well-intentioned clinicians accepting their claims that military records were changed to conceal covert operations. We agree with Dr. Henderson that memories of any kind, including traumatic memories, are unreliable over time. We also agree that it would be a great help to VA clinicians to have easy access to military records documenting whether or not veterans were exposed to traumatic experiences. Certainly, the VA could make it easier for clinicians to conduct better background checks via computerized database searches. Fortunately, reasonably accurate and reliable historical information is available about most veterans' military experiences, including combat activities (covert or otherwise), through the National Military Personnel Records Center, 9700 Page Avenue, St. Louis, Missouri 63132-5100.

B. G. Burkett, M.B.A.
B. Christopher Frueh, Ph.D.

Mr. Burkett is a Vietnam veteran, military researcher, and coauthor of Stolen Valor. *He lives in Plano, Texas. Dr. Frueh is associate professor in the department of psychiatry and behavioral sciences at the Medical University of South Carolina in Charleston.*

Reference

1. Burkett BG, Whitley G: Stolen Valor: How the Vietnam Generation Was Robbed of Its Heroes and History. Dallas, Verity Press, 1998

Comparison of Social Workers' and Psychiatrists' GAF Ratings

To the Editor: I read with interest the article in the March issue assessing interdisciplinary reliability in the use of the *DSM-IV* Global Assessment of Functioning scale (1). The authors' conclusion is that with systematic training, social workers can provide reasonable assessments of a client's functioning. This conclusion is drawn from the results of the study, which showed a positive correlation between the GAF ratings that social workers and psychiatrists gave to discharged inpatients.

May I suggest three alternative conclusions? First, adequately trained psychiatrists can achieve the same level of competence as social workers. Second, trained by a psychologist, both social workers and psychiatrists can become competent in use of the GAF. Third, with similar training, interrater reliability among those using an instrument increases. Which conclusion is the most parsimonious?

Anthony A. Kopera. Ph.D.

Dr. Kopera is affiliated with the Community Counseling Centers of Chicago.