STATEMENT OF
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THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE STATE OF VETERANS WHO MAY BE SUFFERING FROM POST-TRAUMATIC STRESS DISORDER

MARCH 11, 2004

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to express its views on the state of veterans who may be suffering from post-traumatic stress disorder (PTSD) as a consequence of their exposure to the rigors of combat and hardship deployments. We commend the Subcommittee for holding a hearing on this important and timely subject.

Since the beginning of Operations Enduring Freedom and Iraqi Freedom some 125,000 new veterans of these operations have separated from service, including nearly 15,000 who served in both. For the first time in U.S. history, a significant number (11,622 as of February 2004) of these veterans are female. Of the total number of separated veterans who have presented to VA for healthcare nearly 15 percent have been diagnosed with a mental disorder.

The American Legion/Columbia University PTSD Study

These veterans should fare much better than their Vietnam veteran counterparts. Much more is now known about the factors that predispose an individual to chronic PTSD, the qualities of the stressors that may lead to PTSD and the factors in the post-trauma life course that may exacerbate or ameliorate PTSD symptoms. Contributing to this knowledge base, a study conducted by The American Legion and Columbia University was recently published in the *Journal of Consulting and Clinical Psychology*, Vol. 71, No. 6 (December 2003). The study was begun in 1984. In 1998 we had the opportunity to re-survey the population of Legionnaires we had studied in 1984, making this the first longitudinal study to examine risk factors related to the course of PTSD in a random sample on American Legionnaire Vietnam veterans. We now have a sample of 1,377 Legionnaires who served in Vietnam, completed the survey in 1984 and again in 1998. We also have surveys from 1,941 veterans who served in other areas of the world during the Vietnam War and who responded both times.

The study showed that the strongest predictor for having PTSD at follow-up in 1998 was having had PTSD in 1984. Veterans who had PTSD in 1984 were 14 times more likely to have PTSD in 1998. Nearly 12 percent of the population met the criteria for being diagnosed with PTSD in

1998, which is a similar percentage to that observed by other researchers. Thus, large numbers of veterans are at high risk for continuing to suffer from PTSD. Combat exposure is the traumatic event most highly associated with PTSD in these veterans and we have observed a dose-response relationship: the higher the levels of combat, the more likely the development of PTSD. We also observed a heterogeneous course for PTSD over the life span, that is, only 5.3 percent of the population met the criteria at both times. This implies a steady prevalence of about 12-15 percent. This is consistent with reports of World War II veterans. Today more than 123,000 veterans are service connected for PTSD, most as a direct result of combat exposure.

The study also identified other risk factors for a negative PTSD course: minority status, elevated depression and anger and the extent of perceived social support.

- We found that minority status along with perceived community negative attitudes at homecoming and lack of community involvement were risk factors for the course of PTSD suggesting that social stigma or exclusion from the community plays a large role in the persistence of the disorder. Other studies have shown that lower socioeconomic status and educational strata factors may predispose PTSD. Minorities also appear to have the poorest prognosis for recovery from PTSD. The well-known negative attitudes of the public toward returning Vietnam veterans contributed mightily to the chronicity of PTSD in later life; attitudes which our currently returning veterans will not have to suffer. The higher educational levels of the present day all-volunteer force and the hero status being afforded our newly minted combat veterans, along with proactive prevention and treatment methods by both DoD and VA may well contribute to a lower incidence of PTSD in new this new cohort of veterans.

- Our study found that depression and anger were also risk factors for PTSD. Possible explanations for this finding is that that elevated depression and anger may be markers for PTSD severity and persistence and may interfere with the confrontation with and processing of traumatic memories that appear to be necessary for recovery from the disorder. Patient characteristics that predict negative treatment response such as a high level of anger at the beginning of the prolonged exposure may also be associated with more chronic PTSD in later life. Recent reports of higher than usual suicide rates among troops in Iraq should raise red flags for both VA and DoD**.**

- Intense exposure to combat was a major risk factor for Vietnam veterans and is no less so for veterans of the Afghanistan and Iraq wars. These conflicts entail more stereotypical exposure to warfare experiences such as firing weapons at human beings, being fired upon by the enemy or in friendly-fire incidents, witnessing injury and death, going on special missions and patrols, handling remains of civilians, enemy forces and U.S. and allied personnel. In Vietnam, little was known of the effects of months of unabated combat duty on troops. Save for the occasional in-country rest and relaxation (R&R) and a one-week R&R out-of-country, service personnel were more or less in combat for the full tour of duty. There were no “lines” to fall behind for relative safety. Troops in Afghanistan and Iraq are now facing the same type of insurgency environment where anything can and does happen without notice, leading to high anticipatory anxiety. Enlisted soldiers, non-commissioned officers and officers are now trained to identify the

signs of normal "battle fatigue" as well as the signs of severe, incapacitating stress-reactions. Post-battle debriefings are now routinely used to allow soldiers to vent and share their emotional reactions. Troops who exhibit severe war-zone stress reactions are treated humanely and receive special care. The guiding principle is known as Proximity-Immediacy-Expectancy-Simplicity (PIES). Early and simple interventions are provided close to the soldiers unit and the soldier is told his or her reactions are normal and that he or she can expect to return to their unit shortly.

The National Vietnam Veterans Readjustment Study

In response to a mental health crisis among Vietnam veterans of major proportions, Congress, in 1983, mandated the National Vietnam Veterans Readjustment Study (NVVRS) to establish the prevalence and incidence of PTSD and other psychological problems in readjusting to civilian life among Vietnam veterans. Kulka, et al., in Access Denied: Trauma and the Vietnam War Generation reported that of the 3.14 million veterans who served in Vietnam over one-fourth (829,000) were currently suffering from some degree of PTSD. 15.2 percent of male veterans (479,000) and 8.5 percent of female veterans (610) were found to have "full-blown" PTSD and another 350,000 suffered from PTSD symptoms that adversely affected their lives, but were not of sufficient intensity or breadth required for a diagnosis of PTSD. Further analysis of the NVRRS data on the lifetime prevalence of PTSD showed that 30.6 percent of male Vietnam theatre veterans and 26.9 percent of females had the full-blown disorder at some time in their lives.

Prior to 1980, returning Vietnam veterans had few options to which to turn for help with war-related psychological stress. Many veterans were ineligible for treatment at VA hospitals because they had been discharged with no physical or mental disabilities and some VA hospitals, themselves, were found to be dismal in their treatment of psychiatric patients. According to a 1977 report of the National Academy of Sciences, VA psychiatric staff were found to be under-qualified and understaffed throughout the system. Patients were found to be over-medicated and receiving very little psychotherapy. The NVVRS provided the catalyst to change VA's attitude, and resources followed. VA began to take war stress related psychiatric conditions seriously as the scientific literature on the subject gelled in the 1980 *Diagnostic and Statistical Manual of Mental Disorders, 3rd edition* (DSM-III) into the diagnosis of Post-traumatic Stress Disorder, replacing poorly understood psychiatric labels such as "war neuroses" and "gross stress reaction." Fifty-four inpatient PTSD programs and 87 medical center-based outpatient clinics were operating by 1994. The VA's Readjustment Counseling Service, authorized in 1979, began opening Vet Centers around the country.

War-Zone Acute Stress Disorder as a Predictor of PTSD

It should be noted that VA PTSD clinical guidelines now recognize an acute adaptation interval in troops who were in a war-zone for protracted periods of time. The interval spans the period of time from which an individual is objectively free of combat stressors to approximately one month after. Typically, troops are in garrison (either in the U.S. or overseas) or serving in security or infrastructure building roles. This interval corresponds to the interval required for a diagnosis of Acute Stress Disorder (ASD) in the *Diagnostic and Statistical Manual of Mental*

Disorders, 4th edition (DSM-IV) and is used by clinicians to track how a soldier is doing psychologically one month after removal of the acute stressors. ASD may be diagnosed one month after this benchmark. According to the February 2004 Analysis of VA Healthcare Utilization – Report 1, ICD-9 Code 309, Adjustment Reaction, accounted for the most frequent diagnosis of Enduring Freedom veterans evaluated at VA facilities and the second most frequent for Operation Iraqi Freedom veterans. ASD symptom clusters are similar to those described in DSM-IV for PTSD and a diagnosis of PTSD may be considered if symptom clusters persist for an additional month. While cautioning that clinicians not over-pathologize with diagnoses of ASD to avoid labeling and subsequent stigma, the guidelines state ASD is an excellent predictor of PTSD. Studies have revealed that the normative response to trauma is to experience a range of ASD symptoms with the majority of these reactions remitting in the following months. Although acute stress reactions are very common after exposure to severe trauma in war, the majority of troops who initially display distress will naturally adapt and recover. ASD, however, is not a precondition for a diagnosis of chronic PTSD and there is sufficient evidence to support the notion of delayed PTSD.

VA has learned greatly from its work with Vietnam veterans whose lives have been greatly disrupted by PTSD. The chance to work with combat veterans soon after their war experiences represents a real opportunity to prevent the development of a disastrous life course by helping these veterans to process their traumatic experiences and providing medications. This should reduce the degree to which PTSD, depression, alcohol/substance abuse or other psychological problems interfere with the quality of life. These interventions should also support family functioning, reduce social alienation and isolation and lead to improve workplace functioning. General considerations in care of veterans with PTSD include: connecting with the veteran from a patient centered approach taking care to learn the current concerns of the veteran and developing a helping relationship; connecting veterans with each other who often report the most helpful experience was to share with and support other veterans; offer practical help with specific problems relating to family, workplace, finances and physical health; and attending to the broad needs of the person. Education about post-traumatic stress reactions, training in coping skills, the use of efficacious therapies such as exposure therapy, cognitive restructuring and family counseling are generally accepted as methods of care for PTSD. If Afghanistan and Iraq war veterans present at VA medical centers soon after trauma exposure the possibility will exist for early intervention to prevent the development of PTSD through treatment comprised of education, breathing/relaxation training, exposure therapy and cognitive restructuring. These treatments have been shown to prevent PTSD in civilians who meet the diagnostic criteria for ASD following motor vehicle accidents, industrial accidents and assault.

VA specialized PTSD clinical capacity

Mr. Chairman, all VA's new knowledge about the etiology and treatment of war-related stress disorders will be for naught for returning Afghanistan and Iraq war veterans unless adequate facilities and clinical staff are available to handle them.

In the 2003 report of the Special Commission on Post-traumatic Stress Disorder, released before the invasion of Iraq, it was noted that demand for VA PTSD specialized services is growing. Fifty percent of all veterans who were service-connected for PTSD became service connected

within the last five years and the population served by VA specialized PTSD outpatient programs grew by 86 percent between FY 1995 and FY 2001. The Commission noted that the intensity of services provided to veterans service connected for PTSD actually fell by 9.3 percent over the five years preceding the report. This decline in capacity is illustrated by the fact that of the 205,996 veterans who had a VA clinic visit where PTSD was the focus of treatment, only 28 percent received it in a specialized PTSD program. The other 72 percent received treatment in some other setting, including 17 percent who were seen in a non-mental health setting. Additionally, of the 128,000 veterans seen in Vet Centers in FY 2002, only 55 percent were receiving services of any kind in a VA medical center. In it's 2002 report the Commission noted that that the average waiting time to enter a specialized PTSD inpatient program was 47 days with waits approaching one year in some facilities. The Commission concluded that VA's specialized PTSD services are so fully saturated that that they cannot absorb new patients (now, Iraq war returnees) with out diluting the intensity of service provided to each veteran.

Exclusion of Mental Health from CARES

VA provides complicated and unique care to veterans. Time and again it has been shown that the veteran population cannot accurately or fairly be compared to the private sector. It is an older population that experiences myriad co-morbidity issues that complicate treatment. It is what makes them unique in comparison to the general population.

CARES is a data driven process, and as such, the key component, is the data used to forecast future needs of veterans. The CARES process fails to include key data on the long-term care, outpatient mental health and domiciliary needs of VA. VA chose to omit these important health care needs in CARES process. The American Legion fails to understand the effectiveness of recommendations, of which there are many, resulting from the CARES process that do not include these important areas of health care. The omission of these critical issues in the CARES process does not provide an accurate picture of the demand for these services in 2012 or 2022.

CBOCS

CARES Draft National Plan VISN market plans proposed the establishment of 242 new Community Based Outpatient Clinics (CBOCs). Putatively to maintain the integrity of the system, an even growth of demand for services and the ability to provide quality care, the DNCP prioritized the CBOCs into three groups and proposed the establishment of only 48 of them. The criteria that needed to be met to make it into the top 48 were: 1) an access gap; 2) projected future increases in workload; and 3) more than 7,000 projected enrollees currently residing outside of access standards per proposed CBOC. The Undersecretary of Health on October 7, 2003 informed the CARES Commission that priority groups for CBOCs were established in order to limit new enrollees who strain the inpatient infrastructure. The Commission noted that this has the effect of limiting access to outpatient care and is contrary to the goals of CARES to better serve veterans today and in the future. The American Legion agrees with the Commissions recommendation that that new CBOCs be established without regard to the three priority groups outlined in the DNCP. We believe, however, that funding for construction of new CBOCs should come from additional appropriations. VISNs and facilities currently struggle to maintain high

quality and timely medical care to veterans with budgets that area already inadequate. If current VHA medical appropriations are to be used, the CBOCs may never be built.

Currently, one-third of CBOCs do not provide even basic mental health services. The American Legion believes that VA should evaluate the placement of specialized PTSD clinical teams in CBOCs.

Vet Centers

Vet Centers are community-based, storefront style counseling centers that are operated by the VHA's Readjustment Counseling Service at 206 sites around the country. Vet Centers provide a variety of transition and readjustment services including employment services, information about benefits, family services and psychological counseling for combat or sexual trauma. Most of the staff are veterans and many (over 60 percent) have served in a combat zone. A four-member team that may include a psychiatrist, psychologist, clinical social worker, psychiatric nurse or other mental health professionals normally provides Vet Center services. The Vet Center culture has created a safe, non-threatening environment where a veteran can feel free to share the most personal aspects of his or her trauma with other veterans and staff. Individual, group and family therapy is provided. Normalization of PTSD as an acceptable, manageable outcome of war trauma is the main therapeutic goal. Identification of dysfunctional coping mechanisms and learning of new ones and the value of support seeking is taught. The American Legion believes the highly successful Vet Center program should be enhanced with new locations and more staff.

Allen v. Principi

It is well accepted that many veterans with PTSD develop co-morbid alcohol and drug abuse problems secondary to their conditions through self-medication. In its FY 2005 budget submission, VA has proposed legislation to effectively overturn the decision of the Federal Circuit in the case of *Allen v. Principi*. This proposal seeks to bar the granting of VA compensation benefits for alcohol or drug abuse disabilities where such disability is secondary to a service-connected condition. The Court made it clear in their ruling that the statute authorizes service connection where a veteran develops an alcohol or drug abuse disability that is diagnosed as being secondary to or a manifestation of the service connected condition. VA attempting to broadly characterize all alcohol or drug abuse disability as willful misconduct, despite the scientific evidence, and establish a bar to the payment of compensation. This bar would represent a "budget savings" of $55 million in FY 04 and $2.8 billion over ten years. VA successfully pursued a similar legislative tactic in the enactment of PL 105-206, The Transportation Equity Act for the 21st Century, barring benefits for tobacco-related illness where the veteran's tobacco use began in military service VA is now looking to use this as a precedent to once again take away service disabled veterans' right to VA disability compensation. The American Legion adamantly opposes this legislation.

Conclusion

Mr. Chairman and members of the Subcommittee, The American Legion is concerned that, despite the tremendous advances that have been made in the understanding and treatment of

Post-Traumatic Stress Disorder, VA will not have sufficient clinical capacity to provide the specialized PTSD services necessary to prevent our new combat veterans falling into the same downward spiral that befell tens of thousands of our Vietnam veterans. Granted, our 21st century troops are better educated, better trained and more highly motivated than their Vietnam-era counterparts. Severe combat stress reactions are dealt with expeditiously and compassionately in-theatre. They are treated with adulation and respect on return home instead of indifference or derision. As has been noted, these things may well serve to lessen the incidence or severity of PTSD in veterans returning from Operations Enduring Freedom, Iraqi Freedom and the myriad of other missions and deployments around the globe. But Post-traumatic Stress Disorder is, by definition, capable of manifesting itself years or decades after the horrors of the battlefield are over. The American Legion applauds the progress made by VA in understanding and treating this debilitating condition. We also express our gratitude to the Congress for the leadership and resources that have made these advances possible. The American Legion is confident that both Congress and VA will continue to support our returning troops well into the next decades by providing adequate comprehensive health care.

Mr. Chairman, this concludes my statement. Thank you again for your interest in this timely subject. We look forward to working with the Subcommittee on this issue.