



THE WAR WITHIN

Treatment of Traumatic Brain Injury
and Post Traumatic Stress Disorder
Findings and Recommendations



THE AMERICAN LEGION
TBI/PTSD AD HOC COMMITTEE

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For those who fight the war within

The American Legion has worked since its founding on behalf of men and women who have come home psychologically altered by the military experience. The “shell shock” of World War I and “battle fatigue” of World War II ultimately gave way to post-traumatic stress disorder, a condition



poorly understood and rarely treated until years after the Vietnam War ended. Traumatic brain injury and post-traumatic stress disorder so frequently converge on Iraq and Afghanistan troops and veterans today that the combination is regarded as the “signature wound” of this generation’s war.

The American Legion’s PTSD/TBI Ad Hoc Committee has carefully and compassionately studied these conditions and the way in which our government is responding to them. A three-part series in *The American Legion Magazine* (September, October and November, 2011) demonstrated how

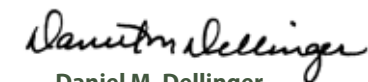
PTSD and TBI affect every family differently and that no magic bullet exists for treatment.

Having met with mental health experts, veterans, families and VA officials, the ad hoc committee has formulated recommendations that include total-family involvement in recovery plans and a willingness to accept alternative treatment programs, such as hyperbaric oxygen therapy, whenever they are effective.

Foremost, the committee recommends that the government make a top priority of adequate mental health services for veterans home from war. Ignoring mental health issues, or failing to find effective treatments, destroys families, leads to substance abuse, homelessness and even suicide. In the long run, ignoring the problem is more costly, in terms of dollars and lives, than addressing it.

The American Legion has always held that compassionate care is the very least a grateful nation can offer those who have faced death to ensure the freedom and safety of others. Sometimes, the war fighter’s wounds are visible – a missing limb, blindness, a spinal cord injury. Other times, the wounds reside so deep, they are nearly impossible to detect. Either way, veterans who suffer war wounds both visible and unseen have an advocate in The American Legion, no matter how their condition was acquired, no matter the war era, no matter the treatment plan they choose, as long as it works for them and their families.

I invite you to read the magazine series and other reports contained within this publication and review the committee’s recommendations to understand the war within, and why we all share a moral obligation to help those who face it every day.



Daniel M. Dellinger
The American Legion
National Commander

The American Legion TBI and PTSD Ad Hoc Committee

Executive Summary

Thousands of servicemembers are returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) with traumatic brain injury (TBI) and post Traumatic Stress Disorder (PTSD), which have been called the “signature wounds” of Iraq and Afghanistan.

While the number of veterans diagnosed with TBI and PTSD has increased significantly, the types of treatment offered and available to help them are limited and inadequate.

To address this problem, The American Legion approved Resolution 13, Creation of an Ad Hoc Committee on TBI and PTSD in 2010. The TBI-PTSD Ad Hoc Committee was developed “to investigate Department of Defense (DoD) and Department of Veterans Affairs (VA) existing science and procedures for treating TBI and PTSD, as well as alternative treatments.”

The committee conducted six meetings and made site visits to numerous facilities, including Mt. Sinai Hospital, Louisiana State University, Walter Reed Army Medical and Tampa VA Medical Center. The committee received briefings from leading DoD and VA clinicians, policy analysts and researchers, and from active-duty servicemembers and veterans receiving treatment for TBI and PTSD.

While the committee’s mission is to evaluate treatments, it has also learned about DoD/VA transition programs, as well as prevention, screening and diagnosis procedures used to treat servicemembers and veterans with TBI and PTSD.

Key Findings

Transition from DoD to VA

Approximately 2.2 million servicemembers have deployed in support of OEF and OIF, with 1.3 million returning home to date. Of those 1.3 million, only half have enrolled in VA for health-care treatment. If servicemembers are injured by an improvised explosive devices (IED) or blast, the medic/corpsman gives the servicemember a brief neurological exam and and Military Acute Concussion Evaluation (MACE) to test cognition and evaluate current symptoms. If the injury is serious or life-threatening, the servicemember is transported to Landstuhl, Germany, and given

an MRI/CAT Scan and the Post-Deployment Health Assessment, and after stabilization, are sent to a Military Treatment Facility (MTF) for further recovery and rehabilitation.

For servicemembers injured and treated at an MTF, the veteran has a seamless transition from a MTF to the VA Polytrauma System of Care. VA liaisons are stationed at all of the MTFs to facilitate a warm handoff from DoD to VA. For other veterans who have not been treated by a MTF, VA provides information at Transition Assistance Program (TAP) briefings upon separation from service. If the servicemember is a Guardsman or reservist, VA provides

outreach/enrollment service through demobilization briefings. VA has OEF/OIF Program Offices in each VA medical center to track and coordinate care for OEF/OIF veterans once they enroll at a facility near their community.

The challenges noted by the TBI-PTSD Ad Hoc Committee with these VA outreach services are that TAP briefings are not mandatory for all service branches, and many servicemembers only want to return home and are reluctant to be screened or willing to disclose a TBI or mental health illness. Confidentiality and stigma continue to negatively affect servicemembers’ willingness to be treated while on active duty, for fear of losing their careers or losing their weapon if the chain of command finds out about their mental health diagnosis.

One of the most significant impediments that servicemembers with TBI and PTSD face in their transition from DoD into VA is the lack of a bilateral medical record. Failure to implement a bilateral medical record has caused significant delays in treating veterans with TBI and PTSD. Lack of access to active-duty medical records has necessitated reliance on the individual servicemember/veteran, who in many cases cannot provide a complete history due to the number of serious medical complications they face. Veterans are forced to make copies of their DoD medical records at their last duty station or request their records from the Personnel Records Center in St. Louis, which can take months to process.

TBI

TBI is defined as a blow or jolt to the head or a penetrating head injury that disrupts brain function. Most TBIs sustained in combat are caused by IEDs and other blasts, such as rocket-propelled grenades or roadside car bombs. The severity of TBI is classified by a DoD/VA clinician as penetrating, or as “mild,” “moderate” or “severe.” Since 2000, DoD

Committee members



William M. Detweiler,
Chairman | American Legion
Past National Commander
1994-1995



Col. (Ret.) Jill W. Chambers,
U.S. Army | 2010 DoD
Woman Of The Year,
recognized for developing a
successful, sustainable

strategy designed to reduce the stigma associated with mental health challenges in a warrior culture



Ronald F. Conley | American
Legion Past National
Commander 2002-2003,
creator of the Legion’s
System Worth Saving

program, which conducts annual site visits of VA medical facilities to ensure the quality and timeliness of VA health care



Ralph P. Bozella | Chairman
of The American Legion
Veterans Affairs and
Rehabilitation Commission,
former American Legion

Department of Colorado Commander and former American Legion National Executive Committeeman for the Department of Colorado.



William W. Kile | American
Legion National Executive
Committee (NEC) 1999-2013,
Chairman of Liaison
Committee for the Veterans
Affairs and Rehabilitation Committee



Robert W. Spanogle | Past
National Adjutant 1981-2008,
Past National Commander
2008, Member President’s
Task Force to Improve Health
Care, 2001-2006



Jeanne Mager Stellman |
Columbia University’s
Mailman School of Public
Health, pioneer in
establishing connections
between Agent Orange

exposure and combat and a variety of health-care conditions later affecting veterans



The American Legion's ad-hoc committee meets in Washington to consider alternative treatments for veterans suffering from post-traumatic stress disorder and traumatic brain injury. Photo by Noel St. John

reports that 230,430 servicemembers have been diagnosed with mild, moderate or severe TBI. The majority of these TBIs diagnosed were mild, which is also commonly referred to as a concussion.

Further complicating the diagnosis of TBI is the overlap of symptoms from other illnesses, such as PTSD, chronic pain and substance abuse. In a VA study in 2009, "Prevalence of Chronic Pain, Post Traumatic Stress Disorder, and Persistent Postconcussive Symptoms in OIF/OEF Veterans," 42.1 percent of veterans were diagnosed with multiple comorbidities associated with diagnosis of mild TBI, including sleep disorders, substance abuse, psychiatric illness, visual disorders and cognitive disorders.

Treatments for TBI and other comorbidities should be symptom-focused and evidence-based in concurrence with current VA/DoD Clinical Practice Guidelines. The DoD/VA evidence-based treatments for TBI are cognitive rehabilitation (attention, memory, social/emotional) and medications for symptoms. Additionally, in some locations, DoD/VA provides "complementary and alternative therapy" such as acupuncture, biofeedback, art therapy, tai chi, medication, breathing exercises, massage, and yoga.

Currently, DoD is conducting clinical trials for hyperbaric oxygen therapy – which uses pressurized oxygen in a

chamber to treat TBI – to determine if it can be added as a potential approach.

PTSD

PTSD was first diagnosed by the Diagnostic and Statistic Manual of Mental Disorders in 1980. Prior to the definition of PTSD, the condition was commonly referred to as Soldier's Heart, Shell Shock, Battle Fatigue and Vietnam Syndrome. PTSD is a disorder caused by exposure to a traumatic event that involves actual or threatened death or serious injury. The primary symptoms of PTSD include re-experiencing, hypervigilance and avoidance/numbing.

Senior DoD officials have encouraged servicemembers, veterans and the medical community to drop the "d" from PTSD because of the stigma of receiving treatment. Several American Legion national officers as well as the TBI-PTSD Ad Hoc Committee, similarly recommended dropping the "s" for these reasons. However, the committee's consensus was to continue to use its current medical definition until the Diagnostic and Statistic Manual of Mental Disorders changed its definition to PTS. Other concerns raised by the committee were that veterans benefits and treatment would be reduced or eliminated if DoD and VA dropped the disorder from the definition. The American Legion will continue to evaluate its positions and

policies to eliminate stigma while ensuring veterans benefits for PTSD are protected.

According to VA, mental disorders, which include PTSD, are the second-largest frequency of diagnoses – currently 50.7 percent – among returning OEF/OIF servicemembers. The number of veterans diagnosed with PTSD by VA since 2005 has nearly doubled, from 235,639 to 438,091 in 2011.

The treatments for PTSD are trauma-focused therapies (i.e. cognitive processing therapy, prolonged exposure), eye movement desensitization and reprocessing, as well as medications that include Selective Serotonin Reuptake Inhibitors (SSRI) and antidepressants such as Celexa, Prozac, Paxil or Zoloft. Prazosin, primarily used to treat hypertension, also has been found through research to help improve sleep disturbances and nightmares related to PTSD. DoD/VA are exploring virtual reality exposure treatment at DoD/VA installations. The efficacy of this treatment also is being researched. In DoD, clinicians use trauma-focused therapies that allow patients flexibility on the types of treatments for PTSD that clinicians can offer. Within VA, however, treatments are more regimented, rather than a broad trauma-focused therapy array of services, VA only allows clinicians to provide cognitive processing therapy and prolonged exposure and medication management, without allowing the veteran to select the treatment that he or she feels is best.

In terms of mental health staffing, VA hired an additional 6,685 mental health professionals since 2005, but challenges with staffing numbers continue. In 2011, Senate Committee on Veterans' Affairs Chairman Patty Murray, D-Wash., directed VHA to conduct a quality survey of VA mental health professionals. The key findings from "A Query of VA Mental Health Professionals Executive Summary

and Preliminary Analysis" of 319 VA mental health professionals, released in September of 2011, found that 70 percent of respondents reported that their VA facilities do not have adequate mental health staff. Additionally, 70 percent of providers responded that their sites had shortages in mental health care. In response to this survey, the VA Office of Mental Health Services has instituted several action plans, including conducting site visits to all VA facilities to evaluate mental health care staffing/workload/spacing shortages, aggressive recruitment of all mental health vacancies, and revising its access metric and performance measures for waiting times and further refining metrics to account for evidence-based therapies.

A VA study, "Correlates of Utilization of PTSD Specialty Treatment Among Recently Diagnosed Veterans at the VA" – published in the *Journal of Psychiatric Services* in August 2011 – concluded that most veterans with new PTSD diagnoses who initiated VA PTSD specialty care did not receive minimally adequate specialty



Former American Legion Washington office executive director John Sommer, who served as a combat medic during the Vietnam War, discusses his experiences advocating for PTSD sufferers. Photo by Noel St. John

treatment. Minimally adequate specialty treatment was defined as nine or more PTSD clinic visits within 365 days of the index positive screen. More VA research is needed to determine the adequate number of specialty mental health care visits necessary to treat veterans with PTSD. Research is also needed to help identify why veterans do not receive minimally adequate specialty treatment because of staffing and/or funding limitations in the VA system, or because individuals with PTSD discontinue their treatment and, if so, why.

Another concern of the TBI-PTSD Ad Hoc Committee is the number of servicemembers who have been diagnosed with PTSD and had their diagnoses reversed by DoD and reclassified as an adjustment disorder, personality disorder or a pre-existing condition – thus denying the veteran compensation and other benefits from injuries/illnesses incurred in service. According to an Enlisted Separations on the Basis of Personality Disorder Policy Memorandum, dated Feb. 10, 2009, “in the case of soldiers who have served or are currently serving in an

imminent danger pay area and are within the first 24 months of active duty service, the diagnosis of personality disorder must be corroborated by the Medical Treatment Facility (MTF) Chief of Behavioral Health and forwarded to the Director, Proponency of Behavioral Health, Office of the Surgeon General.” The Office of the Surgeon General conducts a medical review to consider whether PTSD, TBI or other comorbid diagnoses contributed to the personality disorder diagnosis. However, the Army Surgeon General is conducting an official investigation because forensic psychiatry staff at Joint Base Lewis-McChord’s Madigan Army Medical Center have reversed PTSD diagnoses. Out of 690 cases of PTSD reviewed by the forensic psychiatry unit, 40 percent were reversed. The Army responded that this was an isolated incident and does not affect other military bases.

In March 2012, a study was published in the *Journal of American Medical Association* – “Association of Mental Health Disorders With Prescription Opioids and High-Risk Opioid Use in U.S. Veterans of Iraq and Afghanistan.” – which found

Capt. Robert Koffman, deputy director for clinical operations at the National Intrepid Center of Excellence, listens to a question from a member of The American Legion’s committee.

Photo by Noel St. John



VA Director of Mental Health Operations Mary Schohn explains to the committee the direction of PTSD and TBI care for veterans. Photo by Noel St. John

that 141,000 veterans were diagnosed with pain over the course of a year. Those same veterans who had PTSD, with or without concurrent other mental disorders, were 2.6 times as likely to receive high-risk opioids as veterans who were treated for other conditions not related to PTSD. The paper found “primary care doctors at the VA lack specialized training in the management of comorbid pain and PTSD, despite guidelines which urge caution in prescribing opioid medications for persons with substance-use disorders”. The adverse clinical outcomes cited in the study that could result from prescribing opioids include accidents involving wounds or injuries, opioid-related accidents and overdose, alcohol and non-opioid drug-related accidents and overdose, self-inflicted injuries and/or violence-related injuries such as suicide attempts.

Servicemembers and veterans are reluctant to receive care for mental health and/or comorbid conditions such as TBI or substance abuse because of reasons including confidentiality, stigma/perception of receiving mental health care and rigidity of treatment. If veterans

with PTSD are seen by VA, they are first seen by primary care clinicians, where they stand the chance of being two-and-a-half times more likely than other pain sufferers of being prescribed controlled substances such as opioids. If they are referred to mental health for treatment, their VA treatment protocol is restricted to two therapies, not allowing treatments to be tailored to the needs or personal preferences of the veteran. In many locations, there is insufficient staff with the clinical training for carrying out these therapies. The result could be a discontinuance of PTSD treatment because of either systemic VA problems (i.e. lack of adequate mental health staffing in the form of psychologists, psychiatrists, licensed clinical social workers or ancillary staff); lack of availability for initial/follow up appointments; courteousness/flexibility of providers to engage veterans in their mental health treatment/recovery due to national guidelines/protocols; or because of individual veterans dropping out of PTSD treatment because of schedules, lack of treatment flexibility or other reasons.

Melissa Seligman with portraits of her father, Paul Sutton, who served in Vietnam, and her husband, David, who has been deployed to both Iraq and Afghanistan.



A chronology of combat trauma

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| <p>800 B.C.
In the "Iliad," Homer chronicles combat trauma and survivor's guilt resulting from the Trojan War.</p> | <p>1688
Military post-traumatic stress is first described in medical literature as "nostalgia" by Swiss physician Johannes Hofer.</p> | <p>Napoleonic Wars
Napoleon's chief surgeon recommends a treatment regimen of exercise, listening to music and "useful instruction" for conditions related to combat stress. Symptoms include anxiety, insomnia, melancholy, and heart palpitations.</p> | <p>Civil War
The Union Army identifies 5,200 cases of nostalgia and 2,600 cases of insanity among the troops. In 1864, the War Department orders some of the soldiers transferred to the Government Hospital until their families can retrieve them.</p> | <p>1871
Dr. Jacob Mendes Da Costa observes rapid heart rate, anxiety and hyperarousal among military personnel, giving rise to the term "soldier's heart."</p> | <p>World War I
Soldiers with "staring eyes," violent tremors, inexplicable deafness, blindness or paralysis are described as suffering from "shell shock." The U.S. Army Surgeon General's guidelines, issued in 1917, call for "immediacy," "simplicity," and "expectancy" (of return to the front lines) in treatment.</p> | <p>World War II
The medical community describes PTS as "combat fatigue" and begins to study the connection between the condition and duration/intensity of combat.</p> | <p>Korean War
The <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM), the definitive reference for psychological conditions, calls PTS "stress-response syndrome."</p> | <p>Vietnam War
Veterans are treated for "stress-response syndrome." If symptoms last more than six months after returning from Vietnam, they are judged to be suffering from a pre-existing condition, not PTS.</p> | <p>1980
The American Psychological Association identifies PTSD as a distinct diagnosis.</p> |
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A new generation of veterans confronts post-traumatic stress.

PART I: FAMILIES AFFLICTED

The American Legion's support for veterans suffering from combat stress began shortly after World War I. Newly discharged troops were turning up in jails, hospitals, asylums and on street corners, having suddenly lost contact with their friends, families and themselves. They were shell-shocked and haunted by battles long thought to be over. Legion research illuminated the problem, and helped lead to the creation of the modern VA. Today, after decades of wars and research into the condition, it has a new name – post-traumatic stress – but it remains as mystifying as ever. The Iraq and Afghanistan generation is coming home with a strain all its own, often compounded by traumatic brain injury. A special American Legion committee has been working with top national mental-health experts to find new answers to an old problem, one that stands to strain families across the country for decades to come. The following pages portray just a fraction of those families and how they are handling lives changed by war trauma.

ARTICLES

KEN OLSEN

PHOTOS

AMY C. ELLIOTT

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Melissa Seligman started convulsing when her husband described the aftermath of a suicide bombing he witnessed during his first deployment to Iraq. She had heard that same flat, detached tone, from her father, when he described seeing a helicopter gunner's leg get blown off in Vietnam.

"There's something so horrible about somebody being so traumatized ... there's no emotion attached," Seligman says. "My dad would talk like that. My entire insides would shake until I didn't know what to do."

She eventually realized that the post-traumatic stress that had haunted her father now dogged her husband.

Hundreds of thousands of military families face similar dilemmas as combat troops suffering from PTS come home, attempt to get jobs, reintegrate into society, mend fractured personal relationships and get help from VA's overwhelmed mental health care system. It's a dilemma that reopens invisible wounds for Vietnam veterans who don't want today's generation to endure the same mistreatment they faced when they came home from war. It's also a cautionary tale for a nation too often insulated from the mental-health consequences of wartime military service. The Vietnam experience demonstrates that the price of not treating PTS is paid in suicide, substance abuse, homelessness, unemployment, divorce and domestic violence.

"We're sending our people over there with a very high risk they will come back with psychological problems, and we're not prepared," says Susan Selke, whose son, Marine Corps veteran Clay Hunt, committed suicide after battling PTS and survivor's guilt.

ABOVE:
David Seligman and his father-in-law, Paul Sutton. Seligman's example – and daughter Melissa's work with her blog – encouraged Sutton to get help for his own lingering PTS. Photo courtesy Melissa Seligman

"Substantial unmet need for care."

Some 300,000 Iraq and Afghanistan veterans – nearly 20 percent of returning troops – are coming home with PTS or depression, according a 2008 study by the RAND Corporation, a nonprofit research group. Roughly half have sought treatment from VA. There is "substantial unmet need for care," RAND reports.

This spring, a federal appeals court declared VA's mental-health care system broken, and ordered a lower court to find a way to end delays in care delivery that may be costing veterans their lives. Nearly 86,000 veterans were languishing on VA waiting lists for mental-health care as of April 2008, "a number that may significantly under-represent the scale of the problem both then and now," the 9th U.S. Circuit Court of Appeals said. The court blamed gross inefficiency, not a lack of funding, for VA problems that leave veterans "suffering and dying, heedlessly and needlessly."

Statistics, however, only capture a snapshot in time, says Dr. Julie C. Chapman, director of neuroscience at VA's War Related Illness and Injury Study Center in Washington. It may be years, or even decades, before the mental-health toll of the current wars is known. "Symptoms can submerge and then re-emerge many years later, sometimes during stress or life change."

The case against the 'D'

Post-traumatic stress disorder has carried a potent stigma since the American Psychological Association defined the term for the lingering effects of combat and other terrifying experiences. Blame it on the word "disorder."

Some World War II and Korean War veterans scorned Vietnam veterans when they talked about PTSD, says Thom Paca, who served in Southeast Asia in 1968 and 1969. "They thought we were pansies," Paca recalls. "They thought we should buck up and get over it."

More than half of active-duty soldiers believe that seeking help such as counseling will hurt their careers, according to the Army's comprehensive Health Promotion/Risk Reduction/Suicide Prevention Report. The soldiers who most need help frequently do not seek it out.

"Until the stigma associated with behavioral-health treatment can be overcome, the Army should continue to look at alternative methods for identifying soldiers who may be in need of such care," the report concluded.

American Legion Past National Commander William Detweiler says it's time to bring the language in line with reality.

Post-traumatic stress "is an injury based on a catastrophic event," says Detweiler, chairman of the Legion's ad hoc committee on traumatic brain injury and post-traumatic stress. "Calling it a disorder is what creates the stigma."

That stigma is just as much a product of society as it is a perception of the military community.

"The general feeling I get from people is, 'These poor soldiers,'" says David Seligman, who is getting counseling for PTS after three deployments. "(It's as if) you are a vegetable sitting in a corner drooling on yourself. There are plenty of guys who are phenomenal soldiers who have PTSD."

Jake Wood, who served combat tours in Iraq and Afghanistan, says PTSD is a normal reaction to abnormal circumstances. "Just because you have PTSD doesn't mean you're crazy. It just means you have seen a lot of crazy stuff, and are understandably scarred from it."

“Knowing what war is all about ... **it was hard for me**
to see him go through that.”

The Vietnam nightmares grew steadily worse for Melissa Seligman’s father after his son-in-law, David, began deploying to Afghanistan and Iraq in 2003. “Knowing what war is all about, it was hard for me to see him go through that,” says Paul Sutton. “You live with it for the rest of your life.”

Sutton joined the Air Force on his 17th birthday, and went to Southeast Asia 18 months later. He served four months rescuing downed U.S. pilots, and another year with a unit that provided air-to-ground radio support for allied forces. Coming home in 1966 was worse than he imagined. He says the civilian world either hated him, didn’t understand him, or both.

“There was no support and no appreciation at all for serving my country,” Sutton says. “I did not want to be around anyone. It is still hard for me to be around people.”

He returned home to Kentucky, where he raised his daughter in the outdoors – canoeing, flying and rappelling. She learned to sit quietly with him for hours, seeing things in her father she did not understand. “I knew the war had impacted him,” she says. “But I didn’t have any words to describe it.”

She remembers how his jaw would clench and he would go silent whenever he saw a photo of a buddy from Vietnam. She remembers his startled reactions whenever she touched him.

She remembers telling the story of a little Vietnamese girl who visited his camp. He gave the girl candy and invited her back. She returned with a grenade, pulled the pin, and blew herself up. A few years ago, Seligman’s father told her the rest of the story, the part that most torments him.

“He sat there and cried and said, ‘I did that to her.’”

“I was getting **eaten alive** by things I didn’t understand.”

When U.S. troops returned from Vietnam, America largely failed to welcome them home and could not grasp the magnitude of their mental wounds. Ken Jones felt no connection to life in the States when he came home in 1968 after a year as a scout-squad leader with the 11th Cavalry. He wanted to return to Vietnam, where he understood his place. “You come to the question of core identity,” Jones says. “There’s a cultural displacement when you come back and realize, in a very short time, the place you thought of as home no longer exists.”

Eight months later, Jones started suffering severe anxiety. His blood pressure skyrocketed. “I was getting eaten alive by things I didn’t understand,” Jones says. The trip-wire anger he unintentionally brought home from Vietnam had one benefit: it triggered adrenaline rushes that vanquished his bouts of depression.

Jones threw himself into his work as a financial adviser and pension-management consultant. He went running at night to

Vietnam War veteran Thom Paca has struggled for years with the effects of PTS, suffering setbacks in employment, his personal life and more. Today, he receives VA assistance, but his third marriage is under stress.



exhaust his demons. In the late 1970s, he started writing about his nightmares, which became the basis for his book “When Our Troops Come Home.”

Thom Paca unraveled before he left the war zone. Nine months into his tour as an infantry-weapons squad leader, he “whipped a fellow pretty good with a machine gun,” told off his lieutenant and fled into the jungle. Paca’s buddies tracked him down and persuaded him to return. His commander decided he had battle fatigue, and shipped him to Japan for a psychiatric evaluation.

“I was found ‘physically fit but not responsible for my actions,’” Paca says. That was all the mental-health treatment he received. He returned to Vietnam and spent the last three months of his deployment confined to camp without a weapon. He finished his Army hitch stateside, and left the minute his discharge papers were signed, declining to stay even one extra day for a medical evaluation.

Thirty years, two failed marriages and a string of jobs later, Paca was diagnosed with PTS after a fellow Vietnam War veteran encouraged him to get help. Today anxiety, mood swings and stress are straining his third marriage. “I tell him we have a 50-50 chance,” Paca’s wife, Sharon, says. “But we’re still trying.”

Such stories are familiar to retired nurse Arlene Lynch, who worked with Vietnam War veterans in the Seattle VA Medical Center psychiatric ward in the late 1990s.

“These were kids who should have been driving around in cars looking at girls” instead of going into combat, Lynch says. “They didn’t know what to do with the rage and the anger. It’s no surprise they melted down.”

Coming home to a nation that didn’t want to hear about the war exacerbated the trauma.

“They learned to keep their heads down and their mouths shut,” Lynch says. “But they couldn’t keep all that stuff inside. It manifests itself in suicide, drinking, drug abuse, murders, not being able to do jobs or keep relationships. It was common knowledge among the guys on the psych unit at the VA that twice as many Vietnam vets died from suicide as died in battle.”



Susan Selke, Clay Hunt's mother, and her husband, Richard, hold the flag given to her at Hunt's funeral.

When doing everything right isn't enough

A Marine's suicide shows that even the unlikeliest veteran can fall through the cracks.

Of all the questions raised by Clay Hunt's suicide, perhaps the most perplexing is this: why did a 28-year-old former Marine who was receiving VA health care, taking medications for post-traumatic stress and publicly pushing fellow veterans to get help, give up?

"I think if Clay can lose his battle with PTSD, anyone can," says Jake Wood, Hunt's best friend from the Marines. "He was taking all of the right steps to get help, and he fell through the cracks. The VA system failed him in a very dramatic way."

John Wordin, executive director of Ride 2 Recovery and another of Hunt's friends, says Clay's death "tells us we're not doing enough. It will haunt myself and Clay's mother for a long time."

Hunt grew up riding his bicycle and collecting turtles on the banks of Buffalo Bayou in west Houston. He attended Memorial Drive Methodist Church, where the youth pastor inspired him to volunteer by repairing homes in poor neighborhoods across the South. Hunt played sports and scored well on college-entrance exams, but didn't have the class rank to gain entrance into first choice Texas A&M. After four on-and-off years of community college, he finally earned admission to Texas A&M, but instead decided to join the Marines.

"He said, 'I want to do something bigger than myself, something that is not just about me,'" says

Hunt's mother, Susan Selke. Her son explained it all in a telephone call in the spring of 2005. "It was hard to get that phone call, but it was a good decision for Clay to make at that point in his life. He definitely excelled in the Marines."

Hunt and Wood became friends after being assigned to the same infantry platoon a year later. They were about the same age, had both attended college and had similar interests. "He was a loyal, caring person," Wood says.

The pair deployed to Iraq in January 2007. By early March, they had lost two good friends. Hunt's bunkmate, Blake Howey, was killed by a roadside bomb. Nathan Windsor was mortally wounded when their convoy was attacked. Hunt, pinned down by enemy fire, couldn't help Windsor and couldn't return fire. Windsor died while being airlifted to a hospital.

Those deaths changed Hunt, says his father, Stacy, who received a call from his son soon after Windsor was killed. "For the first time, I could sense a real fear in his voice."

Then a sniper's bullet ripped through Hunt's wrist in March. He was sent back to the United States to recover. "He hated leaving his buddies there," Stacy Hunt says. "He knew what those guys were going through outside of Fallujah."

Selke says that's when the PTSD started – "the trauma of being shot and being separated from his group."

A Purple Heart and PTSD did not end Hunt's combat days, as the family expected. Instead, he rejoined Wood and became one of the Marine Corps' elite scout-snipers. He got married just before his platoon was sent to Afghanistan in March 2008. Soon after his arrival, two close

friends from his former platoon were killed.

"He was starting to get disillusioned with the mission and the war, and it made it really tough for him," Wood says. "We felt pretty impotent sitting back there in Kandahar twiddling our thumbs while our guys are out there getting killed." Hunt's platoon returned to the United States in October 2008, and he left the Marines the following spring.

Re-entering the civilian world was rough. Delays in getting GI Bill benefits forced him to live off his credit cards when he enrolled at Loyola Marymount University.

"It puts stress on every aspect of your life when you have \$15,000 in credit-card debt, you aren't making any money, your wife isn't making much money, you're standing in line four hours to get a counseling appointment, struggling with your transition, and you have to beat your head against the wall to get your benefits," Wood says.

Hunt's frustrations mounted. VA lost his disability-claim paperwork, forcing him to revisit doctors and reconstruct his 200-page file. That exacerbated his PTSD, anxiety and exhaustion. "Clay told me, 'I have to grovel for my benefits,'" Selke says.

Hunt also struggled to understand why he had been spared. The vivid memory of being unable to help his mortally wounded friend, lying on the road in front of him in Iraq, tortured him.

"He told me, 'It's like a bad movie on rewind. It plays, it rewinds, plays, rewinds,'" Selke says. "The medications he took didn't help."

Still, Hunt openly embraced his PTSD and survivor's guilt. "He said, 'I've got a wicked case of PTSD, and I'm going to work on it,'" Selke says. Hunt appeared in public-service announcements for Iraq and Afghanistan Veterans of America (IAVA) encouraging other veterans to get help. He went to Haiti and Chile with Team Rubicon – a volunteer group Wood co-founded – to aid earthquake victims. He volunteered with Ride 2 Recovery, a Los Angeles-based group that builds bicycles and organizes rides for wounded veterans. He appealed for a higher disability rating from VA.

"He was two different guys," Wordin says. "He was Clay Hunt, happy-go-lucky guy, who loved to ride bicycles. And he was Clay Hunt, haunted man, dealing with issues of watching his buddies die in Iraq and Afghanistan. He was quite straightforward about it: 'John, there are some days I just want to kill myself.'"

Hunt filed for divorce in late spring 2010. Two

weeks after returning to college, depression overtook him. He called his mother and told her he was almost unable to function. She talked him into going to VA for help. He briefly lived in Wordin's guest room before deciding to move back to Houston.

Hunt landed a job with a construction company, found an apartment and bought a new truck soon after returning to his hometown. He started dating again. He registered at the Houston VA, and in mid-March, a psychiatrist agreed to switch him back to an antidepressant with fewer side effects. But after a two-hour wait in the pharmacy, Hunt was told that VA didn't stock Lexapro because it was a name-brand drug. The pharmacy told him it would mail the prescription, and sent him on his way without the antidepressant/antianxiety medication he desperately needed, his mother says.

Hunt left the VA more dispirited than ever.

"Antidepressants take time to start to work," Selke says. "He didn't have time to wait for a mailout to reach him. I don't know why his medication was not considered an urgent need."

VA says it cannot comment on Hunt's case. A spokeswoman at the Michael E. DeBakey VA Medical Center in Houston says its pharmacy began carrying Lexapro within the past year, at the request of psychiatrists.

Hunt shot himself in his Houston-area apartment on March 31. Five weeks later, his mother received a letter from VA saying he had won his appeal for a higher disability rating.

"It was like a kick in the gut," Selke says. "He was gone."



Holding his son's baseball mitt, Clay Hunt's father, Stacy, says he wants to find a "way to save more lives."

Indeed, Jones thought he was going to kill himself or go crazy when he finally went to a VA vet center in Anchorage in 1980. He showed some of his Vietnam writings to a counselor, who read six pages and told him, “You’ve come to the right place. We speak this lingo.” Even then, it would take years of work for Jones to get a handle on his stress, depression and anxiety.

“We said, ‘We don’t know what we are, but we aren’t that.’”

The medical community had trouble understanding what Vietnam veterans were going through, even though references to combat trauma and survivor’s guilt date back to Homer’s account of the Trojan Wars. They met with everything from skepticism to misdiagnosis to ridicule.

“One of the most important contributions of Vietnam veterans was they refused to accept the diagnosis of paranoid schizophrenia from VA or civilian doctors,” Jones said. “We said, ‘We don’t know what we are, but we aren’t that.’”

Similar symptoms may have caused confusion, Chapman says. “One of the potential diagnostic criteria for schizophrenia are hallucinations. A soldier’s description of flashbacks might have led a clinician to consider hallucinations, associated with schizophrenia. Similarly, when an individual is exhibiting strong hypervigilance, it might look like paranoia – particularly before PTSD was well-understood.”

The experience of Vietnam veterans brought post-traumatic stress to the attention of the medical community and the nation. “Although combat exposure increases the risk of PTSD in any conflict, a greater number of veterans of the Vietnam War experienced PTSD than have been identified in other conflicts,” Chapman says. “Awareness was raised, and attention was focused.”

The American Psychological Association recognized post-traumatic stress disorder as a distinct diagnosis in 1980. Three years later, Congress mandated a government study on the prevalence of the condition. The National Vietnam Veterans Readjustment Study found that 15 percent of the war’s male veterans had PTSD, compared with 5 percent of the civilian population.

Fourteen years later, 1,400 Vietnam combat veterans who belonged to The American Legion participated in a follow-up study that showed that PTSD had dropped only slightly over that time. “It was important to characterize the lifetime course of this condition – whether it would resolve, remain, or reappear periodically, to what degree, and in what form,” Chapman says.

The Legion follow-up study also found that Vietnam veterans with PTSD experienced higher rates of divorce, cardiovascular disease, fatigue and compromised immune systems. “The distinction between physical health and mental health is artificial,” Chapman says.

While society and the medical community were coming to terms with PTSD, small groups of Vietnam veterans began to meet in informal gathering spots, such as the empty room above the Flower



Retired nurse Arlene Lynch worked with Vietnam War veterans in a VA psych ward in the late 1990s. She is still deeply affected by the isolation and frustration her former patients experienced.

How PTS, TBI can strain a marriage

Some days, Tammara Rosenleaf would rather not be a combat veteran’s wife.

She loves her husband. He is kind, generous and unflappable – a contrast to her stronger, more emotional personality. But the Sean Hefflin she married 13 years ago didn’t come back from Iraq. He can’t remember the smallest task. He can’t focus. He totaled her car and shattered her shoulder during one of the times he mentally checked out.

“Traumatic brain injury has a huge impact on our relationship,” she says. “It’s like being a mom with a 7-year-old.”

Hefflin describes his 13-month Army deployment to Iraq with indifference. “I did a little bit of a lot of things.”

His camp in Baghdad was a favorite enemy target. “There were mortar rounds coming in daily,” he says. “I don’t necessarily believe my combat experience was that traumatic. Odds are better I would die in a car accident here.”

Hefflin’s grandfather died as he was coming home from Iraq. The night of the funeral, Rosenleaf realized that her husband had PTSD. The couple was driving along a foggy, winding road near Olympia, Wash., when an approaching car flashed lights to signal there were deer on the road. Hefflin grabbed her arm, then grabbed the steering wheel and yelled, “Don’t slow down!” She barely kept the car from careening into the ditch. Her arm bore the bruise of her husband’s grip.

Later, Hefflin freaked out when Rosenleaf pulled into a parking spot next to an empty Chinese takeout container he feared might contain a roadside bomb.

She insisted that he get help. He was treated by a former military psychologist near Fort Hood for 18 months.

As Hefflin’s symptoms eased – he says the Army diagnosed adjustment disorder, not PTSD – Rosenleaf started to see signs of TBI, especially after they left the structured military life at Fort Hood and returned to Helena. Hefflin loses to-do lists. He leaves the house to meet his wife for lunch and returns without ever arriving at the restaurant.

Nonetheless, he is extremely bright. “If there was a particular thing Napoleon said on the eve of whatever, Sean would know that,” Rosenleaf says. “What he’s supposed to do today? He can’t remember.”

One spring day while he was driving, “Sean was living in his sleep like he normally does.” He



Sean Hefflin and Tammara Rosenleaf struggle with the changes PTSD and TBI have brought to their marriage.

threaded his way through cars at an intersection and into the path of an oncoming SUV. Rosenleaf, who was sitting in the passenger seat, went to the hospital with a shattered shoulder.

“There’s no way I can continue living with a person who can’t come back from wherever he’s gone,” Rosenleaf said after the accident. “I would give anything to get out from under being a combat veteran’s wife ... I’m talking about leaving a really good man because he can’t remember anything.”

Her frustration is not simply about his memory. She works full time as a case manager for developmentally disabled clients and takes care of most things at home. It’s exhausting. “He’s starting to realize it has serious effects for me,” Rosenleaf says.

VA is trying to determine what is causing Hefflin’s attention problems. She recounts two incidents in Iraq that could have inflicted TBI. In one case, she and Hefflin were conversing online through instant messaging when a blast from a mortar round blew him out of his bunk.

Today, Hefflin remembers a hooch two doors down being blown apart but has no memory that the blast knocked him to the floor. Nor does he recall being hit in the head by a portable toilet upended in a different mortar attack.

A VA neuropsychologist pinpointed evidence of TBI in the left temporal lobe of Hefflin’s brain in February, and a follow-up MRI was scheduled for July. VA has not yet decided if the brain injury is service-connected.

“I want him to be able to function,” she says. “I lost part of my partner. The military owes me half of my partner back.”

Military sexual trauma emerges as a major cause of PTS

Rebekah Havrilla endured four years of relentless sexual harassment and was raped by a fellow soldier toward the end of her tour defusing roadside bombs in Afghanistan, she says. By the end, "I just wanted to survive. I just wanted to go home. I just wanted to get out of the Army."

Leaving the Army, however, didn't put an end to Havrilla's nightmares and anxiety. She's one of tens of thousands of servicemembers who suffer from post-traumatic stress as a result of military sexual trauma (MST). Her case is unusual, however, in that she's receiving some VA disability benefits. MST survivors face a higher burden of proof than combat veterans when applying for PTS benefits. Most are turned away.

Approximately two-thirds of MST claims for PTS are rejected or returned to the veteran for additional documentation, according to data the Service Women's Action Network (SWAN) obtained in a public-records lawsuit against VA.

"The military-sexual-trauma survivor is punished again," says Anuradha Bhagwati, a former Marine captain and executive director of SWAN, which has a separate class-action suit against the Department of Defense over the harassment and assaults. "The government wins, at the end of the day, because they don't have to award benefits."

Burden of Proof. Military sexual trauma is the leading cause of post-traumatic stress among female veterans. The extent of the problem is unknown, because victims are reluctant to come forward. The Pentagon estimates that there were more than 19,000 sexual assaults in the ranks in 2010 – an increase of about 3,000 from 2009. Only 3,158 were officially reported. About 40 percent of MST survivors are men. Around 25 percent of sexual assaults occur during combat deployments.

Survivors face a perplexing double standard from VA when they file PTS claims, says Greg Jacob, a former Marine who is now policy director for SWAN. Last year, VA eased the burden of proof for combat PTS claims. Essentially, veterans no longer need independent evidence to confirm they were exposed to enemy threats such as roadside bombs or mortar attacks.

Sexual-trauma survivors, however, still have to submit corroborating evidence of their assault. That's a significant challenge, even if they report harassment or assault at the time it happens. DoD only keeps rape kits for a year, and sexual-harassment investigations for two years. By the time an

assault survivor gets out of the service and files a PTS claim with VA, the evidence has usually been destroyed, Jacob says.

VA allows so-called secondary evidence, such as statements from friends, relatives or others with whom the survivor may have confided about the assault. It's meaningless, Jacob says. "VA says you can submit it. But it has no guidance for the claims officer to accept it, and hasn't published anything about what the burden of proof is."

Open Access. One arm of VA is being praised for helping MST survivors deal with PTS. The Veterans Health Administration, which oversees hospitals, clinics and patient care, "has done a remarkable job with military sexual trauma," Jacob says. "It will give you any necessary care for free, even if you don't qualify as service-connected." The Veterans Benefits Administration, which makes claims decisions, "needs to catch up," he says.

That observation is borne out by Greg Jeloudov's experience. Jeloudov says he was harassed and then raped during basic training in 2009. When he tried to report the assault, he says he was forced to sign a statement falsely admitting he was gay, and discharged from the Army under the "don't ask, don't tell" policy. "I feared for my life and the safety of my family."

Jeloudov has been unable to keep a job and is estranged from his wife and stepsons, he says. His claim was rejected, but VA has provided medical care for him since September 2010. "I've been seeing an excellent doctor and excellent social workers."

VA also responded to his request to be re-examined, by female VA doctors, when he appealed his claim denial. "They listened to me," he says. "(But) I'm still waiting for the flick of their pen to decide my fate."

Career Crash. Many veterans mourn military careers cut short by sexual trauma. Air Force reservist Mary Gallagher was diagnosed with PTS

Greg Jeloudov was forced to sign a false statement, and discharged from the Army, after reporting an assault.



Air Force reservist Mary Gallagher faces having her military career cut short due to PTS from a sexual assault.

and taken out of the line of duty two months after she was allegedly sexually assaulted by a fellow tech sergeant while they were stationed in Baghdad in November 2009. She expects to be fully discharged by the end of the year unless her condition improves. "I am sad my career had to end with something that never should have happened in the first place," she says.

Gallagher was sent to Iraq in September 2009 with an Air National Guard detachment from Massachusetts. She alerted her supervisor that a fellow tech sergeant started stalking her and tried to break into her room after she rebuffed his sexual advances. Her supervisor's response: "Hey, this stuff happens. Don't worry about it."

A week later, Gallagher says, the tech sergeant sexually assaulted her in the women's restroom. Gallagher bypassed her supervisor and called her home unit in Rhode Island. "I was scared to death," Gallagher says. "He could have easily killed me that day, gotten rid of the body, and reported me as AWOL." The commanders from Gallagher's home unit arranged for her transfer back to the United States and connected her to counseling. A year and a half later, she is planning a new career but remains disenchanted with the military's response. Her assailant was not convicted and is still in uniform. "(That's) the strongest evidence that the program the military has to deal with this issue isn't working," she says.

Andrea Neutzling shares that frustration. She says she was sexually assaulted twice during her 10 years in the Army and Army Reserve. The first incident, in Korea in 2002, resulted in her assailant being confined to base for five days. Then, in 2005, she was allegedly raped by two soldiers from another unit that was on the verge of departing from Iraq. Although she had bruises from her shoulders to her elbows and on her thighs, a chaplain told Neutzling she didn't "act like a rape victim," she says. Her commanders put a "letter of interest" in her file for committing adultery because one of the men was married. The perpetrators were not charged, her sergeant told her later, because it would have prevented

their unit from returning to the United States.

"I had wanted to be in the Army from the time I was in kindergarten," Neutzling says. "I'd like to see things change before my daughter gets old enough to join."

The Challenge of Change. Rebekah Havrilla is most struck by the pervasive harassment that persisted throughout her time in the service. She and other women who graduated from the rigorous Naval School Explosive Ordnance Disposal weren't admired for their skills. Instead, she says, the presumption was that "you provided sexual services to somebody" to get through it.

The harassment became especially unbearable during the last half of her yearlong deployment to Afghanistan, she says. She was the only female, and the lowest-ranking member, of a bomb-disposal team led by a man who she says openly groped her and peppered her with sexually inappropriate comments. Havrilla sought treatment as her anxiety level went through the roof and she started to lose sleep. She was diagnosed with PTS and put on antidepressants and sleeping pills. And then, she says, a colleague raped her.

Of all of that, however, the harassment haunts her the most. "While the rape was traumatic, it was not nearly as devastating to me as the things people did to me on a daily basis," she says.

Today, Havrilla deals with chronic depression and has difficulty sleeping. VA benefits haven't provided much relief. Most VA medical centers are open from 9 a.m. to 5 p.m., and jumping through the system's hoops is a full-time job, she says. That's hard to do if people work, as she does, or are raising children.

"I just want to help women who have been in this situation, and work to change the system."



Andrea Neutzling's lifelong dream of an Army career was dashed as a consequence of two separate assaults.



Oregon Army National Guard veteran Jeff McDowell, who did a combat tour in Baghdad, sought help for his own PTS so he could help his soldiers, and other veterans, with theirs. With that goal in mind, he is now completing a master's program in counseling.

and Dragon restaurant in San Francisco. At first, no one spoke. “They didn’t have a word for what they were experiencing,” Jones says. “They drew strength from each other. At least they knew they weren’t alone.”

That informal effort gave rise to the storefront Vet Centers – later adopted by VA – that would help Paca, Jones and many other Vietnam veterans manage the trauma that followed them home from war. “The tag line,” Jones says, “was ‘Help without Hassles.’”

“You are freaked out until the next thing happens that freaks you out more.”

Thirty years later, Oregon Army National Guard veteran Jeff McDowell turned to the Vet Center in Eugene, Ore., for help dealing with his brutal combat tour in Baghdad. His counselor, the son of a Vietnam veteran with severe PTS, quickly concluded that McDowell also had the condition.

McDowell’s scout platoon conducted approximately 270 missions during its year in downtown Baghdad. That included investigating IED blasts and providing security for government ministries and hotels, as well as occasional forays into Baghdad neighborhoods. “We’d go to check something out, hear a big boom, and just keep going, mission to mission,” says McDowell, who served as platoon sergeant during a 2004-2005 deployment.

Enemy identification was mind-bending for U.S. troops who patrolled Iraq, as it was for those who fought in Vietnam. Insurgents and civilians dressed alike. The rules of engagement changed rapidly. “You are freaked out until the next thing happens that freaks you out more,” McDowell says. “Three-hundred and sixty-five days of that, and you fly back home.”

Like Vietnam veterans, soldiers returning from Iraq and Afghanistan often feel out of place when they try to return to civilian life, so they return to the military and re-enter the war. Job-hunting is arduous. Relationships can be impossible.

“We did an unofficial poll of 300 or 400 soldiers who went over with us,” McDowell says. “We had an 86-percent divorce rate. I can count on two hands the number who don’t have at least one divorce. Some had two, some three.”

McDowell was 40 when he came home from his deployment. The transition was difficult. His contracting business had withered. He was short-fused with his wife and children. He no longer cared about hunting and fishing, which he had loved before his deployment. “I lost my joy,” McDowell says. His wife encouraged him to get help, and he’s parlayed that into a career helping others.

After retiring from the National Guard in 2007, McDowell entered a master’s program in counseling to assist other veterans. “I started seeing some of my guys fall apart,” he says. “I felt responsible for them. I thought, if I can figure some of this stuff out for myself, maybe I can figure it out for the other guys.”

He’s already seeing veterans as part of an unpaid internship with a private, nonprofit counseling group. He hopes to put his skills to work at the Eugene VA Vet Center.

McDowell made careful choices. He got counseling. He participated in a neuro-feedback treatment program. He also decided to never carry a weapon of any kind, knowing that he couldn’t shut off his combat instincts.

“You start thinking about the things you did, the way you reacted, the training you got, and you know you are not the same person,” McDowell says. “I spent a lot of time thinking about this ... about whether I was going to like this (new) person.”

Resources

VA Veterans Crisis Line

(800) 273-8255 (press 1)

www.veteranscrisisline.net

War Related Illness and Injury Study Center – Clinical Services

(800) 722-8340

www.warrelatedillness.va.gov/warrelatedillness/clinical.asp

wriisc.dc@va.gov

National Center for PTSD

(802) 296-6300

www.ptsd.va.gov

ncptsd@va.gov

VA PTSD Coach app (for smart phones)

www.ptsd.va.gov/public/pages/ptsdcoach.asp

The American Legion – DSO Directory

(202) 861-2700

www.legion.org/departmentofficers

var@legion.org

PTSD Foundation of America

(877) 717-7873

ptsdusa.net

National Veterans Legal Services Program

(202) 265-8305

www.nvlsp.org

info@nvlsp.org

Service Women’s Action Network (SWAN) National Peer Support Helpline

1-888-729-2089

www.servicewomen.org

peersupport@servicewomen.org



Melissa Seligman and her husband, David. Her blog and online conversations about the effects of PTS on families spurred him to get counseling for the PTS that was affecting their own marriage.

To an extent, I need David to stay trigger-ready.”

Families struggle with their own stresses caring for loved ones with PTS. “A lot of times, spouses become the sponges,” Melissa Seligman says, “and have nowhere to release it.” They often face their own secondary PTS.

Seligman started convulsing when her husband described the carnage from that suicide bombing in the same flat, emotionless tone her father used to tell his story about the helicopter gunner losing a leg in Vietnam. David had the same startled reaction as her dad when Seligman touched him. And he exploded with anger for no apparent reason. It would be three years, including another combat deployment and a year at Officer Candidate School, before they could confront his PTS.

Like most military spouses, Seligman was reluctant to seek help for herself, worried that she would be taking resources from people in greater need. Then she came across Ken Jones on Twitter, and started talking to him about her experiences with her husband and her father. Not only was Jones a Vietnam combat veteran, but he had grown up in the shadow of his own father’s World War II post-traumatic stress.

“For the first time, I had a translator,” she says. “Ken Jones opened up the world for understanding both men.”

Understanding David’s triggers helps her to realize that his reactions aren’t personal, to negotiate the difficult moments, and to foster his relationship with their children.

Soon, Seligman and Chris Piper – who together co-founded the “Her War, Her Voice” blog – were recording their conversations about combat stress and military families with Jones and posting them on the Internet. David Seligman decided to seek counseling after hearing just one of those conversations.

Even this victory comes with caution, a question about whether too much healing will dull the edge that keeps her husband alive. “To an extent, I need David to stay trigger-ready,” Seligman says. “I need him to be numb to the horrors of war. Because without that numbness, he may make mistakes.”

Inspired by his son-in-law and encouraged by his VA doctor, her father started getting help for his PTS a year ago. Seligman is relieved that the most important men in her life are healing; she no longer shakes when they talk about the events they witnessed. Still, she wishes she had the power to reach into the past and find a way to end her father’s nightmares.

“I always wanted him to be better,” Seligman says. “As a wife and mother, it makes me wonder how I could have changed things if I had just asked him. I wonder who he would have been if someone had listened.” 🌿

Ken Olsen is a frequent contributor to The American Legion Magazine.

The Legion’s tradition of mental-health support

BY PAUL FEDORCHAK

In a world of acronyms, serial numbers and security-clearance codes, platoons of stressed-out combat veterans march out of their doctors’ offices with yet another number – 309.81 – scribbled on their medical files. With this designation, they will get an appointment with a mental-health professional, and yet another chance to talk about recurring nightmares from their days in Iraq, Afghanistan or Vietnam. They will work with their therapists to help break the mental anguish that got them diagnosed with 309.81 – aka post-traumatic stress.

Since long before the diagnosis gained its name in 1980, The American Legion has been an advocate for helping veterans get medical help for dealing with their fears, violence and helplessness. The cause recently gained renewed vigor with the creation of the Legion’s Post-Traumatic Stress/Traumatic Brain Injury Ad Hoc Committee. Formed in October 2010, the group has been regularly meeting, and actively seeking medical direction for helping those in need. And the list of the needy is long.

An article from the January 1994 issue of *The American Legion Magazine* tells of a Vietnam veteran struggling with the day he killed a young girl. She begged him not to eat her as he held her in his arms and she faded away from the wound of his bullet. The 8- or 9-year-old told him that the Viet Cong had chained her to a tree and handed her a submachine gun to fire at the American cannibals. She had earlier wiped out some troops but was too weak this time.

After 25 years, the sergeant, a PTS victim, remained haunted. “He has held a multitude of jobs, moved a dozen times, lived through a broken marriage and sleeps only three or four hours a night. ... He loves his kids immensely,

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Key chapters in advocacy

The American Legion has made studying the treatment of post-traumatic stress and traumatic brain injury a priority for the past two years. But the organization’s history of advocating on behalf of America’s servicemembers and veterans dates back to the Legion’s inception.

1919 | In the year of its birth, the Legion unexpectedly becomes a major advocate for veterans benefits after hearing from members about the dysfunction of governmental agencies.

1921 | Congress establishes the Veterans Bureau after endless pleas from the Legion to “put all the bureaus in one bureau.”

January 1922 | The Legion, pleased with its successful lobbying efforts for disability benefits, applauds Congress for passage of the Sweet Act of 1921. “The burden of proof is now upon the government. If a veteran has developed active pulmonary tuberculosis or a mental disease within two years of the date of his discharge, it is now assumed that the disease is the result of his war service. ... But the Legion must stay on guard. It must see the new regulation is observed fully.”

March 1922 | *The American Legion Weekly* reports on lingering psychological troubles of American Expeditionary Forces (AEF) veterans of World War I. “Medical experts say the shell-shocked soldier got better care in the AEF during the high tide of battle than he is now getting ... in this country three years after the war.”

1930 | Further consolidation of the management of veterans affairs comes with the creation of the Veterans Administration (VA), again at the urging of the Legion.

1933 | The National Rehabilitation Committee fights for disability benefits for veterans who suffer from “functional mental and nervous abnormalities.”

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1950 | The National Executive Committee earmarks \$25,000 for an independent volunteer movement to battle “the greatest remaining health threat – mental illness.”

1968 | The Legion starts the “Our Kind of Guy” program to educate returning veterans on benefits, including those for psychosis.

1978 | The Legion, which worked closely with the author of a scholarly work on the psychological readjustment of Vietnam-era veterans, helps present the book to VA head Max Cleland. Dr. Charles Figley of Purdue University, author of “Stress Disorders Among Vietnam Veterans,” visits Cleland with Robert Spanogle, then the Legion’s Internal Affairs director.

1980 | Many years of work by psychiatrist Leonard Neff and his colleagues lead to the birth of the official diagnosis of Post-Traumatic Stress Disorder (PTSD). His work on the study of “shell shock” gives the medical world a better comprehension of how trauma can surface much later in life. A VA psychiatrist, he challenges the view that most Vietnam vets are to blame for their problems.

1983-1985 | The Legion, long concerned about problems experienced by Vietnam veterans, partners with Columbia University to survey nearly 7,000 veterans on post-traumatic stress and other health issues.

July 1985 | The American Legion-Columbia University Study of Vietnam-era Veterans reveals that combat vets had lower incomes (\$3,000-\$4,000 less), higher divorce rates (25 percent vs. 12 percent) and greater unhappiness than noncombat peers.

September 1985 | The Society for Traumatic Stress Studies hears testimony from the Legion about the post-traumatic stress component of the Legion-Columbia study. John F. Sommer Jr., deputy director of the Legion’s Veterans Affairs & Rehabilitation Division, notes that Vietnam vets with intense combat experience had “general health reports more closely resembling men 10 to 20 years older who did not see combat.”

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but in their eyes he is a remote and cold man. ... He still dreams about those crumpled bodies, the flies and the terrified eyes of a dying little girl in that jungle clearing.”

Her words still resonate: “No eat me, GI. No eat me.”

The emotional challenges of returning home from battle, and reliving its trauma, are not unique to Vietnam. They’ve been around as long as humans have waged war. Civil War soldiers dealt with “soldier’s heart.” World War I doughboys battled “combat fatigue.” World War II troops returned home with “gross stress reaction.” “Post-Vietnam syndrome” was a label for those surviving tours in Southeast Asia. “Battle fatigue” and “shell shock” are other monikers, but in 1980 the challenges of dealing with life’s major stressors became known as “post-traumatic stress [disorder].” Label it how you like, but the horror stories are much the same for those returning from Korea, Iraq, Afghanistan or any other combat zone.

Before the days of diagnostic codes, an *American Legion Magazine* editor shared his view on a World War I combat photo. In an August 1959 recap of the Legion’s first 40 years, Robert B. Pitkin stressed the long-standing need for mental-health care. In reference to this image, he writes, “One photo shows doughboys pressing forward on raw nerve in the Argonne in 1918 to break the Hindenburg line. The strain on them is visible. A certain number exhausted their nervous stability and came home insane. ... In World War I, the Army discharged 50,000 for mental illness, after they’d passed the military physical and mental requirements on induction.”

Much clearly happens between induction and discharge. Just ask Miles S. Epling, the Legion’s 1989-1990 national commander, who received a letter from a Vietnam veteran with a wife and three children. The veteran wrote: “I was afraid. I was afraid I’d never

go home again. I was 19 years old. One night I was crying. I was alone, and I prayed to God to help me hang in there and make it home.

“In the past 20 years, I have had 15 jobs, moved 19 times and been living at the poverty level much of the time. I have applied for over 300 jobs in the past several years, with no luck.” The words pained Epling, who vowed that the Legion would always fight for the likes of this veteran whose “body was in North Dakota, but his mind was still in the Mekong Delta.” Epling noted that the veteran was diagnosed with PTSD and received treatment, but his struggles to survive continued.

Those struggles remain today for veterans returning from Iraq and Afghanistan. Joshua Clark battles ongoing mood swings, and constantly relives the day he narrowly escaped a fatal bomb attack that claimed a civilian, he says in the February 2006 edition of *The American Legion Magazine*. “I don’t know how people deal with me,” he continues. “Even I sometimes can’t deal with me.”

Lydia Epton, a Navy veteran of Desert Shield and Desert Storm, dealt with depression, alcohol, cocaine and the effects of a paralyzing stroke, she says in the same issue. “I had hit bottom. For some reason, I suddenly decided I didn’t want to die, so I got in contact with the VA.” After drug rehab, she entered a PTSD program. “The program did not cure me,” Epton said. “I still have rough times. What it did was allow me to start living my life again. ... I’ve learned I can live life without hurting myself with alcohol and drugs. I can now walk again with my head up. I’ve gained back my self-respect.”

A PTSD diagnosis is certainly not the end of the story for Clark, Epton or any other 309.81 sufferer. It’s merely the beginning of a journey to help find a better life. And the Legion remains dedicated to leading veterans through every step of that journey.

CHAPTERS continued

October 2010 | The Legion forms a Post-Traumatic Stress/Traumatic Brain Injury Ad Hoc Committee to “investigate the existing science and procedures, as well as alternative methods, for treating TBI and PTSD currently being employed by the Department of Defense or Department of Veterans Affairs.” The committee learns of some successes from Dr. Paul Harch, who established an 80-treatment plan of hyperbaric oxygen therapy.

January 2011 | William Detweiler, past national commander and chairman of the ad hoc committee, comments during presentations to the group: “... there is no single treatment that fits all cases. In fact, it was clear from some of the presentations that medical experts cannot yet agree on a single screening procedure for these disabilities.”

January 2011 | As part of its campaign to drop the word “disorder” from the post-traumatic stress diagnosis, the Legion becomes increasingly vocal on the subject. Bill Schrier, national vice commander, comments: “It’s discriminatory, and it’s narrowing what this (servicemember) can do in his or her life. We have to take the stigma attached to PTSD away.” While others argue that doctors and psychiatrists still use “disorder,” Schrier speaks further about the suffering among veterans he sees in his travels around the country. “They have the mentality that they can overcome anything. Why would we want to hang anything on them that’s associated with a disorder? I fight for those young people, and so does The American Legion.”

August 2011 | National Commander Jimmie L. Foster calls for congressional hearings on the use of Risperdal as a drug of choice in the treatment of PTSD. “It is alarming that fully 20 percent of the nearly 87,000 veterans VA physicians treated for PTSD last year were given a medication that has proven to be pretty much useless,” Foster says. He points to a VA study noting that the drug does not alleviate the symptoms of PTSD. “Not only that, but Risperdal is not even approved by the Food and Drug Administration for the treatment of PTSD,” Foster adds.

Tim Hecker was a career soldier, husband and father before he came home from war with PTS and TBI. After limited success with traditional medicine, he found new hope in hyperbaric oxygen treatments.



The American Legion has been helping veterans find answers for post-traumatic stress for over 90 years. As more soldiers come home from war with PTS and traumatic brain injuries, the Legion continues to press for treatment programs that provide real relief. Hyperbaric oxygen, cognitive therapy and mixed martial arts are among the non-traditional options a growing number of sufferers are finding helpful, with or without definitive studies to prove their effect, or government sanction to cover their costs.

PART II: PATHS TO HEALING

Tim Hecker joined the Army at 18 and soon decided to make a career of it. He served 22 years in all, in and out of combat, rising to the rank of master sergeant. In the summer of 1990, he married his high-school sweetheart, Tina, and the couple had three children.

Then Tim couldn't remember having married Tina.

He couldn't tell his sons apart. Their names escaped him.

Injuries suffered in two separate roadside-bomb explosions in a span of two months in Iraq in early 2008 left him with a traumatic brain injury and severe post-traumatic stress. He was no longer the man Tina had married.

"Didn't really remember us having kids," Tina explains. "Didn't remember us getting married. How do you explain to three teenage children that their father doesn't know anything about them anymore, doesn't know when they were born, doesn't know when their birthdays are, can't remember their names necessarily and can't remember any milestones from school? That's very difficult."

He forgot activities they used to share. "Simple little things, like going fishing with the kids. That just stopped. It's hard to explain to kids when you don't really have the answers yourself."

Tina had to quit her part-time job when Tim came home. His doctor appointments put them on the road five days a week, sometimes two-and-a-half hours each way. "You can't leave him by himself because he gets lost," Tina says. "You never know what he is going to do."

STORY BY
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STEVE B.
BROOKS

PHOTOS
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AMY C. ELLIOTT

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Frustrated with her husband's descent and the lack of progress with traditional care, Tina went online and found information about Dr. Paul Harch, a New Orleans-based physician specializing in hyperbaric medicine. His facility, Harch Hyperbarics Family Physicians' Center, uses high-pressure oxygen to treat basic patho-physiologic conditions.

Following a phone call and an initial interview, Tim was selected to be part of Harch's pilot study on the use of hyperbaric oxygen therapy (HBOT) for TBI and PTS. He claims the treatments have given him back most of his pre-injury life.

"By the fourth treatment, I started feeling like a new person," he says at his home in West Edmeston, N.Y. "I was more aware. I could see things. The deeper I got into the treatments, my cognition started to come back – my motor skills and my balance. My vision started to improve. The biggest benefit was my emotional control."

"We're talking a 180-degree turnaround," Tina says. "There are days when he's almost back to normal with his personality."

"I knew something was wrong, but I kept it hidden."

Tim's first encounter with an IED occurred while he was riding in a tractor-trailer in Iraq in January 2008. Two months later, he was riding in a convoy when the Humvee in front of his sustained a catastrophic hit. The blast was so severe that it impacted Tim's vehicle. A field physician examined him after the explosion and determined that he could return to duty. "I was in a (quality-assurance and quality-control) role, so I was traveling from building site to building site, and detached from my unit," Tim says. "So basically, as long as I was able to function, I stayed in the field."

Because he worked away from his unit most of the time, no one noticed that Tim's behavior had changed. "I was a miserable person," he says. "I had migraines. I was very irritable. But everyone assumed, 'He's the ranking NCO. That's just the way they are.' But my communications and my writing and stuff were starting to show signs that something was wrong. I knew something was wrong, but I kept it hidden. In the military, any sign of weakness is not a good thing."

Tim couldn't hide it from his wife, though. "He became quiet," Tina says. "His phone calls, although daily, were very limited. He would talk about the weather, and that was about it. Never asked about kids, never asked about family, never asked about home, community, none of that. He started becoming very agitated, and the slightest little thing that most normal people might have some kind of reaction to, he would blow way out of proportion. It got to the point where I was hearing him threaten others working around them. He wouldn't threaten them directly; he would talk about it to me. That's when I got a hold of his (physician assistant) over there and said, 'Somebody needs to pay close attention. There's some-

Cognitive therapy: The process of relearning awaits government blessing

Dr. Wayne Gordon, a professor of rehabilitation medicine and associate professor of psychiatry at the Mount Sinai School of Medicine in New York, is an advocate of cognitive therapy for veterans, and has briefed the Legion's PTS/TBI Ad Hoc Committee on its uses and benefits. He spoke with The American Legion Magazine about the treatment.

What does the cognitive-therapy process involve?

One way to look at it is there are basic skills that are designed to help people improve their attention, memory and processing speed. And then there are more complex skills that people learn to help them regulate their emotions, think through situations, respond more effectively and efficiently. The first set of skills are usually done on an individual basis, and require a lot of practice over time. The second set of skills are usually done on a root basis, and require a considerable amount of time. The amount of time it takes to treat somebody is really a function of a person beginning to learn a new set of habits.

How long has cognitive therapy been used to treat traumatic brain injuries?

The interventions really started to be developed in 1967, so this is not something that's new. Over time, they've improved and gotten more sophisticated.

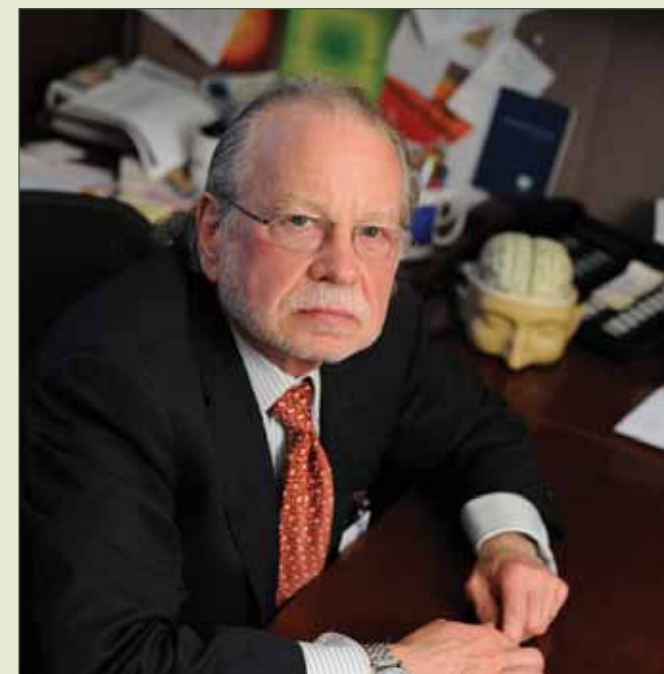
I think it's always been around to treat veterans. I think because there are so many soldiers coming back from the war with traumatic brain injuries, there's more and more pressure on delivering the service.

Is cognitive therapy really just a matter of relearning something that has been lost?

What is going on is a person begins to learn skills that they used to have, and relearn skills, and practice. And then you give the person a set of strategies that he can apply across situations.

What kind of results have you seen in clinical trials?

Consistently, we see that cognitive rehab is an effective intervention, and that comprehensive holistic programs are the most effective.



Dr. Wayne Gordon is hopeful that a new study will validate cognitive therapy.

Why has the federal government been slow to sanction it?

I think the big fear is what it's going to cost them. I haven't seen cost estimates, but if you're talking about soldiers getting several hours a day of treatment over multiple days a week for a period of at least three to six months, you're talking about a huge amount of money.

What is the status of TRICARE coverage for cognitive therapy for TBI and PTS?

I think it's gone through several phases. TRICARE sent it out for its own systematic review about a year and a half ago, got the review back and sent it out for comment, and it was trashed. So they withdrew it. Since then, the Department of Defense has now contracted with the Institute of Medicine to do its own review and report to DoD. I hope the report will be issued by the end of the year. I testified before the committee. It was a very fair group. My feeling is that the committee has no choice but to endorse the intervention, because there's nothing else out there. You can't treat traumatic brain injury with a pill.



Tim Hecker, his wife, Tina, and their daughter, Brianne, have worked together to confront his PTSD and TBI.

thing going on.’ His only suggestion was, ‘We’ll keep an eye on him, check him once a week. And when he gets home, maybe you should take him to the VA.’

Tim redeployed stateside that June. A month later, he went to the VA medical center in Syracuse. “The initial diagnosis was severe PTSD and (mild) TBI,” he says. “They started me on a bunch of antidepressants, and I forget what the other ones were. Basically, I was taking a bunch of pills.

“Things just got worse and worse. Finally, they gave me a diagnosis of post-concussive syndrome. They focused on the PTSD at first, figuring in time the brain-injury symptoms would wear off. That wasn’t the case. They got progressively worse. I have prided myself in being a member of the military for over 20 years, and I felt my whole livelihood slipping away.”

Tina became increasingly frustrated by the prescription-based treatment program. She says that in early 2009, “a pharmacist refused to fill his prescriptions because they were from different doctors, and he said that if he filled them, the combination would have killed Tim. Then he took all the pills he had and dumped them in the toilet. I didn’t even have a say in that. At that point, we needed to do something with him. They really don’t have any suggestions for TBI, other than pills and therapy. Some cognitive therapy. But it’s kind of hard to give someone cognitive therapy when their brain’s not able to process what you’re trying to reteach them.”

Alternative roads to recovery

National Intrepid Center of Excellence

www.nicoe.capmed.mil

(866) 966-1020

resources@dcoeoutreach.org

NICoE is a treatment center in Bethesda, Md., that blends cognitive and holistic therapies in a plan that also includes family education and reintegration support. Family members stay at a Fisher House during treatment.

The Pathway Home

thepathwayhome.org

(707) 948-3031

A California residential recovery program created for OIF/OEF veterans, as well as veterans of the global war on terror who served in other locations. Treatment includes relaxation to help reduce physical responses to tension and stress, and practical instruction in skills for coping with anger, stress and other problems.

Healers and Heroes

njhealersandheroes.com

Created by the Medical Society of New Jersey and the state’s Department of Military and Veterans Affairs, the program gives returning servicemembers opportunities to meet with doctors who have military experience, for informal consultations and referrals.

P2V

p2v.org

info@pets2vets.org

(877) 311-4P2V (4728)

Founded by Air Force veteran and PTS sufferer David Sharpe, P2V pairs up specially trained dogs with active-duty military personnel, veterans and emergency first responders, as well as spouses and survivors. Other organizations, such as Patriot PAWS and Hounds4Heroes, offer similar services. DoD and VA are studying the effects of such programs.

DoD’s T2 Virtual PTSD Experience

t2health.org/vwproj

Accessed through the Second Life virtual-reality program, T2 allows servicemembers to anonymously learn about symptoms of PTSD, and where to get help. A servicemember can create an avatar to navigate through realistic scenarios in Second Life. These include a simulation demonstrating how PTSD may be acquired during a combat-related traumatic event, an explanation of the connections between danger cues and triggers, the role of avoidance in the development of PTSD, and how PTSD is a normal human response to traumatic events.

Tim stayed at an Army Reserve center three hours from home during that time, and Tina had to walk him through his daily routine by telephone. She had to remind him to eat breakfast, shower, get dressed and brush his teeth. When he came home, he spent days sitting in a chair and staring, unless instructed otherwise.

The Heckers' daughter, Brianne, was 16 when she became a caregiver for her dad. "I started trying to figure out how to help," says Brianne, now a freshman at the State University of New York. "We had to continuously ask how he was doing, what he was doing, what he was supposed to be doing, where he was going – sort of keeping him in check. We were always raised to help others and put others before ourselves. It was a change, yes, but I was glad I was able to help."

Still, Tim's condition worsened, and Tina sought help elsewhere. A frequent visitor to military websites, she came across a comment about a story on hyperbaric oxygen treatments that specifically referenced Harch's program. "I started looking up Dr. Harch myself, and that's when I realized he was running a pilot study. I called Tim and asked him, 'What do you think?' He was at zero. I got nothing out of him. He didn't really want to do it. He was sluggish. I told him, 'I'm going to go ahead and do it, and let's see what happens.'"

Tim did a phone interview with Harch and met the study's criteria. In April 2009, he traveled to New Orleans to receive HBOT.

"He went in with a migraine, came out, and it was gone," she says. "He starting picking up in his attitude, and the brightness in his eyes was coming back. He started to remember how to get back to the facility we were staying at. (Before the treatments) he couldn't get from home to a gas station without a GPS. Now he was remembering a place we'd only been in four days."

After the first round of treatments, the Heckers returned to West Edmeston. Brianne quickly sensed a difference in both of her parents. "When they came back, it was like getting new parents back," she says. "It's a big relief to know we won't hit rock bottom again with him."

Tim goes to New Orleans for treatments twice a year; the number of oxygen-chamber "dives," as they are called, is now down to seven per trip. He can always tell when it's time for another round. "It's like you take a flashlight that's got a dim bulb, and you put fresh batteries in it and get this bright light," he says. "That's how I feel emotionally, mentally and physically. As the treatments wear off, I start to get tired. I forget things. My balance gets off. It's just a huge difference."

As a result, Tina is an enthusiastic promoter of Harch and HBOT. "I carry his information with me," she says. "I've brought it to families who've had people who've had injuries. I tell them, 'Give it a chance.'"

Martial arts help PTS sufferers fight their way out of the abyss

BY KELLY CRIGGER

Marine Lt. Lee Stuckey hates medications, but without them he's robbed of sleep by the sweats and tremors of post-traumatic stress. He is one among every eight Iraq and Afghanistan veterans who faces combat PTS. After two tours and a close encounter with an IED, he feels fortunate to have all his limbs, his eyesight and no serious loss of motor skills. But going home posed a new set of challenges. He was placed in the medical platoon at Camp Lejeune, N.C., with a group of fellow Marines also struggling with PTS.

"Marines get frustrated with the traditional treatment of talking it out," Stuckey says. "Guys would just go back to their barracks rooms and drink away their pain all night. It just wasn't a good situation."

An avid martial artist, Stuckey took it upon himself to drag the others into Camp Lejeune's Semper Fit gym. There, he introduced them to Andrea Lucie and her regimen of yoga, meditation, and martial arts.

"A Muay Thai combination is hard for a patient suffering from traumatic brain injury," Lucie says. "But it helps them focus because there are repetitive movements they have to remember, and it's a disciplined act. Marines are disciplined people, so they relate."

By combining vigorous mixed martial arts (MMA) workouts with yoga and meditation for relaxation, Lucie and Stuckey soon found that the Marines were adjusting and sleeping better.

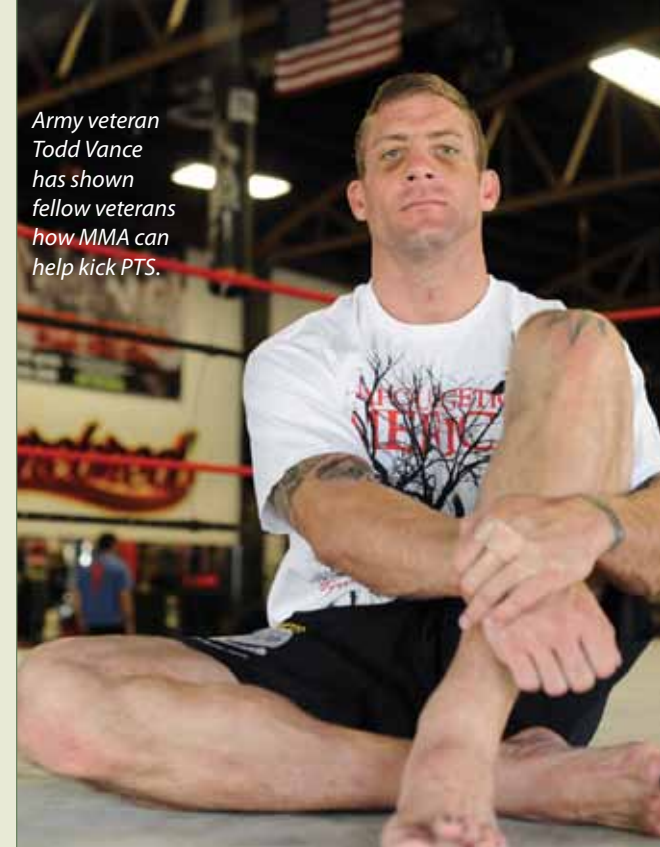
Quite simply, Marines are more interested in physical challenges like martial arts than sitting in group therapy talking about how they feel. They'd rather hit something. MMA provides that outlet so they don't take it out on themselves or others.

"MMA humbles Marines," Stuckey says. "It shows them they don't have to be aggressive – that it's OK to admit when you're suffering."

In San Diego, former Army Sgt. Todd Vance, a veteran of more than 200 combat missions, was going through the same hell as Stuckey, but without a list of medications or a barracks full of comrades to help him.

"I was bad," Vance says. "I was rated an 8 out of 10 on the PTSD scale. I drank until I blacked out, just to sleep. I got into fights all the time, and took a job working construction so I didn't have to talk to anyone. MMA played a huge role in my

Army veteran
Todd Vance
has shown
fellow veterans
how MMA can
help kick PTS.



recovery. If I had a rough day, I could go to the gym and get on the bags until my knuckles were raw."

Vance also sought support at the Mission Valley VA Hospital in San Diego, where many of his fellow veterans had slid into deep depressions, and where he eventually found a meaningful job. That's also where he got an idea. An avid Muay Thai fighter, he worked out a deal with his gym to conduct free MMA classes for veterans. "For about three months, it was the same five guys every week. Now we have about 15 or 20 regulars, and the guys essentially have free memberships to train every day."

Vance's veterans had a different degree of PTS than Stuckey. At Camp Lejeune, Stuckey's Marines had the safety of their barracks. The same wasn't true on the West Coast, where homelessness and drug addiction were prevalent among Vance's students. That presented an obstacle greater than the baseline PTS itself.

At the heart of the problem is the elevated state of mind soldiers have when in combat, resembling a chemically induced high, which they come to feel is normal. When they search for that same feeling when they return – through reckless driving, fighting, and in some cases extreme sports – MMA provides a self-contained outlet. It also provides camaraderie and brotherhood among participants, not entirely unlike a military unit.



Dr. Paul Harch of New Orleans says cost is the main reason more veterans suffering with TBI and PTS don't pursue hyperbaric oxygen treatment.

"The purpose of this is to give them their lives back, give them back their families."

In recent years, Harch has treated dozens of veterans using hyperbaric oxygen. He conducted a study of 15 PTS/TBI patients by administering a battery of tests before and after the treatments. They showed an average IQ improvement of nearly 15 points. Thirteen out of those 15 reported fewer headaches. Nine of the 12 who had insomnia before the treatments cited improved sleep. Seven of the 11 subjects on prescription medication for their conditions cut back on or quit the medications.

Harch also used the military's PTS checklist to score subjects before and after treatments. They showed 30-percent reductions in their PTS scores after hyperbaric oxygen treatments.

"The purpose of this is to give them their lives back, give them back their families," Harch says. "We sent them off to war, and they allow me to sit here in my comfort and do what I'm doing and not worry about being blown up or worry about the security of my family. They put it all on the line, and they need to be rewarded for that. They deserve, at least, an attempt to get back some of that lost function. And that's what this can do."

Harch says the federal government's reluctance to accept HBOT as a legitimate treatment form for PTS and TBI comes down to money. "I firmly believe that's No. 1," he says. "We charge \$200 an hour at our clinic. The Medicare rate is about \$275 an hour. This is billed in hospitals at \$2,000 an hour. DoD has thrown out a figure that you need \$500,000 lifetime to treat a brain-injured veteran for these symptoms and problems. First of all, there's no evidence for that. Secondly, if you even took the 80-treatment protocol that I developed, that's \$160,000 at the billed hospital rate ... The reality is that treatment with drugs and all these other therapies is doubly expensive."

Also, there's an outdated perception about the procedure, Harch says. "This is my generation of doctors. We were taught that (HBOT) is a fraud. Nobody understood how it worked. It got a bad name when it was applied to multiple sclerosis. People stood up and claimed it affected impotence, balding and cancer. There is so much misinformation. We're working against this past body of misperceptions."

"The world became kind of frightening.

You know you're not doing what you used to be able to do."

During a lunch break in his office in Shalimar, Fla., Okaloosa County Court Judge Patt Maney makes short work of a sandwich before speaking easily about how hyperbaric oxygen treatment has benefited him. Four years ago, like Tim Hecker, Maney was in what seemed a permanent daze caused by combat brain injury.

In 2005, Maney – a brigadier general in the Army Reserve – was assigned to the U.S. Embassy in Kabul. As part of the Afghanistan Reconstruction Group, his job was to lend civilian expertise to military efforts in the wartorn nation. One day, while searching for a potable water source in the mountains above Kabul, Maney's convoy came under attack. An IED exploded, blowing his vehicle into the air and flipping it upside down.

Maney and two other passengers walked away from the blast. He went to the embassy, and then to a German army field hospital for evaluation. After several days of treatment, he was assigned back to the embassy, and 10 days later he went to Walter Reed Army Medical Center. "(Our) injuries at that point were probably under-diagnosed," Maney says. "I don't remember what the initial diagnosis was. Ultimately I ended up at Walter Reed with a traumatic brain injury diagnosis. At different times it was called other things: post-concussion syndrome, closed cranial injury, consciousness unknown, cognitive difficulties not otherwise specified."

He spent nearly 20 months there. "A lot of rehab, several surgeries," he says. "The problem with many of the ... blast-type injuries is that there isn't an outward physical manifestation of the injury. I wouldn't remember conversation. I couldn't follow directions, couldn't comprehend. Couldn't balance a checkbook. Couldn't drive."

"At one point, I went over to the National Naval Medical Center in Bethesda, which is about eight miles from Walter Reed," he adds. "I was in uniform. I stopped at a little PX gas station, and I couldn't figure out how to operate a self-service pump. I ended up asking the lady at the other side how to work it. You can imagine her surprise – somebody standing there in a general's uniform asking how to turn on a gas pump."

Maney couldn't concentrate. He had trouble sleeping. Treatment included several different medications that had little effect. "The world became kind of frightening," he says. "You couldn't do what you used to be able to do. I was faced with the realization I was not only going to lose my military position, but I would also lose my civilian occupation and go from being a rather successful independent person to being really dependent on my wife for just about everything."

About that time, Maney called a doctor friend in Fort Walton Beach "just to say hi," he says. His friend suggested HBOT. Maney contacted his doctor at Walter Reed and asked about it, and the



Judge Patt Maney of Florida struggled with driving, directions and other everyday tasks before hyperbaric oxygen treatments turned his life around.

doctor said that while he didn't know much about the treatment, he was willing to try it. In October 2007, Maney began the treatments at George Washington University Hospital.

"The protocol runs for 40 one-hour dives," Maney says.

"After about 10 or so dives, my wife thought she saw improvement, but she didn't say anything – not even to me – because she was afraid it was a false hope. After about 12 or 14, I started thinking I was getting better, but I didn't want to say anything. After about 20 dives, people who had seen me both before and after the injury started commenting to my wife and me: 'You're doing better. You look like you're doing better. You seem to be more engaged. You don't have the long pauses in your conversations. Your sentences tie together. You're talking in paragraphs.'"

After 40 dives, Maney showed substantial improvement. After a 30-day break, he did an additional 40. "By that time, I was able to start reading again," he says. "It had been very frustrating for me to not be able to read. I could pick up a page and read the first sentence. I could pronounce the words and understand the words. But by the time I read the second sentence, I'd forgotten what the first sentence said. As I started getting better and started reading, I did the other 40 dives, and I was able to come back and work full time as a judge."

When Maney meets current and former servicemembers in his community who he suspects are suffering from PTS or TBI but haven't been screened or diagnosed, he recommends HBOT. "I became much more sensitive to the plight of these soldiers and what they go through as they try to navigate what is a very complicated system that is not set up – was not and is not well set up – to deal with traumatic brain injuries or PTSD," he says.

"I ran into a young man who lost both legs in Iraq. His hand was also mangled in an IED blast. He had never been treated, never been evaluated for PTSD or traumatic brain injury. As I've gotten active trying to help these young troops, I've been contacted by people – one Marine, several Air Force, several Army. I've been able to direct them into hyperbaric oxygen therapy. Every single one has shown improvement. Not all of them have gotten back to 100 percent, but if you're functioning at 40 or 50 percent and you get back up to 75 or 80 percent, that's a major quality-of-life improvement."

"Everybody who has argued against hyperbarics, they don't know what they're talking about."

When The American Legion's PTS-TBI Ad Hoc Committee met in early August, VA's Alison Cernich said that as a TBI treatment, hyperbaric oxygen is unproven and requires more research.

"Hyperbaric oxygen really has limited data right now," says Cernich, acting senior liaison for TBI in VA's Office of Rehabilitation Services. "I wouldn't say I recommend or don't recommend hyperbaric oxygen. I would say that in terms of its application, I think some of the claims that are being made are relatively wide, with the evidence relatively sparse."

She adds that VA and DoD are co-funding a clinical trial on HBOT, and a report is expected within a year. She also referenced six severe TBI patients who were treated with hyperbaric oxygen at the University of Pittsburgh but experienced no improvement. "They're not showing any improvements, say, on a functional-independence measure. That rates how well the person can do things independently: stand, sit, walk."

Cernich warns against veterans and families setting expectations too high for an alternative treatment like HBOT.

Even so, Patt Maney and Tim Hecker see themselves as successful case studies for treating the signature wound of the war on terror with hyperbaric-oxygen dives.

"Everybody who has argued against hyperbarics, they don't know what they're talking about," Hecker says. "Until you have suffered from a traumatic brain injury and felt that frustration and anger at not being yourself, and then get it back ... it's amazing."

"If it hadn't been for Dr. Harch, I'd have been labeled with conversion disorder and medically discharged. I understand that with the extent of my injuries and the disabilities I have, cognitively, I can function in society, but I can't function at the level I need to as a master sergeant in the Army. That I can accept. I am going through the process of being retired out of the Army. I can accept it now. I'm going out on my terms. It's not that I'm being pushed to the side. This is what needs to happen." 🌿

Steve B. Brooks is multimedia editor for The American Legion.



*Melissa Seligman
and her husband,
David, with a
photograph of her
father, Paul Sutton.*
Amy C. Elliott

PART III: Rx FOR A BROKEN SYSTEM

If there's such a thing as a post-traumatic stress (PTS) success story, it's that of David Seligman's family. His father-in-law, a Vietnam War veteran, listened when David needed to unload after his first combat tour in Iraq. His wife stood by him through three deployments and weathered the hair-trigger emotions that followed him home from battle. His grandfather, a Marine who fought on Okinawa during World War II, joined the family in encouraging David to get treatment.

"It helped to know that people who had it that bad were saying, 'Getting help is not a weakness,'" Seligman says. "They had credibility. Why would I avoid (treatment options) they wish they'd had?"

Seligman also considers himself fortunate to have had a commander who supported his efforts to seek treatment, as well as the help of a good counselor. And his father-in-law, Paul Sutton, was inspired to get treatment for his own PTS after Seligman pursued it for himself.

It's a success story worth telling. More than half a million people with ties to the wars in Iraq and Afghanistan are affected by PTS and depression. Sufferers include returning troops, their spouses and their children. The effects can include divorce, substance abuse, unemployment and, in severe cases, suicide.

The American Legion's ad hoc committee on PTS and TBI (traumatic brain injury) has been addressing the problem, urging greater focus on mental health for returning troops and veterans, as well as for their families. The Legion is also working to help remove the potentially career-killing stigma from the condition and fighting for top-quality treatment for veterans no matter where they live.

The payoff could be substantial, according to a detailed analysis by the RAND Corp., a nonpartisan, nonprofit research group. Just providing quality care for Iraq and Afghanistan veterans dealing with PTS and depression in the two years following a deployment, according to RAND, would save more than \$2 billion and hundreds – if not thousands – of lives.

"I have always maintained, being an attorney, that when you raise your hand to take the soldier's oath, you enter into a contract with the U.S. government," says William Detweiler, a past national commander of The American Legion and chairman of the Legion's PTS/TBI ad hoc committee. "You agree to follow orders and defend our country to protect its interests and its people. Consequently, if I am injured in keeping that oath and performing my duty, the federal government owes me the benefits that I have earned through my service, including health care and disability benefits."

ARTICLES
KEN OLSEN

PHOTOS
AMY C. ELLIOTT

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“Be sure the family is fully engaged.”

Veterans have struggled for quality mental-health care services and benefits for psychological conditions since the Legion first fought to get post-traumatic stress recognized as a combat injury more than 30 years ago.

“Unfortunately, mental problems – psychological problems – too often are given second-class citizenship within the medical profession in general,” says Jeanne Stellman, professor emeritus and special lecturer at the Columbia University Mailman School of Public Health, and a member of the Legion’s PTS/TBI committee.

The public can be equally dismissive, she says. “Part of the normal human response to mental-health/behavioral-health problems is to tell people to get a hold of themselves. You don’t tell someone with prostate cancer to get a grip and move on. You are fighting medicine. You are fighting human nature, and you are fighting VA bureaucracy.”

Stellman’s prescription is straightforward: get mental-health care off the back burner. Persuade VA and DoD to share their best treatments for PTS and TBI. Create a medical record that will follow a soldier from the military to VA and, once the condition is diagnosed, involve the entire family in the treatment plan.

“One of the hallmarks of post-traumatic stress is withdrawal and avoidance,” Stellman says. “That means that veterans may have trouble keeping (treatment) appointments. One way to make sure they do is to be sure the family is fully engaged.”

Vietnam War veteran Ken Jones, who spent years battling PTS before getting help at a VA Vet Center in Anchorage, agrees. “Recovery is not a do-it-yourself project,” says Jones, who has written two books on the trials faced by returning combat troops. “You get into a doom loop. Nothing you look at ever has any meaning.”

Servicemembers worry that getting mental-health care will cost them security clearances that are important to future careers, says Terri Tanielian, senior research analyst at RAND. Despite recent changes to security-clearance applications, veterans remain concerned that getting help for a mental-health problem could be used against them. The RAND research team recommended that the military and other employers evaluate people for their functional ability to perform their jobs, instead of relying on simple questions about the pursuit of mental health care.

“Investments in quality care pay off.”

VA and DoD must provide top-notch care wherever veterans live, she explains. “VA and the Department of Defense have really excellent state-of-the-art treatments available in some locations,” Stellman says. “But it is not uniformly available to all vets and all soldiers.”

Top-quality PTS treatment is rare, according to RAND’s study of returning military personnel who served in Iraq and Afghanistan. “In the United States, too few individuals with mental-health problems, including our returning veterans, receive high-quality care,” Tanielian says.

Failure to reach more veterans has a high price, according to RAND. In the two years following their deployment, PTS and depression among Iraq and Afghanistan veterans cost the United States \$6 billion (in 2007 dollars) in lost productivity, medical care and suicide, Tanielian says. That doesn’t include the additional costs of drug and alcohol abuse, homelessness, family strain, divorce and other collateral damage.

“We found that the costs associated with lost productivity and suicides decrease significantly when all veterans with PTS and depression got high-quality care,” Tanielian says. “Making such a sweeping change in treatment isn’t easy, but health-care organizations have demonstrated that investments in quality care pay off by improving patient health. For example, VA has been a national leader in quality improvement and the quality of care it provides in many areas.”

“VA lacks the resources to tackle this problem.”

A recurring recommendation in the exploration of post-traumatic stress among today’s veterans is that troops need a longer, more thorough transition to their lives as civilians. “We should have 12 full months to be able to get up to speed on life after the military, not out walking over IEDs and shot at by insurgents right up to the

Labor Department tries to put PTS/TBI sufferers to work

Four years ago, the U.S. Department of Labor started fielding calls from employers who wanted to hire wounded warriors but were leery of PTS and traumatic brain injuries. That prompted DoL to launch the America’s Heroes at Work program, to ease employment challenges for veterans with invisible wounds and debunk myths about PTS and TBI.

“People hear PTSD, and they think about what they see on TV and what they’ve heard in the media,” says Michael Reardon of DoL’s Office of Disability Employment Policy. “We help employers understand what it is, and what it is not.”

Veterans with PTS or TBI face considerable hurdles to finding jobs if they reveal their conditions. Many are reluctant to tell employers that they are getting treatment for PTS or living with TBI, DoL officials say.

“One big thing is just helping people understand PTSD is the result of a trauma ... you can heal,” says Lisa Stern of America’s Heroes at Work. “When you have a broken arm, you go to the doctor, get it treated, and in time it heals. With PTSD, people

learn compensatory strategies for continuing productive lives.”

America’s Heroes at Work provides one-on-one assistance and training to hundreds of employers who want to hire veterans. This includes reminding federal agencies that qualified veterans who have an at least 30-percent disability rating can be hired without applying through the difficult USAJOBS website.

The program also gives free, confidential guidance to employers on providing workplace accommodations for wounded warriors. Not all veterans with PTS or TBI need additional help. Just having the opportunity to work can be enough.

“Most of the time, work is going to keep you together,” says Katia Albanese of the America’s Heroes at Work team. “This is such a critical element in the recovery process. When you go to work, it helps you figure out what your mind and body can do again.”

– Ken Olsen

 www.americaheroesatwork.gov

'The genesis of us'

Decades of research lead Montana veteran to conclude that inner fears must be confronted to break war's grip.

The voices of veterans from World War I to Afghanistan dwell among the islands of Peter Quinn's basement. Carl Jung and Sigmund Freud are there, too, along with Lt. Col. Dave Grossman, pioneer in the psychology of killing. Stuffed pheasants, cattle horns, photographs, wildlife paintings and a Garand rifle encircle the islands – an archipelago, really – where Quinn has collected, indexed, documented and color-coded, with Marine Corps precision, the pieces of a puzzle he has been trying to solve for over half a century.

"All the trappings of 50 or 60 years of work," Quinn says, waving a hand over one of his islands. "I have been determined to educate myself to answer questions I needed to answer."

The collection, which includes tape-recorded interviews with nearly 150 veterans, revolves around two main topics and their relationship to one another: war and psychology.

As a student of human behavior, art and communications, he has collected 92 credits at five different universities as he's bounced around the hemispheres since dropping out of high school to join the Marine Corps in 1953. He was an aircraft mechanic during the Korean War. He helped configure U.S. jets with aerial cameras to spy on the Chinese. He lasted a couple of years out of uniform before he re-entered the military, this time the Army, and put in another four years, stationed at Fort Huachuca, Ariz. A talented artist, Quinn worked in advertising in Los Angeles after his second discharge. In 1968, the Vietnam War lured him back to the business of armed conflict. He went to work in the civil service, testing missiles off the coast of California for the Navy, then back to Fort Huachuca, then to help develop classified training curricula for all U.S. service branches in Central and South America.

He retired from this unusual career in 1987, having shown thousands of active-duty, National Guard and reserve troops how to perform the various functions of Southern Command – defense, search and rescue, narcotics interdiction, disaster relief – without getting themselves killed. "It was down in South America that I realized the criticality of giving these young people the skills necessary to reduce the risks that they would be exposed to," Quinn explains. "I always saw my job as increasing survivability."

Today, in his mid-70s and living alongside a winding dirt road in the Big Belt Mountains of western Montana, he is trying to tie it all together – what it is within certain people that makes them calm and effective in the stress of battle and yet often unable to live with themselves as normal citizens during peacetime. To him, that's a matter of survivability. He is deeply compelled, for instance, by the case of a fellow Korean War veteran whose combat performance was exemplary but who took his own life after discharge, at the age of 28.

Quinn's cassette tapes and case studies typically explore the psychological effects of unimaginable military stresses, such as the interview he recorded with Don Cook of Salmon, Idaho, who was evacuated shortly before Japan seized Manila in World War II. Cook, along with 223 other Army hospital patients, sailed through mine-infested waters from the Philippines to Australia on a ship with a normal capacity of 15 passengers. Survivability. A combatant's relationship with his or her inner self, Quinn says, is the key to living through an external wartime threat.

"The war that wages within us is the one we should be attentive to," Quinn says. "It is no different from war we wage externally with countries. We need to go back to the genesis of us."

He believes that self-realization can help veterans who struggle with post-traumatic stress. He talks about it with those who he knows are suffering. He has had trouble with PTS himself. Through military experiences and studies, his understanding of combat mentality has come into focus.

It all circles back, he says, to defenses one forms during early childhood – the survival mechanism – to ward off negative experiences. For instance, he says, an abusive or overprotective parent can influence a soldier's battlefield performance. Such defenses, Quinn says, are not often addressed, and external stress, like military combat, is a natural outlet. "The reason a person is reluctant to go back and deal with those issues is that they were life-and-death issues. Consciously, he feels that to go back, dredge them up and face them again, the result is

going to be death. So he represses such memories. When you do so, you regress."

Quinn sees inner conflicts as formidable obstacles for troops trying to fulfill missions in places like Vietnam or Iraq, where those being liberated may have a limited ability to change. "In Vietnam, how could you communicate to a peasant farmer when he has to go through a process of self-realization and see a model of freedom and embrace it, when he has never seen it before and has no concept of what you are talking about? Everything he does is geared toward survival."

Likewise, Quinn says, "it's very difficult for a young man in Iraq or Afghanistan, given the improvised explosive devices and the fact that no one really knows if the family you have been dealing with diplomatically was actively engaged in the planning of the IEDs ... it's hard to train individuals to be emotionally detached and then put the diplomatic hat on, when they are emotionally invested in, say, the death of a buddy as a result of a bombing.

"Iraq and Afghanistan have a component that the soldier faces that in previous wars he didn't face. In previous wars, he was a combatant. In Afghanistan and Iraq, he also has to be a diplomat. At one point during the day, he may be engaged with an enemy. At another point in the same day, he may be on a diplomatic mission working with the people of a particular village."

Contributing to the problem, he says, is the challenge of convincing young people to kill in combat when they have been taught all their lives not to harm others. "In order to get a young man to kill, you almost have to de-program him. How do we, in future wars, develop an individual who has an equilibrium which allows him to see the enemy as an individual who has made some wrong choices? We need to prosecute a war to the point of their realizing that error, rather than reverting to slash and burn. Just to throw people at people and expect them to remain objective, how do you not become what it is you are combating?"

Central to his thinking is the need for people of different backgrounds – the combatant, noncombatant, liberator or oppressed – to understand that "my reality is not your reality. Your reality is not my reality. That's what makes us unique in terms of the whole accumulation of stimuli we have been exposed to all our lives. All of those things have molded us, in terms of what is reality to us. Americans have a reality that is not



Korean War veteran Peter Quinn of Broadwater County, Mont., spent a quarter-century serving his country in both the military and civil defense. Today, he presides over a vast collection of materials he hopes will uncover some of the mysteries of post-traumatic stress. Jeff Stoffer

the reality of the Vietnam people, or the Iraqi people, or the Afghans, or whoever."

Quinn's own reality, he explains, is of a troubled childhood that sent him hitchhiking to New Orleans as an adolescent boy in 1950 and seemed destined to land him in prison "with a chip on my shoulder." How he converted that childhood reality into a career of military service and psychological research – how it made him a builder of islands and collector of voices and words – is the puzzle he has spent decades trying to solve. It's led him to conclude that enemy engagement is as much an internal activity as external.

"This last 10 years of study have been cathartic for me. It's brought me face to face with a lot of issues which were latent in me, going back to early childhood, all the way through the military experiences, to present time. It's given me the opportunity to face them, find the courage to face them – and it takes a great deal of courage to face them – and work through them. The wonderful thing that happens is fear faced is fear conquered. It's an amazing thing when that happens."

– Jeff Stoffer

end,” says Jake Wood, a former Marine who served both in Iraq and Afghanistan. That time would allow departing troops to apply for school, write résumés and take civil-service exams while still employed by the military.

“Congress needs to fund and set aside a transition area so these people are no longer on the combat rolls, but not getting discharged,” Jones adds. “Put mental-health people there, and a cadre of people who teach soldiers how to become civilians.”

Federal agencies can help veterans become more employable after discharge by transferring military experience into civilian-career credentials, Wood says. “It’s something as simple as a Navy corpsman not being certified as an EMT after two combat tours in Afghanistan where he’s been stitching guys up in the back of a moving Humvee. Get the Department of Labor and the Defense Department together, and you ought to be able to fix that.”

Finally, Wood says, the transition should include automatic VA enrollment at discharge, so that newly minted veterans are not fighting for health care while looking for work and dealing with the other challenges of the transition. He says that VA has considerable work to do in order to build credibility among today’s generation of wounded warriors.

“VA lacks the resources and the innovation to tackle this problem,” Wood says. “It is a culture, like any government institution, of risk-averse bureaucrats unwilling to make the tough decisions that have potential to improve the system.”

Perception or reality, that assessment has given rise to a number of nongovernment programs and businesses that are either gearing programs to assist PTS sufferers or making military-to-civilian transitions their purpose.

The Returning Veterans Project, for instance, offers a range of free, confidential counseling and health-care services to servicemembers and military families in northwest Oregon and southwest Washington.

Yoga instructor Carla Orellana teaches PTS-focused yoga classes in North Bend, Wash. She says the classes have helped veterans from World War II, Korea and Vietnam, as well as more recent conflicts. The National Veterans Wellness and Healing Center – a nonprofit organization in Angel Fire, N.M. – has teamed up with the New Mexico Department of Veterans’ Services to help couples deal with the grueling toll PTS can take on marriages. Hundreds of such ventures have sprung into existence in recent years to help veterans heal mentally and physically, from mountain retreats to mixed-martial-arts programs.

The success of VA’s Vet Center program mirrors one of the essential purposes of veterans service organizations like The American Legion, because it is built on the power of veterans helping veterans through difficulties. Those who have wrestled with the demons of past wars are uniquely qualified to help the newest generation of returning combatants.

“It is their way of helping,” says Seligman, who has listened closely to the words of Vietnam War veterans who came home to a lot less than he did in the way of public support and understanding about PTS. Their message, he says, is clear: “The help that you all have was not available to us. Take advantage of it.” 🌿

Ken Olsen is a frequent contributor to The American Legion Magazine.

Vets win settlement after illegal PTS discharges

The Air Force discharged Aimee Sherrod three months after she sought help for post-traumatic stress. Back-to-back combat deployments had cost her a career, a marriage and the chance to go to college. Her protests went nowhere. “I was told I could take an administrative discharge or a medical discharge,” she says.

Within a few months, Sherrod was on the street with a 10-percent disability rating. “It was heartbreaking,” she says. “When I told my mom I was enlisting, she didn’t think I’d make it through basic. Even though I didn’t quit the Air Force, I felt like I had failed, like my mother was right.”

She is one of 4,400 Iraq and Afghanistan veterans illegally discharged with less-than-50-percent disability ratings between 2003 and 2008 after PTS made them unable to serve.

A Pentagon-supported class-action settlement will make 1,029 of them eligible for military

disability retirement, health care and reimbursement for treatment costs. Another 1,066 veterans will receive higher PTS disability ratings.

“This is as close as you can come to making them whole,” says Bart Stichman, joint executive director of the National Veterans Legal Services Program (NVLSP), which brought the lawsuit along with the law firm of Morgan, Lewis & Bockius.

Sherrod joined the Air Force in 2001, determined to make it a career. She deployed to Pakistan, Jordan and Iraq. On her third deployment, one of the people in her brigade was critically wounded the second day they were in Baghdad. “I took it very personally,” she says.

One of the most unnerving periods was a three-week lull, during which insurgents didn’t fire on their base. “You asked yourself, ‘Are they stocking up? Are they going to do something big?’” she says. The insurgents stormed the base

after U.S. forces captured Saddam Hussein and British television reported that he was being held at the Baghdad airport.

Sherrod volunteered to help clean search-and-rescue helicopters that ferried the wounded to hospitals. “We found blood in places I’d never seen ... and brain tissue and bone,” she recalls.

Once home, Sherrod spent most of her evenings in bars. If she didn’t drink, she couldn’t sleep. She pushed friends away. “The only place I could feel normal was if I deployed – where it’s OK to have a hair-trigger temper,” she says.

She eventually sought care at Moody Air Force Base in Georgia. The Air Force put her in an alcohol-treatment program and initiated her medical discharge. By February 2005, she was living at her parents’ home in Tennessee, fighting to get her disability rating increased.

After NVLSP started its Lawyers Serving Warriors program – which pairs veterans with pro-bono legal services – it discovered that

dozens had been discharged for PTS with low disability ratings in 2008, violating a law that requires nothing less than 50-percent ratings for those who are discharged due to service-connected PTS. “We found all of the military services had regulations that said you don’t have to follow the 50-percent rule,” Stichman says.

Congress passed a measure reaffirming the law in 2008. But in October of that year, then-Secretary of Defense Robert Gates issued a directive mandating that the 50-percent rule be followed. That did nothing to help those already discharged, so NVLSP and Morgan Lewis filed the lawsuit.

Many of those wrongfully discharged had received 10-percent PTS disability ratings from DoD, and about 60 received 0-percent ratings. Some of those cases were later re-rated at 100-percent service-connected by VA. “How can it be that a person’s PTSD is so severe they can’t continue to perform their duties, and they get a 0-percent rating?”

The American Legion's TBI-PTSD Ad Hoc Committee met three times in 2011, hearing from top experts in DoD and VA mental health care, as well as veterans and practitioners of alternative therapies. The sessions provided the committee with a thorough understanding of the signature wound of today's war and the way in which the government is trying to address it. Following are reports condensed from articles appearing in The American Legion Dispatch or on the Legion's national website:

Jan. 24-25, 2011: No single treatment fits all situations

The American Legion TBI-PTSD Ad Hoc Committee received a briefing Jan. 24-25 from federal agencies and other organizations on current medical treatments and programs related to TBI and PTSD.

The seven-member committee, chaired by American Legion Past National Commander William Detweiler, heard presentations from the departments of Defense, Labor and Veterans Affairs; the Mount Sinai School of Medicine; the Canadian Armed Forces; and others.

"There is no doubt that DoD and VA are working hard in trying to meet the needs of our military personnel who have been diagnosed with TBI or PTSD," Detweiler said. "But there are many variables that must be considered in the treatment of each individual that has sustained these injuries.

"As a result, there is no single treatment that fits all cases," he explained. "In fact, it was clear from some of the presentations that medical experts cannot yet agree on a single screening procedure for these disabilities."

Presentations at this meeting included:

■ **Dr. Wayne Gordon, Mount Sinai School of Medicine**, explained a program he has set up for indentifying mild or moderate cases of TBI. The committee discussed the potential for using The American Legion's posts and departments - as well as its website - to assist in getting the word out to veterans about coming clinical trials for Gordon's program.

■ Committee member **Dr. Jeanne Stellman** provided a technical briefing that centered on the success of using cognitive rehabilitative therapy (CRT) in treating moderate and severe cases of TBI.

"DoD's own Center of Excellence agrees that CRT is an effective treatment, and The American Legion is urging TRICARE to cover such treatment with its insurance, which it is currently declining to do," said Barry Searle, committee facilitator and then director of the Legion's National Security/Foreign Relations Division. "In fact, the committee is recommending that the Legion should press for a congressional oversight committee to investigate the matter, and determine whether TRICARE has a valid reason for excluding CRT in its insurance coverage."

■ **Verna Jones**, director of The American Legion's Veterans Affairs and Rehabilitation Division, said the ad hoc committee's pursuit of knowledge about TBI/PTSD treatments "is as important as the Legion's research on the effects of Agent Orange in the 1970s. We became a leading expert on Agent Orange, and a leading advocate for veterans suffering from its effects. We intend to do the same for servicemembers and veterans who suffer from TBI and PTSD."

■ **Carol Boyer, Department of Labor**, spoke about the "America's Heroes at Work" program, created especially for injured veterans. The DoL program focuses on getting jobs and training for veterans with TBI or PTSD, and assisting with special accommodations such as office lighting, or bringing a pet to work.

■ **Dr. Michael Kirkpatrick, Defense Center of Excellence for Psychological Medicine and Traumatic Brain Injury**, told the committee about the U.S. Army's concern that troops returning from overseas combat aren't being given enough off-duty time to decompress after deployment, or after they are injured. For troops

who stay in-theater, Kirkpatrick said that typical off-duty time was about 72 hours.

■ In comparison, Canadian troops in Afghanistan get as much as two weeks' off-duty time after being injured, according to **Cdr. Cathy Slaunwhite, health services attaché of the Canadian Defence Liaison Staff**. She told the Legion committee that Canadian troops also get four to five days of additional decompression time in Cyprus before returning home.

"The Canadians seem to be emphasizing prevention more than our own DoD," Searle said. "In the States, troops on active duty get a stand-down period of about five to 10 days, and then they go back to their units, but our reserve components only get three to five days. After that, they go back home without any medical follow-up. If they start having symptoms of TBI or PTSD, they are often on their own and may - or may not - reach out for proper medical help."

A common theme voiced during the briefings was the need to improve communication among government agencies, and within the agencies themselves.

March 18-19, 2011: VA and DoD reluctant to accept alternative therapies

The American Legion TBI-PTSD Ad Hoc Committee was created in October 2010 to "investigate the existing science and procedures, as well as alternative methods, for treating TBI and PTSD currently being employed by the Department of Defense or Department of Veterans Affairs."

During the Legion's 51st Annual Washington Conference in March 2011, members of that committee were given an in-depth presentation on one of those alternative methods.

Dr. Paul Harch of New Orleans briefed the committee about the use of hyperbaric oxygen chambers to treat TBI and PTSD, commonly regarded as the signature wounds of the war on terrorism.

Harch has used hyperbaric oxygen treatments for dozens of U.S. veterans who suffered injuries resulting in TBI and who have developed PTSD. He recently completed a study of 15 patients who showed improvements in several physical and mental tests after a series of hyperbaric treatments, which involves patients breathing pressurized oxygen inside a sealed chamber.

Patients went through a battery of pre- and

"It's self-evident that DoD is doing a lot of outstanding work on TBI and PTSD with its research and programs," Searle said. "There also could be more collaboration among the various clinical trials, except that they often don't know about each other."

Detweiler said The American Legion "is committed to see that our military personnel receive the best medical care possible for any injuries or disabilities that result from service to America.

"Our work on this committee will help the Legion to develop resolutions that will urge VA and DoD to provide the best care possible for TBI and PTSD - based on the best treatments and programs as they become available," he said.

The American Legion TBI-PTSD Ad Hoc Committee is charged with collecting relevant information on approved and innovative, nontraditional treatment methods for the two disabilities.

Detweiler announced that the committee would meet next in March and focus on TBI/PTSD treatment for reserve components of the U.S. Armed Forces.

post-treatment tests. Test subjects showed an average IQ improvement of nearly 15 points. Thirteen of 15 saw a reduction in headaches, while nine of the 12 who had reported sleeping issues cited improvements. Seven of 11 subjects on prescription medication for their conditions began using that medication less frequently or discontinued use of the medication following the treatment plan.

Harch also used the military's PTSD checklist and scored all subjects before and after the treatment plan. The subjects showed a 30-percent reduction in how they scored after being treated.

"All of the data and statistics I showed you is necessary," Harch told the committee. "But these were real people. These were brain-injured men and women whose lives are literally destroyed by these injuries. What is not shown here, and what I can't quantify, is the impact (hyperbaric oxygen) has had on them and their families."

Harch cited as an example U.S. Army Reserve Brig. Gen. Patt Maney, who was injured by a roadside bomb in Afghanistan. A judge in Florida, Maney was undergoing cognitive therapy at Walter Reed Army Medical Center that "helped a

little bit," Harch said. But Maney's condition was still so bad that he was unemployable.

Maney underwent 80 hyperbaric oxygen treatments and is back to the bench in Florida, functioning as a judge once again.

But Maney is just one of several success stories, Harch said. Yet there remains reluctance on the parts of DoD and VA to use the procedure for wounded veterans. The primary reason is pretty clear to Harch.

"It's the price tag," he said. "I firmly believe that's No. 1. We charge \$200 an hour at our clinic. The Medicare rate is about \$275 an hour. This is billed in hospitals at \$2,000 an hour. DoD has thrown out a figure that you need \$500,000 lifetime to treat a brain-injured veteran for these symptoms and problems. First of all, there's no evidence for that. Secondly, if you even took the

80-treatment protocol that I developed, that's \$160,000 at the billed hospital rate ... The reality is the treatment with drugs and all these other therapies is doubly expensive."

Harch said the other issue is an out-of-date perception of the procedure.

"What was I taught at (Johns Hopkins University)?" he said. "This is my generation of doctors. We were taught that (hyperbaric oxygen treatment) is a fraud, and the reason is nobody understood how it worked. It got a bad name when it was applied to multiple sclerosis. People stood up and claimed it affected impotence, balding and cancer. There is so much misinformation. In my generation of doctors, we have been led to believe this is a scientifically disproven, fraudulent type of therapy. We're working against this past body of misperceptions."

Aug. 1-2, 2011: Why so many veterans drop out of treatment

Dr. Charles Hoge spent nearly 20 years in the military, retiring as a colonel in 2009. His specialties included psychiatry, which he put to use as head of psychiatry and neuroscience research at **Walter Reed Army Institute of Research (WRAIR)** from 2000-2009 - a time period that included a deployment to Iraq in 2004.

Now a senior scientist at WRAIR and in the Office of the Army Surgeon General, as well as an attending physician at Walter Reed Army Medical Center, Hoge has seen firsthand how the treatments of post-traumatic stress have fallen short during the war on terror. He shared those insights with The American Legion TBI-PTSD Ad Hoc Committee in Washington Aug. 1.

"(Servicemembers and veterans who get) mental health care maybe get one visit or two visits or three visits, and over half are dropping out and not completing a sufficient number of sessions for treatment to be meaningful in terms of recovery," Hoge said. "Despite everything we're doing, the overall reach of treatment for our servicemembers... is relatively low. So then we start asking the question, 'Why is that happening?'"

"Certainly we know there's stigma, which is the concern the individual has about how others will view him or her if they see a treatment - 'My peers will view me differently, my leaders will treat me differently, it will affect my career' - those are the stigma."

Hoge said that other issues, such as taking off work and getting child care, also interfere with treatment plans, as do the negative perceptions

that servicemembers and veterans require mental health care.

"Those are things like, 'I don't trust mental health care. I don't think it's going to work. It's a last resort. It's not for me. If I go see a mental health professional they're just going to prescribe me pills,'" Hoge said. "I can't say 100 percent the reason so many veterans and servicemembers drop out of treatment is because of negative perceptions because we don't have that direct link yet. But we do know that ... in a couple of studies now, it's the negative perceptions which are more strongly predicting the utilization of services to begin with. Some of the traditional ways in which we thought about the reasons why veterans don't come in to see us we may need to rethink a little bit. It's not just only about stigma; it's also about these negative perceptions."

Hoge said that while it is clear there are evidence-based treatments that work and are mandated in every Department of Veterans Affairs facility, "The problem is that if the veteran doesn't like the treatment for whatever reason and drops out of care, it doesn't matter how good the treatment is," he said. "How do we deliver evidenced-based care in a way that meets the veteran where he or she is and is a way that is conducive to them being most willing to remain in care?"

Just days after briefing the committee, Hoge addressed that issue with an editorial in the *Journal of the American Medicine Association* that accompanied a study titled "Adjunctive

Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service-Related PTSD." The study reported that among patients with military-related PTSD who show a resistance to serotonin reuptake-inhibiting antidepressants, the six-month treatment with risperidone compared with placebo did not reduce PTSD symptoms.

In his editorial, Hoge wrote that simply medicating PTSD sufferers isn't the answer. "Improving evidence-based treatments, therefore, must be paired with education in military cultural competency to help clinicians foster rapport and continued engagement with professional warriors.

"Significant improvements in population care for war veterans will require innovative approaches to increase treatment reach. Attention to the occupational context, combat physiology, and mental and physical comorbidities is essential. Validating and implementing collaborative care models based in primary care should be a high priority. Matching evidence-based components of therapy to patient preferences and reinforcing narrative processes and social connections through peer-to-peer programs are encouraged. Family members, who have their own unique perspectives, are essential participants in the

veteran's healing process."

Hoge told the committee that one of the ways to improve treatment reach is delivering care that is most conducive to veterans staying in care. "It may not necessarily be, 'Here's my prescription for medication' or, 'Here's my prescription for full-on exposure therapy. Maybe I need to tell them, 'There are several things that are going to help with treatment. Which one of these are you most comfortable with?' Really engage the person in that way first."

Post-deployment health, Hoge said, needs to be thought of in a "holistic manner. There's a gradual movement toward that. Those sorts of programs where there's better case management... and team care within the primary-care structure, that's now rolling out across the VA, and I think that's a very positive direction."

■ The committee also heard from VA's **Drs. Joel Kupersmith, Matthew Reinhard, Julie Chapman, Sonja Batten and Alison Cernich, Matthew Stiner of Justice for Vets**, and from Legion staff for briefings on the System Worth Saving program.

The committee also considered potential resolutions to guide the Legion in its further investigations into PTSD and TBI.

Report to the Commander's Advisory Committee, Oct. 9, 2011

Following is a report submitted by **The American Legion TBI-PTSD Ad Hoc Committee Chairman William Detweiler to The American Legion National Commander's Advisory Committee on Oct. 9, 2011, in Indianapolis.**

Background

On Aug. 1-2, 2011, The American Legion TBI-PTSD Ad Hoc Committee met in Washington.

As you may know, the committee was established by Resolution 13, Creation of an Ad Hoc Committee on TBI-PTSD, at the Fall 2010 NEC, "to investigate the existing science and procedures and alternative methods for TBI-PTSD."

The committee's last meeting was held on Aug. 1-2, and we received policy briefings from several of the lead authorities in DoD, VA and the private sector on TBI, PTSD research, screening, diagnosis and treatment.

Research

The committee received a presentation from Dr. Joel Kupersmith, Chief Development Officer for the VA Office of Research and Development (ORD). Traumatic brain injury and mental health are priority areas for the Office of Research and Development's Strategic Plan, and funding for PTSD mental health has increased over the last five years.

From fiscal 2006 to fiscal 2010, funding for PTSD research has increased from \$12.7 million to \$30.2 million and VA plans to keep funding for PTSD as a high priority. Some examples of PTSD studies include: neurophysiology, imaging to distinguish between PTSD and TBI, biomarkers, gender differences in PTSD and stigma. Treatment studies include prolonged exposure for PTSD, prazosin for nightmares, virtual reality graded exposure therapy and others.

Dr. Kupersmith told the committee that from fiscal 2006 to fiscal 2011, TBI research funding has increased from \$1.6 million to \$24.1 and similarly

to PTSD, VA plans to keep funding TBI as a high priority. Some examples of TBI studies include diagnosis for cognitive rehabilitation, pain management, drugs that block cell death pathways, mild TBI screening, eye movements, TBI/suicide risk, advanced neuroimaging, TBI as possible precursors to neurodegenerative diseases (i.e. Alzheimer's disease) and biomarkers for chronic neurodegenerative diseases.

A concern noted by the committee was the many different research programs within DoD/VA are highly competitive and do not talk to each other. For example VA's Veterans Health Administration (VHA) has the Office of Research and Development (ORD), TBI Centers of Excellence, National Center for PTSD, Mental Illness Research, Education and Clinical Centers (MIRECCs), War Related Illness and Injury Study Center (WRIISC), and Office of Public Health Epidemiology Service (EES) office. Currently, there is not a single office to oversee and track all of these studies/programs to ensure there is not any duplication of effort and that results can be disseminated.

Furthermore, there is not a best practice currently for DoD/VA to brief veteran service organizations on controversial studies such as the VA risperdone study which was published earlier this month in the *Journal of American Medical Association* (JAMA). Evidently, VA had been prescribing this antipsychotic medication to veterans for their treatment of PTSD. It was found that VA treated over 80,000 veterans for PTSD and 20 percent of the patients received this medication which had no therapeutic effect and had negative side effects – weight gain, sleepiness and increased saliva in the mouth. In addition, this ineffective medication was off-label and not approved by the Federal Drug Administration (FDA) for treatment of PTSD. It's unacceptable that our veterans are being subjected to such ineffective and overprescribed medications. It's exactly why this TBI/PTSD Ad Hoc Committee was developed in the first place to review current treatments as well as recommend new alternative treatments.

Screening

VA implemented a mandatory TBI clinical screening and evaluation program for all returning Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) veterans. If a veteran comes into a VA medical facility, whether it is a VA

medical center or community based outpatient clinic, VA's computerized medical record prompts the provider to ask four TBI screening questions regarding events, immediate symptoms following events, new or worsening symptoms and current symptoms. If all four responses are yes, the veteran is referred for a secondary evaluation with a neuropsychologist.

As of March 31, 2011, 518,775 OEF/OIF/OND veterans have been screened for a possible mild TBI with the following results: 97,048 veterans screened positive and were referred for a comprehensive follow up (72,623 veterans have completed this evaluation so far); 40,154 have been diagnosed with having sustained a mild TBI; and 90 percent are determined to not have TBI.

VA also implemented a mandatory PTSD screening, similar to the TBI screen, which is captured in the computerized medical record. In fiscal 2010, there were 1,533,799 total PTSD screenings administered and of those, 188,339 or 12.3 percent were positive and referral for additional evaluation was made. The difference between the TBI and PTSD screen is the TBI screen is only for OEF/OIF/OND veterans and the PTSD screen is for any era veteran treated within VHA.

Treatment

Dr. Sonja Batten, VA Deputy Chief Consultant for Specialty Mental Health, briefed the committee on VA PTSD programs. VA's budget for mental health programs was \$5.2 billion in fiscal 2011 and the president's budget request for fiscal 2012 includes an increase of \$1 billion for a total of \$6.2 billion.

VA treated a total of 1,886,386 veterans with mental health illness and of those, 438,167 veterans were treated for PTSD. The numbers of mental health and PTSD diagnoses have almost doubled in the last five years. In fiscal 2005, 1,442,250 veterans were diagnosed with a mental health illness, of which 250,000 veterans were treated for PTSD. The number of mental health staff has grown from 13,566 providers to 20,251 in 2011. VA released a Integrated DoD/VA Mental Health Strategy for implementation in the next three years. One of the initiatives is allowing Vet Centers to treat active-duty servicemembers which is a positive step forward and will help protect active duty patient's privacy and confidentiality and connect these service members with assistance and counseling.

During The American Legion System Worth Saving site visits, the task force found that the evidence-based treatments for PTSD included

Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) Therapy, Eye Movement Desensitization and Reprocessing (EMDR) as well as medications such as Selective Serotonin Reuptake Inhibitors (SSRIs) for the symptoms. The first form of treatment generally prescribed is Prazosin which reduces frequency and intensity of nightmares, but can improve overall sleep quality and can reduce other PTSD symptoms. VA has a National Center for PTSD located in White River Junction, Vt., to conduct research, promote best practices, educate veterans, families and the general public and help veterans diagnosed with PTSD. Additionally, VA launched a PTSD Coach Smartphone Application to help users track their PTSD symptoms, link them to public and personalized sources of support, provide accurate information about PTSD and helpful strategies for managing PTSD symptoms.

Dr. Alison Cernich, Acting Senior Liaison, TBI Defense Centers of Excellence for Psychological Health and TBI, provided the committee an update on TBI treatment programs. VA research has found the vast majority of patients presenting for treatment do not often present with TBI alone but have three co-occurring diagnoses - pain, PTSD and TBI (post concussion syndromes). Additionally, recent systematic review of evidence from VA found that for those with TBI the frequency of co-morbid probable PTSD was 33-39 percent.

Currently, TBI severity (mild, moderate, or severe) is classified by MRI/CAT scan, loss of consciousness, alteration of consciousness (confused or disoriented) and post traumatic amnesia (memory loss).

Dr. Julie Chapman, Director of Neuroscience at the War Related Injury and Illness Study Center presented to the TBI-PTSD Ad Hoc Committee. Dr. Chapman is the Principal Investigator for the Markers, Identification, Norming and Differentiation (MIND) for TBI and PTSD study. This VA-funded research study, which begins in the fall, includes 800 OEF/OIF veterans that have been diagnosed with TBI, PTSD or both. The study will clarify differential diagnoses between TBI and PTSD and build objective, consistent, and independent diagnostic criteria in order to properly treat the right diagnosis.

Problems/ Challenges

While VA has continued to make advancements in the research, screening, diagnosis and treatment of TBI and PTSD, many concerns still remain.

■ Currently, there are no definitive treatments for TBI and providers are treating the symptoms. One the biggest challenge is the first TBI positive screen and secondary evaluation of TBI because it is often complicated by the clinical overlap of TBI with PTSD and Substance Abuse Disorder.

■ A concern is that veterans may be diagnosed with the wrong medical condition and the medication treatment for both TBI/PTSD is different.

■ Dr. Charles Hoge, one of the military's leading researchers and director of psychiatry at Walter Reed Army Medical Center, briefed the TBI/PTSD Ad Hoc Committee. Hoge's concern he raised with the committee was the resistance and reluctance among servicemembers and veterans to receive and continue their mental health care. Hoge discussed recommendations to improve delivery of mental health care: continued integration of mental health into primary care, better marketing of effective medications/ treatments and stigma reduction and including family in treatments will help in the future.

■ Communications appears to be a real problem. The last speakers during the meeting could not agree on the same set of figures, and there is a terrible lack of communication between the Washington offices of these agencies and the field. There does not seem to be an agreement as to what drug or drugs are being used to treat PTSD. The presentation from Col. Hoge spoke of two sleep medicines. and another article that he referenced spoke of an entirely different drug.

We have repeatedly asked VA for TBI/PTSD statistics on:

- The numbers of servicemembers diagnosed with mild, moderate, severe TBI
- Numbers of servicemembers diagnosed with PTSD
- Numbers of servicemembers screened for both TBI/PTSD
- Numbers of servicemembers treated for both TBI/PTSD
- Which servicemembers and veterans were treated for (TBI, PTSD) and remained

on active duty, guard or reserve or were discharged and treated by the VA or private facility
We are continuing to press DoD/VA for a single accounting system for TBI/PTSD statistics. Similar to research programs, there is a disconnect between getting statistics and which office has what information.

Recommendations

The TBI-PTSD Ad Hoc Committee has taken several actions since the last meeting. They include:

1. Two resolutions were drafted, recommended and approved at National Convention on Virtual Lifetime Electronic Medical Center and Traumatic Brain Injury and Post-Traumatic Stress Disorder Programs.

a. Virtual Lifetime Electronic Record

DoD and VA still do not have a bilateral medical record (which is now called Virtual Lifetime Electronic Record, or VLER).

Servicemembers and veterans cannot enroll or be treated because of the delays they face with obtaining their records. During the System Worth Saving VA Medical Centers site visits this year, lack of a joint VA medical record has continued to be the number one impediment to seamless transition.

Lack of access to active-duty medical records has necessitated reliance on the veteran who cannot provide a complete history. Veterans are forced to make copies of their DoD medical records at their last duty station or request their records from the Personnel Records Center in St. Louis, which can take months to process. In one case during a System Worth Saving site visit, a veteran said he was trying to get copies of his record, and the base told him that they were out of paper.

This resolution calls for completion of the Virtual Lifetime Electronic Record Initiative by fiscal 2013. Currently, it is estimated that a joint record will take another six years, which is unacceptable considering the unprecedented numbers of servicemembers returning home with

injuries and illnesses and the continued delay this will create.

b. Traumatic Brain Injury and Post Traumatic Stress Disorder Programs

This resolution calls for:

- Congress to provide oversight and funding to DoD and VA for innovative research into Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy and other nonpharmaceutical treatments

- Congress increase DoD/VA budget for research, screening, diagnosis and treatment of TBI/PTSD and both DoD/VA develop joint offices for collaboration between DoD/VA research

- DoD/VA both establish a single office for their research

- Servicemembers/veterans that participate in DoD/VA research studies give their consent and be provided with a disclosure of any negative effects of treatment

- DoD/VA accelerate research efforts to properly diagnose and develop evidence-based treatments for TBI/PTSD

- Servicemembers and veterans only be prescribed evidence based treatments for TBI/PTSD and not non FDA approved medications or non-evidence based treatments.

2) Letter was sent to the House Veterans Affairs Chairman Jeff Miller to request a congressional hearing on TBI/PTSD. In the fall, The American Legion will testify and present findings and recommendations of the TBI-PTSD Ad Hoc Committee.

3) A press release was issued on ineffective and overuse of medications for PTSD. The VA&R division is working with the department service officers (DSOs) across the country to identify veterans that received risperdone and other ineffective medications for our congressional testimony.

The committee continues to provide The American Legion with current TBI/PTSD program updates, best practices, challenges and help make recommendations for improvement in these areas.

TBI-PTSD Ad Hoc Committee After Action Report

JAN. 16-17, 2012

The TBI-PTSD Ad Hoc Committee was developed in 2010 to investigate existing science and procedures for treating TBI/PTS, as well as the use of alternative treatments. This meeting was scheduled in preparation for the committee to report its findings and recommendations to the national commander and National Executive Committee (NEC) at its May 2012 meeting.

The speakers during the meeting ranged from clinicians to policy and research professionals, including:

Mary Schohn, Ph.D., spoke on behalf of the Department of Veterans Affairs (VA) as director of Mental Health Operations.

John Sommer, retired senior executive director of the Legion's Washington office, gave a historical perspective of PTDS from Vietnam to the Gulf War.

Terri Tanielian, director of the Center for Military Health Policy Research for the RAND Corporation.

Cap. Robert Koffman, deputy director for Clinical Operations of the National Intrepid Center of Excellence, highlighted complementary and alternative treatments of TBI and PTSD.

Bradley Karlin, Ph.D., National Mental Health Director for Psychotherapy and Psychogeriatrics, gave an update on VA's cognitive processing therapy and prolonged exposure treatment for PTSD.

Katherine Helmick, M.S., deputy director, TBI, Defense Centers of Excellence for Psychological Health and TBI, spoke from the Department of Defense's (DoD) perspective on TBI care in the Armed Forces.

Current Returning Veteran Statistics

Approximately 2.2 million servicemembers have deployed in support of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND), with 1.3 million having returned home to date. Of those 1.3 million members, only half have been enrolled in VA's Veterans Health Administration (VHA). The other returnees have either not enrolled or are still on active duty.

Additionally, 800,000 of those veterans have had two or more deployments or extended deployments that did not allow sufficient decompression time. As a result, those veterans who have been diagnosed with PTSD and/or TBI

are more susceptible to additional problems such as substance abuse, depression, and suicides.

PTSD

Over the course of military and medical history, PTSD has been referred to Da Costa Syndrome, Soldier's Heart, Shell Shock, Battle Fatigue, War Neurosis and Vietnam Syndrome.

The first PTSD definition appeared in 1980 in the third edition of the "Diagnostic and Statistical Manual of Mental Disorders," the physician's guide for coding mental problems.

PTSD is divided into two categories: acute PTSD and Chronic PTSD. Acute PTSD symptoms last more than one month, but less than three months, after exposure to trauma. Chronic PTSD symptoms last longer than three months after exposure to trauma.

VA statistics reflect that its mental health staff has increased from 13,566 in fiscal 2005 to 20,251 in fiscal 2011. However, the number of veterans treated for PTSD during that time almost doubled. In fiscal 2005, 235,639 veterans were treated for PTSD. In fiscal 2011, 438,091 veterans were treated for PTSD. Thus, the increase in VA mental health staff is not keeping up with the demand for care.

Of the diagnoses among OEF/OIF veterans, mental health disorders amount to 51.2 percent of the diagnosis, second to the leading diagnosis of musculoskeletal injuries.

Although there appears to be a challenge in translating research into clinical practice, VA and DoD professionals claim that most of the studies on TBI/PTSD have validated the evidence-based treatments that currently are being used to treat these injuries. Evidence-based treatments are defined as treatments that have gone through a series of lengthy tests and are approved by the Federal Drug Administration.

VA utilizes both therapy and medication management for treatment of PTSD. All 153 VA medical center (VAMC) facilities and a majority of VA community-based outpatient clinics (CBOCs) provide evidence-based treatments for PTSD.

Both cognitive processing therapy and prolonged exposure were recommended as the evidence-based psychotherapy treatments for PTSD by the DoD/VA Clinical Practice Guidelines in 2010. A link to these guidelines can be found online at: http://www.healthquality.va.gov/ptsd/ptsd-sum_2010a.pdf. VA is providing

training to all of the VAMCs and CBOCs to provide these treatments.

During the course of the ad hoc committee meetings, several drugs were referred to as being preferred drugs for the treatment of PTSD. The medication Prazosin, primarily used to treat nightmares, also has been shown in research and in clinical practice to reduce the frequency and intensity of PTSD symptoms. In addition, Selective Serotonin Reuptake Inhibitors (SSRI) antidepressants – Citalopram (Celexa), fluoxetine (Prozac), paroxetine (Paxil) and Sertraline (Zoloft) – also are being used to treat PTSD.

TBI

TBI has been referred to as the “signature wound” of the wars in Iraq and Afghanistan.

The severity of TBI is classified as mild, moderate or severe. Close to 80 percent of TBI diagnoses of Iraq and Afghanistan veterans is being classified as mild TBI (mTBI) or concussion injuries.

DoD reports that since 2000, 230,430 servicemembers have been diagnosed with TBI in the various degrees of severity.

The challenge in diagnosing the severity of TBI is that it is associated with several co-morbidities, including chronic pain, PTSD and substance abuse. It was estimated in a 2009 study provided to the committee that 42.1 percent of the veterans diagnosed with mTBI have associated co-morbidities such as those listed above.

The generally accepted and prescribed treatment for TBI is cognitive rehabilitation (attention, memory, social/emotional) and medications.

Complementary and alternative therapy practices that can be found at the National Intrepid Center of Excellence and various VAMCs include acupuncture, biofeedback, art therapy, tai chi, meditation, breathing exercises, massage, yoga and many others.

Additionally, hyperbaric oxygen therapy (HBOT) – the use of pressurized oxygen as a drug in a compression chamber – is being explored and used in some military and VA facilities. DoD currently is conducting its third trial on the use of HBOT to treat TBI. The result of this study will be released in a year. DoD is trying to determine if HBOT therapy can be added as an accepted treatment for these injuries.

Military/Veteran Perspective

One of the highlights of the meeting was the

frank and candid discussion with an active-duty servicemember from the U.S. Army. His discussion centered on the reality servicemembers face in their treatment, rehabilitation and recovery from TBI/PTSD.

This soldier was diagnosed with both TBI and PTSD and was treated in a warrior transition unit. The doctors prescribed 18 different medications to treat his TBI/PTSD symptoms. He applied for and was accepted into a three-week intensive inpatient treatment program at the National Center of the Intrepid in Bethesda, Md. Upon admission, doctors asked him how many medications he was taking and promised in three weeks to reduce them by half. After he left the center and returned to his unit, doctors disregarded the treatment and progress he made and put him back on the original 18 medications.

He said the stigma of being treated for a mental injury is alive and well in the military. Servicemembers know if they receive mental health treatment, it’s a career “ender.” The media negatively portrays veterans diagnosed with PTSD, which makes businesses reluctant to hire a veteran with this diagnoses.

It was recommended by the servicemember that The American Legion develop OEF/OIF peer-to-peer support groups nationwide to encourage veterans to come into the Legion and have a place where they can organize and discuss their war experiences. American Legion Past National Commander Robert W. Spanogle supported this initiative and also recommended The American Legion reach out to local military units prior to their deployments.

Committee Recommendations

/Follow Up Actions:

The committee decided that a letter to VA Secretary Eric Shinseki should be drafted by the staff to urge VA to do more to hire veterans. VA had a 30 percent veterans hiring rate in 2011; Shinseki’s goal is 40 percent.

The American Legion appointed a Scientific Advisory Committee to consider and investigate the complaints of veterans who have been diagnosed with PTSD and had those diagnoses reversed by a DoD or VA examiner and reclassified as a personality disorder and/or pre-existing condition, thus denying the veteran compensation and other benefits.

The VA&R Commission will continue to work with The American Legion Department of Colorado on the OEF/OIF peer-to-peer group

program and assist in developing a resolution and national support for this initiative.

The ad hoc committee unanimously urges the VA&R Commission to recommend to the national commander and the NEC that a TBI/PTS Ad Hoc Committee or Subcommittee under the VA&R Commission – with the same members for continuity – be appointed to continue to look at

the issues involving care and treatment of servicemembers that are suffering with these injuries.

The VA&R staff will assist the TBI/PTS Ad Hoc Committee to develop a final report of its actions, findings and recommendations for presentation at the May meeting to the VA&R Commission and NEC.

TBI and PTSD Ad Hoc Committee After Action Report

SUNDAY, FEBRUARY 24, 2013

The TBI and PTSD Ad Hoc Committee met on Sunday, February 24 at the Washington Hilton in Washington, DC. The purpose of the meeting was to prepare final resolutions and the committee report for presentation to the 2013 Spring National Executive Committee (NEC) in Indianapolis.

Also, during the committee's meeting, Colonel Ron Poropatich, M.D., (ret), Executive Director, Center for Military Medicine Research, Health Sciences at University of Pittsburgh presented on innovative TBI and PTSD programs. Dr. Poropatich retired from the US Army after serving more than 30 years as a Pulmonary/Critical Care Medicine physician. His last assignment was at the US Army Medical Research and Materiel Command (USAMRMC) at Fort Detrick, MD serving as the Deputy Director of the Telemedicine and Advanced Technology Research Center (TATRC).

Telemedicine

While being stationed in Afghanistan, Dr. Poropatich helped establish telemedicine program for soldiers to improve their access to receiving mental health treatment. A secure network was established in Afghanistan throughout all of the 93 Forward Operating Bases where soldiers could go online and in a private room, receive consultation and appointment with Psychologists so they did not have to be flown to major bases in Afghanistan for treatment. Dr. Poropatich is being published in the Telemedicine and e-Health, "The U.S. Army Telemedicine and m-Health Program: Making a Difference at Home and Abroad" for public dissemination and release in May 2013.

mCare

A second topic addressed by Colonel Poropatich was the Telemedicine and Advanced Technology Research Center at the U.S. Army Medical Research and Materiel Command established a mobile communications system to offer remote care to soldiers, which was called "m-Health." The purpose of m-Health was to connect service members via mobile phones to manage their medical care when they return home. These phones were introduced in 2009 to Warrior Transition Units (WTUs) and Community Warrior Transition Units (CWTUs) and allowed the

ability to provide securing messaging and security between case managers and wounded, ill and injured service members. The phones offered a simple way for medical providers to ensure that soldiers had a comprehensive transition plan, and text them messages to ask what problems they are having, things to get better and how to learn new transition skills (education, financial, etc.) Dr. Poropatich is working with the Department of Army to approve the dissemination of mCare across the country at all WTU and CWTUs and recommended that The American Legion help coordinate community service and assistance through access to service members via mCare (cell phone) technology.

High Definition Fibro Tracking

A third innovative project that Dr. Poropatich presented on was a project that University of Pittsburgh researchers were developing called High Definition Fibro Tracking. The High Definition Fibro Tracking is a new imaging tool that allows physicians to see high-definition views of the brain's wiring that would not be captured from traditional MEG, MRI and other brain scans. Most of the traditional MEG, MRI scans detect TBI in moderate or severe levels but High Definition Fibro Tracking is focused on detecting mild TBI. The technology allows images to be captured of axons to determine if there are any broken axons that could affect short term or long term memory.

Next Steps

The TBI and PTSD Ad Hoc Committee and VA&R Division will keep in touch with Dr. Poropatich to discuss opportunities for The American Legion to be involved in the mCare project. Dr. Poropatich will be connecting the TBI and PTSD Ad Hoc Committee and VA&R Commission with the individuals that developed the mCare technology software in Canada. Further discussion and approval will be needed to through an American Legion resolution to authorize submission of a proposal that addresses potential cost, and clear roles and responsibilities of The American Legion in the mCare initiative. The intended goal of The American Legion would be to serve as the single point of contact in the community to coordinate resources and assistance for wounded, ill and injured service members connected through the

mCare. In addition, the TBI and PTSD Committee will continue to work closely with Dr. Poropatich and the Pittsburgh researchers on High Definition Fibro Tracking.

TBI and PTSD Ad Hoc Committee Discussion and Way Forward

The committee discussed the past seven meetings' findings and deliberations in preparation for the final report to the Spring NEC meeting in Indianapolis. One of the areas that the committee unanimously supported was the need for the TBI and PTSD to remain a priority of The American Legion. With the numbers of returning veterans, and veterans from previous wars, it is important that The American Legion remain at the forefront of these injuries, treatment and care in the future.

Appendix I

NATIONAL EXECUTIVE COMMITTEE OF THE AMERICAN LEGION
INDIANAPOLIS, INDIANA
OCTOBER 13-14, 2010

Resolution No. 13: *Creation Of Ad Hoc Committee On Traumatic Brain Injury (TBI)*

Origin: Veterans Affairs and Rehabilitation Commission

Submitted by: Veterans Affairs and Rehabilitation Commission

(As Amended)

WHEREAS, Traumatic Brain Injury (TBI), the “Signature Wound” of the war in Southwest Asia, can be sustained not only from explosions but also from any incident involving a concussion to the brain; and

WHEREAS, There is reason to believe that alternative treatment options exist for TBI and Post Traumatic Stress (PTS) which are not currently being adequately researched by the Department of Defense (DoD) or the Department of Veterans Affairs (VA); now, therefore, be it

RESOLVED, By The National Executive Committee of The American Legion in regular

meeting assembled in Indianapolis, Indiana, on October 13-14, 2010, That The American Legion create an ad hoc committee to investigate the existing science and procedures as well as alternative methods for treating Traumatic Brain Injury (TBI) and Post Traumatic Stress (PTS) not currently being employed by the Department of Defense (DoD) or Department of Veterans Affairs (VA) for the purpose of determining if such alternative treatments are practical and efficacious; and, be it finally

RESOLVED, That the National Commander has the authority to add to or remove members from the ad hoc committee so long as it does not negatively impact the committee’s ability to prepare a preliminary report for the consideration of the NEC at its May 2011 meeting for the purpose of making such recommendations as it deems appropriate.

Appendix II

Interim Report of the Traumatic Brain Injury/Post Traumatic Stress Ad Hoc Committee to the National Executive Committee, May 4-5, 2011

SECTION I. WHAT WE HAVE LEARNED

1. Primary treatment across the agencies and branches of service (active, reserve and guard) is pain management rather than symptom treatment (drugs).

A. There is every indication that the pharmacology approach is not the answer – may be causing more problems and leading to suicides out of frustrations

B. An Army report in 2010 on suicides found that 1/3 of the force was on at least one prescriptive drug.

2. Deployments of soldiers do not allow sufficient time between deployments for the average soldier to decompress. We have found through our research that the Canadians have a much more robust follow-up procedures and additional down time between deployments.

3. There is a shortage of mental health professionals in both DoD and VA. There have been reports that funds have been cut from mental health budgets to support the homeless priority of the secretary.

A. There is little supervision of veterans and soldiers taking their prescribed drugs (narcotics) – particularly veterans who have left active duty and are not reservists or national guardsmen. Reservists, when they return home from combat are given up to a 90-day supply of narcotics, and are told not to report back for training for 30 to 90 days.

B. Again using Canada as an example the soldier’s commander is required to track reserve personnel home and do follow up checks on progress in re-socializing at 30 and 90 days and 1 year. DoD says it has a hard time finding our soldiers.

4. Widespread “survivor guilt” prevails in the soldiers who saw combat and have PTS and/or TBI. Treating a combat veteran with TBI/PTS is not the same as treating a civilian.

A. Stigma is still prevalent even with the real warriors campaign in place it was admitted that acknowledging a problem can impact careers.

B. The Army seems to be utilizing a significant amount of sound bites and buzz words such as “cycle of resiliency” but they do not necessary translate into actual activity.

5. A seamless transition from DoD to VA does not exist system wide.

6. Personnel in transition units in some cases are not properly trained.

A. Staffers are working in high stress and complex duty.

B. Staffers need to be checked for PTS.

C. Caseloads are too large.

D. Many staffers are not combat veterans. In many cases they can not emphasize with the wounded.

SECTION II. WHAT IS THE DEPARTMENT OF DEFENSE DOING AND TREATMENTS BEING USED?

We are unable at this point to give you a complete list of what treatments are being used by the Department of Defense to treat members of the military diagnosed or complaining of post traumatic stress and/or traumatic brain injuries.

However, we do know the following:

1. While in theater, soldiers with PTS/TBI symptoms are examined, treated generally with drugs and given some time off from their units, usually 72 hours to a week.

2. Four wounded transition units are now working in the combat zones to quickly evaluate, diagnose and recommend treatment or evacuation of members suffering from these injuries.

3. Following deployment, the soldier returns, unless seriously wounded and requiring hospital care, to their families, with little or no follow up care, unless requested.

4. The military physicians tend to emphasize the use of psychological drug therapy.

5. Attached members (members who were added to a unit) are sent home with little or no follow up care or contact from the unit, particularly members of the reserve and national guard who are individual augmentees to a unit.

6. Families are not regularly included in the treatment of the service member.

7. Some military hospitals are using cognitive therapy, but it is considered too expensive for wide spread use.

8. Group psychiatric care is being used in most locals.

9. Hyperbaric oxygen therapy treatment is being used in some hospitals.

10. Battle mind resilience training and pre deployment evaluations have been implemented to determine the mental health of a soldier before he or she is deployed. Families are included in this effort.

11. Warrior transition units have been established in 8 locations around the country. The WTUS provide a triad method of care - squad leader, social worker and health care provider.

12. The National Intrepid Center of Excellence has been established with private funding at Bethesda Navy Medical Center.

Current Department of Defense research projects include:

1. Use of hyperbaric oxygen therapy

2. Various drug protocols

3. Cognitive therapy initiatives

4. Public/private initiatives similar to the center for excellence and the intrepid fallen heroes fund project

SECTION III. WHAT IS THE DEPARTMENT OF VETERANS AFFAIRS DOING - CURRENT TREATMENTS?

1. VA physicians tend to emphasize the use of psychological drug therapy.

2. Group psychiatric therapy is widely used, however due to budget constraints; the group meetings are widely spaced.

3. The VA has established the veterans justice outreach of PTS veterans who are charged and convicted with various crimes.

4. The homeless veterans programs of the VA have been enhanced with funding due to the personal concern of the secretary to reach out to these men and women, many of whom are suffering from PTS and possibly TBI.

5. There is some use of hyperbaric oxygen therapy treatment.
6. There is some use of cognitive therapy
7. There is some use of “simulated activity” treatment to transition veterans back into society.
8. Rehabilitative treatment includes job training, counseling, and work with the families to assist the veteran toward a normal life in society.

SECTION IV. WHAT IS OUR FUTURE COURSE OF ACTION TO FULFILL THE MISSION OF THE AD HOC COMMITTEE?

We need to continue to request briefings from the Department of Defense and the Department of Veterans Affairs to get a better understanding as to the treatments and medical protocols that are being used in each system.

There does not appear to be a simple answer as to what treatment or treatments are most effective in the treatment of TBI and PTS. For the most part, the medical community is treating an “unknown.” One form of treatment does not fit all.

Treating physicians have their “preferences or biases” and refuse to consider some of the so called “alternative” treatments, such as hyperbaric oxygen therapy and bio feedback.

Several new initiatives have begun since the Ad Hoc committee was formed, and the committee needs to be briefed on these efforts.

SECTION V. WHAT LEGISLATION SHOULD THE LEGION PROPOSE TO INSURE THE PROPER CARE OF SOLDIERS SUFFERING WITH TBI AND PTS INJURIES?

Currently, House Resolution 396 by representatives Platts and Paswell is pending in the House. This would require VA to pay for treatments which have been FDA approved for other medical purposes but appear to be effective in treating TBI.

The “elephant in the room” is clearly the cost of treatment. There have been statements made

that the cost of treating a patient with TBI and/or PTS may be as high as \$500,000.00 per patient. Currently, it appears that Congress would rather study the issue long term rather than face the reality that more funds are needed to cover the treatment needed research to provide the best in medical care for members suffering with these injuries.

Further, we should recommend that funding be provided for independent evaluation and testing of some of the more promising so called “alternative” methods of treatment. There are indications that the studies of some of these treatments are not being fairly evaluated by the medical staffs of the VA and DoD hospitals and clinics where they are being tested.

The committee believes that it is too early to make a recommendation on treatment legislation. However, the committee has submitted to the National Security and Veterans Affairs and Rehabilitation committees a resolution advocating legislation which addresses “stove piping” of information concerning patient care across federal entities.

The committee also recommends The American Legion support the need for increased funding of more mental health care professionals, in theater for the evaluation and treatment of TBI and PTS injuries. Finally there should be longer periods of time to “decompress” immediately after the injury, and a longer time between deployments for injured service members.

The committee did author a press release concerning cognitive rehabilitation. The issue was that both DoD and VA utilize the treatment but TRICARE refuses to pay for it. The committee also submitted a request to congress for a hearing to understand why TRICARE is not paying. The result is that there was a promise to hold a hearing and TRICARE has commissioned additional trials to determine effectiveness. We believe that this was in no small part to The American Legion’s efforts.

Appendix III

NINETY-THIRD NATIONAL CONVENTION OF THE AMERICAN LEGION MINNEAPOLIS, MINNESOTA

AUGUST 30, 31, SEPTEMBER 1, 2011

Resolution No. 110: Traumatic Brain Injury and Post Traumatic Stress Disorder Programs

Origin: Convention Committee on Veterans Affairs and Rehabilitation

Submitted by: Convention Committee on Veterans Affairs and Rehabilitation

WHEREAS, According to the Department of Veterans Affairs (VA) Office of Public Health estimates in July 2011, 2.3 million servicemembers have deployed to support Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND), 1,318,510 have left active duty and are eligible for VA health care, of which, 645,491 have enrolled in VA for health care; and

WHEREAS, The “signature wounds” of Iraq and Afghanistan are Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD); and

WHEREAS, Mental disorders are the second largest frequency of diagnoses among returning OEF/OIF/OND servicemembers which are currently estimated at 50.7 percent; and

WHEREAS, In 2007, VA established a TBI, PTSD Clinical Reminder in VA’s electronic medical record for any new patient to identify veterans that need additional screening for a possible TBI or PTSD diagnosis; and

WHEREAS, VA has screened and diagnosed hundreds of thousands of veterans with TBI/PTSD and continues to have several challenges in the proper diagnosis and treatment of TBI and PTSD because of the overlap of symptoms; and

WHEREAS, According to VA, the overlapping symptoms between mild TBI and PTSD are headaches, dizziness, fatigue and noise/light intolerance, re-experiencing, avoidance and emotional numbing; and

WHEREAS, Currently, there are not any definitive medical treatments for TBI and providers/clinicians use therapy and medications to treat the symptoms; and

WHEREAS, Evidence-based treatments for PTSD include Cognitive Processing Therapy, Prolonged Exposure Therapy, Eye Movement Desensitization and Reprocessing, as well as medication management; and

WHEREAS, VA’s Veteran Health Administration has several different research offices involved in studying TBI/PTSD including: VA Office of Research and Development; TBI Centers of Excellence; National Center for PTSD; Mental Illness Research, Education and Clinical Centers; War Related Illness and Injury Study Center; and Office of Public Health Environmental Epidemiology Service Office but lacks central oversight for management of all the different research studies and trials through the current decentralized research model; and

WHEREAS, The Department of Defense (DOD) and VA developed a DOD/VA Integrated Mental Health Strategy which recommended as one of the strategic objectives to “develop a system to deliver evidence-based psychotherapies” but in the plan it does not mention coordinating research jointly between both departments; and

WHEREAS, The American Legion developed a TBI/PTSD Ad Hoc Committee in 2010 to investigate the existing science and procedures and alternative methods for treating TBI/PTSD; and

WHEREAS, The committee has found several concerns including: the overlapping of symptomology between TBI/PTSD and Substance Abuse Disorder which makes it difficult to diagnose and treat the correct injury/illness; ineffective and overuse of medications; and reluctance of servicemembers and veterans to receive and continue mental health treatment; and

WHEREAS, VA conducted a study on Risperidone, a second generation antipsychotic, which is not approved by the Federal Drug Administration for use in treating PTSD; and

WHEREAS, Researchers of the study concluded that Risperidone did not improve PTSD symptoms but had several negative side effects which included weight gain, sleepiness and increased saliva in the mouth; and

WHEREAS, Researchers in the study concluded that in FY 2010, VA treated 86,852 veterans for PTSD last year, of which nearly 20 percent were prescribed this off-label and ineffective

medication, and currently the only antidepressants and serotonin reuptake inhibitors such as sertraline and paroxetine are currently approved for treatment; and

WHEREAS, Veterans that have participated in past DOD/VA TBI/PTSD research studies have not always been properly informed that they are participants in the study and are not given a disclosure of the effects of any treatment they may be receiving through a study; and

WHEREAS, Additionally, the TBI/PTSD committee in their charge found several new innovative treatments for TBI/PTSD which include Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy that have not been prioritized for clinical studies to determine if they are evidence-based treatments; now, therefore, be it

RESOLVED, By The American Legion in National Convention assembled in Minneapolis, Minnesota, August 30, 31 and September 1, 2011, That The American Legion urge Congress to provide oversight and funding to the Department of Defense (DOD) and Department of Veterans Affairs (VA) for innovative Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) research currently used in the private sector, such as Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy and other non-pharmacological treatments; and, be it further

RESOLVED, That The American Legion urge

Congress to increase the budgets for DOD and VA to improve the research, screening, diagnosis and treatment of TBI/PTSD as well as provide oversight over DOD/VA to develop joint offices for collaboration between DOD/VA research; and, be it further

RESOLVED, That DOD/VA both establish a single office for their agency's research and serve as a clearinghouse to track all DOD or VA research, and that all DOD/VA individual research programs and activities coordinate and provide monthly and as needed updates on research activities; and, be it further

RESOLVED, That servicemembers and veterans who participate in DOD/VA TBI/PTSD research studies are properly informed and give their consent to be included in the study as well as be provided with a disclosure of any negative effects of treatment; and, be it further

RESOLVED, That DOD/VA accelerate research efforts to properly diagnose and develop evidence-based treatments for TBI/PTSD; and, be it finally

RESOLVED, That The American Legion urge Congress to exercise oversight over DOD/VA to ensure servicemembers and veterans are only prescribed evidence-based treatments for TBI/PTSD and not prescribed off-label and non-Federal Drug Administration approved medications or treatments for TBI/PTSD.

Appendix IV

NATIONAL EXECUTIVE COMMITTEE OF THE AMERICAN LEGION INDIANAPOLIS, INDIANA

MAY 9 – 10, 2012

Resolution No. 25: *TBI and PTSD Ad Hoc Committee*

Origin: Veterans Affairs and Rehabilitation

Submitted by: Internal Affairs Commission

WHEREAS, The Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) Ad Hoc Committee was established by Resolution 13, "Creation of an Ad Hoc Committee on TBI and PTS," at the Fall 2010 National Executive Committee meeting; and

WHEREAS, The purpose of the committee was "to investigate the existing science and procedures and alternative methods for treating TBI and PTSD not currently being employed by the Department of Defense (DoD) or Department of Veterans Affairs (VA) for the purpose of determining if such alternative treatments are practical and efficacious"; and

WHEREAS, The committee held six meetings and received policy briefings and updates from the lead authorities in DOD and VA and in the private sector on treatment for TBI and PTSD; and

WHEREAS, The committee has fulfilled its responsibilities and requirements set forth by Resolution 13; and

WHEREAS, As TBI and PTSD continues to remain the "signature wounds" of Iraq and Afghanistan and with the increase of Vietnam veterans suffering from PTSD, there remains a continued need for The American Legion to remain at the forefront of these conditions; now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on May 9-10, 2012, That The American Legion extend the TBI and PTSD Ad Hoc Committee for a period of one year; and, be it finally

RESOLVED, That the National Commander or his designee make a final report at the 2013 American Legion Spring National Executive Committee meeting concerning the TBI and PTSD Ad Hoc Committee findings and recommendations.

Appendix V

NINETY-FOURTH NATIONAL CONVENTION OF THE AMERICAN LEGION
INDIANAPOLIS, INDIANA
AUGUST 28, 29, 30, 2012

Resolution No. 285: Traumatic Brain Injury and Post Traumatic Stress Disorder Programs

Origin: Convention Committee on Veterans Affairs and Rehabilitation

Submitted by: Convention Committee on Veterans Affairs and Rehabilitation

WHEREAS, According to the Department of Veterans Affairs (VA) Office of Public Health estimates in July

2011, 2.3 million servicemembers have deployed to support Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND), 1,318,510 have left active duty and are eligible for VA health care, of which, 645,491 have enrolled in VA for health care; and

WHEREAS, The “signature wounds” of Iraq and Afghanistan are Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD); and

WHEREAS, Mental disorders are the second largest frequency of diagnoses among returning OEF/OIF/OND servicemembers which are currently estimated at 50.7 percent; and

WHEREAS, In 2007, VA established a TBI, PTSD Clinical Reminder in VA’s electronic medical record for any new patient to identify veterans that need additional screening for a possible TBI or PTSD diagnosis; and

WHEREAS, VA has screened and diagnosed hundreds of thousands of veterans with TBI/PTSD and continues to have several challenges in the proper diagnosis and treatment of TBI and PTSD because of the overlap of symptoms; and

WHEREAS, According to VA, the overlapping symptoms between mild TBI and PTSD are headaches, dizziness, fatigue and noise/light intolerance, re-experiencing, avoidance and emotional numbing; and

WHEREAS, Currently, there are not any definitive medical treatments for TBI and providers/clinicians use therapy and medications to treat the symptoms; and

WHEREAS, Evidence-based treatments for PTSD include Cognitive Processing Therapy, Prolonged Exposure Therapy, Eye Movement Desensitization and Reprocessing, as well as medication management; and

WHEREAS, VA’s Veteran Health Administration has several different research offices involved in studying TBI/PTSD including: VA Office of Research and Development; TBI Centers of Excellence; National Center for PTSD; Mental Illness Research, Education and Clinical Centers; War Related Illness and Injury Study Center; and Office of Public Health Environmental Epidemiology Service Office but lacks central oversight for management of all the different research studies and trials through the current decentralized research model; and

WHEREAS, The Department of Defense (DOD) and VA developed a DOD/VA Integrated Mental Health Strategy which recommended as one of the strategic objectives to “develop a system to deliver evidence-based psychotherapies” but in the plan it does not mention coordinating research jointly between both departments; and

WHEREAS, The American Legion developed a TBI/PTSD Ad Hoc Committee in 2010 to investigate the existing science and procedures and alternative methods for treating TBI/PTSD; and

WHEREAS, The committee has found several concerns including: the overlapping of symptomology between TBI/PTSD and Substance Abuse Disorder which makes it difficult to diagnose and treat the correct injury/illness; ineffective and overuse of medications; and reluctance of servicemembers and veterans to receive and continue mental health treatment; and

WHEREAS, VA conducted a study on Risperidone, a second generation antipsychotic, which is not approved by the Federal Drug Administration for use in treating PTSD; and

WHEREAS, Researchers of the study concluded that Risperidone did not improve PTSD symptoms but had several negative side effects which included weight gain, sleepiness and increased saliva in the mouth; and

WHEREAS, Researchers in the study concluded that in FY 2010, VA treated 86,852 veterans for PTSD last year, of which nearly 20 percent were prescribed this off-label and ineffective medication, and currently the only antidepressants and serotonin reuptake inhibitors such as sertraline and paroxetine are currently approved for treatment; and

WHEREAS, Veterans that have participated in past DOD/VA TBI/PTSD research studies have not always been properly informed that they are participants in the study and are not given a disclosure of the effects of any treatment they may be receiving through a study; and

WHEREAS, Additionally, the TBI/PTSD committee in their charge found several new innovative treatments for TBI/PTSD which include Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy that have not been prioritized for clinical studies to determine if they are evidence-based treatments; now, therefore, be it

RESOLVED, By The American Legion in National Convention assembled in Indianapolis, Indiana, August 28, 29, 30, 2012, That The American Legion urge Congress to provide oversight and funding to the Department of Defense (DOD) and Department of Veterans Affairs (VA) for innovative Traumatic Brain Injury (TBI) and Post

Traumatic Stress Disorder (PTSD) research currently used in the private sector, such as Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy and other non-pharmacological treatments; and, be it further

RESOLVED, That The American Legion urge Congress to increase the budgets for DOD and VA to improve the research, screening, diagnosis and treatment of TBI/PTSD as well as provide oversight over DOD/VA to develop joint offices for collaboration between DOD/VA research; and, be it further

RESOLVED, That DOD/VA both establish a single office for their agency’s research and serve as a clearinghouse to track all DOD or VA research, and that all DOD/VA individual research programs and activities coordinate and provide monthly and as needed updates on research activities; and, be it further

RESOLVED, That servicemembers and veterans who participate in DOD/VA TBI/PTSD research studies are properly informed and give their consent to be included in the study as well as be provided with a disclosure of any negative effects of treatment; and, be it further

RESOLVED, That DOD/VA accelerate research efforts to properly diagnose and develop evidence-based treatments for TBI/PTSD; and, be it finally

RESOLVED, That The American Legion urge Congress to exercise oversight over DOD/VA to ensure servicemembers and veterans are only prescribed evidence-based treatments for TBI/PTSD and not prescribed off-label and non-Federal Drug Administration approved medications or treatments for TBI/PTSD.





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