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Testimony before the
Senate Committee on Veterans' Affairs

Hearing on Pending Health Care Legislation

S.2573 Veterans' Mental Health Treatment First Act

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Mr. Chairman, thank you for the invitation to appear before the Committee. I am a psychiatrist who formerly worked with disabled Vietnam veterans at the West Haven VA Medical Center in Connecticut from 1988-1993. Currently, I am a resident scholar at the American Enterprise Institute (and work, part-time, at a local methadone clinic). I have been interested in applying the lessons we learned in treating Vietnam veterans to the new generation of service personnel returning from Iraq and Afghanistan.

The purpose of my remarks today is to endorse the concept behind S. 2573 Veterans' Mental Health Treatment First Act.

The animating idea behind the legislation is that young men and women who are suffering from military-related mental illness service will benefit most when they pursue treatment with the goal of recovery before labeling themselves beyond hope of improvement - and thus a candidate for total and permanent service-connected disability status.

As a clinician I agree wholeheartedly with the premise of the bill that the most appropriate sequence begins with treatment, moves to rehabilitation, and then - if necessary - goes on to assessment for disability status.

The following vignette underscores the intrinsic wisdom of the bill.

Clinical scenario

Imagine a young soldier wounded in Iraq. His physical injuries heal but his mind remains tormented. He is flooded with memories of bloody firefights, he can't concentrate, and sudden noises make him jump out of his skin.

He is 22 years old and was discharged from the military a few months ago. He is certain he'll never again be able to hold a job, tolerate being around people, develop an intimate relationship, go on to have a family, and fully function in society. "Why even bother with treatment?," he thinks, "the situation is hopeless." Convinced he is facing life as a psychiatric invalid and worried about financial security he applies for total and permanent disability from the Department of Veterans' Affairs.

Yet the last thing this 22 year old man needs is confirmation of his fearful pessimism. Unfortunately, that will be precisely the message he gets if his claim is approved for full permanent and total disability: "You're right, there is no hope of significant recovery. You are irreparably damaged."

How can we make a responsible determination about an individual's life-long psychiatric incapacitation before he or she has even allowed himself to be helped?

Implications - Judging an individual doomed to a life of invalidism before he has even had a course of therapy and rehabilitation is drastically premature. This is particularly so when the young soldier is being evaluated for mental disability status while still on active duty.
Full disability status may actually undermine the possibility of recovery; its implicit message is that the beneficiary has a very small likelihood of improvement. As a result, the status itself can become a self-fulfilling prophecy for the patient.
Without question, some patients will remain severely and irretrievably impaired by their war experience. Treatment will help them, almost surely, but return to the workforce may not be possible. These men and women deserve generous disability compensation.

Yet so many others do have the potential to resume work, greater family participation, and engagement in their community. The problem is that once a patient receives a monthly check because he is diagnosed with (a treatable) psychiatric illness, his motivation to hold a job can diminish. Full disability would naturally lead him assume-often incorrectly-that he is no longer able to work, and then, the longer he is unemployed, the more his confidence in his ability to work erodes and his skills atrophy.

At home on disability, he adopts a "sick role" that ends up depriving him of the estimable therapeutic value of work. Lost are the sense of purpose and competence work gives (or at least the distraction from depressive rumination it provides), the daily structure it affords, the occasion for socializing it creates, and the opportunity to reach for goals. That work serves as a prophylactic against psychological distress is especially evident among veteran retirees.

This is a good place to mention remission rates of PTSD. According to the National Vietnam Veterans' Readjustment Study (NVVRS, 1988) fifty percent of those who develop the diagnosis of PTSD will recover fully over time. A recent re-analysis of the NVVRS, (Science, vol. 313 18 August 2006) found the lifetime rate of PTSD to be 18.7 percent vs. point prevalence (current) of 9.1 percent. Notably, those with a lifetime history of PTSD but not current PTSD exhibited virtually no lingering functional impairment at the time of assessment Thus, to grant total disability compensation in light of a fifty percent chance of total remission (and a much higher chance of achieving partial or near-total remission) makes little sense.

Is disability compensation a barrier to seeking treatment?

In 2006 the Veterans' Disability Benefits Commission asked the Institute of Medicine (IOM) to evaluate the evidentiary basis for various influences of compensation on treatment and recovery. The IOM panel concluded that "PTSD compensation does not, in general, serve as a disincentive to seeking treatment."

Healthy skepticism surrounding this conclusion is warranted, not least because there are so few studies on the subject. Moreover, the IOM conclusion is based on studies of Vietnam veterans. I will elaborate presently on why the IOM report does not justify dismissing the importance of a "treatment first" approach for young veterans from Iraq and Afghanistan.

First, let us briefly review the data they interpreted. The IOM committee reviewed six studies of veterans claiming combat-related PTSD.

Longitudinal studies - Three of the six examined data from the phases before and after disability status was granted.

The best known is a 2005 study conducted by the Inspector General of the DVA. Ninety-two cases were examined and revealed that most veterans' self-reported symptoms of PTSD become steadily worse over time until they reached the 100 percent disability level-at which point there is an 82 percent drop in use of VA mental health services (but no change in VA medical health service use.)

These findings are contradicted by two studies from the Minnesota VAMC which found increased attendance at treatment after receipt of disability compensation. Samples sizes were 452 and 102, respectively. Authors reported an increase in the number of sessions attended and in the percentage of patients who used services.Patient drop out after receipt of disability compensation is not a problem, they concluded.

Comparison of compensation-seeking patients versus non-seeking regarding service use - A 2004 study from the Charleston VA reported the study of 68 veterans as having found that compensation-seeking veterans were more likely to use PTSD services compared to non-seekers. Yet, notably, the actual paper itself denies any significant difference in PTSD service utilization between the two groups.

Comparison of compensation-receiving patients and non-recipients regarding symptom reduction -This 2006 study found an equivalent degree of symptom reduction among 54 veterans at the Boston VAMC with chronic PTSD irrespective of their receiving disability compensation.

Comparison of compensation-seeking patients versus non-seeking regarding symptom reduction - Researchers at the West Haven VAMC published a 1998 study of 1,000 compensation-seeking veterans undergoing either outpatient or inpatient treatment. Symptom reduction was observed among the outpatient cohort but not among the inpatients. Notably, despite amelioration of symptoms, employment was low at one year following treatment initiation: outpatient subjects had worked, on average, almost seven days per month (an increase of less than a full day compared to pre-treatment) and inpatient subjects worked just under two days per month (a decline from slightly over two days pre-treatment).

Limited relevance to today's situation - Many features of these studies limit their relevance to the subjects of today's hearing, namely young veterans returning from Iraq and Afghanistan who (1) suffer new-onset PTSD symptoms (2) seek or receive total and permanent disability status, and who (3) have not received sustained, quality treatment.

By contrast, the studies examined by the IOM examine involve almost exclusively Vietnam veterans with chronic PTSD who are already in treatment.
These are two very different populations. Most veterans of the Vietnam War who came to the attention of VA psychiatrists were neither diagnosed with PTSD, nor treated, until over a decade after experiencing combat trauma. Presenting for treatment so many years later typically means a diagnostic picture is very complex (e.g. overlaid with substance abuse problems, long-term employment difficulties, and diagnoses such as depression). At this advanced stage, responsiveness to treatment is usually compromised.
Consider, also, the age of most of the Vietnam veterans who were subjects of the studies. They were in their forties and fifties when seeking disability and had been ill for many years; for most, the struggles with long-standing psychiatric conditions were an acknowledged aspect of daily life and personal identity. By comparison, veterans from Iraq and Afghanistan have not been ill for such a long time. They are in a different, earlier phase of life, still configuring what their post-service lives will be. Within this vulnerable period their perceptions of their capabilities and futures are being formed; so are the meanings they give to their symptoms.
In short, this is a highly impressionable stage; a time to offer untreated veterans a message of promise and hope, not enduring disablement.
Finally, bear in mind that the studies reviewed by the IOM reveal very little about real-world functioning. In fact, the take-home lesson from the single study that measured change in occupational functioning (West Haven) was that symptom reduction is a poor proxy for overall improvement. Recall, the study found post-treatment employment rates of only two to seven days of work per month among disability-seekers. True, attendance at treatment sessions and measurable reductions in symptoms may be a sign of engagement with the VA, but this is only a part of the picture: the major goal of treatment is social reintegration and re-entry, especially into the workplace community.
Studies of treatment utilization among compensation seeking Vietnam veterans tell us little to nothing about the potential for functional improvement/recovery in young, never-treated veterans returning from Iraq.

Note, also, that the studies' observations are consistent with the well-established finding within civilian populations that individuals who receive disability compensation are less likely to work when compared to their counterparts who do not receive compensation but exhibit the same degree of mental illness severity (see p. 6-3, IOM).

Disability doesn't necessarily inhibit treatment seeking, but it inhibits recovery. Not only does full disability status signify dysfunction, it presents a basic disincentive to recovery.

Making treatment work first and work well

We must think of PTSD and other war-related mental conditions as a treatable and time-limited affliction. We must treat it early when symptoms are most responsive to treatment.
There are excellent treatments for the component parts of PTSD (e.g., the phobias, anxiety, depression, existential dislocation). Treatments include desensitization protocols (such as Virtual Iraq), cognitive-behavioral therapy, psychotherapy, and medication. There is often a period in which treatment and rehabilitation overlap.

Rehabilitation is critical to psychiatric recovery and familial and community reintegration. And the most effective efforts capitalize on the well-established finding that patients' prognoses depend on what transpires in the "post-trauma" phase. One element of this is the patient's self-image. How does he view himself "post-event"? Is his expectation one of recovery? Does he view himself as in control? Is he hopeful?

In addition to the importance of a forward-looking stance is the extent to which problems of reintegration are managed. This is why quality rehabilitation addresses marital discord, readjustment to civilian life as well as to being a parent, vocational training, and financial concerns. Some veterans will need help with skills in relating to family, friends, neighbors, colleagues, and bosses.

When daily life can be made more manageable, the patient feels more in control. Not only can he tolerate some symptoms better (sleep problems, distressing memories), those symptoms will fade faster. He will be less likely to ascribe morbid interpretations to symptoms and to less apt to feel discouraged. Demoralization is not a formal diagnosis, but in my experience, it can be the difference between someone who throws in the towel and someone who prevails. The virtue of rehabilitation is that it can turn risk factors for a prolonged course of illness into protective factors.

Conclusion

Veterans who are afflicted with PTSD or other mental disorders in the wake of their military experience deserve the best treatment. But it is imperative that we pair concern over the quality of care with serious consideration of the philosophy guiding the timing of that care. Imagine giving young men and women permission to surrender to their psychological wounds without first urging them to pursue recovery. Imagine even trying to make an accurate determination of one's potential for recovery before he or she has even received therapy. For many young veterans, a "treatment first" approach could mean the difference between a rich civilian life and withdrawal into disability.