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POST TRAUMATIC STRESS DISORDER AND PERSONALITY DISORDERS: CHALLENGES FOR THE U.S. DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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POST TRAUMATIC STRESS DISORDER AND PERSONALITY DISORDERS: CHALLENGES FOR THE U.S. DEPARTMENT OF VETERANS AFFAIRS

WEDNESDAY, JULY 25, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Michaud, Herseth Sandlin, Mitchell, Hall, Hare, Berkley, Salazar, Rodriguez, Donnelly, McNerney, Walz, Buyer, Stearns, Moran, Baker, Brown of South Carolina, Brown-Waite, Turner, and Lamborn.

Also Present: Representative Kennedy.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. This hearing of the House Committee on Veterans' Affairs is called to order. Today, we will be focusing on the relationship between treatment for post traumatic stress disorder (PTSD) for our returning veterans from Iraq and Afghanistan and the diagnosis of personality disorder and how that affects later support for our veterans.

Once again it seems that America has to be educated by the media. Just as we found out about Walter Reed from good reporting in the Washington Post we have had incredibly persuasive documentation on this issue from members of the press, especially one of our panelist here today, Mr. Kors, working for both *The Nation* and *ABC News*. And we thank you for educating America and we will hear more from you.

What the press has learned is that thousands of cases, over 20,000 of the cases in recent years, of soldiers who were claiming PTSD or other mental issues with regard to their service and their claim for disability were in fact diagnosed with a personality disorder. Then the military says that this was a pre-existing condition, which begs the question, of why these young men and women were taken into the Armed Services to begin with and what our obligation is after that occurs, but allows discharge with a very difficult time to get later care from the U.S. Department of Veterans Affairs (VA).

If the facts that we have read in the press are true or if the statements that we read in the press are true, this is doing an incredible disservice to our young men and women who are serving

this Nation. We have heard that they are not getting the full story of what the implications are for that PTSD discharge. We have representatives of servicemembers and servicemembers who have talked to the press that we will hear today that they were not given the full truth in their evaluations. They were lied to in terms of the implications of this diagnosis.

In addition, there is some indication that higher policy is leading to this or—policy made at higher levels. I have personally talked to a doctor psychiatrist who told me that his commander told him to make the diagnosis of personality disorder rather than PTSD which would lead to further cost and obligations by this Nation to our veterans.

So we have a real problem here. Not only are soldiers being denied treatment for a very real problem, but they are put in the position where it is very, very difficult to get that treatment even later on. So once the servicemember is diagnosed with personality disorder we want to know what happens at the VA and how to deal with—how the VA deals with those veterans. Is the burden on the veteran to prove that he or she doesn't have a personality disorder? Will that diagnosis prevent the veteran from receiving healthcare once the initial period for coverage ends? What barriers does the veteran face?

So we want to look at this, at first from the soldier's perspective and that is what our first panel is about, to let them tell the story of what happens with this diagnosis, how that affects their lives and the lives of their comrades..

So we thank you all for being here. It takes a lot of courage for you to testify and talk about your own lives. And I know that is hard. And we will hear from Mr. Kors who talked to many, many of these veterans. We will have a panel that deals with the response from the VA and, in this case, the Army Surgeon General. We want to know if this is being taken seriously; what is being done if these statements are true; what is being done to rectify it.

There is legislation that has been introduced. I believe in the Senate that makes personality disorder on the diagnosis not a valid one. That would get rid of that as a potential diagnosis in dealing with, or at least in terms of the obligations that we have for treatment, and we may have to do that on the House side also.

So we have, I think, a very important issue to look into today. We thank both the soldiers who are here, their representatives and the reporter who first brought this to America's attention.

I would yield to the Ranking Member of this Committee, Mr. Buyer.

[The prepared statement of Chairman Filner appears on p. 74.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. What was originally focused and appropriate for this review was a Subcommittee hearing on post traumatic stress disorder compensation and veterans claims at the Department of Veterans Affairs. That is how this began. We have now morphed it out of the Subcommittee to the Full Committee. And the focus is now on lanes outside the jurisdiction of this Committee. If the Chairman wanted to explore these matters, what would have been substantive and helpful to all of us is for this to have been a joint

hearing with the House Armed Services Committee. While we can have witnesses before us, we can take no substantive action. There are many times when we are the receiver of individuals based on policies and actions from the U.S. Department of Defense (DoD).

So a lot of this is important, but we should be working in concert with the House Armed Services Committee. The legislation I think that the Chairman was referring to, was legislation introduced by Senator Obama, and Senator Obama's legislation would stay the discharges for a personality disorder. I think that is a bad idea. We have individuals who are taken into the military. We do the best we can as a nation to screen individuals. At some point through the military matriculation process, individuals begin to exhibit certain types of actions that would not be appropriate. When you put a weapon into someone's hands and you ask them to work in concert and as a team with other individuals, it requires mental steadfastness. And it requires a lot of other institutional values and virtues in order for that team to work with great cohesion and for them to be the very best.

And we have no idea as a country when an individual is going to break down. And in fact, if there are personality disorders, we have no idea when they are going to exhibit themselves. And to disarm the military from this ability to essentially discharge this individual so there is no harm not only to the individual, but also to the team, is extremely important.

So while what perhaps well intentioned, I think Senator Obama's legislation would be very harmful to the military and thereby the national security of the country. It is also equally important for us not to confuse PTSD and personality disorder. These are clinical diagnoses. For individuals to be discharged from the military for personality disorders, you just can't have a company commander or a first sergeant or a master chief come forward and say, "Well, I think this person has got a personality disorder. I want to get rid of them." I mean these are clinical judgments made by psychiatrists and doctorate level psychologists through a peer review process. And this allegation that they can just be thrown out is false.

So while much of the testimony we are going to hear today is interesting and might be helpful, much of this is outside the jurisdiction of this Committee. I also do recognize that when we take an issue to the Full Committee, generally the Veterans' Affairs Committee seeks the counsel and input from many of the chartered veterans service organizations (VSOs), and they are absent here today. And I find that to be a curious matter.

I yield back.

The CHAIRMAN. Thank you, Mr. Buyer. I guess once again we understand only for the last 4 years, these issues were not taken up and not explored. This is a scandal. And I don't care who's jurisdiction it is, although we have tremendous jurisdiction in this. It is up to this Congress to deal with it.

Are there any other opening statements by my colleagues? Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. I just would make a comment that eventually it will become our problem, because when someone is diagnosed in-

correctly, eventually that individual is going to come to the VA and that diagnosis remains with that individual. So it will become our problem as dealing with veterans.

The other reality is this: I worked over 8 years in the area of mental health and I understood very quickly when I was told that in order for us to provide any service to any individuals, they have to receive a specific type of diagnosis otherwise we couldn't deal with them. And so that also drove unfortunately a lot of times what we could do or not do based on the specific diagnosis that they were given.

So I am, and it is an area that we ought to be, concerned about and I know personally this, in terms with when you are diagnosed in that area, presupposes that the individual came in with those problems prior to. And so, that is important for us to come to grips with that as quickly as possible and making sure that that is not occurring and is not happening. And if anyone is going to get diagnosed, that we do everything we can to diagnose them appropriately as much as we can. And in some cases, if that is the case then we got to go back and reassess in terms of what has been happening and what is occurring with those soldiers that are out there.

And so with that, I will stop and look forward to the testimony.

The CHAIRMAN. Thank you, Mr. Rodriguez. Mr. Hare.

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Mr. Chairman, I would respectfully disagree with the Ranking Member. I think this is well within this Committee's jurisdiction. I cannot, for the life of me, believe that we would see 22,000 plus of our best and our brightest treated like this. I think it is grossly unfair. I think it is beneath what they certainly have deserved. There is substantive action that I would suggest to my friends on the other side that we can take and that would be including perhaps sponsoring my bill H.R. 3167, the "Fair Mental Health Evaluation for Returning Veterans Act."

I would again disagree with the Ranking Member. I don't think Senator Obama idea is a bad idea at all. I think from my perspective, when we see something wrong I don't think we need to wait around for another Committee to tell us what is wrong. I think we need to, as a Committee, get together and to try to help our servicemen and women. So from my perspective, I think this is well within the purview of this Committee. I commend the Chair for holding this. I have said many times at this Committee, if not us, who? And if not now, when?

And I want to thank you, Mr. Chairman, for doing this and to the witnesses I look forward to hearing this. But we cannot take the treatment of people in our military like this anymore. And I am not here to worry about whether or not the Armed Services is here. I am here. We are here. And I want to hear from these witnesses. And I want to see this problem solved.

So I thank you, Mr. Chairman, for giving us the opportunity to listen today. Thank you.

The CHAIRMAN. Thank you, Mr. Hare. We will hear from the first panel. If you have a written statement, that will be made a part of the record.

Jason Forrester is a representative from Veterans for America (VFA). We thank you for what your group is doing and we thank you for being here today.

STATEMENTS OF JASON W. FORRESTER, DIRECTOR OF POLICY, VETERANS FOR AMERICA; JONATHAN TOWN, FINDLAY, OH (VETERAN); JOSHUA KORS, NEW YORK, NY, REPORTER, *THE NATION*, AND CONTRIBUTOR, *ABC NEWS*; AND PAUL SULLIVAN, EXECUTIVE DIRECTOR, VETERANS FOR COMMON SENSE

STATEMENT OF JASON W. FORRESTER

Mr. FORRESTER. Thank you, Mr. Chairman. Chairman Filner, Ranking Member Buyer, Members of the Committee, Veterans for American works closely with Congress, DoD, the media, active-duty troops and veterans to identify the unique challenges facing today's military. Much of our work is investigative. Specifically, our work at Ft. Carson, Colorado, where we first met Specialist Town, and our current work at Camp Pendleton, California, has prompted considerable media attention and Congressional action and has helped identify where our country is failing our servicemembers.

Given the distressing disconnect between VA and the DoD, the greatest service that VFA can provide today is to highlight the trends we have identified and are working to correct within DoD and to offer some ideas regarding how the VA can help ensure that those who have served in Iraq and Afghanistan get the assistance they deserve.

It is important for VA to understand that the experiences of nearly one million servicemembers from Iraq and Afghanistan who are still on active duty and who will eventually enter the VA system. The DoD's Mental Health Task Force found that 49 percent of Guard members, 38 percent of soldiers, and 31 percent of Marines are experiencing some mental health issues after serving in Iraq and or Afghanistan. DoD characterized post traumatic stress disorder as a signature wound of today's wars. At Ft. Carson, we found soldiers who had been diagnosed with chronic PTSD who are only receiving 1 hour of individual therapy per month. Often, these soldiers saw a new therapist each visit.

At Ft. Carson, we worked with soldiers who were not receiving the treatment they needed even though they clearly indicated on their post-deployment health reassessment that they were having difficulty readjusting to post-deployment life.

In some cases, these soldiers had been re-deployed only to have their wounds compounded by further exposure to combat. In other cases, undiagnosed and untreated PTSD led soldiers to turn to drugs and alcohol. The civilian medical community has long recognized that substance abuse is a symptom of PTSD. Unfortunately, it is DoD policy not to treat soldiers for PTSD until their substance abuse problems are addressed. There are no DoD dual track PTSD and substance abuse programs. We have worked with several soldiers who have suffered greatly from this deficiency and in a few cases, have gotten them into VA facilities that offered dual track care.

Since PTSD is so prevalent, VA must increase the number of dual track programs that treat substance abuse and PTSD. VA can help greatly reduce anti-mental healthcare stigma by increasing its outreach to servicemembers and their families on bases and within military medical facilities. Today's servicemembers need to know that PTSD is an injury and that they deserve every opportunity to recover. PTSD is not a sign of weakness. It is a proven medical reality of sustained exposure to combat.

Finally, another distressing trend that we identified at Ft. Carson was the prevalence of pre-existing personality disorder discharges for soldiers with clear service-connected mental health problems. The consequences of such a dismissal are severe, including denial of VA benefits due to the disorder being, "pre-existing." At Ft. Carson we met numerous soldiers who had been diagnosed with a pre-existing personality disorder regardless of the fact that they were deemed fit when they entered the service and regardless of the fact that they have been diagnosed with PTSD post-deployment to Iraq and Afghanistan.

Pre-existing personality disorder discharges remove the government's burden to help the servicemember deal with their service connected injuries. It is unacceptable to ask an American to sacrifice for this country and not to treat the consequences of their service.

In May of this year, as a result of our work at Ft. Carson, a congressional staff delegation returned there where they met with the soldiers and family members who we had been helping. This visit prompted a U.S. Government Accountability Office (GAO) investigation into mental health treatment in the military and it led to a bipartisan group of 31 Senators sending a letter to Secretary Gates calling for a moratorium on pre-existing personality disorder discharges. This problem provides a great opportunity for VA leadership.

While VA has no obligation to treat a veteran with a pre-existing personality disorder discharge, these men and women need help. To address this problem, VA should create a streamlined process for face to face medical evaluations for such discharges. We owe these veterans a second chance to get much needed help for their service connected injuries.

This concludes my statement. Thank you.

[The prepared statement of Mr. Forrester appears on p. 77.]

The CHAIRMAN. Thank you very much.

Jonathan Town is an Army veteran who was diagnosed with a personality disorder. And I understand after all the publicity about your case, the VA, or you can tell us, the VA has decided they we owe you treatment. We thank you for your courage in coming forward. Many soldiers who are in the same position as you are do not feel comfortable about testifying, and we thank you for speaking on behalf of thousands of soldiers.

STATEMENT OF JONATHAN TOWN

Mr. TOWN. Thank you for the opportunity. Mr. Chairman, distinguished Members of the Committee, ladies and gentleman, thank you for inviting me to address the Committee to tell my story.

On January 20, 1961——

The CHAIRMAN. Mr. Town. Could you just—get the microphone right up to you and make sure it is turned on. It is hard sometimes to hear, if not.

Mr. TOWN. On January 20, 1961, a United States military veteran and Purple Heart awardee who was being sworn in as President at that time said during his inaugural speech, "Ask not what you can do for your country, ask what—ask not what your country can do for you, ask what you can do for your country."

Since January 2000, countless citizens have answered this call to duty and served in the United States Armed Forces. Thousands, in fact, 22,500 of these servicemembers who served honorably have been discharged from the military with a Chapter 5–13, Personality Disorder Discharge. The result of which they have all been denied medical care and disability benefits by our government.

There has now arisen a debate about whether these discharges were done to save the government money or to help with the military wartime and deployment strength. Regardless of the reason, it is an outrage that these servicemembers and their families have been put through this.

Now I would like to tell you my story. I served 4½ years honorable years at Fort Knox, Kentucky, as an administrative specialist. I was then given orders to permanent change of station (PCS) to Korea. After arriving in Korea, I was told that the unit I was assigned to had just received it's deployment orders to Iraq. In August 2004, the STEEL battalion which I was now a part of, deployed to Ramadi, Iraq. On October 19, 2004, I was running mail for our battalion and incoming rounds started exploding across the street from where my vehicle was parked. While running for shelter in my S–1 shop's office, a 107 millimeter rocket exploded three feet above my head, leaving me unconscious on the ground with a severe concussion, shrapnel in my neck and blood pouring from my ears.

I was taken to the battalions aid station where I was treated for these various wounds. I was given quarters for the rest of the day and went back to work the next day. Two months later, I was awarded a Purple Heart for my injuries I suffered on that traumatic day in October. This is when everything started to go downhill health-wise for me. Throughout the next 9 months while continuing to serve my country, I battled severe and non-stop headaches, bleeding from my ears, and insomnia.

We finally got the word that we were headed home and then I would finally be able to get some assistance for the medical issues I was going through. After a few days back in the United States, I realized a new battle was taking place. My ability to adjust to loud noises, large groups of people and forgetting what happened to my unit and myself while we were in Iraq was going to be another battle.

About 45 days after coming back stateside to Ft. Carson, Colorado, I was finally able to see a psychiatrist. The first few meetings with the doctor were good and it seemed like he actually cared about helping me get through my issues, if it were possible. Then word came down that our unit was going to be re-deployed. The next time I went to see the doctor, he informed me that he was going to push a Personality Disorder Chapter and explained why.

The doctor said, "You have the medical issues that call for a medical board, but the reason I am going to push this Chapter is because it will take care of both the needs of the Army and the needs of you. You will be able to receive all the benefits you would if you were going to go through a medical board, get out of the military, and focus on your treatment to get better. For the military, they can get a deploy-able body to fill your spot."

I told him that this is—if this is what the thought was best for the military and my family that he could do what he needed to do. I never realized that everything that was said to me during that day was all lies. I went through the final out process to leave the military. The day I was signing out, I was told by the final out personnel that I would not receive any severance pay or benefits and I actually owed the military $3,000.

I do not know everyone in this room, but I think that if you were to work hard for a company or an agency, only to be told that you owe them money, that you owed them money when you went to leave, you would obviously be—you would obviously think something is wrong. If it weren't for my family taking us in and supporting us both financially and emotionally and new friends helping us, I don't know where my family and I would be right now.

The last 9 months have been spent trying to get assistance both medically and financially through the Veterans Department, getting the word out to the public about what is happening to my fellow servicemen and myself, and trying to get my family and myself back on our feet.

Eight months after being denied medical benefits as a Chapter 5–13 discharge, the Veterans Administration awarded me the disability status that my Purple Heart and wounds I suffered entitled me to. I am fortunate because my story received national exposure, unfortunately there are many, many injured military personnel Purple Heart winners also who have never received their benefits that they are entitled to.

In the absence of a concerted effort by the Committee to right this horrible wrong, I am afraid that the other 22,499 veterans will not be as lucky as me.

I think the government should fix the personality disorder issue in the time it takes a servicemember to receive the start of their disability from the time they leave the Armed Forces. The Chapter 5–13 personality disorder should be completely taken out of the DoD regulation, or if the military really wants a way to get servicemembers out of the service that do not have over 6 months of active service or have not been deployed overseas, then it needs to be written that way in the regulations.

It is 100 percent wrong to be able to use this discharge for any servicemember that has been on active service for a substantial amount of time or who has fought in a war for their country. Some have suggested a way to reduce the amount of time a servicemember has to wait till they finally start receiving disability after leaving the Armed Forces. The servicemember starts his or her disability paperwork and process at the station where he or she is currently stationed 2 months prior to getting out of the service. The servicemember should not be able to final out from their branch of military until he or she is either guaranteed or denied their dis-

ability claim. By going through this route it will allow the servicemember to receive their first disability check immediately after their last paycheck from the Armed Services and they will be able to receive medical assistance as soon as they leave the service.

Such a system would also facilitate the electronic transfer of the servicemembers medical records from the service branch of the veteran—to the Veterans Administration, thus allowing the Department of Defense to better work hand in hand with the Veterans Administration to assist these soldiers in need.

In closing, I want to state that I did not have a personality disorder before I went into the Army, as they have stated in my paperwork. I did not suffer severe non-stop headaches. I did not have memory loss. I did not have endless, sleepless nights. I have post traumatic stress disorder and traumatic brain injury (TBI) now due to injuries I received in the war for which I received a Purple Heart. I shouldn't be labeled for the rest of my life with a personality disorder and neither should my fellow soldiers who also incorrectly received this stigma. I would like to ask the Committee and panel members to thoroughly think about the ideas I have mentioned to fix some of the issues we as veterans are facing. Please help those who have helped their country and remember that every time the military discharges a servicemember out of the Armed Service the way I was discharged, not only do you destroy hope for healing, but they destroy the soldier's families hope for healing as well.

[Applause.]

[The prepared statement of Mr. Town appears on p. 78.]

The CHAIRMAN. Thank you, Mr. Town, you did not sign up to have to do this, but you are helping a lot of people and we thank you for——

Mr. TOWN. It is an honor.

The CHAIRMAN [continuing]. Your courage.

Joshua Kors is a journalist. He has written on this topic extensively and has been the source of much of the facts and stories around us, both for *The Nation* and for *ABC News*. So we thank you, Mr. Kors, for what you have done and we look forward to your testimony.

STATEMENT OF JOSHUA KORS

Mr. KORS. Good morning. I have been reporting on the personality disorder discharge for the last 10 months.

The CHAIRMAN. Please speak close to the microphone so we can hear.

Mr. KORS. I have been reporting on the personality disorder discharge for the last 10 months and I am here today to talk about the 22,500 soldiers discharged in the last 6 years with that condition.

A personality disorder discharge is a contradiction in terms. Recruits who have a severe pre-existing condition like a personality disorder do not pass the rigorous screening process and are not accepted into the Army. The soldiers I interviewed this past year passed that first screening and were accepted into the Army. They were deemed physically and psychologically fit in a second screening as well before being deployed to Iraq and served honorably

there in combat. In each case, it was only when they came back physically and psychologically wounded and sought benefits that this pre-existing personality disorder discharge was discovered.

Discharging soldiers with a personality disorder prevents them from being evaluated by a medical board and getting immediate medical care. This can be life threatening for our soldiers. A good example is Chris Mosier who served honorably in Iraq where he watched several of his friends burn to death in front of him. After that, he developed schizophrenic-like delusions. He was treated at Ft. Carson for a few days then discharged with a pre-existing personality disorder. He returned home to Des Moines, where he left a note for his family saying that Iraqis were after him, they are in Iowa, then shot himself.

Surgeon General Gale Pollock agreed to review a stack of personality disorder cases. After 5 months, she produced a memo saying her office had, "thoughtfully and thoroughly" reviewed the cases, including Jon Town's, and determined all of them to be properly diagnosed. With further reporting I discovered that as part of that thoughtful and thorough 5-month review, Pollock's office did not interview anybody, not even the soldiers whose cases she was reviewing. Some of those soldiers said they called the Surgeon General's office offering information about their ailments. Their efforts were rebuffed.

The one thing the Surgeon General's office did do was contact a doctor at Ft. Carson where many of the personality diagnoses were made, and ask him whether his doctors got it right the first time. The doctor said yes, his staff's original diagnoses was correct and Pollock shut down the review at that point.

The Surgeon General's office denied that for many months, insisting that the review was conducted by a panel of health experts who were not involved in the original diagnoses. This wasn't a case of one many reviewing his own work, they said. But eventually it did come out that the only reviewer was Colonel Steven Knorr, who as Chief of Behavioral Health at Ft. Carson, oversaw many of the personality disorder diagnoses and in his capacity as a psychiatrist was reportedly involved in creating many of them as well.

When the problems with Walter Reed became public, the Pentagon took two actions: It accepted the resignation of Surgeon General Kevin Kiley and it hired the public relations firm LMW Strategies with a $100,000 no-bid contract to put a positive spin on those events. This past week as these personality disorder discharges became public, VA Secretary Nicholson stepped down. And today, Surgeon General Pollock is not here to discuss the issue.

As a journalist it is not my role to make any recommendations, but I do want to share with you the hopes of the wounded veterans I spoke to this year, which is a hope that someone be held responsible and that officials go back through the 22,500 cases and seek out the thousands of Jon Towns who are waiting there, struggling right now without benefits or the media spotlight.

[The prepared statement of Mr. Kors appears on p. 80.]

The CHAIRMAN. Thank you, Mr. Kors.

And concluding this panel will be Paul Sullivan representing Veterans for Common Sense. And we thank you again for your ef-

forts at making these kinds of situations public for the American people to understand.

STATEMENT OF PAUL SULLIVAN

Mr. SULLIVAN. Thank you, Mr. Chairman. Chairman Filner and Members of the Committee, thank you very much for inviting Veterans for Common Sense to testify about post traumatic stress disorder and about personality disorder discharges among our Iraq and Afghanistan war veterans. My oral testimony focuses on offering solutions so our veterans receive prompt medical care and prompt disability benefits for PTSD.

So far, the Department of Defense has discharged more than 22,000 veterans in the past 5 years with a personality disorder or PD. The current DoD system assumes soldiers are malingering. And the current VA system is designed to fight fraudulent claims. These DoD and VA barriers to prevent abuse of the system are blocking too many deserving veterans from getting the high quality medical care from VA, and the prompt disability benefit payments from VA that they need and they earned.

When the military uses PD to discharge a veteran who fought honorably, then the military is breaking it's own rules. Chapter 5–13 states that if a veteran was in combat then the military is generally prohibited from using PD. VA's recent review of PTSD claims found no evidence of fraud. A veteran discharged with PD is usually denied VA healthcare and benefits based on VA rules prohibiting services for a pre-existing condition.

Here are VA's latest statistics on post traumatic stress disorder. As of March 31, VA diagnosed 52,000 Iraq and Afghanistan war veterans with PTSD. However, VA approved only 19,000 PTSD claims. This disparity should be investigated.

Veterans for Common Sense urges Congress to adopt a robust package of policies listed in our written statement so Iraq and Afghanistan veterans with PTSD receive prompt medical care and benefits. Here are our top three proposals.

First, Congress should legislate a presumption of service connection for veterans diagnosed with PTSD who deployed to a war zone after 9/11. A presumption makes it easier for our dedicated and hard working VA employees to process the veterans claims. This results in faster medical treatment and faster benefits for our veterans.

Second, the military should stop discharging Iraq and Afghanistan war veterans uses PD. The military should review all personality disorder discharges for veterans deployed since 9/11. Congress should order VA to review applications for healthcare and benefits where PD was an issue at VA.

Third, DoD and VA should establish a policy to reduce the stigma against people with mental health conditions that military studies confirm hinders many of our war veterans from seeking care. The scope of PTSD in the long term is enormous and it must be taken seriously. PTSD is real. When all of our 1.6 million servicemembers eventually return home form the wars in Iraq and Afghanistan, based on the current rate of 20 percent, then VA may face up to 320,000 total new veterans diagnosed with PTSD.

In conclusion, Mr. Chairman, if America fails now to act and overhaul the broken DoD and VA disability systems, there may be a social catastrophe among many of our returning Iraq and Afghanistan war veterans. That is why Veterans for Common Sense reluctantly filed suit against VA in Federal Court this week. Time is running out. The consequences of failure among our veterans are severe, including broken families, lost jobs, stigma, drug abuse, alcoholism, crime, homelessness, and suicide. The disastrous consequences are preventable, yet our window of opportunity to prevent these problems from happening is closing.

Thank you, Mr. Chairman. I would be more than happy to answer any of your questions.

[The prepared statement of Mr. Sullivan appears on p. 83.]

The CHAIRMAN. Thank you all very much. You have made some very powerful statements. I am going to call on Members of our panel in the order in which they got here. The Chairman of our Health Subcommittee is Mr. Michaud and the floor is yours for 5 minutes.

Mr. MICHAUD. Thank you very much, Mr. Chairman. I want to thank the panel for the enlightening testimony. And I have a few questions. First of all, for Mr. Town. You had mentioned in your testimony that when you went through the final out process to leave the military, when you signed out that they said that you actually owed them money. What was the reasoning they gave why you owed them $3,000? Was it for medical bills or?

Mr. TOWN. While I was in Iraq I re-enlisted for 6 years and a $15,000 tax-free bonus while in Iraq. And when I came back stateside, or when I was being chaptered out, they said I had—I had served 1 year of that 6 years. So I stilled owed $12,000 roughly. And there was, I had leave that I was selling back to Defense Finance and Accounting Service, and I sold my leave back. And how it came out is, I still owed $3,000 of that $12,000. And that is how that debt was made.

Mr. MICHAUD. Okay. Thank you. For Mr. Sullivan, you had mentioned the lawsuit and being a former VA employee we have been dealing with a lot issues dealing with traumatic brain injury, and PTSD. If the lawsuit is successful and VA has to respond, the lawsuit might also say in order to respond to the huge influx of men and women from this conflict and previous conflicts, Vietnam era conflict, what are your thoughts about the VA not utilizing to the degree that they probably should be to take care of the influx as far as contracting out services, particularly in rural areas for mental health services? Would you comment on that? Do you think that that is what they should do in the short term to help with the influx is to fee for services?

Mr. SULLIVAN. Thank you for your question, Congressman. I am not an expert on rural care for veterans, but there are two pretty simple standards that VA should be held to. The first standard is when a veteran comes home from war and he needs an appointment for a mental health condition. It shouldn't matter if he lives in Nome, Alaska, or New York City. The servicemember turn veteran should be able to see a mental healthcare provider as soon as possible so the condition doesn't worsen.

It is better for the veteran to get treatment sooner, it is also cheaper for the taxpayer so that you don't have more complicated problems later on. So it would be a very good idea for VA to make sure, especially for Guard and Reserve units, that they beef up their rural programs.

One note related to that. I mentioned that there are fewer claims for PTSD that are approved then there are veterans who are diagnosed. One related concern is this: National Guard and Reserve, mainly from rural areas, are about half as likely to file a claim. However, Congressman, they are about twice as likely to have their claim denied. So not only do they need access to healthcare, they also need access to a good representation to assist them with their claim.

Mr. MICHAUD. Well why is it that they are half as likely to file, because they don't know about the services or they just afraid of the stigma that is attached to it?

Mr. SULLIVAN. I don't know the answer to that, Congressman. However, I did raise it while I worked at VA and it was in some of the briefing materials that I provided to VA executives. However, I am not aware that they took any action. You may want to ask them if they have investigated the discrepancy and if they have any answers.

Mr. MICHAUD. Okay. Thank you. And my last question to Mr. Kors is being a journalist you definitely have the power to inform the public of what is going on. Have you ever been persuaded by one side or another to be more aggressive or less aggressive as you move forward in dealing with this issue of claims?

Mr. KORS. Sure. Well any journalist works hard to keep their neutrality, but certain issues seem logical when looking at them. For example, in Jon Town's case, they gave him a Purple Heart for his wounds of war, but yet Surgeon General Pollock says he was not wounded in war. Contradictions like that call out the strangeness, the sense of absurdity here. And I think actually that question deserves a little more detail.

Following the review that said that Jon's case and the stack of others was properly diagnosed, the Pentagon released a second statement that went a lot farther. A statement by Lieutenant Colonel Bob Tallman, what has become known to the reporters reporting on this issue as the Tallman memo. In the Tallman memo, they said not only did they review the stack of cases presented to them, but they went back and reviewed all the cases from the last 4 years at Ft. Carson where Specialist Town was based. After it was revealed that—after it was revealed that there were no interviews in this 5-month thoughtful and thorough review, I later discovered that the 4-year review was simply invented.

I called Lieutenant Colonel Tallman to ask him about this. How they could call this a thoughtful and thorough review when not a single soldier was interviewed. And he said to me, well he really didn't think that they could. And he said, "Joshua, let me be clear with you. I didn't write this memo and I have no knowledge of it's contents." He told me that the memo was ghost written by Surgeon General Gale Pollock's office. Something that Pollock's office readily admitted. And after it was revealed that the review was simply in-

vented, the 4-year review referred to here, they really said that was all the information they could provide.

Mr. MICHAUD. Thank very much. That is very enlightening. Thank you very much for all of the work that you all are doing, I really appreciate it.

The CHAIRMAN. Thank you. Mr. Moran?

Mr. MORAN. Mr. Chairman, thank you very much. I appreciate the opportunity to learn about this circumstance that our servicemen and ultimately veterans are facing.

Mr. Kors, apparently—if I understand the situation, apparently pre-existing, that word is very significant. And I guess my initial question is, are there findings with our servicemen and women, that they have a personality disorder as a result of actions or activities that occur in war that result in the designation of a personality disorder for which the there is no pre-existing—let me ask this question. I am not very clear, but I want to make sure do we have a non pre-existing condition? And in that case, is there a different result? Or is everything found in these circumstances to be pre-existing and, therefore, the consequences are bad in each and every case? What makes Mr. Town's situation different? Are other servicemen and women found to have a personality disorder but not a pre-existing one?

Mr. KORS. Well that is exactly the point, Congressman. And that is why it is such an important VA issue. The VA is not required to treat pre-existing conditions. They are required to treat wounds of combat. And why is Town's case unique? It is not and that is precisely the point.

I looked at cases of one soldier for example who suffered a bilateral hernia in Iraq. His condition was decided as the result of pre-existing personality disorder. Another case, for example, the soldier who damaged the lens of eyeball in Iraq. That ocular damage was seen as the result of a pre-existing personality disorder.

Mr. MORAN. Are there cases in which there is no finding of a pre-existing condition? And those soldiers are treated differently than Mr. Town?

Mr. KORS. Well in Town's case, as in all the others, there is no previous history. And in fact, it goes further to the way that the Army looks at how one does—how do they discover that a person had a condition that was pre-existing? Standard Army policy is to interview no one. In fact, I got a call recently from a psychiatrist at a major east coast Army facility who said that he is the only person in the in his Fort Hospital who does interview families. You know, for Town's case for example, you know, perhaps his family would of noticed if he had severe hearing loss before joining the Army.

This doctor was the one and only who did seek out families to interview to see whether it was pre-existing. He said he was ceaselessly mocked by both the Chief of Behavior Health at his Fort's hospital, and others, as being completely out of step with the Army and VA ways.

Mr. MORAN. So the finding of the condition to be pre-existing is nearly automatic in each and every case?

Mr. KORS. It is simply asserted without proof. I think that is the best—I mean you know at that point we really have to look at why

this is happening. And that was a considerable part of my 10-month investigation.

Jon Town and the others here have talked about the financial components. By preventing these wounded veterans from receiving their benefits, the military is saving $12.5 billion in disability and medical care. With that financial pressure comes political pressure. I spoke to multiple trial defense services lawyers who said the commanders at their base were pressuring doctors to falsely diagnose. What one told me he knew this was happening because the commander had come to him and confessed to doing it.

On a basic level, on simply a practical level, the hospitals there are overrun, both at the Army and the VA. And you have situations where they need to get someone out of their hair fast to free that space up for the four or five soldiers who are waiting to take it. As Frank Ochberg, the doctor who codified post traumatic stress disorder for the government said, there's a further public relations issue that even goes deeper than simply getting soldiers out of their hair. And that is making soldiers like Jon Town invisible. If Town comes back with a Purple Heart and severe problems with memory, with sleep, with headaches, we can delete him from the cost of the war if we simply say it was a pre-existing condition unrelated to his military service.

Mr. MORAN. Mr. Town, thank you very much for your service to our country. You indicate now that the VA is providing benefits to you? Is that true?

Mr. TOWN. Yes, sir.

Mr. MORAN. But are those benefits unrelated to a personality disorder?

Mr. TOWN. Correct. They actually diagnosed me with post traumatic stress disorder. The VA has.

Mr. MORAN. And are you being treated by the VA for those for that condition?

Mr. TOWN. Yes, sir.

Mr. MORAN. And the reason that you were successful or your case is no longer considered ineligible for benefits because it was pre-existing is what? Why the change? Is there some medical——

Mr. TOWN. Well——

Mr. MORAN [continuing]. Finding that allowed the VA to reach a different conclusion or——

Mr. TOWN. No.

Mr. MORAN [continuing]. They just reached a different conclusion?

Mr. TOWN. No. They just—I saw this psychiatrist for about 25 minutes when I got to the Dayton VA. And she was pretty much in tears after I had talked to her for about 25 minutes. And that was all she needed for her evaluation of what I had been going through for the last 2 years.

Mr. MORAN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Moran, just as I understand it, personality disorder is by definition pre-existing. If the other possibility is PTSD which means we gave it to you, which means you are eligible.

Mr. SULLIVAN. That is correct.

The CHAIRMAN. And, you know, Mr. Town was called, I think from a very pretty high level of in the VA, after all the publicity came out about it. He——

Mr. MORAN. The—excuse me, Mr. Chairman. But the distinction is that the VA still has not—they will still consider Mr. Town, at least initially, of having a pre-existing personality disorder. Now they have reached the conclusion he has post traumatic stress syndrome, which then qualifies him for assistance from the VA.

Mr. KORS. Congressman? That is another key issue here. The VA flatly rejected the Army's diagnosis. In cases where a soldier gets a tremendous amount of press, this often happens. He was decided after the Army decided he wasn't disabled at all the VA decided he was 100 percent disabled. And top officials at the VA explained to me why this is such a severe problem for the VA. False diagnoses of personality disorder short flagged—short circuited the VA's red flag system. That is internal VA speak for the way in which the VA keeps it's eye out for those who are severely wounded to get them immediate medical and disability benefits.

They keep their eye out by looking at the Army's medical board and who comes out of the medical board with a very high disability rating. Soldiers like Jon who got a pre-existing personality disorder are denied the opportunity to see a medical board, thus they don't get a disability rating at all, thus they fly under the VA's radar and in Jon's case, didn't receive a single doctor's visit for 8 months.

Mr. MORAN. So, Mr. Chairman, we have one diagnoses by the military and one diagnosis by the VA resulting in a different outcome?

Mr. KORS. That is right.

Mr. MORAN. Thank you.

The CHAIRMAN. Right. But that person has to come to the VA, there has to be an aggressive effort. And in conditions which make them very vulnerable and they have to fight for that new diagnosis. So fighting the bureaucracy when you are suffering from these kinds of things is not the easiest thing to do.

Mr. KORS. In Jon's case he submitted his paperwork five times before the VA decided to take up his case and look at his medical condition.

The CHAIRMAN. Thank you. Mr. Hare, you have the floor.

Mr. HARE. Thank you, Mr. Chairman. I have to tell you I am beyond even angry. I don't even know what word I can use.

Let me—I want to see if I can sum up this because this is almost surreal. As I understand it, we have over 22,000 people who have who got in the military, somehow slipped under the radar screen. Now they are being diagnosed incorrectly. Mr. Town, I am amazed that not only did they, since you obviously weren't wounded according to them, that not only they asked for $3,000 I am surprised they didn't ask for your Purple Heart back.

I think this is amazing. And so if I get this straight then, nobody has reviewed any of these cases for any of these people at all, but they made up the fact that they did. They, someone in the military or some has said, that they interviewed these people. Nobody, not one person has been talked to about this. And their lives and their families and everybody is affected. And not one person. So I guess what I would like to understand is, and maybe somebody on the

panel could help me out here, in your opinion, did this really say to treat people like Mr. Town and thousands of other people to save $12.5 billion in savings that they don't have to pay out? And then you had to try to get this five times on your own? And what about the people that give up or they feel frustrated that some how—and now we are suing the veterans once again, have to go back and sue people because of the way they are being treated. Unbelievable.

And I want to commend you, Mr. Kors, for your reporting on this issue. I know this is just maybe an opinion I would like to get from you. Are you after doing this investigation convinced that the reason that these people that this happened to them was they were just trying to get out of saving $12.5 billion?

Mr. KORS. I think there are a multitude of reasons. And, you know, it goes from the ground level to the top level. I think where the pressure on the commanders to pressure the doctors to purposely misdiagnose comes from. That is something that, you know, perhaps we are here today to look at.

You are absolutely right that the 22,500 soldiers in the last 6 years, none of them had been looked at. Not the 5,600 from the Army itself, or the of the stack of cases directly presented to the Surgeon General. I think another key feature we need to look at when we are figuring out how this happened is to talk at a ground level how this goes from doctor to soldier. As Specialist Town said, he like every soldier I looked at was directly lied to by their military doctor. The doctor would say, "If you accept the personality disorder discharge you will get disability pay, you will get VA medical care, you will get to keep your signing bonus for the years that you are too wounded to serve." Their final day as they are walking out the door, their last day in uniform, they find out none of those promises are true.

For the soldiers that further resist, those block of soldiers all told me of an arm twisting tactic that the doctors would use. They would say, "Look, you know you don't have a personality disorder, we know you don't have a personality disorder. But if you accept this discharge we can get you out in a few days whereas if go for medical board, it will take about 6 months. Your unit is redeploying to Iraq and you are wounded. Your job in Iraq is going to be to cover your friends back. Do you really want your friends to die because you fought for further benefits? Wouldn't it be better to forget about the benefits and let your friends live."

And at that point a lot of these guys say, "Well you know, I know I don't have a personality disorder, certainly wasn't pre-existing as is mandated by the personality disorder discharge. But, you know, I care about my fellow unit members. I want them to live. Sure, I'll take it."

Mr. HARE. I will tell you this, someone mentioned that somebody needs to be held responsible for this. And whoever that somebody or someone are, I hope this Committee will thoroughly hold those people responsible. In my opinion, they have no business, absolutely no business dealing with any of these men and women in the military. I think this is shameful. Absolutely shameful. And to have to sue, you know, and thank goodness that you are doing that.

And I guess one last question, Mr. Town, and I thank you for your service and for your bravery and for your steadfastness. What do you think from your perspective, you sir, what do you think this says to the people who are currently serving? Not just to those 22,000, who is next? I mean and to the people who are going to enlist that if something happens they are going to try to duck it by mislabeling you and putting the blame on you. What do you think it says?

Mr. TOWN. Hopefully right now it says a lot and the situation gets fixed. And they take it out of the regulation. They fix the way that the veterans are receiving their disability when they get out of service and how long it takes. And people see then that the VA, the DoD, the government does care about their soldiers. And I hope there is citizens out there that are thinking about serving don't veer away from the Army. Army was, I mean you know, I would have done 40 years in the Army if I could. I loved it. Loved it to death. And hopefully that doesn't discourage anybody from joining the military or the people that are in the military right now. And the situation can get fixed in the near future so they are taken care of. Yes, sir?

Mr. HARE. Thank you.

Mr. FORRESTER. If I may, Congressman, just quickly regarding what is at the root of the problem and so to the question of who is to blame. I would like to take a step back and say that I think that this is an issue that crosses partisan lines. There is no partisan divide on this issue. Fortunately, the DoD Mental Health Task Force which reported out about a month ago has done a great service for this country. And I would, I am sure that many of you have read it, but for those who haven't I would recommend that you read it, because in this official document of the DoD Mental Health Task Force, they talk about the great magnitude of the mental health problems coming out of the war. They talk about the inadequate resources that have been devoted to treating mental health problems within the military, the poor training that exists in some cases. And then the pervasive stigma against treatment.

As people within the military mental health community will tell you, the military, as we know, is part of society. And so these are in some ways societal problems where people haven't been well educated on the mental health needs and mental health, proper mental health treatment as for instance, your bill works to address some of these issues. Once again, I am heartened by the fact that in the Senate—while Senator Obama was quite prominent in the proposing of this amendment to have a moratorium on PD dismissals—as we know, the letter calling for this was signed by 31 Senators. This is a bipartisan group. Fortunately the four offices that lead on this issue in the Senate are Senator Christopher Bond from Missouri, Senator Joe Lieberman from Connecticut, Senator Barbara Boxer from California, and then Senator Obama among others. So just to tell you, those four offices, putting those four offices together shows that this is not a partisan issue, this is an issue that we as a country are beginning to recognize the magnitude and as I said, fortunately, documents such as the DoD Mental Health Task Force, we will just call it an achievable vision have helped to lay out the path forward.

Mr. HARE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Lamborn?

Mr. LAMBORN. Thank you, Mr. Chairman. Mr. Kors, this is a very important issue and I want to look at the numbers that you are using to make sure that we are using the best numbers possible.

You talk about 22,500 soldiers. Now I see that from your table on page three that you are including in that number of Army, Air Force, Navy, and Marines.

Mr. KORS. That is right. The 22,500 from the last 6 years that spans the entire Armed Forces. You can see how this is a problem that is crossed services lines. In the last 6 years in just the Army, it is 5,631.

Mr. LAMBORN. Okay. Now out of that those troops, how many of them that were discharged under the Chapter for personality disorder do you believe had PTSD?

Mr. KORS. We don't know. We don't know. Having reported on this issue and looking at dozens of cases, all of the soldiers either had PTSD or like in Jon's case, traumatic brain injury. But who exactly these people are I think is precisely why we are here today.

Mr. LAMBORN. Okay. I have only got 5 minutes so I will have to interrupt here. Now of that 22,500 I noticed that 8,000 are Army and Marines. And 14,000 are Air Force and Navy. Now I think you would agree with me that the brunt of the ground combat has been the Army and Marines. Our Air Force and Navy have done really wonderful on other things, but the brunt of the ground combat are of those two branches of the services. And of those 8,000, how many of them do you think had PTSD versus pre-existing personality disorder?

Mr. KORS. I just don't know. Those figures simply don't exist yet because no one is looking.

Mr. LAMBORN. Now the 14,000 who were Air Force and Navy, do you think that they had post traumatic stress disorder?

Mr. KORS. You know, part of the difficulty of finding out the answers to those questions is that getting access to the medical records for those soldiers has been locked off to the media. It has only been soldiers like Jon Town who have bravely stepped forward or internal people like Jeff Peskoff who processed these personality cases——

Mr. LAMBORN. Okay. Thanks.

Mr. KORS [continuing]. Come forward——

Mr. LAMBORN. Okay. Thank you.

Mr. KORS [continuing]. That shares these numbers.

Mr. LAMBORN. Now without seeing all of these individually, I don't know the answer either, but is it more likely that PTSD is associated with ground combat, even though it can probably come from a lot of different other reasons, but is it a safe assumption that it is more associated with ground combat and the experiences, the traumatic experiences, suffered in ground combat as opposed to some of the other military service experiences?

Mr. KORS. I think that is a safe assumption. The soldiers I looked at all had served in Iraq came back changed by that experience.

Mr. LAMBORN. And you used the years 2001 and 2002 in this same table, but the current conflict in Iraq started in 2003. So wouldn't it be more accurate to start it from 2003 forward? And if you did that you would have 5,500 instead of 8,000. I mean would that be a fair gloss to put on this number?

Mr. KORS. If you wanted to look at that segment, I mean, that would certainly be, you know, a good approach as well.

Mr. LAMBORN. Okay. Well anyway I just wanted to ask those questions, Mr. Kors, because 22,500 tells me something different than, you know, 5,500.

Mr. KORS. Uh huh.

Mr. LAMBORN. Either way, this is a vital thing and I do wish we were working with the Armed Services Committee on this as well, but we are not, so we will do what we can. But thank you all for being here today.

Mr. KORS. Thank you.

Mr. FORRESTER. May I quickly add, Mr. Chairman? The GAO—there is—I am sorry Congressman Lamborn. But there is a GAO investigation afoot that is asking the kind of questions that you are asking right now. And we have and among others we have been in touch with them and they have asked for input. So we are hopeful that within the next few months they will release their report and that they will be able to provide a lot more information on this.

I know that one of the criteria that they are looking at is have the regulations been followed when PD discharges have been affected. And so once we start to get that sort of level of detail, I am hopeful that we will have a much better understanding of the numbers.

Mr. LAMBORN. Okay. Thank you all for being here today.

Mr. TOWN. Thank you.

Mr. LAMBORN. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Lamborn. Let me make clear, by the way, that we are working with the Armed Services Committee. They just could not schedule either a Subcommittee and our Full Committee before the August recess, and I thought it was important for us to hear about this problem. So we are working with them and we will continue to do that.

Mr. McNerney is next, please.

Mr. MCNERNEY. Thank you, Mr. Chairman. First of all, I want to thank Mr. Town and all the active duty members in the audience and all the veterans in the audience for their service. It is difficult to listen to what we have heard today without feeling something is amiss here. And it is going to be our duty to get to the bottom of that and to find out what the proper course of treatment is.

There is something in particular that is bothering me a little bit about the data that you have presented here Mr. Kors, in your presentation. It looks to me like the rate of examining or coming up with this discharge, this personality disorder discharge, hasn't increased that much since the start of the war.

Mr. KORS. Uh huh.

Mr. MCNERNEY. Now that tells me that this problem or this treatment of servicemembers has been going on for a long time before the war started. Could you address that please?

Mr. KORS. Absolutely. I spoke with a psychiatrist who had been looking at this personality disorder issue, you know, back as far as the Vietnam era and said this has been a common thing. We see this outside the military as well with insurance problems people discovering pre-existing conditions as a way of not paying. It is a longstanding problem.

Mr. MCNERNEY. So the war itself hasn't been something that has caused a large increase in this sort of treatment, is that true?

Mr. KORS. Well, the numbers on a broad scale would say not. I think at individual installations it is, it has. We look at Ft. Carson where Jon Town is from. Jeff Peskoff who stepped forward for our Night Line broadcast and talked about the discharges there. He said that it started off normal and then at one point he was getting two or three personality discharges a day. Then he say the numbers sharply rise in recent years.

So how that averages out over, you know, Ft. Campbell, Ft. Polk, all the other installations, we just don't know at this point.

Mr. MCNERNEY. Well it is certainly incumbent upon us to make sure that no servicemembers are treated in an inappropriate way. I am just trying to understand if we look at the numbers for the Air Force, they are higher before the war and the Navy, then they decrease, whereas, the Army—excuse me—seems to increase. So we, as a Committee, need to look at this pattern. If it has been continuing on since the Vietnam war, how many of people have been mistreated like this? And if not, what is the appropriate way to describe the situation?

Mr. KORS. Frank Ofberg, the doctor I referred to earlier who codified post traumatic stress disorder, he said in the olden days it was actually much worse when there was no such thing as post traumatic stress disorder. He said at that point you either got a false personality disorder diagnosis or nothing. There was no alternative. At least now, some lucky few who fight aggressively are able to reach a medical board and get disability pay.

Mr. MCNERNEY. Thank you, Mr. Kors.

The CHAIRMAN. Thank you, Mr. McNerney. Mr. Brown?

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. Thanks for holding this hearing today. And it has just been very informative for me and I know, and as personal note my brother-in-law had PTSD and his last few years on Earth was not very pleasant. And so, we understand the need for it and this is something that we have been addressing for some time. Thank you for coming and help sharing some of the information that has, you know, surrounded that issue.

Mr. Sullivan, are you a veteran?

Mr. SULLIVAN. Yes. I am an Army veteran. I served in the First Armor Division as a cavalry scout in the invasion of Iraq in 1991.

Mr. BROWN OF SOUTH CAROLINA. Okay. My question is, and I guess like Mr. McNerney, is looking at those numbers that, you know, before the Iraqi conflict and after Iraqi conflict, is there a good pre-screening for the enlistees that come into the military to be sure there are no pre-existing conditions?

Mr. SULLIVAN. Is that addressed to me or to——

Mr. BROWN OF SOUTH CAROLINA. Yes. Yes. To you. Anybody who wants to answer. I guess I am trying to get a handle of how the

numbers really hadn't changed very much on a yearly basis, but before and after the conflict. And so, I am just trying to look for some other reasoning in this questioning. So I am just going to start with that. I have got some other follow ups on that too.

Mr. SULLIVAN. Thank you, Congressman. What Veterans for Common Sense is doing is asking for the investigation. We know that there is a GAO investigation that started on this. Our concern is this: Is deployment one of the factors in the personality disorder diagnosis discharge? We are concerned that it may be impacted at specific military installations like Ft. Carson where it may be going up. And it may be masked by decreases at other locations.

So, Congressman, we won't know until there has been a thorough analysis. What that Joshua Kors has done is provide the initial statistics to indicate that there is a problem. What we need is some further analysis to make sure we get at the why. And then as soon as we know that, then we can begin to correct it.

That is why we also called for a moratorium on the Personality disorder discharges until they can figure out what is going on.

Mr. BROWN OF SOUTH CAROLINA. And I guess that is what raised the question to me is that is there something in the military lifestyle that maybe I know that the battle weariness is certainly one of those components. But or is there something that is in training or something that is involved in the military that would, you know, would influence the PTSD? And I guess that is since those numbers certainly don't seem to move very much whether we are at war or not at war, there must be some underlying other reasons that influence PTSD. I know you know certainly with the Mr. Town, I can understand his. But there are other events that must influence you know PTSD too. And I guess that is a broader range and I don't whether Mr. Kors whether he actually looked at that or not or whether he was just focused, just on the those influenced by some level of battle.

Mr. KORS. Pardon me. Whether I looked at what now?

Mr. BROWN OF SOUTH CAROLINA. The overall picture. You saw those numbers, right? That they the numbers really have not moved much prior to the conflict in Iraq and the years, the last 3 years coming up to that. And I have, you know, so I was—I am just kind of concerned that if there are some other major issues out there in the military that would influence causing PTSD other than just being a part of the battle conflict.

Mr. KORS. I just can't say. And I should back up Paul's comment by saying it is not just important to talk about the why, but the who. Who are these, you know, 22,000 people? Who are these 5,600 from the Army? I know the veterans groups like Paul has expressed to me. There is a hope that not only will we look to Obama's amendment to stop this from happening, but to go back and look at the thousands of other Jon Towns who need help right now.

Mr. BROWN OF SOUTH CAROLINA. And let me say, I am very sympathetic for that. And I think we have got to address that. But what I am more concerned with, not more concerned with, but absolutely concerned with is, is there, if we can some how eliminate the cause.

Mr. FORRESTER. Congressman, if I may? To this question of what causes PTSD, the Mental Health Advisory Team, MHAT IV. Well there have been four of them now. This is done by the Army Surgeon General's office. They have done detailed studies on what is happening in theater at present and how combat experiences among other stresses, family stresses, combat, and so forth, are affecting the mental health.

And this is once again a good resource that we have and that I think will be fed into these GAO studies and others to get a better idea of how this whole system fits together from CONAS to theater and back. The DoD Mental Health Task Force, when they talked about the resource problem, they talked about a lot of the mental health resources having been surged into the field as people would expect. So that has a left a deficiency in the United States and a lot of the military facilities.

And fortunately, and I know Ft. Carson has been raised a number of times, but to take Ft. Carson, the leaders at Ft. Carson are talking about increasing the number of mental health providers. They know they have a mess on their hands——

Mr. BROWN OF SOUTH CAROLINA. Right.

Mr. FORRESTER [continuing]. And they are doing what they can to address it. So as we all know it is a mini—a multi faceted problem and so hopefully after more study we will have a better idea of how it all fits together.

Mr. BROWN OF SOUTH CAROLINA. Well let me say, thank you very much for coming and thank you Mr. Town for your perseverance on this. And although I know that you are one of 22,000, at least you know you have been able to get your message. And we certainly have a commitment to those other 22,000 to be sure their needs are being met too.

But I just wanted to put in there a caveat too that we would like to be able to help solve the recurrent problem, whatever it is in the military to be sure that those lifestyles are being addressed that would help prevent more. I know you had a particular incident that you can relate to, but maybe a lot of others can't. But it is certainly a major concern. It has been a major concern of mine since I have been on this Committee for 7 years. And I appreciate you all's advocacy on it.

And thank you all for being here. Thank you, Mr. Chairman.

Mr. SULLIVAN. Congressman Brown, if I could add one other point. Not only is combat one of the important variables, we also have an increase in sexual assault and rape both of women and men, servicemen and women in theater. And that can also play a role in the development of PTSD and someone who went to a war zone. And sometimes someone who did go to a war zone.

Mr. TOWN. And, sir, I actually have a comment as well. As far as the screening that you were asking about. I was screened prior to coming into the military. I was screened prior to PCSing to Korea. I was screened prior to deploying to Iraq. I was screened when I came back from Iraq and that is when I was diagnosed with a personality disorder.

Mr. BROWN OF SOUTH CAROLINA. So the other screening's reflected no indication at all?

Mr. TOWN. Correct.

Mr. BROWN OF SOUTH CAROLINA. Okay. Thank you very much.

The CHAIRMAN. Thank you, Mr. Brown. Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you, Mr. Chairman. And first I want to personally thank you for holding this hearing and I am glad you didn't wait. And I am really concerned and I think that it might even be worse because if someone is diagnosing and is doing it for the purpose and knows full well that the purposes are to try to just come up with then there is no doubt that they could be doing that on other diagnoses. I know that if my son or daughter were diagnosed in this way that I would quickly ask for a second opinion if not a third. I am interested in the recommendations that you have, Mr. Sullivan, and I know the Chairman has already touched upon them, about trying to come up with a way for our soldieries who fall under a war zone to automatically have to go through some process of assessment so that they won't be a—there won't be a stigma to that. And just make it a mandatory kind of approach that that would be doing.

Does your lawsuit include the Department of Defense and the VA or is it just the VA?

Mr. SULLIVAN. At this time the lawsuit, I have a copy of it with me if you want to see it, is against the Department of Veterans Affairs, but it also includes the Department of Justice and some of their responsibilities.

Mr. RODRIGUEZ. The DoD. Now you also asked, you know, and I agree that we need to go back and reassess, not just those 22 because once again if there is a psychiatrist there that has diagnosed them wrong, whatever other diagnosis ought to be in question. You know and so I think that we have a more serious situation.

I had done some studies when I taught 11 years at the School of Social Work, and I knew that there were some disparities and discriminatory practices as it dealt with certain diagnosis when it came to women or African Americans and those kind—have you picked up on any types of disparities besides you know individuals and PTSD?

Mr. KORS. On racial or gender lines I haven't. But you make a very strong point about the doctors themselves. I am so glad you asked that.

As I mentioned before, Surgeon General Gale Pollock tapped Colonel Steven Knorr, the Chief of Behavior Health at Ft. Carson, as the one and only reviewer. And when we look at who he is, I think that is critical. National Public Radio's Daniel Zwerdling, an award winning reporter, wrote a fantastic recent piece about Knorr as this key figure in this national review. And I just want to read a small snippet of that.

"Knorr has written a memo warning commanders that trying to save every soldier is 'A mistake.' We can't fix every soldier, Knorr's memo states, we have to hold soldiers accountable for their behavior. Everyone in life besides babies, the insane, the demented and the mentally retarded has to be held accountable for what they do in life."

Knorr's memo, which he posted on his office's bulletin board, also warns commanders not to make another mistake. "Procrastination on discipline and separation, translation, officers should get rid of troubled soldiers quickly."

He seems a strange choice to be the one and only person to look at these issues.

Mr. RODRIGUEZ. And it is unfortunate. I want to personally thank you, Mr. Town, for being here with us. I want to personally thank you for your service to our country and for what you are doing now, and because I know that it will have an impact in terms of what are we going to be doing to making sure that we do the right thing and start in that direction.

And so—yes, sir?

Mr. FORRESTER. If I may, very quickly add, Congressman regarding your question about the racial and or sexual issues within the military. At present the Wounded Warrior Bill in the Senate has a provision calling for a comprehensive study of the readjustment needs of this generation of servicemembers and veterans. This amendment was unanimously approved by the Senate Armed Services Committee about a month ago. And was also later approved on the Floor and we are hopeful that it will make its way to Conference eventually.

This study would get at the kind of questions that you are asking. Let us look at our military from top to bottom. Those people who are coming out of these wars, as we know each war creates a unique set of needs. And so our argument is that we should not wait a decade as we did after the Vietnam war to do a national study of the readjustment needs of this generation and all—and there are many diverse parts as we know.

And so I would also urge Members of this Committee to consider this provision which there may be a House version introduced soon as well.

Mr. RODRIGUEZ. And I agree. And that there is also a large number of individuals afterward that have committed suicide. And that is something that we all need to look at. I know I heard a personal story about a soldier that supposedly committed suicide in Iraq, and was treated very differently from the other soldiers that have lost their lives. And of course the family is devastated.

And so I am still trying to get a personal assessment of that since the parents had a discussion with the soldier the day before, and all indications were that things were okay. So once again, let me thank the entire panel for what you are doing here and hopefully we will get to the bottom of it. Thank you.

The CHAIRMAN. Thank you. Mr. Stearns. Okay. I have the list if you want to change, that's fine. Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you, Mr. Chairman. There certainly, when reading through the testimony, I didn't, Mr. Kors I have to say I did not see the television show. But reading through the testimony, certainly I am glad that the Chairman said that he is working with the Armed Services Committee, because this clearly is a Department of Defense situation.

The CHAIRMAN. Ms. Brown-Waite, if you could use the microphone. Thank you.

Ms. BROWN-WAITE. Certainly. It is a Department of Defense situation where they made that decision. But, Mr. Kors, I want to ask you a question. I am completely diametrically opposite to this. I had a constituent who had been diagnosed with personality disorder. Turned 18. Went to the local recruiter and the local recruiter

said stop taking your medicine, do not tell anyone. This very impressionable 18 year old got into the military. Had a nervous break down. Parents and grandparents both contacted me.

Had you the opportunity to look into this at all about recruiters misleading those people before they join, as an incitement to join getting them to not take their medication because some of the recruiters are desperate. If you could answer that.

Mr. KORS. Congresswoman, I am glad you mentioned that. Just recently my conversation with that psychiatrist from the prominent east coast Army facility, he talked about that approach to recruiting soldiers, warm bodies as they call it with the recruiting shortage that we are facing now because of the Iraq war. He quoted his Chief of Behavior Health at the Hospital as phrasing it this way: Regardless of what their problems are, if they are not homicidal or suicidal, let's get them to Iraq. If they can't function anymore, as was the case with Jon's memory loss, let's find a way to slip them out the side door with a pre-existing condition.

Ms. BROWN-WAITE. You know it is very interesting because specifically what happened was this young man only spent out of 2½ months, he only spent 2 weeks in boot camp. The rest of the time they were paying for him to be in a private facility. I was talking with the brass and saying to them, I can get you his previous mental health records. This recruiter, by the way who only got a slap on the wrist, who really encouraged him first of all to stop taking his medication and to virtually lie to get into the military. I can't help but believe that this doesn't happen more often.

And then, when he was in, it was a "he is here and we are going to make a man out of him. You are not getting him out." Well the parents went and contacted the Army. My office contacted the Army. I spoke to his commanding officer who basically said "he is here, he is ours, you are not getting him back. If he lied, he committed fraud. We will bring him up on charges, but we are not letting him go."

It was last summer I spent a great deal of my summer fighting for this young man who never ever should of been enlisted in the military. And when, you know, when this issue goes before the Armed Services Committee, Mr. Chairman, I hope that you will also make sure that that issue is brought up. That is a serious problem. The one thing that I said was, "So you are willing to spend almost $1,000 a day to keep this young man in a private facility, when you would not want him next to you on the battlefield," because certainly the multiple mental health issues that he had do not make him any where near fit for the military, let alone to go into a war zone.

It was it really was—he at that point was a captured prisoner by the U.S. Army. So I do hope that we will also look into that situation where truly he had a personality disorder. They had him and they were not going to let him go. So it is 180 degrees from the situation with Mr. Town.

But let me ask one other question.

Mr. KORS. Congresswoman? I just——

Ms. BROWN-WAITE. Yes.

Mr. KORS [continuing]. Can I address that issue? The accusation you highlighted that the soldiers lied during their incoming screen-

ing is, has really been, the salt in the wounds for these disabled soldiers.

Ms. BROWN-WAITE. I didn't say that.

Mr. KORS. No, no. No. This is what the——

Ms. BROWN-WAITE. Right.

Mr. KORS. No, no, no. You meant you quoted——

Ms. BROWN-WAITE. Right.

Mr. KORS [continuing]. The Army officer as saying that. And that has been a common refrain from the upper brass of the military in ourNightline piece. Surgeon General Gal Pollock's top psychiatric official Ellsbeth Richey quoted that accusation as really the only understanding of how these soldiers with the severe psychological pre-condition could get into the military, they simply didn't cough up the information during their initial screening.

Ms. BROWN-WAITE. One other question, Mr. Chairman, if you will indulge me. I also have heard from some in the mental health community who are treating veterans with PTSD who are telling me that in an effort to save some money, that the VA has gone to a 13-session PTSD module. And it really is a module of treatment that is meant for a sexual abuse or a rape victim. Have you at all, anybody on the panel, also been aware of that phenomena?

Mr. KORS. No.

Ms. BROWN-WAITE. Okay.

Mr. FORRESTER. No, ma'am.

Ms. BROWN-WAITE. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. Thank you. Ms. Herseth Sandlin?

Ms. HERSETH SANDLIN. Thank you, Mr. Chairman. And I too want to thank you for this very important hearing and thank each of our witnesses today for their very unique and important roles in bringing attention to this very serious matter. And I have a few statements that I think are necessary for the record before posing some questions based on the discussion that has already taken place. And I look forward to the further analysis that will be provided so that we can better identify how we target our manner of addressing this problem. I, for one, don't need any further evidence or analysis that this a problem. And if we want to focus on the numbers that is fine, but the fact that we have one individual and Mr. Town who was treated this way, whether it is 22,000 or 5,500; whether it is just from the Army and Marines or the Air Force and the Navy, which we should all acknowledge the Air Force and the Navy have contributed a number of servicemembers who have been in ground combat. So making these distinctions among the branches, making distinctions about what years we are talking about, whether we start with 2001 or 2003, I don't need any further evidence. And part of it is because we have to take this issue in the broader context of what we have been dealing with in the last few years that this is additional evidence that we were not prepared to take care of another new generation of veterans.

So we can talk about making distinctions about years and about numbers and about branches, but I think we have enough evidence already to say that this is a problem. And the further analysis will shed light on how we best address effectively solving the problem. I also think that there has been important testimony here today

about the broader context of society at large and hopefully we will make some important progress there by passing Congressman Patrick Kennedy's bill on mental health parity so that this problem can be addressed, not just in the military, not just in DoD installations and the VA facilities, but in the private insurance industry, in our public health programs, and the values issue of how we take care of one another.

I think it speaks volumes that the Surgeon General isn't here today despite the invitation to join us. Mr. Town, I can understand why the psychiatrist that you met with at the VA was in tears after about 25 minutes. When you re-enlisted in Iraq, was that after the explosion in October of 2004?

Mr. TOWN. It was before the explosion.

Ms. HERSETH SANDLIN. And all of the prior screenings that you described, was there any screening once you were in Iraq, either prior to re-enlistment or after re-enlistment?

Mr. TOWN. They had a screening 2 months after we got to Iraq. I can't be—I can't remember what it was about, but they had a screening for medical issues at that time.

Ms. HERSETH SANDLIN. Okay. And I think that either you testified or Mr. Kors you did, in addition to being diagnosed with PTSD, Mr. Town, have you also been diagnosed with traumatic brain injury?

Mr. TOWN. Yes, ma'am.

Ms. HERSETH SANDLIN. When you met with the doctor at Ft. Carson, and either you can answer this or others on the panel, if there were concerns that the doctor, the psychiatrist, at Ft. Carson had about the symptoms that you were exhibiting even though there was no diagnosis there of PTSD, but there was clearly a concern on his part about redeploying you. Were there any other options other than the personality disorder to prevent Mr. Town's redeployment?

Mr. TOWN. Soldiers can go through a medical board. And it is a little lengthy process, but you go in front of a board of medical doctors and they listen to your case. And they make a decision if you are not fit for duty or fit for duty at that time.

Ms. HERSETH SANDLIN. And thank you for explaining that and I know that is a lengthier process, but there is no other option for a treating psychiatrist other than the personality disorder or the medical board process to prevent a redeployment in the—in the case of a servicemember who is clearly suffering from the affects of prior ground combat for PTSD? Is there any other——

Mr. SULLIVAN. Well what I hear you asking for, Congresswoman, is there a second opinion? And the answer is I am not aware that there is. And one of the biggest problems facing soldiers unlike Specialist Town is that they have no advocate. It is a denial of their civil rights. It is a denial of their dignity as a human being, and an American soldier that they be provided with some assistance before being discharged for a medical reason, especially if it involves a brain injury that is clearly documented or a mental health condition.

Denying the soldier basic due process is unconscionable after they have been wounded. And if I may give this analogy: How many people here would agree that if I was in a car wreck, that

the attorney of the person who ran into me, and it was their fault of course, was at my bedside in the hospital asking me to sign paperwork on a settlement. We know that that is absolutely unethical. And what is happening in these situations because the soldiers don't have advocates, they are losing out on the due process. That needs to be fixed. Not only for the service, but also at VA.

Ms. HERSETH SANDLIN. Thank you, Mr. Sullivan. Mr. Chairman, if I might ask one quick follow up question?

The CHAIRMAN. Please.

Ms. HERSETH SANDLIN. Mr. Town, or Mr. Kors I know you are very familiar with Mr. Town's case. Did you—you said that you filed five different times with the VA before they would actually review your case?

Mr. TOWN. Yes, ma'am. I filed one a month prior to me getting out of service. One 2 months after and a month in between the next three. And the last one I filed was a month prior to the article being written in *The Nation* by Joshua. And that is when I got the call from VA that said, "Hey, we have caught wind of—we want you to come down to Dayton as soon as possible."

Ms. HERSETH SANDLIN. Thank you all. Thank you, Mr. Chairman.

Mr. KORS. I followed up with the VA on exactly how that happened. Their—the VA's explanation was pretty simple. They said, "We lost it." We lost each of those five submissions.

The CHAIRMAN. Thank you Ms. Herseth Sandlin. I ask unanimous consent to allow our colleague Congressman Patrick Kennedy to sit with us. He has been a leader on issues of mental health. Thank you for joining us. Hearing no objection. Ms. Brown, if you have one question before you have to go?

Ms. BROWN OF FLORIDA. Yes. Thank you. Thank you, Mr. Chairman for holding this hearing. And first of all let me thank Mr. Town for your service. Thank you very much. And I do have a question for you, but let me just say to Mr. Kors, it is important to see the media at the forefront of government. And when they don't do their job, this is the result, we have a failure in the system.

I always know it is more than one side, but we have to get it out there. And all of us know the amount of casework for veterans we do in our offices, when the system is giving them the run around. And we, you know the Members of Congress, we stop it for individual veterans, but the system needs to be fixed.

Let me say, Mr. Town, I have a question for you. Later we are going to hear from Colonel Crow and in his testimony he states that, "Before separation soldiers have the opportunity to consult with an attorney." And they are told about their abilities to petition the Army Discharge Review Board or the Army Board of Correction or Military Records for Administrative Review of their cases. Did this happen with you, sir?

Mr. TOWN. I did go see the Judge Advocate General (JAG). The process is as you go see JAG with your non-commissioned officer (NCO) or the person in command of you. You go over there, they say that you need to sign this paper, this paper, this paper and they give you a paper. I actually do not have that with me, but I will have to get that document. And it said what I was suppose to

get when I left the Army with this personality disorder discharge. And it had, you know, the severance pay, benefits, and free, you know, the free burial. A whole of list, a whole page and a half of stuff. And of course that was all lies and that was given to me by JAG there at Ft. Carson.

Ms. BROWN OF FLORIDA. Okay.

Mr. KORS. Congresswoman? The——

Ms. BROWN OF FLORIDA. Yes?

Mr. KORS [continuing]. Army Board of Military Correction of Records is an interesting organization I looked into. And in the past year, all the cases that I reviewed, only one was overturned in through that Board. That was the case of William Woldridge who began suffering schizophrenic delusions after he accidentally ran over a young Iraqi girl who was pushed into the road. He was hauling a supply truck and she was killed. She was about the age of his young daughter. And later in his apartment in Arkansas, he was haunted by the mangled ghost of that girl.

That condition was seen as the result of a pre-existing personality disorder and he fought it through the Army Board of Correction of Records. That case was pretty clear, not just because of the facts of the case, but also because the only reason it was overturned was because he had a top connection in Washington who worked behind the scenes at the Board to create that overturn.

Ms. BROWN OF FLORIDA. Thank you. And thank you, Mr. Chairman.

The CHAIRMAN. Mr. Stearns?

Mr. STEARNS. Yeah. Thank you, Mr. Chairman and I thank you for holding this hearing. I am a little more optimistic than the gentle lady from South Dakota when she said the VA is not prepared to take care of another generation of veterans. I think with the money and resources that we have provided them, I think they are working admirably to do that. There is going to be cases like this and this is reprehensible what happened to Mr. Town. But I think when that the VA is working diligently and I think this case is an example where there needs to be improvement. Obviously, this Committee doesn't have the full jurisdiction. The jurisdiction is in the Department of Defense and that is where the hearing should be. But we welcome the opportunity to talk about this.

Mr. Kors, you keep mentioning the 22,000 and Mr. Lamborn brought out that the 22,000 is included in that number is not even when the Iraq war had started in 2003. And he pointed out that roughly only 5,500 were actually Army/Marine combat veterans. Of the 22,000, do you know how many were combat veterans who actually served in combat?

Mr. KORS. No. And that is another key point as well.

Mr. STEARNS. Right.

Mr. KORS. Bob Woodruff and I asked that question to Colonel Ellsbeth Richey in our Nightline report and she didn't know either.

Mr. STEARNS. Do you think that is a relevant point?

Mr. KORS. I think it is. And I think a full review that hopefully could come from a hearing like this——

Mr. STEARNS. Yeah.

Mr. KORS [continuing]. Will determine just how many of those thousands of soldiers served in Iraq.

Mr. STEARNS. Colonel Bruce Crow who is coming later in this panel, has talked a little bit about statistics and he gave, for example, about 70,000 soldiers were discharged from the active Army, just the Army, in 2006. Of those discharged roughly 1,100 were separated for personality disorder of which roughly 300 of those individuals had served in a theater of combat. To the uniform civilian and contract healthcare professionals that care for soldiers, the thought of even one soldier being inappropriately discharged for personality disorder is disturbing.

So I mean, that really explains how the Veterans Administration feels too. With that in mind, in fact, the acting Surgeon General, Major General Gale Pollock, has directed each and every one of these 300 records be reviewed by behavior health professionals to verify that appropriate actions were taken and that all health concerns were considered in the discharge.

So I think the VA is well aware of this problem, and is trying to make efforts. Mr. Kors, I think in your statement, your opening statement, you indicated that perhaps the Secretary of Veterans Affairs had to step down and you linked it with Walter Reed—when you mentioned that in your previous sentence—and the Surgeon General Kiley resigning also. I don't think it is fair to say that Senator Nicholson stepped down because of the personality disorder discharges.

Mr. KORS. No. No. I certainly didn't mean it——

Mr. STEARNS. But your statement here implies it and I think you are inappropriate to indicate that in the same sentence when you talk about these other people resigning.

The CHAIRMAN. Did you say Senator Nicholson?

Mr. STEARNS. Secretary Nicholson.

The CHAIRMAN. Thank you.

Mr. STEARNS. Thank you for the correction. Yeah.

The CHAIRMAN. We were wondering why——

Mr. STEARNS. Right. Right. No. So I just if you would like in open testimony to say that is not what you implied, that would be appreciated.

Mr. KORS. I don't think that the fallout from the publicity on this issue was certainly helpful to him, but I did not mean to make a one-to-one correlation.

Mr. STEARNS. Right. And I didn't think you did, so I wanted to make sure that you had that opportunity to disclaim that.

Mr. Sullivan, when you made your suit, did you contact any VSOs to say here's the evidence, the American Legion, or any of the VSOs to say, what do you think? Just yes or no.

Mr. SULLIVAN. I would direct that question to the attorney handling the suit, Gorden Erspamer at Morrison and Foerster in San Francisco.

Mr. STEARNS. Well aren't you the one that—you are the executive director of the Veterans for Common Sense. You are making the suit, is that correct?

Mr. SULLIVAN. Yes. That is—I am not making it on my own behalf, the organization is.

Mr. STEARNS. Yeah, the organization. And you are the executive director, so you are what we call the talking head for the group. And with that in mind, did you ever call any VSO? Did you ever

contact the American Legion about this suit or the Veterans of Foreign Wars or anybody?

Mr. SULLIVAN. Again, Congressman——

Mr. STEARNS. If not, I am curious——

Mr. SULLIVAN [continuing]. I already answered the question. If you want to ask that, you can ask the lead attorney on the case. Thank you.

Mr. STEARNS. Well I think the lead attorney would be a good one to contact, but he takes his directions, I think, from the organization that is making the suit, which is the Veterans for Common Sense. So I just think that for the suit to have to be extremely valid, should also encompass some of these VSOs and their opinions, I would say.

Let me ask the last question. In reading the lawsuit you filed in Federal Court, Mr. Sullivan, it is unclear to me what you expected the court to do. Were you looking for an injunction of some kind or something else? What do you—what does your organization ultimately expect to happen?

Mr. SULLIVAN. Thank you for asking the salient question, Congressman. The bottom line goal of the suit as described in it is very simple. If a servicemember goes to war and they come back wounded, injured, ill, and they need medical care, the country has an obligation, social contract, to provide that care. They don't, the veteran should not have to file 23-page claim form. The veteran should not have to wait endlessly for Health Maintenance Organization (HMO) like decisions. The veteran should be able to see the doctor right away. We are very familiar with the case of the veteran Jonathon Shulzy in Minnesota who tried to go VA multiple times and was turned away. A very disturbing case. That shouldn't happen.

In a similar manner, the suit is looking to fix this other question. If a veteran is disabled and has difficulty working or having problems with the quality of their life and they need disability benefits, again the veteran shouldn't have to wade through endless paperwork by themselves to try to get a reasonable disability check so that they can put food on the table for their family, pay their rent, and make sure they don't go bankrupt or get foreclosed. It is a very solemn obligation our country has with that veteran. And we want to make sure that the veterans have their civil rights protected as individuals, that they get the due process that they earned. For example, having an attorney when they initially file a claim so that when they want to be able to get the healthcare and benefits they earned, they don't have to wait.

These are basic, common sense, human dignity issues. And we can talk about numbers, Congressmen, or who is on the suit or who is not. The court issue right now that the backlog of claims is soaring. It is taking longer for veterans to get their disability checks. Veterans are being turned away because some VA facilities don't have mental healthcare. And that is according to VA's own top officials.

Those two things need to be fixed, Congressman. We went through some of this with the gulf war where veterans were coming back and if we had problems trying to get care. And I remember working at VA and when I saw the numbers coming in on men-

tal healthcare and some other disabilities, I used facts and numbers and what I thought was very thorough analysis to send up a red warning flag that the crisis had hit VA. And unfortunately VA did not ramp up in 2004, in 2005. And we are suffering the consequences now for the failure to act earlier.

The suit will have the purpose of not allowing addressing this issue in court, which every American has the right to do, but the suit will also raise the issue in the court of public opinion, because at the end of the day, the people run the country. And if they start call their Congressmen and their Senators and saying, "Lets make sure that veteran gets his healthcare. Lets make sure that veteran gets his disability benefit." Then we also served another purpose. And that is what I hope we can do what we can do with the suit.

Mr. STEARNS. Thank you, Mr. Chairman.

Mr. KENNEDY. If I could speak out of order. I believe this lawsuit is a catalyst to get the VA to work with community mental health providers to get the necessary mental health to our veterans yesterday and today that they can't postpone any longer. The VA is not at capacity right now. As you know, this Congress appropriated $500 million in last year's supplemental for mental health that the VA was not able to expend because it didn't have the mental health professionals to hire.

The reason they couldn't hire them is that they weren't out there. They shouldn't be hiring them, they should be contracting out with existing mental health providers already in the community. But guess what? The VA doesn't want to contract out because the VA wants to keep everything in-house because they are so insular. Because no one wants to share their turf. And who is suffering because of this turf battle but the veterans. And I hope as a member of the Milcon VA Appropriations Subcommittee, that in the conference, that we get to put this Committee's authorizing language allowing for the VA to share resources with outside mental health providers into the Milcon VA Appropriations Conference Committee Report so that we can force the VA to contract with outside mental health providers, in this Conference Committee Report that will be coming up.

And I thank you, Mr. Sullivan, for instigating this lawsuit.

Mr. BUYER. Will the gentleman yield?

Mr. KENNEDY. Yes. Be happy to yield.

Mr. BUYER. Mr. Kennedy, I will work with you and I work with Mr. Michaud. Before you came in, that was Mr. Michaud's point in particular to try to be persuasive to the VA to do more contracting of care. It shouldn't just for mental health, but for many other types of rehabilitative——

Mr. KENNEDY. Absolutely.

Mr. BUYER [continuing]. Services and I will work with the gentleman.

Mr. KENNEDY. Absolutely. Thank you.

The CHAIRMAN. Thank you, Mr. Kennedy and thank you for your leadership on this.

Mr. Baker.

Mr. BAKER. Thank you, Mr. Chairman.

The CHAIRMAN. We just had—Mr. Donnelly is next. And then you.

Mr. DONNELLY. Thank you, Mr. Chairman. And thank you Mr. Town for your service and to all the veterans here.

I wanted to ask you, Mr. Town, you were diagnosed with traumatic brain injury, is that correct?

Mr. TOWN. Correct.

Mr. DONNELLY. When you were leaving the service, what options did they tell you you had in regards to treatment for your traumatic brain injury?

Mr. TOWN. Dr. Wexler, the psychiatrist that I was going to, he stated that when I got out the VA would take care of me.

Mr. DONNELLY. Did he tell you that there were specific VA centers that specialized in traumatic brain injury?

Mr. TOWN. No.

Mr. DONNELLY. Okay. Did they ever indicate to you while you were still on active duty that you had an option to go to places like the Chicago Rehabilitation Institute?

Mr. TOWN. No.

Mr. DONNELLY. It was pretty much just said the VA can work with you and good luck?

Mr. TOWN. Pretty much. Yes, sir.

Mr. DONNELLY. Secondly, when did you first see the terms of your termination? You indicated that you worked with JAG. When did they first start to tell you, "Here are the terms that you will go out under."

Mr. TOWN. When I saw JAG they showed me the terms of the benefits that I was going to receive when I left the service, but the day I actually left the service is when I found out what the real benefits were and that it was a pre-existing condition. That was the first time I ever found out that is was a pre-existing condition to me being in the military, thus meaning it is not service connected.

Mr. DONNELLY. Did you have a copy of what they had previously promised you?

Mr. TOWN. Yes. I have a copy, not with me. I have to get that out. I will get that.

Mr. DONNELLY. And at the time you were leaving the service did you say, "Hey, listen, I have got a whole different plan here that was promised to me."

Mr. TOWN. Yes, sir.

Mr. DONNELLY. And their response was?

Mr. TOWN. That they didn't have a responce. The gentleman who does the final out has actually come forth and done interviews now. And the day I was signing out he actually gave me IAVA's card and said that they had been doing this injustice by what they were doing to the veterans that are getting out of the service. And suggested that I call IAVA and talk to them and see what I could do about this situation.

Mr. DONNELLY. So the gentleman signing you out at the time he was signing you out basically told you that you were getting a raw deal?

Mr. TOWN. Yes, sir.

Mr. DONNELLY. Okay. And you showed him and you said, "Listen, I have been promised other terms." He said those terms are no longer applicable?

Mr. TOWN. Correct. And then he showed me the paperwork that said I had a re-enlistment bonus that I needed to pay back. They were going to only let me sell back 30 days of my leave and all that was going to go to my debt. And then I still owed $3,000 to the military.

Mr. DONNELLY. And when you were first told about the terms that were so different from the final terms, did they give you any documents to sign off at, at that time, or how long before your final departure did you finally get the documents that said, "These are the final terms. Sign here."

Mr. TOWN. That day.

Mr. DONNELLY. No 24-hour buyer's remorse?

Mr. TOWN. No. It was that day.

Mr. DONNELLY. Okay. Again, thank you very much for your service and to all of you for being here today.

Mr. TOWN. Thank you, sir.

The CHAIRMAN. Thank you, Mr. Donnelly. Mr. Baker?

Mr. BAKER. Thank you, Mr. Chairman. First, just a brief report to the Ranking Member and Chairman and we still don't have a decision on the VA hospital replacement in New Orleans between the State and the VA. Just want to keep the Chairman's attention on that matter.

Having said that, let me express deep concern for the reports of the mistreatment and negligent behavior that appears to have occurred on significant number of occasions. I do not believe one case is an acceptable outcome that results in someone's claims not being adequately met. But I do think it important to balance the hearing record to some extent in recognizing at least for the VA, the Committee has responsibility for that enterprise only in this matter. That it is an entity made up of significantly higher number of veterans being employed, almost 33 percent. There is about 220,000 employees. That means within the walls of that agency describing it nationally, there are in excess of 72,000 veterans. I cannot imagine anyone who is more dedicated to the adequate and fair treatment of veterans than veterans.

Of the residual number of employees, many an excessive number, are lifetime people committed to serving the military veterans of this Nation. I would not want us to leave the hearing today and have the words in part of the written testimony the unconscionable, outrageous, intentional actions taken by the Department of Veterans Affairs to prevent Iraq and Afghanistan war veterans from receiving prompt care and disability compensation to be the only statement with regard to the performance of this agency.

Reading from one of the witnesses own comments citing as of June 2007, 202,000 Iraq and Afghan war veterans have made disability claims. As of June 2007, 157,00 had been satisfied. That is a 77-percent rate of those who have applied, have gotten some resolution. So I say on behalf of the decent people trying to do the right thing with perhaps limited resources, yeah, we don't get it right all the time, but I am not willing to throw them all out on the street and say they are all a bunch of thugs trying to beat people out of their just due.

I am here simply to say lets move in a measured pace; lets find out those who have acted in an unprofessional and irresponsible

manner; lets provide the consequences for that conduct, but not at the same time disregard the service of those who have put their own life on the line and who are now serving within the agency at a number in excess of 72,000 people.

I yield back.

The CHAIRMAN. Thank you, Mr. Baker. Mr. Hall?

Mr. HALL. Thank you, Mr. Chairman. And thank you, Mr. Town and the rest of our panel for your presence and your testimony and your service.

I would point out to my colleague, Mr. Baker, at 77 percent a rate of applicants who are satisfied with the result is good, but not necessarily in most schools considered excellent. And I would hope that when it comes time this September for bonuses to be given to those in the top brass of the VA, that they will be given for excellent performance, not just merely for passing performance.

I have a couple of stories to relate for my district. Last night, there was a hearing of the CARES (Capital Asset Realignment for Enhanced Services) Commission at the Montrose New York VA Center. And I just asked my district director, has sent me a report, because I of course couldn't be there. And she said there was a lot of anger from vets as to how they are being treated by the VA and the process. They feel a decision has already been made to move service and sell off the land despite all their testimony and opposition. This is a facility in Westchester County, the most affluent county in New York; the most affluent county in my district; one of I think five of the most affluent counties in the country where there is a homeless population made up about 23 percent of veterans on the street.

And the facilities that they are planning to close and possibly we understand sell off to private, you know, condos or townhomes along the Hudson River. It is beautiful. You can see why a developer would want to acquire this property. It is currently treating psychiatric cases and PTSD and my belief and that of the veterans in my district is that the taxpayer of this country paid for these facilities to take care of veterans that we are just beginning now to understand the gravity and the size of the problem that we are going to be dealing with returning veterans from the Iraq and Afghanistan wars.

We are hearing stories of diplomats having PTSD. Of truck drivers for contractors having PTSD. Of families and children having PTSD because of the repeated stress, the repeated deployments and seeing on the news explosions and burning and bodies and not knowing if it is their daddy. When you are a child, it is much easier to be affected severely by these things than when you are a supposedly rational adult.

I also wanted to mention the case, one of many like all of us who we deal with veterans cases in our districts, and we recently had a soldier who had just left the service and become a VA client, Alex Lazos who was being kept in a VA hospital for extended time for treatment and was about to be released. He had witnessed the death of an Iraqi girl in the cross fire, held her while she died. And then came back here and was having nightmares and was being told that he was okay. And that he was not eligible for classification. And he was given a zero rating. And called our office. He

shouldn't have to call his Congressman, but he did and I am glad that the people in my office were capable and got him a 100 percent rating. And he is now getting the treatment that he needs and the medical and psychiatric treatment and also the disability compensation that he needs while he puts his life back together.

And, you know, we are talking about people, we are talking about the on-going impact and expense of a war which was a war of choice. And the longer we stay in this war the more expensive it is going to be in both human and financial terms.

I am curious to get to questions about, and maybe Mr. Sullivan you might know this or other panel members, how many of the soldiers are released so far and since 2001 or 2003, whatever the average is, with other than honorable discharges?

Mr. SULLIVAN. Congressman, we have requested that information under the Freedom of Information Act. However, we have not received a full response. I do believe there is pending legislation, H.R. 1354 in the House, and in the Senate it is S. 117. It recognizes and honors the former Ranking Member of the Committee, Congressman Lane Evans. And it calls for a thorough set of data to be gathered by VA military. And it calls for extensive reports on the financial and human cost of the war. And of the things——

Mr. HALL. Okay. And I——

Mr. SULLIVAN [continuing]. That that bill calls for is information on the types of discharges.

Mr. HALL. Thank you. My time is running out so I just wanted to, I am sorry to interrupt you, but noting that I believe it is Mr. Forrester's testimony said that 49 percent of Guard members, 38 percent of soldiers, and 31 percent of Marines are experiencing some mental health issues after serving in OIF/OEF. After the Vietnam War, it turned out to be in some cases years, decades even, before soldiers came forward and were diagnosed with PTSD.

So I would guess that those numbers are going to go up. And I, too, would associate myself with the comments of the Ranking Member and Mr. Kennedy and Mr. Michaud and I believe the Chairman and others who will hope to use private resources that are available and that are coming forward and offering to help so that we can make sure that our veterans get help in the timely fashion that they deserve.

I yield back, Mr. Chairman. Thank you.

Mr. KORS. Congressman? If I could address the story you told about your constituent, it was very sad about the soldier who was denied, as you were remarking, after watching that child die. It was stories like that, that we came across in our year of reporting that was a tip off to myself and to the Army Times and to other journalist who have looked into this personality disorder issue. That there were questions of leadership here. Not just with Surgeon General Pollock, but down the line. I think about the review of personality disorder cases at Ft. Carson. When this story broke they went back, they said, and did a review of 56 more personality disorder cases at Ft. Carson. Again, in which nobody, not even the soldiers themselves were interviewed. They determined all of those cases to be properly diagnosed, but they noted to me that they could only find 52 of the cases. I asked the leaders at Ft. Carson how they knew the other four were properly diagnosed when they

had lost or misplaced them. And they said they couldn't answer that question.

The CHAIRMAN. Thank you, Mr. Hall. Mr. Buyer?

Mr. BUYER. I am neither a doctor of psychology nor of a psychiatrist and I look forward to the testimony of Dr. Kilpatrick and Dr. Satel.

Let me ask this question: To our reporter, I found this very interesting, but I just can't ever remember a reporter testifying before Congress and sitting on a first panel. Very peculiar. Is personality disorder a recognized clinical diagnosis?

Mr. KORS. Yes, Congressman, it is.

Mr. BUYER. Yeah. In your statement you said recruits who had a severe pre-existing condition, like a personality disorder, do not pass the rigorous screening process. What is that? What is a rigorous screening process?

Mr. KORS. Well, I think Mr. Sullivan——

Mr. BUYER. No, I am asking you. What is you said that recruits——

Mr. KORS. Uh huh.

Mr. BUYER [continuing]. Who have a pre-existing condition like a personality disorder do not pass the rigorous screening process.

Mr. KORS. Uh huh.

Mr. BUYER. What is the rigorous screening process?

Mr. KORS. Soldiers coming into the Army undergo a rigorous physical and psychological screening process. Precisely what tests are done in that screening, I think that is something that others in the panel could better answer.

Mr. BUYER. Did you, have you served in the military?

Mr. KORS. No, sir.

Mr. BUYER. Do you know what you are talking about when you say a rigorous screening process? What are you talking about?

Mr. KORS. Well the doctors I spoke to and the soldiers and the veterans leaders all describe that initial screening as rigorous. And went over precisely how they were screened.

Mr. BUYER. You give an emphatic conclusory statement. "Recruits who have a severe pre-existing condition like personality disorder do not pass the rigorous screening process and are not accepted into the Army." That is a black and white conclusive statement. Yet, you have no personal experience nor you can give this Committee testimony about what a rigorous screening process is.

Mr. KORS. Congressman——

Mr. BUYER. I—no.

Mr. KORS [continuing]. I don't think there is anybody in this room——

Mr. BUYER. I am going to——

Mr. KORS [continuing]. Who would argue with the fact that the Army's screening process is rigorous.

Mr. BUYER. Basic training is a matriculation process of militarization. Is that what you are referring to as a rigorous screening process? I don't know what you are referring to.

Mr. KORS. The process you underwent——

Mr. BUYER. No, no. I am asking the reporter. You can't reach for a life-line. You give an emphatic statement to this Committee. I just want to know what you are relying on. So you are not relying

upon any personal experience, nor can you explain to this Committee what a rigorous screening process is.

I will just go to the next question. Let me go to, you give this statement, "Commanders pressuring doctors for diagnosis." Who? What and where? What commander pressured doctors for diagnoses? What commander pressured a doctor? Where did that occur? When did it occur? Who is the commander and what was the doctors name?

Mr. KORS. Congressman, I am not at liberty to reveal their name. A lot of these people who came forward were extremely scared that their careers were at stake. I have been asked in most cases to keep them in the background.

Mr. BUYER. So you make an allegation to this Committee about commanders pressuring doctors for diagnoses, but you will not give the name of a commander; you will not give the name of a doctor and you have no factual basis then to submit to the Committee?

Mr. KORS. I——

Mr. BUYER. I will ask the next one.

Mr. KORS. I don't think——

Mr. BUYER. "Every person who lied about the personality disorders discharge. Every person has lied about the personality disorder discharge benefits." That is your quote. Who? Who lied? What person lied to an individual? Tell me the person's name, when and where did it occur? Help this Committee.

Mr. KORS. You are talking about the doctors.

Mr. BUYER. You are saying every person lied about personality disorder discharge benefits. What doctor did that? Give me a name.

Mr. KORS. I will, but first let me just go back and——

Mr. BUYER. No. Give me a name with regard to this question. What doctor lied about this?

Mr. KORS. Congressman, I would like to answer your questions.

Mr. BUYER. Please——

Mr. KORS. I would like to answer your question.

Mr. BUYER. All right.

Mr. KORS. I think every journalist relies on those who speak off the record. I don't think I could do a story like——

Mr. BUYER. All right. So I am not going to get an answer from you then.

Mr. KORS. I don't think we could do a story—no, I will.

Mr. BUYER. Let me ask this one:

Mr. KORS. Doctor Mark——

Mr. BUYER. An example of a doctor presenting—yes, you also said you gave examples of doctors presenting persuasive scenarios to why a soldier should accept a personality discharge. You are not going to give that doctor's name either I suppose?

Mr. KORS. I certainly will.

Mr. BUYER. So you answered a northeast fort clinical——

The CHAIRMAN. Mr. Buyer, he said he would answer the question. So give him a chance to answer the question.

Mr. KORS. I will give the doctor——

Mr. BUYER. Hold on just a second. Hold on. Let me get in the last one and then you can go.

Mr. KORS. All right.

Mr. BUYER. You also mentioned a northeast fort clinical chief, ". . . get them to Iraq or find a pre-existing condition." So also tell me what is the name of that Fort and who is the clinical chief?

Mr. KORS. Again, I am not going to volunteer his name or his location. But you asked about——

Mr. BUYER. Well then let me just say this, Mr. Chairman, what is really challenging when we have a reporter testify before a Committee is that the reporter then gets to speak, use this type of syllogism to a Committee. They get to speak in generalities as the major premise and we don't know with regard to the credibility or embellishments. As a minor premise they get to use innuendo and the results then at times can be reckless indictments.

The CHAIRMAN. It sounds very much like a Congressman I know too.

Mr. BUYER. That is very challenging. Well the mirror looks pretty good.

[Applause.]

Mr. BUYER. Well, Mr. Chairman, then the mirror looked pretty good this morning to you.

Let me just say this: I am just saying I have a challenge here because we have a reality. The reality is what disturbs me the most is not the fact that there are individuals who may be diagnosed with a pre-existing condition. What bothers me is that, if the individual wasn't discovered somewhere along the process when they go to war, then they come back with problems, and with the next panel we will be able to get with the actual doctors, that is what is most important here. These doctors, because what is bothersome to me as a soldier is, once that person goes to a war zone and they come back, we shouldn't be saying that this was a pre-existing condition.

But I am not a doctor. But I am just saying that bothers me immensely.

The CHAIRMAN. Thank you.

Mr. BUYER. With that I yield back.

Mr. KORS. Mr. Chairman? If you give me 30 seconds to answer his question——

The CHAIRMAN. Please.

Mr. KORS [continuing]. I would be happy to do that.

Let's divide this into two sections. No amount of pressure you put on me will move me to reveal my off-the-record anonymous sources. That is not going to happen.

Second, you asked for a name of a doctor. I would be happy to volunteer one that came up repeatedly in my reporting. Dr. Mark Wexler at Fort Carson, he was Specialist Town's doctor and several others. And I know the group, Veterans of America, represented here also encountered many cases with him also encountered many cases with him. If you are really interested in specific cases with Dr. Mark Wexler named here in this Committee, I am sure Jon will be happy to tell you precisely how that one specific doctor behaved.

The CHAIRMAN. Thank you. We are going to have to recess in a few minutes for votes. I was going to again thank the panel and say how chilling your testimony was, how compelling. Specialist Town, your description of having to sell back leave to make up for your bill is just absolutely disgraceful, just disgraceful. We have

put you in a war where you were brain injured. We tried to diagnose you to avoid any later cost for benefits and for treatment and then we give you a bill for the privilege of all of that. That was very chilling.

What is even more chilling is the questioning by the Ranking Member. We have a problem here. Everybody, almost everybody said whatever the numbers are, whatever—we have a problem here. Nobody was questioning, I would say to Mr. Baker, nobody was questioning the commitment of people either in the VA or the military. But the system is leading to this situation. The system is leading to this. No matter how good the individuals are, how committed—I have been told by a doctor, Mr. Buyer, and I am not going to reveal his name here because he thought he would be fired, that he was told by his commanders to diagnose people with PTSD and get them out. I asked him to testify. He was fearful of that.

So we don't have to go beyond what we have here, as Ms. Herseth Sandlin said. We have the evidence right here. It is incumbent upon us to act and to act very quickly and that is why I called this hearing even though we have joint responsibility here. We have people like Specialist Town who are suffering because they served their Nation. That should not be, that should not be an option for this Nation.

And we thank you for being here. You are going to help us correct this. We are going to work on this system and we are going to make sure that those who serve, that we have repaid them with the care and the honor and the dignity that they deserve.

We will recess. I will—this panel can be dismissed. We will go into panel two when we return from the votes.

[Recess.]

The CHAIRMAN. I apologize for the intermission. We just can't avoid it.

Panel two, you have also had the advantage of listening of panel one, so I hope that you can take that testimony into account in your oral testimony. Your written statement will be made a part of the record.

Professor Shea is an expert, I am told, in distinguishing between personality disorder and PTSD. And I hope we can hear from you, Dr. Shea.

Dr. SHEA. Thank you, Mr. Chairman. I am honored at the opportunity to——

The CHAIRMAN. Is your microphone turned on? Make sure the microphone is right in front of you.

STATEMENTS OF TRACIE SHEA, PH.D., PSYCHOLOGIST, POST TRAUMATIC STRESS DISORDER CLINIC, VETERANS AFFAIRS MEDICAL CENTER PROVIDENCE, RI, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS (ON BEHALF OF HERSELF); DEAN G. KILPATRICK, PH.D., DISTINGUISHED UNIVERSITY PROFESSOR, DIRECTOR, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA, AND MEMBER, COMMITTEE ON VETERANS' COMPENSATION FOR POST TRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, THE NATIONAL ACADEMIES; AND SALLY SATEL, M.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF TRACIE SHEA, PH.D.

Dr. SHEA. Thank you. Mr. Chairman, I am honored at the opportunity to provide testimony to the Committee on issues related to post traumatic stress disorder and personality disorders.

I come before this Committee not as a representative or spokesperson for the Department of Veteran Affairs, but as a mental health researcher who has conducted research on personality disorders. My thoughts and opinions which I will share with you today are my own and should not be taken as VA views or policy.

The Committee has requested my testimony regarding PTSD and personality disorders in context of servicemembers and veterans. I am just going to start to quickly review what the definition of a personality disorder is, according to our official diagnostic manual. Personality disorder is defined as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. It is manifested in cognition—that means ways of thinking and perceiving—interpersonal functioning, meaning relationships, impulse control and affect, in other words, the range of the emotions and the expressions of feelings.

Now, what is important here is that for a diagnosis to be made, there are several requirements that need to be met. First of all, you need to see persistence of the behavioral pattern over time and it also needs to be present in multiple situations, not circumscribed situations. Second, its onset should have begun—its onset needs to have started by late—at least by adolescence or early adulthood. So this is not something as we understand personality disorders officially in our diagnostic system that would show up in later adulthood.

Third, there needs to be evidence of significant distress or impairment in functioning associated with this pattern of behavior. Fourth, and this is also important to the current topic, the pattern of behavior should not or cannot be better accounted for as a manifestation or a consequence of another mental disorders. And I will come back to that. Fifth, the pattern is not due to the direction physiological effects of a substance such as drug or alcohol or medication or a general medical condition, and certainly, traumatic brain injury would be an example of that.

Since the onset of personality disorders occurs by late adolescence or early adulthood, there should be evidence of the behavior pattern prior to adulthood. You would not expect a history of very

solid, good, psychosocial functioning prior to adulthood in an individual with a personality disorder. You would expect problems to have shown up.

It is really critical to rule out other mental disorders that might be responsible for the kind of behaviors you may see in making a clinical diagnosis of personality disorder. Following traumatic experiences, persistent or repeated traumatic stressors, it is particularly important to determine if those behaviors may be due to PTSD. And this is a statement that our diagnostic manual, the DSM–4 explicitly states, and I quote, "When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of post traumatic stress disorder should be considered." So as a clinician, you really need to note that and look for that.

Exposure to severe and prolonged trauma can result in behaviors that look like personality disorders. There are criteria such as outbursts of anger, irritability and anger, feeling extremely detached and socially withdrawn, having a very restricted range of affect or a very volatile affect. These are all features that are associated with PTSD but look like personality disorders.

There is even a diagnosis in the International Classification of Diseases that is called "enduring personality change after catastrophic experience" and this diagnosis is used in cases of persistent change in personality following extreme stress. Features of this International Classification of Diseases diagnosis include, again, changes after exposure to severe trauma, hostility, distressful attitude toward the world, social withdrawal, constant feeling of feeling empty or hopeless, persisting feeling of "being on edge" or being threatened without any external cause, in other words, showing up in increased vigilance and irritability, and a permanent feeling of being changed or being different from others.

Again, you see these features often, I have often in my work with veterans, seen features like this that can be linked back to the trauma. The critical distinction is, again, whether they represent change in personality following exposure to severe traumatic stress in terms of what diagnosis you would give the individual.

I also want to say that despite the fact that I am focusing here today on the distinction between personality disorders and PTSD, they are not mutually exclusive. They can co-exist. An individual with a personality disorder can develop PTSD and that happens. So it is not an either/or situation.

VA psychologists, which I am also, in addition to my academic work, conduct assessments for service-connected disability applications. These, what are referred to what they call compensation and pension exams, follow established guidelines and cover psychosocial functioning and symptoms of mental disorder that are present prior to, during and following military service. Military experience, including exposure to traumatic events, is assessed, and the timing of the onset of symptoms in relation to military service is determined in these exams.

Most of the exams that I personally have conducted have been to establish service connection for PTSD. And essentially they require a detailed questioning of symptoms of PTSD as well as other mental disorders, and again, with a focus on the timing of the

onset of the problems. If there is a pattern of maladaptive behavior existing prior to military service, it is again important to determine whether there has been a change in connection with military service. Diagnoses reflect—diagnoses will reflect a personality disorder if present, but in my personal experience, this has been rare.

I thank you for this opportunity to testify and I will be pleased to answer any questions you may have. Thank you.

[The prepared statement of Dr. Shea appears on p. 87.]

The CHAIRMAN. Thank you, Dr. Shea.

Dr. Dean Kilpatrick is Distinguished University Professor at the Medical University of South Carolina and Director of the National Crime Victims Research and Treatment Center and also a member of the Committee on Veterans' Compensation for PTSD of the Institute of Medicine and National Research Council for The National Academies.

Thank you for joining us.

STATEMENT OF DEAN G. KILPATRICK, PH.D.

Dr. KILPATRICK. Good afternoon, Mr. Chairman, Mr. Ranking Member and other Committee Members. Thank you for the opportunity to testify on behalf of the Committee on Veterans' Compensation for post traumatic stress disorder. As was just mentioned, this Committee was convened by the National Research Council and the Institute of Medicine. Its work was requested by the Veterans Administration which provided funding for this study.

Our Committee recently completed a report entitled, "PTSD Compensation and Military Service," that addresses some of the topics under discussion today. I am pleased to share with you the content of that report, the knowledge I have gained as a clinical psychologist and researcher on traumatic stress, and my experience as someone who previously served as a clinician at the VA for approximately 10 years.

I will begin with some background information about post traumatic stress disorder, although from hearing the testimony and the questions today, I think the Committee understands post traumatic stress disorder pretty well. So I think I will just summarize that it is a disorder that, while it first was identified in 1980 in the DSM–III, the symptoms that have been described after people experience traumatic events including war have really been around for centuries. And so, even though the diagnosis is new, the pattern of behavior that people experience is not new.

Our Committee's review of the scientific literature and the VA's current compensation practices identified several areas where changes might result in more consistent and accurate ratings for disability associated with post traumatic stress disorder. Excuse me.

There are two primary steps in the disability compensation process. The first is a compensation and pension, or C&P, exam. Testimony that our Committee heard indicated that clinicians often feel pressured to severely constrain the time they devote to conducting a PTSD C&P exam. In fact, one clinician mentioned that it was not uncommon to take as little as 20 minutes to do such an examination. The protocol, however, that has been identified by a best practices manual developed by the National Center for PTSD of the VA

indicated that it really should take maybe 3 hours or even more in complicated cases.

So our Committee believed that the key to a proper administration of the VA's compensation and pension examination program is a very thorough C&P examination conducted by an experienced mental health professional. Most of the problems and issues with the current process can be addressed by providing the time and resources necessary for a thorough examination. The Committee also recommended that a system-wide training program be implemented for clinicians who conduct these examinations in order to promote uniform and consistent evaluations.

The second step in the compensation and pension process is the rating of the level of disability associated with service-connected disorders identified in the clinical examination. I think the for the purpose of this hearing today, it is important that it not only be something that occurred during service, but if you had something preexisting that was aggravated by something that happened in service, that that also should be part of the evaluation.

The Committee found that the criteria used to evaluate the level of disability resulting from service-connected PTSD were, at best, crude and overly general. They were not specifically designed to measure disability associated with PTSD. Our Committee recommended that new criteria be developed and applied that specifically address PTSD symptoms and that are grounded firmly in the standards set out for mental health professionals doing these evaluations.

As a part of this effort, the Committee suggested that the VA take a broader and more comprehensive view of what constitutes PTSD disability. In the current scheme, occupational impairment, the ability to work, drives the determination of the rating level. Under the Committee's recommended framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated and the claimant would be rated on the dimension upon which he or she is most affected.

The Committee believes that special emphasis on occupational impairment in the current criteria unduly penalizes veterans who may be capable of working, but significantly symptomatic or impaired in other dimensions. So, for example, a veteran might be able to work pretty well by overcoming the PTSD symptoms, but might have a lot of trouble in his family life and relationships with other people. Thus, if you just focus on occupational impairment, you may, in fact, create a disincentive to work, which is a very important element in recovery.

Determining ratings for mental disabilities for PTSD is more difficult than for some other disorders because there is a subjective component to it in that it is mostly a symptom-based disorder. To provide, or to promote, rather, more accurate, consistent and uniform PTSD disability ratings, the Committee recommends that the VA establish a specific certification program for raters who deal with PTSD claims and provide the training to support that, and then also to recertify raters. Rating certification should foster greater confidence in ratings decisions and in the decisionmaking process.

To summarize, the Committee identified three major changes that are needed to improve the compensation evaluation program for veterans with PTSD. First, the C&P exam should be done by mental health professionals who are adequately trained in PTSD and who are allotted adequate time to conduct the exams. Second, the current VA disability rating system should be substantially changed to focus on a more comprehensive measure of the degree of impairment, disability and clinically significant distress caused by PTSD. Third, the VA should establish a certification program for raters who deal with PTSD claims.

Our Committee had numerous other recommendations, as you can tell by the size of this report. I have just sort of hit the high points here. And they are detailed in the body of the report. I believe that the report has been distributed to the Committee as a part of my testimony. And I would thank you very much for your attention and would be happy to answer any questions.

[The prepared statement of Dr. Kilpatrick appears on p. 89.]

The CHAIRMAN. Thank you so much.

Dr. Sally Satel is with the American Enterprise Institute (AEI).

STATEMENT OF SALLY SATEL, M.D.

Dr. SATEL. Thank you, Mr. Chairman and Congressman Buyer and Committee Members. Thank you again for the invitation to be here. I am a psychiatrist and I formerly worked with veterans at the West Haven VA in Connecticut and currently I am at AEI.

Just one word about the Chapter 5–13 discharges that were spoken about so much earlier. They raised two main questions. The first, of course, has been exhaustively discussed and the attention it is getting is very much deserved. It is the question of whether military evaluators are erroneously ascribing impairments caused by active duty to preexisting personality disorder.

The second question is a mirror image of the first, that is to say it involves situations in which personality disorder discharge is indeed accurate. We don't know what the distribution is between misapplications and accurate ones, however. But clearly, some soldiers are going to fall into that personality disorder category; there is a chance, though, that he or she has gotten too far into his tour of duty by the time that diagnosis is made.

So the question becomes whether the military's screening procedures and ongoing evaluations are adequate to identify these problem personnel, in a timely manner. And that issue may sound like a military issue, but it has relevance for Veterans Affairs as well. After all, it is those individuals, men and women with pre-military evidence of severe misconduct or those who have become disciplinary problems early in active duty are particularly vulnerable to developing psychiatric impairment under the strain of combat. And upon discharge, they may turn to the VA mental health facilities for long-term care for treatment—treatment of psychiatric conditions that might have otherwise been prevented with proper screening.

Now, if and when they get to the VA, I really don't worry so much that clinicians are going to misdiagnose PTSD as personality disorders. And in fact, it seems to be the case that Chapter 5–13 discharges often reflect an administrative decision than a clinical

confusion. But in any case, the core symptoms of post traumatic stress disorder and neuropsychiatric impairments like traumatic brain injury are distinguishable from preexisting personality disorder. And I don't think there is much debate about that at all.

Yet, even though they are distinguishable, as Dr. Shea mentioned, there is no question that the two problems can occur together in the same patient. In fact, one of the most striking observations made by VA psychiatrists since the mid 1980's is that the longer a patient suffers with PTSD, the more likely he is to also have evidence of personality disturbance. And I use the word personal disturbance and not personality disorder, which as we know, is a preexisting, pre-military phenomenon, because what looks like a personality disorder, may actually be a character change induced by the experience living with symptoms of PTSD for many years.

Now, remember, so much of this research has been done on Vietnam veterans and so many of them—I don't have numbers, but I would venture to say it is the vast majority—did not come forward for help for at least 5 years after returning home, and sometimes 10 and 15 years later. There was no outreach at the time. PTSD wasn't even an official diagnosis recognized by the American Psychiatric Association until 1980. And the National Center for PTSD didn't exist until 1989.

So by the time those veterans, those Vietnam veterans, did come to the attention of the VA, their conditions had often festered and become quite complicated. And as I mentioned before, living with pervasive anxiety, nightmares and other sleep disturbances can lead to intense anger, chronic mistrust, depression, substance abuse and social isolation, the kinds of features that contribute significantly to disability, these are also features that make it very hard to treat a patient who has suffered them for 10 and 15 years and also to determine which is the dominant disability, the symptoms of chronic PTSD or the maladaptive behaviors, the personality disturbances, that it induced.

So the vital lesson here is that new veterans, the young men and women now returning from Iraq and Afghanistan, must get treatment as early as possible. That is when combat induced stress syndromes are going to be most responsive to care and also when there are ripe opportunities to address the considerable burdens of readjustment. Financial problems, family and marital issues, occupational dislocation, these are enormously important. They are not psychiatric conditions. They are social problems. And they are burdens that can make a huge difference in how well veterans cope and return to civilian life and also the extent that they can cope with mental distress. Distress, which I should emphasize, will most likely resolve over time, and will respond well to the treatment if care is provided early.

Certainly, some veterans will continue to suffer profoundly even with treatment and won't be able to resume a productive life. That is what compensation is for. I hope and predict they will be a small minority. With early and competent treatment, however, there is good reason to be optimistic that the vast majority of veterans returning from Iraq and Afghanistan will do well. They will be changed by the war. How could someone not be? But most will not be permanently damaged.

Thank you very much.

[The prepared statement of Dr. Satel appears on p. 91.]

The CHAIRMAN. We thank all of you for helping us understand this better. Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman.

Just a couple of questions. You heard the testimony earlier where it was Jon Town who said that he was screened before he—when he went into the service, screened when he went to Korea, screened when he went to Iraq. There was no indication that he had a personality disorder, and actually, I think he was even screened once he got into Iraq. Then when he came out, he had personality disorder.

I would like to ask each of the three panelists, is it possible that you can miss so many different types—so many different screenings in that process? I guess I will start with Dr. Satel.

Dr. SATEL. Well, I would be very—I would be quite skeptical that you could miss it at that many levels. At enlistment, it is often hard to predict who will not succeed and I know that screening has been a very confounding process for the military family for years. Since World War II it has been questionable. I understand, however, this is just from my reading, not from my personal experience, that there are an increased number of so-called moral waivers being given out and these are for people who have known felonies. Multiple felonies should certainly raise a red flag.

But, you know, those who have a personality disorder that hasn't manifested in gross ways like for example, as an arrest record, at enlistment, may well show maladaptive behavior as they progress through active duty. Imagine a cardiac stress test. Boot camp and early deployment are often the psychological equivalent. And if you have a fragile personality, a tendency toward maladaptive coping, it would be very surprising to me if that didn't rise to the surface during intense phases of duty.

I would predict that someone with a serious preexisting problem in relating to others would not progress too far through the system before coming to the attention of peers and command. That is my opinion.

Mr. MICHAUD. Yes. Doctor.

Dr. KILPATRICK. Well, I would just add that in the case where someone is, you know, injured in combat, that PTSD would certainly come to mind a lot quicker than personality disorder as the explanation for change in behavior.

Dr. SHEA. I would just add that I think it is possible to miss mild personality disorders, but I think it doesn't—that is not so much the issue. I think the issue is, is there a change? Is the behavior that is being used as a basis for the diagnosis of personality disorder, does it represent a change following the experience in military service? And if so, then it is not preexisting in that sense. It could be exacerbated or it could be new onset. Thank you.

Mr. MICHAUD. And my second question, I think Dr. Kilpatrick brought it up, but for the other two—I haven't read the report which I will definitely be reading. How long would it take if someone is to evaluate someone either before they go into the service or after they come out to adequately detect whether it is a personality disorder or whether they have PTSD? And I think it was Dr.

Kilpatrick that said you can't do it in 20 minutes or something like that. What is the normal timeframe for someone to go through that process?

Dr. KILPATRICK. Well, the VA deserves an enormous amount of credit for their National Center for PTSD which developed a model protocol that is not a one-size-fits-all, but gives some basic parameters for doing these compensation and pension examinations. It suggests the types of information that should be gathered which includes information about pre-service functioning and sources of social support, as well as evaluating the level of combat and exposure to other war zone stressors and to evaluate all of these things.

And I believe that they did not set an exact time limit, but approximately 3 hours, but I mean basically the notion that we are saying is, if you make a 20 minute examination, you are more likely to miss something. If you do a more comprehensive evaluation and basically get it right the first time, then maybe veterans will have a better view of the fairness of that evaluation because of its thoroughness.

And secondly, you are just more likely to get it right which will maybe save money down the line because there are appeals. And people who do not feel like they have had their sort of "day in court" in terms of a fair evaluation and a thorough evaluation may, in fact, later be more likely to appeal these, which again, takes a lot of resources.

Mr. MICHAUD. Does Dr. Shea and Dr. Satel, do you agree with what Dr. Kilpatrick just said?

Dr. SHEA. I do. I just would like to add, I mean I have done many, many of these exams in the VA in my role as a clinical psychologist at the VA and I can say that you always want more time because the issues can be complex. You don't want to cut the veteran off. You want to hear the full story. You want to get as much detail as you can.

You also are realistically working within time limits. I do not think you can do this exam in 20 minutes. Personally, I try my best to get them done, interview time an hour, the whole process, including going over the chart, dictating a report, I don't think I have ever done in under 2 hours. I have spent 3 to 4 hours on complicated cases. You just do that if you have to.

The other point I would say is that individuals vary quite a bit in terms of how difficult or easy they are to interview. Some people are very good reporters and those interviews move quite smoothly. They are able to articulate what their experiences are in a way that makes it easy. Other people are more difficult.

Dr. SATEL. Just one quick point. One of the reasons it can take 3 to 4 hours—20 minutes is so brief it is mind boggling—is because, depending on the case, one has to spend a fair amount of time interviewing spouses and collateral sources of information, employers, and previous physicians, and so on.

The CHAIRMAN. Thank you.

Mr. Buyer.

Mr. BUYER. Thank you very much. I may have to step out soon. We have a briefing from Secretary Shalala and former Senator Dole on the Commission's findings. So I want to thank you for your submitted testimony. I had a chance to read it. I wish you had been

the lead panel. You could have helped us immensely. And I think what I take from this hearing is there is a good reason why reporters don't testify.

We rely upon one's testimony to be factually based and there was a lot of free wheeling going on. And so your testimony is very important to us because we have to make policy decisions based on what is happening out there. There is this impression and the allegation that has been made, almost an embellishment, that we have this large number, 22,000—one of my colleagues even made the conclusion that I wrote down that they are diagnosed incorrectly. That it is all made up. And so a pretty strong impression is being placed out there and that is why I had to ask the reporter is it, in fact, a disorder? Is it a clinical diagnosis? I am glad he said yes.

The challenge for us is that we in the VA, we are the receiver of whatever the DoD does. So I am curious about your counsel to us, as we also oversee the armed services in our other capacities as Members of Congress. Is it in the country's best interest for us to say to DoD that you cannot discharge a soldier because of a personality disorder? What is your opinion with regard to that? Please, we will go right down the line.

Dr. SHEA. I will say that that is a—I think that is a quite difficult question personally for me to address, because I think there are very complex issues involved in that that have to do with military needs that I am not aware of. What I would say is that I think it is critical that the evaluation that is made be very comprehensive, second opinions be allowed, that records from prior history be gathered, that every effort is made to determine what the consequences of the service were so that the person can receive adequate treatment and receive adequate benefits to which they are entitled.

Mr. BUYER. Thank you. Dr. Kilpatrick.

Dr. KILPATRICK. Well, I would say—I would echo that and agree with it and say that it is a difficult thing. But I think we need to be very careful because when you say personality disorder, that has a very pejorative term to it, I mean whether in fact it is true or not. And so I guess in any case, what you have done, the military has either accepted someone in who has a preexisting personality disorder that was not captured, or may have been, in fact, aggravated by, you know, something that happened in service, may be misdiagnosed as a, you know, personality disorder when it is a change in personality functioning as a function of having PTSD or other war zone related-problems.

So obviously there are some people who it takes a while to get caught up to and particularly severe antisocial behavior people who may not be fit for service. On the other hand, we need to be, I think, very careful about describing people who may not be fit for service right now, but who actually might be fit for service if their PTSD was treated. And so, I mean, it is a difficult situation, but summarily deciding if they are not getting along well now, that must be that they have a personality problem and therefore we are going to kick them out of service which then has some implications for their VA benefits later, including access to services, you know, can be problematic.

Mr. BUYER. Well, that is problematic and also rather callous if, in fact, that is why it is being done. I mean I do recall even being a JAG on active duty with regard to—as a lawyer for the hospital whereby the clinicians actually counsel the commanders. You know, this allegation that the commanders are putting pressure upon the docs, it is usually the docs saying to the commanders "do not put a weapon in this guy's hand." Usually it is the counsel coming back to the commanders and telling the commanders what to do, that is what my experience has been.

Dr. Satel, do you have any opinion based off of the testimony of the other two?

Dr. SATEL. I certainly agree with what my colleagues have said. I suppose when you hear the word "personality disorder," that should be a signal that a careful, what we call differential diagnosis process, has to be instituted. And if everything else is ruled out and you are left with someone who is just unfit because they cannot adapt to the norms of the military, you have to certainly act on that. You don't want someone who is incapable of cooperating with others, of following orders, disrupting group morale. Also, as I said, such individuals are often at a higher risk for developing combat stress syndromes.

But remember, if a soldier is behaving erratically, impulsively, defiantly or bizarrely, the first thing is to make sure we are not talking about traumatic stress injuries or bipolar illness or early schizophrenia. New onset of schizophrenia was one of the cases described earlier today. But if not, and this is someone who is just not psychologically equipped to conform to the rigors of the military, then that needs to be dealt with. But most important is to rule out other explanations for inappropriate actions on the part of the individual.

Mr. BUYER. Doctors, I appreciate your testimony. I am just a layperson and I look at my 27 years experience in the military. I have recognized in that crucible of basic training and AIT, that certain things can apply certain stressors, whereby people—you will be able to recognize certain behaviors or conduct. And then they get referred to the hospital for some type of treatment or end up with diagnosis.

The concern I think that the Chairman has and myself and other Members of the Committee is we would think that many of these things could be identified early on, and that an individual would actually go to war and that is when the so-called a preexisting condition is then discovered, and they are discharged after they come back home. Even as a layperson, as a military guy, something doesn't fit here, doesn't seem right to me.

And I read in your testimonies, both of you—all three of you are—in agreement that you can have a preexisting disorder, but you can also have PTSD; is that correct?

Dr. KILPATRICK. Yes.

Dr. SHEA. Yes.

Mr. BUYER. Okay. So your testimony about careful analysis is with regard to the DoD. When they make this discharge determination, and when the VA receives it, the VA has to examine this judgment with a rebuttal presumption, and be able to come in and chal-

lenge what DoD has done. Would that—would you agree with that? In other words, we shouldn't just accept——

Dr. SATEL. Yes.

Mr. BUYER. We shouldn't accept that the VA should also have the ability to have their own second opinion with regard to the benefits, especially for these individuals that come back after war. Would you all agree with that?

Dr. SATEL. Yes, I would.

Dr. SHEA. Yes.

Mr. BUYER. All right. Thank you very much.

Dr. KILPATRICK. And part of the problem is, is that people, a lot of people with PTSD will develop alcohol problems. They will have impulse control problems which may mimic some of the personality problems that are disturbing to people. So that is why the diagnosis is important, because something can be done for the PTSD.

Mr. BUYER. Okay. Thank you very much.

The CHAIRMAN. We thank the panel. The panel was in total agreement, while you were out of the room, Mr. Buyer, that they were quite skeptical that personality disorder would not be found out whether it is early screening or basic training or beginnings of combat or whatever, that they would not find that and have to do that post-deployment would be very unusual at the very least.

Given that judgment of yours, I mean, Dr. Shea, were you surprised at the testimony on the first panel which seemed to indicate that many, many of these combat veterans were being diagnosed with personality disorder? Did that surprise you at all?

Dr. SHEA. The particular cases that I heard and have read about, yes, I am stunned by those particular cases, from what I have read. They don't—it sounds like an inaccurate procedure. I can say that. I mean I think it is hard to speak to the other cases because we simply don't know the details.

The CHAIRMAN. Right. I understand. But I mean the numbers in the testimony that we have had seems to say that. If a veteran comes to you for a C&P examination, does the fact that they have been diagnosed with personality disorder by the military have any sway with you? Is it harder for them to even get that far in the disability process and how would that affect your evaluation?

Dr. SHEA. Well, let me say for the first part, I would defer that to Dr. Katz who is on the next panel because he is much more familiar with the eligibility requirements and how that process works than I am.

In terms of lending it to me, and if I see—I would look very carefully at the medical records. I would look very carefully at any documentation that was provided. I would look at treatment records. I would probe for those—but most importantly, what I would be doing is looking for symptoms of post traumatic stress disorder if that was the basis of the evaluation. I would have it in the back of my mind that this person had been diagnosed with a personality disorder, but I would be looking for, again, what specific behaviors and symptoms have onset and what was the relationship to the traumatic stressors. What kind of traumatic stressors did they experience and what—can they link these symptoms of PTSD to those? And that would be my concern. I would frankly be less con-

cerned about the personality disorder unless I thought that I had to be careful not to make a mistake in diagnosing——

The CHAIRMAN. It was implied by their testimony that it is hard even to get to that point. Again, you don't know about that. You want me to ask Dr. Katz; is that what you are saying?

Dr. SHEA. Yeah. I am not totally familiar with all of the eligibility requirements for getting there. But I know we see people who have prior diagnoses with personality disorder. So I know that they can be seen by the VA, but I don't know of anybody else.

The CHAIRMAN. And what—is there any generalization you can make? In your evaluation, have you overturned all of those, or some of them, or none of them? Was there a PTSD diagnosis from you in contradiction to the personality disorder diagnosis?

Dr. SHEA. Well, we are not typically asked to comment on the previous diagnosis.

The CHAIRMAN. Right. But you give some sort of diagnosis.

Dr. SHEA. Yes.

The CHAIRMAN. I was just wondering, were all of them given PTSD diagnosis or none of them or half of them? I mean——

Dr. SHEA. Oh, you mean—excuse me——

The CHAIRMAN. For those who had a personality disorder that you can recall, a diagnosis from the military, how, in general, do you diagnose them?

Dr. SHEA. I have not had any compensation exams that have come to me in recent times that have listed military diagnosis separation due to personality disorder. So I just haven't had that come up.

The CHAIRMAN. I thought you said that you have seen those, so you know they can get in.

Dr. SHEA. Well, I know through the years I have treated many, many veterans, a lot of Vietnam veterans, as well as some of the more recent Iraq veterans. And those veterans I may not be doing comp and pen exams. I am just treating them. And I know that they have a history in——

The CHAIRMAN. So you haven't given a C&P exam to anybody who had a personality disorder? So for all you know, they may have been screened out before you got there. I mean——

Dr. SHEA. That is a possibility. Yeah.

The CHAIRMAN. Or just, you know, the luck of the draw that you——

Dr. SHEA. Yeah. I can't speak to that.

The CHAIRMAN. Okay.

Dr. SHEA. That is right.

The CHAIRMAN. Well, we thank all of you for being here. We thank you for helping us understand this better and we will ask the third panel to come forward.

I have diagnosed a personality disorder on schizophrenia in your changing of the nameplates. So you are trying to confuse us also, right? You are not really Dr. Katz. Okay. I think we should discharge you immediately from the VA.

Thank you for being here. Dr. Ira Katz is the Deputy Chief for Patient Care Services for Mental Health in the Veterans Health Administration, Department of Veterans Affairs, accompanied by Ron Aument, Deputy Under Secretary for, Benefits, Veterans Bene-

fits Administration (VBA), and Paul Hutter, Executive in Charge in the Office of General Counsel.

Dr. Katz, you have the floor.

STATEMENTS OF IRA R. KATZ, M.D., PH.D., DEPUTY CHIEF PATIENT CARE SERVICES FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RONALD R. AUMENT, DEPUTY UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; PAUL J. HUTTER, EXECUTIVE IN CHARGE, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND COLONEL BRUCE CROW, CHIEF, DEPARTMENT OF BEHAVIORAL MEDICINE, BROOKE ARMY MEDICAL CENTER, FORT SAM HOUSTON, TX, AND CLINICAL PSYCHOLOGY CONSULTANT TO THE ARMY SURGEON GENERAL, DEPARTMENT OF THE ARMY, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF IRA R. KATZ, M.D., PH.D.

Dr. KATZ. Hello, Mr. Chairman and Members of the Committee. I, too, was moved by what I heard from the first panel, as everyone in the room must have been. I want to, before beginning my prepared presentation, comment about the issues that were raised in the last panel. The VA's evaluation, whether it is an evaluation for purposes of treatment planning or compensation and pension evaluation, is a de novo evaluation that is independent and unbiased, evaluating the patient before us and not bound or in any way determined by prior evaluations in DoD. The VA evaluation is patient-centered——

The CHAIRMAN. But somebody has to come forward for that. And if they were told, for example, by the Army that they weren't eligible for the VA based on personality disorder, they may never show up to you, right? You would give them a de novo exam if they showed up. But if they don't show up, you obviously can't do it?

Dr. KATZ. Right. We work hard to promote access and to de-stigmatize mental health to promote access.

I want to speak about the issue that was raised in the previous panel about the fact that multiple diagnoses are the rule and about how VA applies the principles that PTSD frequently coexists with other mental health conditions. I would like to request that my written testimony be submitted for the record.

The CHAIRMAN. Certainly.

Dr. KATZ. As of the end of the first half of 2007, almost 720,000 servicemen and women have separated from the Armed Forces after service in Iraq or Afghanistan and over a quarter million have sought care in VA. About 95,000 received at least a preliminary mental health diagnosis and among these, PTSD was experienced by about 45,000 or 48 percent of those with a mental health condition. It is the most common of the mental health conditions, but it is not the whole story, and depression is a close second.

The average veteran with a mental health problem received about 1.9 separate diagnoses. Multiple diagnoses, as was suggested, is the rule, not the exception. There can be several reasons for this. First, injuries of the mind, like injuries of the body, can

be nonselective, depending upon psychological, physiological or genetic vulnerabilities. The same stress or trauma could give rise to multiple conditions. It can produce, for example, PTSD and depression or PTSD or a panic disorder.

Second, the disorders can occur sequentially. Some veterans with PTSD may try to treat their own symptoms with alcohol and wind up with a diagnosis related to problem drinking. Third, some preexisting mental health conditions, like milder personality disorders, could be quite compatible with occupational functioning even in the military, but they may increase a person's vulnerability to stress-related disorders like PTSD.

VA has intensive programs to ensure that mental health problems are recognized, diagnosed and treated. There is outreach to bring veterans into our system and once they arrive, there is extensive screening for mental health conditions. Specifically, VA screens all new returning veterans for PTSD, depression, traumatic brain injury and problem drinking. The prompts for these screens are built into our electronic medical records.

The CHAIRMAN. I am sorry. Dr. Katz, did you say—who does the screening? Did you say—I didn't hear that sentence.

Dr. KATZ. Usually it is the first provider that sees the returning veteran——

The CHAIRMAN. No, is it the VA?

Dr. KATZ [continuing]. Usually the primary care provider.

The CHAIRMAN. I am sorry. Was it the VA or the military did you say?

Dr. KATZ. VA definitely screens everyone who comes to us for the——

The CHAIRMAN. Right. But you didn't say everyone who comes to us in that sentence. You said every veteran is screened. There is a crucial distinction between every veteran is screened and every veteran who comes to us is screened.

Dr. KATZ. I agree. We work hard——

The CHAIRMAN. I want to know what you said.

Dr. KATZ. We work hard at outreach to get people to us——

The CHAIRMAN. I understand. But I bet you haven't gone to those 22,500 and tried to get them in and see what is going on with them.

Dr. KATZ. We have gone to almost all of the post-deployment health reassessment sessions to really work——

The CHAIRMAN. Did you call in the 22,500 people who have——

Dr. KATZ. No, sir.

The CHAIRMAN. So that is what I would call outreach.

Dr. KATZ. For those who screen positive for mental health conditions, the next step is comprehensive diagnostic and treatment planning evaluation. If someone screens positive for symptoms of PTSD, we are, of course, interested in whether or not they have PTSD. But we are also interested in whether or not they have depression or panic disorder or problem drinking or other problems. Regardless of the specific diagnosis, we treat the person, not his or her label.

Clinical science regarding PTSD had advanced dramatically since Vietnam. There is a firm evidence base for several classes of treatment for PTSD, both medication based and talk-therapy based.

Specifically, several anti-depressants have been found effective and safe for the treatment of PTSD and many other medications are being studied.

Two specific forms of cognitive behavior therapy, prolonged exposure therapy and cognitive processing therapy, appear to be even more effective than medications and VA has currently developed training programs to make these treatments more available in all of our facilities.

In addition, there is increasing evidence for the effectiveness of psychosocial rehabilitation treatments to help veterans with residual symptoms function in their family, community and on the job, even if they have symptoms left after other treatments.

When patients have more than one condition, and most do, clinicians must evaluate the severity of the conditions and the patient's preferences. Plans must allow for combinations or sequences of treatment as appropriate following clinical practice guidelines.

VA also employs evidence-based strategies for beginning PTSD and substance abuse treatment simultaneously when they both occur. It may be difficult to diagnose personality disorders in the face of PTSD or other mental health conditions. For veterans with relevant symptoms, the clinical approach in VA is to treat PTSD first. A subsequent step would be to evaluate what symptoms or impairments remain and to plan treatments accordingly.

In summary, treatment for PTSD and other mental health conditions can work. For veterans with multiple conditions, there must be a multi-stage process beginning with an evidence-based intervention for the most severe of the patient's conditions. Treatment begins with the most severe and continues until the person recovers and beyond.

Thank you for this opportunity to testify. I and my colleagues will be pleased to answer any questions you may have.

[The prepared statement of Dr. Katz appears on p. 95.]

The CHAIRMAN. Thank you, Dr. Katz.

Colonel Bruce—is it Crow or Crou?

Colonel CROW. Crow.

The CHAIRMAN. Crow, is Chief of the Department of Behavior Medicine at the Brooke Army Medical Center and is with us today as the Clinical Psychology Consultant to the Army Surgeon General.

We have your written statement, Colonel. If you can respond to the first panel as opposed to going through what you guys are doing. You know, all you guys are doing everything right. As Dr. Katz said, he was affected by the first panel. I hope you were. I would like you to respond to it in your statement. If you think they are wrong, tell us. If you think they are right, what are we going to do about it?

Colonel CROW. Well, Mr. Chairman, I actually have a oral statement that is a little bit different, a little bit shorter than my written testimony. I would like to read that, if I may.

Ms. BROWN-WAITE. Mr. Chairman, I want to make sure that his written statement is going to be entered into the record.

The CHAIRMAN. All written statements will be made a part of the record.

Ms. BROWN-WAITE. And he does have the opportunity——

The CHAIRMAN. He can do whatever he wants. I would ask him to—we put the VA and the DoD as the last panel instead of the first panel, as has been the practice here, because after the first panel goes, they all walk out and they don't listen to the citizens and the stakeholders. So now they have had a chance—and I appreciate your sitting through that—to hear. And it seems to me if I were in their position, I would say well, they don't know what they are talking about, we do this, or yes, they are right and here is what we are going to do to fix it. They have this opportunity and if they choose to pass it up, well, we will try to get to these matters in questions. But I would say that that is not the most responsive way to be.

You have the floor, Colonel.

STATEMENT OF COLONEL BRUCE CROW

Colonel CROW. Mr. Chairman and Congressman Buyer who is not here, thank you for the opportunity to address the distinguished Members of this Committee. I am Colonel Bruce Crow, the Clinical Psychology Consultant to The Army Surgeon General and Chief of the Department of Behavioral Medicine at Brooke Army Medical Center in San Antonio, Texas.

The soldiers of the U.S. Army deserve the very best mental healthcare available. We know there is a stigma against seeking mental health services in our society and in the military, which is made worse if soldiers don't trust us as mental health providers. The Army has highly qualified psychiatrist, psychologists and social workers who are uniform or work as civil service or contract employees. We are helping thousands of soldiers and their family members every day deal with problems of living. We are expected to do our job well and to improve our system when we find problems.

Questions have been raised about whether Army psychiatrists and psychologists have been negligent for misdiagnosing soldiers with personality disorder instead of correctly recognizing symptoms of PTSD or traumatic brain injury. This would be wrong and should not happen. The ethics and standards of our professions dictate that our patients receive accurate diagnoses and appropriate treatment.

I strongly believe our providers have the best interests of soldiers at heart. Our obligation is to our patients first and above all else. We are committed to reviewing our clinical procedures related to making a diagnosis of personality disorder pursuant to administrative separation under Army regulation. If there are problems with this process, they need to be fixed.

The Acting Surgeon General of the Army, Major General Pollack, has initiated a review of the administrative, medical and mental health records for nearly 300 soldiers who served in combat and were subsequently discharged for a personality disorder. This initial review will include the 295 soldiers separated from the Army in 2006 who had served in Iraq and Afghanistan and had received a separation for personality disorder. There were an additional 791 soldiers discharged for personality disorder who had not served in combat, for a total of 1,086 personality disorder separations in 2006.

For the period 2001–2006, the Army separated a total of 5,631 soldiers due to a personality disorder. A much smaller portion of that number have served in combat. I may add, I don't think the numbers would tell us whether or not we should be concerned about a problem. One is too many and we should look to see if there is a problem.

This review will be conduced by a team of senior mental health providers looking at compliance with the procedures, quality of clinical documentation and whether there are indicators that these soldiers had conditions that should have been referred for medical board evaluation. The results of this review will help determine whether additional reviews should be conducted. We expect to have results by early September with release to the Senior Army and DoD leadership and then to Congress.

The Army has designed an administrative separation process that is intended to provide checks and balances so that soldiers are treated fairly and correctly. It would be absolutely unacceptable for our mental health providers to participate in any way of a misuse of this process.

We have made many improvements to the Army mental health system in the past few years and we believe we provide the highest quality, most comprehensive, and most responsive mental healthcare of any military in the world. We know there is more work to do and more to learn about the psychological effects of combat on our soldiers. Every soldier is important to us. Especially important are those who need our help dealing with traumatic stress or recovery from a brain injury.

We are dedicated to making our system better and we welcome the opportunity to demonstrate our commitment to the highest qualify of psychological care for our deserving warriors and their families.

[The prepared statement of Colonel Crow appears on p. 96.]

The CHAIRMAN. Thank you, Colonel.

I will start the questioning with Mr. Michaud. But just given some of the charges that we have heard and some of the history, I would say that it is great that you are doing this review now. It is a little late, but I am glad you are doing it. I think it should be done by an outside panel, an independent panel. I don't trust you to tell me what you all did, because you are going to tell me it is right. We all know that. So why bother?

Let's get an outside review. I am going to try to put that into legislation because you should not be reviewing these kind of charges that are based on—you are going to get the information from the same people who are being charged with negligence and you are going to ask them, well, was it right? We know what these reviews are. You reviewed the first stack, Surgeon General Pollack did, and every one was perfectly right. They didn't ask a soldier. They didn't ask anybody else. They just asked the doctor who gave the diagnosis so why should we trust this review?

Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman.

My first question is for Dr. Katz. If you were asked to review someone who—a case that someone had a personality disorder, to

do a thorough and thoughtful review, what would you do in that situation?

Dr. KATZ. The first thing I would do is look for everything else besides the personality disorder. We have effective and safe evidence treatments for many psychiatric disorders. The evidence and effectiveness for treatments of personality disorders is lagging somewhat behind. So as a physician and someone wishing to help, I would want to make sure that I have looked for and excluded all other more treatable conditions before making the diagnosis of a personality disorder.

Mr. MICHAUD. Would you also want to talk to the individual?

Dr. KATZ. That goes without saying. I assumed you were talking about an examination of the patient.

Mr. MICHAUD. Well, getting back to the question I brought up earlier where Surgeon General Pollack was asked to do a thorough and thoughtful—or do a review without—and she did. I mean they did and they never talked to the individual. So that is why I was kind of curious. If you are to do a thorough review, what would the process be? And I agree with your comments. If you were to do one, then it would seem to me you would have to talk with the individual involved.

Colonel, the Chairman had mentioned about—and you mentioned, you are doing a review of the process and the Chairman had mentioned about having an independent review process. In light of everything that is going on, particularly with Walter Reed, and I have heard my constituents who said that they were asked to be redeployed even though they had what they thought were PTSD problems, but still they were told that they had to go back over there. What is your thought about having an independent review of this process? Would you object to that?

Colonel CROW. No, sir, not in general. I mean if there are questions about the quality of work done by us, and it is more—there would be more confidence in a review by an external group of experts, I don't think fundamentally there would be an objection to that. I think when this idea was conceptualized by our Surgeon General, the idea was this is something that we could do, we can do immediately. We have access to the records. But if the level of concern is such that you want to have a high degree of confidence and not an appearance that it an in-house and potential conflict of interest, I don't think there would be an objection to that.

Mr. MICHAUD. Okay. When someone goes into the military, we heard from the first panel that there is a rigorous process that an individual has to go through. When you have active-duty members, then you have the Guard and Reserves. What is happening over in Iraq and Afghanistan, what process, or is there a reevaluation for the Guard and Reserve members to go through that rigorous process before they are asked to be deployed over in Iraq?

Colonel CROW. Well, sir, the process was described as rigorous. I would not describe it that way at all. In terms of the initial processing into the military for medical processing, it is basically a self-report questionnaire and the psychiatric questions, they really have to do with is there a history of certain kinds of serious psychiatric conditions, depression, psychiatric hospitalization, suicidal behavior and so forth. There is not direct——

The CHAIRMAN. Colonel, did you—excuse me for interrupting. Did you just say the Army of the United States of America takes troops into active duty without any rigorous medical evaluation? Is that what you just said?

Colonel CROW. Sir, there is not rigorous psychological evaluation. There is——

The CHAIRMAN. So you are saying a rigorous psychological evaluation. Go on to one of the—in a combat situation which we know is incredibly difficult and causing trauma and you can sit there and say that the Army of the United States of America does not have any rigorous psychological evaluation. That is incredible. I just want to make sure I heard it right.

I am sorry, Mr. Michaud. You still have more time.

Mr. MICHAUD. Thank you.

I guess the distinction, what I would like to know, Colonel, is where a big portion of the men and women who are fighting over in Iraq and Afghanistan are from the Guard and Reserves, and a lot of these folks haven't—are up there and they really haven't had that ongoing military experience like the active duty force. So I am just trying to figure out since a good portion are over in Iraq, is there anything that the Department of the Army is doing to make sure that before they ship them to Iraq and Afghanistan that they are able to deal with the issue. And actually, I heard from the earlier panel that there is a rigorous process. So that is why I asked if they had to go through that rigorous process to make sure that they are able to do the job that they have to do.

Colonel CROW. Sir, I think the way that I would conceptualize it is the presumption is that someone who has enlisted in the Army is able to withstand the duty demands. Once they have cleared the basic training, that they are able to perform in their duty. And unless it is determined otherwise, then the presumption would be that they are fit for duty.

We do have two sets of screenings that are directly related to deployment. At the point of redeployment, there is what is called a post-deployment health assessment. So all soldiers who have been to deployment and are returning are asked a series of health questions that do include some questions about psychological functioning. And 90 to 120 days following return from deployment, there is an assessment called a post-deployment health reassessments for all military, Guard, Reserve, as well as active component, that asks about health status, as well as more extended questions about psychological functioning that are more sensitive to things like depression and post traumatic stress.

The CHAIRMAN. Ms. Brown-Waite.

Ms. BROWN-WAITE. First of all, I want to thank you all for being here today.

And Dr. Katz, if there are this 20 some thousand who had been diagnosed and dismissed by the military with personality disorders, do you know where they are so that they can be helped? Is there any coordination going on now that we know that there may be a problem in the system? Do you know where these people are?

Dr. KATZ. I do not. There is increasing communication and list sharing to match people up. We are good at tracking those who were discharged via a medical evaluation route, those with

polytrauma and other related severe injuries, visible or invisible. But those who are discharged via more ambulatory routes are followed primarily through the PDRHA and beginnings of liaison with VA there and by community outreach and education.

Ms. BROWN-WAITE. PDRHA, tell me what that is.

Dr. KATZ. Post Deployment Health Reassessment that the Colonel was speaking about. These are evaluations that are conducted by DoD with co-participation from VA, primarily Vet Center staff, usually peer outreach people to try to make contact.

Ms. BROWN-WAITE. What about those that DoD has released with a diagnosis of personality disorder? Is there any way that you could reach them? Is there the sharing of the information? In other words, Colonel Crow, if someone is released from DoD with a personality disorder diagnosis, is that—do you ever do followup?

Colonel CROW. No, ma'am. Followup of their living situation or——

Ms. BROWN-WAITE. Followup of their mental health needs.

Colonel CROW. No, ma'am.

Ms. BROWN-WAITE. And obviously they are not eligible for the VA because they have been discharged because of a diagnosis of a prior condition.

Dr. KATZ. No. That is really not the case.

Ms. BROWN-WAITE. Okay.

Dr. KATZ. They are very much eligible for VA care and benefits.

Mr. Aument, do you want to talk about the benefits side and I will talk about care?

Mr. AUMENT. Certainly. In fact, I think it is worth clarifying that, as long as there is an honorable discharge or a general discharge, anything other than dishonorable conditions, a diagnosis of personality disorder does in no way disqualify a veteran from receiving disability compensation or VA healthcare eligibility.

We would go through precisely the same evaluation process if a veteran came to us seeking disability compensation for PTSD. We would go through precisely the same process evaluating that claim that we would for any other veteran who came to us with that type of a claim.

The CHAIRMAN. Would you yield for 1 second?

Ms. BROWN-WAITE. As long as the panel isn't going to be attacked, sir.

The CHAIRMAN. Okay. Would you—do you know how many people who come to the VA with this personality disorder discharge have come to the VA for help? Do you know?

Mr. AUMENT. No, I do not, Mr. Chairman.

The CHAIRMAN. Do we keep that information?

Mr. AUMENT. No, we would not, Mr. Chairman. In fact, that information is not even reflected on their DD214. We would have to go through and actively review their service medical records and somehow capture that information for future use. And quite frankly, if it is not relevant to a determination of PTSD, we would have no reason to collect that information.

Ms. BROWN-WAITE. Let me ask another question reclaiming my time. Would a Benefits Delivery at Discharge (BDD) physical with VA and DoD practitioners evaluate a servicemember to understand

the history and possibly the exacerbation of mental health conditions, new or old?

Mr. AUMENT. Do you want to take that, Doctor, or do you want me to——

Dr. KATZ. Any reliable and valid evaluation should include those components.

Ms. BROWN-WAITE. But I think I am asking do they.

Mr. AUMENT. It depends upon what type of conditions have been claimed. For benefits delivery at discharge, we conduct the examinations that are relevant to the disabilities that are being claimed as part of that process. For example, if there has been no PTSD or other mental disorder disability that has been claimed, it is unlikely that we would conduct any extensive mental health examination.

Ms. BROWN-WAITE. I see that my time is up. Let me ask one other question. Is part of the problem that the young man who testified earlier, Jonathan Town, where he submitted the information multiple times, is part of the problem that the computer system has different programs to it? I know I experienced this when trying to help a constituent and got a very helpful person on the line from VA disability and he said well, I knew the paperwork was there because the constituent sent it in three times. I send it in once and he said let me go to this program, let me go to this program, let me go to this program. There were four different programs.

So perhaps that was part of the problem, because I know I was being told that constituent's paperwork wasn't there when I knew it was there. He had sent it in several times. My office sent it in registered mail with return receipt. So we knew they had it. Is that part of the problem?

Mr. AUMENT. I think in this case, Congresswoman, that is probably the heart and soul of the problem. What you are identifying here is a processing shortcoming on VBA's part in this particular case, that we are certainly accountable for. But I don't believe it was anything having to do with this particular condition, just probably some sloppy service on our part.

Ms. BROWN-WAITE. Well, this happened—this happened 3½ years ago. So I am asking you have you gotten—have you improved the computer tracking system at all?

Mr. AUMENT. Yes.

Ms. BROWN-WAITE. Tell me how.

Mr. AUMENT. Part of the processing changes that have been made has been to upgrade the claims processing system starting from the very time that a claim is received, Congresswoman. We have not completed that process. It is part of the replacement of the compensation and pension payment and processing system. It is the effort that is called Vetsnet, which, has a little troubled history, but I believe we are on track now for improving that and providing better service to veterans.

Ms. BROWN-WAITE. Let me ask you one other question. If today an application is made for a disability, how many different programs could that information be entered into? It was 4, 3½ years ago. How many today?

Mr. AUMENT. I would say today, a receipt of a claim for disability compensation would be entered in no more than two systems, probably only one, but no more than two.

Ms. BROWN-WAITE. And that is system-wide?

Mr. AUMENT. That is correct.

Ms. BROWN-WAITE. Okay. All right. Thank you. I yield back.

The CHAIRMAN. But Specialist Town's applications were not 3½ years ago. They were far more recent and he said only on the fifth one when he had a lot of publicity did he ever get notice.

Let me ask a few questions and make a few observations. The first panel shocked me. You guys shocked me even more.

Colonel, you came into my office yesterday to explain to me this wonderful chain teaching approach of PTSD. And we are going to educate the whole Army about this. And you said the whole basis of this chain teaching is that support has to come from the top so everybody knows it. And yet the implication of what you said earlier was that to the Army, psychological stuff is hardly very important. You said there is a high probability they will adapt. We don't have to worry about it.

What kind of signal is that sending if the physical and the mental—you have not parity whatsoever in your own mind. So how can a soldier ever understand what PTSD is if at the very top you are not understanding these issues?

Colonel CROW. Sir, I could comment about the chain teaching. What we were wanting to describe is that we recognize that stigma for seeking mental health services is a barrier to care. We recognize——

The CHAIRMAN. And did you say anything today that would remove that stigma? You said they will adapt. Real men adapt. Real women adapt. Don't worry about this stuff with the psychological thing. You went through basic training and you are going to be a soldier. That is what you said today. So how does that get rid of the stigma?

Colonel CROW. Sir, I didn't intend to give that connotation.

The CHAIRMAN. The implication——

Colonel CROW. I think the question had to do is whether there is rigorous——

The CHAIRMAN. Yes, and you dismissed it. You said we just assumed that they are going to adapt to the conditions after basic training. That is what you said. So clearly, it is not important to you and that is what people get. And if they have something, well, you better not admit it.

I have talked to soldiers and marines who filled out the questionnaire about on entrance, on separation, that they are supposed to self report about any medical conditions. They told me when they submitted their questionnaire, their commander or whatever said you have go redo this. You cannot admit any of this psychological stuff. They will keep you here another 6 months. You want to go home. Change your questionnaire.

We have soldiers getting out of there that are slipping through the cracks that have no evaluation for either brain injury or for PTSD. You are sending back for second and third deployments people who have brain injury and PTSD. If I was in your position, Dr. Katz or Mr. Aument, and heard what I heard at the beginning, I

would have shocked this Committee and said, you know, if there are 22,500 people that have been diagnosed, maybe wrongly according to the testimony, with personality disorder, let's go find them all, not just 10, not just 259. Let's go after the 22,000.

The Army is a great record keeper, right? We could find them. You say you have outreach. I don't know—I doubt if you are going after—I would take a sample of these by the way and we may have to do this in legislation, take a sample of the 22,000, maybe 1,000 and find out what is going on with them, bring them to the VA. Don't just wait for them to come in.

We are responsible for them. We sent them into war. We sent them into whatever we sent them to, whether they are in combat or not. We have an obligation to them. And you all sit here and say well, we have outreach and no, we don't know how many of those personality disorders come in.

And Mr. Aument, you said everybody knows that they could come in and we will do a de novo review. It doesn't have any—none of what they had before affects us. But if you are a soldier and you were told at age 20 that you are not eligible for VA benefits, as these guys had papers that told them that, and you cannot show up because you had a preexisting condition, what are the odds that they are going to show up? I think pretty small, although let's find out. Let's go after—let's take 5 percent of that 20,000 and find out. Did all 1,000 come in?

If you told me you went after 1,000 and they are all now getting adequate treatment at the VA, I wouldn't be talking like this. But I doubt that is the fact. But prove me wrong.

Anyway, given the fact that both the military and the VA heard this testimony, which is very, very shocking, that there is a systematic and a policy-driven misdiagnosis of PTSD as personality disorder to get rid of the soldier early, to prevent any expenditures in the future which are calculated in the billions of dollars, I would take that pretty seriously if I were you guys and say something about that. But, you said you are affected, but nobody said well, let's go look at those 22,000. Maybe these guys are wrong. We are only basing it on a few people.

Well, find out. I mean these are pretty serious, pretty serious allegations. And if we had doctors' names and one was listed and I have some that have told us that they were misdiagnosing, it seems to me that you should go find that out, Colonel Crow. You are just going to look at 300 records and everything will be fine. Maybe there will be one or two.

There is something going on in your organization that is wrong and it is hurting our young men and women. It has to hurt your effectiveness as a fighting force. I mean for all I know, we are doing so bad in Iraq because you are sending all these brain injured kids back to the second deployment. I mean that could account for how terrible the effort is we are doing.

But we have got a lot to do here. And if I heard one thing from either organization, that you took it seriously and wanted to do something about it and we are going to ask the Congress to give us the money to go after these 20,000—why don't you ever ask us that? I didn't hear anything like that.

Dr. KATZ. Well, we are grateful for the money we have received, including the supplemental funding and——

The CHAIRMAN. Yes, but nobody asked for that. We asked for it.

Dr. KATZ. And are using them to improve access, capacity and quality to make VA mental health services——

The CHAIRMAN. Well, that is a generalization. I want to know, I want you to tell me that we are going to look at 1,000 of these 20,000 PD diagnoses and figure out what happened to them, working with the Army, get their names and addresses, go after them. That would show me you cared about access.

All these generalizations don't tell me anything because I have people coming into my office every day—and Ms. Brown-Waite talks about specific soldiers coming in, who tell us they can't get—they have called the VA. They think they have PTSD and they have got to wait for three, four, or 5 weeks to call back. Now, we know people have committed suicide in that interval.

But everybody says we are outreaching. Soldiers come into our office or call us. They cannot get the help they need. They are dissuaded from coming in and, when they come in, there is a limited number of sessions they can have and on and on. So something is wrong.

Dr. KATZ. We will take your suggestion for these specific outreach and followup studies——

The CHAIRMAN. Thank you.

Dr. KATZ [continuing]. And determine what can be done with existing records

Ms. BROWN-WAITE. Mr. Chairman?

The CHAIRMAN. Yes, ma'am.

Ms. BROWN-WAITE. First of all, I have not told you people came into my office on PTSD issues.

The CHAIRMAN. No. You talked about specific cases.

Ms. BROWN-WAITE. I have talked about specific cases, yes, including one this morning. I just wanted the record to be made clear. And I think that perhaps the record may not also be clear about the conversation with Colonel Crow. That is not the testimony that he gave here today. It may have been what he said in your office. But your assessment of his saying oh, they will be all right, that is not the testimony that he gave here today.

The CHAIRMAN. If you read the transcript of his testimony, he said, and we can take down his words and see it right now, but we won't. He said, when asked about the rigorous examination and I said you mean you don't have a rigorous examination? He said, well, I was speaking mainly of the psychological. And then in answer to a question from Mr. Michaud, he said that—not exactly quoting, but something to the effect that we assume that they will adjust after basic training to the, to the war situation, right? I mean that is what I heard. Is that what you heard or something like that?

Mr. MICHAUD. Yes. We would have to look at the record because I couldn't hear.

The CHAIRMAN. And besides, if he said completely different words and that is what this poor little Congressman heard, then he is not communicating correctly and we gave him a chance to change it. But he gave the impression, and I am sure it is in the

transcript, that the psychological evaluation was not as rigorous and was not as important because a real soldier will adjust.

And that is the whole problem we have.

Ms. BROWN-WAITE. I don't believe he said important.

The CHAIRMAN. That is why these people on panel one came to us, because we don't have an understanding of these issues and we don't have treatment of them and we have a systematic effort, apparently, to try to get rid of them without having more problems. They don't follow them. They took them into the Army. It seems to me we have some obligation there. And we don't follow them up or anything. They are back who knows where.

So I hope that we can look at some of those personality disorder evaluations. Thank you, Dr. Katz for saying that. And we are going to either—the Surgeon General asked for an independent evaluation or we will put it in legislation. But if you think that we are going to believe an evaluation of 259 cases, whichever ones you happen to pick, I will tell you now I am not going to believe it.

So why bother? Let's have an independent evaluation and we will try to deal with it.

Mr. Michaud.

Mr. MICHAUD. Yeah, I just—I would have two quick questions, but I don't know if Mr. Rodriguez had any questions. But my two quick questions actually, one for Dr. Katz is, you talked about taking care of our veterans. Quick question, what do you do with someone who is a veteran who is employed by a company like Blackwater who is currently over in Iraq and Afghanistan but they might be a Priority 8 veteran but they need help with traumatic brain injury or PTSD? Would you take that individual into the VA system? And I don't need an answer today if you can't——

The CHAIRMAN. What if they are not a veteran and they have been injured in the war?

Mr. MICHAUD. So that would be my question for them. The additional follow-up question to the Colonel would be, you had mentioned earlier that every soldier is important to you. Some of the concerns that I have heard from the men and women who have been over in Iraq, who have come back from Iraq, when you look at the ratings, if everyone is really important when you look how you deal with the disability ratings, it is different than the VA.

You look at the injury, as I understand it, whereas the VA looks at an individual as a human being, as a whole person. And that is why we are seeing a disparity in ratings. And when you are reviewing this process, hopefully that you would look at the soldier as an individual, and yes, they might have lost a limb over in Iraq, but yes, they also might have caused other problems such as PTSD or TBI. So hopefully that review process will look at an individual as a whole person, similar to what the VA does.

Dr. KATZ. We will respond to the question about the veteran/contractor for the record.

[The following was subsequently received:]

VA would provide care to a veteran who serves as a contractor in either Iraq or Afghanistan, if the veteran is already enrolled in the VA health care system. If the veteran is not enrolled in the VA health care system, the veteran could apply for enrollment, and VA would make an enrollment decision based upon applicable eligibility factors.

If the veteran had no other qualifying eligibility factor such as a service-connected disability, recipient of a Purple Heart award and income under the applicable VA means test threshold or determined to be catastrophically disabled, the enrollment restriction for new priority 8 veterans would apply.

The CHAIRMAN. Mr. Rodriguez, do you have a concluding comment or question?

Mr. RODRIGUEZ. I haven't had a chance to——

The CHAIRMAN. Oh, I am sorry. I apologize for missing you. I am sorry.

Mr. RODRIGUEZ. And I apologize. I didn't get a chance to listen to the panel either, to the whole panel. I know Dr. Katz well, you know. So good seeing you again.

I don't know how many of you actually listened to the initial testimony. As we look at the numbers of 22,000, I would presume, and I want you just to comment on it, that that is disproportional in terms of the diagnosis for that specific diagnosis. Would that be accurate in saying that, that that is, you know, if there are 22,000?

Dr. KATZ. There have been 720,000 individuals discharged or separated from the military after service in Iraq and Afghanistan.

Mr. RODRIGUEZ. Seven hundred and——

Dr. KATZ. Twenty thousand.

Mr. RODRIGUEZ. Okay.

Dr. KATZ. Two-hundred fifty thousand have come to the VA for care.

Mr. RODRIGUEZ. So 22,000—usually there is a percentage out there for, I guess, one-half percent or a percent of the population falls into schizophrenia, what other percentages—so is that something that is out of the, you know——

The CHAIRMAN. How many of those 250,000 were diagnosed by the VA with personality disorder?

Dr. KATZ. I could get back to you about that. That is not one of the diagnoses we follow most closely.

[The following was subsequently received:]

From October 1, 2001 to March 31, 2007, 252,095 OEF/OIF veterans were either evaluated or treated at VA medical centers. Of that number, 2,316 OEF/OIF veterans were seen for personality disorders (ICD–9 CM, 301).

It is important to note the ICD diagnoses used in this analysis to obtain the number of OEF/OIF veterans seen for personality disorders were obtained from computerized administrative data. Although diagnoses are made by trained healthcare providers, it may include provisional diagnoses before confirmation by specialists, diagnostic tests, and a followup evaluation.

Mr. RODRIGUEZ. Yeah. I was just wondering——

The CHAIRMAN. Because you are not looking for it. You told us you are looking for PTSD. They are looking for personality disorder——

Mr. RODRIGUEZ. Yeah, because I think—I just wonder where there is a disproportional number in that population of that specific diagnosis. That is the only reason I was asking.

Secondly, we know that—and it also brings some concerns. And I know the Colonel and I am familiar with Brooke Army Medical Center. They do great work there. Do we know in terms of the data that we have now if there is a disproportional number may be coming out of Fort Carson or other areas with that diagnosis or do we know that for a fact, or we don't have that information?

Colonel CROW. No, sir. You are raising some very good questions in terms of prevalence rates of the diagnosis, let's say, of personality disorders in general. How have they—variance stayed constant over time, before war, after war, given the different demographics of the soldiers that are coming in. There would be a lot of questions, I think, that could help answer whether or not there seems to be a variance at this point in time with making that diagnosis.

Mr. RODRIGUEZ. But see, there is a pattern that maybe from some areas or some psychiatrist doing, going in that direction versus others, in terms of their decisionmaking.

I would also be concerned—and you mentioned it also that if there is one that we misdiagnosed that is one too many. And so of the ones that we have dishonorably discharged, and I don't know if we have those figures, if they were due to self-medication, because I know that sometimes when they are ill, there is a tendency to self-medicate and maybe get illegal drugs. And I know that that is grounds for dishonorable discharge.

And I am curious now whether there are some people under that category that could have been ill and were not caught and now find themselves dishonorably discharged as a result of trying to self-medicate. Do we have any idea?

Colonel CROW. No, sir. I am now thinking of a way that we would be able to answer that.

Mr. RODRIGUEZ. We would have to go after the discharge—they were dishonorably discharged, to get a grasp to see if there is any, you know, because if we have made mistakes in diagnosing, and I know full well that someone may be seriously ill and we misdiagnosed, then we could have also, that person could easily have gone to try to self-medicate in the process of doing that and then find themselves, even though they might have had a great record with the military, find themselves dishonorably discharged as a result of that.

And so I would be concerned if there is just one who deserves to have, not to have fallen into that category. I wonder if you have any comments on that. Have we ever done any assessments of that?

Dr. KATZ. We have seen the press reports about that happening and are very concerned about those tragedies. There are processes in VA for appealing less than honorable discharges to reclaim eligibility for benefits.

Mr. RODRIGUEZ. The Chairman said, you know, we are in a situation and we hear the report. I guess the frustration is if we don't hear anything, we are not going to come up with a plan as to what is best to get to it unless we hear that, and the report tells us that no, everything was above board. But if not, what would you recommend under those circumstances having heard the allegations?

Colonel CROW. Well, sir, I think if the question is, is the Army and perhaps the other military services doing an accurate job of diagnosing personality disorders as they are administratively separated, I think there would be some other indicators that we could look at. One of the things that I had mentioned in my oral statement was there is supposed to be checks and balances in this process. And one of the balances, if you will, is a review by a legal offi-

cer to make sure that procedures were followed, that the soldier who is being separated understands the nature of the separation, agrees with it, understands their benefits.

That is not a medical procedure. I don't know if there are suspicions or problems with that balance. Part of the problem may be complaints by soldiers that this is not working well. I really wouldn't know that. But I think that would be another potential indicator.

Mr. RODRIGUEZ. Yeah, because I know that that particular diagnosis automatically disqualifies the personality disorder, basically indicating that—now, the other diagnosis of schizophrenia, we haven't heard anything on that. But that onsets also early adult and it is under pressure that it reveals itself. Do we have any data on those individuals?

Dr. KATZ. Among those who have come to VA for clinical care, among the 250,000, the number of those who have served in OIF or OEF who have come back with a psychosis is really quite small, under 2,000.

Mr. RODRIGUEZ. Yeah. And in the regular population, that is about 1 percent or less. So that seems—I don't know what the numbers are. So is that about appropriate?

Dr. KATZ. It is a percent or less that have a psychosis. There are other psychoses besides schizophrenia, but one would expect that the people with early onset, the most severe forms of schizophrenia would not be in the military.

Mr. RODRIGUEZ. Okay. Thank you very much.

The CHAIRMAN. Thank you. Do you have any final thoughts, Ms. Brown-Waite?

Ms. BROWN-WAITE. Mr. Chairman, I would ask that the record be reflected for the true statement that Colonel Crow made. I just want to make sure that there is no misinformation out there. I just think that that would be appropriate.

The CHAIRMAN. That is part of the—this is officially transcribed. So all his words will be in the record, as will mine.

Mr. Kennedy——

Ms. BROWN-WAITE. I just wish that there could be some way that your words and your interpretation could be indicated that—because I think that there was a very clever weaving of what he said and how you interpreted it. And that concerns me.

The CHAIRMAN. Well, thank you for saying I am so clever.

But Mr. Kennedy, do you have any final thoughts?

Mr. KENNEDY. Thank you. Yes, Mr. Chairman. I just wanted to point out once again, as a Member of the Veterans' Appropriations Subcommittee, that, you know, we are looking forward to doing a Conference Committee and looking to address the immediate—you know, we are talking all about these problems, but we have got all these veterans out there suffering right now. And we have got to get help to them right away. There is a lot of talk going on, but we need action.

And we need to make sure that we get these services out to them as soon as possible without delay and we need to do it this year posthaste and I hope in this Conference Committee that we can take this authorizing language that this Committee has been working on on the contracting out and put—set aside dollars for the

Veterans Integrated Service Networks (VISNs) to specifically use to contract out for mental health services and other services with local community health providers to obtain the services desperately needed by these veterans, that they are not now currently getting and due to the fact that the need is so great and the capacity is so limited within the VA.

And the intransigence it seems as though that there is, within the VA, to want to share, you know, to go outside itself to—and I know there is this insular attitude. I don't know if any of you could talk to me about where that comes from. I know it is kind of a sacred cow. I mean I am hearing it—I hear it from my VSOs. They don't even want to hear me talk about any contracting out of VA services because God forbid, you know, anything but the VA provide services to veterans.

But I am telling you this. My veterans don't care where they are getting their services now. That World War II generation wanted to be with the World War II generation. Korea wanted to be with the Korean generation. But after that, these new veterans, they don't care where they get their care. They want their care. Okay? And they don't care if they are with their fellow veterans. They want to make sure they get their care.

I just as soon we take a gold card and give it to every vet that comes back and say you go out there and you get your care. This notion that we are now trying to protect these sacred cows so as to—and in the process letting our poor veterans go out there and in the middle of all of this have to wait in line and, you know, fight for what should truly already be theirs to me is just something that is inexplicable.

But maybe you guys could shed some light on this issue to me. You understand the issue, and I think we all do, that there is a cohort of veterans from an earlier age that all love to be together because of that sense of common experience, that there is that bonding. They like to be together. But there is a new generation of veteran that frankly wants to just get their healthcare, get their benefits and get on with their lives, that isn't as consumed with this notion of where they get it. They just want to get their healthcare.

And maybe you can answer me why there is this sacred cow and why we can't get these VISNs to give up their sacred territory about contracting out with community mental health providers, per se.

Dr. KATZ. Mr. Kennedy, I would like to respond by saying I have admired your advocacy, knowledge and passion for the mental health issues for many, many years. All of us in the mental health professions are very, very glad you are here.

I think that what we are protective and paternal about isn't our turf, but the quality of care, as well as access to care. And we would very much appreciate the chance for technical discussion with you about how to optimize both access and the quality of care.

Mr. KENNEDY. Well, let's work on appropriate language. But one thing I think that would be a conflict is if a local VISN director has to make a choice of deciding where to put the money and they are going to take that budget and that budget is going to be chosen as to whether they are going to take their money out of their hide and

spend it on a community mental health center or not, where are they going to spend it. They are going to spend it within their own budget to make ends meet as opposed to, you know, take a chance that looking at this local community health center that does great work down the way.

Now, that local community health center has certified mental health professionals. Now, frankly, the experience of these veterans run the gambit. Now, granted, you have the post traumatic stress disorder and the VA has certain expertise. And in fact, we are studying some of that in my district that is some of the most cutting edge in the PTSD area. But there is a great deal of work in substance abuse, in marital counseling, in a whole host of areas that frankly, you know, there is plenty of room where the VA doesn't need to be—where they can be maximizing the use of these mental health professionals.

When you have got over 40 percent of the Guard and Reservists right now suffering from PTSD, I would think that you would err on the side of caution of getting them access to some kind of mental health professional rather than saying hey, we want the perfect to be the enemy of the good. I don't think we want the perfect to be the enemy of the good, because frankly, even if a mental health provider is not an expert in PTSD, it doesn't mean that they don't have the kind of training that they need to deal with trauma, because trauma itself is not something that they aren't ill-equipped to deal with in general.

So let's work together on this because with the magnitude of this problem, we can't wait. We both agree that waiting is not the answer. Failure, you know, is not a solution, as they said in Apollo 13, because we know that delay here makes this problem worse, not better. And I thank you for your work and your concern about this.

And maybe I could ask, one of the problems I heard about at my local VA hospital was that if not asked about whether an Army, a Guard Reservist was being treated for PTSD, they would be called back up. That was specific to my VA in Providence. My PTSD supervising doctors told me that they were—saw some of their patients being sent back to Iraq and as a matter of policy, the Navy specifically prohibited, but the Army did not. They said that the Army, if they did not specifically ask whether they were treating someone for PTSD, that the VA did not have to volunteer that information. Is that true?

Dr. KATZ. VA's policy is to share information without significant barriers for those with whom we share clinical care. The redeployment decision is a command authority administrative decision and VA's policy on sharing clinical information for administrative command authority reasons is to require that the veteran consent to VA sending the information to DoD.

We are concerned that there may be cases for whom that exposes veterans to risk, but we are concerned that without a consent provision we may not be recognizing the rights of people who may want a military career and respond to treatment to continue their military careers. It is a tough tightrope in balancing rights and responsibilities.

Mr. KENNEDY. Well, what it seems to me is, they are concerned that they can't say that I am getting treatment because they know the military is going to say goodbye and their military career is going to be over. Whereas, if they said no, I am getting treatment, the military would say okay, you can stay in the military, but here are some other options for you in the military.

That is what I think is not—is the missing piece here. Instead, what we have is, we have the military saying, you know, don't ask, don't tell. And in the process, we may have someone who comes back into the unit that may be a threat to the unit if they are not properly treated, if they are not safe to themselves and to the unit.

I mean you have basically said, if they are not—you are balancing on the one hand the individual's needs with the unit's needs, correct? So how do you do that?

Dr. KATZ. VA's policy is to provide this information to DoD with the veteran's consent. And our assumption is that the Department of Defense examines people about to be redeployed for mental health and other physical conditions that could limit their effectiveness.

Mr. KENNEDY. Right. Well, my—the thing is, my PTSD doctor in Rhode Island said that they were—he was actively treating PTSD Guard and Reservists who were on medical leave, Reservists, okay, so that they were called up again and he wasn't consulted as to whether they should be called back into active service and so they went back to Iraq and presumably they joined their unit and presumably they were fit to join their unit and they weren't a threat to the security of the unit or themselves.

But it is interesting that that is—that that fine point has not been worked out. I believe in protecting the private confidentiality of the soldier. But I also believe in the safety of the unit and I don't think that in order to protect the privacy of the soldier we need to sacrifice the safety of the unit, and I don't believe that the soldier's future career needs to be jeopardized.

I think that there ought to be other options for that soldier to pursue. That is the big conundrum, that there is this notion that if they reveal that somehow they have sought treatment, that they somehow have no other—their options are limited, absolutely limited from then on, which, of course, as we know, is not true. So that I think is where the stigma comes in.

Colonel CROW. I would like to make a comment. I am not sure that it will really address what you are saying. But I think the assumption has been made throughout the course of the day that once diagnosed with post traumatic stress disorder it is sort of a end of the line——

Mr. KENNEDY. Right.

Colonel CROW [continuing]. Kind of connotation, and that is not the case as we see it.

Mr. KENNEDY. Right.

Colonel CROW. What we know is, we have soldiers who are diagnosed with post traumatic stress disorder who continue to do their job. They want to do their job. They want to stay on active duty and perform. So there is not an automatic disability associated with post traumatic stress disorder.

We also know that the models of treatment that have been developed came from a different population at a time when we didn't know very much about PTSD and we believe that it is extremely important to rapidly develop, to the extent that we can, models of treatment that allow us to provide interventions close to the time that the traumatic event and the symptoms appear. That is not a situation that we had in Vietnam. It is a situation that we do have now as an opportunity. However, the professions and the science had not matured to the point where we have off-the-shelf capability to do that. That does need to be developed.

We are extremely grateful that there has been a considerable sum of money that will be provided to the Department of Defense to help both with research, as well as new clinical programs that I think will help quite a bit.

I also think it would be remiss to leave the impression that the mental health providers in the Army or Department of Defense don't know what they are doing. We have extremely well-qualified and extremely well-trained individuals. If there are problems with individuals who are outside the variance of clinical practice, by all means, that needs to be correct. But we have dedicated professionals. We have strong ethics within the Army of taking care of soldiers and trying to do what is right. And I think that needs to be recognized and not overlooked.

The CHAIRMAN. Thank you. Thank you, Colonel Crow.

Mr. KENNEDY. If I could, Mr. Chairman, we don't have enough of them.

Colonel CROW. That is true.

Mr. KENNEDY. We don't have enough of them and we also have had an ethic of "pull yourself up by your bootstraps," too much of that ethic recently from the political establishment in this town as of the last few years that, you know, believe in God and country and you will make it through. And that, my friends, has been what has been wrong with this. If you believe in God and country, you will be all right. If you don't, that is, you know, you have got some moral deficiency here.

That is what we have got to get over. This is a real disease, a real effect of war and it is not some moral failing of the person and not some character defect and unfortunately, so much of the—there has been so many mixed messages coming from political leadership at the VA and from the Administration, whether it be other administration—Justice Department, through the politicization of those other departments, and so forth, that have sent these messages out that I think has made it very difficult for people who have been trying to seek care, to go out there and think that it is all right for them to seek care.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Kennedy. Thank you for your leadership on this.

We thank the panel for being here and this meeting is adjourned.

[Whereupon, at 3:06 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner
Chairman, Full Committee on Veterans' Affairs

Thank you all for coming here today. The purpose of this hearing is to examine: (1) how the VA addresses Personality Disorders; and (2) the recent report by the Institute of Medicine on VA PTSD claims.

Let me start by saying that this is a real issue. Estimates are that about one-third of Iraq and Afghanistan veterans may show signs of PTSD. A national report last year said that the number of veterans seeking help at VA walk-in Vet Centers for PTSD rose from 4,500 to over 9,000 between October 2005 and June 2006.

Mental health issues, however, are not confined to OIF/OEF veterans. There are many older veterans who have yet to be properly treated or diagnosed. Until recognized in the early eighties, PTSD was considered a temporary "war neurosis." For servicemembers who didn't recover, the default diagnosis was to search for an underlying Personality Disorder.

My concern is that this country is regressing and again ignoring legitimate claims of PTSD in favor of the time and money saving diagnosis of Personality Disorder. For instance, in the last 6 years, the military has discharged over 22,500 servicemembers due to Personality Disorders. Unfortunately, this Committee does not have oversight responsibility for DoD; however, I have asked them to be present today because they can provide insight on the initial mental health treatment of our veterans.

Providing veterans with the correct medical diagnosis is key for a variety of reasons ranging from receiving proper treatment to eligibility for military and veterans benefits.

Once a servicemember is diagnosed with a Personality Disorder, he or she has a much more difficult time receiving benefits and treatment at the VA. I want to know how the VA deals with veterans who have been labeled with a Personality Disorder.

Does the burden fall on the veteran to prove that he or she doesn't have a Personality Disorder? Will such a diagnosis prevent the veteran from receiving health care once initial VA coverage ends? What extra barriers does this veteran face?

I am also very interested in learning more about the May 7th PTSD Compensation and Military Service Report, which addressed the current status of the VA's PTSD claims process. The Report was completed by a Committee of preeminent professionals in the mental health field and was paid for by the VA.

The Report offered numerous recommendations on how the VA could improve its PTSD claims process. I want to hear the VA's opinion on whether they can implement the many suggestions offered in the Report. Or, is this Report going to wind up like so many others before it—on a dusty shelf somewhere in the vast VA?

In closing, I want to say that our servicemembers who come back to the states from serving in OIF/OEF should not be forced to fight a second battle to receive a proper medical diagnosis and the benefits and medical care they deserve. One battle in a lifetime is more than enough.

Prepared Statement of Hon. Corrine Brown
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman for calling this hearing today to discuss the relationship between PTSD and Personality Disorders and treatment at the VA.

PTSD has been called many names through to many wars. From "soldier's heart" in the Civil War, to "shell shock" in World War I and "combat" or "battle fatigue" in World War II.

Other terms used to describe military-related mood disturbances include "nostalgia," "not yet diagnosed nervous," "irritable heart," "effort syndrome," "war neurosis," and "operational exhaustion."

Yet the name is not important for the disease, but how those affected are treated.

The men and women in our military are risking their lives to defend the freedom of this country and for us to throw them away after their operiational usefulness has ended is inhuman and un-American.

I am reminded of the words of the first President of the United States, George Washington, whose words are worth repeating at this time:

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their country."

I look forward to hearing the testimony of those panelists here today and learn how to best help those who have bravely served our Nation in war.

Prepared Statement of Hon. Stephanie Herseth Sandlin
a Representative in Congress from the State of South Dakota

Thank you, Chairman Filner for holding this hearing to review assertions that Post Traumatic Stress Disorder claims are being misclassified as pre-existing personality disorders and also to review the May 7, 2007, report from the Institute of Medicine and National Research Council on the Department of Veterans' Affairs PTSD disability rating system.

I also would like to thank all of today's witnesses. I look forward to hearing your testimony.

Like the rest of my colleagues on this Committee, lam committed to the quality health care that our servicemembers and veterans deserve and were promised, including honest and fair medical evaluation and treatment.

Mr. Chairman, thank you again for holding this hearing. I look forward to working with you to resolve these problems and other problems associated with the Department of Veterans' Affairs and Department of Defense's PTSD disability rating systems.

Prepared Statement of Hon. Cliff Stearns
a Representative in Congress from the State of Florida

Mr. Chairman,

Thank you for holding this important hearing on Post Traumatic Stress Disorder (PTSD) and Personality Disorders among returning servicemembers from areas of conflict. I am pleased we are holding this hearing today, and look forward to participating in this discussion.

PTSD is the most prevalent mental disorder among returning Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) servicemembers. The hallmark characteristics of PTSD include flashbacks, nightmares, intrusive recollections or re-experiencing of the traumatic event, avoidance, and numbing. When such symptoms last under a month, they are typically associated with acute stress disorder, not PTSD. In order for a diagnosis of PTSD, symptoms have to persist for at least a month and cause significant impairment in important areas of daily life. However, some studies indicate that more than 80% of people with PTSD also experience a major depressive or other psychiatric disorder. Therein lies the difficulty in accurately evaluating a patient has suffering from PTSD, or a Traumatic Brain Injury (TBI) or as having a personality disorder. I am pleased that beginning in 2005, the Veterans Health Administration created "Returning Veterans Education and Clinical Teams" in medical centers to help, educate, evaluate, and treat returning veterans with mental health and psychosocial issues. These programs collaborate with other VA Medical Center PTSD, substance abuse and mental health programs, and with polytrauma teams, TBI and primary care services, as well as with Vet Centers in an attempt to provide comprehensive treatment. By the end of this year, the VA anticipates that it will have 90 of these programs operational throughout the country.

While the treatment for PTSD is improving in the VA system, we are here today to ensure that all those who need such mental health services are correctly identified, getting the appropriate treatment, and able to receive the appropriate compensation for their disability. A recent report from the Institute of Medicine regarding PTSD compensation was very interesting and raised some good points. I was

interested by the Institute's finding that the VA's current approach using the Global Assessment of Functioning (GAF) scale when evaluating severity of PTSD for compensation and disability claims was inaccurate and needed to be re-evaluated. In fact, the report states that the GAF scale is, "only marginally applicable to PTSD because of its emphasis on the symptoms of mood disorder and schizophrenia and its limited range of symptom content." In particular, the Institute advocates that the system should look at the veterans' everyday life and social interactions and not solely upon the impact upon the veterans' employability.

Among some of the Institute's recommendations was the suggestion the VA use only experienced mental health professionals to diagnose patients claiming to suffer from the disorder, rather than standard claims processors. The variation among evaluations spans sometimes from a 20-minute conversation to the recommended full 3-hour evaluation. Standardization among these evaluations is imperative to ensure patients are diagnosed and treated correctly. To that end, VA leaders should align their guidelines to those set by the American Psychiatric Association, and implement certification procedures for workers dealing with PTSD claims.

I feel it is important to note that the focus of this Committee hearing should be on the VA claims process and criteria for PTSD claims. While there have been publicized reports of problems with the screening and discharge processes at the Department of Defense, the jurisdiction and problem before this Committee is how the VA processes and evaluates claims from veterans asserting PTSD for service-connected disability status. It is a complex issue involving many psychiatric components, and I look forward to our panels of witnesses shedding light on the intricacies in these diagnoses for us today.

Thank you.

Prepared Statement of Hon. Ginny Brown-Waite
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman,

I appreciate all of the witnesses, and I especially would like to thank all the healthcare professionals present here today. Your involvement and expertise helps this Committee ensure we are meeting the healthcare needs of the men and women that have so bravely served their country in the Armed Forces.

The men and women of our military not only face grave physical danger while on the battlefield but in some cases experience life altering traumatic events that effect their ability to lead a normal life when they come home. Today's hearing draws attention to a report by the Institute of Medicine on how the VA handles claims of post traumatic stress disorder. Post traumatic stress disorder is a serious medical condition and our veterans should receive the care they need to live a healthy and productive life.

Once again, I welcome you to the hearing and look forward to hearing your thoughts on the issue before us today.

Prepared Statement of Hon. Harry E. Mitchell
a Representative in Congress from the State of Arizona

Thank you, Mr. Chairman. I am very pleased that this Committee is addressing the issue of service-members who have been denied treatment of their PTSD due to a determination of a preexisting personality disorder. This topic is one which needs all the attention we can give it. While I understand that this situation is happening in our Armed Forces, I believe that Congress as a duty and responsibility to shed light on this deplorable situation.

It has always amazed me that it is somehow acceptable to treat people suffering from "unseen" mental injuries any differently than if they had a visual wound or impairment.

I look forward to hearing from our panelists and to working with this Committee to do everything in our power to make sure that this practice stops.

Mr. Chairman, I ask that we continue to follow up with these soldiers when they transition to our jurisdiction in the Veterans Affairs system to make sure that they get the services they need while this egregious policy is being rectified.

Prepared Statement of Jason W. Forrester
Director of Policy, Veterans for America

Chairman Filner, Ranking Member Buyer, Members of the Committee:

It is an honor to be here today.

Veterans for America—formerly the Vietnam Veterans of America Foundation—focuses solely on meeting the needs of America's newest generation of servicemembers, and veterans. We work very closely with the Department of Defense, Members of Congress, the media, active-duty troops and veterans to identify the unique challenges facing today's military.

Much of our work is investigative. Members of VFA have visited every major demobilization site in the United States and abroad. Specifically, our work at Ft. Carson, Colorado—where we first met Specialist Town—and our current work at Camp Pendleton, California, has prompted considerable media attention and congressional action, and has helped identify trends and areas where our country is failing our servicemembers.

We also work closely with veterans trying to navigate the mammoth VA bureaucracy. However, given the distressing disconnect between VA and the DoD, the greatest service that VFA can provide here today is to highlight the trends we have identified and are working to correct within DoD and to offer some ideas regarding how the VA can help in the process of ensuring that those who have served in Iraq and Afghanistan get the assistance they deserve.

It is important for VA to understand the unique situations and experiences of the nearly one million servicemembers from Iraq and Afghanistan who are still on active duty—and who will be in the VA system sooner or later.

It is our hope that once the VA has a greater understanding of the specific needs of today's military and a greater understanding of the deficiencies within DoD that the VA can help those who were failed before they became veterans.

The DoD's Mental Health Task Force's report found that 49% of Guard members, 38% of soldiers, and 31% of Marines are experiencing some mental health issues after serving in Iraq and Afghanistan. The Task Force recognized that programs within DoD did not adequately reflect the increasing demand. These shortcomings are caused partly by a lack of resources. In addition, stigma is a significant hurdle blocking treatment. In the Task Force report, DoD characterized PTSD as a "signature" wound of wars in Iraq and Afghanistan.

Our investigative work supports these findings and demonstrates the immense challenge of implementing solutions across the military.

At Ft. Carson, we found soldiers who had been diagnosed with chronic PTSD who were only receiving 1 hour of individual therapy a month. Often, these soldiers saw a new therapist each visit. In an attempt to compensate for this deficiency, many soldiers were prescribed medicines to help them deal with their PTSD. It was not uncommon for us to meet soldiers on over 15–20 different medications at once.

At Ft. Carson, we worked with soldiers who, having clearly indicated on their Post-Deployment Health Reassessment (PDHRA) that they were having difficulty readjusting to life post-deployment, were not receiving the treatment they need. In some cases, these soldiers have been redeployed only to have their wounds compounded by further exposure to conflict. In other cases, undiagnosed and untreated PTSD led soldiers to turn to drugs and alcohol.

The civilian medical community has long recognized that alcohol and drug use is a symptom of PTSD, and, fortunately, many in the military also recognize this. That said, this reality poses a significant challenge for our military and has had unfortunate consequences for our servicemembers. The maintenance of discipline is the top priority for the military and the pressure to bring together units to be deployed is immense. The combination of these two factors have inhibited adequate treatment of the behavioral manifestations of PTSD.

At Ft. Carson, many soldiers addicted to alcohol and drugs have been referred to the Army Substance Abuse Program (knows as ASAP), as Army regulations dictate. While this program can be very beneficial to soldiers who have only drug and/or alcohol addictions, it does not help soldiers with service-connected PTSD. It is policy within DoD not to treat soldiers with drug and/or alcohol addictions for their PTSD until their addictions have been addressed. There are no dual-track PTSD and substance abuse programs within the DoD. We have worked with several soldiers who have suffered greatly from this deficiency and, in some cases, we have managed to get them help within VA facilities that offer dual-track care.

We also have seen many cases other where soldiers with PTSD have been other-than-honorably discharged—losing any hope of treatment for their service-connected injuries.

Many of the same issues are found at Camp Pendleton. The Marine Corps still has not identified adequate approaches for dealing with behavioral issues associated with mental health challenges. As a result of our work, VFA believes that the stigma associated with mental health is greater in the Marine Corps than in the Army. The Marine Corps often confines Marines with behavioral issues to the brig. In the brig, Marines are still given their medications, if they were lucky enough to have received a diagnosis. However, they receive no therapy and are left to deal with the consequences of their service-connected injuries alone.

These problems within the DoD have created considerable challenges for the VA. VA needs to recognize this challenge by creating new programs designed for this generation of servicemembers. Since PTSD is so prevalent—and dual-track treatment options within DoD for mental health issues and substance abuse are absent—VA must increase the number of dual-track alcohol/substance and PTSD programs. VA must also create new programs for Iraq and Afghanistan veterans with unique needs—such as women and Guard and Reserve members.

VA can help greatly with the issue of stigma by increasing its outreach to servicemembers and their families on bases and within military medical facilities. Today's servicemembers need to know that PTSD is an injury and that they deserve every opportunity to recover. PTSD is not a sign of weakness. It is a proven medical reality of sustained exposure to combat.

Finally, another distressing trend that we identified at Ft. Carson was the prevalence of pre-existing personality disorder discharges for soldiers with service-connected mental health problems. From 2001–2006, the Army discharged over 5,600 soldiers for pre-existing personality disorders; over 22,500 have been discharged for this reason across all the services. A personality disorder diagnosis often requires servicemembers to repay their re-enlistment bonuses and denies them their combat-related disability pay.

Some within the Army's personnel system have argued that personality disorder discharges are an easy way out for the Army and, unfortunately, for soldiers who are tired of reprimands and suffering. That said, the consequences of such a dismissal are severe, including denial of VA benefits due to the disorder's "pre-existing" nature.

At Ft. Carson, we met numerous soldiers who had been diagnosed with a pre-existing personality disorder discharge—often in under an hour—regardless of the fact that they were deemed fit when they entered the service and regardless of the fact that they had been diagnosed with PTSD post-deployment to Iraq and/or Afghanistan.

Pre-existing personality disorder discharges remove the burden from our society to help the servicemember deal with their service-connected injuries. It is unacceptable to ask an American to sacrifice for this country and not treat and recognize the consequences of their service.

In May of this year, as a result of our work at Ft. Carson, a congressional staff-delegation returned to Ft. Carson where they met with the soldiers and family members who we have been helping. This visit prompted a GAO investigation into mental health treatment in the military, and it led to 31 senators sending a letter to Secretary Gates calling for a moratorium on pre-existing personality disorder discharges.

While we are hopeful that this moratorium will come into effect immediately, it still would not address the problem of those who have already been inappropriately discharged.

This problem presents a great opportunity for VA leadership.

The VA has no obligation to treat a veteran with a pre-existing personality disorder discharge since the discharge implies that their injuries are not service-connected. That said, these veterans can still visit Vet Centers. However, they do not have immediate access to adequate medical care. This being the case, the VA should create a streamlined process for face-to-face medical evaluations for those with pre-existing personality disorder discharges.

We owe these veterans a second chance to get much needed help for their service-connected injuries.

This concludes my prepared statement. I would be pleased to answer any questions.

Prepared Statement of Jonathan Town, Findlay, OH

On January 20, 1961 a Veteran who was being sworn in as our president said during his inaugural speech "Ask not what your country can do for you, ask what

you can do for your country". Since January 2001 over 22,000 people have answered this call and served in the United States armed forces only to be chaptered out of the military with a Personality Disorder discharge. It has become a debate if it was done to save the military money or to help out with military war time and deployment strength. Regardless of the reason, it is an outrage that these servicemembers, including myself and their families have been put through this.

I would like to tell you my story. I served 4½ honorable years at Fort Knox, Kentucky as an administration specialist. I was then given orders for "Permanently Change of Station" to Korea. After arriving in Korea I was told that the unit I was assigned to had just received its deployment orders to Iraq. In August, 2004 the "STEEL" battalion (which I now was part of) deployed to Ramadi, Iraq. On October 19, 2004, I was running mail for our battalion when incoming rounds started exploding across the street from where my vehicle was parked. While running for shelter in our S–1 shop's office, a 107mm rocket exploded 3 feet above my head leaving me unconscious on the ground. After regaining consciousness, I was taken to the battalion's aid station where I was treated for various wounds including a severe concussion, shrapnel wound in my neck and bleeding from my ear. I was given quarters for the rest of the day and went back to work the next day. This is when everything started to go downhill health-wise for me. Throughout the next 9 months, while continuing to serve my country, I battled severe headaches, bleeding from my ear, and insomnia. We finally got the word that we were headed home and I thought I would finally be able to get some assistance for the medical issues I was going through. After a few days back in the United States, I realized a new battle for me was taking place. My ability to adjust to loud noises, large groups of people, and forgetting what had happened to my unit and myself while we were in Iraq was going to be yet another battle.

About 45 days after coming back stateside to Fort Carson, Colorado I was finally able to see a psych doctor. The first few meetings with the doctor were good and it seemed like he actually cared about helping me get through my issues if it were possible. Then word came down that our unit was going to be redeployed. The next time I went to see the doctor he informed me that he was going to push a personality disorder chapter and explained why. The doctor said "You have the medical issues that call for a medical board but the reason I am going to push this chapter is because it will take care of both your needs and the Army's. You will be able to receive all of the benefits that you would if you were to go through a medical board; get out of the military; and focus on your treatment to get better. For the military they can get a deployable body in to fill your spot". I told him that if this is what he thought was best for the military and my family that he could do what he needed to do. I never realized that everything that was said to me during that day were all lies.

I went through the "final out process" to leave the military. The day that I was signing out I was told by the "final out" personnel that I would not receive any severance pay or benefits and that I actually owed the military $3,000. I do not know everyone in this room but I think that if you where to work your heart out for a company or agency only to be told that you owed them money when you went to leave you would obviously think something is wrong. If it weren't for my family taking us in and supporting us both financially and emotionally and for new friends helping us, I don't know where my family and I would be right now. The last 9 months have been spent trying to get assistance both medically and financially through the Veterans department; getting the word out to the public about what is happening to my fellow servicemen and myself; and trying to get my family and myself back on our feet. I'm now receiving treatment and disability pay from the VA. I am fortunate because there are many, many injured military personnel that still have not gotten to this point.

I think the government should fix the Personality Disorder discharge issue and the time it takes a servicemember to receive the start of their disability from the time they leave the armed forces. The Chapter 5–13 Personality Disorder discharge should be completely taken out of any DOD regulation or if the military really wants a way to get servicemembers out of the service (that do not have over 6 months of active service or have not been deployed overseas) then it needs to be written that way in the regulations. It is 100% wrong to be able to use this discharge for any servicemember that has been on active service for a substantial amount of time; who has fought in a war or who has served in a war zone for their country.

An idea I have heard about I could fix how long a servicemember has to wait till they finally start receiving disability after leaving the armed forces. The servicemember starts his or her disability paperwork and process at the station where the he or she is currently stationed 2 months prior to getting out of the service. The

servicemember should not be able to final out from their branch of the military until he or she is either granted or denied their disability claim. By going through this route, it will allow the servicemember to receive their first disability check immediately after their last paycheck from the armed service. The Department of Defense should work "hand in hand" with the Veterans Department to assist the soldiers in need.

In closing I want to state that I did not have a personality disorder before I went into the Army as they have stated on my paperwork. I have post traumatic stress disorder and traumatic brain injury now due to injuries from the war. I shouldn't be labeled for the rest of my life with a personality disorder and neither should my fellow soldiers who also incorrectly received this label. I would like to ask the Committee and panel Members to thoroughly think about the ideas I have mentioned to fix some of the issues we as veterans are facing. Please help those who have helped their country.

Thank you.

Prepared Statement of Joshua Kors, Reporter, *The Nation* and Contributor, *ABC News*

Good morning. I've been reporting on personality disorder for the last 10 months, and I'm here today to talk about the 22,500 soldiers discharged in the last 6 years with that condition.

A personality disorder discharge is a contradiction in terms. Recruits who have a severe, pre-existing condition like a personality disorder do not pass the rigorous screening process and are not accepted into the Army.

The soldiers I interviewed this year passed that first screening and were accepted into the Army. They were deemed physically and psychologically fit in a second screening as well, before being deployed to Iraq, and served honorably there in combat. In each case, it was only when they came back physically or psychologically wounded and sought benefits that their pre-existing condition was discovered.

Discharging soldiers with a personality disorder prevents them from being evaluated by a medical board and getting immediate medical care. This can be life-threatening for our soldiers. A good example is Chris Mosier, who served honorably in Iraq, where he watched several of his friends burn to death in front of him. After that, he developed schizophrenic-like delusions. He was treated at Ft. Carson for a few days, then discharged with a pre-existing personality disorder. He returned home to Des Moines, where he left a note for his family saying the Iraqis were after him there in Iowa, then shot himself.

Surgeon General Gale Pollock agreed to review a stack of personality disorder cases. After 5 months, she produced a memo saying her office had "thoughtfully and thoroughly" reviewed the cases, including Jon Town's, and determined all of them to be properly diagnosed. With further reporting, I discovered that as part of that "thoughtful and thorough" 5-month review, Pollock's office did not interview anybody, not even the soldiers whose cases she was reviewing. Some of those soldiers said they called the Surgeon General's office offering information about their ailments. Their efforts were rebuffed.

The one thing the Surgeon General's office did do was contact a doctor at Ft. Carson, where many of the personality disorder diagnoses were made, and ask him whether his doctors got it right the first time. That doctor said yes, his staff's original diagnoses were correct, and Pollock shut down the review at that point.

The Surgeon General's office denied that for many months, insisting that the review was conducted by a panel of health experts who were not involved in the original diagnoses. This wasn't a case of one man reviewing his own work, they said. But eventually it did come out that the only reviewer was Col. Steven Knorr, who as Chief of Behavior Health at Ft. Carson, oversaw many of the personality disorder diagnoses and, in his capacity as a psychiatrist, was reportedly involved in creating many of them as well.

When the problems with Walter Reed became public, the Pentagon took two actions: it accepted the resignation of Surgeon General Kevin Kiley, and it hired the public relations firm LMW Strategies with a $100,000 no-bid contract to put a positive spin on those problems. This past week, as these personality disorder discharges became public, VA Secretary Nicholson stepped down. And today Surgeon General Pollock will sit before you.

As a journalist, it's not my role to make any recommendations, but I do want to share with you the hopes of the wounded veterans I spoke to this year, which is a hope that someone be held responsible, and that officials go back through the

22,500 cases and seek out the thousands of Jon Towns who are waiting there, struggling right now without benefits or the media spotlight.

Personality Disorder Discharges (2001–2006)

Year	Army	Air Force	Navy	Marines
2001	805	Unavailable	1,389	443
2002	734	1,523	1,733	460
2003	980	1,496	1,316	328
2004	988	1,307	1,253	414
2005	1,038	928	1,176	475
Nov. 2006	1,086	1,085	1,076	442
Totals:	**5,631**	**6,339**	**7,943**	**2,562**

Source: Department of Defense
*Navy numbers are for fiscal, not calendar, year.

TOTAL (2001–Nov. 2006): 22,475

Total for 2001: 2,637 (which includes the Air Force's one unavailable year)
Total for 2002: 4,450
Total for 2003: 4,120
Total for 2004: 3,962
Total for 2005: 3,617
Total for 2006: 3,689

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO ATTENTION OF

DASG-ZA

23 MAR 2007

MEMORANDUM FOR Mr. Steve Robinson, Director of Veteran Affairs, Veterans for America, 1025 Vermont Avenue, NW, 7th Floor, Washington, DC 20005

SUBJECT: Review of Fort Carson Cases

1. This memorandum follows up on your request for a record review of selected cases from Fort Carson. We have carefully reviewed the cases that you provided: SPC Davis, Corey; PVT Davis, Mickey; PFC Harvey, Jason Johnathan; PVT Jennings, Tyler; SPC Morris, James; PFC Sinak, Melissa; SPC Town, Johnathan; and SGT Duncan, Jonathan.

2. We asked Fort Carson to review each case carefully and provide us a treatment summary. There is clear evidence that these cases were thoughtfully and thoroughly evaluated and reviewed by both the behavioral health system and command. The behavioral health providers did thorough assessments and appropriately referred the Soldier for substance abuse and behavioral health treatments. In several cases, the Soldier declined referrals or went to Military One Source. By design, Military One Source has no feedback mechanism, so we have no information on those cases.

3. It is certainly possible that there are cases of Soldiers with symptoms of Post Traumatic Stress Disorder or Traumatic Brain Injury that were not diagnosed or treated. We appreciate your attention to these critical issues to help ensure our Soldiers continue to receive appropriate care and treatment.

4. Point of contact for this memorandum is COL Elspeth C. Ritchie, at (703) 681-1975, or elspeth.ritchie@us.army.mil.

GALE S. POLLOCK
Major General
Acting The Surgeon General

Press Release/March 27, 2007

"Post Traumatic Stress Disorder (PTSD) is real. The Army's leadership—up and down the chain of command starting with the Acting Secretary of the Army and the Vice Chief of Staff of the Army—are actively involved in getting the entire Medical Evaluation Board and Physical Evaluation Board process right. The Army has no greater obligation to its returning 'Wounded Warriors' than to provide them with the absolute best medical care possible; and if we come up short, then the Army will react immediately to remedy the problem.

Leaders from the Office of the Army Surgeon General had the cases Mr. Robinson brought to them thoroughly evaluated and reviewed. While we cannot address individual medical cases in this venue, it was determined that the behavioral health providers did thorough assessments and appropriately referred the soldiers for substance abuse and behavioral health treatments. A more detailed response is being provided to Mr. Robinson.

The behavioral health officers at the Army hospital at Fort Carson reviewed the Chapter 5–13 cases in soldiers who were diagnosed with PTSD. The data demonstrated that there were no soldiers separated under Chapter 5–13 in the last 4 years who should have undergone a medical evaluation board. It should be noted

that a personality disorder diagnosis does not necessarily mean that a medical evaluation board is needed. It indicates that a soldier has personality traits that are not compatible with military service.

Soldiers who are separated under Chapter 5–13 receive honorable Discharges and, if they have served 6 or more years on active duty, they are eligible for separation pay. Additionally, it is Army policy not to separate a soldier for a personality disorder under Chapter 5–13 if that disorder amounts to a disability. If the disorder amounts to a disability, the soldier should be separated under the disability evaluation procedures of AR 635–200.

Further, it is certainly possible that there are cases where soldiers with symptoms of Post Traumatic Stress Disorder or Traumatic Brain Injury are not diagnosed or treated. We are grateful each time someone raises a concern. Nothing is more important than insuring that these men and women are provided the best possible health care.

We understand that many wounded and injured soldiers, who have supported the Global War on Terror, as well as their families, continue to endure hardships. The Army is committed to providing the best possible medical care for the men and women who have volunteered to serve this great nation and has recently launched the Wounded Soldier and Family Hotline: 1–800–984–8523.

The purpose of the hotline's call center is twofold: to offer wounded and injured soldiers and family members a way to seek help to resolve medical issues and to provide an information channel to senior Army leadership so they can improve how the Army serves the medical needs of our soldiers and their families."

Lieutenant Colonel Bob Tallman, Spokesman for the U.S. Army

Prepared Statement of Paul Sullivan
Executive Director, Veterans for Common Sense

Chairman Filner and Members of the Committee, thank you for inviting Veterans for Common Sense to testify about "PTSD and Personality Disorders: Challenges for the VA." VCS is a non-profit organization based in Washington, DC focusing on issues related to national security, civil liberties, and veterans' benefits.

My testimony focuses on offering solutions to the many unconscionable, outrageous, and intentional actions taken by the Department of Veterans Affairs and by the Administration to prevent our Iraq and Afghanistan war veterans from receiving prompt medical care and disability compensation for PTSD. My testimony is based on more than 15 years' of experience as a veterans' advocate and as a VA project manager.

There are two common sense standards VA should meet. First, when a war veteran needs mental healthcare, our Nation must provide it immediately from a certified mental healthcare professional so the veteran can avoid a broken family, lost job, drug abuse, alcoholism, crime, homelessness, and suicide.

Second, when a veteran needs disability compensation for a mental health condition, our Nation must provide it immediately, without endless bureaucratic hassles, so the veteran can put food on the table, pay the rent, and take care of his or her family.

When the Department of Defense discharges a servicemember who fought honorably in combat for a personality disorder, then the military is breaking its own rules. DoD regulations state that if a servicemember was in combat, then the military is generally prohibited from using a personality disorder diagnosis.

DoD's actions have serious consequences. A veteran discharged for a personality disorder is usually denied access to VA healthcare and disability benefits based on VA regulations that prohibit providing services for a pre-existing condition.

In light of the military's inappropriate discharges, what can Congress and VA do now to begin to resolve this fiasco? VCS will describe the scope of PTSD among Iraq and Afghanistan war veterans, and then VCS will offer solutions. More than 1.6 million of our fellow Americans have deployed to the two war zones.

As of December 2006, about 686,000 are now veterans eligible for VA healthcare and benefits. A staggering 36 percent, or 229,000 veterans, were already treated at VA medical facilities. Of those treated, more than one-third, or 84,000 veterans, were diagnosed and treated for a mental health condition, including more than 20 percent, or 45,500, for PTSD.

As of June 2007, more than 202,000 Iraq and Afghanistan war veterans have already filed disability compensation claims against VA. Of the 157,000 claims approved by VA, more than 19,000 veterans are service-connected for PTSD. The

PTSD claims will continue to rise as the number of PTSD patients rise, especially when the deployed veterans exhaust their 2 years' of free healthcare.

When all of our troops return home, at the current rate, VA faces nearly 600,000 potential mental health patients, including 320,000 diagnosed with PTSD. The number will grow as hundreds of thousands more of our servicemembers deploy for a third or fourth combat tour in an escalating war that surrounds our troops with 360-degree combat 24 hours per day, where our troops switched from being the predator to being the prey. The number of claims will also continue to rise, including those for PTSD.

VCS urges Congress to adopt nine new policies so that more of our war veterans with PTSD don't fall through the cracks—the period of time between when a servicemember discharges from the military and the new veteran begins receiving all of his or her healthcare and disability benefits.

Failure to reduce the stigma and delay in providing healthcare and benefits will most likely result in a social catastrophe among many of our returning Iraq and Afghanistan war veterans—including broken families, lost jobs, stigma, drug abuse, alcoholism, crime, homelessness, and suicide. Many of these consequences are preventable. Please act now and take advantage of this quickly closing window of opportunity.

Proposed Solutions to Personality Disorder and PTSD Crisis

First, VCS urges Congress to order the Department of Defense to immediately stop discharging war veterans with a personality disorder diagnosis. If the military allowed the servicemember to enlist, then a personality disorder diagnosis should be given only in cases of fraud after providing the servicemember with full due process. Congress should also order the military to conduct a review of all personality disorder discharges for veterans deployed since September 11, 2001. Congress should also order VA to review applications for healthcare and disability compensation where VA denied access based on a personality disorder.

Second, Congress should order DoD and VA to establish a policy to reduce the stigma against people with mental health conditions. Military studies confirm this stigma hinders many of our war veterans from seeking mental healthcare. America can and should welcome our veterans home with full and prompt access to mental healthcare.

Third, VCS urges Congress to demand full enforcement of Public Law 105–85, the law requiring all servicemembers to be examined for physical and mental health conditions before and after deployment. This law implements a critical lesson learned from the gulf war, when the military failed to examine our troops before and after deployment. The military's negligence resulted in a lack of information about gulf war illnesses among more than 100,000 Desert Storm veterans that still stump scientists today.

Fourth, Congress can enact legislation creating a presumption of service connection for PTSD for veterans who deployed to a war zone since September 11, 2001, who are diagnosed with PTSD. A deployment since September 11, 2001, should be considered as combat under 38 USC 1154. A presumption makes it easier for VA to adjudicate the claim, and results in faster medical treatment and faster disability compensation payments for veterans. Congress should also explore automatically approving all VA claims at a modest rate within 30 days, for a period up to 1 year, for deployed veterans' claims. VCS supports this bold recommendation initially made by Harvard Professor Linda Bilmes.

Fifth, Congress should enact legislation significantly expanding VA's highly successful Vet Centers and allowing VA readjustment counselors to provide mental health services to active duty servicemembers, either at existing facilities or at new offices on military bases. This expanded service might first be targeted at military installations that have shortages of mental healthcare providers and bases expecting large redeployments from the war zones. This way, the supply of mental health professionals can meet expected and significant surges in demand. Congress should also consider allowing families to participate in the readjustment counseling process at Vet Centers.

Sixth, Congress should enact S. 1606, which was added to the National Defense Authorization Act in the Senate. This bill directs DoD to streamline policies and reduce the number of veterans falling through the cracks. The most important part of the bill, in our view, is the provision mandating that DoD provide free medical care for veterans discharged for a medical condition at less than 30 percent. Based on the series of government Accountability Office reports over the past 10 years, this legislation should be amended to mandate that DoD provide VA immediate access to full military and medical records immediately after a veteran's discharge so that VA can expedite medical treatment and claims processing.

Seventh, Congress should enact S 1354, which directs VA to define the war zones, collect data, and prepare cost and benefit use reports about the Iraq and Afghanistan wars. This proposal mandates "truth in government" so Congress and the public are fully and regularly informed about the human and financial costs of the two wars. This proposal will also tremendously improve VA planning and budgeting. Without consistent and timely reports for the expanding Iraq and Afghanistan war population, VA may once again fall $3 billion short and be unable to provide medical care to veterans.

Eighth, in a related matter, VCS urges Congress to enact S 849 so that VA and DoD comply with all Freedom of Information Act requests in a complete and timely manner. VA routinely delays or denies our FOIA requests about the Iraq and Afghanistan wars. VA's stonewalling unduly hinders VCS from providing fact-based advocacy. VCS used DoD and VA documents obtained under FOIA to assist Harvard Professor Linda Bilmes with estimating the cost of the two wars for VA at between $350 billion and $700 billion over 40 years. VCS also obtained obscure DoD reports confirming the two wars caused more than 65,000 casualties, defined as a person who is dead, wounded, injured, or ill (DoD and the press routinely mislead the public by providing the incomplete count of 25,000 casualties). VCS also publicized the fact that VA statistics reveal that National Guard and Reserve are half as likely to file VA disability claims than Active Duty. However, the National Guard and Reserve are twice as likely to have their claim denied.

Ninth, Congress and VA should consider a package of PTSD-related reforms:

- VA should set clear timeliness standards to screen and provide care for PTSD.
- VA should outsource current demand for PTSD treatment to the private sector, so veterans receive timely care, until such time as VA can hire permanent staff.
- VA must accept a PTSD diagnosis from private professional psychiatrists. If VA disputes the non-government diagnosis, then VA should approve the PTSD claim until the claim decision is final so that the veteran receives prompt medical care.
- VA must update the outdated and incomplete PTSD rating schedule to take into consideration quality of life issues raised recently by the Institute of Medicine. The rating schedule should be veteran-friendly and be based upon the latest medical and scientific findings.
- VA must require all claims adjudicators to receive prompt and intensive training on PTSD claims. This high-priority item should be accomplished quickly because of the escalating claims backlog and the reasonable expectation of hundreds of thousands of more PTSD claims.
- VA must be held accountable when VA makes mistakes. When a veteran wins a case based on appeal or remand, then VA should be required to pay back interest and penalties. Without accountability, VA will continue to inappropriately delay and deny veterans PTSD claims.

Background Describing VA's Crisis

Sadly, Mr. Chairman, the current VA political leadership failed our veterans as the VA claims backlog grew 50 percent in the past 3 years. In a bitter irony, VA handed out $3.8 million in cash bonuses to top VA political leaders while the overall situation deteriorated at VA. More veterans are waiting much longer to receive disability compensation payments. In response to the outcry over the bonuses, VA said it wanted to retain top executives who could earn more outside government. In our view, bonuses are for exemplary performance only. Public service is an honor, not an ATM machine.

Due to the current poor political leadership, VA's doctors and claims staff are unable to provide either immediate treatment or prompt payments because of inappropriate interference by VA political appointees. In effect, VA's political appointees locked VA's doors and blocked access to healthcare and disability benefits. If not for the intervention of Congress in May to appropriate $1.8 billion in emergency funds to hire more doctors and claims adjudicators, VA's crisis would continue worsening.

In early 2005, while working at VA, I briefed political appointees and executives at VA headquarters about the sharply escalating mental health and PTSD disability claims among Iraq and Afghanistan war veterans. I personally advised several VA executives, including Ruth Whichard, Mike McLendon, Jack McCoy, Ronald Aument, Lois Mittelstaedt, and several others, that the claims situation was worsening as the two wars deteriorated and the number of eligible veterans continued growing. I advised them, in writing, that more claims processors be hired to meet the steeply rising demand, especially the even faster rise in mental health and PTSD claims. I provided several e-mails documenting these briefings to your staff in March 2007.

After my briefings, top VA political appointees shamefully broke faith with our veterans. Instead of hiring more physicians and claims processors to meet the growing demand, top VA political appointees fought against our war veterans and locked the doors.

At one briefing in 2005, a political appointee since fired for his role in the lap top theft scandal, Mike McLendon, revealed that the Bush Administration was fighting against our war veterans. At one meeting, McLendon said there were too many PTSD claims, the veterans were filing them too soon after returning home, our veterans were too young to be filing claims, and it costs VA too much money to assist them. McLendon went further with a factually incorrect and highly offensive statement that if our returning Iraq and Afghanistan war veterans simply "believed in god and country, then they would not come home with PTSD." I immediately advised my supervisor about this incident, and I also advised your staff about it in early 2006.

After my several briefings to political appointees in 2005 warning them of the current problem, VA launched a systematic effort to block, hinder, restrict, and otherwise prevent our newest generation of combat veterans from receiving the mental healthcare they need and that they earned. In effect, VA locked the doors to cover their refusal to prepare for the surge in returning Iraq and Afghanistan war veterans with PTSD.

VA's Four Anti-PTSD Policies Adopted in 2005

- VA ordered a re-evaluation of 72,000 previously approved PTSD claims rated at 100 percent. If implemented, VA's policy would have further increased the 600,000 claim backlog by shifting VA claims adjudicators away from working on new claims to work on already approved claims. Luckily, Congress intervened and stopped VA from implementing this outrageous policy. In the one thousand PTSD claims VA reviewed, VA found zero cases of fraud.
- VA instituted a "second signature" requirement for approving new claims for PTSD at 100 percent. This VA policy would have also increased the backlog by requiring additional work for each claim by a second VA employee. Luckily, veterans groups raised the alarm and VA suspended this policy. Congress should legislate a termination of this policy.
- VA contracted with the Institute of Medicine for the stated purpose of validating the diagnosis of PTSD. VA's hidden purpose was to narrow the definition of PTSD so that fewer veterans would qualify for VA healthcare or VA disability benefits, thus blocking future claims and saving VA money. Luckily for our veterans, IOM validated the serious nature of PTSD.
- VA again contracted with IOM for the stated purpose of validating PTSD disability payment amounts. VA's hidden purpose was to reduce the amount of money paid to veterans suffering from PTSD, thus saving VA money. Fortunately for veterans, IOM responded with a report saying VA should consider quality of life issues when determining a veteran's level of disability.

When viewed together, these four anti-PTSD policies sent a signal to veterans, veterans' groups, and Congress that VA would fight against PTSD claims filed by Iraq and Afghanistan war veterans. We will never know how many veterans stopped fighting VA and then needlessly suffered from broken families, lost jobs, alcoholism, drug abuse, crime, suicide, and homelessness.

Under the guise of saving taxpayer money, VA's 23-page claim form and Byzantine claims process serve to inappropriately reduce the number of eligible and entitled veterans receiving assistance for mental healthcare and disability benefits, especially for PTSD.

As a result of these and other anti-veteran policies recently adopted by VA, VCS was given no other choice than to file suit against VA in Federal Court this week. VCS hopes to bring attention to the plight of our returning war veterans with mental health conditions, especially those misdiagnosed with personality disorder and thus denied VA healthcare and disability benefits.

America must not repeat the social catastrophe after the Vietnam War and gulf war, where veterans faced enormous road blocks when seeking healthcare and disability benefits. Veterans are citizens, too, deserving of full civil rights, equal access, and due process when dealing with our government when we return home from war.

Allow me to close with this very sharp warning that the U.S. 9th Circuit Court of Appeals issued last week in its ruling against VA for resisting payments to Vietnam War veterans suffering from chronic lymphocytic leukemia due to Agent Orange poisoning.

"What is difficult for us to comprehend is why the Department of Veterans Affairs . . . continues to resist the payment of desperately needed benefits to Vietnam War

veterans who fought for their country and suffered grievous injury as a result of our government's own conduct. . . .

"These young Americans who risked their lives in their country's service and are even today suffering greatly as a result are deserving of better treatment from the Department of Veterans Affairs than they are currently receiving. . . .

"We would hope, that this litigation will now end, that our government will now respect the legal obligations it undertook in the consent decree 16 years ago, that obstructionist bureaucratic opposition will now cease, and that our veterans will finally receive the benefits to which they are morally and legally entitled."

[Attachments to Mr. Sullivan's testimony are being retained in the Committee files and include the following:]

1. VA Benefits Activity, Veterans Deployed to the Global War on Terror, Prepared by VBA Office of Performance Analysis & Integrity, June 25, 2007;
2. VA Facility Specific OIF/OEF Veterans Coded with Potential PTSD Through 2nd Qt FY 2007;
3. Analysis of VA Health Care Utilization Among U.S. Southwest Asian War Veterans, Operation Iraqi Freedom, Operation Enduring Freedom, VHA Office of Public Health and Environmental Hazards, April 2007;
4. Study by Linda Bilmes, John F. Kennedy School of government, Harvard University, entitled "Soldiers Returning from Iraq and Afghanistan: The Long-term costs of Providing Veterans Medical Care and Disability Benefits," January 2007 http://www.mofo.com/docs/pdf/PTSD070723.pdf; and
5. Complaint filed against VA written by Gordon Erspamer, Esq., of Morrison & Foerster: http://www.mofo.com/docs/pdf/PTSD070723.pdf

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Prepared Statement of Tracie Shea, Ph.D.
Psychologist, Post Traumatic Stress Disorder Clinic
Veterans Affairs Medical Center Providence, RI
Veterans Health Administration, U.S. Department of Veterans Affairs

Good morning Mr. Chairman, I am honored at the opportunity to provide testimony to the Committee on issues related to Post Traumatic Stress Disorder (PTSD) and Personality Disorders.

Mr. Chairman, I come before this Committee, not as a representative or spokesperson for the Department of Veterans Affairs (VA) but as a mental health researcher who has conducted extensive research on Personality Disorders. My thoughts and opinions, which I will share with you today, are my own and should not be taken as VA's views or policy.

As a psychologist on the clinical staff of the Post Traumatic Stress Disorder Clinic at the Veterans Affairs Medical Center in Providence, Rhode Island for the past 17 years, I have assessed and treated hundreds of veterans. I also conduct research on personality disorders and on PTSD as part of my academic role as professor of Psychiatry and Human Behavior at the Warren Alpert Medical School, Brown University. Of note to the topic of today's hearing, I was a member of the Subcommittee responsible for the revision of the Personality Disorders section for the 4th edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM–IV).

The Committee has requested my testimony regarding PTSD and Personality Disorders in the context of servicemembers and veterans. My comments will focus on requirements set forth in VA and used at all VAMC facilities for an adequate assessment and diagnosis of personality disorder. With regard to the use of appropriate procedures, I will speak to my personal experience conducting assessments as a psychologist at the VA in Providence.

Definition of Personality Disorder

A Personality Disorder is defined by the DSM–IV as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, manifested in cognition (ways of perceiving or interpreting events, others' behavior), affect (range, intensity, lability, appropriateness of emotional response), interpersonal functioning, or impulse control. For a diagnosis to be made, several requirements must be met:

1. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations. This means that problematic behaviors should be evident in multiple situations.
2. The pattern of behavior is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

3. There is evidence of significant distress or impairment in functioning associated with the enduring pattern of behavior.
4. The pattern of behavior is not better accounted for as a manifestation or consequence of another mental disorder.
5. The pattern is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. head trauma).

Distinguishing Between Personality Disorder and PTSD in Servicemembers Following Stressful Event

There are several implications of these requirements for determining a diagnosis of personality disorder following deployment. Since the onset of personality disorders by definition occurs by late adolescence or early adulthood, there typically should be evidence of the behavior pattern prior to adulthood. A history of solid adjustment and good psychosocial functioning prior to adulthood would not be expected in an individual with a personality disorder.

It is critical to rule out other mental disorders that may be responsible for the maladaptive behaviors in making a clinical diagnosis of personality disorder. Following an extended event characterized by traumatic stressors, it is particularly important to determine if problematic behaviors are due to PTSD. The DSM–IV explicitly states "When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of Post Traumatic Stress Disorder should be considered" (p. 632). Exposures to severe or prolonged trauma can result in behaviors that look like features of personality disorders. PTSD criteria include irritability or outbursts of anger, feeling of detachment or estrangement from others, and restricted range of affect (unable to experience feelings such as love). In addition, the DSM–IV describes several associated features of PTSD that may be present, including self-destructive and impulsive behavior, social withdrawal, feeling constantly threatened, and impaired relationships with others.

The recognition of possible personality changes following severe or prolonged stress is apparent in the International Classification of Diseases (ICD–10), which includes a diagnostic category of "Enduring personality change after catastrophic experience." This diagnosis is used in cases of persistent change in personality following extreme stress, including prolonged exposure to life-threatening situations, characterized by two or more of the following features newly present after the trauma:

1. A hostile or distrustful attitude toward the world.
2. Social withdrawal.
3. A constant feeling of emptiness or hopelessness.
4. An enduring feeling of "being on edge" or being threatened without any external cause, as evidenced by an increased vigilance and irritability.
5. A permanent feeling of being changed or being different from others (estrangement).

These features may be present in individuals exposed to extreme trauma. Again, such features overlap with many of the criteria for Personality Disorders. The critical distinction is whether they represent change in personality following exposure to severe traumatic stress. Although I have focused here on the distinction between Personality Disorders and PTSD, it is important to recognize that these conditions can co-exist. A person able to function in spite of a mild-to moderate personality disorder can develop PTSD after trauma. An additional consideration I have not discussed is Traumatic Brain Injury (TBI), which is sometimes associated with behavioral changes that may look like features of personality disorders, for example, aggression, poor impulse control, or suspiciousness. For individuals with exposure to head injury (including closed head injury), neuropsychological testing may be indicated to rule out brain injury as a cause of such behaviors.

Assessments at the VA

VA psychologists conduct assessments for service connected disability applications. These "compensation and pension" exams follow established guidelines, and cover psychosocial functioning and symptoms of mental disorder present prior to, during, and following military service. Military experience, including exposure to traumatic events, is assessed, and the timing of the onset of symptoms in relation to military service is determined. Most of the exams that I personally have conducted have been to establish service connection for PTSD. These require detailed questioning of symptoms of PTSD and other mental disorders, including timing of onset. If there is a pattern of maladaptive behavior existing prior to military service, it is important to determine whether there has been a change in connection with

military service. Diagnoses reflect a personality disorder if present but, in my personal experience, this has been rare. As noted above, a personality disorder can also co-exist with PTSD. In my experience, these exams take about 60 minutes on average, but can take longer in more complicated cases.

Also of note is that VA policy now requires screening of all OEF / OIF veterans for TBI. Positive responses to the screen are followed up with more detailed assessments by neuropsychologists.

Summary

To summarize, events characterized by repeated exposure to traumatic stress can result in symptoms and behaviors that appear, on the surface, to resemble personality disorder. A clinical diagnosis of personality disorder should be made only when it can clearly be established that the behavioral patterns and associated psychosocial impairment or distress were present by late adolescence or early adulthood, existed prior to stressful events, and cannot be better explained by the experience during an event of traumatic stress or brain injury. In addition to a comprehensive psychological assessment of the individual, consultation with family members or others with knowledge of the individual prior to service is advisable when considering a personality disorder diagnosis. The significance of an accurate diagnosis cannot be underestimated.

Thank you for this opportunity to testify. I will be pleased to answer any questions you may have.

Prepared Statement of Dean G. Kilpatrick, Ph.D.
Distinguished University Professor
Director, National Crime Victims Research and Treatment Center
Medical University of South Carolina, and Member
Committee on Veterans' Compensation for Post Traumatic Stress Disorder
Institute of Medicine and National Research Council
The National Academies

Good morning, Mr. Chairman and Members of the Committee. My name is Dean Kilpatrick and I am Distinguished University Professor in the Department of Psychiatry and Behavioral Sciences and Director of the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Thank you for the opportunity to testify on behalf the Members of the Committee on Veterans' Compensation for Posttraumatic Stress Disorder. The committee was convened under the auspices of the National Research Council and the Institute of Medicine. These institutions are operating arms of the National Academy of Sciences, which was chartered by Congress in 1863 to advise the government on matters of science and technology. The work of the Committee was requested by the Department of Veterans Affairs, which provided funding for the effort.

Our Committee recently completed a report entitled *PTSD Compensation and Military Service* that addresses some of the topics under discussion in this hearing. I am pleased to be here today to share with you the content of that report, the knowledge I've gained as a clinical psychologist and researcher on traumatic stress, and my experience as someone who previously served as a clinician at the VA.

I will begin with some background information on posttraumatic stress disorder. Briefly described, PTSD is a psychiatric disorder that can develop in a person after a traumatic experience. Someone is diagnosed with PTSD if, in response to that traumatic experience, he or she develops a cluster of symptoms that include:

- ***reexperiencing*** the traumatic event as reflected by distressing recollections, memories, nightmares, or flashbacks;
- ***avoidance*** of anything that reminds them of the traumatic event;
- ***emotional numbing*** or feeling detached from other people;
- ***hyperarousal*** as reflected by trouble sleeping, trouble concentrating, outbursts of anger, and having to always be vigilant for potential threats in the environment; and
- ***impairment*** in social or occupational functioning, or clinically significant distress.

PTSD is one of an interrelated and overlapping set of possible mental health responses to combat exposures and other traumas encountered in military service. Although PTSD has only been an official diagnosis since the 1980's, the symptoms associated with it have been reported for centuries. In the U.S., expressions including

shell shock, *combat fatigue*, and *gross stress reaction* have been used to label what is now called PTSD.

Our committee's review of the scientific literature and VA's current compensation practices identified several areas where changes might result in more consistent and accurate ratings for disability associated with PTSD.

There are two primary steps in the disability compensation process for veterans. The first of these is a compensation and pension, or *C&P*, examination. These examinations are conducted by VA clinicians or outside professionals who meet certain education and licensing requirements. Testimony presented to the Committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD C&P examination—sometimes to as little as 20 minutes—even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take 3 hours or more to properly complete. The Committee believes that the key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced mental health professional. Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination. The Committee also recommended that a system-wide training program be implemented for the clinicians who conduct these exams in order to promote uniform and consistent evaluations.

The second primary step in the compensation process for veterans is a rating of the level of disability associated with service-connected disorders identified in the clinical examination. This rating is performed by a VA employee using the information gathered in the C&P exam. The Committee found that the criteria used to evaluate the level of disability resulting from service-connected PTSD were, at best, crude and overly general. Our Committee recommended that new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the *Diagnostic and Statistical Manual of Mental Disorders* used by mental health professionals. As part of this effort, the Committee suggested that VA take a broader and more comprehensive view of what constitutes PTSD disability. In the current scheme, occupational impairment drives the determination of the rating level. Under the Committee's recommended framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated, and the claimant would be rated on the dimension on which he or she is more affected. The Committee believes that the special emphasis on occupational impairment in the current criteria unduly penalizes veterans who may be capable of working, but significantly symptomatic or impaired in other dimensions, and thus it may serve as a disincentive to both work and recovery.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the Committee recommends that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. Rater certification should foster greater confidence in ratings decisions and in the decisionmaking process.

To summarize, the Committee identified three major changes that are needed to improve the compensation evaluation process for veterans with PTSD:

- First, the C&P exam should be done by mental health professionals who are adequately trained in PTSD and who are allotted adequate time to conduct the exams.
- Second, the current VA disability rating system should be substantially changed to focus on a more comprehensive measure of the degree of impairment, disability, and clinically significant distress caused by PTSD. The current focus on occupational impairment serves as a disincentive for both work and recovery.
- Third, the VA should establish a certification program for raters who deal with PTSD clams.

Our committee also reached a series of other recommendations regarding the conduct of VA's compensation and pension system for PTSD that are detailed in the body of our report. I have provided copies of this report as part of my submitted testimony.

Thank you for your attention. I will be happy to answer your questions.

Prepared Statement of Sally Satel, M.D.
Resident Scholar, American Enterprise Institute

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. 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.

Background

A particularly unsettling story appeared on *ABC News* on July 12 called "Used Up and Spit Out—The Personality Disorder Discharge." The segment portrayed two young men who had served in Iraq with military distinction but then suffered what appeared to be, in one case, posttraumatic stress disorder, and in the other, a traumatic brain injury inflicted by a close-range rocket blast as well as post traumatic stress disorder. Ultimately, both soldiers were given a "separation because of personality disorder" discharge (Chapter 5–13) from the Army.

In the wake of these and other reports of Chapter 5–13 discharges, lawmakers, veterans' advocates, and military families have wondered if the military is using personality disorder discharges to avoid covering the healthcare needs of servicemembers. Without question, to use the diagnosis of personality disorder to deny proper care and benefits to men and women who have served honorably and were injured in their service is a grave clinical error, not to mention a deep injustice.

Relevance to the Department of Veterans Affairs

Understandably all eyes are on the Department of Defense because that is the jurisdiction in which Chapter 5–13 discharges originate. Yet the matter of personality disorder separation has implications for the Department of Veterans Affairs as well. Just as it is a serious mistake to diagnose a soldier who became mentally impaired as a result of military service as suffering, instead, from a personality disorder (and discharge him on that basis), overlooking opportunities to identify significant behavioral problems among soldiers—at enlistment or early in training or after deployment—imposes an equally significant challenge for the VA. Why? Because it is these individuals who are particularly vulnerable to developing psychiatric impairment under the strain of combat stress. Upon discharge, they may turn to VA mental health facilities for long-term treatment that may have been prevented with proper screening or more effectively resolved with immediate care within the service.

A Brief Word on Personality Disorders and the Military

What is a personality disorder (PD)?—Personality disorders are defined by the Diagnostic and Statistical Manual as enduring maladaptive patterns of behavior and cognition that leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning. The early signs are usually evident in adolescence or early adulthood.

Does military service cause PD? No, but it might intensify underlying maladaptive traits and PDs and these can make the soldier unfit for duty. This scenario, it seems to me, would form an appropriate foundation for the use of a Chapter 5–13.

Can stress injury look like PD? Yes. In addition to the anxiety features that characterize a stress reaction, behavioral problems such as misconduct and disobedience can accompany it. At any given point in time such a serviceman or woman might appear to have a PD but if review of his or her enlistment record (e.g., evidence of criminal activity) and, especially, review of training file reveal solid performance, most likely the soldier is wrestling with a stress reaction, perhaps full-blown PTSD.

Can a soldier have both PTSD and PD? Yes. However, presumably an individual with both conditions was once judged mentally fit to assume active duty. Such judgments were made first at the time of enlistment, then throughout training, and eventually before deployment. If a soldier progressed that far and had been considered mentally fit along the way, it is only logical to conclude that whatever deterioration he suffered was due to his military service. This calls into question the judgment that he is now mentally unfit because of a pre-existing personality disorder

"that is so severe that the soldier's ability to function effectively in the military environment is significantly impaired." [1]

Thus, if many soldiers are being discharged late in their tours of duty, diagnosed with PD through Chapter 5–13, two questions must be considered: First, are the PD diagnoses accurate in the first place? The media and lawmakers have focused on this important question. Secondly, if they are indeed accurate, are enlistment and ongoing screening procedures adequate to identify these problems earlier?

Adequacy of screening?—A soldier unfit for duty because of a PD can often be identified in the training or early deployment phases of duty. Boot camp and related activities are emotionally intense and demanding crucible. As such they act as a natural "stress test," unmasking a person's innate problems with coping and impulse control—difficulties that the he or she could otherwise compensate for in civilian life. Individuals' tendencies to become hostile, aggressive, resistant to authority under pressure, suspicious of others' motives, and disruptive to unit cohesion will likely assert themselves in the context of these environments, to the notice of those around including command and especially peers.[2]

Thus, the time to intercept these individuals in order to treat or discharge them as unfit for duty, as the military deems appropriate, is at intake, during training, before they are deployed, or early in the in the deployment period. Yet it is my understanding that the Pentagon has lowered standards to meet quotas and that an increased number of so-called moral waivers have been granted so that recruits with felony records and other significant evidence of behavioral problems can enlist.[3] Those waivers may be officially overlooking exactly the behaviors that are symptoms of personality disorders.

There is a modest literature on screening. I will mention just two interesting reports. A 2003 report called *Reducing the Threat of Destructive Behavior by Military Personnel,* which was commissioned by the Deputy Assistant Secretary of Defense, documents a meaningful correlation between pre-service history (e.g., arrests, convictions, disciplinary problems, and especially, failure to finish high school) and in-service criminal behavior, destructive acts, and attrition.

The report identified two main areas of concern regarding initial selection and continuing evaluation procedures of military personnel

> "(1) lack of effective prescreening procedures to identify military entrants with criminal records and other behavioral adjustment problems, and
> (2) inadequate management practices that have allowed the retention on active duty of military personnel who have shown a pattern of substandard behavior."

A 4-year followup study by Eli Flyer, for the Naval Post Graduate School, and John Noble of the Navy Recruiting Command found that Navy recruits who did not complete high school had a significantly higher attrition rate during their initial tour compared to graduates.[4]

The controversy surrounding Chapter 5–13 discharges would suggest need for a re-evaluation of screening protocols currently used by DoD.

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[1] AR 635–200 Active Duty Enlisted Administrative Separations http://gidischarges.org/odpmc/army/index.html, accessed July 23, 2007.

[2] Fiedler E, Oldmanns T, Turkheimer E. "Traits associated with personality disorders and adjustment to military life: predictive validity and self and peer reports." *Military Medicine.* 169 (3) (2004), pp. 207–211.

[3] Badkhen, Anna. "Army Relaxes Its Standards to Fill Ranks: Critics say push to meet quotas may let unstable recruits join up." *San Francisco Chronicle.* June 11, 2006.

[4] Flyer, Eli and Noble, John. *Development and Validation of a Biographical Questionnaire to Screen GED/Non-High School Graduate Applicants for Navy Service: Four-Year Follow-Up Findings.* On file with author. Note: 50% of drop outs were within the first year of active duty. The researchers asked 7,000 Navy recruits to complete an eight-item questionnaire about pre-enlistment behaviors (e.g., difficulty taking orders, previous suicide attempts, having run away from home, having visited a mental health professional). Those who did not complete high school (about 1,000 of the recruits). Non-graduates with the most pre-enlistment problems (the bottom quartile) and had an attrition rate of 72 percent compared to graduates who had an attrition rate of 52 percent; while grads in the top three quartiles had a mean attrition rate of 33 percent. Also note, there is a well-documented relationship between cognitive factors such as educational attainment and IQ and development of stress reactions and PTSD which can lead to attrition. Failure to finish high school may partly reflect this phenomenon. For review see Gilbertson MW, Paulus LA, Williston SK, Gurvits TV, Lasko NB, Pitman RK, Orr SP. "Neurocognitive Function in Monozygotic Twins Discordant for Combat Exposure: Relationship to Posttraumatic Stress Disorder". *Journal of Abnormal Psychology.* 115 (3) (2006), pp. 484–495; For relationship between educational level and active duty stress casualties, see Helmus TC, Glenn RW. "Steeling The Mind: Combat Stress Reactions and their Importance for Urban Warfare." *RAND.* **Document** MG–191–A, 2005.

Misapplication of the Chapter 5–13 discharge sets up a kind of Catch-22 for the DoD. First the military deems a recruit sufficiently mentally fit to be sent into training and then into a war zone, but then when psychiatric problems arise it turns around and claims that those problems were there all along—problems that should have shown up earlier in their tour of duty.

Patients with PTSD and Personality Disorder Who Seek Care at VA Facilities

Co-occurrence—PD and PTSD, especially chronic PTSD, are common in treatment seeking populations.[5] It is generally difficult to parse the relationship because there are few longitudinal, prospective studies. The vast majority of studies are cross-sectional, or snap-shot, analyses making it difficult to infer temporal order.

Possible explanations of co-occurrence:

1. *PD can predispose to PTSD*—This is a plausible inference to draw from the considerable volume of data showing that traits and predispositions associated with PDs (borderline and antisocial types, in particular) are the same ones that enhance risk for developing PTSD after traumatic experience. These dispositions and traits include childhood conduct disorder, neuroticism (a tendency to react to adversity with depression or anxiety), impulse control problems, early family instability, and exposure to traumatic events (which are more common in children and teens with behavioral difficulties and adults with antisocial personality).[6]
2. *PTSD can "look like" PD*—The symptoms of PTSD such as anxiety, nightmares and sleep deprivation can lead to irritability, intense anger, aggression, substance abuse, and emotional instability—symptoms commonly associated with borderline personality disorder and/or asp. One could call this pseudo-personality disorder. It should remit if the underlying stress reaction is treated and resolves. If PTSD becomes chronic, however, these dysfunctional attributes may persist.
3. *Living with chronic PTSD can induce personality changes*—An analogy can be made to chronic pain patients insofar as it is unknown whether many of the psychopathological features observed in chronic pain patients (e.g., anger, manipulativeness, suspiciousness, interpersonal hostility to comply, emotional instability) are the consequence of chronic pain and its related difficulties, or whether pre-existing psychopathology predisposed some individuals to develop chronic pain.[7]

   Thus, there are three potential pathways by which veterans can manifest symptoms of PTSD and features of personality disorders at the same time: maladaptive personality features (1) were present before military service, (2) are a byproduct of the trauma and should resolve when the stress reaction re-

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[5] Richman H, Frueh BC. "Personality disorder symptomatology among Vietnam veterans with combat-related PTSD." Anxiety. 2(6) (1996), pp. 286–295; Southwick SM, Yehuda R, Giller EL Jr. "Personality disorders in treatment-seeking combat veterans with posttraumatic stress disorder." *American Journal of Psychiatry.* 150 (1993), pp. 1020–1023; Bollinger AR, Riggs DS, Blake DD, Ruzek JI. "Prevalence of personality disorders among combat veterans with posttraumatic stress disorder." *Journal of Traumatic Stress.* 13(2) (2000), pp. 255–271; T. Keane, D. Kaloupek. "Comorbid Psychiatric Disorders in Posttraumatic Stress Disorder: Implications for Research." *Annals of the New York Academy of Sciences.* 821(1) (1997), pp. 24–34.

[6] Brewin CR, Andrews B, Valentine JD. "Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults." *Journal of Consulting and Clinical Psychology.* 68(5) (October 2000), pp. 748–66; Ozer E, Best SR, Lipsey TL, Weiss DS. "Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis." *Psychological Bulletin.* 129(1) (2003), pp. 52–73; Breslau N, Davis GC, Andreski, P. "Risk factors for posttraumatic stress disorder-related traumatic events." *American Journal of Psychiatry.* 152(4) (1995), pp. 529–35; **King DW,** King LA, Foy DW, Gudanowski DM. "**Prewar factors in combat-related posttraumatic stress disorder: structural equation modeling with a national sample of female and male Vietnam veterans."** *Journal of Consulting and Clinical Psychology.* 64(3) (June 1996), pp. 520–31; Jang KL, Stein MB, Taylor S, Asmundson GJG, Livesley WJ. "Exposure to traumatic events and experiences: aetiological relationships with personality function." *Psychiatry Research.* 120 (2003), pp. 61–69; Schnurr PP, Vielhauer MJ. "Personality as a risk factor for posttraumatic stress disorder." In *Risk Factors for Posttraumatic Stress Disorder.* Ed: R. Yehuda. Washington, DC: American Psychiatric Press, 2000

[7] Weisberg, JN. "Studies Investigating the Prevalence of Personality Disorders in Patients with Chronic Pain." In *Personality Characteristics of Patients With Chronic Pain.* Eds: Gatchel R, Weisberg N. Washington, DC: American Psychological Association, 2000.

mits, (3) are a response to living with PTSD.[8] In the absence of prospective studies or baseline information on individuals it is difficult to distinguish between these scenarios.

4. *PTSD aggravates features of PD*—In civilian settings, we frequently observe that when patients with longstanding personality disorders encounter stressful experiences such as physical illness, pain, bereavement, divorce, or on the job tension, they often fail to adapt and behave more erratically, impulsively, etc.
5. *PD alone: see below.*[9]

VA clinicians are unlikely to misdiagnose PTSD and/or Traumatic Brain Injury (TBI) as personality disorders. The core symptoms of PTSD and neuropsychiatric impairment are distinguishable from PD. Sometimes these diagnoses are made simultaneously in the same individual, and when they are it can be hard to know which is dominant, especially prior to a course of treatment. Even so, PTSD and TBI, by definition, are caused by service and are not pre-existing.

Treatment: Clinicians will be familiar with the scenarios outlined above and treat patients accordingly with combinations of cognitive-behavioral therapy, desensitization/exposure therapy, psychopharmacology, family counseling, and vocational rehabilitation.[10] It is essential to treat veterans with PTSD and severe readjustment problems as early as possible when their conditions will be most responsive to therapeutic intervention. This can often make the difference between a time-limited impairment and chronic mental illness. Patients with both chronic PTSD and features of a personality disorder can be less responsive to treatment.[11] A point worth raising here is the importance of qualified staffing at VA mental health facilities. Anecdotal reports suggest that many facilities do not have adequate numbers of clinicians who can perform cognitive-behavioral therapies. This is a deficit that must be addressed.[12]

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[8] Axelrod S, Morgan CA, Southwick SM. "Symptoms of Posttraumatic Stress Disorder and Borderline Personality Disorder in Veterans of Operation Desert Storm" *American Journal of Psychiatry*. 162 (2005), pp. 270–275.

[9] *No PTSD or other Axis I Mental Disorder*: There may be situations in which a veteran has no diagnosable features of PTSD but seeks treatment because he is struggling with problems at home or on the job because of a severe personality disorder.

a. *Exacerbation of maladaptive personality traits due to service*: It is possible that war stress alone intensified a pre-existing personality disorder. Although veterans with severe PD may not be particularly sympathetic, one could argue that the military should have been better attuned to the fact such men and women can be too psychologically fragile to handle the great pressure of the combat environment and that more intensive screening at enlistment and during the first term was warranted.

b. *No change in intensity of PD traits*: It is always possible that some veterans seeking care at the VA will be as maladapted to civilian life after their service duty as they were when they first entered the service. In other words, they were made no worse as a result of their military service. Granted, such a scenario may not occur too often, yet for the sake of completeness it is worth considering. The first question it raises is why such men and women were permitted to enlist in the military or to deploy in the first place—an issue discussed earlier. Nonetheless, since they did indeed serve in Iraq or Afghanistan, the VA has responsibility for their mental health needs. (But not for granting disability benefits because the problem is not service-connected).

[10] "Practice Guidelines for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder." American Psychiatric Association. Accessed on July 20, 2007. www.psych.org/psych_pract/treatg/pg/PTSD–PG-PartsA-B-C-New.pdf

[11] Dunn NJ, Yanasak E, Schillaci J, Simotas S, Rehm LP, Souchek J, Menke T, Ashton C, Hamilton JD. "Personality disorders in veterans with posttraumatic stress disorder and depression." *Journal of Traumatic Stress.* 17(1) (February 2004), pp. 75–82; Bollinger AR, Riggs DS, Blake DD, Ruzek JI. "Prevalence of personality disorders among combat veterans with posttraumatic stress disorder." Journal of Traumatic Stress. 13(2) (April 2000), pp.255–270.; Rosenheck R. "Malignant post-Vietnam stress syndrome." *American Journal of Orthopsychiatry.* 55 (1985), pp. 166–176;Hyer L, Woods MG, Bruno R, Boudewyns P. "Treatment outcomes of Vietnam veterans with PTSD and the consistency of the MCMI." *Journal of Clinical Psychology.* 45(4) (July 1989), pp. 547–542; Mazzeo SE, Beckham JC, Witvliet Cv C, Feldman ME, Shivy VA. "A cluster analysis of symptom patterns and adjustment in Vietnam combat veterans with chronic posttraumatic stress disorder." *Journal of Clinical Psychology.* 58(12) (December 2002), pp. 1555–1571.

[12] A specific form of exposure-desensitization therapy under development is called "Virtual Iraq." Studies are in progress. The therapy was developed with funding from the Naval Research Office and is considered promising. The veteran wears a virtual-reality helmet and goggles and headphones. A therapist manipulates virtual situations via a keyboard to best suit the individual patient during 45–50 minute sessions. By gradually re-introducing the patients to the experiences that triggered the trauma, the memory becomes tolerable and feelings of panic no longer accompany once-feared situations (such a driving on city streets, being in crowds). http://www.defense-update.com/products/v/VR-PTSD.htm, accessed July 21, 2007

Disability Determination—The eligibility standard for disability payments differs from that of treatment. In order to qualify for disability on the basis of specific injuries or illnesses, an explicit causal connection between those afflictions and military service must be demonstrated.

Last May, the Institute of Medicine released a report entitled PTSD Compensation and Military Service. It emphasized the need for a consistent evaluation process across centers and the dire importance of competent evaluation (quality evaluations often take several hours, involve extensive review of medical and military records, and, critically, interviews of collateral sources of information). I agree with these points.

Summary

Improved behavioral and psychological screening for enlistment is needed to help predict behavioral adjustment to the military.

VA clinicians are unlikely to misdiagnose PTSD and/or TBI as personality disorder. The core symptoms of PTSD and neuropsychiatric impairment are distinguishable from PD.

VA must be equipped with mental health staff trained in state of the art PTSD treatment. Treatment should be delivered at early as possible to avert development of chronic syndromes.

In determining disability there should be a consistent, high quality evaluation process across centers.

Prepared Statement of Ira R. Katz, M.D., Ph.D.
Deputy Chief Patient Care Services Officer for Mental Health
Veterans Health Administration, U.S. Department of Veterans Affairs

Good morning Mr. Chairman, thank you for this opportunity to speak about multiple diagnoses and specifically about the principle that Post Traumatic Stress Disorder (PTSD) frequently coexists with other mental health conditions.

Multiple Mental Health Problems

As of the end of the first half of FY 2007, almost 720,000 service men and women have separated from the armed forces after service in Iraq or Afghanistan, and over 250,000 have sought care in VA. About 95,000 received at least a preliminary mental health diagnosis. Among these, PTSD, experienced by over 45,000 or 48 percent is the most common.

The average veteran with a mental health problem received approximately 1.9 diagnoses. There could be several reasons. First, injuries of the mind, like injuries of the body can be non-selective. Depending upon psychological, physiological, or genetic vulnerabilities, the same stress and trauma can give rise to multiple conditions, for example PTSD and depression or panic disorder. Second, the disorders may occur sequentially. Some veterans with PTSD may try to treat their own symptoms with alcohol and wind up with a diagnosis related to problem drinking. Third, some pre-existing mental health conditions like milder personality disorders may be quite compatible with occupational functioning, even in the military, but may increase vulnerability to stress-related disorders like PTSD or depression.

How Does VA Deal With This Problem

VA has intensive programs to ensure that mental health problems are recognized, diagnosed, and treated. There is outreach to bring veterans into our system, and once they arrive, there is screening for mental health conditions. For those who screen positive for mental health conditions, the next step is a comprehensive diagnostic and treatment planning evaluation. In this, the question is about what is causing the veteran's suffering or impairment, and what can be done about it. If someone screens positive for symptoms of PTSD, we are interested in whether or not they, in fact have PTSD. But we are also interested in whether or not they have depression, or panic disorder, or problem drinking, or other problems. Which do we treat? We treat them all. Or more significantly, we treat the person, not his or her labels.

Clinical science has advanced dramatically since the Vietnam War. We now know how to diagnose PTSD, and how to treat it. Accordingly, we are hopeful that we can prevent the lasting suffering and impairments that occurred after that war. There is a firm evidence-base for several classes of treatment for PTSD, both psychopharmacological or medication based and psychotherapeutic or talk/behavior based. Specifically, several of the antidepressants that act on the neurotransmitter

serotonin have been found to be effective and safe for the treatment of PTSD, and many other medications are currently being studied. Two specific forms of cognitive behavioral therapy, prolonged exposure therapy and cognitive processing therapy appear to be even more effective than the medications, and VA is currently developing high throughput training programs to make them increasingly available within our medical centers, clinics, and Vet Centers. In addition, there is increasing evidence for the effectiveness of psychosocial rehabilitation. For veterans for whom there may be residual symptoms after several evidence-based treatments, treatment is available to help them function in the family, in the community, or on the job.

Given That There Are a Number of Effective Treatments, How Do We Decide Which to Provide?

Actually, the question should be which to offer first and which comes next. The first treatments are usually offered on the basis of both the provider's judgment and the patient's preference. However, we monitor treatments and outcomes, and if the first doesn't work, we modify it.

What happens when patients have more than one condition? The choice of what to treat first depends on the severity of the conditions, the provider's judgment, and the patient's preferences. Plans must allow for combinations or sequences of treatments, as appropriate following Clinical Practice Guidelines or other sources of guidance.

There may have been a time in the past when coexisting conditions may have been barriers to care, when it was hard to treat people with PTSD and alcohol abuse because PTSD programs required people to be sober, and substance abuse programs required them to be stable. This no longer occurs. In fact, there are now evidence based strategies for beginning PTSD and substance abuse treatment simultaneously. One approach, called Seeking Safety was developed in the VA, and is being disseminated broadly.

It may be difficult to diagnose personality disorders in the face of PTSD or other mental health conditions. For patients with relevant symptoms, the clinical approach in VA is to treat the PTSD first. A subsequent step would be evaluate what symptoms or impairments remain, and to plan treatments accordingly.

The message I want to deliver in this hearing is that treatment for PTSD can work. For veterans or others with multiple conditions, treatment may be a multistage process beginning with an evidence based intervention for the most severe of the patient's conditions, and continuing in a way that depends upon the outcome. Overall, the message should be cautiously optimistic.

Thank you for this opportunity to testify. I will be pleased to answer any questions you may have.

Prepared Statement of Colonel Bruce Crow
Chief, Department of Behavioral Medicine
Brooke Army Medical Center, Fort Sam Houston, TX, and
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Mr. Chairman, Congressman Buyer, and distinguished members of the Committee, thank you for the opportunity to discuss the behavioral health status of the brave men and women in your Army. The Army leadership recognizes the profound impact the combat environment has on the mental and emotional well-being of soldiers and their families. Last week, the Army kicked-off an unprecedented awareness campaign to educate more than one million Active, Reserve and National Guard soldiers over the next 90 days about Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBI). Development and implementation of this chain teaching program has been one of the highest priorities for both the Secretary and Chief of Staff of the Army. The presentation and materials were vetted throughout the Army, not only in the medical channels, but through the leadership and soldier focus groups as well.

Coincidentally, today at the Pentagon over 200 General Officers and Senior Executive Service civilians are participating in this PTSD and mild TBI Chain Teaching Program. The presentation is a combination of briefing slides and video clips. Commanders and leaders use an accompanying script to ensure the material is presented accurately and consistently throughout the Army. Let me briefly highlight what we are attempting to achieve:

- First, leaders and soldiers throughout the chain of command, to include the Army Chief of Staff, must take care of themselves and their buddies. Knowing

how to recognize symptoms of PTSD and TBI and being aware of the available treatment options are the first steps toward addressing these issues.

- Second, seeking mental health treatment should not be perceived as a sign of weakness. Rather it should send a powerful signal of strength and personal courage. We are aware that mental health treatment carries with it a certain stigma. Soldiers must understand that seeking treatment for PTSD is no different than being treated for medical conditions such as hypertension. Untreated psychiatric conditions have an impact on soldier readiness and well-being. The Army is committed to providing the very best treatment possible.

Shifting gears, I'd like to briefly address personality disorders, as I know this has been a topic of much discussion within the media and the halls of Congress. As the clinical psychology consultant to the Army Surgeon General, I am deeply distressed to hear that some of our soldiers feel they have been wrongly separated from the Army for personality disorders. I have heard some alarming numbers thrown around in the media and would like to set the record straight. About 70,000 soldiers were discharged from the Active Army in 2006. Of those discharged, 1,086 were separated for personality disorder, of which 295 of those individuals had served in a theater of combat. To the uniformed, civilian, and contract health care professionals that care for these soldiers, the thought of even one soldier being inappropriately discharged for personality disorder is disturbing. With that in mind, the Acting Surgeon General, Major General Gale Pollock, has directed each and every one of those 295 records be reviewed by behavioral health professionals to verify that appropriate actions were taken and that all health concerns were considered in the discharge. That extensive record review is currently underway.

Another misconception is that separating a soldier for personality disorder is simply an administrative decision made by a member of the Chain of Command to do away with problem soldiers. Separation on the basis of personality disorder is authorized only if a diagnosis is made by a psychiatrist or doctoral-level clinical psychologist with the required DoD professional credentials and privileges. The disorder must be so severe that the member's ability to function effectively in a military environment is significantly impaired. Existing military clinical quality assurance processes such as routine peer review of provider records also reduce the likelihood of provider deviation from the community standard of care. To protect their legal rights, every soldier pending separation for a personality disorder is afforded the opportunity to consult with an attorney prior to separation. Additionally, former soldiers who believe that they were improperly or unfairly separated may petition the Army Discharge Review Board or the Army Board for Correction of Military Records for administrative review of their cases. Legal counselors advise soldiers of this right prior to their separation.

As mentioned, a Personality Disorder is a diagnosis that must be made by a psychiatrist or Ph.D. level clinical psychologist. There are actually ten different specific personality disorders, each with a set of characteristic behaviors. One common characteristic that is shared by all individuals with a personality disorder is that they have extreme difficulty modifying their problem behaviors and generally do not respond well to psychological treatment. These problem behaviors are typically disruptive to a military unit and are often associated with discipline problems. When they are judged to be unlikely to change or respond to clinical treatment, these behaviors can form the basis of an administrative separation.

When a soldier is referred by their Commander to a psychiatrist or psychologist for a personality disorder evaluation, it is typically because there have been behavior problems that have not responded to counseling and other remedial efforts by the chain of command. The psychiatrist or psychologist basically looks for three things: 1) whether there is a diagnosis of a personality disorder; 2) whether there is a favorable prognosis for psychological treatment; and 3) whether there is a diagnosis that should be considered for a medical evaluation board. If the evaluation concludes that a personality diagnosis is warranted AND there is poor prognosis for treatment or change in behavior AND there is no psychiatric diagnosis that would lead to a medical board, the soldier's commander is informed that the soldier may be further processed for administrative separation because of personality disorder.

Although soldiers suffering from a psychiatric disorder, such as PTSD, can sometimes exhibit behaviors that are similar to individuals with a personality disorder, the diagnoses can be distinguished by behavioral health professionals. Psychiatric diagnoses made by military providers are based on the same criteria used in the civilian health care sector, and codified in the 4th edition of the Diagnostic and Statistical Manual (DSM–IV). All psychiatric diagnoses include observable behaviors coupled with significant psychological distress or impairments in social or occupational functioning.

I mentioned earlier that the Army's Surgeon General's Office will conduct a review of nearly 300 records of soldiers who had deployed to a combat theater and were subsequently separated due to personality disorder. This review has already been initiated and is being conducted by a team of senior mental health providers. The team will review mental health records, administrative records, and medical records to determine if appropriate procedures were followed and whether improvements are needed in the way clinical evaluations for personality disorder are conducted as part of the administrative separation process. If lessons can be learned that will improve the quality of these clinical evaluations, we want to know and are interested in making this information available to our Army behavioral health providers.

In 2006 the Army diagnosed 9,500 OIF/OEF deployed soldiers with PTSD, including some who had deployed in previous years. We recognize that for some soldiers, symptoms will emerge after a period of time, perhaps years following their combat deployment. Findings from our Mental Health Advisory Teams tell us that between 15 to 20% of deployed troops report symptoms of post combat stress. As the war continues and soldiers incur multiple deployments we expect the number of soldiers suffering from PTSD and presenting for treatment to rise. Correspondingly, as these soldiers leave military service, the number of veterans seeking treatment is also expected to grow. As our education and training efforts are fully implemented, we hope that the stigma of seeking care will decrease, which could lead to an increased demand for services in both the military and veteran populations.

When it comes to diagnosis and treatment of PTSD, the Armed Forces and the VA have some of the most experienced providers in the world. Even though our Army psychiatry and psychology training programs include comprehensive training in PTSD, we are working in collaboration with the VA's National Center for PTSD to develop additional training and tools for our behavioral health providers. We have also begun providing training in PTSD to primary care providers, nurses and social workers working in our Warrior Transition Units. A pilot program titled RESPECT–MIL also provides behavioral health training to our primary care providers and enhances their ability to identify, treat, and refer patients with mental health concerns. This pilot was so successful at Fort Bragg that we are pushing it across the Army to 15 additional installations this year. At the Surgeon General's office we established a Behavioral Health Proponency Office to oversee and coordinate behavioral health programs across the entire command.

A major challenge we are facing involves recruiting and retaining active duty and civilian mental health providers. To address staffing shortfalls, the U.S. Army Medical Command recently committed over $50 million to hire more than 200 behavioral health professionals to fill requirements across the Army. By bringing on more providers, we intend to increase access to mental health services and increase our outreach capability.

I want to assure the Congress that the Army Medical Department's highest priority is caring for our Warriors and their Families. Like most of my colleagues, I am here because I believe in supporting soldiers for what they do every day in defense of our country and our way of life. I will do everything in my power to ensure soldiers and their Families receive the best health care available.

Thank you for holding this hearing and thank you for your continued support of the Army Medical Department and the Warriors that we are honored to serve.

Statement of Hon. Jeff Miller
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

It is abundantly clear how prevalent the issue of mental health is with not only veterans returning from the Global War on Terror. This Committee has given a great amount of attention to traumatic brain injury, but equally serious is post traumatic stress disorder.

PTSD has proven to be as dangerous an enemy as any; there is no one specific symptom defining it. It can derive from a range of causes, and the disorder itself can act itself out in a range of manners. On top of that, a veteran might not know that he or she has it, and therefore not seek treatment. While the medical community strives to diagnose PTSD among our active and former servicemembers as early and accurately as possible, it must be understood that it is still a developing science.

I look forward to today's testimony and the input the panel members will provide. This Committee remains dedicated to seeing that the Department of Veterans' Affairs provides the best treatment possible to those in need.

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