Military Veterans PTSD Reference Manual

I. S. Parrish

Published in 2001 by
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Bryn Mawr, PA


Mr. Parrish;
I would like to thank you for your words of wisdom. I am assisting my Father with this process, and needless to say he has grown weary of dealing with the government. What I have read has been helpful, as well as encouraging.
Thank You
Kelly Dawson

I recently purchased your book and wished I had the opportunity to review it prior to applying for disability benefits two years ago.

Eric Newton
11ACVVC
Dec 99

Two days after I filed, I got a call from my VVA S.O., who asked if I was sitting down and proceeded to tell me that I had been rated at 100% for Ptsd and depression......VVA rep said that the VA rater said that it was "an honor to work on my file".....Absolutely a god send and also your correspondence with me.

Randy Getchell
Nov 99
Written by a Vietnam veteran for Vietnam veterans, this guide discusses the history and etiology of PTSD and traditional and non-traditional treatments for the disorder. It contains extensive step-by-step instructions to guide veterans with PTSD through the process of applying for disability benefits from the Department of Veterans Affairs, with particular attention to the steps a veteran can take to obtain the necessary documentation for filing a claim.

Fred Lerner, D.L.S., Information Scientist
National Center for Post-Traumatic Stress Disorder
June 1999

It seems to me that you have created a tremendously affirming and practical tool for veterans...

Margaret L. Peck
FOIA/Privacy Act Officer
DVA, Board of Veterans' Appeals
March 1999

As one who has had to deal with PTSD and have spent the past 10 years as a Veteran Advocate, I find this book very useful. From the beginning of the history, definitions cause and effects to treatment. The coverage of dealing with the Department of Veterans Affairs is a step by step guide to filing a claim with a good insight on what to expect along the way with detailed information on how to proceed. I would strongly recommend this book for veterans that are dealing with or think they may have PTSD and for their families to get a better understanding and for any Veteran advocate that may not be up on the condition. A well done guide without a doubt.

Willie G Dougherty
State of Texas Veterans Representative
Mar 1999

Received my copy today. What a great job.

Dr. Joseph M. Carver, Ph. D., Psychologist
Feb 1999.
I am the wife (well long time companion) of a Vietnam vet...(helicopter pilot with the 191st Sep 68 to Sep 69 died Sep 98).. he knew he had PTSD and was told so at one of the first Vet centers (Pittsburgh) in the early 80’s..Its frightening to me to see your details that so clearly outlined Kerry's life...His case was classic PTSD. Your book could be an autobiography of his anguish.

PS: The information you provided is quite helpful to Kerry's children to understand him, Kerry never allowed them to know him well.

DEDICATION

This manual is dedicated to Vivian, my wife of more than 45 years.
Since this manual was first published in 1999 a few things have changed. I attended a PTSD Resident Rehabilitation Program (PRRP program), applied for Social Security and was turned down (It was later approved), and had my disability for PTSD upgraded from 50% to 70% and have been awarded 100% disability for Total and Permanent Unemployability.

The manual has sold about a two thousand copies, mainly over the internet, without advertising. I have been told that several non military community counselors are also using it for reference with trauma victims other than PTSD.

My condition remains fairly stabilized as long as I remember to take my medications. I see a RN Practitioner every 30 days and a general health counselor about the same. It is still difficult to believe that the PTSD will never completely go away but I continue to strive for a better quality of living. So should you. The alternative is alcoholism, drugs or just plain misery.

I read an article the some time ago about laboratory experiments involving guinea pigs that were being injected with blood from a human who was extremely angry and the blood caused the guinea pig to die within 2 hours. That’s the type of toxic chemicals that we create if we fail to control our problem.

I wish you luck and patience.

Inous S. (Bub) Parrish
Jan 2008
ACKNOWLEDGEMENTS

My thanks to VA Staff Dr.’s O’Brian and Spencer who listened, cared, and dispensed both medication and valuable advice during this most trying of times.

I extend my thanks and best wishes to the members of my daytime VA Clinic therapy group as well as the evening support group I attend at a local Vet Center supervised by Domingo Santana, himself a three tour Marine, Vietnam Veteran.

Some unexpected, but welcome assistance came from Margarett Peck at the Board of Veterans Appeals, Dr. Joseph M. Carver for the unrestricted use of his article on *Emotional Memory Management: Positive Control Over Your Memory*, Mr. Anthony Pomes of the Avery Publishing Group for permission to use chapters from the book *Prescription for nutritional Healing, 2ed, by Phyllis A. Balch*, Margaret O. Adams of the National Archives, Frederick J. Graboske of the Marine Corps Historical Center, the office of Dixie Dysart and Archivist at the Air force Historical Research Agency, the office of Theodore J. Hull of the Center for electronic Records (National Archives).

I may have packed it in if not for an encouraging personal phone call from Mrs. Patience Mason, author of *Recovering From the War*, editor of the *Post-Traumatic Gazette* and wife of ex-Huey driver and author Robert Mason. She also took the time to look over the entire project and provide invaluable editorial comments while under a great deal of personal stress.

Thanks to the unknown Personnel Specialist who turned down my request for Door Gunner while serving in the Republic of Vietnam, my CA friend, Dr. Harold Simms, who helped bring this manual to reality through his knowledge of publishing, and Tom Hutchinson (Tom was killed in an airplane crash in May 2001) who tells me jokes and steals from my horde of cookies daily.

Last, but certainly not least, several fine people, in addition to Mrs. Mason, assisted in the editing of this work. My friend and co-worker George “Joey” Etheredge not only performed the most detailed evaluation but has had the dubious privilege of working in the same room with me for over two and a half years, PTSD and all. Fellow vets Steve Ahrens, Bernie Davies and Roger Whiting (Roger passed away in February 2001) also thought enough of me to labor over the entire manuscript and return many fine observations.
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INTRODUCTION

The Veterans Administration is currently treating approximately 1,000,000 Post Traumatic Stress Disorder (PTSD) cases as of January 2008, a total of 299,978 of those veterans are receiving compensation. There are literally MILLIONS of other combat veterans who suffer from PTSD yet have no idea what is causing their problems or what to do about it.

If you are one of these veterans you have a choice. You can continue to deny that you have problems (multiple divorces, drinking/drugs, unemployability, lack of friends and social activity, flashbacks and nightmares) or seek assistance, with the aid of this manual.

This manual is also designed to assist you, the combat veteran, in securing deserved financial remuneration due you because of your involvement in something so heinous that it will effect you for the rest of your life.

I wish you luck and bid you “Welcome Home”.

I. S. (Bub) Parrish, MSG
US Army Retired
THESE SOLDIERS SERVED

These soldiers walked through hell and having passed through the flames lost a part of their soul. They watched their friends get shot and maimed and themselves paid a physical and mental toll.

They prayed for life and they prayed for death as they coped daily with tragedy and pain. They saw and heard things that would kill most men and now they attempt to forget in vain.

Mostly shunned when they came home because of things done by a few others they could only morn. They risked the life that God gave them and all they received from their nation and friends were jeers and scorn.

They walk, talk and even laugh like other men as they pretend the past is forgotten and that they are healed.

But deep inside a part of them is as dead as those that returned in plastic bags, forever in the earth concealed.

These soldiers served their nation in wartime in those lands of beauty, horror and wrath. They went because they were called and they
served because it was the honorable path.

By I. S. Parrish

Chapter 1

History and Definitions of PTSD

Section I. GENERAL

01-01. General. Since you are reading this manual one of the followings things is probably taking place:

a. You think you may have Post Traumatic Stress Disorder (PTSD).
b. You are being treated for PTSD.
c. You know someone who has PTSD.

Before you begin this journey you need to know what Post Traumatic Stress Disorder (PTSD) is.

Approximately eight year ago I did not know what PTSD was and I believed that Veterans who claimed to have PTSD were using their claims to shield them from the consequences of their own stupidity or alcohol/drug abuse. Boy was I wrong.

In this chapter I will present a brief history of PTSD and define PTSD in language you can understand so that;

a. You can determine whether or not you may be afflicted with PTSD.
b. When the time comes you will be better equipped to express your symptoms to your doctor, justify your claim in your stress letter, and explain your condition to your interviewer.

Section II. HISTORY

01-02. General. Prior to the studies done on Vietnam veterans, there were very few scientific studies of what we today call Post Traumatic Stress Disorder (PTSD).

01-03. The 1800’s. During the early 1800’s military doctors began diagnosing soldiers with “exhaustion” following the stress of battle. This “exhaustion” was characterized by mental shutdown due to individual or group trauma. Like today, soldiers during the 1800’s were not supposed to be afraid or show any fear in the heat of battle. The only treatment for this “exhaustion” was to bring the afflicted soldiers to the rear for a while then send them back into battle. Through extreme and often repeated stress, the soldiers became fatigued as a part of their body’s natural shock reaction.

During that time, in England, there was a syndrome know as “railway spine” or “railway hysteria” that bore a remarkable resemblance to what we call PTSD today, exhibited by people who had been in the catastrophic railway accidents of the period. In 1876 DR. Mendez DaCosta published a paper diagnosing Civil War combat veterans with “Soldiers Heart”: The symptoms included startle responses, hyper-vigilance, and heart arrhythmia’s.

01-04. The 1900’s. During WWI overwhelming mental fatigue was diagnosed as “soldier’s heart” and “the effort syndrome”. An article published on a now restricted Internet web site maintained by Med. Access entitled “Chronic Fatigue Syndrome” states that “…some 60,000 of the British forces were diagnosed with the problem and 44,000 of these were retired from the military because they could no longer function in combat”. (www.medaccess.com/cfs/cfs_02.htm (this page is no longer accessible without a password)

The term “shell shock” emerged during WWI followed in WWII by the term “combat fatigue.” These terms were used to describe those veterans who exhibited stress and anxiety as the result of combat trauma. The official designation of “Post Traumatic Stress Disorder” did not come about until 1980 when the Third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) was published.
01-05. The Diagnostic and Statistical Manual of Mental Disorders (DSM). This “bible”, published by the American Psychiatric Association (APA), provides the “official” definition of all mental illnesses. When first published in 1952 what we now know as PTSD was called “stress response syndrome” and was caused by “gross stress reaction”.

In the second edition (DSM-II), 1968, trauma-related disorders were lumped together in an area called “situational disorders”. Mrs. Patience Mason, author of Recovering From The War: A woman’s Guide to Helping Your Vietnam Veteran, Your Family, And Yourself, and After The War, points out that those Vietnam Veterans treated for the disorder during that period were informed that if their symptoms lasted more than 6 months after their return from Vietnam they had a “pre-existing” condition, making it a “transient situational disorder”, and the problem was deemed not service connected. This resulted in a lot of “walking wounded” and I am certain attributed to the high suicide rate suffered by Vietnam Veterans of that time. More Vietnam Veterans have committed suicide than were killed in the war.

Finally, in the third edition, 1980, DSM-III the title “Post-traumatic Stress disorder” was used and placed under a sub-category of “anxiety disorders”. In the current edition, 1994, DSM-IV, “Post-traumatic Stress Disorder” is again used but has been placed under a new “stress response” category and remains in the “anxiety disorder” category.

You may have noticed above that what started out as a “syndrome” turned into a “disorder”. According to Taber’s Cyclopedic Medical Dictionary a “syndrome” is “a group of signs and symptoms that collectively characterize or indicate a particular disease or abnormal condition” and a “disorder” is an illness. PTSD changed from being part of a collective indicator to a singular illness, a significant medical distinction.

With few exceptions, up until DSM-IV, most combat veterans were diagnosed with “shell shock”, which didn’t warrant long term treatment. Other combat veterans were merely diagnosed with “bad nerves” which not only didn’t warrant long term treatment, but also induced a “get over it” attitude from the military and medical communities. This type attitude was personified in the movie “Patton” when General Patton, played by George C. Scott, threatened apparently uninjured military hospital patients with malingering.

The initial definition of PTSD described a psychological condition experienced by a person who had faced a traumatic event which caused a catastrophic stressor outside the range of usual human experience (an event such as war, torture, rape, or natural disaster). This definition separated PTSD stressors from the “ordinary stressors” that were characterized in DSM-III as “Adjustment Disorders”, such as divorce, failure, rejection and financial problems.

Section III. DEFINITIONS

01-06. American Psychiatric Definition. The following is a quote, references to children excluded, from The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), Washington, DC, American Psychiatric Association, 1994, section 309.81, beginning on page 427. The supplemental information, in parenthesis and bold, is provided by Mrs. Patience Mason.

This disorder is described as occurring when:

“A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self (i.e. combat, friendly fire, being mortared or rocketed, wounded, captured, driving a truck on a mined road, flying in a helicopter that was shot at, jumping out of a helicopter into a hot LZ) or others (if you had a buddy who was wounded or lost squad members, family member, or seeing anyone who has recently been killed or injured such as being a medic or nurse on a trauma ward, body bagging, seeing someone you didn’t know killed, seeing kids, women or other Americans or civilians who had been killed, or wounded, etc.)

(2) the person’s response involved intense fear, helplessness or horror.”

According to the DSM-IV, “ B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
(2) recurrent distressing dreams of the event.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three (or more) of the following:

(1) efforts to avoid thoughts, feelings or conversations associated with the trauma (If you try not to think about the war or if you try not to feel love because you lost a beloved buddy, try never to feel guilt because you think you fucked up over there, try never to be happy because you were ambushed when you were feeling fine, try never to get angry because you’re afraid of what you might do)

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma (never watch war movies, don’t hunt, don’t go to veterans day parades or associate with other vets, can’t stand authority figures because of the REMF’s or the lifers, etc.)

(3) inability to recall an important aspect of the trauma (particular battles or periods of time that you can’t remember or whether those guys were killed or just wounded)

(4) markedly diminished interest or participation in significant activities (what did you used to do that you don’t since your PTSD came on? Lots of guys with PTSD stay home watching TV which is this symptom. Others still get out but they’ve given up hunting, or going places where there are crowds or whatever)

(5) feelings of detachment or estrangement from others (No one can understand what it’s like. I’m on the outside looking in at all these people who haven’t a clue. I don’t care about things or people the way I used to)

(6) restricted range of affect (e.g., unable to have loving feelings) (unable to cry when parent dies or kid dies, told you have no feelings, can’t feel love for wife, etc.)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or even a long life span).” (may be still driving drunk or stoned, still jumping out of airplanes or taking other risks, afraid to commit to anyone or anything, etc.)

The Diagnostic criteria in section 309.81, DSM-IV, goes on the state:

“D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep;
(2) irritability or outbursts of anger;
(3) difficulty concentrating (Read a page and can’t remember it? Forget what your wife just told you or constantly hear “I told you that yesterday?” Feel dumb because you don’t follow a lot of conversations, etc., or just can’t focus because part of you is scanning for danger all the time?)
(4) hypervigilance (always looking for danger, worrying about people getting hurt, still looking for tripwires and sitting with your back to the wall, avoiding crowds, etc.)
(5) exaggerated startle response (hit the dirt at the sound of a backfire, can’t be touched when asleep, etc.)

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more
Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor”
(Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, fourth Edition.
Copyright 1994 American Psychiatric Association.)

Experiencing any or all of these symptoms does not mean you are "crazy," but that you are suffering the
normal effects of trauma brought on by an abnormal event.

In order to establish service connection for PTSD, the evidence must establish that during active duty a
veteran was subjected to a stressor or stressors that would cause characteristic symptoms in almost anyone.
Evidence of combat or having been a prisoner of war may be accepted as conclusive evidence of a stressor
incurred during active duty. Evidence of combat includes receipt of the Purple Heart, the CIB, or other similar
citation.

01-07. Department of Veterans Affairs (VA) Definition, The Technical Versions. The following, issued by
the Department of Veterans Affairs (VA) in the Code of Federal Regulation (CFR), part 38, offers the “official”
definition you will be most concerned with:

a. “Post-Traumatic Stress Disorder. 3.304 (f) (f) Post-traumatic stress disorder. Service connection for
post-traumatic stress disorder requires medical evidence diagnosing the condition in accordance with
§4.125(a) of this chapter; a link, established by medical evidence, between current symptoms and an
in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred.
Although service connection may be established based on other in-service stressors, the following
provisions apply for specified in-service stressors as set forth below:

(1) If the evidence establishes that the veteran engaged in combat with the enemy and the
claimed stressor is related to that combat, in the absence of clear and convincing evidence to the
contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or
hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of
the claimed in-service stressor.

(2) If the evidence establishes that the veteran was a prisoner-of-war under the provisions of
§3.1(y) of this part and the claimed stressor is related to that prisoner-of-war experience, in the
absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is
consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay
testimony alone may establish the occurrence of the claimed in-service stressor.

(3) If a post-traumatic stress disorder claim is based on in-service personal assault, evidence
from sources other than the veteran's service records may corroborate the veteran's account of the
stressor incident. Examples of such evidence include, but are not limited to: records from law
enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or
physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family
members, roommates, fellow service members, or clergy. Evidence of behavior changes following the
claimed assault is one type of relevant evidence that may be found in these sources. Examples of
behavior changes that may constitute credible evidence of the stressor include, but are not limited to:
a request for a transfer to another military duty assignment; deterioration in work performance;
substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or
unexplained economic or social behavior changes. VA will not deny a post-traumatic stress disorder
claim that is based on in-service personal assault without first advising the claimant that evidence from
sources other than the veteran's service records or evidence of behavior changes may constitute
credible supporting evidence of the stressor and allowing him or her the opportunity to furnish this type
of evidence or advise VA of potential sources of such evidence. VA may submit any evidence that it
receives to an appropriate medical or mental health professional for an opinion as to whether it
indicates that a personal assault occurred.

(Authority: 38 U.S.C. 501(a), 1154)
b. **Mental Disorders** - 4.125  Diagnosis of mental disorders.

(a) If the diagnosis of a mental disorder does not conform to DSM-IV or is not supported by the findings on the examination report, the rating agency shall return the report to the examiner to substantiate the diagnosis.

(b) If the diagnosis of a mental disorder is changed, the rating agency shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating agency shall return the report to the examiner for a determination.

(Authority: 38 U.S.C. 1155)

4.126  Evaluation of disability from mental disorders.

(a) When evaluating a mental disorder, the rating agency shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during periods of remission. The rating agency shall assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner's assessment of the level of disability at the moment of the examination.

(b) When evaluating the level of disability from a mental disorder, the rating agency will consider the extent of social impairment, but shall not assign an evaluation solely on the basis of social impairment.

(c) Delirium, dementia, and amnestic and other cognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for delirium, dementia, or amnestic or other cognitive disorder (see §4.25).

(d) When a single disability has been diagnosed both as a physical condition and as a mental disorder, the rating agency shall evaluate it using a diagnostic code which represents the dominant (more disabling) aspect of the condition (see §4.14).

(Authority: 38 U.S.C. 1155)

01-08. The European Description. If you are not confused enough have a look at the description offered by the World Health Organization in Geneva. The good part is that PTSD is now recognized world-wide as a “real” disorder. The bad part is found in their “Diagnostic Guidelines”. What follows is an excerpt from their Internet Home Page:

"Post-Traumatic Stress Disorder
F43.1 This arises as a delayed and/or protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (e.g. natural or man-made disaster, combat, serious accident, witnessing the violent death of others, or being the victim of torture, terrorism, rape, or other crime).... Typical symptoms include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks") or dreams, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. Commonly there is fear and avoidance of cues that remind the sufferer of the original trauma. Rarely, there may be dramatic, acute bursts of fear, panic or aggression, triggered by stimuli arousing a sudden recollection and/or re-enactment of the trauma or of the original reaction to it...."
The onset follows the trauma with a latency period which may range from a few weeks to months (but rarely exceeds 6 months). The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of patients the condition may show a chronic course over many years and a transition to an enduring personality change.

Diagnostic Guidelines
This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A "probable" diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible…..

ICD-10 copyright 1992 by World Health Organization
Internet Mental Health (www.mentalhealth.com) copyright 1995-1997 by Phillip W. Long, M.D.
This is an excellent page and worthy of study.

Section IV. DOWN AND DIRTY

01-09. Information You Can Use. According to a study (the National Vietnam Veterans Readjustment Study, NVVRS) performed in the mid 80’s 15.2% of the male Vietnam veterans, surveyed at that time, suffered from PTSD and 30% of heavy combat male Vietnam veterans suffered from PTSD. Even though no survey was done, 16,354,000 veterans served during WW-II and 5,700,000 served in Korea.

Lets split the difference and say that 20% of all the veterans then and now suffer from PTSD of some intensity.

The Veterans Administration confirms that approximately 19,196,000 veterans are still living. That would mean that some 3,838,200 veterans suffer from PTSD and as of July 1997 only approximately 500,000 were being treated and only 102,000 are receiving disability compensation. This means that only approximately 1.3% of those veterans are being treated and only .3% of those being treated are receiving disability compensation.

EIGHT months after I applied for PTSD I received my C & P (Compensation and Pension) examination for PTSD. Four months after that I received a decision and an award for 10% disability for PTSD.

During that YEAR My son forced me out of our small Internet business because I was becoming very combative with our customers and angry with him over everything. I was unable to drive my vehicle in heavy traffic without getting physically ill and VERY angry and I began to seclude myself in my home because of depression and anxiety.

Within 30 days I had submitted a Notice of Disagreement (NOD) for the PTSD based on my deteriorating mental condition. After SIX more miserable months I was granted a hearing with the Regional Decision Review Officer (DRO) and after SIX more months, I received an upgraded to my PTSD claim to 50%. It took 2 years and 5 days. I applied for and upgrade to my PTSD and for un-employability in the year 2000. In Mar 2001 I was awarded 70% for PTSD and un-employability (which makes me 100% disabled).

Section V. GETTING STARTED

01-10. In Very Simple Terms. What causes PTSD in combat veterans? A Traumatic Event and then MEMORIES of that event. These memories cause a chemical imbalance in the brain when they are TRIGGERED by conscious and sub-conscious events.

This is the worst part of untreated PTSD, not only do conscious reminders (war buddies, smells, sounds, movies) cause the brain to go GAGA but unconscious thoughts will trigger the chemical imbalance (anniversary dates, seeing someone who looks like a buddy lost in combat). Days, weeks, months and sometime years later you begin to have anxiety attacks or become depressed. In most of us these events are short lived and we go on as before, with no noticeable change in our lives.
In many of us the events build up and finally drag us down, as happened in my case and as has happened with some of you.

Section VI. SEQUENCE OF EVENTS (BARE BONES)

1. Contact the nearest VA hospital or clinic and make an appointment with the Mental Health department. The VA will not process your application unless you have been diagnosed with PTSD by a VA doctor.

2. File a "statement of Illness" letter. Send a letter to your Regional Office with a Subject line of “Statement of Illness”. Simply state that you are suffering from PTSD and need treatment.

3. If you are eligible, file a claim. There should be a Service Representative in the VA facility.

4. Continue your treatment program and start on your Stress Letter.

5. Submit your Stress Letter. (Do this even though you may not be required to so you can establish Evidence of Record)

Note: The extent to which you were stressed in combat has no major bearing on the amount of your disability determination (This does, however, establish service connection). The amount of disability you may eventually end up with will be determined by your CURRENT social in-adaptability.

6. C & P (Compensation and Pension ) Interview - This is where a medical doctor describes your current mental condition for the record.

7. Your Claim file is then returned to your regional office for review and determination.

Herein lies the heart of your disability determination. Your fate is decided by the comments of the C & P interviewing official, a VA "Rating Specialist", and the VA Rating Board.

ALWAYS MAKE COPIES OF EVERYTHING (GENERAL INFORMATION)

There is a serious problem in the system that you should be aware of. In Feb of 2000 I attended a resident PTSD program that lasted for 45 days. I was pretty strung out when I arrived and felt some better when I left. When you attend these programs you will be given an update of your GAF score when you depart. If you show some improvement and your GAF is changed (you could be asked how you feel or you may be rated on your conduct and attitude in the program), to a higher number, the VA may request you be re-evaluated to see if they can decrease your disability rating because of your improved condition.

Almost EVERYTHING you say to your Doctor, at ALL appointments, is noted in your files, even your demeanor is noted.

ALWAYS BE AWARE OF WHO YOU SPEAK TOO AND WHAT YOU SAY

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Section IV. PERSONAL EXPERIENCE

01-11. The Eye Opener. When I finally forced myself to go to a VA Clinic I was in a very high state of anxiety and depression had already begun to set in. I had had a bout with depression shortly after retirement so I was aware of some of the signs. I had never experienced a high state of anxiety before and did not even know what PTSD was. Some of you will have the same symptoms, most will not. Since my diagnosis I have been talking to more of my veteran friends about PTSD and finding out that most, if not all, of them have it to some degree and many of them have been under counseling for some time but had not spoken to me, or anyone else, about it because they thought their friends would think they were feigning illness.
SITREP- WWII Era (1939):
The cyclotron of John Ray Dunning splits an atom for the first time in America; The first commercial transatlantic passenger air service begins; New York’s La Guardia Airport opens; The first American made helicopter is flown; Hewlett-Packard is founded; FM radio receivers go on sale for the first time; “Batman” is launched by DC Comics; the books The Grapes of Wrath and How Green Was My Valley are released; the movies “Gone With The Wind” and “Drums Along the Mohawk” are released; the songs “I’ll Never Smile Again” and “South of the Border (Down Mexico Way)” are released; the New York Yankees win the World Series by defeating the Cincinnati Reds 4 games to 0.

WW II Era (1940):
Winston Churchill succeeds Neville Chamberlain as Britain’s prime minister; the first peacetime military draft in U.S. history begins October 29; President Roosevelt wins reelection to third term with 54 percent of popular vote; the first Social Security checks go out January 30; the new Chevrolet coupe sells for $659; the book For Whom the Bell Tolls, is written by Ernest Hemingway; the Broadway play Pal Joey opens at the Barrymore theater; the songs “The Last Time I saw Paris” and “You Are My Sunshine” were released; the Cincinnati Reds win the World Series by defeating the Detroit Tigers 4 games to 3.
Section I. GENERAL

02-01. General. In the previous chapter I offered several definitions of PTSD as provided by the general medical community and the Department of Veterans Affairs. This chapter will help you understand those definitions by first explaining some of the reasons you react to trauma the way you do, and secondly by explaining a little about brain chemical imbalances and the meaning and dangers of "triggers".

Section II. THE WAY WE WERE

02-02. General. To help us understand our ongoing experience with this PTSD thing we have to go back to what took place before we went to war. In a research paper written in May 1992 entitled Veterans, Combat and Stress, about Vietnam Veterans, John Russell Smith, then a graduate student at Duke University, says "It is not the traumatic experience of war itself but the meaning that those events have for the individual which creates trauma".

Those events we experienced in war and believe to be inhuman or insane are only so because of our learned ethics and values. Because we believed in God and country, mom and apple pie. Because we believed that serving our country was expected and that our country was doing the right thing.

We were innocent as a people and a nation and we believed we were invincible. We were proud and honorable. We were the watch-dogs of the free world. We made a good showing in WWI, WWII and a decent one in Korea. We expected to do the same in Vietnam, the Gulf war, and IRAQ/Afghanistan.

02-03. Research Findings. In 1992 Dan and Lynda King of the National Center for PTSD, Boston analyzed data collected from the 1980's "National Vietnam Veterans Readjustment Study" (NVVRS). In their article PTSD Among Vietnam Veterans: Recent Research Findings they wrote:

"As you might expect, the most important contributor to PTSD is the level of exposure to traumatic events in the war zone itself, what we call combat exposure. This is not a surprising finding, but what was particularly interesting was that the effect of combat on PTSD for the veteran was channeled through his perceptions of the experience. That is, any combat event that a veteran might have experienced in Vietnam, such as being in an ambush or a fire fight, tended to influence PTSD indirectly, through his interpretation of what happened. In addition, the level of combat exposure influenced the veteran's sense that the overall environment of Vietnam was threatening, uncomfortable, or malevolent. We found the veteran's perception of the 'malevolent environment' of Vietnam also to be a contributor to PTSD symptoms. So it appears that combat exposure, as expected, is implicated--the more combat, the more PTSD--but its influence is indirect.

We considered the possible role of prewar risk or vulnerabilities that might, in addition to his Vietnam experience, contribute to the veteran's PTSD symptoms. A very important element was the age of the veteran when he went to Vietnam. As we all know, younger men were more likely to be of lower rank, and thus prone to directly experience the heavier combat. This indirect link of the veteran's age through combat may not be particularly revealing, but we also documented a direct link between the veteran's age at entry to Vietnam and his reported PTSD symptoms. This finding is suggestive of a maturation-based explanation: The younger the veteran was when he served in Vietnam, the less he was capable of "working thru" his experience and the more PTSD symptoms he felt when he returned.

Another risk factor for PTSD was the veteran's history of exposure to traumatic events prior to entering the military. By trauma history, we mean being in a serious auto accident, being a victim of assault, being in a
house fire, and other similar kinds of experiences. Prewar trauma history operated in a very interesting way to produce PTSD symptoms. Those men who were in heavy combat and had a history of prewar exposure to traumatic events reported higher levels of PTSD symptoms while those in heavy combat without a prior trauma history reported fewer symptoms. This difference in reported PTSD symptoms did not occur for veterans who were exposed to low levels of combat. So, there seems to be a kind of “piling on” effect—a prewar trauma history plus exposure to heavy combat can lead to more PTSD symptoms. Characteristics of the veteran's family of origin also indirectly contributed to PTSD.

We found that the more troubled the veteran's family was, the younger he was when he entered Vietnam. Also, the veteran's family of origin characteristics were associated with his having problems with educational and legal authority. In turn, the veteran's educational and legal problems before entering the military were related to his exposure to prewar traumatic events (the more problems, the more events), his age at entry to Vietnam (the more problems, the younger), and his exposure to combat while in Vietnam (the more problems, the more combat). So, although family of origin characteristics were not directly related to PTSD, they did seem to predict other factors that were, in turn, either directly implicated (for example, age at entry into Vietnam) or indirectly implicated (for example, pre-military educational and legal problems).”

(Reprinted by permission of the Authors, Dan and Lynda King).

A statistic from the NVVRS not mentioned by Dan and Lynda King in their article is that 66% of Vietnam veterans exposed to high war zone stress have had diagnosable PTSD and 33% still do today.

02-04. The Erosion of Meaning. Also from John Russell Smith’s paper Veterans, Combat and Stress we find “There have always been veterans for whom the grand rationales……have not provided meaning for their experience…..The erosion of meaning, honor and duty in the first industrialized war, WWI, gave rise to widespread malaise mistakenly named shell shock (Leed, 1979). The loss of meaning in that war gave birth to existentialism, the philosophy of meaninglessness. Even more so during Vietnam, the erosion of sanction for the war, the lack of clear purpose, the duplicitous manipulation of political leaders and the divisive debate among the American people evaporated the meaning of the soldier's sacrifices.”

The entire article may be found on the Internet at “http://www.vbarnet.com/pages/vetfiles.htm” (This page is no longer available).

Another unique stress for Vietnam veterans was the rapid manner in which they returned from their hostile environment. In previous wars weeks or months passed before the veteran returned home from the battlefield, due to the length of the war and transportation limitations. During this time, they were with other people who had experienced similar things. Vietnam veterans usually served one year in the “zone” and the majority went and returned by themselves (not with a unit).

After some 30 weeks of being programmed to kill (Basic, A.I.T., etc.), being surrounded by killing for 52 weeks, the Vietnam veteran was quite often taken from the “bush” in the morning and, after only 24 - 48 hours, delivered to American soil and his family (and sometimes anti-war demonstrators) with no cool down period in between. The shock was often confusing and sometimes devastating.

Along the same vane as the paper done by Dr. John Russel Smith is a book written by Jim Goodwin, Psy. D., entitled Post-Traumatic Stress Disorders of the Vietnam Veteran: Observations and Recommendations for the Psychological Treatment of the Veteran and His Family. This work is sponsored and published by the Disabled American Veterans organization and is freely reproduced and distributed by the VA. The following is taken from the chapter entitled “The Etiology of Combat-Related Post-Traumatic Stress Disorders”.

“Surprisingly, with American involvement in the Vietnam War, psychological battlefield causalities evolved in a new direction. What was expected from past war experiences – and what was prepared for – did not materialize. Battlefield psychological breakdown was at an all-time low, 12 per one thousand (Bourne, 1970). (Authors note: this was compared to 23 percent evacuations for psychiatric reasons during WW II and 6 percent in the Korean War).”

Dr. Goodwin contributes this misleading statistic to what he refers to as the “DEROS fantasy”. Soldiers “held on” because they knew that they would rotate back to the states in 1 year (except of the Marines who served 13 month tours). This was particularly difficult and “The struggle for most was an uphill battle. Those motivations that kept the combatant fighting – unit esprit de corps, small group solidarity and an ideological belief that this was the good fight (Moskos, 1975) – were not present in Vietnam. Unit espirit was effectively slashed by the DERO system. Complete strangers, often GIs who were strangers even to specific unit’s specialty, were transferred into units whenever individual rotations were completed.”
There were other unique aspects of group dynamics in Vietnam. As a seasoned veteran got down to his last two months in Vietnam, he was struck by a strange malady know as the “short timer’s syndrome”. He would be withdrawn from the field. His buddies would be left behind in the field without his skills, and would be left with mixed feelings of joy and guilt…Feelings of guilt about leaving one’s buddies to whatever unknown fate in Vietnam apparently proved so strong that many veterans were often too frightened to attempt to find out what happened to those left behind.”

Another factor unique to the Vietnam was that the ideological basis for the war was very difficult to grasp. In World War II, the United States was very clearly threatened by a uniformed and easily recognizable foe. In Vietnam, it was quite the opposite. It appeared that the whole country was hostile to American forces. The enemy was rarely uniformed, and American troops were often forced to kill women and children combatants. It was an endless war with rarely seen foes and no ground gains, just a constant flow of troops in and out of the country. The only observable outcome was an interminable production of maimed, crippled bodies and countless corpses. The rage that such conditions generated was widespread among American troops. It manifested itself in violence and mistrust toward Vietnamese (DeFazio, 1978), toward the authorities, and toward the society that sent these men to Vietnam and then would not support them. Rather than a war with a just ideological basis, Vietnam became a private war of survival for every American individual involved.

Dr. Goodwin goes on to explain that “The vast majority of Vietnam combat veterans I have interviewed are depressed….Accompanying the depression is a very well developed sense of helplessness about one’s condition. Vietnam-style combat held no final resolution of conflict for anyone. Regardless of how one might respond, the overall outcome seemed to be just an endless production of casualties with no perceived goals attained. Regardless of how well one worked, sweated, bled and even died, the outcome was the same. Our GIs gained no ground: they were constantly rocketed ormortared. The found little support from their “friends and neighbors” back home, the people in whose name so many were drafted into military service. They felt helpless. They returned to the United States, trying to put together some positive resolution of this episode in their lives, but the atmosphere at home as hopeless. They were still helpless. Why even bother anymore?”

And finally he says, ‘The veterans’ rage is frightening to them and to others around them….Along with the rage at authority figures from the Vietnam ear, these veterans today often feel a generalized mistrust of anyone in authority and the “system” in the present era. Many combat veterans with stress disorders have a long history of constantly changing their jobs.’”

I thank Dr. Jim Goodwin, himself a Marine Corps veteran of Vietnam combat, and the Disabled American Veterans (DAV) for making this information available.

(Authors Note: This is the same thing that is taking place now in Iraq)

Section III. MEMORIES

02-05. General - While most PTSD survivors usually come to understand what has caused their problems very few know what affects their behavior. The most amazing fact that I uncovered while writing this manual is that after all these years there is still no full understanding of how traumatic memories and emotions interact with biological and psychological triggers. While some research has been done, only a little is known about the ways brain chemicals and daily social interactions affect PTSD survivors. With so little information it has been difficult for the pharmaceutical and psychotherapeutic communities to develop a definitive therapy or course of treatment for PTSD.

(Authors Note: After 11 years of treatment and I still take 3 anti-depressants and two anti anxiety medications.)

02-06. Memories as Pictures. Some of the simplest concepts I have run across while doing research for this manual have had the most impact on my personal growth and recovery. For instance if we were able to “remember” pain, we would certainly go mad before puberty. On the other hand we also do not have the ability to remember pleasure, which would be an asset to most of us. God was good to us when he glued all of the parts together and decided how the brain would work.

Where am I going with this? Have you ever come to the realization that every thought we have creates an image? Try it….it is impossible to not “see” a memory. If we think of an orange.. we “see” an orange. While the brain registers everything we see, hear or feel, our images are not always historically correct. Much depends
on our relative position in the memory causing event and whether or not the event was “memorable”. On the whole we only clearly “see”, or remember, those events that stand out as the worst or best in our lives.

These realizations gave me a better understanding of what “flashbacks” and intrusive thoughts are to trauma victims. These memories, or images, are more often than not accompanied by emotions. The combination of these memories and emotions is what affects us negatively as we attempt to function on a daily basis. What are the physiological causes and effects of these intrusive thoughts?

Section IV. BRAIN CHEMICALS

02-07. The brain operates on chemicals. In his Internet article Emotional Memory Management (www.zoomnet.net/~jcarver/emotmem.html) (This web page is no longer available on the internet) Dr. Joseph M. Carver writes, “Chemicals produce emotional responses in the brain and body. Just like a certain combination of flour, sugar, butter, and other foods can combine and produce a German chocolate cake, these chemicals combine in our brain to produce certain moods, reactions, and feelings.

Just like an automobile contains various fluids (brake, window washer, transmission, oil, anti-freeze, etc.), the brain operates on chemicals known as “neurotransmitters”. While the subject is too technical for this paper, it is known that these brain chemicals called “neurotransmitters” produce various emotional conditions. Like the oil in our automobile, neurotransmitters have a normal level in the brain and can be “low” or “high” depending upon certain situations.

Some typical neurotransmitters:

a. Serotonin: Perhaps the most actively researched neurotransmitter at this time, serotonin is known to be related to depression, headaches, sleep problems, and many mental health concerns. When serotonin is low in the brain system - depression and other mental health problems are produced….Antidepressants, such as Prozac and Zoloft, work by increasing serotonin in the brain. As our Serotonin level returns to normal, our depression lifts.

b. Dopamine: Abnormally high levels of this neurotransmitter in the brain produce paranoia, excitement, hallucinations, and disordered thought (schizophrenia).

c. Norepinephrine: Related to anxiety and depression, high levels in the brain produce strong physical-anxiety manifestations such as trembling, restlessness, smothering sensations, dry mouth, palpitations, dizziness, flushes, frequent urination, and problems with concentration. A “panic attack” is actually a sudden surge of norepinephrine in the brain.

d. Endorphins: Substances produced by the body that kill pain or produce a feeling of well-being. In marathon runners, these substances are responsible for the “runner’s high”.

The levels of these chemicals or neurotransmitters in the brain create our mood. A chronic low level of serotonin, as when experiencing long-term severe stress, produces strong depression.

The low serotonin creates symptoms such as:

105 Frequent crying spells
106 Loss of concentration and attention
107 Early morning awakening (about 4:00 am)
108 Loss of physical energy
109 Increase in thinking/mind speed, pulling bad memories
110 “Garbage” thoughts about death, dying, guilt, etc.
111 Loss of sexual interest

Emotional Memory files contain instructions for the brain to use these neurotransmitter ingredients to produce the mood in the file. We note that all antianxiety, antidepressant, and antipsychotic medications focus on changing the levels of these chemicals in the brain.”

And finally Dr. Carver writes “Thoughts change brain chemistry. That sounds so simple but that’s the way it is, with our thoughts changing neurotransmitters on a daily basis. If a man walks into a room with a gun, we think “threat”, and the brain releases norepinephrine. We become tense, alert, develop sweaty palms, and our heart beats faster. If he then bites the barrel of the gun, telling us the gun is actually chocolate, the brain rapidly changes its’ opinion and we relax and laugh - the jokes on us.
We feel what we think! Positive thinking works. As the above example suggests, what we think about a situation actually creates our mood.”

**02-08. Discoveries** - “UT Researchers Discover How Brain Chemical Affects PTSD”. In the December 11th 1997 issue of the Austin American-Statesman newspaper reporter Dick Stanley writes “There’s new hope for people with post-traumatic stress disorders from child abuse, rape, warfare and other traumas. Researchers at the University of Texas Medical Branch at Galveston report in today’s issue of the journal Nature that the disorders might be caused by excessive amounts of key chemical in the amygdala, a part of the brain that plays a critical role in mediating fear and other emotional responses in people and animals.”

The article goes on to say that “Previous research along these lines have found numerous hints that the neurotransmitter glutamate might be responsible for the learned-fear response, both for legitimate fears we need to survive and the fears associated with previous traumas.” (Authors Note: An article on the internet, printed in 2004 indicates that this is still in experimentation.)

An article on the same research was found on the Internet entitled PTSD Treatment: An Outline and Review, (users.aol.com/fedprac/11lubin.htm) (This web page is no long available on the internet) written by Hadar Lubin, MD. In short he says “Uncontrollable stress produces profound alterations in numerous neurotransmitter systems” and that “the amygdala has been implicated in the formation of re-experiencing symptoms such as flashbacks.”

Another chemical imbalance, not brain related, can be caused by the Adrenal Glands. Dr. Aphrodite Matsakis, PhD, in her book I Can’t Get Over It says (New Harbinger Publications, 1996) “…if you were in an emergency state for too long, your adrenals might be damaged due to the overuse, and thus do not respond properly. The adrenal glands were not made to handle prolonged stress.” I have not seen any other research on this topic so I do not know how plausible it is, but I know my adrenal gland was working like hell in Vietnam.

And finally I found an interesting article in the May 31, 1999 issue of U. S. News and World Report entitled “A snapshot of depression” by Joannie M. Schrof, which says“…A study conducted at the University of Texas Health Science Center in San Antonio used brain imaging techniques (authors note: I believe they are referring to a cat scan type of picture) to reveal a lack of communications between regions of the brain where cognitive tasks like planning and paying attention are performed (the neocortex) (authors note: this is referred to as the “new” part of the brain) and regions where emotions are processed (the limbic system) (authors note: the limbic is what is considered the “old” part of the brain, the edge, border, or fringe part). When one region revs up and requires more blood, the other region shuts down, using less. In normal brains, that feedback loop is flexible. In depressed individuals, the loop runs wild, so the cortex becomes stuck in a dysfunctional state and the limbic system in a hyperactive one”. The study was conducted by Helen Mayberg, currently serving as chair of neuropsychiatry at the University of Toronto.

**Section V. TRIGGERS**

**02-09. Effects of Every Day Living**. As we watch TV, drive to work, walk in the mall or just celebrate a holiday we often experience strong feelings, sometimes even “flashbacks”, without being aware of what is happening to us. Psychiatrists call these events “triggers”. These triggers are not always negative and not always caused by traumatic events. When we see a tiger on a billboard we might get a mental image of an Exxon Gas station or Kellogg’s Frosted Flakes, depending on our point of reference. These are commercially created “triggers”.

On the other hand we might hear a noise, smell an odor, experience an anniversary date or see a particular picture related to a long past traumatic event and be overcome with negative emotions or act out or shut down or leave or try to commit suicide. If we have buried the event or events deep enough we will not even know why we are experiencing those feelings.

Most veterans live with these triggers on a daily basis with no particular mental consequence. For survivors of PTSD, triggers overwhelm their natural mental defenses which shield them from their traumatic past experiences. Understanding this is often the first step to recovery. If you have experienced being triggered and not yet sought medical assistance, do so now. This is not something you can handle on your own. If you have not yet reached the stage where you feel you need medical help you might try one or more of the following when these triggers occur:

a. Remove yourself from the trigger.
b. Pound on a pillow.
c. Talk to yourself (“I am safe. I am not in Vietnam”) or yell out loud.
d. Perform a vigorous physical activity (this is VERY good).
e. Listen to soothing music.

Section VI. MEMORY, CONCENTRATION, ANGER

02-10. Memory and Concentration. There is a fine line between “memory problems” and having “difficulty concentrating”. Normally we hear from the medical community that depression causes “memory problems”. “Difficulty concentrating” is usually listed separately. Having suffered from depression (I still have bouts as I write this manual) I believe depression causes “difficulty concentrating” which in turn causes what we perceive as “loss of memory”. Most, if not all of my “forgetfulness” stems from not being able to concentrate on what I am doing and perhaps a week later I find that I have “forgotten” something that I should have done. The “memory problems” are the result of this lack of concentration the previous week.

While in treatment at my local Veterans Clinic I have witnessed several veterans with PTSD actually becoming depressed because they think they are losing their minds (memory problems). This often causes them to become even more depressed (very close to suicide).

02-11. Another effect of Trauma is Anger. A common thread amongst the veterans I have spoken with seems to be anger. Nothing in my personal research indicates a medical reason for anger. I remember hearing as a teenager that “anger was a wasted emotion”. The American Heritage Dictionary defines anger as, “A feeling of extreme hostility, indignation, or expiration; rage; rath”. In a combat situation anger can save your live. So why are you angry now?

I offer a few personal thoughts based on my having served in Vietnam. See if your feelings are not similar:

I am angry because our harsh experiences in Vietnam and the deaths of over 58,000 of our friends and fellow soldiers were a wasteful part of a political game. Three different presidents, Kennedy, Johnson and then Nixon refused to pull out of Vietnam because they each wanted to avoid the legacy of being the first U.S. president to lose a war. Probably before, and definitely after, the Tet debacle of 1968 many government officials and advisors came to the realization that we would NEVER win the war and yet 40,000 (the majority of those killed) American soldiers died in Vietnam after Tet of 1968 and before the United States finally withdrew.

I am angry at not having been able to do more for my buddies in Vietnam. Not having saved the life of a certain buddy in Vietnam. Having killed in Vietnam. Angry because I am alive, and many of my friends are dead.

Having said that, consider the following, which I found on the Kaiser Permanente “Your Health” Internet website:

“Chill out and live longer - Angry men tend to be buried sooner. Researchers believe that anger causes the release of stress hormones into the blood-stream. That may be why, in a study by the Harvard School of Public Health, men with the highest anger scores on a personality test were much more likely to develop heart disease. About three times as likely, in fact.

The study, of 1,300 men age 40-90, also found that angrier men tended to drink and smoke more.”

I am aware of the fact that just thinking about not being angry will not make the anger go away. The VA usually has stress reduction classes and anger control programs. Join one. I did, and it helped.

Section VII. THE WARNING OF THE COMMONS

The life committed to nothing larger than itself is a meager life indeed. Human beings require context of meaning and hope. We used to have ample context, and when we encountered failure, we could pause and take our rest in that setting – our spiritual furniture – and revive our sense of who we were. I call the larger setting the commons. It consists of the belief in the nation, in God, and one’s family, or in a purpose that transcends our lives.
In the past quarter-century, events occurred that so weakened our commitment to larger entities as to leave us almost naked before the ordinary assaults of life. As has often been observed, the assassinations, the Vietnam War, and Watergate combined to destroy for many the idea that our nation was the means through which we could accomplish lofty goals. Those of you who grew up in the early 1960s probably sensed this, as I did, on November 22, 1963 (John Kennedy shot), as we watched our vision of the future wiped out. We lost hope that our society could cure human ills. It’s a commonplace, perhaps, but an accurate observation, that many in my generation shifted their commitment, out of fear and out of despair, from careers in public service to careers in which we could at least make ourselves happy.

This shift from the public good to private goods was reinforced by the assassinations of Martin Luther King, Jr., Malcom X, and Robert Kennedy. The Vietnam War taught those a bit younger the same lesson. The futility and cruelty of a decade of war eroded youth’s commitment to patriotism and America. And for those who missed the lesson of Vietnam, Watergate was hard to ignore.

So commitment to the nation lost its ability to provide us with hope. The erosion of commitment, in turn, caused people to look inward for satisfaction, to focus upon their own lives. While political events were nullifying the old idea of the nation, social trends were nullifying God and the family, as scholars have noted. Religion or the family might have replaced the nation as a source of hope and purpose, keeping us from turning inward. But, by unfortunate coincidence, the erosion of belief in the nation coincided with breakdown of the family and a decline of belief in God.

A high divorce rate, increased mobility, and twenty years of low birthrate are the culprits in the erosion of family. Because of frequent divorce, the family is no longer the abiding institution it once was, a sanctuary that would always be there unchanged when we needed balm on our wounds. Easy mobility – the ability to pick up and move great distances – tends to shatter family cohesion. Finally, having no siblings or just one – which is the case in so many American families – isolates a person. The extra attention that results when parents are centered on just one or two children, although satisfying to the kids in the short run (it actually ups their mean IQ about half a point), in the long run gives them the illusion that their pleasures and pains are rather more momentous than they are.

So put together the lack of belief that your relationship to God Matters, the breakdown of your belief in the benevolent power of your country, and the breakdown of the family. Where can one now turn for identity, for purpose, and for hope? When we need spiritual furniture, we look around and see that all the comfortable leather sofas and stuffed chairs have been removed and all that’s left to sit on is a small, frail folding chair: the self. And the maximal self, stripped of the buffering of any commitment to what is larger in life, is a setup for depression.

Either growing individualism alone or a declining commons alone would increase vulnerability to depression. That the two have coincided in America’s recent history is, in my analysis, why we now have an epidemic of depression. The mechanism through which it works is leaned helplessness……….when individuals face failures they cannot control, they become helpless.


Section VII. PERSONAL EXPERIENCES

02-12. Personal Experiences. I have PTSD. Thirty years worth of “triggers” finally brought me to my knees. Many things that affect us - growing older, the loss of parents and friends - seem at first to be normal events, unfortunate, but not unexpected. However, upon reflection all of these events turned out to be triggers in one form or another, and they will happen to all of us.

Most people pass through these events after a certain amount of anxiety and grief, however veterans not only suffer the emotional stress of these events but also relive the stress and emotional scars from past trauma. Many veterans wonder why it took so long for them to manifest PTSD. One opinion, which I share, is espoused by Dr. C.B. Scrignar in his book on PTSD states, “In the experience of the author, Delayed Onset is actually a term used to describe delayed diagnosis of PTSD. The delay, therefore, is not in the onset but in the recognition and treatment of a preexisting PTSD……Vietnam-era veterans have frequently received the diagnosis of Delayed Onset of PTSD; however, the real delay was in the acceptance by the U. S. government of
the traumatic effects of war upon combat soldiers. Undeniably, if veterans, especially wounded combat soldiers, had been examined prior to discharge, a significant number would have been diagnosed with PTSD.’’

When I had my first bout with depression I though I was going crazy or getting Alzheimer’s. I just happened to be working at a VA Hospital and had a very supportive supervisor and fellow workers. I would do things one day and have no idea the next what I had done or where I had put things. This got very spooky. I remember when I went over to the Mental Health ward to get help the first thing they asked me was what day this was and who the president was.

SITREP - WW II Era (1941):
The Lincoln Continental is introduced by the Ford Motor Company; the “Sad Sack” is originated by George Baker; the book Darkness at Noon is written by Arthur Koestler; the movies “Citizen Cane” and “The Maltese Falcon” are released; the songs “White Cliffs of Dover” and “Deep in the Heart of Texas” are released; the New York Yankees win the World Series by defeating the Brooklyn Dodgers 4 games to 1.

WW II Era (1942):
Napalm developed by Harvard chemist Louis F. Feiser; The Women’s Auxiliary Army Corps (WAAC) established by act of Congress May 14; The Waves (Women Accepted for Voluntary Emergency Service) authorized by act of congress July 30; The books The Moon Is Down by John Steinbeck and Breakfast With the Nikolides by Rumer Godden are published; The movies “Casablanca” with Humphrey Bogart, “Gentleman Jim” with Errol Flyn and “The Male Animal” with Henry Fonda are released; the songs “Don’t Get Around Much Anymore” and “A String of Pearls” are released; the St. Louis Cardinals win the World Series by defeating the New York Yankees 4 games to 1.

ROOM OF SORROW

Deep within the recesses of my mortal soul lies a room where secrets they be kept,

there are visions and pieces of time, in this place where the devil himself has slept.

When moments of despair over me do wash and horrific images crowd my mind,

I know the door to this room has fractured and unpleasant thoughts I do find.

This room is a dark and loathsome place, kept best under lock and key,

it's intended for the storage of unwanted specters, never to be let free.

There are times when I slip in to mentally fondle some thought, long ago stored in shame,

the Deceiver whispering in the recesses, at my doorstep laying the blame.

Skeletons line the walls where paint has chipped, then fallen, and dark nasties do reside,

old crates brim with horrid stories, dusty shelves are full and demons do confide.

Through our life love we might receive, happiness at times even offers a sweet tomorrow,
knowing we must go on, smiling in pain, laughing at death, there will always be, The Room of Sorrow.

By I. S. Parrish
Chapter 3

Traditional Treatment

Section I. GENERAL

03-01. General. What follows are very simplified descriptions of several treatments for PTSD. An attempt has been made to use Medical jargon only where required as part of a direct quote. If the meaning of a quote is unclear, please refer to appendix B for a simpler definition.

The first short section describes the lack of understanding or real treatment of PTSD prior to the Vietnam war. The next section explains several ongoing treatment methods, and the final section details current treatment options taking place at local VA Medical Centers and Vet Centers. (A list of VA facilities can be found in Appendix G).

It is beyond the scope of this manual to cover every conceivable treatment method. Treatments are often individualized and may change on a daily basis. This chapter explains the treatments which are the most widely recognized at the time of this writing.

Section II. LACK OF TREATMENT

03-02. General. Up until September of 1994 I find no evidence that the military participated in any type of “trauma relief” briefings. In 1994 two Field Manuals were released. FM 8-51 (Combat Stress Control) and FM 22-51 (Leaders Manual for Combat Stress Control). If used properly by the chain of command these Field Manuals may reduce PTSD in future generations of combat soldiers. To bad it took so long to recognize the problem. In FM 8-51, chapter 3, paragraph “f”, it states, “The most important preventive measure for PTSD is routine after-action debriefing in small groups” and in FM 22-51, chapter 6, paragraph “f” it states, “…The after-action review should be conducted as soon as it is safe for the leader to bring his team together……The after-action debriefing process shares the after-action review’s concerns with details of what happened. It goes further by actively encouraging the team members to share and talk out their emotional responses to the event….The objective of after-action debriefings following traumatic incidents is to promote “healing” by opening up, “cleaning and draining” any unpleasant or painful memories.” FM 22-51 even encourages “Follow Up After-Action Debriefings as explained in chapter 6, paragraph “g”…..”Prior to redeployment home, units should schedule time for everyone to verbally review the high and low points, talk through any unresolved issues, and conduct memorial ceremonies, if appropriate.”

None of this was done for veterans of WWI, WWII, Korea, Vietnam, nor the Persian Gulf or Iraq, to the best of my knowledge.

A perfect example is given in the article by DR. John Russell Smith, entitled “Veterans, Combat and Stress.” He quotes from several actual case histories taken from a U. S. Army psychiatrist’s notebook written in Vietnam during the period 1965-66:

Case 15. “This is a 35 year old Sergeant First Class with an advisory team in the Delta. His complaints are of fatigue and shortness of breath for about two months. Two months ago, it turns out, he had some near misses from sniper fire and mortar rounds. Then while wading in a river with the commander of his Team, he suggested they stop for a rest, which the Major agreed to. In about 10 seconds, a mortar round landed in front of them, about where they would have been if they had not stopped to rest. Patient and the Major talked about how lucky they were to have stopped. He then forgot about the incident. A shortness of breath, which led him to have to STOP AND REST frequently…..(emphasis in original text)”.

Dr. Smith goes on the say that “Most of these men were not hospitalized, not evacuated, not treated, and were sent back to duty within a few hours” and that “The primary mission of the psychiatrist in the military is to preserve troop strength, not help individuals…”

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It’s encouraging to know that most civilians working in high trauma contact jobs like Emergency Medical Technicians and Police Officers participate in programs that allow them to talk through a trauma almost immediately following the incident.

Section III. INDIVIDUAL THERAPY

03-03. General. The types of individual therapy methods listed here are for informational purposes only. I am not recommending any of them, that decision must be made by the individual survivor and therapist.

03-04. Abreaction. This is a method of directly confronting the patient with the traumatic event using hypnotherapy, sodium amytal interview, and ventilation. Hypnotherapy involves the hypnosis of the patient and unconscious questioning about past events. Sodium amytal is a sedative, sometimes called “truth serum” which causes a person to talk freely and without inhibition. Ventilation is just allowing the patient to talk freely without medication or hypnosis.

03-05. Implosive Therapy or Imaginal Flooding. The idea is to have the patient recall the traumatic memories so many times that they lose their potency. This treatment is normally preceded by training in muscle relaxation, behavioral skills and problem solving. Though proven effective I feel this method is the most “brutal”.

03-06. Stress Inoculation Training (SIT). The focus here is to teach the patient to be more assertive and less passive. This treatment is used with patients who have become passive due to guilt and fear of the event recurring. Patients are taught to manage anxiety, control negative thoughts or images and to better cope with their disorder. This “teaching” rather than counseling technique has been proven effective in reducing anxiety, PTSD symptoms and depression.

03-07. Cognitive Behavioral Treatments. The patient is helped through confronting intrusive memories. The idea is to have the patient confront the traumatic memories/images and assist him/her in relaxation techniques.

03-08. Prolonged Exposure. This method embraces the reliving and confrontation school of thought (again a brutal but effective method) and uses 9 sessions in which information is gathered, a treatment is mapped out, exposure to the traumatic memories takes place and closure is hopefully achieved.

03-09. Eye Movement Desensitization Reprocessing (EMDR). In this method a therapist moves his/her finger from side to side in front of the patient’s eyes in a rhythmic motion. The exact reason this method works is not quite understood yet. It is, however, proving to be both effective and long lasting. Because this treatment is so promising, EMDR is covered in depth in chapter 4. (Also see below)

- EMDR has been listed as an effective treatment by the American Psychiatric Association, Departments of Defense and Veterans Affairs, International Society for Traumatic Stress Studies, and numerous international agencies. See list below.
- More than a dozen controlled clinical trials support the use of EMDR for trauma such as that resulting from natural disaster, and EMDR has been used successfully to treat war- and terrorism-related trauma.
- With little modification, EMDR has been used successfully in response to a variety of mass-casualty events, and can be integrated with educational formats.
- EMDR has an impact on intrusive imagery (such as nightmares and flashbacks), numbing, and hyperarousal symptoms of PTSD, as well as on associated grief and depression.
- In several direct comparisons with cognitive-behavioral therapy, EMDR offers equivalent effects more quickly (fewer sessions or no homework), process analyses indicate less distress for individuals undergoing treatment. (WWW. Emdr.com)

03-10. Shock therapy. The best article I found on this subject is located at: www.cerebromente.org.br/n04/historia/shock_i.htm. This technique is still practiced. Last year I was scheduled for a session, but talked my way out of it.

03-11. Dynamic/Supportive Psychotherapy. This is the primary treatment now being used by the Department of Veterans Affairs. The process usually involves talking about the traumatic experience(s), helping the patient
to come to terms with guilt, and facilitating behavioral changes designed to help the patient to adapt to the disorder.

Section IV. GROUP THERAPY

03-12. General. The main goals of group therapy are to counter the sense of isolation and social withdrawal, loss of control, and mistrust which affects most PTSD affected veterans. In addition the groups allow participants to support others, share traumatic experiences with those who have “been there”, and help decrease the sense of loneliness experienced by many trauma survivors.

The definition and inclusion of PTSD in the DMV-III in 1980, grew out of group therapy sessions known as “rap groups” that Vietnam veterans participated in during the early 1970’s.

03-13. Guided. The clinician uses a round robin or random system to urge participants into sharing recent experiences and feelings. While seeming to offer no objective results, a sense of belonging is established and participants soon discover that the others in the group have experienced worse traumatic events than they experienced themselves.

03-14. Free Style. These groups are moderated, but not guided, and any subject is acceptable for discussion. Again, a sense of belonging is established and participants soon establish much needed friendships. Much like the Guided approach the individual “heals” at his/her own pace without any seeming objective results.

03-15. Cognitive-Behavioral. This is the most structured process, using individual and group relaxation and assertiveness training in order to achieve defined therapeutic goals.

Section V. FAMILY THERAPY

03-16. General. Because PTSD has had, and can still have such an impact on the family of the survivor, family therapy is becoming more common. Since the wife, or husband, often has no idea of what is going on inside the partner, many marriages affected by PTSD end in divorce. Specific treatment has been established to include improving communications, educating family members on the causes and effects of PTSD, and improving coping skills. It is not uncommon for the spouse of a person with PTSD to suffer from PTSD as the result of living with a person with PTSD.

Section VI. REHAB

03-17. Different Approaches. Because of the self isolation of many trauma survivors an effort is made to have them get involved in community projects and perform volunteer work. This often promotes self esteem and helps eliminate that feeling of being worthless because of their inability to function in most social arenas. This combined with vocational support, job training, recreational activities, and even creative arts therapies has proven successful for many PTSD sufferers. These approaches will differ with every treatment location.

I will not go into detail here about Voc. Rehab regulations. Rather I will tell you what I went through and offer some information provided by the VA. If you are as little as 10% Service connected disabled you may qualify for these benefits.

1. I submitted an on line application and was contacted by the Voc. Rehab. Representative in my area.

   a. I then received a letter from the VA setting me up with an appointment with the local Voc. Rehab. Representative.

   b. I received and filled out a VA Form 28-1902 and turned this in to the Vo. Rehab. Rep. On my first visit.

2. I next submitted a list of things I felt that I needed. (In my case a request for phone service, a certain kind of software and a laptop computer).
3. I was sent to a psychologist for testing. During this meeting I answered oral questions, took several written tests and several hands on tests (You may or may not be required to do this).

4. My Voc. Rehab. Representative then made the decision to deny me Vocational Rehabilitation and Employment service and offered me the Independent Living Program (ILP).

5. The Voc. Rehab. Representative then drew up a “Rehabilitation Plan”, which I was required to agree to and complete. This was done on a VA Form 28-8872. In my case the plan called for psychotherapy and marital therapy, and financial counseling. After going through half of the counseling I received software for making web pages and a brand new Dell Laptop worth some $2000.00. The plan ran from February through September of the same year. If I had violated my plan I could have been made to return my software and computer.

Section VII. VA PROGRAMS

03-18. General. The following is taken directly from a web page maintained by the “National Center for Post-Traumatic Stress Disorder” and located on a server at Dartmouth University. It was posted by Dr. Julian Ford. The topic title is “Specialized PTSD Treatment Programs in the U.S. Department of Veterans Affairs”:

(Authors Note - Many of the above types of therapy are being used at various VA centers).

The Department of Veterans Affairs Medical Centers provide a network of more than 100 specialized programs for veterans with PTSD, working closely in conjunction with the Vet Centers operated by VA’s Readjustment Counseling Service. Each specialized PTSD program offers veterans education, evaluation, and treatment conducted by mental health professionals from a variety of disciplines (such as psychiatry, psychology, social work, counseling, and nursing).

**Outpatient PTSD Programs** - include three basic types of clinics in which veterans meet with a PTSD specialist for regularly scheduled appointments:

- PTSD Clinical Teams (PCTs) provide group and one-to-one evaluation, education, counseling, and psychotherapy.
- Substance Use PTSD Teams (SUPTs) offer outpatient education, evaluation, and counseling for the combined problems of PTSD and substance abuse.
- Women's Stress Disorder Treatment Teams (WSDTTs) provide women veterans group and one-to-one evaluation, counseling and psychotherapy.

**Day Hospital PTSD Programs** - include two basic approaches to providing a "therapeutic community" that veterans with PTSD can participate in several times weekly for social, recreational, and vocational activities as well as for counseling:

- Day Treatment PTSD Units provide one-to-one case management and counseling, group therapy, education, and activities in order to help clients live successfully with PTSD. Treatment and socialization activities are scheduled on a several-hour-a-day basis during the day and evening hours.
- Residential (Lodger) PTSD Units also offer one-to-one case management and counseling, group therapy, education, and activities on a several-hour-a-day basis. While enrolled in daytime and evening PTSD treatment, lodger clients may live temporarily in secure quarters that do not have 24-hour nursing supervision.

**Inpatient PTSD Programs** - include four basic types of services conducted while veterans reside in hospital units providing 24-hour nursing and psychiatric care:

Authors note - **VERY IMPORTANT** - Under current regulations if you already have a service-connected disability for PTSD and you participate in an Inpatient PTSD Program which has a duration of over 21 days you are entitled to receive payment of 100% (if you do not already get paid for 100%) during that time frame. A few facilities will automatically do the paperwork for you but most WILL NOT. You may be eligible for several thousand dollars. You will need to submit a VA Form 21-4138 (Statement In Support of Claim) to the Benefits Counselor at the facility or mail it to the Regional Office (RO).
Specialized Inpatient PTSD Units (SIPUs) provide trauma-focused evaluation, education, and psychotherapy for a period of 28 to 90 days of hospital admission.

Evaluation and Brief Treatment of PTSD Units (EBTPUs) provide PTSD evaluation, education, and psychotherapy for a briefer period ranging from 14 to 28 days.

PTSD Residential Rehabilitation Programs (PRRPs) provide PTSD evaluation, education, counseling, and case management emphasizing resuming a productive involvement in community life. PRRP terms tend to be 28 to 90 days. I attended this program at Sheridan, Wyoming in February of the year 2000. What follows are my observations and recommendations:

This is what I would call a "soft-core" program as the emphasis is towards helping the PTSD survivor cope with everyday life through education and relaxation training (there is no requirement to talk about the stressor stuff). The Staff at the Sheridan, Wyoming VAMC I attended were outstanding, caring individuals and I would recommend that location to anyone. I learned many new things and share them below. I will say here that our group had anywhere from 4 to 10 people in it at any one time. People arrived and departed at different times, normally about 2 per week.

One of the friends I made while participating in the program, Ed, made a very profound statement during the week before we were scheduled to leave. While walking back to our rooms at the end of the day he said, "If you can figure out what is wrong with yourself, the VA will help you." This can be taken in several ways. What he meant was "Until" you identify your own problem (say PTSD) VA cannot help you, nor can you help yourself.

I recommend you ask the following questions before you arrive at the VA facility:

1. Do they have washing machines or some sort of laundry service?
2. Do they supply wash powder and personal soap?
3. Do they provide towels?
4. Can you keep your automobile on the hospital grounds (if you will be driving yourself)?
5. Can someone pick you up from the bus, train station, or airport if you use public transportation?
6. If you travel by car and put in for travel pay will the facility you are going to pay travel for both ways? (Some facilities now only pay you to return home and have you file a claim at your home facility for the amount owed to get you to the treatment facility. You can also ask your home facility if you can file for advanced travel pay.)
7. If individual electrical appliances are allowed in the rooms (radio, TV, laptop computers)?
8. What drugs are you NOT suppose to bring (I was informed that I could not bring a certain Valium type drug that was prescribed for my anxiety. Indeed I had to stop taking the drug 30 days prior to arrival)
9. Ask about in room personal property security. Will you need to bring a lock?
10. Ask if they have Internet access. If you need to check your email I would advise you to set up a free account with Yahoo, Altavista or one of the other search engines. (The library at the VAMC I entered had a library with Internet and I also used the public library downtown.)

The following is a list of items I recommend you take with you:

1. Three changes of pants and shirts, other than the set you have on.
2. Flip flops for the shower.
3. Moccasins for casual wear in the evenings (some facilities have a leather or craft shop where you can make a pair).
4. Eight pairs of socks.
5. Three additional sets of underwear (Minimum).
6. Comfortable shoes.
7. A coat for winter.
8. A sweat suit for after hours (many inpatient programs will provide pajamas and robes).
9. Towel (if not provided).
10. Several dollars in change for vending machines.
11. Writing paper, envelopes and stamps.
12. Pre-paid phone card. If you plan on calling home it is usually cheaper to purchase prepaid phone cards than calling collect or direct from a pay phone.

Personal stuff:

1. Razor and blades.
2. Tooth brush and paste.
3. Comb.
4. Shaving soap.
5. Deodorant.

The following is a list of optional things you may wish to take (at your own risk):

1. A radio or small TV with head phones.
2. Swim suit (most facilities have pools and many provide suits if you do not have one)
3. Coffee cup (the facility I went to provided a free plastic cup)
4. Pen/pencil and not pad (study material will be provided)
5. A bag of candy to munch on after hours, if your diet allows.
6. Catch-up work. Since you will usually have weekends off you might bring along a couple of projects to work on. If part of your reason for going to the facility is to relax then disregard this item.
7. You should also be prepared to identify all of the medications you are currently taking (either write down the name, dosage, Dr., etc. or bring them with you when you check in).

Do NOT take the following items:

1. Weapons (Knives or guns).
2. Alcohol or un-prescribed drugs. (You will be allowed to take you other prescribed drugs)
3. A lot of cash (I found that I could easily survive on about $10 a week).

In processing.

Initial in-processing (This can take from one to four days)

Check in - I reported in to the Mental Health Clinic and immediately filled out several forms. One was a release form and the other mostly concerned insurance information. I also answered several personal questions (address, current phone #, etc) so the clerk could update my computer records. The VA facility in Wyoming asked if I had a "Living Will" and if I desired to update it or create a new one. I chose to create a new one.

Screening - I was next screened by a resident nurse. She asked how PTSD affected my daily life, general medical questions, and what type of medications I was currently taking. She then administered a Tetanus shot, since I had not received one for some time and "popped a bubble" under the skin on my forearm for a TB test, also because I had not had one for some time.

Exam - I was given a cursory exam by a PA and had the opportunity to bring up any physical problems I wanted to have attended to while I was in the PRRP program.

Bracelet - The front office clerk then fitted me with a patient ID bracelet.

Staff psychiatrist - I then was interviewed by a psychiatrist and all he did was check on my medication and have them all renewed so I would not run out while in the program.

Room assignment - I was next assigned to a room and given an initial briefing. I was directed to present my personal belongings for inspection (checking for weapons and drugs) and finally shown to the cafeteria.

Case Worker - I next met with my Case Worker to fill out additional papers. He asked quite a few
questions pertaining to past and present PTSD symptoms. This is still considered the "screening" stage as they have the authority to Not accept you for the program.

Chaplain - The Chaplain performed a written spiritual inventory and asked if I had any special spiritual needs.

TB test - Nurse read my TB test results.

Further Screening - I spoke with another social worker (Physiologist) just before lunch. She asked life history questions about family and military career. Also about PTSD symptoms, anger, memory problems, etc..

Evaluation - I met with the PRRP staff to sign a contract that I would abide by the rules and then we discuss my schedule.

Treatment Update - I met with my case worker and several other staff to discuss my program of treatment as well as my After Care Plans (what I planned to do about treatment after I finished the program here). I was given a schedule for the week and asked if the topics I had indicated as important last week were still the ones I wanted to address during my stay.

Medication Adjustment - Visited with the head psychiatrist and decided to increase at least one of my medications because of several negative symptoms.

**What did we do?**

What follows is a listing of the types of classes and exercises we participated in during my stay.

**Occupational and Physical Therapy (OT)** - The VA facility I was at had a lapidary, free hand and paint by numbers, several types of plastic models, and a couple of computers (no internet). Most of the work you had to do in the arts and crafts area. Reported to physical therapy area. I chose to ride an Airdyne bike for 20 minutes two times a week.

**Relaxation Therapy** - This is the heart of the program and usually produces the most positive results. We had class and exercises on breathing techniques and breathing practice (gut breathing instead of chest breathing), a AUTOGENIC RELAXATION session, an exercise with our eyes closed while listening to a recording, we participated in Hydro Relaxation which was done in a small swimming pool (we floated around in the water for about 20 minutes with floatation devices under our heads and our knees). We also participated in a exercise using what the instructor called the "Flex/Relax/Balloon" method (You work your way through your body, starting with your feet, and use the "Flex/Relax" technique". The "Balloon" portion is visualization and you mentally fill the balloon with stress then watch the balloon ascend into the heavens), and finally we were given a book titled The Relaxation Stress Reduction Workbook, by Davis, Eshelman, and McKay.

**General Education** - This was a "hodge podge" of topics that started our day out, given by different instructors. We had classes on recognizing relapses, Schizophrenia, Bi-polar problems (a person has major emotional peaks and valleys) and major depression, and on how physical activity can benefit you in your fight against depression. We also had classes on substance abuse, anger management and how to use anger in a positive manner, how to do a resume, cover letter, and other job finding hints, Duel Diagnosis (This is when a person has not only a mental problem (PTSD) but also an addiction problem), Aftercare (what to do to help yourself after discharge), nutrition, a discussion on Cognitive Behavior Therapy (CBT) ("you feel what you think"), and finally a very informative class on Anxiety and Depression.

**Open Group and Specialty Track Meetings** - These were held at different times of the day, the first being permeated by a schedule update. All of these classes related in some way to PTSD. We had classes on trust, grieving, an open discussed on assertiveness verses aggressiveness, the causes of PTSD and the symptoms. We also had classes on medications and reading the labels, the effects of sleep depredation, the many changes in our lives that were bringing PTSD to the forefront after so many years, - a discussion on
seeking a purpose for your life and learning how to love again, giving up hate, guilt, anger, and anger management.

General Recreation - We went bowling once a week and went on several field trips to nearby museums and points of interest.

**Job Skills** - Job Skills Session One - Next group was pertaining to job skills. Took a timed written test (to be explained later).
Job Skills Session Two - We watched two videos on interview techniques for disabled people and basic interview preparation techniques.
Job Skills Session Three - The instructor returned and interpreted a couple of tests we took earlier. They both were designed to show you fields of employment you should pursue because of your interests.
Job Skills Session Four - We watched a video on how to behave at a job interview.

**Spirituality** - This was a voluntary class for those feeling the need for spiritual renewal.
Spirituality Session One - The Protestant Chaplain gave an acceptable class on GUILT. This is another topic that gives many PTSD survivors problems without them knowing it. I will study GUILT and GRIEVING together and expand in my Manual.
Spirituality Session Two - Lively discussion on Guilt and forgiveness. Most of us carry a lot of guilt because we survived, we did not do enough in Vietnam, and one man spoke of his guilt for having to use the VA system when he did not feel he had done enough in Vietnam to deserve treatment.
Forgiveness was discussed in the context of forgiving the Government for sending us to Vietnam, forgiving ourselves if we had done something in combat that we would not have otherwise done.

**Conversation** - Conversation Session One - This is a basic communications skills class designed to help those of us who have trouble meeting people and engaging them in conversation.
Conversation Session Two - Talked about maintaining a conversation after starting one with other people.

**Therapeutic Challenges** - Session One - We spent some two hours on team building, interaction Games. One was a trust walk where one person was blindfolded and the other talked him/her through a field littered with small plastic balls. Another was the design of a "Space Module", containing a raw egg that a team of four had to design and make using straws and masking tape. The egg was dropped from a height of 10 feet to see if it would break (all four designs in our overall group safely sustained the drop).
Session Two - We participated in a "Trust Walk" (yes they still do that!). Broke into pairs and first walked our partner close to a wall without hitting it then went on a longer walk outside and had blindfolded person stop to feel different items as well as having him/her walk over different types of terrain.

**Out Processing and Stuff**
Find out who the records specialist is who can send you copies of your file. Sometime close to when you are about to leave Submit a VA Form 10-5345 (Records Release) and have that person mail you a copy of your "Discharge Summary". You may also have that person mail a copy to a Service Representative, a lawyer, or the like, but it make take twice the 20 or so days one copy will take. Drop by the pharmacy to make certain you have picked up all of your medications and ask for a FREE pill holder/organizer.
I found it helpful to get a phone listing of the staff I had worked with.

**Final Comments**
This was a helpful and rewarding experience. I went into the program wanting some positive changes and I feel I have made progress in that direction. The staff were supportive and caring (not just the program staff but everyone I came in contact with at the facility).

A thing that may have some bearing on your disability, if you already have one, is the GAF (Global Assessment Functioning) evaluation. To gage your progress and the success of the program you will probably have a GAF done when you arrive and after you complete the program. This is a subjective evaluation usually performed by a psychiatrist or psychologist and measures your current social
adaptability. The danger lies in the fact that if you were last evaluated at say 40 and the doctor now evaluates you at 60, because you show progress, you could feasibly be reevaluated by your Regional Office and given a lesser disability. The only advice I can offer is even if you feel better and are more capable of dealing with your disabilities (anger, anxiety, depression, etc.) make certain you tell your case worker or psychiatrist of your continued feelings and worries and problems. I am not advocating that you lie or embellish the truth, just be certain you express your feelings as they relate to your condition, if they are still bothering you. This same GAF score, which by the way runs from 0 - 100 with 0 representing a completely dysfunctional person, can help you with your disability claim or if you reopen your claim, if the score is low enough.

**Update. (The year 2001)**

Seven year after attending the PRRP program - I have had many ups and downs during this past seven years. Hardly a week goes by that I have not applied some of the things I learned at the program. If I forget to take my medications for one day I usually go back down in the dumps. Sometimes I only forget some of my medications and I begin to feel the tuggs of anxiety.

I can still not handle any "out of the ordinary" events in my life.

I miss the care given there and the feeling of safety and often wish I could return for another tour. I may do that some day but for now my wife does not want to be left alone again for 45 days. I get the desire to return to the program now and again. I am remaining stable by going to a NP in Billings, and a general counselor here in my home town. I do not feel that I can break off from this help.

(End of PRRP program information)

• PTSD Substance Use Programs (PSUs) provide combined evaluation, education, and counseling for substance use problems and PTSD. PSU admissions range from 14 to 90 days. (www.dartmouth.edu/dms/ptsd/Help_for_Vets.html).

Section VIII. THE TRUTH OF THE MATTER

**03-19. Discussion.** In his article “PTSD Treatment: An Outline and Review” Dr. Hadar Lubin points out that: “The effects of trauma on a person’s psychological, biological, behavioral, cognitive, and social existence are profound, pervasive, and long lasting. The complexity of symptom patterns and the extent to which trauma affects the interpersonal and social functioning of patients and their families suggests need for a comprehensive treatment approach. No one treatment modality can successfully target all PTSD symptoms or can effectively address all maladaptive responses to the traumatic event.” (http://users.aol.com/fedprac/10lubin.htm)

Section IX. PERSONAL EXPERIENCE

**03-20. Personal Experiences.** One of the first things the psychiatrist at the VA recommended to me was to join a therapy group. I indicated to him that I was not a groupie, did not belong to any fraternal organizations because I had no interest in telling “war stories” and did not feel a group would help. However, I was willing to explore any avenue that might alleviate my agony so I decided to attend a couple of meetings.

At the first meeting I felt like an outsider and I almost decided not to attend again. However, I was seeking answers and so I continued attending the weekly meetings. I slowly began to learn many of the PTSD “buzz” words and began to feel accepted. I have encountered many veterans who have suffered much more than I have, and I have received a great deal of personal support from the other veterans. You will also find that once you obtain a disability for PTSD you may be required to undertake some for of therapy offered by the VA.

Since I penned the original manual I attended a PRRP program. My comments are above.

SITREP - WW II Era (1943):
The United Nations began to form; for the first time Penicillin is applied to the treatment of chronic diseases; the American Broadcasting Company (ABC) is created by Edward Noble; the books *Arrival and Departure* by Arthur Koestler and *The Big Rock Candy Mountain* by Wallace Stegner are published; the Films “For Whom the Bell Tolls” with Gary Cooper and “Sahara” with Humphrey Bogart are released; the songs “You’d Be So Nice to Come Home to” and “Mairzy Dotes” are released; The New York Yankees win the World Series by defeating the St. Louis Cardinals 4 games to 1.

**WW II Era (1944):**
President Roosevelt wins reelection to a fourth term with 53 percent of the popular vote; by decision of the Supreme Court Americans can no longer be denied the right to vote because of color; the book *The Golden Fleece* is written by Robert Graves; Kodacolor film is introduced by Eastman Kodak; the films “Laura”, “National Velvet”, and “Lifeboat” are released; the songs “I’ll Walk Alone”, “Don’t Fence Me in”, and “Twilight Time” are released; the St. Louis Cardinals win the World Series by defeating the St. Louis Browns 4 games to 2.

**WWII Era (1945):**
President Roosevelt dies April 12; ball point pens go on sale October 29; Ebony magazine begins publication in November; the books *Forever Amber* by Kathleen Winsor, and *That Hideous Strength* by C.S. Lewis are published; the films “The Lost Weekend”, “The Body Snatcher”, and “Objective Burma!” are released; the songs “It’s Been a Long, Long Time”, “Let It Snow”, and “For Sentimental Reasons” are released; the Detroit Tigers win the world Series by defeating the Chicago Cubs 4 games to 3.
Chapter 4

Non Traditional Treatment: Professionally Assisted

Section I. GENERAL

04-01. General. First let me state that I AM NOT a Medical Doctor, Psychiatrist or Psychologist, nor do I hold any special training in the medical field. The topics discussed here are provided as possible additions or alternatives to “standard” PTSD treatment, and some of them may be considered “standard” at your place of treatment. Always communicate with your Doctor before trying any treatment not specifically prescribed by him/her. If you have no doctor I advise you to visit your nearest VA Treatment Facility as soon as possible and begin a supervised program.

I have tried some of the treatments listed here and will share my results as I go. Each of the treatments have been used to treat PTSD, although they vary in popularity and success. This chapter offers summaries of the Eye Movement Desensitization and Reprocessing (EMDR) technique, Magnetism and the brain, EEG Driven Stimulation (EDS) and Neurofeedback. With that mouth full, lets begin...

Section II. EMDR

04-02. General. EMDR stands for “Eye Movement Desensitization and Reprocessing”. This revolutionary and controversial new trauma treatment technique was discovered by Dr. Francine Shapiro in May 1987, as she was walking through a public park. In her book Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures she shares “[While on my walk] I noticed that some disturbing thoughts I was having suddenly disappeared. I also noticed that when I brought these thoughts back to mind, they were not as upsetting or as valid as before….I started paying very close attention to what was going on. I noticed that when disturbing thoughts came into my mind, my eyes spontaneously started moving very rapidly back and forth in an upward diagonal [motion].”

In very simple terms EMDR involves the reduction of trauma induced emotions through the use of visual and/or auditory techniques established and refined by Dr. Shapiro.

04-03. Theories which suggest how EMDR Works. Even some 17 years after the introduction of EMDR no one has discovered exactly how or why the process works. In a interesting article by Dr. Edward S. Hume, Department of Psychiatry Community-General Hospital, Syracuse, Dr. Hume writes, “Now, I have a couple of theories as to how and why EMDR might work… First of all, consider work done on the different ways that the two halves of our brains look at the world: the left side of the brain (controlling the right side of our bodies) is more positive in outlook, more analytical, looking ahead. Call it your pilot personality.

The right side of the brain tends to have a more morose outlook, more holistic, scanning the world for threats. Call it your tail gunner. I suspect that the alternate-side stimulation occurring in EMDR might be simultaneously stimulating positive networks in the left brain while invoking negative networks in the right brain.”

He continues, “Let us next consider the function of dreams: all but the most primitive mammals dream…This is why we can get away with frontal lobes that are not a foot across. Normal memory is literally remembered: it is re-assembled from stored clues or instructions which rely on contextual cues to fill in details. A traumatic "memory", however, is stored very differently. Better to call it a "reverie", because all the sights and sounds and sensations of the original moment are stored as if freshly experienced…

When we dream, we have the opportunity to put the reverie into perspective, let it go, and store only the instructions for normal memory……While we dream, our eyes move (in what are called Rapid Eye Movements,
or REMs). I suspect this may be due to alternating influences from the right and left halves of the brain. Even if that is not what happens, the eyes still move.

EMDR may come close enough to imitating those eye movements that the work of dreams can be done while the patient is awake. Since the patient is already awake, the dream does not have to end. It can continue while the patient holds onto the her-and-now, and the work of the dream may be finished. Memory is left where once there was only reverie.

Now the sleeper may sleep, and not be frightened from sleep by horrid nightmares. Healing has happened. Just a theory, you understand.”

A bit deep but I think you get the general idea. I highly recommend you read Dr. Humes’ entire article, “About EMDR” located at on the Internet at http://www.pshrink.com/emdrfile.html.

Not even the founding psychologist, Dr. Shapiro, can explain why EMDR works. In her book (see paragraph 04-06 above) she points out that it took 10 years to figure out how penicillin worked and that “The theories [about EMDR] involve the method’s procedural elements, and specific hypotheses address the eye movement component. The latter attribute the therapeutic effect of the eye movements to the disruption of stereotypic responses, distraction, hypnosis, synaptic alterations, REM sleep concomitants, a compelled relaxation response, or activation of cortical functions, including the rhythmical stimulation of an external pacemaker and a bihemispheric activation that induces integrative processing.”

What all that means is that she doesn’t really know how it works.

04-04. Phases of EMDR Treatment. Because of the complexity of the entire process I will list the phases developed by DR. Shapiro, but not go into any detail. These phases were developed and refined over a 5 year period, and have proven successful in the majority of controlled cases documented. They are:

a. Phase one: Patient History and Treatment Planning.
c. Phase three: Assessment - Identification of target (memory).
d. Phase four: Desensitization - Finger movement (or other acceptable method).
e. Phase five: Installation - Here an effort is made to replace the negative cognition’s.
f. Phase six: Body Scan - Patient holds positive cognition in mind, scans body to identify and relieve tension through further eye movement (or other desensitization) techniques.
g. Phase seven: Closure - A debriefing of patient to return him/her to neutral emotional status at end of each session.
h. Phase eight: Reevaluation - This actually occurs prior to a new session by using a review of the previous session.

Let me repeat that the above is a VERY simplified version of the eight phase process and should not be attempted as a means of self treatment.

04-05. Recent Discoveries. Staff writer, for the Austin American-Statesman, Austin, TX., Claire Osborn in an article entitled “Counselors use eye therapy to help kids with trauma”, December 1997, writes about a child who is afraid of being bitten by mosquitoes because his mother was bitten by spiders and an aunt died of encephalitis from a mosquito bite. The child was afraid to “go to school because he was scared of dying”. The mother of the boy took him to a Child Guidance Center “…where counselors are studying whether a controversial technique (authors note: remember that this technique was first discovered, introduced and clinically proven in the late 1980’s - don’t you love the speed at which the medical field moves?) used on Vietnam veterans suffering from post-traumatic stress syndrome also works on child trauma survivors.”

The article goes on to say that the technique is hailed by some and scorned by others in the psychiatric community. James Beysner, chief of psychology with the Department of Veterans Affairs’ North Texas Health care System in Dallas, stated that “Many people in the mental health field….are skeptical of EMDR.” then points out that “…he had practiced EMDR and found it to be equal to or better than other therapy techniques.”

EMDR is an established method of treatment for many trauma survivors, especially combat trauma survivors, and was being used with a high degree of success at the VA center where I was being treated when I wrote this manual.
And finally, in an article entitled “Overview and General Description” published as part of the “Mining Co. Guide to Mental health resources”, there is this:

“Fourteen controlled studies support the efficacy of EMDR, making it the most thoroughly researched method ever used in the treatment of trauma. The most recent 5 studies with individuals suffering from events such as rape, combat, loss of a loved one, accidents, natural disasters, etc. have found that 84-90% no longer had post-traumatic stress disorder after only three treatment sessions. A recent study financed by Kaiser Permanente revealed that EMDR was twice as effective in half the amount of time when compared to the standard traditional care. However, clients and clinicians should note that EMDR is not a race. While many people show dramatic responses in a short amount of time, there are also those who will progress more slowly and that the slower progression is not abnormal. Just as in any therapy, we all progress at the rate appropriate to the individual and the clinical situation.”

04-06. Personal Experience. On the one occasion I participated in a EMDR session I came away with a much more positive attitude. The event being treated has not bothered me to any major degree since. I plan to continue my treatment using this method. (Additional sessions offered no relief – 2008)

Section III. MAGNATISM AND THE BRAIN

It began as just another research project, in this case to examine the effects of various drugs on patients with a severe mood disorder. Using an advanced brain scanning technology – the clumsily named echo-planar magnetic resonance spectroscopic imaging procedure, or EP-MRSI – researchers at Boston’s McLean Hospital scanned the medicated and un-medicated brains of 30 people with bipolar disorder in order to detect possible new treatments for the more than 2 million American adults who suffer from the disease.

But something unexpected happened. A patient who had been so depressed she could barely speak became ebullient after the 45 – minute brain scan. Then a second patient, who seemed incapable of even a wan smile, emerged actually telling jokes. Then another and another. Was this some bizarre coincidence? Aimee Parow, the technician who made these observations (she is now a medical student in New York) didn’t think so. She mentioned the patients’ striking mood shifts to her boss, and together they completely refocused the study: to see if the electromagnetic fields might actually have a curative effect on debilitating melancholy.

As it turns out, they did. As reported in January 1994 in the American Journal of Psychiatry, 23 of the 30 people who were part of the study reported feeling significantly less depressed after the scan. The most dramatic improvements were among those who were taking no medication. The researchers are cautious. Says Bruce Cohen, McLean’s president and psychiatrist in chief: “I want to emphasize that we are not saying this is the answer….but this is a completely different approach in trying to help the brain than anything that was done before.”

Looking back. It’s a completely different approach because of the way the magnetism is applied to the brain. But it’s an example of burgeoning new research on an old idea: that the brain is an electromagnetic organ and that brain disorders might result from disarray in magnetic function. The idea has huge appeal to psychiatrists and patients alike, since for many people the side effects of psychiatric drugs are almost as difficult to manage as the disease itself. And 30 percent of the nearly 18.8 million people who suffer from depression do not respond to any of the antidepressants available now. People with other severe mental disorders – schizophrenia, obsessive-compulsive disorder – might benefit as well. And while no one fully understands exactly why or how the brain responds as it does to electrical currents and magnetic waves, intriguing new research is offering some possible explanations…..

A related treatment, called rapid transcranial magnetic stimulation or RTMS, creates a current in the brain by using a magnetic field that crosses the exterior of the skull. It has also proved successful in treating depression. Much like the way a defibrillator works in the heart, RTMS uses a powerful magnet to deliver an electronic jolt to the brain. In clinical trials, many patients who failed to respond to several other treatments improved within a week, and the vast majority were significantly better after two weeks of daily 20 – minute sessions. “Transcranial magnetic stimulation is, in a way, a misnomer,” says Alvaro Pascual-Leone, a neurologist at Beth Israel Deaconess Medical Center in Boston. “The main effect is not because of the exposure
to the actual magnetic field but because of the way that a rapidly changing magnetic field pulse may be generating a current."

(Taken from the Science and Society section of U.S. News and World Report, February 16, 2004, written by Marianne Szegedy-Maszak)

04-07. Personal Experience. I have had no experience with this type of treatment.

Section IV. BRAIN WAVE ALTERING

04-08. EEG Driven Stimulation (EDS). EEG is short for electroencephalogram, a process which measures brain waves, not to be confused with electrocardiogram (EKG) which is a process which measures the electrical activity of the heart. EDS uses gently flashing lights to help alleviate Post-Traumatic Stress Disorder symptoms. According to the “Post Trauma Treatment Associates (PTTA)”, whose clinical director is Carolyn Robertson, M.A.,M.S., CEAP, this type of treatment has helped people who suffer from:

1. Depression
2. Anxiety
3. Violent or explosive episodes.
4. Panic attacks
5. Low energy and endurance during the day
6. Sleeping problems at night.

According to PTTA, “the above problems exist concurrently with EEG (brain wave) slowing. EDS should be seen only as a reliable and reasonably rapid way to reduce EEG slowing, and not as a magical solution for a wide variety of complex disorders - an outcome "too good to be true."

The EDS treatment begins by monitoring a person's brain waves with an EEG Using the changing EEG patterns, the frequency of the flashing lights is adjusted. The person in treatment is then exposed to the flashing lights. Because most patients are light sensitive, the first phase of the treatment desensitizes them to the light stimulation during this time frontal EEG slowing is strongly decreased. The next phase of treatment, says PTTA, “involves systematic discovery and treatment of all other sites of EEG slowing on the scalp.” That is a fancy way of saying they put greased electrodes all over your head.

“There is no conscious learning or practicing involved. People sit in a chair, eyes closed, and rest from 5 minutes, to 20 minutes (on average), to a couple of hours per treatment. Daily treatment is most effective and reduces total numbers of sessions needed. Average numbers of treatments is 20, however the treatment duration varies considerably with the duration and complexity of the person's problem(s).”

PTTA also recommends that you utilize regular psychiatric care while participating in their treatment program. You can visit the Post Trauma Treatment Associates Internet Home Page at “http://www.post-trauma.com”.

04-09. Personal Experience. I have not personally participated in this type of treatment although several veterans in one of my groups have and reported positive results. I have used a set of glasses and headphones that simultaneously flashes light and plays tones. Developed and sold by a company by the name of “Minds Eye”, this device is soothing to use and if you have the $300 to spend, offers at least temporary mental relief.

04-10. Neurofeedback. This technique is also known as EEG biofeedback and is a learning strategy that enables a patient to alter his/her brain waves. What follows was extracted from a FAQ (Frequently Asked Questions) page maintained by Mr. David Kaiser on the internet:

Neurofeedback involves at least two computers, one for the patient and one for the therapist. The therapist’s computer is usually positioned behind the patient. This enables the therapist to monitor the patient's EEG (brain waves) at any time during the session without disturbing the feedback.
Using a gel or paste electrodes are adhered to the patient’s scalp and earlobes. While reclining, the patient then interacts with what is called the “game computer”. The kicker is that the patient uses EEG (brain waves) to interact with the game computer.

The FAQ points out that “Each display contains four EEG data streams (below each stream are text and average data values). The top line, slightly squiggly, is the person's entire EEG recorded from the scalp by the single active electrode. The three wavy lines below show activity in three separate EEG frequency bands or rhythms -- theta, SMR, and high beta bands. The patient's goal is to increase certain EEG frequency bands (e.g., SMR) while decreasing others (e.g., theta & high beta).

The patient monitors his/her EEG frequency band activity NOT as wavy lines on the therapist machine, but as elements of a game on the game computer. Each frequency band appears as a colored rectangle which grows larger or smaller in response to his/her brain wave activity.”

The FAQ goes on the say, “the Neurofeedback training is a painless, non-invasive procedure. One or more sensors are placed on the scalp, and one to each ear. The brain waves are monitored by means of an amplifier and a computer-based instrument that processes the signal and provides the proper feedback. This is displayed to the trainee by means of a video game or other video display, along with audio signals. The trainee is asked to make the video game go with his brain. As activity in a desirable frequency band increases, the video game moves faster, or some other reward is given. As activity in an adverse band increases, the video game is inhibited. Gradually, the brain responds to the cues that it is being given, and a "learning" of new brain wave patterns takes place. The new pattern is one which is closer to what is normally observed in individuals without such disabilities.

Neurofeedback has been successfully used with anxiety, depression, and sleep disorders. It is not possible to predict with certainty that training will be successful for a particular condition. But for the more common conditions we see, a reasonable prediction of outcome is usually possible. More important, however, the effectiveness of the training can usually be assessed early in the course of training. For most conditions, there are no known adverse side effects of the training, provided that it is conducted under professional guidance.”

The FAQ concludes with, “EEG training is a learning process, and therefore results are seen gradually over time. For most conditions, initial progress can be seen within about ten sessions. Initial training goals may be met by twenty sessions, at which time the initial re-tests are usually performed.

Many medical and psychological insurance plans now cover neurofeedback for various conditions. The cost of the training differs among offices depending on location, the professional status of the person delivering the service, and on supplementary services offered.

04-11. Personal Experience. I have not had any Neurofeedback treatment, to date, so I am unable to vouch for its results. It is a professionally acknowledged, if not widely accepted, treatment plan.

SITREP - Korean War Era (1950):
The United States Recognizes Vietnam; President Truman escapes an assassination attempt November 1; Haloid Co. of Rochester, N. Y. produces the first Xerox copying machine; the book Across the River and Into the Trees by Ernest Hemingway is released; the movie The Father of the Bride starring Spencer Tracy is released; the movie Harvey with James Stewart is released; the television show What's My Line begins; the songs “My Heart Cries For You”, “Cherry Pink and Apple Blossom White”, and “Rag Mop” are released; General Foods introduces Minute Rice; The New York Yankies win the World Series by defeating the Philadelphia Phillies 4 games to 0.

Korean War Era (1951):
The U.S. Army explodes an atomic device over the Nevada desert November 1; the cartoon “Dennis The Menace” appears in newspapers on February 11; the book Catcher in the Rye by J.D. Salinger is released; the book Cain Mutiny by Herman Wouk is released; the television shows “Search For Tomorrow” and “I Love Lucy” begin; the movies The African Queen with Humphrey Bogart, A Streetcar Named Desire with Marlon Brando, and Death of a Salesman with Fredric March are released; the songs “Kisses Sweeter Than Wine”, “Unforgettable”, and “It's All In The Game” are released; the New York Yankies win the world Series by defeating the New York Giants 4 games to 2.
Chapter 5
Non Traditional Treatment: Self Help

Section I. GENERAL

05-01. General. The material in this chapter, like the material in chapter 4, is provided for informational purposes only. Always consult your doctor before attempting any new program or treatment. I have tried all of the techniques listed here and will, as in the previous chapter, share my results as I go. Each of the techniques have been used to treat PTSD although they vary in both popularity and success. This chapter offers summaries of the effects of Color in your life, Nutritional Healing, Sound Waves that use “window frequencies” to stimulate and relax the brain, Brain exercises, Emotional Memory Management (EMM), and Writing as therapy.

Section II. USE OF COLOR(S) IN THERAPY

05-02. General. Color is one of those things we think we pay very little attention to but which actually affects us on a daily basis. Understanding how color may affect you, your thoughts, and your moods may make living with PTSD a bit easier.

05-03. Color Affects Mood and Treats Diseases. Red and different hues of Red are thought to be warm and active while Blue, Violet and Green are cool, passive and calming. Several psychologists have carried out research to determine the effect of color on moods. N.A. Wells found that “deep Orange has the most exciting influence, then Scarlet and Yellow-Orange, while Yellow-Green then Green are the most tranquilizing.” Dr. Robert R. Ross of Stanford University found that Gray, Blue and Purple were associated with tragedy while Red, Orange, and Yellow with comedy. William A. Wellmann of California claims that “Red is associated with vigor, Yellow with warmth and joy, Green with abundance and health, Blue with spirituality and thought, Brown with melancholy, Gray with old age, white with zest and awareness, and Black with gloom.” Robert Gerard, in a doctoral thesis in psychology for the University of California at Los Angeles, found that the higher chronic tension a person had “the more they were affected physiologically by Red. Blue had a reverse effect, for anxious subjects were calmed by it…and because blue lowers blood pressure, it may have possibilities in the treatment of hypertension.”

05-04. Using Color in Coping With PTSD. In his book Color Psychology and Color Therapy Faber Birren says that “bright colors arranged in garish patterns” were used to paint the rooms of troubled soldiers after World War I as a treatment for what was then known as “shell shock.” The theory behind the treatment was that nervousness may have been aggravated by monotony and relieved through excitation.

After years of investigation a physician named Felix Deutsch wrote an article called Psycho-Physical Reactions of the Vascular System to Influence of Light and to Impression Grained Through Light, in the Folia Clinica Orientalia, Volume I, which was published in 1937. He gathered many case histories relating to the effects of color on blood pressure. In another study he had patients stare through colored window glass into a small garden then questioned them regarding their general feelings and impressions. He found that “The emotional excitements which are recognized through changes in blood pressure, pulse-frequency and rhythm, are brought forth through association. Green may recall nature, mountains, lakes. Red may recall the sunset, the fireplace. These superficial associations lead to deeper lying memories, which explain the affective emphasis of the attitudes toward the colors. Thus the therapy of color is successful as it affects the emotions. The patient is relieved of anxiety. He finds himself “transferred to a world which is more pleasing and presents fewer conflicts…through the changed appearance of the environment the individual is lifted out of reality.”
Make a conscious effort in controlling the colors that surround you in daily life. Create an atmosphere of contentment by using colors which stimulate positive images rather than “trigger” negative feelings and emotions. Much of this will actually take place subconsciously once the color changes are made. In other words if Green reminds you of the forest and you really love walking or camping in the woods, surround yourself with Green. If Blue reminds you of the ocean and brings back positive memories of a cruise or just the sounds of the sea, surround yourself with Blue. Some people even have whole walls covered in a forest or ocean mural.

05-05. My Experience. I will admit to having purchased a Lava Lamp since my diagnosis with PTSD. I find that watching the yellow blobs rising and falling in the aquatic blue liquid relaxes me on less stressful days.

Section III. NUTRITIONAL HEALING

05-06. General. Many of us do not realize how large a role food plays in maintaining our mental well being. I will not attempt, in this small space, to educate you on proper nutrition. Instead, I would like to offer you a few eating tips that can help your body deal with anxiety and depression while being treated for PTSD.

Some of the recommendations in this section include the addition of herbs and other nutritional supplements to your diet. In depth information about these and other supplements can be found in a terrific book entitled Prescription for Nutritional Healing by James F. Balch, M.D. and Phyllis A. Balch, C.N.C., from which almost this entire section is taken. I recommend that you follow supplement recommendations for 3 to 12 months. Always take supplements with a full glass of water. I suggest you purchase and read the entire book for the sake of your overall health.

Always consult a medical doctor or health care professional before changing your living or eating habits.

05-07. Anxiety. Prescription for Nutritional Healing says, “Anxiety disorder can be either acute or chronic. Acute anxiety disorder manifests itself in episodes commonly known as panic attacks. A panic attack is an instance in which the body’s natural ‘fight or flight’ reaction occurs at the wrong time…Stress causes the body to produce more adrenal hormones, especially adrenaline. The increased production of adrenaline causes the body to step up its metabolism of proteins, fats, and carbohydrates to quickly produce energy for the body to use…Chronic anxiety is a milder, more generalized form of this disorder.”

The following foods, supplements, herbs, and recommendations may help your body replace nutrients that it is losing as it copes with the physical effects of anxiety.

a. Food: “Include in the diet apricots, asparagus, avocados, bananas, broccoli, blackstrap molasses, brewer’s yeast, brown rice, dried fruits, dulce (seaweed), figs, fish (especially salmon), garlic, green leafy vegetables, legumes, raw nuts and seeds, soy products, Whole grains, and yogurt.

b. Nutrients: Calcium (2,000 mg daily), magnesium (600 - 1,000 mg daily), Floradix Iron + Herbs from Salus Haus (As directed on label), Multivitamin and mineral complex with potassium (99 mg daily), Vitamin B complex (as directed on label) plus extra vitamin B1 (50 mg 3 times daily with meals) and vitamin B6 (50 mg 3 times daily with meals), niacinamide (1,000 mg daily), Vitamin C (5,000 - 10,000 mg daily, in divided doses), Zinc (50 - 80 mg daily. Do not exceed a total of 100 mg daily from all supplements), Chromium picolinate (200 mg daily), DL-Ohenylalanine (600 - 1,200 mg daily. Discontinue use if no improvement is seen in one week).

c. Herbs: Bilberry, ginkobilaba, and milk thistle for flavonoids; catnip, chamomile, cramp bark, kava kava, hops, linden flower, motherwort, and pasionflower to promote relaxation; skullcap and valerian root to promote sleep; AVOID ephedra, which can aggravate anxiety.

d. General Recommendations:

1. Try eating small, frequent meals rather than the traditional three meals a day.
2. Limit intake of animal protein (meat).
3. Avoid foods containing refined or simple sugar…carbonated soft drinks and alcohol.
4. Do not consume coffee, black tea, chocolate, or anything else that contains caffeine.
5. Learn relaxation techniques and exercise regularly.”

05-08. Depression. Prescription for Nutritional Healing says, “People with depression typically withdraw and hide from society. They lose interest in things around them and become incapable of experiencing pleasure.
Symptoms of depression include chronic fatigue, sleep disturbances, changes in appetite, headaches, backaches, digestive disorders, restlessness, irritability, quickness to anger, and loss of interest in hobbies.

Foods greatly influence the brain’s behavior… the levels of brain chemicals called neurotransmitters, which regulate our behavior, are controlled by what we eat, and neurotransmitters are closely linked to mood. The neurotransmitters most commonly associated with mood are dopamine, serotonin, and norepinephrine. When the brain produces serotonin, tension is eased. When it produces dopamine or norepinephrine, we tend to think and act more quickly and are generally more alert.

The following foods, supplements, herbs, and recommendations may help your body replace nutrients that it is losing as it copes with the physical effects of depression.

a. Food: Eat a diet that includes plenty of raw fruits and vegetables, soybeans, soy products, brown rice, millet, and legumes. Salmon and white fish are good…and you will benefit from eating turkey. Omit wheat products and the artificial sweetener aspartame (Equal, NutraSweet). (authors note: You may have noticed that if you have both anxiety and depression, as is common with PTSD, fruits, vegetables, fish, soy products, and legumes are common to both but you may want to omit whole grain products).

b. Nutrients: L-Tyrosine (Up to 50 mg per pound of body weight daily. Take on an empty stomach with 50 mg vitamin B6 and 100 - 500 mg vitamin C. Best taken at bedtime), Sub-Adrene from American Biologics (As directed on label), Zinc (50 mg daily. Do not exceed a total of 100 mg daily from all supplements), Taurine Plus from American Biologics (As directed on label). The following vitamins listed by “cc” are by injection - Vitamin B complex (2 cc once weekly or as prescribed by physician), Vitamin B6 (pyridoxine)(1/2 cc once weekly or as prescribed by physician), Vitamin B12 (1 cc once weekly or as prescribed by physician) OR liver extract (2cc once weekly or as prescribed by physician) plus Vitamin B12 (1 cc once weekly or as prescribed by physician) OR Vitamin B complex (100 mg 3 times daily) plus pantothenic acid (Vitamin B5)(500 mg daily) and Vitamin B6 (pyridoxine)(50 mg 3 times daily) plus Vitamin B3 (niacin)(50 mg 3 times daily. Do not exceed this amount) and folic acid (200 mg daily).

c. Herbs: Balm, also know as lemon balm, ephedra (ma Huang) (DO NOT USE IF SUFFERING FROM ANXIETY), ginger, ginko biloba, oat straw, peppermint, kava kava, and St. Johnswort.” Note: Notice some repeats from anxiety treatment recommendations).

d. General Recommendations:
   1. Avoid foods high in saturated fats (fried foods).
   2. Avoids all forms of sugar, alcohol, caffeine, and processed foods (nobody said it was going to be easy).
   3. Keep your mind active and get plenty of rest (I used the writing of this manual to keep me sane).
   4. Try using color to alleviate depression. (See Section II of this chapter).
   5. Vigorous exercise and appropriate music can help eliminate bouts of depression.
   6. People who smoke are more likely than nonsmokers to be depressed.”


05-09. My Experience. Although I have made several efforts to adjust my nutritional habits I have found no significant changes in my anxiety or depression levels. I feel this is mainly because of the medications I am on and the difficulty of tracking cause and effect in this area. I hope that someone in the medical field will come up with a proven program using a combination of food, nutritional supplements and herbs to assist PTSD patients.

I would like to mention one danger associated with nutritional adjustments that may have contributed to my depression. Looking back I can associate 2 of my 3 bouts of depression with times in my life when I was on low carbohydrate diet. Only one other time have I been on a low carbohydrate diet. In that instance I did not suffer a bought of depression, however I happened to be in a very rewarding and satisfying job. Coincidence? Unknown at this time.

Section IV. SOUND WAVE THERAPY

05-10. General. What I refer to as Sound Wave Therapy is probably better know as relaxation or stress reduction therapy. Even though soothing music can have a relaxing effect on most people, what I am referring to here goes beyond that. I have had success with two Sound Wave Therapy programs. One is marketed as a stress
reduction tape, while the other is advertised as having something to do with “window frequencies”. I found that both programs can offer those suffering with PTSD at least a brief respite.

05-11. Relaxation and Stress Reduction. The first tape, *Letting Go of Stress* by Emmett E. Miller, M.D. and Steven Halpern, PH.D. and produced by “Source”, was given to me by one of the psychologists at the VA center where I am undergoing treatment for PTSD. After my initial visits to the VA and while waiting to see the results of my body’s response to the prescribed medications, my psychiatrist recommended that I attend a stress management class. The tape was provided as part of that class and I still use it on occasion. There are four twenty minute episodes. You can listen to the tape on any cassette tape playback device (the folks at my VA will even loan you a player if you do not have one) It is a good idea to listed through padded earphones. The earphones block out a lot of unwanted distractions.

The first session takes you through a “Muscle Tension Relaxation” sequence that I found to be the best of the four sessions. The second one involves “Deep Breathing”, the third a “Trip to the Beach” with waves and stuff, and the fourth, and final session, emphasizes “positive imaging”. Each has a pleasant musical background. To be effective the tape should be used three times a day.

I used mine twice a day. On the days when I could concentrate and was not too hyper, the tape helped me feel less stressed and more relaxed.

05-12. Addressing Brain Waves. The second and more effective tape is called *Brain Power* by Kelly Howell and is produced by “Brain Sync Corporation”. The following is a quote from the brochure found inside the tape box, “*Brain Power* delivers a special combination of window frequencies, ranging from high beta down to delta, which have been associated with higher cognitive function, visual acuity, concentration, creativity, and relaxation…. *Brain Power* will balance both right and left hemispheres of the brain, while allowing you to enter the peak performance brain state known as “Flow”.

I am not certain what all that means but I found the tape very gripping and easy to listen to. There are no words but rather a “beat” and rhythm combined with light music that produces an pleasant mind numbing effect. The program carries you to the edge of sleep then lifts you out, without giving you a jolt, several times over a 30 minute period. The tape has two 30 minute sides and I have found that in most cases one side at a time works just fine. Oh yeah, you need stereo headphones.

05-13. Personal Experience. The second tape works for me. I have found that when I used it on a regular basis, at least three times a week, my memory has been sharper and my concentration has not been so hard to come by. This baby is great if you are having trouble getting to sleep. I also recommend you try different concentration techniques such as deep breathing, total body relaxation, and watching a Lava Lamp (love my Lava Lamp).

Both of the above tapes state in their brochures that they are “not a medical device” and should not be used as a substitute for appropriate medical care.

Section V. BRAIN EXERCISES


05-15. Personal Experience. I have tried several of the exercises recommended in *The Brain Workout Book*, and I believe they have improved my concentration. The chapter on “Controlling Unruly Dreams” has also helped.

Section VI. EMOTIONAL MEMORY MANAGEMENT (EMM)

05-16. Separating Emotion From Memory. In my search for various treatments for PTSD I stumbled upon several concepts that were new to me. This particular one, created by Dr. Joseph M. Carver, actually makes sense, AND IT WORKS.

I present here the parts of Dr. Carver’s work that I feel are the most relevant to survivors of PTSD. I would encourage you to visit Dr. Carver’s Internet Web Site (No longer available) at “http://www.zoomnet.net/~jcarver/emotmem.html” and read the entire article Emotional Memory Management: Positive Control Over Your Memory:
“Every second we are alive, our brain functions. At a very basic level it maintains our breathing, our blood flow, our body temperature, and other aspects that allow us to stay alive and thinking. Emotional Memory Management, or EMM, is concerned with the thinking part of brain functioning. Almost every aspect of daily functioning is directly related to our memory. As you read this document, your brain recognizes words and provides definitions as you read - pretty fast operating when you think about it! While this discussion is not concerned with reading or word-memory, it is concerned with the manner in which the brain pulls memory files, makes those files, and how those files influence our daily life.

The following discussion is based on psychological and neurological research, combined with on-going theories regarding memory, thought control, and therapy/counseling. Several theories and the results of research have been combined by the author in a manner which allows the practical and daily use of advanced knowledge on topics of memory and brain functioning. As research in this area continues, the author anticipates new, neurological definitions of previously-labeled psychological concepts such as ‘the subconscious’ or the various defense mechanisms.

While the underlying theories are very technical, the concept is presented in a non-technical manner. After reading this information, you are encouraged to practice the techniques, be curious about how your file system works and observe it in operation, and make the most of the new knowledge and understanding available.

Much like a modern-day computer, the brain stores memories in a system of files... Recent studies in neurology tell us that the files contain not only data/information, but emotions as well.

Memory files thus contain two parts, the information about the event and the feeling we had at the time of the event.

Graphically put:

Memory file = Information + Feelings at the time

How Memories are made...

A memory is stored in long-term storage or “dumped” depending on it’s emotional value... Most of us cannot remember our many trips to the grocery store or service station. However, we will always remember times which have a good or bad value such as the time a store was robbed when we were there, the time an old lady threatened us over a can of green beans, or the time we spilled gasoline all over our clothes in one of those self-serve pumps... As years pass, we build up quite a file system. We build up a collection of good memories and bad memories. Our brain has the ability to pull these memories at the drop of a hat - almost instantly.... Those with emotional memories can not only give you the exact details, but a variety of random and irrelevant details surrounding the event. This is how powerful “emotional memory” (EM) can be.”

Dr. Carver goes into great detail at this point on how chemicals effect the brain and the memory/emotion process. I covered some of this same information in Chapter 2, so we will by-pass it here. However, I do want to list the “rules” he brings out in that section:

“Rule: The brain operates on chemicals. These chemicals produce emotional responses in the brain and body.

Rule: Thoughts change brain chemistry.

Rule: The brain is constantly, every second, pulling files for our reference.

Rule: The emotional part of a memory begins 90 to 120 seconds after a file is pulled.

Rule: The brain only allows one file out at a time.

Rule: The brain doesn’t care which file is active.

Rule: Like the files, the brain only allows one feeling or emotion to be active at a time.

Rule: You can’t argue with a file.
Rule: Any stimulation can pull a file.

Files and Physical/Mental Trauma…

One of the most common situations in which emotional memory files create severe problems is in physical or mental trauma. Trauma, or severe emotional memory, can be created by physical assaults, combat experiences, crime, death of a loved one, viewing severe accidents, surgery, or brush-with-death experiences… in trauma, the brain not only memorizes everything about the event - including the emotions - but adds the surroundings as well… old Emotional Memory (EM) trauma files are often at the heart of long-standing difficulties… correction is often a matter of taking manual control of those situations, creating new files, and “watering down” the old files.

Rule: The brain pulls the most recent and most powerful file first.

How to Know When A File Is Operating…

If you find yourself thinking about a past trauma or bad situation, you may have an old file out and also be depressed and stressed. When depressed or stressed, the brain becomes our worst enemy, pulling files that have strong negative content and making us relive and reexperience old events… an older male suddenly thinks, feels guilty, and grieves about his experiences in combat (WW II, Korea, Vietnam, etc.). When the brain pulls these old files we know brain chemistry is upset.

Rule: The Brain doesn’t know if a file is real or imagined!

Making New Files…

112 Since our brain can’t tell real from imagined experiences, practice making new files to replace your old.

113 Depressed and anxious individuals always imagine negative experiences… If depressed or anxious, think the opposite of the brain’s normal disposition - daydream or imagine only positive experiences. It may sound strange but your brain will think your life is better (it only knows what it’s told!) and will chemically lift your mood gradually.

114 Pick an area in which you are having trouble. Create/Invent new files to deal with that situation. If uncomfortable around your supervisor at work or your relatives, imagine positive scenes in which you solve conflicts or make adjustments.

Developing a Treatment Plan…

Let’s suppose we have a strong Emotional Memory (EM), perhaps the result of an automobile accident, a childhood trauma, a life-threatening experience, a physical assault, a public embarrassment, or something equally emotionally traumatic. We can develop a treatment plan to eliminate the ‘emotional’ part of the memory. We can never eliminate the details of the memory/experience - only brain damage or disease wipes out complete memories. The goal in the treatment of Emotional Memories (EM) is to eliminate the emotional component - the part that causes us emotional pain. If the emotional component/part is taken away, we can relate the story without fear of being upset or returning to that mood.

One of the fastest and easiest ways to complete that task is to ‘water down’ the emotional part of the memory. To do this, imagine having a letter saved on a computer word processor. Each time you retrieve the letter - it looks the same, reads the same, and says the same thing. If we pull it up on the computer screen, read it, then save it - nothing has changed. This is what happens when we relate Emotional Memory (EM) events to others without adding to the memory or file. What happens if we pull up that word processor letter each day. Each time we pull it up on the screen, we add one long sentence to the letter - a sentence that is silly, unrelated to the letter, or just a bit off-base - then save it again. After two weeks we’ve added 14 sentences to the letter and the original letter is now gone. It’s something totally different now. We use this technique to eliminate emotional parts of Emotional Memory (EM).

Summary…

We are a collection of memories - that’s who we are, what makes up our personality, what controls our behaviors, and what often produces our moods. The good Emotional Memory (EM) is a
blessing to us, remembering good times during childhood, our favorite songs/events, and old friends. However, we have all collected bad or often traumatic Emotional Memory (EM) files as well. The goal of Emotional Memory (EM) Management is to control or eliminate the emotional part of those files. If we can do that, our history of bad experiences becomes just that - history.

Those files become a record of where we’ve been and experienced, not something that continues to control our moods and behaviors.

In daily living and especially during times of stress, our memory file system is very important. It is a system that is active every second, works automatically, and can change our mood within two minutes. Our office has presented the above information with the hope that you can lower your stress and live more effectively by controlling your emotional memory files rather than allowing them to control you! Remember - our emotional file system is like our breathing, it will operate on automatic or we can take manual control. Knowing how the system operates allows us more control over our memories and daily lives.”

Joseph M. Carver, Ph.D., Psychologist
(Used by permission of author)

05-17. My Experience. I have used the “water down” technique, explained above, on several unwanted memories/emotions with positive results. I had been plagued for years with the memory of seeing a white cat hit and killed by an automobile. I kept seeing this event replay itself in slow motion when I would worry about one of my own cats, or just when feeling down. I wrote the sentence “The white cat has gone to a peaceful and beautiful place” at the top of a legal pad and for two weeks added a new, “crazy” sentence, such as “Small frogs wear small dresses” or “My boss has a large pimple on his nose”, below it. I can now think about the white cat being killed without the emotion. I wish you luck if you decide to try the same experiment.

Section VII. WRITE ABOUT IT

05-18. Write a book. A professor of psychology at the University of Texas, James Pennebaker, contends that writing about your traumatic experiences is just as good therapy as talking about it. Dr. Pennabaker pioneered what is know as “Mind-body connections” in the mid 1980’s using blood samples of participants before and after a writing experiment and found an increase of what is known as “T-helper cells” for as long as six weeks afterward. Though not widely accepted at the time, and still controversial, other universities are now duplicating the same process.

Dr. Penebacker contends that writing style or correctness has no bearing on the outcome. The patient is asked to “…write for yourself”. The process involves “…writing and rewriting about whatever ails you - for as little as 20 minutes a day for three to five consecutive days - until you have a complete and coherent narrative with a beginning, a middle and an end. You may feel a little sad or depressed when it’s over. But you may also find that you stop thinking about whatever it was that moved you to write.”

And finally when asked why it works, Dr. Pennebaker said “…just organizing feelings and thoughts about traumas is beneficial, since trying to avoid thinking or talking about something is stressful.” (Austin American Statesman, Mar 1, 1998).

05-19. My Experience. Part of what has kept me sane during the last year has been the writing of this manual. It has provided a means of focus and release. Much of me is scattered throughout the text and each chapter brings satisfaction. A Vet Center counselor asked me the other day what I was going to do after the manual is finished and I said “I can begin helping others, which I feel will complete my healing.”

Although you must be prepared for the consequences of regurgitating your traumas, sometimes literally, the act of writing and the seeing on paper what happened during those traumas can free you from the guilt and disgust and allow you to understand and come to terms with what happened. You did what you were able or required to do. Nothing more could have been asked, by God or man.

Some of this understanding, and healing, will take place when you write your stress letter. Always have a friend or doctor available in case of fall out.

SITREP - Korean War Era (1952):
The first pocket-size radios are introduced by Sony; the Today Show debuts on NBC; the first Videotape is demonstrated in California; the book *East of Eden* is written by John Steinbeck and *The Old Man and the Sea* is written by Earnest Hemingway; the songs “Do Not Forsake Me”, “Your Cheatin Heart”, and “Lullaby of Birdland” are released; the films “High Noon”, “The Quiet Man” and “The Greatest Show On Earth” are released; the New York Yankees win the World Series by defeating the Brooklyn Dodgers 4 games to 2.

**Korean War Era (1953):**
Joseph Stalin dies at the age of 73; the American Stock Exchange is created; the IBM 701 is the first IBM computer; TV Guide and Playboy Magazine begin publication; the books *The Adventures of Augie March*, *Casino Royale*, and *Battle Cry* are published; the songs “I Believe”, “Oh! My Pa Pa”, and “That’s Amore” are released; the New York Yankees win the World Series by defeating the Brooklyn Dodgers 4 games to 3 (their fifth win in five years).
Chapter 6
Medications

Section I. GENERAL

06-01. General. There are several types of medications you may be given for PTSD. This chapter will list possible side effects and general comments from both doctors and medical guides. This chapter also includes my personal experiences with PTSD medications. (I AM NOT advising the reader to ask for or take any of the medications listed; each is listed for informational purposes only. If you are female ask your doctor about gender specific side effects. Many of the descriptions are not clinically accurate; they are written from a layman’s point of view). The definitions are not taken from any single book but rather several, which are listed in the bibliography. If you have a computer and access to the Internet an excellent laymen’s source on medications may be found at “www.virtualdrugstore.com/druglist.html”. (Authors Update Note – My revision in 2001 added nothing to this section. About 95% of the information is still accurate but a few drugs need to be added, I am certain. Ask your doctor about new medications.)

06-02. Reasons for Medication. The following are PTSD symptoms which may be affected by medication:

a. Depression. Quite often you will become depressed and not even know why. Normally this depression is brought on by “Triggers” (as described in Chapter 2) set off by current events. Depression can, amongst other things, affect your memory.

b. Anxiety. This is what first began to gnaw on me several months before I turned myself in for treatment. I began to wake up in a state of anxiety which remained with me for most, if not all, of the day. I equated it, to my psychiatrist, as a feeling of waiting for a mortar attack. This began to cause me to stay up later and later at night because I didn’t want to wake up with the almost consuming anxiety.

d. Nightmares. You may be having, or may start to have nightmares. I began to kick my wife during the night in attempts to fend off something happening in my dreams. Half the time I could not remember what the dream was about. Some of the dreams that I did remember were graphic and very realistic, including both smell and feeling. You may also begin, if you are not already doing so, to wake up in the middle of the night. I had the feeling there was something I was suppose to do but I did not know what it was. This is no specific medication for the elimination of nightmares but most psychiatrist will prescribe a “sleeping pill”.

06-03. Things to ask your doctor.

- Is medication the best option for my problem?
- Am I willing to put up with unpleasant side effects in return for anxiety relief?
- What non-drug treatments for anxiety might help?
- Do I have the time and am I willing to pursue non-drug treatments such as cognitive-behavioral therapy and meditation?
- What self-help strategies might help me get my problem under control?
- If I decide to take medication, should I pursue other therapy as well?
- How will the medication help my problem?
- What are the common side effects?
- Are there any food and drinks I will need to avoid?
- How will this drug interact with my other prescriptions?
- How long will I have to take the medication?
• Will withdrawing from the medication be difficult?
• Will my anxiety return when I stop taking the medication?

Section II. SYMPTOM TREATED

06-04. Depression

a. Medication. Amitriptyline (See Elavil)
b. Medication. Amitriptyline with Perphenazine (See Triavil)
c. Medication. Aventyl (See Pamelor)
d. Medication. Bupropion (See Wellbutrin)
e. Medication. Disipramine (See Norpramin)
   (1). Some Side Effects. Aches in muscles and bones, constipation, inability to fall asleep, headaches, nausea, vivid dreams, irregular heartbeat, and fainting.
   (2). General Comments. Will take between 2 to 4 weeks to take effect. Should be taken with food to avoid dizziness. Never take a double dose to make up for a missed dose. This medication has been associated with persistent or painful erections. Inform your doctor of any other medications you may be taking.
g. Medication. Doxapin (See Sinequan)
h. Medication Duloxetine (Insufficient data, Ask your Doctor.)
i. Medication. Effexor
   (1). Some Side Effects. This bad boy has a whole bunch of possible side effects. Abnormal dreams, anxiety, constipation, dizziness, nausea, rash, tremors, belching, and orgasm disturbance (ask your doctor), just to name a few.
   (2). General Comments. It may take several weeks for this medication to kick in. Never take Effexor close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. Never take two doses to make up for a missed one. If you have ever been addicted to drugs mention this to your doctor. Do not stop taking this medication without discussing with your doctor.
j. Medication. Elavil
   (1). Some Side Effects. Abnormal bowel movements, constipation, frequent urination, dry mouth, decreased sex drive, nightmares, nausea, unexpected dizziness, tingling in arms and legs, weakness, breast development in men, and swelling of testicles.
   (2). General Comments. This drug is called a tricyclic antidepressant (see Glossary section) and should never be taken in conjunction with a MAO (see Glossary section) inhibitor. It may take several weeks before Elavil becomes effective. Never skip doses. Never take two doses at the same time to make up for a missed dose. Make your doctor aware of reactions you have had to other drugs. Do not take Effexor close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. Never take two doses to make up for a missed one. If you have ever been addicted to drugs mention this to your doctor. Do not stop taking this medication without discussing with your doctor.
k. Medication. Endep (See Elavil)
l. Medication Escitalopram (Insufficient data, ask your Doctor)
m. Medication. Fluoxetine (See Prozac)
n. Medication. Imipramine (See Tofranil)
o. Medication. Mirtazapine (See Remeron)
p. Medication. Nardil
   (1). Some Side Effects. Constipation, dizziness, headache, fatigue, sexual difficulties, rapid breathing, skin rash, and sweating.
   (2). General Comments. This is a MAO (See Glossary section). There are several foods you must avoid while taking this medication (ask your doctor). These include the following: Beer, caffeine, cheese, liver, and yogurt. Ask you doctor about other medications you must avoid. This medication make take up to 4 weeks to begin having an effect. It would be a good idea to wear a Medical Alert bracelet while taking this medication. Do not stop taking this medication without asking your doctor (may cause withdrawal symptoms).
q. Medication. Nefazodone (See Serzone)
s. Medication. Nortriptyline (Insufficient data, ask your Doctor)
   (1). Some Side Effects. Black tongue, constipation, anxiety, delusions, frequent urination, nausea, increase or decrease in sex drive, nightmares, sweating, and swollen glands.
   (2). General Comments. This drug is called a tricyclic antidepressant (see Glossary section) and should never be taken in conjunction with a MAO (see Glossary section) inhibitor. Make certain your doctor
knows of any other medications you are currently taking or recently stopped taking. May take up to 4 weeks to 
take effect. Never take two doses to make up for a missed dose. Do not take if you have had a recent heart attack.
Discuss any previous medical problems with your doctor before taking this medication. Must be discontinued 
prior to surgery.

t. **Medication. Pamelor**

(1). **Some Side Effects.** Breast development in males, black tongue, anxiety, constipation, 
dizziness, excessive urination at night, increased or decreased sex drive, irregular heart beat, swelling of the 
testicles, and skin spots.

(2). **General Comments.** This drug is called a tricyclic antidepressant (see Glossary section) 
and should never be taken in conjunction with a MAO (see Glossary section) inhibitor. May take several weeks 
to take effect. Never take two doses at the same time if you have missed a dose. Make certain your doctor is 
aware of any other medications you may be taking. Do not take if recovering from a heart attack. Discuss all 
previous medical problems with your doctor. You cannot drink alcohol or eat certain foods while taking this 
medication.

u. **Medication. Paroxetine** *(See Paxil)*

v. **Medication. Paxil.**

(1). **Some Side Effects.** Constipation, dizziness, male genital disorders (ask your doctor), 
nausea, weakness, and tremors.

(2). **General Comments.** Produces results in 1 to 4 weeks. Discuss any other drugs you may be 
taking, even over the counter drugs, with your doctor. Do not take a double dose if you miss a dose. Never take 
Paxil close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. 
Inform your doctor if you have a manic disorder. Inform your doctor of any pre-existing medical condition or 
disease. Do not drink alcohol.

w. **Medication. Phenelzine** *(See Nardil)*

x. **Medication. Prozac**

(1). **Some Side Effects.** Chills or fever; trouble in breathing; skin rash or hives; difficulty in 
concentration; drowsiness; anxiety or nervousness; muscle pain; diarrhea; increased sweating; abnormal dreams; 
decreased sexual drive; dryness of mouth; frequent urination.

(2). **General Comments.** This is a Serotonin inhibitor *(See Chapter 2 on brain chemical 
imbalances).* The main effect is to allow combat vets more time to think before they act, particularly in anger. In 
addition, it may have a direct anti-depressant effect. May take weeks to kick in. *(Jonathan Shay, M.D., Ph.D., 
Staff Psychiatrist, Boston VA Outpatient Clinic).*

y. **Medication. Remeron**

(1). **Some Side Effects.** Abnormal dreams, constipation, dizziness, increased appetite, back 
pain, and nausea.

(2). **General Comments.** Is thought to work by adjusting the balance of the brain’s chemical 
messengers *(neurotransmitters)* especially norepinephrine and serotonin *(see Chapter 2 on brain chemical 
imbalances).* Takes effect in 1 to 4 weeks. Never take two doses to catch up for a missed dose. Tell your doctor 
of any drug reactions you may have. Never take Remeron close to or in conjunction with any MAO *(see the 
Glossary section at the end of this manual)* inhibitor. Report any “flu-type” symptoms to your doctor 
immediately. Inform your doctor if you have a cholesterol problem. Tell your doctor of any history of seizures, 
drug use, or any physical or emotional problems. Do not drink alcohol.

z. **Medication Seligiline** *(Insufficient data, ask your Doctor)*

aa. **Medication. Sertraline** *(See Zoloft)*

bb. **Medication. Serzone**

(1). **Some Side Effects.** Constipation, dizziness, nausea, weakness, decreased concentration, 
prolonged or inappropriate erections, and decreased sex drive.

(2). **General Comments.** Takes several weeks for the drug to kick in. Do not take two doses to 
make up for a missed dose. Never take close to or in conjunction with any MAO *(see the Glossary section at the 
end of this manual)* inhibitor. Make your doctor aware of any pre-existing medical conditions or addictions to 
Drugs. Tell your doctor about any other drugs you may already be taking.

cc. **Medication. Sinequan**

(1). **Some Side Effects.** Breast development in males. Changes in sex drive, constipation, hair 
loss, hallucinations, nausea, and swelling of the testicles.

(2). **General Comments.** Used for treatment of depression and anxiety. It is a tricyclic 
antidepressant *(see Glossary section).* Never take close to or in conjunction with any MAO *(see the Glossary 
section at the end of this manual)* inhibitor. Inform your doctor if you are taking any other prescription or 
nonprescription drugs. It may be several weeks before this medication takes effect. Never take two doses to 
make up for a missed dose. Notify your doctor or dentist before any surgery. Do not drink alcohol.

dd. **Medication. Surmontil**
(1). **Some Side Effects.** Black tongue, blocked intestines, breast development in men, constipation, delusions, dizziness, frequent urination, hair loss, hallucinations, heart attack, increased or decreased sex drive, and swelling of testicles.

(2). **General Comments.** It is a tricyclic antidepressant (see Glossary section). Never take close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. May take up to 4 weeks to take effect. Never take two doses to make up for a missed dose. Do not take if recovering from a heart attack. Make your doctor aware of any pre-existing medical conditions. Make your doctor aware of any other medications you are taking.

**ee. Medication. Tofranil**

(1). **Some Side Effects.** Black tongue, blocked intestines, breast development in men, constipation, delusions, dizziness, frequent urination, hair loss, hallucinations, heart attack, increased or decreased sex drive, and swelling of testicles. Can cause sensitivity to light.

(2). **General Comments.** This is a tricyclic antidepressant (see Glossary section). Never take close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. Do not drink alcohol. This medication takes from 1 to 3 weeks to begin working. Never take two doses at a time to make up for a missed dose. Do not use if recovering from a heart attack. Inform your doctor if you are taking any other medications. Tell your doctor if you develop a sore throat or fever while on this drug. Expect extreme drowsiness if combined with alcohol or other antidepressants.

**ff. Medication Tranylcypromine (Insufficient date, ask your Doctor)**

**gg. Medication. Trazdone (See Desyrel)**

**hh. Medication. Triavil**

(1). **Some Side Effects.** This drug has more side effects than any other drug listed here. Permanent involuntary muscle spasms and twitches in the face and body, asthma, black tongue, breast development in males, constipation, coma, convulsions, hair loss, hallucinations, increased or decreased sex drive, protruding tongue, stroke, sweating, swelling of testicles, and urinary problems.

(2). **General Comments.** Used to treat anxiety and depression. This drug is a combination of a tricyclic antidepressant (see Glossary section) and a tranquilizer. Never take two doses at once to make up for a missed dose. Make your doctor aware of any other medications you may be taking. Do not take after suffering from a heart attack or bone marrow condition. Never take close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. Make certain you doctor is aware of any other pre-existing medical condition, no matter how slight. May cause many types of withdrawal problems. Notify your doctor if you develop a fever for no reason.

**ii. Medication. Trimipramine (See Surmontil)**

**jj. Medication. Venlafaxine (See Effexor)**

**kk. Medication. Wellbutrin**

(1). **Some Side Effects.** May cause weight loss, constipation, acne, chest pain, chills, confusion, flu-like symptoms, hair loss, impotence, painful ejaculation, painful erection, retarded ejaculation, sexual dysfunction, and possible toothache.

(2). **General Comments.** This drug is a tricyclic antidepressant (see Glossary section) but tends to have a stimulating effect. Never take close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. Usually taken in three doses, 6 hours apart. Do not drink alcohol. Never take two doses to make up for a missed dose. Tell your doctor if you have ever experienced seizures. Do not take this drug if you have or have had any type of eating disorder.

**ll. Medication. Zoloft**

(1). **Some Side Effects.** Agitation, confusion, dizziness, difficulty with ejaculation, gas, increased sweating, acne, bad breath, breast development in men, hair loss, hiccups, loss of appetite, pain upon urination, abnormal dreams, sleepwalking, and yawning. May cause hyperactivity.

(2). **General Comments.** Thought to work by boosting the amount of serotonin in the brain (See Chapter 2 on brain chemical imbalances). Never take close to or in conjunction with any MAO (see the Glossary section at the end of this manual) inhibitor. Takes from several days to several weeks to begin having an effect. Never take two doses at once to make up for a missed dose. Notify your doctor of any pre-existing medical disorder. Do not drink alcohol. Notify your doctor of any medications you are on.

### 06-05. Anxiety

a. **Medication. Alprazolam (See Xanax)**

b. **Medication. Atarax**

(1). **Some Side Effects.** Drowsiness, tremors, and convulsions.

(2). **General Comments.** An antihistamine (see Glossary section) used to relieve anxiety and tension. For short term, 4 months or less, use only. Do not take two doses a once if you miss a dose. Notify your doctor of any other medications you may be taking. Avoid alcohol. First dose may be by injection.
c. **Medication. Ativan**  
   (1). **Some Side Effects.** Dizziness, weakness, depression, memory impairment, and skin problems.
   (2). **General Comments.** Used for short term treatment in anxiety cases. Belongs to a class of drugs known as benzodiazepines (see Glossary section) which generally act as tranquilizers. Stop use only on advice of doctor. Do not take a double dose to catch up with a missed dose. Inform your doctor of all medications you are on. Inform your doctor of any pre-existing medical problems.

d. **Medication. Buspar**  
   (1). **Side Effects.** Chest pain, confusion, depression, constipation, sore throat or fever, lightheadedness, nausea, decreased concentration, dryness of mouth, trouble sleeping, nightmares or vivid dreams.
   (2). **General Comments.** Never take close to or in conjunction with a MAO (see the Glossary section at the end of this manual) inhibitor. May take a few weeks to kick in. May help some people with intrusive thoughts and nightmares. Never take a double dose to make up for a missed dose. Inform you doctor of any other medications you are on. Inform you doctor of any pre-existing medical problems.

e. **Medication. Buspirone** (See Buspar)

f. **Medication. Chloridiazepoxide** (See Librium)

g. **Medication. Clorazepate.** (See Tranzene)

h. **Medication. Compazine,**

   (1). **Some Side Effects.** This medication has a laundry list of side effects not the least of which is the possibility of permanent involuntary muscle spasms and twitches. Asthma, breast development in males, constipation, heart attack, impotence, painful erections, and protruding tongue.
   (2). **General Comments.** Used occasionally for anxiety. Usually provided in suppository form. Never take two doses in attempt to catch up with missed dose. Inform your doctor of any other medications you are on. Inform your doctor of any pre-existing medical condition. Do not take alcohol.

i. **Medication. Diazepam** (See Valium)

j. **Medication. Equanil** (See Miltown)

k. **Medication. Hydroxyzine** (See Atarax)

l. **Medication. Libritabs** (See Librium)

m. **Medication. Librium**

   (1). **Some Side Effects.** This drug can be habit forming. You may experience withdrawal symptoms upon discontinuance. Constipation, increase or decrease in sex drive, sweating, and convulsions. Inform you doctor if you are taking any other medication and if you have a pre-existing medical condition. Do not take alcohol.
   (2). **General Comments.** Belongs to a class of drugs known as benzodiazepines (see Glossary section) which generally act as tranquilizers. Do not take a double dose to make up for a missed dose.

n. **Medication. Lorazepam** (See Arivan)

o. **Medication. Meprobamate** (See Miltown)

p. **Medication. Miltown**

   (1). **Some Side Effects.** Can be habit forming and you may experience withdrawal symptoms upon discontinuation. Bruises, dizziness, nausea, skin eruptions, vomiting, inflammation of the rectum, and peeling skin.
   (2). **General Comments.** This drug is a tranquilizer. Never take a double dose to make up for a missed dose. Do not stop taking without doctors permission. Inform you doctor of any physical problems or if you are taking any other medications.

q. **Medication. Oxazepam** (See Serax)

r. **Medication. Prochlorperazine** (See Compazine)

s. **Medication. Serax**

   (1). **Some Side Effects.** Can be habit forming and lose effectiveness over time. You may experience withdrawal symptoms. Drowsiness, change in sex drive, slurred speech, muscle cramps, convulsions, sweating, and vomiting.
   (2). **General Comments.** Belongs to a class of drugs known as benzodiazepines (see Glossary section) which generally act as tranquilizers. Never take a double dose to make up for a missed dose. Inform your doctor of any pre-existing medical condition and of any medications you are currently on. Do not take alcohol.

t. **Medication. Stelazine**

   (1). **Some Side Effects.** This drug is the king of side effects in the anxiety class. May cause permanent muscle spasms and twitches. Asthma, blood disorders, breast development in males, constipation,
ejaculation problems, flue-like symptoms, heart attack, lockjaw, protruding tongue, sensitivity to light, and seizures.

(2). General Comments. For treatment of severe mental disorders as well as anxiety. Often provided in liquid form and must be diluted. Do not use alcohol. Do not take a double dose to make up for a missed dose. Inform your doctor of any pre-existing medical conditions and if you are on any medications. Do not stop taking medication without doctors permission. Notify doctor immediately of fever or sore throat. Do not use alcohol.

u. Medication. Tranxene
   (1). Some Side Effects. Can be habit forming and you may experience withdrawal symptoms upon discontinuation. Dizziness, fatigue, irritability, mental confusion, convulsions, impaired memory, and vomiting.

   (2). General Comments. Belongs to a class of drugs known as benzodiazepines (see Glossary section) which generally act as tranquilizers. Never take a double dose to make up for a missed dose. Inform your doctor of any other medications you may be on.

v. Medication. Trifluoperazine (See Stelazine)
w. Medication. Valium
   (1). Some Side Effects. Can be habit forming. You may experience withdrawal symptoms upon discontinuation. Dizziness, fatigue, changes in sex drive, depression, constipation, hallucinations, slurred speech, vertigo, and skin rash.

   (2). General Comments. Belongs to a class of drugs known as benzodiazepines (see Glossary section) which generally act as tranquilizers. Never take a double dose to make up for a missed dose. Inform your doctor of any pre-existing medical problems or if you are on any other medication. Do not take alcohol.

x. Medication. Vistaril (See Atarax)
y. Medications. Xanax
   (1). Some Side Effects. This can be habit forming and you may experience withdrawal symptoms upon discontinuation. Constipation, decreased or increased sex drive, difficult urination, dream abnormalities, impaired memory, overall sexual dysfunction, fear, hallucinations, rage, seizures, muscle cramps, and twitching.

   (2). General Comments. Is effective in treating depression in conjunction with anxiety. Never take a double dose to make up for a missed dose. Inform your doctor of any pre-existing medical conditions and if you are taking any other medications. (authors note: Jonothan Shay, M.D., Ph.D., Staff Psychiatrist, Boston VA Outpatient Clinic recommends combat veterans NOT use this drug).

06-06. Nightmares
   a. Medication. Cyproheptadine (see Periactin)
   b. Medication. Periactin
      (1). Some Side Effects. Anemia, constipation, difficulty urinating, and hives.
      (2). General Comments. This is an antihistamine used by doctors to help lesson the severity of nightmares. The biggest drawback is waking up every morning very “groggy”.

06-07. Pay Attention. You need be aware that the first medications you are given may not produce the desired results. Almost all of the anti-depressants/anxiety drugs can take a couple of weeks to kick in. This is exactly what happened to me. The first two drugs I was given did not work. This means I was going out of my gourd for about six weeks before getting any relief.

Also keep in mind that after all these years this is still not an exact science. When I learned about the chemical imbalance in my brain (as explained in chapter 2) I asked my psychiatrist if it were not medically possible to determine this imbalance by a blood test or, God forbid, a spinal tap. Nope. If you are lucky the first medication works, if not, they have to try another one.

It is also important to take the medications as instructed by your psychiatrist. Along with the anti-depressant/anxiety medication Olanzipine, I also take Paxek, Methyphenidate, and Lithium Carb.

The only side effects I have experienced to date are a loss in sex drive (which is serious enough) and the need for a laxative every second or third day. You will have to adapt to keep the monster at bay.

WARNING

69
The information in this chapter is general and brief by design. The information is intended to help Combat Veterans understand what medications they may be taking and for what reason, in layman’s terms. This chapter does not cover all possible drugs, uses, or side effects, nor is the information intended as medical advice. This information should not be used as the only method for the evaluation of the risks and benefits of a particular drug or drug combination.

SITREP - Vietnam Era (1965):
Malcom X is shot dead at Harlem’s Audubon Ballroom; Diet Pepsi is release for the first time by the Pepsi Cola Company; Sony introduces Betamax video recorders; The book The Last of the Pleasure Gardens by Francis King is released; The movie The pawnbroker starring Rod Steiger released; The Rolling Stones release “I Can’t Get No Satisfaction”; The Grateful Dead begin their singing career; The song “Sounds of Silence” by Simon and Garfunkel is released; the song “I Got You Babe” released by Sonny and Cher: the Los Angeles Dodgers win the World Series by defeating the Minnesota Twins 4 games to 3.

Vietnam Era (1966):
Gov. George Wallace signs a bill September 2 forbidding Alabama’s public schools to comply with the Office of Education’s desegregation guidelines; The book In Cold Blood by Truman Capote is published; Comedian Lenny Bruce is found dead of a drug overdose in his Holywood, Calif. house on August 3; Television drama Star Trek begins; popular songs “Alice’s Restaurant”, “Monday, Monday”, and “Elenor Rigby” released; The Baltimore Orioles win the World Series by defeating the Los Angeles Dodgers 4 games to 0.
PTSD Worksheet

STARTING OFF

115 Letter or claims form mailed or filled out at the VA to start disability claim procedures on ____________.

116 First appointment at the VA on ____________.

117 Take to VA:
   a. All DD 214’s _______.
   b. Copy of VA Form 20-8332a (Disability Notification) (if received) _______.
   c. List of all medications you are currently taking _______.
   d. Completed VA Form 21-527 (Financial Statement) _______.
   e. Information on any other medical insurance _______.

118 If there is a VA counselor at the VA center, take:
   a. Completed VA Form 21-526 (if first time filing for disability) _______.
   b. VA Form 21-4138 (if upgrading an existing disability) _______.
   c. Have him request a copy of your “C” file from your regional office (Use FOIA if necessary) _______.
   d. Request a copy of any records you have at the facility you are being treated at if you have had any previous treatment ____________.

119 I received a confirmation that my disability claim was received by the Veterans Administration Regional Office (VARO) on _____________.

STRESS LETTER

120 I have begun gathering documentation for my stress letter.
   a. Name ___________________________ , phone # _____________ and organization _________________________________ of Veteran Service Officer (VSO).
   b. Appointments:
      1.
      2.
   c. Submitted DA Form 180 to NARC to obtain Personnel Records, including DA Form 20, on ____________ received on _____________.

72
d. Submitted request for Medical Records on ___________ and received on ___________.

e. Sent DA Form 20 to U.S. Armed Services Center for Research of Unit Records (USASCRUR) requesting supporting documents __________ and received on ____________.

121 Requested additional historical data from:

<table>
<thead>
<tr>
<th>Place</th>
<th>Date Requested</th>
<th>Received on</th>
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<td>1.</td>
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<tr>
<td>2.</td>
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</table>

122 Received initial request for Stress Letter from VA Adjudication officer at the local VA Regional Office (VARO) on ___________ and due back by (no later than 1 year) ___________.

--

123 Stress letter packet submitted to regional office on (copies Made) ___________

124 Letters received from Regional office saying claim still in process:

1.  
2.  

125 C & P Exam scheduled on ___________.

a. Call and ask your Psychologist/Psychiatrist to update your records prior to the interview date (make certain a “Diagnosis” of PTSD exists) ___________.

b. Request a copy of the medical records held at your local VA Clinic/Hospital prior to your C & P interview ___________ Received _____________.

c. Contact interviewer and ask if Stress letter will stand alone or if you must verbalize each traumatic event ____________.

d. Reviewed DSM and VA definition of PTSD ________.

e. Made notes of work, arrest, and marriage history ____.

126 Date of VARO hearing? _____________.

127 Claim awarded/denied _________ on _______ (if denied see appeals below).

Request a copy of your COMPLETE “C” file, if not provided after hearing ___________ Received ___________. (Do not request BEFORE hearing as this will show down the process)

APPEALS

128 Deadline to file Notice of Disagreement (NOD) (one year from date of denial)

__________ and date actually filed _____________.

129 Date VA mailed Statement of Case (SOC) __________.
130 Date VA mailed Supplemental SOC ____________.

131 Deadline to file VA Form 9 (60 days from date VA Mailed SOC or one year from date of VA Denial ____________ and date you mailed ____________.

132 Date to meet your Service Representative for pre-hearing discussion ____________.

133 Date ________________ and location of Board of Veterans Appeals (BVA) hearing ________________________.

134 BVA Appeal awarded/denied __________ on ________ and docket # ____________________.

135 Deadline to file Notice of Appeal (NOA) with U.S. Court of Veterans Appeals (CVA) ____________ (120 days from date of BVA decision).

136 Date appeal mailed ____________ and VCA Docket # ________________________.

MISCELLANIOUS

137 The nearest Vet Center is located at _________________________ and my counselors name is ___________________________ and phone # ____________________.

138 Name ____________________________Telephone ______________ of VA Psychiatrist.

139 Name ____________________________Telephone ______________ of VA Psychologist.

140 Telephone of VA center ________________.

141 Name ____________________________Telephone ______________ of VA Medical doctor:

142 Medications:

1. 

2. 

3.
THE FACES IN MY DREAMS

After thirty years I still see faces in my dreams,
some who never grew to be old men.
Most went off to war with honor and pride,
hoping their future they would win.

The images float by like specters,
I see some laughing while others cry.
Each one from a different background,
none thought they might be mangled or die.

I had hoped to put them all to rest,
I had hoped that time would make them fade.
But as the years slip by the more I remember,
the more of my dreams they do invade.

By I. S. Parrish
Chapter 7

Working With The Department of Veterans Affairs (VA)

Section I. GENERAL

07-01. General. You will find early on that working with the Department of Veterans Affairs (VA) is like dealing with any military or governmental organization; you will have to wait for almost everything, they never have enough money or staff, if they can lose your records they will. At some point in the application and treatment process you may become frustrated and angry over the apparent combative attitudes of individuals and the institution. You have two options; strike out verbally and/or physically thereby wasting time and energy or putting forth your best smile and saying thank you.

I feel the personnel working for the VA, with rare exception, are trying, within the framework of government regulations, to help the veterans they serve. Because you will be struggling with PTSD it will not always be easy. Sometimes you will have to ask the same question several times to several different people. Just keep asking, in a civil manner, and eventually you will get results. With these tactics in mind, and by following the suggestions in this manual, much of the frustration will be minimized if not eliminated. This chapter has information on facilities, first contact, and the claims and appeals process.

Section II. FACILITIES AND SERVICES

07-02. General. Oddly enough most veterans know very little about the VA or what the VA offers. It would take a separate book to describe all of the benefits available. I am doing my best to restrict my material to PTSD issues. If you have a general question contact your local facility, VA Representative, Service Organization (VFW, VVA, etc.) or dial 1-800-827-1000. If you have access to the Internet stop by the “Department of Veterans Affairs” home page (http://www.va.gov/) where you will find a complete printing of the 2001 Federal Benefits Guide for Veterans and Dependents.

What follows is a list of facilities, offices and organizations that offer assistance and care to veterans:

a. Veteran Service Organizations (VSO) - While these are not funded or controlled by the Department of Veteran Affairs, they still must be mandated to operate as a veterans organization. These are local organizations such as Veterans of Foreign Wars (VFW), “American Legion”, “Vietnam Veterans of America”, “Disabled American Veterans”, and many, many more. A complete list of this type of organization is provided in Appendix D. The reason I mention them here is that they offer assistance with the preparation and submission of Stress Letters and the Appeals process by means of “Service Representatives (SR)” or “Veteran Service Officers (VSO)”. Call your Department of Veterans Affairs Regional Offices (VRO) for a list of local VSO’s.

b. State Veterans Affairs Offices - These can be city, county, or state operated offices. Each office will provide slightly different services depending on staff and funding. You will normally find benefit counselors to assist you with home and educational loans, claims and appeals assistance and special programs provided by that particular state. The state of Texas, for instance, offers a special program to help veterans purchase land. These type offices to by many different names. If you look in your local phone book you may find “Veterans Commission”, “Department of State Veterans Affairs”, “Military and Veterans Office”, or “Division of Veterans Affairs”, to name a few. The key word here is “Veteran”.

c. Benefits Offices - A limited number of these type facilities have counselors available for assisting veterans with the preparation of claims and applications. Go to “www1.va.gov/directory/guide/home.asp” and look under the state and city to see if such an office is available in your area.

d. Department of Veterans Affairs Regional Offices (VRO) - These offices are part of the VA structure and process benefits claims and appeals. They also have counselors available for assisting with the preparation of claims and applications.

e. Vet Centers - Established in 1979 as part of the VA’s Vietnam Veterans Outreach Program, there are currently over 202 Centers and Satellites, with at least one in each state. These centers are staffed by social workers, psychologists and paraprofessionals. Originally mandated to assist only Vietnam veterans, now any era veteran may visit. Counseling is provided to help veterans resolve war-related psychological difficulties, including PTSD. Assistance includes community outreach, education, and individual and family counseling. There is no charge for these services and case coordination can be arranged with local VA hospitals and clinics.
(The “no charge” aspect may be important to you prior to receiving your service connected or disability if you are required to make “co-payments”). See Appendix G for a listing of these centers.

f. VA Clinics - These are outpatient facilities and will vary in size and capabilities by location. There is normally a pharmacy, mental health division, lab which can perform immunizations (free flu shots are normally administered) and blood tests, and medical staff to perform examinations and minor medical procedures. (see appendix G).

g. VA Hospitals - These are full service hospitals. Amongst other things they offer in/outpatient PTSD counseling and treatment. Several have residential rehabilitation programs which include up to 10 weeks of structured individual and group therapy. (see appendix G).

h. The National Center for PTSD - Established in 1989 by the VA has their Executive Division at the VA Medical Center (116D), White River Junction, Vermont 05009. In addition they have a Behavioral Science and Women’s Health Science Division in Boston, Massachusetts, a Clinical Neurosciences and Evaluation Division in West Haven, Connecticut, a Clinical Laboratory and Educational Division at Menlo Park, California, and a Pacific Islands Division at Honolulu, Hawaii.

Section III. INITIAL CONTACT

07-03. First Contact with the VA or Going Back After a While. It is important that you notify the VA as soon as you know that you are having a health problem. If you will be unable to get to the nearest VA Facility for some time, mail a brief statement saying that you are having trouble with your nerves (my advice is to send it registered). I have presented a short “Statement of Illness” letter in Chapter 10, Section III. This can be extremely important since any disability or service connected status you may eventually be awarded is based on the date you file with the VA concerning your problem. Under current regulations compensation begins on the first day of the month following the month of application.

If you have not been to a Department of Veterans Affairs Clinic or Hospital or if it has been a while since you last visited a VA facility a few things may have changed. Since the post Vietnam war money crunch the VA has gotten leaner and meaner. I can remember the changes just beginning to take place shortly after my retirement in 1985. You can also expect to be issued an VA ID card on your first visit.

07-04. Certain documents are required on your first visit. Call your local VA Hospital/Clinic or the 800 number provided above, to locate the nearest facility. Ask them to mail you any necessary paperwork prior to your first appointment. As a minimum you will need to take the following:

a. A copy of ALL of your DD 214’s. (See appendix K, Section VII, to order lost documents).
b. A copy of VA Form 20-8332a-1 (Disability Notification) if you were issued one by the VA.
c. A list of any medications you are currently taking.
d. VA Form 21-527 (Income, Net Worth, and Employment Statement). You may be exempt from filling out this form if you already have a disability. Ask. (see Chapter 10, Section V, for hints on filling out the Form). Use your previous years income tax papers and the taxable income amount. (You will be required to update this form annually until you receive a disability of at least 50%).
e. Information on any Medical insurance you or your spouse have. (see Appendix J (38 CFR), Billing Insurance Companies).

If there is a VA Benefits Counselor available at the Hospital/Clinic take along whichever Form below applies and you will save yourself a future trip:

a. VA Form 21-526 (Veterans Application for Compensation or Pension). This is for a first time filing. See chapter 10, Section IV, for instructions.
b. VA Form 21-4138 (Statement in Support of Claim). This is if you are trying to upgrade an existing disability or filing for the first time on a new disability but you have already filed a VA Form 21-526 in the past. See chapter 10, Section V, for instructions.

You will find a copy of VA Form 21-526 and 21-4138 in Appendix H of this manual.

Trust me on this. You are better off filling out these forms at home where you can locate the information needed at your leisure.

07-05. Who Has to Pay? If you go to the VA for anything other than service connected treatment you will have to make a co-payment unless your attributable income falls below a government defined "means test" threshold.

Effective with the 2008 “means test”, unless you are rated 50% service connected or receiving certain other VA payments, if you and your spouse are making in excess of $34,717 a year, you are going to pay. This is
the base figure and changes with number of dependents and authorized exemptions. If this really concerns you
have the VA employee who accepts your initial application explain the determination process.

If you are required to make co-payments and have CHAMPUS/TRICARE do not forget to file for
reimbursement just as you would with a civilian doctor. When you are awarded service-connected status and
apply for reimbursement from the VA these payments will need to be deducted.

The VA is very serious about the co-payment. You will be required to sign a statement saying you are
aware of the co-payments and expect to pay them or they can refuse you treatment.

The VA is also serious about the unnecessary breaking of appointments, (see Appendix I, 38 C.F.R.,
Refusal of Treatment by Unnecessarily Breaking Appointments) and can turn you away based on your "refusal
to accept VA treatment". You will find, however, that most VA facilities are a bit more tolerant of missed
appointments by PTSD patients as depression and anxiety can effect your memory. Always call if you have to
cancel an appointment or as soon as you realize you have missed an appointment.

07-06. Cost of Treatment. At this time a veteran is required to pay approximately $5 for each 30-day supply of
medication on an outpatient basis for treatment of a non-service-connected disability or condition. This is more
than fair since most medications are very costly. There is a charge of approximately $50.00 per daily visit. One
good thing is that you can fit as many appointments into one daily visit as possible and still only pay the one
charge.

Bear in mind that when you begin your treatment for PTSD it will not yet have been ruled service
connected so you can expect to make co-payments unless you fall below the income threshold or after starting
your treatment you are able to receive help at a local Vet Center, where there is no charge. However, if your
PTSD is eventually deemed service connected or you receive a percentage disability (discussed later in this
chapter), you will receive reimbursement for any expenses incurred for treatment of PTSD from the date you
filed your claim and maybe even back to when you were discharged from the military. You must APPLY for
this reimbursement by taking or mailing a copy of your disability letter to the Treasurer you have been making
payments to.

Section IV. FILING AN APPLICATION FOR DISABILITY

07-07. Eligibility. You are entitled to VA disability compensation for any medical condition or injury that was
incurred in or aggravated by your military service assuming you were released form active military duty with an
other than dishonorable discharge. There is no time limit to apply for VA disability but doing so within the first
year after discharge will work to your advantage. (http://www.va.gov/benefits/comp.htm).

07-08. Should you Apply For A PTSD Disability? If you can prove your case you could receive a disability
check of $298 per month ($334 with one dependent, as of Dec 2000), tax free. If you receive a retirement check
the taxable amount will be reduced by that amount. This figure is based on a 30% disability.

However, before you apply for a disability because of PTSD several things must already have happened:

   a. You fit the VA definition of having PTSD (see chapter 1 of this manual) and
   b. You fit the definition as found in the Diagnostic and Statistical Manual of Mental Disorders, 4th
edition (DSM-IV), found in chapter 1 of this manual.
   c. You have been diagnosed with and are being treated for PTSD.

07-09. Initial or Upgrade to disability? If you are uncertain as to whether you are filing an initial or upgrade to
a disability call, or have your Representative call, 1-800-827-1000 for verification.

   Something worth mentioning here that I was not aware of. Even though the military may discharge you
with a 50% disability, the VA will not pay you for that disability until a C & P (Compensation and Pension -
explained below) evaluation is performed by the VA. These disabilities will be considered service-connected by
the VA but monetary compensation is not authorized until after the VA says you have a disability.

07-10. Filing an Initial Application for Disability. The determination of whether PTSD, or any other disability
you file for, may have been "service-connected" is made by the C & P Service - an arm of VA’s Veterans
Benefits Administration.
As stated above, if you have never filed for a disability you will need to fill out and file a VA Form 21-526, Veterans Application for Compensation or Pension. Prepare yourself as this sucker is 21 pages long. The good news is that 7 of those pages are instructions. If you retired from any branch of service you normally would have filled out one of these forms during out-processing but may never have received a copy of the evaluation. You might call the “800” number and see if there is already one on file.

07-11. Filing to Upgrade your current disability because of PTSD. As stated above, if you have filed a previous claim for a disability, of ANY kind, you will need to fill out and file a VA Form 21-4138, Statement in Support of Claim.

Section V. VA CLAIMS PROCESS IN GENERAL

07-12. Development Guide For C & P (Compensation and Pension) Benefits. In 1995 a work group made up of Veteran Administration Regional Office (VARO) representatives from around the country, in conjunction with the VA C & P Training department, formulated a “Development Guide” at the VACO in Washington, DC. The completed document is some 50 pages long and provides VA claims processing personnel a standardized claims processing technique. Below I have provided excerpts from that “Development Guide” so you can see approximately how your claim is handled at the VA Regional Office.

“THE CLAIMS PROCESS: QUESTIONS FOR EVERY CASE

1. What is the issue?
2. Under which laws/regulations can we establish entitlement?
3. What do the facts have to demonstrate to establish entitlement?
4. What evidence do I need to establish the facts?

REMINDEERS

NO SPECIFIC ISSUE = NO CLAIM = NO END PRODUCT
INCOMPLETE CLAIM = INFORMAL CLAIM

A. The Four Stages of the Claims Process

1. Issue(s) to be Decided

Well-grounded, plausible claim?

If so, we have a duty to assist.

2. Development of Facts

What evidence is necessary to resolve the issue(s)?

What evidence is of record?

Develop for all additional evidence necessary to resolve the issue(s).

3. Decision - The Application of Facts & Law

a. Facts - Derived from Step 2 and development.

b. Law

(1) Title 38 USC

(2) Regulations - 38 CFR
(3) Precedent Decisions

(4) COVA

(5) GC Opinions

4. Notification (38 USC 5104)

Authors note: I will not be getting into the “Law” area from 3(b) above. However, 38 CFR and Title 38 USC is defined in Appendix B.

B. Basic Development Process

Review application for completeness, information identifying the veteran, and claimant's signature.

List all claimed conditions and identify type of claim (original, reopened, increase, pension, etc.).

Verify correctness of End Product.

Determine if potential eligibility based on service exists for benefit claimed.

If pension is claimed, review income and dependency first and determine eligibility.

If service, income, and dependency appear to be complete, continue development.

Service Development

Develop for anything needed from military service department (service verification, SMRs, personnel file).

A. Background

A decision to establish service connection is in order if the facts, shown by the evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or, if preexisting such service, was aggravated while in service.

The development of evidence to support a determination of service connection may include four elements:

1. Service Medical Records
2. Continuity - evidence of ongoing treatment from military service to present.
3. First treatment - evidence to show the first treatment for the claimed disability following service.
4. Recent treatment - evidence to show recent treatment and current severity for the claimed condition. In many cases this will be a VA examination.
5. In the case of preexisting conditions, request treatment prior to service.

Service Medical Records (SMR)

In all cases you will need SMRs.

Direct Service Connection

A disability determined to be service-connected due to service or aggravated by service. It is either shown in the SMR treatment record, or on discharge exam. VA exam may be requested to establish current level of disability or residual of an acute disease or injury.

Direct service connection may also be established for a condition which existed prior to entry into service (EPTE) and was aggravated beyond its natural progression during the veteran's period of service. (38 CFR 3.304 and 3.305)"

C. Developing Re-opened Service Connected Claims (EP 020 series)
1. Condition previously denied service connection:

With the exception of reopened PTSD claims, if the veteran does not submit new and material evidence to reopen claim, inform veteran that claim was previously disallowed, the date of the disallowance and the reasons for disallowance. Veteran should be informed he must submit new and material evidence to reopen claim. He should be given 60 days to submit the new and material evidence. The claim should be kept under end product control.

D. SPECIFIC CLAIMS ISSUES

5. Post Traumatic Stress Disorder (PTSD):

Do not request Treatment Since Service (continuity). If the veteran received any of the following awards/decorations, development to the veteran to establish a stressor is not required.

- Combat Infantry Badge
- Marine Corps Expeditionary Medal
- Purple Heart
- Navy, Expeditionary Medal
- Medal of Honor Air Medal (with "V" for Valor)
- Distinguished Service Cross
- Combat Action Ribbon
- Navy Cross
- Combat Medical Badge
- Air Force Cross
- Distinguished Flying Cross
- Silver Star
- Bronze Star (with "V" for Valor)
- Navy Cross
- Combat Medical Badge
- Air Force Cross
- Distinguished Flying Cross
- Silver Star
- Bronze Star (with "V" for Valor)
- Air Force Commendation Medal (with "V" for valor)
- Navy Commendation Medal (with "V" for valor)
- Parachutist Badge with Bronze Service Star
- Joint Service Commendation Medal (with "V" for valor)
- Army Commendation Medal (with "V" for valor)
- Navy Commendation Medal (with "V" for valor)

Authors note: A more detailed definition of each award and device can be found in the “Guide for Submission of PTSD Research Requests” maintained by local Veteran Service Representatives (the copy of the “Guide” I present in appendix K omits these definitions).

If the veteran does not have one of the above decorations or if he does not have a combat military occupational specialty (MOS), and the claim is for a combat related event, send development letter to the veteran and request the veteran's Personnel file/201 file from the Service Department. To aid in the securing of information to support the claim, the "Information in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (PTSD)" (copy follows) should be attached to the development letter sent to the veteran. If the claim is for a non-combat related event, send development letter to the veteran and request the veteran's Personnel file/201 file from the Service Department. To aid in the securing of information to support the claim, the "Information in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (PTSD)" (copy follows) should be attached to the development letter sent to the veteran. Only when available evidence is insufficient to establish a stressor should a letter be sent to Environmental Support Group (ESG) to verify the stressor.

Authors note: The Environmental Support Group (ESG) has been renamed and is now the “U.S. Armed Services Center for Research of Unit Records” (USASCRUR) which is mentioned in chapter 8 of this manual and is a key player in your PTSD disability claim process.

VA medical facility personnel have been asked to include a completed "Evidence Necessary for ESG Verification of Stressor" (copy follows) when preparing a VA examination report for PTSD. A copy of this document should also be attached to the letter to ESG.

Information in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (PTSD)

Evidence Necessary for ESG Verification of Stressor

The goal of an Environmental Support Group (ESG) search is verification of the claimed stressor for PTSD. The stressor is defined in the DSM-III-R, p. 250: "...an event that is outside the range of usual human experience that would be marked distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relative or friends; sudden destruction of one's home or community; seeing another person who has recently been or is being, seriously injured or killed as a result of an accident or physical violence." This covers not only traditional combat situation stressors, but also war zone related experiences such as serving in MASH units, graves registration units; or being a survivor of a sexual assault while on active duty.
Provide the information necessary to begin an ESG search for stressor verification as described in the Mental Health & Behavioral Sciences Manual: M-2, Part X, Chapter 2, June 29, 1993, page 2-6, f. (2) (a)-(d) outlining the "clear and concretely detailed description of the stressor(s)".

(End of Development Guide For C & P)

Authors note: Also see appendix I (Manual M-2), PTSD Examination.

As you can see from the above, certain guidelines are followed and definite information and material is required in order for the VA to successfully process a disability claim. If you are unable to provide supporting documents to your claim or if the required material cannot be found or verified by USASCRUR your claim is not likely to be approved.

Specific details as relates to a PTSD C&P will be covered later in this chapter.

The “bible” used by the VARO is called the “VA Adjudication Manual M21-1”. I was not able to get a copy for my research.

Section VI. ADDITIONAL INFORMATION

07-13. Ask The VA For Help. The VA is Required by Veterans Claims Assistance Act of 2000 to assist you with "developing the facts" in the filing of your claim to include the seeking of documents from other federal agencies to support your claim. This Act again allows the VA to assist veterans with the development of their claim, superseding the decision of the Court of Appeals for Veterans Claims in Morton vs. West.

Key parts of the Act are as follows:

SEC. 3. ASSISTANCE TO CLAIMANTS.

(a) Reaffirmation and Clarification of Duty To Assist.--Chapter 51 of title 38, United States Code, is further amended by striking sections 5102 and 5103 and inserting the following:

``Sec. 5102. Application forms furnished upon request; notice to claimants of incomplete applications

``(a) Furnishing Forms.--Upon request made by any person claiming or applying for, or expressing an intent to claim or apply for, a benefit under the laws administered by the Secretary, the Secretary shall furnish such person, free of all expense, all instructions and forms necessary to apply for that benefit.

``(b) Incomplete Applications.--If a claimant's application for a benefit under the laws administered by the Secretary is incomplete, the Secretary shall notify the claimant and the claimant's representative, if any, of the information necessary to complete the application.

``Sec. 5103. Notice to claimants of required information and evidence

``(a) Required Information and Evidence.--Upon receipt of a complete or substantially complete application, the Secretary shall notify the claimant and the claimant's representative, if any, of any information, and any medical or lay evidence, not previously provided to the Secretary that is necessary to substantiate the claim. As part of that notice, the Secretary shall indicate which portion of that information and evidence, if any, is to be provided by the claimant and which portion, if any, the Secretary, in accordance with section 5103A of this title and any other applicable provisions of law, will attempt to obtain on behalf of the claimant.

``(b) Time Limitation.--(1) In the case of information or evidence

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that the claimant is notified under subsection (a) is to be provided by
the claimant, if such information or evidence is not received by the
Secretary within 1 year from the date of such notification, no benefit
may be paid or furnished by reason of the claimant's application.
``(2) This subsection shall not apply to any application or claim
for Government life insurance benefits.

``Sec. 5103A. Duty to assist claimants

``(a) Duty To Assist.--(1) The Secretary shall make reasonable
efforts to assist a claimant in obtaining evidence necessary to
substantiate the claimant's claim for a benefit under a law administered
by the Secretary.
``(2) The Secretary is not required to provide assistance to a
claimant under this section if no reasonable possibility exists that
such assistance would aid in substantiating the claim.
``(3) The Secretary may defer providing assistance under this
section pending the submission by the claimant of essential information
missing from the claimant's application.
``(b) Assistance in Obtaining Records.--(1) As part of the
assistance provided under subsection (a), the Secretary shall make
reasonable efforts to obtain relevant records (including private
records) that the claimant adequately identifies to the Secretary and
authorizes the Secretary to obtain.
``(2) Whenever the Secretary, after making such reasonable efforts,
is unable to obtain all of the relevant records sought, the Secretary
shall notify the claimant that the Secretary is unable to obtain records
with respect to the claim. Such a notification shall--
``(A) identify the records the Secretary is unable to
obtain;
``(B) briefly explain the efforts that the Secretary made to
obtain those records; and
``(C) describe any further action to be taken by the
Secretary with respect to the claim.
``(3) Whenever the Secretary attempts to obtain records from a
Federal department or agency under this subsection or subsection (c),
the efforts to obtain those records shall continue until the records are
obtained unless it is reasonably certain that such records do not exist
or that further efforts to obtain those records would be futile.
``(c) Obtaining Records for Compensation Claims.--In the case of a
claim for disability compensation, the assistance provided by the
Secretary under subsection (b) shall include obtaining the following
records if relevant to the claim:
``(1) The claimant's service medical records and, if the
claimant has furnished the Secretary information sufficient to
locate such records, other relevant records pertaining to the
claimant's active military, naval, or air service that are held
or maintained by a governmental entity.
``(2) Records of relevant medical treatment or examination
of the claimant at Department health-care facilities or at the

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expense of the Department, if the claimant furnishes information
sufficient to locate those records.
``(3) Any other relevant records held by any Federal
department or agency that the claimant adequately identifies and
authorizes the Secretary to obtain.
``(d) Medical Examinations for Compensation Claims.--(1) In the case

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of a claim for disability compensation, the assistance provided by the Secretary under subsection (a) shall include providing a medical examination or obtaining a medical opinion when such an examination or opinion is necessary to make a decision on the claim.

"(2) The Secretary shall treat an examination or opinion as being necessary to make a decision on a claim for purposes of paragraph (1) if the evidence of record before the Secretary, taking into consideration all information and lay or medical evidence (including statements of the claimant)--

"(A) contains competent evidence that the claimant has a current disability, or persistent or recurrent symptoms of disability; and
"(B) indicates that the disability or symptoms may be associated with the claimant's active military, naval, or air service; but
"(C) does not contain sufficient medical evidence for the Secretary to make a decision on the claim.

"(e) Regulations.--The Secretary shall prescribe regulations to carry out this section.

"(f) Rule With Respect to Disallowed Claims.--Nothing in this section shall be construed to require the Secretary to reopen a claim that has been disallowed except when new and material evidence is presented or secured, as described in section 5108 of this title.

"(g) Other Assistance Not Precluded.--Nothing in this section shall be construed as precluding the Secretary from providing such other assistance under subsection (a) to a claimant in substantiating a claim as the Secretary considers appropriate."

(b) Reenactment of Rule for Claimant's Lacking a Mailing Address.--Chapter 51 of such title is further amended by adding at the end the following new section:

"Sec. 5126. Benefits not to be denied based on lack of mailing address

"Benefits under laws administered by the Secretary may not be denied a claimant on the basis that the claimant does not have a mailing address."

SEC. 4. DECISION ON CLAIM.

Section 5107 of title 38, United States Code, is amended to read as follows:

"Sec. 5107. Claimant responsibility; benefit of the doubt

"(a) Claimant Responsibility.--Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under laws administered by the Secretary.

"(b) Benefit of the Doubt.--The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance

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of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant."

(END OF "THE ACT")
You can help yourself by locating supporting material in any of the other sources of information listed in this manual, and providing them with everything you know about the event involved. Provide them with the name and address of that source. Some VSO’s recommend you quote the above 38 CFR section in your letter but I am certain USASCRUR is aware of the regulation.

Section VII. New VA On Line (VONAPP) benefits filing process.

07-14. VONAPP. A new program "Veterans On Line Applications", or VONAPP for short, is now available if you are applying for compensation, pension, and vocational rehabilitation benefits.

On the new page, found at VONAPP at http://vabenefits.vba.va.gov/vonapp/default.asp, it says:

"The VONAPP (Veterans On Line Applications) website is an official Department of Veterans Affairs (VA) website designed so U.S. military veterans and some service members within six months of separation or retirement can apply for compensation, pension, and vocational rehabilitation benefits through the Internet. This is a first step towards an electronic VA. VONAPP will allow veterans, and in the future, dependents and other VA claimants, electronic access to file applications with us on-line.

You have available:
VA 21-526, Veteran’s Application for Compensation and/or Pension, and VA Form 28-1900, Disabled Veterans Application for Vocational Rehabilitation. We plan to add more forms as fast as we can."

The forms can be downloaded in "PDF" format, printed and mailed to the VA or you can also file the form on line by going to the VONAPP home page and then clicking on the "Start VONAPP" button. For some reason the process requires you to use a LOGIN and PASSWORD to start the on line application.

Fee Based Medical Care

Your doctor must first recommend you for fee based medical care and then submit paperwork to that effect. In remote areas like I currently live in it can mean the difference between medication updates and treatment. You will still need to speak to a VA doctor at some point to renew your meds.

Authors Note: The VA clinic I have been receiving treatment from for the last eight years has been without a psychiatrist for about seven of those years. I have been “Treated” for those seven by a contract RN in another city.

38 USC Sec. 1703. Contracts for hospital care and medical services in non-Department facilities

- (a) When Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Secretary, as authorized in section 1710 of this title, may contract with non-Department facilities in order to furnish any of the following:
  - (1) Hospital care or medical services to a veteran for the treatment of -
    - (A) a service-connected disability;
    - (B) a disability for which a veteran was discharged or released from the active military, naval, or air service; or
    - (C) a disability of a veteran who has a total disability permanent in nature from a service-connected disability.
  - (2) Medical services for the treatment of any disability of -
    - (A) a veteran described in section 1710(a)(1)(B) of this title;
    - (B) a veteran who (i) has been furnished hospital care, nursing home care, domiciliary care, or medical services, and
(ii) requires medical services to complete treatment incident to such care or services; or

- (C) a veteran described in section 1710(a)(2)(E) of this title, or a veteran who is in receipt of increased pension, or additional compensation or allowances based on the need of regular aid and attendance or by reason of being permanently housebound (or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance), if the Secretary has determined, based on an examination by a physician employed by the Department (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in Department facilities.

- (3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a Department facility or nursing home care under section 1720 of this title until such time following the furnishing of care in the non-Department facility as the veteran can be safely transferred to a Department facility.

- (4) Hospital care for women veterans.

- (5) Hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State (other than the Commonwealth of Puerto Rico) not contiguous to the contiguous States, except that the annually determined hospital patient load and incidence of the furnishing of medical services to veterans hospitalized or treated at the expense of the Department in Government and non-Department facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the furnishing of medical services for veterans hospitalized or treated by the Department within the 48 contiguous States and the Commonwealth of Puerto Rico.

- (6) Diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, furnishing medical services at independent Department out-patient clinics to obviate the need for hospital admission.

- (7) Outpatient dental services and treatment, and related dental appliances, for a veteran described in section 1712(a)(1)(F) of this title.

- (8) Diagnostic services (on an inpatient or outpatient basis) for observation or examination of a person to determine eligibility for a benefit or service under laws administered by the Secretary.

- (b) In the case of any veteran for whom the Secretary contracts to furnish care or services in a non-Department facility pursuant to a provision of subsection (a) of this section, the Secretary shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.

- (c) The Secretary shall include in the budget documents which the Secretary submits to Congress for any fiscal year a detailed report on the furnishing of contract care and services during the most recently completed fiscal year under this section, sections 1712A, 1720, 1720A, 1724, and 1732 of this title, and section 115 of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 501).

38 USC Sec. 1710. Eligibility for hospital, nursing home, and domiciliary care

- (a)
(1) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and may furnish nursing home care, which the Secretary determines to be needed -
   - (A) to any veteran for a service-connected disability; and
   - (B) to any veteran who has a service-connected disability rated at 50 percent or more.

(2) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and may furnish nursing home care, which the Secretary determines to be needed to any veteran -
   - (A) who has a compensable service-connected disability rated less than 50 percent;
   - (B) whose discharge or release from active military, naval, or air service was for a disability that was incurred or aggravated in the line of duty;
   - (C) who is in receipt of, or who, but for a suspension pursuant to section 1151 of this title (or both a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section;
   - (D) who is a former prisoner of war;
   - (E) who is a veteran of the Mexican border period or of World War I;
   - (F) who was exposed to a toxic substance, radiation, or other conditions, as provided in subsection (e); or
   - (G) who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title.

(3) In the case of a veteran who is not described in paragraphs (1) and (2), the Secretary may, to the extent resources and facilities are available and subject to the provisions of subsections (f) and (g), furnish hospital care, medical services, and nursing home care which the Secretary determines to be needed.

(4) The requirement in paragraphs (1) and (2) that the Secretary furnish hospital care and medical services shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations Acts for such purposes.

(b) The Secretary may furnish to a veteran described in paragraph (2) of this subsection such domiciliary care as the Secretary determines is needed for the purpose of the furnishing of medical services to the veteran.

(2) This subsection applies in the case of the following veterans:
   - (A) Any veteran whose annual income (as determined under section 1503 of this title) does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension under section 1521(d) of this title.
   - (B) Any veteran who the Secretary determines has no adequate means of support.

(c) While any veteran is receiving hospital care or nursing home care in any Department facility, the Secretary may, within the limits of Department facilities, furnish medical services to correct or treat any non-service-connected disability of such veteran, in addition to treatment incident to the disability for which such veteran is hospitalized, if the veteran is willing, and the Secretary finds such services to be reasonably necessary to protect the health of such veteran. The Secretary may furnish dental services and treatment, and related dental appliances, under this subsection for a non-service-connected dental condition or disability of a veteran only (1) to the extent that the Secretary determines that the dental facilities of the Department to be used to furnish such services, treatment, or appliances are not needed to furnish services, treatment, or appliances for dental conditions or disabilities described in section 1712(a) of this title, or (2) if (A) such non-service-connected dental condition or disability is associated with or aggravating a disability for which such veteran is receiving hospital care, or (B) a compelling medical reason or a dental emergency requires furnishing dental services, treatment, or appliances.
(excluding the furnishing of such services, treatment, or appliances of a routine nature) to such veteran during the period of hospitalization under this section.

- (d) In no case may nursing home care be furnished in a hospital not under the direct jurisdiction of the Secretary except as provided in section 1720 of this title.

- (e) (1) (A) A Vietnam-era herbicide-exposed veteran is eligible (subject to paragraph (2)) for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such exposure.

(B) A radiation-exposed veteran is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disease suffered by the veteran that is -

(i) a disease listed in section 1112(c)(2) of this title; or

(ii) any other disease for which the Secretary, based on the advice of the Advisory Committee on Environmental Hazards, determines that there is credible evidence of a positive association between occurrence of the disease in humans and exposure to ionizing radiation.

(C) Subject to paragraphs (2) and (3) of this subsection, a veteran who served on active duty in the Southwest Asia theater of operations during the Persian Gulf War is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any disability, notwithstanding that there is insufficient medical evidence to conclude that such disability may be associated with such service.

(D) Subject to paragraphs (2) and (3), a veteran who served on active duty in a theater of combat operations (as determined by the Secretary in consultation with the Secretary of Defense) during a period of war after the Persian Gulf War, or in combat against a hostile force during a period of hostilities (as defined in section 1712A(a)(2)(B) of this title) after the date of the enactment of this subparagraph, is eligible for hospital care, medical services, and nursing home care under subsection (a)(2)(F) for any illness, notwithstanding that there is insufficient medical evidence to conclude that such condition is attributable to such service.

(2) In the case of a veteran described in paragraph (1)(A), hospital care, medical services, and nursing home care may not be provided under subsection (a)(2)(F) with respect to -

(i) a disability that is found, in accordance with guidelines issued by the Under Secretary for Health, to have resulted from a cause other than an exposure described in paragraph (4)(A)(ii); or

(ii) a disease for which the National Academy of Sciences, in a report issued in accordance with section 3 of the Agent Orange Act of 1991, has determined that there is limited or suggestive evidence of the lack of a positive association between occurrence of the disease in humans and exposure to a herbicide agent.

(3) Hospital care, medical services, and nursing home care may not be provided under or by virtue of subsection (a)(2)(F) -

(A) in the case of a veteran described in paragraph (1)(A), after December 31, 2002;

(B) in the case of a veteran described in paragraph (1)(C), after December 31, 2001; and

(C) in the case of a veteran described in paragraph (1)(D), after a period of 2 years beginning on the date of the
veteran's discharge or release from active military, naval, or air service.

(4) For purposes of this subsection -

(A) The term "Vietnam-era herbicide-exposed veteran" means a veteran (i) who served on active duty in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, and (ii) who the Secretary finds may have been exposed during such service to dioxin or was exposed during such service to a toxic substance found in a herbicide or defoliant used for military purposes during such period.

(B) The term "radiation-exposed veteran" has the meaning given that term in section 1112(c)(3) of this title.

(5) When the Secretary first provides care for veterans using the authority provided in paragraph (1)(D), the Secretary shall establish a system for collection and analysis of information on the general health status and health care utilization patterns of veterans receiving care under that paragraph. Not later than 18 months after first providing care under such authority, the Secretary shall submit to Congress a report on the experience under that authority. The Secretary shall include in the report any recommendations of the Secretary for extension of that authority.

(f) (1) The Secretary may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care under subsection (a)(3) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) of this subsection.

(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to -

(A) the lesser of -

(i) the cost of furnishing such care, as determined by the Secretary; or

(ii) the amount determined under paragraph (3) of this subsection; and

(B) before September 30, 2002, an amount equal to $10 for every day the veteran receives hospital care and $5 for every day the veteran receives nursing home care.

(3) (A) In the case of hospital care furnished during any 365-day period, the amount referred to in paragraph (2)(A)(ii) of this subsection is -

(i) the amount of the inpatient Medicare deductible, plus

(ii) one-half of such amount for each 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period.

(B) In the case of nursing home care furnished during any 365-day period, the amount referred to in paragraph (2)(A)(ii) of this subsection is the amount of the inpatient Medicare deductible for each 90 days of such care (or fraction thereof) during such 365-day period.

(C) (i) Except as provided in clause (ii) of this subparagraph, in the case of a veteran who is admitted for nursing home care under this section after being furnished, during the preceding 365-day period, hospital care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of hospital care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such nursing home care until -

(i) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or
(II) the end of the 365-day period applicable to the hospital care for which payment was made, whichever occurs first.

(i) In the case of a veteran who is admitted for nursing home care under this section after being furnished, during any 365-day period, hospital care for which the veteran has paid an amount under subparagraph (A)(ii) of this paragraph and who has not been furnished 90 days of hospital care in connection with such payment, the amount of the liability of the veteran under paragraph (2) of this subsection with respect to the number of days of such nursing home care which, when added to the number of days of such hospital care, is 90 or less, is the difference between the inpatient Medicare deductible and the amount paid under such subparagraph until -

(I) the veteran has been furnished, beginning with the first day of such hospital care furnished in connection with such payment, a total of 90 days of hospital care and nursing home care; or

(II) the end of the 365-day period applicable to the hospital care for which payment was made, whichever occurs first.

(D) In the case of a veteran who is admitted for hospital care under this section after having been furnished, during the preceding 365-day period, nursing home care for which the veteran has paid the amount of the inpatient Medicare deductible under this subsection and who has not been furnished 90 days of nursing home care in connection with such payment, the veteran shall not incur any liability under paragraph (2) of this subsection with respect to such hospital care until -

(i) the veteran has been furnished, beginning with the first day of such nursing home care furnished in connection with such payment, a total of 90 days of nursing home care and hospital care; or

(ii) the end of the 365-day period applicable to the nursing home care for which payment was made, whichever occurs first.

(E) A veteran may not be required to make a payment under this subsection for hospital care or nursing home care furnished under this section during any 90-day period in which the veteran is furnished medical services under paragraph (3) of subsection (a) to the extent that such payment would cause the total amount paid by the veteran under this subsection for hospital care and nursing home care furnished during that period and under subsection (g) for medical services furnished during that period to exceed the amount of the inpatient Medicare deductible in effect on the first day of such period.

(F) A veteran may not be required to make a payment under this subsection or subsection (g) for any days of care in excess of 360 days of care during any 365-calendar-day period.

(4) For the purposes of this subsection, the term "inpatient Medicare deductible" means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) on the first day of the 365-day period applicable under paragraph (3) of this subsection.

(g) The Secretary may not furnish medical services under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of subsection (a)(3) of this section unless the veteran agrees to pay to the United States the amount determined under paragraph (2) of this subsection.

(1) A veteran who is furnished medical services under subsection (a) of this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such services shall be liable to the United States, in the case of each visit in which such services are furnished to the veteran, for an amount equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpatient visit in a Department facility. Such estimated average cost shall be determined by the Secretary.
This subsection does not apply with respect to home health services under section 1717 of this title to the extent that such services are for improvements and structural alterations.

(h) Nothing in this section requires the Secretary to furnish care to a veteran to whom another agency of Federal, State, or local government has a duty under law to provide care in an institution of such government.

07-15. Unemployability. Somewhere along the line, usually when you are awarded at least a 30% disability, the VA will ask you if you are able to find employment. The question actually serves three purposes. They often work with local employment offices that assist veterans find work, you may qualify for rehabilitation training, or you may qualify for an award by the VA of Total and Permanent Unemployability.

A problem here is that unless you have at least a 70% combined rating they are not required by regulation, see below, to consider you. However, an award of unemployability automatically bumps you up to 100% disabled for pay purposes even if your physical disability is less than 100%.

CFR 38 CFR 4.16 states:

“(a) Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities: Provided That, if there is only one such disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more…..(b) It is the established policy of the Department of Veterans Affairs that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled. Therefore, rating boards should submit to the Director, Compensation and Pension Service, for extra-schedular consideration all cases of veterans who are unemployable by reason of service-connected disabilities, but who fail to meet the percentage standards set forth in paragraph (a) of this section. The rating board will include a full statement as to the veteran's service-connected disabilities, employment history, educational and vocational attainment and all other factors having a bearing on the issue.”

Even though the above regulation says that you may be awarded unemployability with less than a 70% disability for a single rating unless you have VERY SPECIAL circumstances, this is probably not going to happen. This does not prohibit you from pointing out this portion of the CFR to the VA and asking them to explain why you WOULD NOT qualify.

If you are awarded service-connection for PTSD and you are unemployed or having a difficult time staying employed submit a VA Form 21-8940 (Veteran’s Application for Increased Compensation Based on Unemployability) at your earliest convenience. In addition to filling out the Form 21-8940 you will probably be asked about your most recent employment, to provide the VA with signed copies of Form 21-4142 (Authorization for Release of Information) and to attend a C & P for further evaluation.

See chapter 10 for pointers on filling out the Form 21-8940.

By the way, when and if you achieve the 70% disability mark for PTSD the VA will normally award you Total and Permanent Disability for Unemployability at that time. If not be certain to apply for it.

07-16. What percentage, if any, of disability can you expect? If your Stress Letter is incomplete or lacking supporting documentation, your Doctor does not diagnose you with PTSD and/or your C & P interview does not support your claim, you can expect a reduced or no disability at all.

As my VA psychologist explained it the percentage of PTSD disability awarded to an individual is based on the degree of problems that individual experiences in the Work and Social arenas (see Appendix J (38 CFR), Evaluation of Psychiatric Disability). For example if you are constantly being fired, moving from job to
job, having problems with your bosses, are divorced, have no friends, and engage in no outside activities you have a good chance of getting a 30% or more disability. See Appendix J (38 CFR), Social in-adaptability, for the book definition.

A VA rating board determines your degree of disability using the "General Rating Formula" (see Appendix J (38 CFR)).

I will take a moment here to explain how the VA awards multiple disability percentages. If you already have a 30% disability for a bad back and you are awarded 30% for PTSD this does not mean you now have a 60% disability. The VA subtracts the larger disability amount, 30 %, from 100% which gives your 70%. Now, for the second rated condition the VA starts at 70% and multiplies by the second 30% which is 21%, added to the 30% you already have equals 51%, rounded down to 50%. This process continues for additional disabilities, always starting with your last disability rating.

07-16. You may have to wait more than a year for a determination. Several vets in one of the groups I attend have been trying to get their disability for 3 years, some longer. It took 1 year and one week for me to received my disability determination. This is the main reason you will want to provide as much information as you can on your initial or upgrade application for disability. However, you can appeal and I have covered that process at the end of the “Sequence of Events”, below.

Section VII. SEQUENCE OF EVENTS

07-17. What is About To Take Place? I found out that there is a fairly predictable sequence of events. Before you even begin this process I advise you to re-read chapter 1 to make certain you actually have PTSD, as defined by the civilian and military agencies. Many of you will find, as I did, that you have been experiencing symptoms of PTSD for many years without knowing what the problem was, or that a problem existed at all. I am not recommending that every vet with a troubled life claim PTSD as the cause of his or her problems. I am recommending that you get help before your mental condition forces you to. Brace yourself for the following:

a. Report to the VA for your first interview with a psychiatrist. For some of you, as with myself, this will not be a choice. Re-read this chapter so you will be aware of what to expect and so you will have the necessary documents with you, if this will be your first visit.

Authors note: Some VA Regional offices may REQUIRED that you first be diagnosed with PTSD by a psychiatrist and take either the Millon Clinical Multiaxial Inventory (MCMI-2) or Minnesota Multiphasic Personality Inventory (MMPI-2) before you can apply for a PTSD disability.

b. Submit VA Form 21-526 (Veterans Application For Compensation or Pension) or VA Form 21-4138 (Statement In Support of Claim). If you have never filed a claim you must submit a VA Form 21-526. Anytime there after you will submit a VA Form 21-4138) .As stated previously a VA benefits counselor will normally be located in the VA clinic or hospital. You can also contact one of the authorized Veteran Service Organizations (see Appendix D) for assistance. Review the portion of chapter 10 that spells out what should be included on these forms. If nothing else, submit a Statement of Illness, see chapter 10, Section III.

Authors note: Approximately 10 weeks after I submitted my Form 21-4138 I received the following form letter:

(My name and address)

We are still processing your application for COMPENSATION. We apologize for the delay. You will be notified upon completion of processing. If you need to contact us, be sure to show the file number and full name of the veteran.

If your mailing address is different than that shown above [since this process can take more than a year, it is possible you may have moved], please advise us of your new mailing address. You should notify us immediately of any changes in your mailing address.

IF YOU RESIDE IN THE CONTINENTAL UNITED STATES, ALASKA, HAWAII OR PUERTO RICO, YOU MAY CONTACT THE VA WITH QUESTIONS AND RECEIVE FREE HELP BY
CALLING OUR TOLL-FREE NUMBER 1-800-827-1000 (FOR HEARING IMPAIRED TDD 1-800-829-4833).

Signed by Adjudication Officer

[all caps above are in the original letter]

(End of Letter)

Based on my personal experience the VA will send you the above, or a similar letter, approximately every 60 days until your claim is resolved.

c. Begin a treatment program and start on your Stress letter. In addition to the VA Hospitals and clinics around the country there are over 200 VA Readjustment Counseling Service Centers (see Appendix G) that almost certainly have a PTSD program as well as employment assistance and marital counseling. As pointed out in chapter 3 each VA facility will approach treatment of PTSD from a different angle. I know this seems odd but you must take into account the backgrounds and beliefs of the individual psychologists and psychiatrists assigned to each facility. Even the resident programs in the larger hospitals will differ, for this same reason. This stage will be required, unless you are already under treatment in a civilian facility, in order to receive your eventual PTSD interview.

d. Return The Stress Letter. Approximately three weeks after I filed the Form 21-4138 I received the following form letter:

Dear Mr. Parrish:

We need the following evidence to process your claim for service connection for post-traumatic stress disorder.

A complete detailed description of the specific traumatic incident(s) which produced the stress that resulted in your claimed post-traumatic stress disorder, including dates and places the incident(s) occurred, and the unit (division, regiment, battalion, company) to which you were assigned or attached at the time. If the incidents(s) involved the death of one or more friends, furnish their names.

Reports from private physicians, if any, who have treated you for this condition since discharge. The reports should include clinical findings and diagnosis. If you have been treated for this condition at a Department of Veterans Affairs (VA) facility, furnish the date(s) and places(s) and we will obtain the report(s).

This evidence should be submitted as soon as possible, preferably within 30 days. If it is not received in VA within 1 year from the date of this letter, benefits to which entitled is established may not be paid for any period prior to the date of its receipt. Failure to furnish this evidence could result in the disallowance of your claim.

If you can FAX the information, please include a copy of this letter in your transmission. Our FAX number is (254)757-[XXXX].

Sincerely Yours,

(Signature of Adjudication Officer)

(End Of Letter)

You will not hit the 30 day mark. No sweat. TAKE THE TIME TO GET ALL OF THE SUPPORTING INFORMATION YOU CAN. I also recommend you do not fax the letter, if you are asked to, but instead return to the VA Counselor who assisted you file the initial claim and have him look the letter over (follow his suggestions on changes) and ask him/her to send the letter for you. No matter how you chose to send the letter, make backup copies.

You may also send additional information to your Adjudication Officer, in support of your evidence after you make the original submission. The letter you receive requesting your stress events evidence will probably have your Adjudication Officer’s name on it. If not, your case file number has a reference to that individual. Be aware that by sending in this “updated information” you will slow down the evaluation process.
and possibly cause your claim to be lost or misplaced. If the new evidence you find is strongly relevant to one or more events, the effort is worth the risk. Another action that will definitely slow down the process is a Congressional Inquiry. A number of extra documents have to be exchanged and your claim will almost certainly be added to the bottom of the stack when action is complete.

e. **C & P (Compensation and Pension) Interview.** Some time after your regional VA office receives your stress letter you will be sent a notification requesting that you report to the nearest Department of Veterans Affairs Clinic or Hospital for a “C & P” examination (I submitted a claim Form on Aug 14, 1997, received request for stress letter Oct 12, 1997, had C & P interview Apr 21, 1998: it took over 8 months). Your Claim, or “C”, file is sent from the regional office to the clinic or hospital where your examination will take place. The interview will be based on your records obtained from your “C” file and from other local records (You should already have requested a copy of your “C” file).

f. You may receive a letter or the C & P appointment may be added to your existing list of appointments and that updated list sent to you.

I would advise you to contact your psychiatrist and/or psychologist and have them update your records in advance of this interview and ask them if they have “Diagnosed” you with PTSD (this may be REQUIRED in some locations).

Read over the “PTSD Examination” (Manual M-1) section in appendix J of this book and be aware that an examination sheet similar to the one that follows will be used by the rating specialist (the specialist is normally one of the qualified medical staff at the VA where you are undergoing treatment). Note that the heart of the examination sheet parallels the description of PTSD in DSM-IV:

- Name:
- SSN:
- Date of Exam:
- C-Number:
- Place of Exam:

Narrative: Service-connection for post-traumatic stress disorder (PTSD) requires medical evidence establishing a clear diagnosis of the condition, credible supporting evidence that the claimed in-service stressor actually occurred, and a link, established by medical evidence, between current symptomatology and the claimed in-service stressor. It is the responsibility of the examiner to indicate the extreme traumatic stressor leading to PTSD, if he or she makes the diagnosis of PTSD. It is the responsibility of the rating specialist to confirm that the cited stressor occurred during active duty.

A diagnosis of PTSD cannot be adequately documented or ruled out without obtaining a detailed military history and reviewing the claims folder. This means the initial review of the folder prior to examination, the history and examination itself, and the dictation for an examination initially establishing PTSD will often require more time than for examinations of other disorders. Ninety minutes to two hours on an initial exam is normal.

A. Review of Medical Records
B. Medical History (Subjective Complaints):

Comment on:

1. Past Medical History:
   a. Previous hospitalizations and outpatient care.
   b. Medical and occupational history (the time between last rating examination and the present need be accounted for, UNLESS the purpose of this examination is to ESTABLISH service connection, then complete medical history including description of stressors and history since discharge from military service is required.
   c. Review of Claims Folder is also required on initial exams to establish or rule out the diagnosis.

2. Present Medical, Occupational and Social History - over the past one-year.
   a. Frequency, severity and duration of psychiatric symptoms.
   b. Length of remissions, to include capacity for adjustment during periods of remissions.
   c. Extent of social impairment and time lost from work over the past 12-month period. If employed, identify current occupation and length of time at this job. If unemployed, note in complaints whether veteran contends it is due to the effects of a mental disorder. Further discuss in DIAGNOSIS what factors, and objective findings support or rebut that contention.

3. Subjective Complaints:
a. Describe fully.

C. Examination (Objective Findings):
Address each of the following and fully describe:

1. Stressor information: Clearly describe the stressor. Particularly if the stressor is a type of personal assault, including sexual assault, provide information, with examples, if possible, of behavioral, cognitive, social, or affective changes that the veteran links to the stressor. Include information on related somatic symptoms. If there is a history of multiple stressors, assess the impact of each, to the extent possible.

Authors note: I was very concerned about having to rehash the stressors for the interviewer. You can ask your interviewer to allow your “stressor letter” to “speak for itself”, which they are allowed to do, however, since your disability percentage is partially determined by your present state of mind and ability to function socially, it may be to your advantage to suffer through the “reliving” of the stressor events so the interviewer can witness the impact the stressors still have on you.

2. Mental status exam to confirm or establish diagnosis in accordance with DSM-IV:
   a. Are all diagnostic criteria to establish a diagnosis for 309.81 Post-traumatic Stress Disorder, as specified in DSM-IV, fully met?
   b. For initial examination to establish service-connection fully discuss the criteria in steps A through F supporting or ruling out the diagnosis.
   c. Describe any associated symptoms.
   d. Specify onset and duration of symptoms as acute, chronic, or with delayed onset.

3. Describe in detail the linkage between the stressor and the current symptoms and clinical findings.
4. Describe and fully explain the existence, frequency, and extent of the following signs and symptoms, or any others present, and relate how they interfere with employment and social functioning:
   a. Impairment of thought process or communication.
   b. Delusions, hallucinations and their persistence.
   c. Inappropriate behavior cited with examples.
   d. Suicidal or homicidal thoughts, ideations or plans or intent.
   e. Ability to maintain minimal personal hygiene and other basic activities of daily living.
   f. Orientations to person, place, and time.
   g. Memory loss, or impairment (both short and long-term).
   h. Obsessive or ritualistic behavior, which interferes with routine activities and describe any found.
   i. Rate and flow of speech and note any irrelevant, illogical, or obscure speech patterns and whether constant or intermittent.
   j. Panic attacks noting the severity, duration, frequency, and effect on independent functioning and whether clinically observed or good evidence of prior clinical or equivalent observation is shown.
   k. Depression, depressed mood or anxiety.
   l. Impaired impulse control and its effect on motivation or mood.
   m. Sleep impairment and describe extent it interferes with daytime activities.
   n. Other symptoms and the extent they interfere with activities.

D. Diagnostic Tests:

1. Provide psychological testing if deemed necessary.
2. If testing is requested, the results must be reported and considered in arriving at the diagnosis.
3. Provide specific evaluation information required by the rating board or on a BVA Remand.
   a. Competency: State whether the veteran is capable of managing his or her benefit payments in the individual's own best interests (a physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of in competency unless the veteran is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs.)
   b. Other Opinion: Furnish any other specific opinion requested by the rating board or BVA remand furnishing the complete rationale and citation of medical texts or treatise supporting opinion, if medical literature review was undertaken. If the requested opinion is medically not ascertainable on exam or testing please state why. If the requested opinion cannot be expressed without resorting to speculation or making improbable assumptions say so, and explain why. If the opinion asks, "...is it at least as likely as not..." fully explain the clinical findings and rationale for the opinion.
4. Include results of all diagnostic and clinical tests conducted in the examination report.

E. Diagnosis:
Provide:
1. The diagnosis must conform to DSM-IV and be supported by the findings on the examination report.
2. If the diagnosis is changed, explain fully whether the new diagnosis represents a progression of the prior diagnosis or development of a new or separate condition.
3. If there are multiple mental disorders, delineate to the extent possible the symptoms associated with each and a discussion of relationship.
4. Evaluation is based on the effects of the signs and symptoms on occupational and social functioning.

Note: VA is prohibited by statute from paying compensation for a disability that is a result of the veteran's own ALCOHOL OR DRUG ABUSE, whether based on direct service connection, secondary service connection, or aggravation by a service-connected condition. Therefore, when alcohol or drug abuse accompanies or is associated with another mental disorder, separate, to the extent possible, the effects of the alcohol or drug abuse from the effects of the other mental disorder(s). If it is not possible to separate the effects, state why.

F. Global Assessment of Functioning:

NOTE: The complete multi-axial format as specified by DSM-IV may be required by BVA REMAND (authors note: BVA stands for Board of Veterans Appeals and to “Remand” means to send back or return. The “multi-axial” and “axis” stuff is complicated medical jargon which you can ask your shrink about if you wish a 15 minute explanation full of $5 words, which will leave you baffled. It did me.) or specifically requested by the rating specialist. If so, include the GAF score and note whether it refers to current functioning over the past year, etc.

If multiple Axis I or Axis II diagnoses exist, attempt to the extent possible, to provide a GAF score for the service connected conditions alone as well as a separate overall GAF score based on all mental disorders present, and explain and discuss your rationale. (See the above note pertaining to alcohol or drug abuse, the effects of which cannot be used to assess the effects of a service-connected condition.) If it is not possible to separate the symptomatology, explain why.

GAF Scores can cause you much pain. Be aware that EVERY time you see your doctor you will probably receive a GAF. Shortly after my return from the PRRP program I attended in Sheridan, WY., I received notification of a new C & P to evaluate me for a change in disability rating because of my improved GAF score. It seems I had entered the PRRP program I with about a 50 and came out with a 65.)

DSM-IV is only for application from 11/7/96 on. Therefore, when applicable not whether the diagnosis of PTSD was supportable under DSM-III-R prior to that date. The prior criteria under DSM-III-R are provided as attachment.

(HEIGHT OF EXAMINATION SHEET EXAMPLE)

Authors note: My “Rating Decision” letter (furnish by the disability rating board after a disability determination has been made) said the following about my PTSD C & P interview:

“The VA examination gives a diagnosis of posttraumatic stress disorder and the examiner relates this to the Veterans experiences in Viet Nam. On examination the Veteran is cooperative and oriented in all spheres. He moved cautiously into the examining room. His speech was raoid and quite pressured. He avoided eye contact and his mood was depressed and anxious. His memory was grossly intact except for remembering the names of men he served with in Viet Nam, the exception being his two close friends. He reflected anger when talking about Viet Nam. He was clearly guarded and suspicious but there was no evidence of paranoia or delusions. He is capable of managing his benefits.”

There are two types of “tests” or “inventories” often given by a VA psychiatrist or psychologist to PTSD patients. They are administered by computer and take from 20 to 45 minutes to complete. Both are designed to provide the doctor with information on the patients’ current mental condition. The shorter of the two
called the Millon Clinical Multiaxial Inventory (MCMI-2) is a 175 question completely true/false based inventory. The second, called the Minnesota Multiphasic Personality Inventory (MMPI-2) has about 450 mixed types of questions. Your answers to the questions provides a printout showing your state of depression and anxiety, etc. They have both proven accurate and useful in treatment. Your doctor may or may not ask you to take one of the tests and whether or not the results are used in part your PTSD evaluation is up to the individual doctor.

f. Into The Bureaucratic Gristmill. Your “C” file, which now contains the C & P exam, is then returned to the regional office for board evaluation and disability determination.

g. Decision Packet. Just over 1 year after I submitted by application for disability I received a decision packet the VA Regional Office in my area. The packet contained the following:

   a. Decision letter (stating the amount of disability allowed, explanation of disability amounts to be received, information on how the effect my retired pay, information in filing an appeal, and phone numbers for questions)

   b. Rating Decision (a letter explaining their decision on each of the disabilities I had applied for)

   c. Disabled Veterans Application for Vocational Rehabilitation (Form 28-1900) and accompanying VA Form 28-8890 explaining Vocational Rehabilitation Benefits.

   d. Disability Compensation Award Attachment Important Information (VA Form 21-8764 (JF))(information on check delivery, hospital and outpatient treatment, dental treatment, additional compensation for dependents, government life insurance, and a few other items that may or may not apply to the individual veteran).

   e. Notice of Procedural and Appellate Rights (VA Form 4107).

   My advice is to take the entire packet to your Service Representative if you have any questions about the disability awarded. If you received the disability you anticipated or feel is adequate for your condition YOU HAVE COMPLETED THE DISABILITY APPLICATION PROCESS. On the other hand if you are not satisfied with the Rating Decision, file an appeal.

Section VIII. APPEAL OF DISABILITY DETERMINATION

07-18. General. Before reading the information on Appeals read the letter from Mr. Robert White.

By; Robert White

I'm a former case development paralegal for the BVA. If you do the following you will have a better than average chance of winning your claim.

1. Gather all the military, private and VA medical records (get copies made).

2. Review your military medical records and make a list of every ailment that you had while on active duty.

3. Cross reference all your military ailments with your civilian ailments. If the problem persists or a secondary issue has cropped up as a result of the issue that developed during your time in the military then you need to apply for that issue (as a secondary issue).

4. Go to the VA web site, www.va.gov, and down load all the Fast Letters, Memo's (go to “SEARCH” at the bottom of the first VA Web Page and type in Fast Letters and then Memo’s) and any other documentation that will support your case.
5. Go to the DAV, PAV and any other VSO web sites and bookmark them (and download anything related to your claims).

6. Get statements from all private doctors or other medical provider, have them state that your problems are DEFINITELY service connected. If the doctor uses the word possibly or probably the Medical Provider will have given the VA the excuse it needs to dismiss the doctors statement. But, if all the doctor can say is probably, don't throw it away. Get more than one doctor to say the same thing then write if two doctors say the same thing, then the reasonable doubt rule should apply and the probability is slim that the issue ISN'T service connected.

7. Get statements from anyone who knows you and your issues. Have these individuals state how the problems affect you (example: It is hard to bend over, or squat, or hear, etc..) Did you know you can get statements from anyone that knows you, yes your wife, kids, parents, co-workers even the guy/gal walking along the street. All of these people can contribute! All their statements are evidence that must be considered. If you have them put their phone number down on the statement and request the adjudicator to call (not if they have any questions), the adjudicator is required to call.

8. NOT USED.

9. If you have been going to a Vet Center, request a copy of their records. They are independent of the VA medical system (CAPRI) so you need to get a statement or copy of your providers notes or both from your treating Social Worker.

10. If you have gone to Voc Rehab, you were evaluated by them. Do a Privacy Act request and get all copies of evaluations and anything else (to include reports of contact [ROC]). The Voc Rehab evaluations carry some weight, since they are independent evaluations. Get copies of the contractor evaluations and the VA's Voc Rehab evaluations.

11. Go to [http://www.warms.vba.va.gov/bookc.html](http://www.warms.vba.va.gov/bookc.html). Look up what your issue is and determine the percentage that you want to apply for. Now 98% of the Veteran Service Rep's (VSR's) will tell you not to give a percentage, but if you don't ask for a percentage and you are awarded 0% for an issue, you can't complain because they gave you exactly what you asked for. If the adjudicator denies your issue and you did not ask for a certain percentage, then you have to prove they didn't follow proper procedure (this is very hard to prove). Your VSR will tell you that the law can change. Great, if it increases then just fax, email (w/receipt) or mail in an updated request. If the percentage decreases, you don't need to do anything. The Veterans Claims Assistance Act of 2000 allows you to the law that is most favorable to you to be applied to your claim so don't change your percentage.

12. If you have been seeing a counselor at the VA Hospital, then get him/her to write you a statement of how bad they think you are. Plus, write up a statement on your own, let the adjudicator know about your background, your stressors and how this effects your daily life. Always and I mean Always have this statement lean towards your being suicidal, wanting to kill people and your wanting to harm not only yourself but others.

13. Current law favors the Vet. The VA fights it but you can use this to your advantage. Invoke VCAA (Veterans Claims Assistance Act of 2000). Read, understand and learn what VCAA can do for you. If you are within a year of the VCAA letter you received, then you have rights to
reopen old cases, don't let that pass. (go to
http://www.ptsdmanual.com/vcaa2.htm for clarification)

14. Go the VA web site, go to the http://www.va.gov/vbs/bva/ or
http://www.veteransresources.net/database.html to research all BVA
(Board of Veterans Appeals) opinions on your issues. These legal
opinions as well as the courts opinions narrows the focus of how the
adjudicator can look at the evidence.

15. You need to put together a narrative that reads like a graduate paper.
You will refer to evidence that you collected (items 1-9) as well as. You
tell your story as to how you were injured. I would also compile all the
evidence by issue. Yellow highlight that pertains to you and your issues.
Site this in your narrative.

16. You are entitled to claim all periods of active duty, all periods covered
under Vocational Rehabilitation and any injuries suffered under the care
of the VA for the purposes of disability claims (issues). You need to list
all periods of active duty, to include ADT and reserve time. There are
limited benefits for non-active duty personnel. By stating the periods of
active duty, and providing documentation (such as copies of orders), you
will increase your chances of winning your claim.

17. Go to your private doctor. Have him do the C&P exam the correct
way. Go to the C&P office at your local VA Hospital (if your too far
away, have them either email or fax to you the exam criteria). Make sure
he is a specialist (preferably board certified) in the field. Then show him
the exams you were given by the VA as well as all your personal medical
records on this issue. Ask him if he concurs with their exam. If he doesn't,
get him to put it in writing and cite the different tests that he performed to
support his conclusions. Thus you beat them at their own game. When
you write it up, make sure you had the "COMPLETE" C&P exam done
by a private doc and the VA doc's refused to perform the proper tests.
Under the reasonable doubt rule, you have proven your case, and they
failed to prove theirs.

The VA is like a willful child. You have to pull the child by the ear and
lead it in the direction that you want it to go. If you let anyone else do this
for you, then your doing yourself a disservice. The VSR's are overworked
and after you leave their office, will pull up a template and plug in the
issues and submit a formatted claim. Which one do you think will have a
better chance.

The only way to speed up your claims is for you to be dying. There is no
accelerated claim process. Trust me when I say this, your situation is no
worse than most, I have seen worse. Some individuals claims had gone on
for 22 years. I have heard of longer. My guess is you will get something
but not what you expect unless you follow the steps I have outlined
above. The money you get will be minimal compared to what you need. If
you have a rating of at least 20%, then you should apply immediately for
Vocational Rehabilitation (if you haven't already done so). Voc rehab will
give you between $500 to $600 a month while your in school (full time.)
At the same time you can retrain for a new career.

You all know your stories, tell the VA how you were injured, cite the
times you went to the medial facility, and later the follow-up care you
have received from your private doctor. Invoke the REASONABLE
DOUBT clause as well as VCAA. Site VBA and Court of Appeals legal
cases that support your claim that you are entitled to a certain percentage
rating.
YES, review the ratings percentages. Think of your worst day (pain, etc.) and rate yourself on that basis. After a few years your pain will probably be at that level, unless you can get the symptoms reversed somehow.

I listed every time I went to the doctor, provided a copy of that medical record, highlighted the medical record and bunched them together in a group so the claims examiner did not have to hunt for the information. I IDIOT proofed the claim! I wrote my claims and other peoples claims (and they received everything they have asked for) because I anticipated the weaknesses in the claim and found the law or regulation that supported that weakness.

I also looked up medial studies to support my claim and provided those studies (were my case might be weak or a secondary issue) to help in the adjudication process. I especially like VA or DoD or National Institute of Health medical studies. Its hard to argue with yourself when yourself (the government) has come to the conclusion that the problem exists and what the symptoms are (which are the same symptoms your reporting).

Remember, the service organizations receive thousands of requests for representation. These organizations use canned letters that are ok, but not necessarily in your best interest. If you provide them with most if not all of the research, it will make their life easier when they go to write the cover letter. They will know what cases to cite and can do a better job in supporting you (if you choose to use them).

***** I constantly read about the VA messing things up, but I never hear of anyone taking the bull by the horns and doing anything about it. Most people rely on the VA to do the right thing. Or you rely on the service organization to do the right thing. Don't count on them. You have to be responsible for your own actions.******

Having worked at the BVA and having done the prep work for the appeals, I can state one good reason why they take forever. You as the veteran did a lousy job of documenting what was needed to win. You had enough evidence to raise doubt in their minds, but not enough evidence to justify or prove you have a existing issue and if the issue was aggravated by the service, or voc rehab or your visit to the VA. Follow the steps below to gather as much evidence as possible. If that fails, the BVA paralegals have 3-5 4" binders full of address and other resources that they can call upon to develop your case. If you want to win, you have to do a better job at preparing your case.

A REQUEST: If you follow the steps listed above, would you let me know how well you did on your claim. Thanks. To date, I have a 95% success rate.

Robert White

(End 0f letter from Mr. Robert White)

**07-19. Definitions.** Veterans and other claimants for VA benefits have the right to appeal decisions made by a VA regional office (VRO). These appeals can be for denial of claims, because you are not satisfied with the percentage of disability awarded or your C & P examination was not adequate for compensation purposes. However, there is no reason to waste your time or the VA’s time if you have no basis for appeal.

Authors note: After I filed my NOD I received the following letter from the VARO:
Dear Mr. Parrish:

We have received your notice of disagreement.

This letter describes the initial process by which we will attempt to resolve your disagreement.

We will try to resolve your disagreement.

Our office will try to resolve your disagreement through the Post-Decision Review Process. As part of this process, a Decision Review Officer (DRO) will be assigned to your case.

How does the Post-Decision Review Process work?

Complete review: The Decision Review Officer will check your file for completeness. Then a review will be made of your evidence and arguments, statements from you representative, and any other information available in your claims folder. This may lead to a request for additional evidence. You may be asked to participate in an informal conference by the Decision Review Officer to clarify questions about your disagreement.

New decision: The Decision Review Officer will then make a new decision. You will be notified of the decision. If you still do not agree with that decision, you will need to submit a substantive appeal so your case can be sent to the Board of Veterans’ Appeals. Instructions on how to file a substantive appeal will be provided in our letter notifying you of the decision by the Decision Review Officer.

(Authors note: The recently adopted 38 CFR 3.2600 states:

“(a) A claimant who has filed a timely Notice of Disagreement with a decision of an agency of original jurisdiction on a benefit claim has a right to a review of that decision under this section. The review will be conducted by an Adjudication Officer, Veterans Service Center Manager, or Decision Review Officer, at VA’s discretion. An individual who did not participate in the decision being reviewed will conduct this review. Only a decision that has not yet become final (by appellate decision or failure to timely appeal) may be reviewed. Review under this section will encompass only decisions with which the claimant has expressed disagreement in the Notice of Disagreement. The reviewer will consider all evidence of record and applicable law, and will give no deference to the decision being reviewed.

b) Unless the claimant has requested review under this section with his or her Notice of Disagreement, VA will, upon receipt of the Notice of Disagreement, notify the claimant in writing of his or her right to a review under this section. To obtain such a review, the claimant must request it not later than 60 days after the date VA mails the notice. This 60-day time limit may not be extended. If the claimant fails to request review under this section not later than 60 days after the date VA mails the notice, VA will proceed with the traditional appellate process by issuing a Statement of the Case. A claimant may not have more than one review under this section of the same decision.

(c) The reviewer may conduct whatever development he or she considers necessary to resolve any disagreements in the Notice of Disagreement, consistent with applicable law. This may include an attempt to obtain additional evidence or the holding of an informal conference with the claimant. Upon the request of the claimant, the reviewer will conduct a hearing under Sec. 3.103(c).

(d) The reviewer may grant a benefit sought in the claim notwithstanding Sec. 3.105(b), but, except as provided in paragraph (e) of this section, may not revise the decision in a manner that is less advantageous to the claimant than the decision under
review. A review decision made under this section will include a summary of the evidence, a citation to pertinent laws, a discussion of how those laws affect the decision, and a summary of the reasons for the decision.

(e) Notwithstanding any other provisions of this section, the reviewer may reverse or revise (even if disadvantageous to the claimant) prior decisions of an agency of original jurisdiction (including the decision being reviewed or any prior decision that has become final due to failure to timely appeal) on the grounds of clear and unmistakable error (see Sec. 3.105(a)).

(f) Review under this section does not limit the appeal rights of a claimant. Unless a claimant withdraws his or her Notice of Disagreement as a result of this review process, VA will proceed with the traditional appellate process by issuing a Statement of the Case. (g) This section applies to all claims in which a Notice of Disagreement is filed on or after June 1, 2001. “

(Authority: 38 U.S.C. 5109A and 7105(d))

[66 FR 21871, May 2, 2001]

You may be Represented

If you designated an organization to represent you in presenting your claim to VA, the Decision Review Officer will work with a representative from the organization while trying to resolve your disagreement. If you have not already done so, you should contact your representative directly to discuss your case.

However, an agent or attorney can charge you only for service performed on or after the date of a final decision by the Board of Veterans’ Appeals. Tell us if you want someone to represent you and we will send you the necessary forms.

We hope we will be able to resolve your disagreement to your satisfaction. If you have questions about the information in this letter call us at 1-800-XXX-XXXX.

Sincerely yours

(END OF LETTER)

The Decision Review Officer (DRO) is a fairly new VA position. Started in 1966, Decision Review Officers are now located at all major VA offices. An article by Jim Hall in the Sep/Oct 1998 DAV Magazine says that DROs are “highly skilled and experienced VA Employees who focus on identifying issues and areas of disagreement for resolution early in the appeals process. DROs are granted difference of opinion authority and can prepare single signature decisions on clear and unmistakable error cases. This means the claim can be reviewed without being bound by the previous decision. Difference of opinion authority is limited to claims for which the appeal period has not expired and grants of benefits sought in connection with those claims.

They have jurisdiction from the receipt of a notice of disagreement and review the rating decision to see if it can be revised or reversed on evidence already on record.”

VERY IMPORTANT. You need to request a “local hearing” and not to “reopen” your claim or request a BVA hearing, at this stage.
**What follows the Statement of the Case?**

Within 60 days of the date when the local VA office mails you the Statement of the Case, you need to submit a Substantive Appeal. However, if the one year period from the date the VA regional office or medical center mailed you its original decision is later than this 60-day period, you have until that later date to file the Substantive Appeal.

To file a Substantive Appeal, simply fill out and submit a VA Form 9, which is attached to the Statement of the Case that the RO sends you. An important part of the VA Form 9 is the section used to request a BVA hearing.

The VA Form 9 is very important to your appeal. On this form, you should make sure that you clearly state the benefit you are seeking and that you point out any mistakes you think VA made when it issued its decision. You should also identify anything in the Statement of the Case that you disagree with.

If you submit new information or evidence with your VA Form 9, the regional office will prepare a Supplemental Statement of the Case. A Supplemental Statement of the Case (SSOC) is similar to the Statement of the Case, but addresses the new information or evidence you submitted. If you are not satisfied with the SSOC, you have 60 days from date when the SSOC was mailed to submit, in writing, what you disagree with.”

(Used by permission of the BVA).

Authors note: My original claim came back with an award of 10% for PTSD. My condition had deteriorated significantly since my initial claim and several people, including my Vet Center counselor, recommended I apply for an upgrade immediately. He pointed out that my records would still be at the VRO for about 30 days so time was definitely a factor.

I repeat, it would be wise to have a Veteran Service Officer (VSO) working with you on these documents and proceedings. In addition to the type representative named earlier you can also use a lawyer (good luck since the lawyer is restricted by law as to the fee he may charge and most lawyers will not work for that price).

Authors note: Approximately 10 - 20% of the appeals that go before the Board are reversed in favor of the claimant.

If you lose your appeal at the Board of Veterans Appeals (BVA) you have several choices: a. do nothing further; b. appeal to the U.S. Court of Veterans Appeals (COVA); c. go back to the BVA and ask them to reconsider your claim; or d. reopen your case at the VRO.

Authors note: You may also find the U.S. Court of Veterans Appeals abbreviated as CVA.

Vietnam Veterans of America (VVA) offers the following advice on their Internet home page as relates to “Appealing to Court”:

“If your representative believes the BVA did not properly address the evidence in favor of your claim or did not make sure all the evidence was obtained or just thinks the BVA was wrong, consider filling an appeal to the U.S. court of Veterans Appeals. To appeal to the court, send your name, address, phone number, and the date of the BVA decision, (I would also add your Claim #) to:

Clerk of the Court
U.S. Court of Veterans Appeals
625 Indiana Avenue NW
Washington, DC 20004
FAX: 202-501-5848

Understand that the Court of Veterans Appeals (COVA) does not conduct a new trial or hearing nor does it hear new evidence from witnesses or use any sort of jury. What the Court does do is review all documents presented up to the BVA and then may or may not hear oral arguments from the Veteran Plaintiff and
the Department of Veterans Affairs. You do not get a trial, you get a review. The review will determine if the VRO committed an error significant enough to materially affect the outcome of your case.

If you have the time and a computer go to the Paralyzed Veterans of America Homepage (www.pva.org) find a link called “Resources for Professionals” and then “The US Court of Veterans Appeals” link. This is an exhaustive and easy to read history and detailed explanation of the COVA.

Finally, there is the matter of “new and material evidence”. Ms. Margaret Peak, of the Board of Veterans’ Appeals, offers the following information:

“.new and material evidence…..refers to the standard of evidence required to reopen a claim where a previous decision has become final. This would apply to a regional office or BVA decision that was not appealed within the time allowed, or a claim that has been through the entire appellate process. In effect, a previously denied claim, where there is a final decision, can be reopened at any time by the submission of new and material evidence.

The regulation defining “new and material evidence” for purposes of reopening a claim is found at 38 C.F.R. paragraph 3.156(a) and reads as follows: “New and material evidence means evidence not previously submitted to agency decision makers which bears directly and substantially upon the specific matter under consideration, which is neither cumulative nor redundant, and which by itself or in connection with evidence previously assembled is so significant that it must be considered in order to fairly decide the merits of the claim.”

Section IX. FILING FOR SOCIAL SECURITY BENEFITS

07-20. Duel Compensation. Under current regulations you can receive VA disability compensation and Social Security disability benefits at the same time. That's the good news. The bad news is.... You are about to enter the twilight zone. The Social Security Administration (SSA) is ANOTHER government organization, ergo, more waiting and frustration is in store for you. Knowing what to expect and what forms are required will help eliminate a great deal of frustration and will cut down on the time required to receive your benefits.

The SSA Internet web page is located at "www.ssa.gov" where you can download blank forms and find up-to-date information on rulings and regulations. The SSA falls under CFR (Code of Federal Regulation) 20 (Employee Benefits).

07-21. Qualifying for Benefits. Be aware that you are not eligible for SS payments until you have been out of work at least 6 months and if you win your case in the first round it may take another three months before you begin receiving any payments. However, according to SSA Publication 05-10029, dated May 1996, “..you will receive your first Social Security disability check dating back to the sixth full month from the date we decide your disability began (but no more than one year of back benefits can be paid).”

The SSA explains how they determine a disability in their Publication 05-10029. They state “It's a step-by-step process involving five questions. They are:

a. Are you working? If you are and your earnings average more than $500 a month (this amount may have changed to $700.00 a month by now, check the SSA home page), you generally cannot be considered disabled.

b. Is your condition “severe”? Your impairments must interfere with basic work-related activities for your claim to be considered. (Authors note: The SSA has a lot of control over what the word "severe" means. Even though there is a written definition of the word the Administrative Law Judge, in particular, will use it to his/her advantage, against you. Take every opportunity to define your symptoms and problems as being “severe”.)

c. Is your condition found in the list of disabling impairments? We maintain a “List of Impairments for each of the major body systems that are so severe they automatically mean you are disabled. If your condition is not on the list, we have to decide if it is of equal severity to an impairment on the list. If it is, your claim is approved. If it is not, we go to the next step. (Authors note: PTSD is not identified in the “List of Impairments”,

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which was pointed out to me by the Administrative Law Judge I went before, however, there is a "Mental Disorder" section (paragraph 12.00) and symptoms of PTSD may be found in sections on "Organic Mental Disorders", "Schizophrenic, Paranoid and other Psychotic Disorders", "Affective Disorders", "Anxiety Related Disorders", and "Personality Disorders". I believe you will have the best luck comparing your symptoms with the "Anxiety Related Disorders" section.

d. Can you do the work you did previously? If your condition is severe, but not at the same or equal severity as an impairment on the list, then we must determine if it interferes with your ability to do the work you did in the last 15 years. If it does not, your claim will be denied. If it does, your claim will be considered further. (Authors note: This is yet another area where the SSA has a great deal of latitude in determining your disability. You will need to debunk, as much as legally possible, your current ability to perform past work because of your PTSD.)

e. Can you do any other type of work? If you cannot do the work you did in the last 15 years, we then look to see if you can do any other type of work. We consider your age, education, past work experience, and transferable skills, and we review the job demands of occupations as determined by the Department of Labor. If you cannot do any other kind of work, your claim will be approved. If you can, your claim will be denied.

Authors note: This is the killer question. EVERY effort will be made to identify ANY kind of work you might be able to perform so they can disapprove your disability application. In every disapproval I received their was ALWAYS a statement about my still "being able to perform some sort of work". You MUST make every effort to force them to decide your case based on PTSD alone. When I received my initial denial it stated "We have determined that your condition is not severe enough to keep you from working. We consider the medical and other information, your age, education, training, and work experience in determining your ability to work. We understand your condition concerns you and you may not have the ability to do your past work. However we find you retain the ability to do other types of work." They did not tell me what other types of work I am capable of performing. Note also the almost 'Word for Word' text from their regulations.

You also need to be aware of the following...."Section 404.1532(a) of such regulations (20 CFR 404.1532(a)) states:

1. If an individual performed work during any period in which he alleges that he was under a disability. . . the work performed may demonstrate that such individual has ability to engage in substantial gainful activity. . . .

And……section 404.1534(a) (20 CFR 404.1534(a)) of this regulation states, in pertinent part:

1. Where an individual who claims to be disabled engages in work activities, the amount of his earnings from such activities may establish that the individual has the ability to engage in substantial gainful activity. Generally, activities which result in substantial earnings would establish ability to engage in substantial gainful activity ….. Where an individual is forced to discontinue his work activities after a short time because his impairment precludes continuing such activities, his earnings would not demonstrate ability to engage in substantial gainful activity.

And…..Subparagraph (b) of this section of the regulations then in effect, pointed out that:

1. An individual's earnings from work activities averaging in excess of $140 a month shall be deemed to demonstrate his ability to engage in substantial gainful activity unless there is affirmative evidence that such work activities themselves establish that the individual does not have the ability to engage in substantial gainful activity under the criteria in §§ 404.1532 and 404.1533 and paragraph (a) of this section. (Emphasis supplied)[1]

[1] The amount of monthly earnings which creates a presumption of substantial gainful activity has, since January 1, 1974, been $200.00. See 39 FR 32757, September 11, 1974, and 40 FR 31778, July 29, 1975. This amount may change because of increases in earnings levels."

SSR 76-4a: SECTIONS 216(i) and 223(d) (42 U.S.C. 416(i) and 423(d)) -- DISABILITY INSURANCE BENEFITS -- SUBSTANTIAL GAINFUL ACTIVITY -- REBUTTAL OF PRESUMPTION OF ABILITY TO
Your benefits can be discontinued by the SSA if your medical condition improves or if you work at a "substantial" level. Currently the SSA considers earnings of $500 or more a month "substantial". It is possible to earn more than $500 a month and retain your benefits under certain "work incentives", which will be explained in the booklet you will receive along with your first disability check.

**07-22. Representation.** You may wish to hire a lawyer that specializes in SS benefits. You must file a Form SSA-1696-U4 (Appointment of Representative) with the SSA as soon as you have chosen your representative. The selected representative may not charge you without first receiving permission from the SSA. (SSA Publication 05-10075).

Authors note: I engaged the services of a lawyer after my application was initially turned down. He specialized in VA and SSA cases, particularly with Veterans. A Form SSA 1696-U4 (Appointment of Representative) was filled out by the lawyer and faxed to me for signature (I called the SSA and they said a faxed copy was acceptable). The lawyer also sent me a simple contract outlining the current allowable charges by the SSA. He is entitled to 25% of the recovery (this recovery only includes "back" benefits" owed to me by the SSA not future benefits) or a maximum of $4000.00. If he does not win my case I pay NOTHING except possibly fees incurred for obtaining medical or other records. You will need to mailed a copy of the Form SSA 1696-U4 and the lawyers contract to the SSA and a copy of all the documents you have accumulated concerning the claim to the lawyer.

If you engage a lawyer make certain he/she emphasizes that you are applying for a MENTAL disability and to concentrate on discounting the PHYSICAL jobs the SSA will say you are still able to perform.

Authors note: IMPORTANT. Before you begin the process I advise you to obtain and submit a Form SSA-7050 (Request for Social Security Earnings Information). As part of your initial application packet you will be required to fill out two documents that require work history for the past 15 years. Obtaining the information form the SSA insures that you do not submit incorrect data and also serves as a reminder of your work record in case you no longer have that information available in your own files. You may be required to pay as much as $50 for this information. See chapter 10 for instructions on filling out this form.

Another useful thing to have done before the process begins is a “Medical Assessment of Ability to do Work-Related Activities - Mental” by your psychiatrist. There use to be a SSA-1152 Form for this exact purpose but it may or may not be available. See my homepage at “www.ptsdmanual.com/ssadocs”, for a copy of the original Form. Attach this completed form to your disability application.

**07-23. Filing your Claim.** To get started you must:

a. Call 1-800-772-1213. You will normally be asked if you wish to go to the nearest SSA office for an interview or if you prefer to file your claim by telephone. Save yourself time and aggravation and take the phone interview (if they do not offer this option, ask for it). The representative I spoke with told me the time and date I would be called (27 days out) and said that I would receive a reminder in the mail. The representative also informed me that I would need an ORIGINAL copy of my DD 214 and birth certificate.

Authors note: I did not receive a reminder in the mail, so, mark your calendar just in case. Also be advised that the call can come anytime within an hours time, thirty minutes prior to or after, the agreed upon time.

b. Accomplish the claim interview. The phone interview will take approximately 30 minutes. Ask the interviewer for an 800 number, just in case you get disconnected. Most of the interview will consists of questions about your work history with emphasis on unusual changes in your work habits (sharp increases or decreases in income). You will be asked if you were ever self employed, or if you are currently drawing Workman’s Comp., and if you have ever received a print-out of your SS contributions (they will offer to send you one if you say no). The SSA representative informed me that it would take about 90 days to receive a determination and that I could appeal that determination if I did not agree with it. She also said I would receive a packet containing a medical questionnaire and a list of any documents I would need to send in. If you are not able to provide an original copy of your birth certificate and DD 214 that will be OK but the process will take longer as the SSA will need to send for those documents and wait for them to arrive before the claim can be further processed.

The representative said the disability claim evaluation would be done by a "local state agency" and told me the approximate amount that I would receive if my claim was approved and asked if I had a bank account available for automatic deposit.
Authors note: Approximately two weeks after I applied for benefits I received a letter from the "Department of Public Health and Human Services, Disability Determination Services, my home state. A representative from that office informed me that they would process the medical portion of the disability application (this would be the local state agency the SSA spoke of). The letter informed me that the process would take between 60-120 days, that my doctors would be contacted along with past employers, schools and other sources. The letter also said that I might be contacted and that if I had additional treatment to contact them with that information or any information that I might have left off of my original claim.

07-24. Filing out The Forms. Filling out the forms. One day after the phone interview I received an envelope full of forms and other documents. It may take you several hours to complete the requested information. Here is what I found in the envelope:

a. Stamped return envelope.

b. Cover letter. This letter requested I mail them ORIGINAL copies of my birth certificate and DD Form 214 and asked that this be done in 10 days. There is no Claim Number listed, as in VA correspondence. Always reference your Social Security number when dealing with the SSA.
Authors note: When they ask for your DD 214 they really mean ALL of your DD 214’s you. I mailed my final, retirement DD 214 and some days later received a request for the ones previous to that one. More wasted time.

c. Letter SG-SSA-16. This was a three page documents more or less containing the information covered in the telephone interview. Make certain the information presented is accurate or make corrections and initial where appropriate. You will also find several items you will be agreeing to when you sign the letter such as a change in your medical condition and your work status. You will need to sign and date this letter.


e. Form SSA-3368-BK (Disability Report - Adult). Again, see chapter 10.
Authors note: Both of the above SSA Forms are tedious and will require your patience to complete properly. Get someone to assist you if necessary, but do not submit incomplete or inadequate information.

f. Form SSA 827 (Authorization for Source to Release Information to the Social Security Administration (SSA). This is the SSA version of VA Form 10-5345 (Request for and Consent to Release of Medical Records). Do not do anything to these forms except sign them and have them witnessed. IMPORTANT - Have the form witnessed by a "competent adult", which the SSA states can be a spouse or social worker. Have them witnessed even if they do not ask for it. Make extra copies of the originals as you may need them again later in the process.

f. Personal Data Questionnaire. This appears to be a local questionnaire included in the packet for the benefit of the Department of Public Health and Human Services in my home state. You may or may not receive this questionnaire so I have not included it in chapter 10 however you will find a copy at www.ptsdmanual.com/ssadocs .
You will also find instructions for all the above Forms on the SSA Internet site.

Make copies of everything before you mail it in. You may wish to send the packet back by Registered mail but if you do you will not be able to use the self-addressed, stamped envelope provided. I recommend you spend the extra few bucks and return it by Registered mail, particularly if it contains original copies of your birth certificate and/or DD 214.

Two weeks after I submitted my claim I received a letter of acknowledging and the return of the original documents I had submitted with the application.

07-25. Appeals. Authors note: If you need to submit an appeal, and you almost assuredly will, you will have to "update" your claim file at each level. I make this statement now because you will need to keep track of anything that happens that might concern your claim. If you have any change in medication, visit a doctor or hospital or are treated for anything related to your claim you will have to note this on required forms between each appeal. Get in the habit of noting these things in the beginning of the process.

Types of Appeals
a. Reconsideration - This is accomplished at the same SS office where you initially applied for benefits but by a different person than the one who made the initial decision.

b. Hearing by Administrative Law Judge - This appeal is accomplished by an administrative law judge (this is a judge who presides over public hearings involving the promulgation (to post in public) of regulations and decides contested cases and appellate cases) within 75 miles of your home. You may request NOT to attend this hearing in person, however, this is not advisable unless you have a representative present. There is move information on the ALJ below.

c. Review by the Appeals Council - This is a SSA council which will make a decision based on the material presented or return your claim to the administrative law judge for further review.

d. Federal Court review - For this appeal you must file a lawsuit in a federal district court.

Authors note: In 1997 32% of the appeals submitted were allowed to go forward and 68% were denied without getting to the "Reconsideration" stage.

07-26. Filing Appeals on Time or Proving Cause for Being Tardy. Let me take a moment here and emphasize the importance of filing your appeals on time (within 60 days). If you do not file your appeal on time you may still file another application, BUT, you may lose some benefits, or not qualify for any benefits. This is because you are starting all over again.

The following pertains to the 60 day appeals filing requirement...

"Our rules in 20 CFR sections 404.909(a), 404.933(b), 416.1409(a), and 416.1433(b) provide that a request for reconsideration and a request for hearing before an administrative law judge (ALJ) must be filed within 60 days after the date of receipt by the claimant of the notice of the determination being appealed. However, the regulations also provide that a claimant can request that the 60-day time period for filing a request for review be extended if the claimant can show good cause for missing the deadline. The request for an extension of time must be in writing and must give the reason why the request for review was not filed timely.

When the claimant fails to timely request reconsideration or an ALJ hearing, the Agency applies the criteria in section 404.911 or section 416.1411, as appropriate, in determining whether good cause for missing the deadline exists."

Section 404.911(a) states:

"In determining whether you have shown that you had good cause for missing a deadline to request review we consider –

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review. “

07-27. First Denial. Approximately 48 days after I submitted my claim I received a letter informing me that my claim had been denied. The letter was some 4 pages long and listed the material used to decide my case (you may view the entire denial letter at “www.pstdmanual.com/ssadocs”). The letter informed me that I must submit my appeal on a Form SSA-561-U2 (Request for Reconsideration), which they did not provide, (obtainable under "Forms" at the SSA Internet site = www.ssa.gov/online/), however, a pamphlet enclosed with my denial letter says you may also submit a signed letter requesting an appeal. Instructions of filling out the SSA-561-U2 Form can be found in chapter 10.

Authors note: IMPORTANT. You can save yourself another couple of weeks by submitting a Form SSA-3441-bk (Reconsideration Disability Report) along with the Form SSA-561-U2 and a half dozen SIGNED AND WITNESSED Forms SSA-827 (Authorization for Source of Release Information to the Social Security Administration). I was not informed of this in my letter of denial but if you go to the SSA web site and then the "Forms" area you will find the following statement, "If you determine you need to complete an SSA-561-U2
and your disability claim was denied because we determined you do not meet our medical, or vocational, requirements, you need to complete the SSA-3441-bk. If you are uncertain whether this is the appropriate form, review the letter you received. It will tell you why we denied your application."
Instructions for filling out the Form SSA-3441-bk are provided in chapter 10.

07-28. General Information on Filing your Request for Reconsideration. You may, and should request that the SSA send you copies of any reports submitted by your doctors and the state agency Staff psychiatrist. I requested this information and received copies of the VA treatment interviews they evaluated and the following statement made by their contracted staff psychiatrist:

"The claimant is a 55 Y/O man who has been diagnosed as having a PTSD and depression. While concentration and pace are slightly variable these appear to be adequate for the timely completion of simple tasks without the need for inordinate supervision. The claimant will do best at work where he need not deal with the general public and where he need have no more than brief and superficial contact with coworkers and supervisors. He should be capable of at least unskilled work".

This “expert” medical determination by the SSA contracted psychiatrist was made NOT from a personal interview but two short write-ups done by my VA doctor.

07-29. Second Denial. Approximately 84 days after I submitted by appeal and 132 days after my initial application I received my second benefits denial.

The "Notice of Reconsideration" said the following:

"Upon receipt of your request for reconsideration we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your case has been thoroughly evaluated; this includes the medical evidence and the additional information received since the original decision. We find that the previous determination denying your claim was proper under the law." It further stated, "You state that you are disabled due to Post traumatic stress disorder. Your medical reports show you have some limitations from your Post traumatic stress disorder and depression. However, your condition does not qualify you for benefits at this time. We understand you have mental problems but we find you still are able to do unskilled types of work. We expect your condition will improve. We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training, and work experience in determining how your condition affected your ability to work. We understand your condition concerns you and you may not have the ability to do your post work. However we find you retain the ability to do other types of work."

The Next Step – Administrative Law Judge

Your next step in the appeals process is to request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals.

Even though the denial packet I received did not contain any blank forms you will need to submit the following (all of them are available on the SSA web site):

a. Form HA-501 (Request for Hearing by Administrative Law Judge) - The instructions say you may write a letter instead of this form but you can bet the SSA will send you this form after you submit a letter because some required data will be missing.

b. Form SSA 3441-bk (Claimant's Statement When Request for Hearing is Filed and the Issue is Disability).

c. Form SSA-827 (Authorization to Release Medical Information). Send in 5 of these forms, SIGNED and WITNESSES.

d. Form HA-4608 (Waiver of Your Right to Personal Appearance Before an Administrative Law Judge). This form is required only if you are unable to attend the hearing.

 e. Form HA-4631 (Claimant's Recent Medical Treatment). If you have NOT had any medical treatment since your "Reconsideration" appeal submit this form anyway and check "NO" in section B (1).
f. Form HA-4632 (Claimant's Medications). This is another redundant form but fill it out anyway, making certain it is consistent with other forms asking for information on your medications.

g. Form HA-4633 (Claimant's Work Background) Fill out and return ONLY if you have worked since you filed your "Reconsideration" appeal.

You will find instructions for filling out most of these forms in Chapter 10 or by going to the SSA Internet web page.

I received a letter from the SSA approximately one week after I submitted my appeal to go before an Administrative Law Judge. Actually it was a copy of a letter sent to my lawyer. The highlights were:

"We will mail a Notice of Hearing to you and your client at least 20 days before the hearing to tell you its time and place."

"At the hearing the ALJ will consider the issue(S) raised and the evidence now in the file and any additional evidence you provide."

"The Notice of Hearing will state the issues the ALJ plans to consider at the hearing."

"Because the hearing is the time to show the ALJ that the issues should be decided in your client's favor, we need to make sure that the file has everything you want the ALJ to consider. You and your client are responsible for submitting needed evidence. After the ALJ reviews the evidence in the file, he or she may request more evidence to consider at the hearing."

"If you wish to see the evidence in your client's file, you may do so on the date of the hearing or before that date. If you wish to see the files before the date of the hearing, please call us."

"The ALJ or the ALJ's designee may decide to meet with you before the hearing to review the case. If so, we will write to tell you about the conference."

07-30. **Notice of the ALJ Hearing.** You will receive several documents in your Notice of Hearing packet. My packet contained the following:

a. Notice of Hearing - This document announces the place and time of the hearing. It states the issues in the case. It may or may not state that a Vocational Expert and/or psychiatrist will be present to testify.

b. Letter to Vocational Expert - A request for the Vocational Expert to appear at the hearing. (This might be for a psychiatrist.)

c. Acknowledgment of Notice of Hearing - A document with your name an SSN on it asking if you will or will not be present for the hearing. You must check the appropriate box, sign and date the form and provide your telephone #. Mail the form to the SSA in the postage free envelope provided.

A copy of these documents are available for viewing at [www.ptsdmanual.com/ssadocs](http://www.ptsdmanual.com/ssadocs).

07-31. **The ALJ Hearing.** Just prior to the hearing my lawyer was given the opportunity to review the files on record. There was a ALJ, my lawyer, a transcriber (the session was recorded and transcribed) and a Vocational Expert (contracted by the SSA) present. The hearing was conducted in the following sequence:

a. The Judge started by asking me questions for about 20 minutes. He asked such questions as "Can you bend and lift items?, what do you do on a typical day? What my education was, and what my work history was for the last 10 years, and about my last job. He was setting the table for the Vocational Expert to tell what type of work I would be able to do.

b. He next let my lawyer ask me questions. My lawyer asked me clarification questions related to answers I had given the ALJ that would act in my favor.

c. The Judge next called on the Vocational Specialist to tell him what type of work I should be able to do.
d. My Lawyer was next permitted to ask the Vocational Specialists questions about other things I could not do because of my disability (unable to concentrate, unable to work for a supervisor, bad memory, etc.). After my lawyer asked his questions relating to my disability he asked the Vocational Specialist "considering the disabilities I have just listed, what jobs you have listed can my client perform?" The Vocational Specialist said, "NONE".

e. The Judge asked If I had anything else to add.

f. The Judge closed the hearing by telling me that I would receive a letter advising me of his decision. (This decision usually takes three to four months.)

I would advise you to request a copy of the ALJ hearing as soon as possible as you may need it to file another appeal.

07-32. Third Denial. Almost four months after the ALJ hearing I received a letter with an UNFAVORABLE decision.

Authors note: It has taken 1 year, 4 months and 5 days to reach this point in the process.

You will find most of my “Notice of Decision” at www.ptsdmanual.com/ssadocs. The complete document is too large to reproduce here.

There will be a List of Exhibits attached to your Notice of Decision. Submit a request for a copy of any of these you do not already have if you need to submit an appeal to the Appeals Council.

07-33. Next to Final Appeal. Appeals Council - You may file an appeal by submitting a SSA Form HA-520 (Request for Review of Hearing Decision/Order) (not furnished with the decision but available on the SSA Internet Page). This appeal may be sent to your local SSA office, a hearing office or mailed directly to the Appeals Council (save time by sending it directly to the Appeals Council). If you have a lawyer it needs to go to him/her for signature. You have 60 days to file your appeal.

07-34. Reopening Your Claim. You may also "Reopen" your case. For instance, between the time of the ALJ hearing and his decision I received a change in my VA disability status. My PTSD was increased from 50% to 70% and I was awarded unemployability, however, you may reopen your case “for any reason” within 12 months. The SSA regulation, 20 CFR, states:

§404.988 Conditions for reopening.
A determination, revised determination, decision, or revised decision may be reopened--

(a) Within 12 months of the date of the notice of the initial determination, for any reason;

(b) Within four years of the date of the notice of the initial determination if we find good cause, as defined in §404.989, to reopen the case;

§404.989 Good cause for reopening.
(a) We will find that there is good cause to reopen a determination or decision if--

(1) New and material evidence is furnished;

(2) A clerical error in the computation or recomputation of benefits was made; or

(3) The evidence that was considered in making the determination or decision clearly shows on its face that an error was made.

(b) We will not find good cause to reopen your case if the only reason for reopening is a change of legal interpretation or administrative ruling upon which the determination or decision was made.

07-35. If you Need to Reopen Your Claim. The entire process begins over again. Call the national phone number or your local SSA office and state that you wish to “Re-Open” your claim. Make certain the representative knows that you are NOT filing a NEW claim.
The same things are about to happen as when you started your original claim. You will receive a new application packet within a few days which will contain the following:

a. Cover letter - They may request items such as Birth certificate or DD 214

b. SF-SSA-16 Form - This contains the information you gave to the SSA Interviewer such as date of birth, etc.

c. SSA-827 Form - Authorization for source to Release Information to the Social Security Administration (SSA) - You will sign and return these.

d. Personal Data Questionnaire (Un-numbered form) - I filled this form out the first time I applied.

e. SSA-3369-BK Work History Report - I filled out this form for my first application.

You are required to return the package within 10 days. These are the same forms you filled out for your original claim. Make sure all of the data matches other than what may have changed since you first filed.

07-36. Review of benefits. Should you eventually receive your SS benefits they will be reviewed as follows:

a. In 6 to 18 months if improvement is "expected".

b. In 36 months if improvement is "possible".

c. In 5 to 7 years if improvement is "not expected"

What is your Master Record?

Your Master Record is a computer-based system of records that contains all of your basic information. It starts when you have your first contact with the VA. Since it is a computer-based program, the information is brought up in "screens". Three of the main "screens" are:

Master Record Screens

- M11 - Status Screen - This screen contains your name and address as well as your date of birth, amount of your disability check (if any), branch of service served in, Type of service discharge, Power of Attorney holder (If applicable), and some other disability information.

- M12 - Award Screen - This screen contains a history of your disability awards and the amount awarded. It also contains a suspense section that is used to remind the VA to check on certain things such as the number of dependents you have.

- M13 - Rating Data - This screen contains your employability code, combat disability code, combined disability rating percentage, and the Diagnostic codes for your disabilities. Each of your disabilities is listed along with the percentage of disability and whether or not it is service-connected and a description of each disability.

Screen M13 looks like this

An important item, if you are applying for CRSC, might be the COMBAT block in screen M13. It should be "Code 2" which comes out as "Comp" (One or more combat disabilities, all of which are compensable.), Code 3 which comes out as "noncomp" (One or more combat disabilities, none of which are compensable), or Code 4 which comes out as "both" (One or more combat disabilities, not all of which are compensable). This indicates that you are service-connected with disabilities that are Combat Related (These definitions are found in VA Manual M21-1, Part VI, Chapter 3, Para 3.17).

You can see from my sample M13 screen printout (See above link) that VA had me as a Code 1 - None, which means I was listed as "No combat disabilities". I submitted a request for change and it now reads Code 4.

Send for a copy of your Master Record using the sample letter below:

START OF LETTER
DATE
ADDRESS OF REGIONAL VA OFFICE
RE: FOIA/PA Request for Copy of Master Records

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This is a formal Freedom of Information Act (5 USC 552) and Privacy Act (5 USC 552a) request made by ________________, SSN __________________, Branch of Service ___________, service dates of _______________ to _______________.

Please provide me a copy of my "Master Record", screens M11, M12, M13.

If you have questions, please contact me at ____________________.

Respectfully,

NAME, SIGNATURE

END OF LETTER SAMPLE

Authors Note: If you need to request a change in the COMBAT area of screen 13, send another letter to your regional VA with the following:

Your VA M21-1, Part VI, paragraph 3.17 defines "Combat Disabilities" as "any injury received in action against an enemy of the United States or as a result of an act of such an enemy. This includes wounds by missiles, injuries, or psychological trauma (PTSD) experienced in accidents, explosions, airplane crashes, etc., during a period when the veteran was in combat. Request that you change my Combat Code, Master Record, Screen 13, to a 2, 3, or 4, whichever is appropriate."

Authors Note: The last sentence of the above paragraph (3.17) says "No combat determination is to be made unless evidence of record clearly relates the disability to combat origin or acts of the enemy." In Part III of the M21-1, chapter 1, para 1.01 it says "Decisions on VA benefit eligibility and entitlement are based on the evidence of record. Evidence consists of documents, records, testimonials and information in other forms provided by, or obtained for, a claimant. VA has a duty to assist a claimant who files a substantially complete claim in obtaining evidence to substantiate his or her claim before making a decision on the claim. We are charged with granting every benefit supported by the law".

When you state that the stressor or stressors occurred in a combat situation (Usually in your Stress Letter), and it becomes a part of your claim, this is considered "evidence of Record". See my notes on "Evidence of Record".

Section X. PERSONAL EXPERIENCE

07-37. My First Visit. On the first visit to my local VA Clinic the helpful interviewer I spoke with did two things:

a. She issued me a new VA ID card.

b. She advised me to have my disability upgraded since mine was less than 30%.

The clinic in my area has a Regional VA Counselor on the premises so the process was easy.

The day I was there I filled out two VA Forms 21-4138, Statement in Support Of Claim, on the counselors advice. One was to request an upgrade of my service connected problems that were less than the magic 30%. Since you are obviously older than when you last filed whatever problems you had when you left the service your service connected problems may have deteriorated significantly enough to gain you an increase in your stated disability.

The second VA Form 21-4138 was for PTSD. I may not have filed at that time but the counselor asked why I was there and I told him I had just been diagnosed with PTSD. The counselor then informed me that it could take up to year for a determination to be made on either or both of the claims.

On several occasions I received an updated appointment schedule in the mail. On one I noticed what was labeled as a “LAB” appointment and another called “ADMIN”. I was not suppose to eat prior to the “LAB” and arrive early for the “ADMIN” appointment. Call if you are not certain what the appointment is for and save your self time and anger.

The process was lengthy and often frustrating. Be prepared to wait.

By the way. Here is something for you teckno nerds out there. You can find a general information section at the VA home page on the Internet (www.va.gov) where you can send email and receive answers to your online questions. Be VERY exact and explicit in your questions to this online help service and be prepared to wait for 30 days or more for an answer. I submitted several questions to this address during the writing of this manual. On one I was given a partial answer and instructed to call the "800" for additional information and for another I was advised to check my local library for the answer. The email address is "varo@mail.hic.net".
As of this printing my experience with the Social Security Administration is ongoing. They have a problem with PTSD because it is not specifically defined in their “List of Impairments”. If anything they are HARDER to work with than the VA, will not answer your mail queries, take a VERY LONG time to process your claim, and operate in a different world using their own rules. Do you detect anger and frustration there? You should.

Pension, Not Disability. There is a little know benefit reserved for combat veterans known as a "Non-Disability Combat Veteran Pension". I will not spend much time here dealing with pensions, however, if you qualify you might be interested in applying. Under current regulations you must have served in certain combat areas, be un-employable, and have VERY LITTLE income. Check with your local Service Representative for details.

SITREP - Vietnam Era (1967):
The six day war between Israel and Syria begins; surgeon Christian Barnard performs the world’s first heart transplant in Cape Town, South Africa; *Rolling Stone* magazine begins publication in November; *Rosemary’s Baby* is written by Ira Levin and *Topaz* is written by Leon Uris; the movies “Bonnie and Clyde”, “The Graduate”, and “In Cold Blood” are released; the songs “Gentle on My Mind”, “Can’t Take My Eyes off You” and “All I Need Is You” are released; the Green Bay Packers defeat the Kansas City Chiefs in the First Super bowl; the St. Louis Cardinals win the World Series by defeating the Boston Red Sox 4 games to 3.

Vietnam Era (1968):
North Korea seizes the spy ship U.S.S. Pueblo; Martin Luther King is killed April 4; the show 60 Minutes debuts on television; the books *The Day of The Scorpions* and *Myra Brekenridge* are published; the movies “Rosemary’s Baby” and “2001: A Space Odyssey” are released; the songs “Mrs. Robinson” and “Lady Madonna” are released; Green Bay beats Oakland in Super bowl II; the Detroit tigers win the World Series by defeating the St. Louis Cardinals 4 games to 3.
Chapter 8
Writing The Stress Letter

Section I. GENERAL

08-01. General. One of the most difficult things you will be required to accomplish during your battle with PTSD is the writing of your “Stress Letter.” It will be difficult because of the emotional impact and because of the effort and time required to write an effective letter. This letter is your “justification” for having PTSD and must be submitted to the Department of Veterans Affairs if you intend to apply for disability compensation. (Don’t get up-tight about having to justify your combat tour. First, remember you are dealing with the government, and second, it’s like applying for a physical disability, if you ain’t got it you don’t get it).

I would like to point out that the Stress Letter is used by the VA to establish that you experienced a stressor, not the severity of the stressor. Your actual disability and percentage of disability will eventually be determined by your PTSD C & P (Compensation and Pension) interview a local VA Rating Specialist and your CURRENT social (in)adaptability.

This chapter will include a discussion of the dangers of writing the letter, some pointers on obtaining supporting evidence for your letter, an explanation of how you can write your stress letter, notes explaining what happened to me as I wrote my letter, and a list of places where you can get help in writing the letter.

08-02. Don’t Be Ashamed. Let’s get one thing straight at the beginning of this chapter. You are a combat veteran, you have nothing to be ashamed of, and you are entitled to benefits if, as a result of your combat duty, you sustained physical, mental or emotional damage.

Whether you walked the bush, rode on a boat, flew in the sky, performed support activities in the rear echelon or performed any other combat related duties, you were there. If you are suffering from PTSD then something traumatic happened to you. All of the guys who spent time in the bush faced trauma on a daily basis. All of the guys who supported the guys in the bush had their share of stress whether it was derived from being shot at, mortared, or just living daily with the fear of being injured or killed.

Since I spent almost my entire tour in Vietnam in Saigon, as a communications center specialist, I was ashamed to write down my paltry experiences after reading about and hearing first hand accounts of what other vets went through in the field. I got over this in a hurry as I sat down to and began to reflect on the events that took place before and during my tour in Vietnam.

Section II. DANGERS

08-03. Beware The Danger of Remembering. What follows is a short diary of my personal experience:

Wed., Oct 29 - Began to write my “stress” letter in earnest [Since I knew I would have to do this eventually, having been warned by my psychologist, I had already done a brief outline of what I could, or wanted, to remember]. Very high anxiety level, faster heart beat and almost physical sickness. Only through two incidents but already very disturbed. Things got worse. After I left the house, to go to work, my anxiety level began to rise. By the time I arrived at my office I was mentally confused. I felt actual fear and when I called the VA to ask for a doctor I could not remember my SSN. Close to being completely dysfunctional. I finally was able to speak with my psychologist about 4 hours later (someone forgot to give him my message).

Thur., Oct 30 - I am determined to get this behind me. Have begun to write on my stress letter again. Was OK for a while but anxiety level began to rise so I put it aside again.
Fri., Oct 31 - Visited one on one with my psychologist. I spoke of problem on Oct 29th. He explained that my episode was not that uncommon [I wonder why he didn’t tell me this before].

I did not include those journal entries in an effort to alarm you. I merely want you to be prepared for what might happen. Each person reacts differently to the stresses of relating traumatic events and you may have no problem managing the stress of your own traumatic recollection. My advice, after experiencing the above, is to have someone nearby that knows what you are going through, be it a fellow vet or your doctor.

Authors note: To put the above in perspective, I actually reported to the VA for help for the first time on Aug 14, 1997. This means that even though I had been under treatment for more than 10 weeks, simply beginning work on the stress letter almost put me over the edge again.

Section III. SUPPORTING EVIDENCE

Do You Need Supporting Evidence?

In paragraph 08-04 of my Manual I indicated that there was a reference to certain decorations being accepted as proof of stressors and that 38 CFR, which I quoted as being listed in my Appendix "J" attested to this. This is no longer correct.

Change 91 to Part III, Chapter 5.14 changed the wording so that the listed Awards are "Examples" that may serve as evidence. However, Change 65, Part VI, Chapter 11.38 still states that "If the claimed stressor is related to combat, in the absence of information to the contrary, receipt of any of the following individual decorations will be considered evidence of participation in a stressful episode:". This is followed by a list of awards.

Even if you are not required to send in a stress letter, I recommend you do so anyway so that it becomes part of your official records and to make certain you include the following at the end of your letter: "These events took place during or as the result of a combat situation and occurred in action against an enemy of the United States. I swear the above information is true and correct to the best of my knowledge".

Evidence of Stressors in Service

(1) **Conclusive Evidence.** Any evidence available from the service department indicating that the veteran served in the area in which the stressful event is alleged to have occurred and any evidence supporting the description of the event are to be made part of the record. Corroborating evidence of a stressor is not restricted to service records, but may be obtained from other sources (see *Doran v. Brown*, 6 Vet. App. 283 (1994)). If the claimed stressor is related to combat, in the absence of information to the contrary, receipt of any of the following individual decorations will be considered evidence of participation in a stressful episode:

- Air Force Cross
- Air Medal with "V" Device
- Army Commendation Medal with "V" Device
- Bronze Star Medal with "V" Device
- Combat Action Ribbon
- Combat Infantryman Badge
- Combat Medical Badge
- Distinguished Flying Cross
- Distinguished Service Cross
- Joint Service Commendation Medal with "V" Device
- Medal of Honor
- Navy Commendation Medal with "V" Device
- Navy Cross
- Purple Heart
- Silver Star
Other supportive evidence includes, but is not limited to, plane crash, ship sinking, explosion, rape or assault, duty on a burn ward or in graves registration unit. POW status which satisfies the requirements of 38 CFR 3.1(y) will also be considered conclusive evidence of an in-service stressor.

(2) **Evidence of Personal Assault.** Personal assault is an event of human design that threatens or inflicts harm. Examples of this are rape, physical assault, domestic battering, robbery, mugging, and stalking. If the military record contains no documentation that a personal assault occurred, alternative evidence might still establish an in-service stressful incident. Behavior changes that occurred at the time of the incident may indicate the occurrence of an in-service stressor. Examples of behavior changes that might indicate a stressor include (but are not limited to):

- Visits to a medical or counseling clinic or dispensary without a specific diagnosis or specific ailment;
- Sudden requests that the veteran’s military occupational series or duty assignment be changed without other justification.

Lay statements indicating increased use or abuse of leave without an apparent reason such as family obligations or family illness;

- Changes in performance and performance evaluations;
- Lay statements describing episodes of depression, panic attacks, or anxiety but no identifiable reasons for the episodes;
- Increased or decreased use of prescription medications;
- Increased use of over-the-counter medications;
- Evidence of substance abuse such as alcohol or drugs;
- Increased disregard for military or civilian authority;
- Obsessive behavior such as overeating or undereating;
- Pregnancy tests around the time of the incident;
- Increased interest in tests for HIV or sexually transmitted diseases;
- Unexplained economic or social behavior changes;
- Treatment for physical injuries around the time of the claimed trauma but not reported as a result of the trauma; and
- Breakup of a primary relationship.

In personal assault claims, secondary evidence may need interpretation by a clinician, especially if it involves behavior changes. Evidence that documents such behavior changes may require interpretation in relationship to the medical diagnosis by a VA neuropsychiatric physician.

c. Development

(1) For instructions regarding development of service records, medical treatment, and evidence of stressor or personal assault, refer to Part III, subparagraphs 5.14b and 5.14c.

(2) Unless medical evidence adequate for rating purposes is already of record, request an immediate examination. When requesting an examination, state in the remarks section of VA Form 21-2507, "Request for Physical Examination." "Claims folder to be made available to examiner upon request."

d. Incomplete Examinations and/or Reconciliation of Diagnosis. If an examination is received with the diagnosis of PTSD which does not contain the above essentials of diagnosis, return the examination as incomplete for rating purposes, note the deficiencies, and request reexamination.

(1) Examples of an unacceptable diagnosis include not only insufficient symptomatology, but failure to identify or to adequately describe the stressor, or failure to consider prior reports demonstrating a mental disorder which could not support a diagnosis of PTSD. Conflicting diagnoses of record must be acknowledged and reconciled.

(2) Exercise caution to assure that situational disturbances containing adjustment reaction of adult life which subside when the situational disturbance no longer exists, or is withdrawn, and the reactions of those without neurosis who have "dropped out" and have become alienated are not built into a diagnosis of PTSD.

e. Link Between In-service Stressor and Diagnosis. Relevant specific information concerning what happened must be described along with as much detailed information as the veteran can provide to the examining physician, referring to the time (year, month, day), geographical location (corps, province, town or other landmark feature such as a river or mountain), and the names of others who may have been involved in the incident. The examining psychiatrist or psychologist should comment on the presence or absence of other traumatic events and their relevance to the current symptoms. Service connection for PTSD will not be established either on the basis of a diagnosis of PTSD unsupported by the type of history and description or where the examination and supporting material fail to indicate a link between current symptoms and an in-service stressful event(s).

f. Review of Evidence

(1) If a VA medical examination fails to establish a diagnosis of PTSD, the claim will be immediately denied on that basis. If no determination regarding the existence of a stressor has been made, a discussion of the alleged stressor need not be included in the rating decision.

(2) If the claimant has failed to provide a minimal description of the stressor (i.e., no indication of the time or place of a stressful event), the claim may be denied on that basis. The rating should specify the previous request for information.

(3) If a VA examination or other medical evidence establishes a valid diagnosis of PTSD, and development is complete in every respect but for confirmation of the in-service stressor, request additional evidence from either the Environmental Support Group (ESG) or Marine Corps. (See Part III, paragraph 5.14.)

(4) Do not send a case to the ESG or Marine Corps unless there is a confirmed diagnosis of PTSD adequate to establish entitlement to service connection. Correspondingly, always send an inquiry in instances in which the only obstacle to service connection is confirmation of an alleged stressor. A denial solely because of an unconfirmed stressor is improper unless it has first been reviewed by the ESG or Marine Corps.
(5) If the ESG or the Marine Corps requests a more specific description of the stressor in question, immediately request the veteran to provide the necessary information. If the veteran provides a reasonably responsive reply, forward it to the requesting agency. Failure by the veteran to respond substantively to the request for information will be grounds to deny the claim based on unconfirmed stressor. (See Part III, paragraph 5.14.)

5.14 POST TRAUMATIC STRESS DISORDER (PTSD)

a. Post-traumatic Stress Disorder. Service connection for post-traumatic stress disorder (PTSD) requires medical evidence diagnosing the condition in accordance with 38 CFR 4.125(a); a link, established by medical evidence, between current symptoms and an in-service stressor; and credible evidence that the claimed in-service stressor occurred. (38 CFR 3.304(f))

b. Evidence of a Stressor in Service. Obtain all available evidence from the service department showing that the veteran served where the stressful event occurred. Also obtain evidence supporting the veteran’s description of the event.

(1) Combat Stressors. The following individual decorations are examples of decorations which may serve as evidence that the veteran engaged in combat:

- Air Force Cross
- Air Medal with "V" Device
- Army Commendation Medal with "V" Device
- Bronze Star Medal with "V" Device
- Combat Action Ribbon
- Combat Infantryman Badge
- Combat Medical Badge
- Distinguished Flying Cross
- Distinguished Service Cross
- Joint Service Commendation Medal with "V" Device
- Medal of Honor
- Navy Commendation Medal with "V" Device
- Navy Cross
- Purple Heart
- Silver Star

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If the evidence established that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran’s service, the veteran’s testimony alone establishes the occurrence of the claimed in-service stressor. (38 CFR 3.304(f) and 38 U.S.C. 1154(b))

(2) Non-Combat Stressors. PTSD may result from a non-combat stressor, such as a plane crash, ship sinking, explosion, rape or assault, duty on a burn ward or in a graves registration unit.

(3) POW Status. If the evidence establishes that the veteran was a prisoner-of-war under the provisions of 38 CFR 3.1(y) and the claimed stressor is related to that prisoner-of-war experience, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran’s service, the veteran’s testimony alone establishes the occurrence of the claimed in-service stressor. (38 CFR 3.304(f) and 38 U.S.C. 1154(b))

c. Development
(1) If the veteran indicates pertinent treatment in a VA facility, Vet Center, or elsewhere, request hospital report(s) and clinical records.

(2) If the evidence does not establish that the veteran was engaged in combat with the enemy, or the evidence does establish this but the claimed stressor is not related to that combat, then credible supporting evidence is required to establish that a stressor occurred. (38 CFR 3.304(f)) In cases where available records do not contain this, develop for this evidence as follows:

(a) Request specific details of the in-service stressful incident(s): date(s), place(s), unit of assignment at the time of the event(s), description of the event(s), medal(s) or citation(s) received as a result of the event(s), and, if appropriate, name(s) and other identifying information concerning any other individuals involved in the event(s). (See Exhibit B.9.) As a minimum, the claim must indicate the location and approximate time (a 2-month specific date range) of the stressful event(s) in question, and the unit of assignment at the time the stressful event occurred. Inform the veteran that this information is necessary to obtain supportive evidence of the stressful event(s) and that failure to respond or an incomplete response may result in denial of the claim.

Note: Do not ask the veteran for specific details in any case in which there is credible supporting evidence that the claimed in-service stressor occurred.

(b) Use only one of these codes at a time in PIES. Use O19 for simple PTSD claims and O18 for personal trauma. Do not use the free text and list all of the information mentioned in the manual. The response team at NPRC knows which pages to send for simple PTSD cases. In personal trauma cases, they will send copies of everything. There should be no occasion where both O18 and O19 are used. If the claim is for both personnel trauma and PTSD, the use of code O18 will include pages that would have been sent in response to code O19. In either event, no additional instructions need to be added to the PIES request.

• ARMY: “Personnel Qualification Record,” DA Form 2-1. The form is used for both Officers and Enlisted personnel, and first came into use in January 1973. Prior to that, DA Form 20 and DA Form 66 were used.

• NAVY: Enlisted record of "Transfer and Receipts" (p 12), pages 32 and 33. Enlisted record of "Administrative Remarks" (p. 4-9, 13), page 34. Officer record, NAVPERS 1301/51, "Officer Data Card," page 35. DD214 and enlistment contracts are usually included.

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• AIR FORCE: “Airman Military Record,” AF Form 7, Enlisted, pages 36 through 39. Officer Military Record (AF Form 11), pages 39 and 40. Performance Reports for both Officer and Enlisted.

• MARINE CORPS: Enlistment contracts, discharge papers, MABMC-11 (discharge order) and service records usually provided. Pages 3, 5-6, 8-9, 12-13, and 17 included.

• COAST GUARD: Enlisted Record, "Endorsement on Order Sheet" (DOT Form CG 3312B). Officer Record, "Service Records Card," CG 3301, CG 3303 and CG 3305, pages 3, 5, 6-7. DD214 and enlistment contract.

(3) If medical evidence establishes a valid diagnosis of PTSD, and development is complete in every respect but for confirmation of the in-service stressor, contact either the U.S. Armed Services Center for Unit Records Research (CURR) or the Marine Corps (subparagraph (3)(b)). Requests to that office must include the following:

• A two-month specific date range when the stressful event occurred;
• The veteran’s unit of assignment at the time of the stressful event; and
• The geographic location where the stressful event took place.

Additional information identified by CURR as helpful in conducting research includes:

• Medals or citations received by the veteran; and
• Stressful events witnessed by the veteran. Specific information including the names of other soldiers or sailors involved, dates, units of assignment, and their geographic location is essential.

Note: CURR maintains a database of pending research requests. Any research requests identified as inadequate will be closed out. Additional development should be undertaken prior to resubmission of the request to CURR. Stations may, at their discretion, render a final decision on cases if they determine that the information needed to conduct research is unobtainable. The file should be documented to this affect.

(a) For all services except the Marine Corps send the letter to: U.S. Armed Services Center for Unit Records Research (CURR), 7798 Cissna Road, Suite 101, Springfield, VA 22150-3197. Their telephone numbers are (703) 806-7835 or 7838. If necessary, you may also contact the Coast Guard at: Commander, Military Personnel Command, MPC-S-3, 2100 Second St. SW, Washington, DC 20593-0001.

(b) For Marine Corps veterans with service after 1956, send the letter to: Commandant of the Marine Corps, Headquarters United States Marine Corps, MMSB10, 2008 Elliot Road, Suite 201, Quantico, VA 22134-5030. Their telephone numbers are (703) 784-3935, 3939, or 3940. For veterans with service before 1956, send to: Marine Corps Historical Center, Building 58, Washington Navy Yard, Washington, DC 20374-9580. Their telephone numbers are (202) 433-3483 or 3840. All command chronologies are located at the Historical Center as well as unit diaries before 1956, and some unit diaries for the period 1956 to 1966. Quantico should have all unit diaries from 1956 on. In some instances, the military may forward the RO’s inquiry to the other facility for a better answer.

(c) Enclose copies of information received from the veteran and the service department with these requests. A sample letter is enclosed in exhibit B.12. This letter should not be sent until a valid diagnosis of PTSD is of record.

(4) If sufficient evidence is already of record to grant service connection for a claimed condition, do so. If not, but there is a confirmed diagnosis of PTSD, send an inquiry to the CURR or the Marine Corps. However, always send an inquiry in instances in which the only obstacle to service connection is confirmation of an alleged stressor. A denial solely because of an unconfirmed stressor is improper unless it has first been reviewed by the CURR or the Marine Corps.

(5) Occasionally, the CURR or the Marine Corps will request a more specific description of the stressor in question. Failure by the veteran to respond substantively to the request for information will be grounds to deny the claim based on unconfirmed stressor.

d. PTSD Claims Based on Personal Assault

(1) Veterans claiming service connection for disability due to an in-service personal assault face unique problems documenting their claims. Personal assault is an event of human design that threatens or inflicts harm. Examples of this are rape, physical assault, domestic battering, robbery, mugging, and stalking. Although these incidents are most often thought of as involving female veterans, male veterans may also be involved. Care must be taken to tailor development for a male or female veteran. These incidents are often violent and may lead to the development of PTSD secondary to personal assault.

(2) Because assault is an extremely personal and sensitive issue, many incidents of personal assault are not officially reported, and victims of this type of in-service trauma may find it difficult to produce evidence to support the occurrence of the stressor. Therefore, alternative evidence must be sought.
(3) To service connect PTSD, there must be credible evidence to support the veteran’s assertion that the stressful event occurred. This does not mean that the evidence actually proves that the incident occurred, rather that there be at least an approximate balance of positive and negative evidence that it occurred.

(4) Review the claim and all attached documents. Develop for SMRs and MPRJ information as needed.

(a) Service records not normally requested may be needed to develop this type of claim. Responses to the development letter attachment shown in Exhibit B.11 may identify additional information sources. These include:

- A rape crisis center or center for domestic abuse,
- A counseling facility,
- A health clinic,
- Family members or roommates,
- A faculty member,
- Civilian police reports,
- Medical reports from civilian physicians or caregivers who may have treated the veteran either immediately following the incident or sometime later,
- A chaplain or clergy,
- Fellow service persons, or
- Personal diaries or journals.

(b) Obtain any reports from the military police, shore patrol, provost marshal's office, or other military law enforcement. Development may include phone, fax, e-mail, or correspondence as long as documented in the file.

(5) Identifying possible sources of alternative evidence will require that you ask the veteran for information concerning the incident. This should be done as compassionately as possible in order to avoid further traumatization. The PTSD stressor development letter used by regional offices to solicit details concerning a combat stressful incident is inappropriate for this type of PTSD claim. Use Exhibit B.10 or a letter developed locally for this type of claim.

(6) The attachment to the development letter shown in Exhibit B.9 is inappropriate for PTSD claims based on personal assault and should not be used for that purpose. Instead use Exhibit B.11 to this letter or an attachment developed locally.

(7) Rating Veterans Service Representatives (RVSRs) must carefully evaluate all the available evidence. If the military record contains no documentation that a personal assault occurred, alternative evidence might still establish an in-service stressful incident. Behavior changes that occurred at the time of the incident may indicate the occurrence of an in-service stressor. Examples of behavior changes that might indicate a stressor are (but are not limited to):

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(a) Visits to a medical or counseling clinic or dispensary without a specific diagnosis or specific ailment;

(b) Sudden requests that the veteran’s military occupational series or duty assignment be changed without other justification;

(c) Lay statements indicating increased use or abuse of leave without an apparent reason such as family obligations or family illness;

(d) Changes in performance and performance evaluations;

(e) Lay statements describing episodes of depression, panic attacks or anxiety but no identifiable reasons for the episodes;

(f) Increased or decreased use of prescription medications;

(g) Increased use of over-the-counter medications;

(h) Evidence of substance abuse such as alcohol or drugs;

(i) Increased disregard for military or civilian authority;

(j) Obsessive behavior such as overeating or undereating;

(k) Pregnancy tests around the time of the incident;

(l) Increased interest in tests for HIV or sexually transmitted diseases;

(m) Unexplained economic or social behavior changes;

(n) Treatment for physical injuries around the time of the claimed trauma but not reported as a result of the trauma;

(o) Breakup of a primary relationship.

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08-04. Do You Need Supporting Evidence? If you received one or more of the following awards/decorations, you satisfy the VA Requirement (see Appendix J, under 38 CFR, Post-Traumatic Stress Disorder) that you were involved in a combat stressor and you are NOT REQUIRED to submit a stress letter:

Combat Infantry Badge Marine Corps Expeditionary Medal, Purple Heart Navy, Expeditionary Medal, Medal of Honor Air Medal (with "V" for Valor), Distinguished Service Cross Combat Action Ribbon, Navy Cross Combat Medical Badge, Air Force Cross Distinguished Flying Cross, Silver Star Bronze Star (with "V" for Valor), Air Force Commendation Medal (with "V" for valor), Parachutist Badge with Bronze Service Star, Joint Service Commendation Medal (with "V" for valor), Army Commendation Medal (with "V" for valor), or Navy Commendation Medal (with "V" for valor).

You must still provide evidence that you received the award/decoration (a copy of either the DD Form 20 or DD Form 214) and most Service Representatives recommend you submit a stress letter anyway. As I stated earlier, the stress letter has no real bearing on the amount of disability you may eventually receive, it simply establishes the stressor and provides the reviewing/awarding authority at VA with a better feel of what you endured that is causing your current problems.
08-05. Getting Started. Start gathering material immediately (Use “The PTSD Personal Worksheet” provided between chapters six and seven of this manual. This Worksheet will help you keep track of what you have done and need to do and in some cases, the proper sequence). You will need as much information as you can obtain about people, dates, and events. As I worked through this procedure I was able to recall a lot of events but the names, faces, locations and dates eluded me. You are going to be fighting a couple of factors here. Most of us have hidden a lot of this information within the deep recesses of our mind and it has been over 30 years since these events took place. This is a normal thing, considering the disorder we are working with. You probably will have, as I did, a driving need to get past the stress letter as quickly as you can even though you actually have up to a year to submit your information.

08-06. Take Your Time. Chances are not good you will be awarded a disability if all you submit is a sequence of events with no dates, names or organizations. Note carefully the information provided in appendix J (Manual M-2) and appendix K). It is true that you can appeal the decision handed down by the board, however the first determination may take up to a year, and it may very well take several more years to complete the appeals process.

08-07. Cutting You Some Slack. The VA is required to lean in your favor if there is “reasonable doubt” in your case. According to 38 CFR, sections 3.102 and 3.303 (see Appendix J (38 CFR), Reasonable doubt and Service Connected, Part 2 (Principals Relating to Service Connection)) “It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, ....and when...a reasonable doubt arises...such doubt will be resolved in favor of the claimant” and “Each disabling condition shown by a veteran’s service records...[will be examined]...with due consideration to the policy of the Department of Veterans Affairs to administer the law under a BROAD and LIBERAL interpretation consistent with the facts in each individual case.” They can only do this if you have at least provided minimal supporting documentation.

Section IV. WRITING YOUR STRESS LETTER

Hints on Writing Your Stress Letter

In addition to the information in my book please see the following:
1. The single most important factor in (U.S. Armed Services Center for Research of Unit Records) USASCRUR’s ability to successfully research PTSD claims is how full and completely the stressing experiences are described.
2. A stress incident described in detail - - one relating the who, what, when and where - - will likely be within USASCRUR’s capability to verify by using the various available records. Stressors such as the “feeling of death” or the “smell of death” are not the types of events that are recorded in existing combat records.
3. The statement, I saw my friend killed”” may be true, but it is neither researchable nor verifiable. The statement, “I saw John Soldier killed during a fire fight in June 1969,” can be researched. When the veteran making the claim is not the one injured, the unit of the killed or wounded soldier should be provided.
4. To say, “I saw much action,” may be true, but again, is largely unverifiable. The statement, “I was in many mortar attacks during June 1968,” can more easily be researched. If the type of attack is known, and the number of casualties can be given, an USASCRUR researcher can frequently identify the incident if the records are available. If an incident happened aboard a Navy ship, the name, hull number, type of ship, and approximate date should be provided.
5. When researching casualty information, both the last and first names should be given. Dates and units are also helpful. Cases cannot be researched where only the first names or nicknames of individuals are provided. Common names need as much additional information as possible. No listing of casualties by units is currently available. Providing as much information as possible concerning the casualty will make research more effective. In addition to the name, type of injury or type of incident, will assist USASCRUR.
6. Anecdotal (unrecorded and unpublished) incidents are not researchable, even though they might be completely true. The following are examples of anecdotal incidents that cannot be verified through research: “The barber who cut my hair at the local barber shop was later found to be an enemy sapper,” or “A badly wounded soldier died in my arms.”
The above is an excerpt from the “Guide for the Preparation and Submission of Post Traumatic Stress Disorder Research Requests” which is from Appendix K of my book.

08-08. The Work Begins. Start by taking the following actions:

a. Request a complete copy of your personnel records by submitting a SF 180 (A copy is provided in appendix H) to the “National Personnel Records Center (NPRC)”. See last section of appendix E for the addresses of the appropriate NPRC and chapter 10, Section IV, for instructions on filling out the form.

b. Request your Medical Records. See chapter 10, Section III.

c. Request a copy of your Claim, “C” file from the VA. See chapter 10, Section III.

d. After your records come in from the NPRC, send a copy of your DA Form 20 (enlisted), or DA 66 (officer) to the “U.S. Armed Services Center for Research of Unit Records (USASCRUR)” if you served in the Air Force, Army, Navy or coast Guard. If you served in the U.S. Marine Corps send your DA Form 20 or 66 to the “USMC Historical Center”. (Both addresses may be found in Chapter 9). Request they provide you with any support evidence at their disposal based on the units and times of assignment shown on your DA form 20 or 66.

If you do not feel you have enough supporting evidence, contact some of the other agencies (listed in Chapter 9) in an attempt to find additional documentation. If you feel your files are weak from the get-go, request records from additional agencies (see chapter 9) at the same time you submit your request to USASCRUR.

The VA is Required by 38 CFR sections 3.103 and 3.159 (see Appendix J (38 CFR), Assistance in Developing Claims) to assist you with “developing the facts in the filing of your claim to include the seeking of documents from other federal agencies in the support of your claim”. What they will do is contact the “U.S. Armed Services Center for Research of Unit Records (USASCRUR)” for additional documentation.

Do you see something happening here? If you have already received any relevant material from USASCRUR, the NPRC, and you have received your medical records, you will have virtually everything the VA will use when your stressor is evaluated. When you submit your stress letter, if you include a copy of all of the USASCRUR materials you have received, informing them you received the applicable materials from them, the process of comparing the VA’s records (also obtained from the USASCRUR) to your stress letter, and supporting materials, will be greatly simplified. This will speed up your claim process.

There is a very useful pamphlet in print called the Guide for the Preparation and Submission of Post Traumatic Stress Disorder Research Requests. Even though the VA is the custodian of the guide it is published by Guess who? None other than the “U.S. Armed Services Center for Research of Unit Records (USASCRUR)”. They are very protective of this pamphlet for some reason and will only provided it to Veteran Service Officers (VSO). I was able to located a copy through a local VSO and you will find a reprint of the guide, excluding forms and logs, at appendix K of this manual.

I would advise you to have a local VSO review your paperwork for accuracy and content. Then gather it up, fill out and add the four part Stress letter package provided in chapter 10 and return it to the VA Regional Office (VARO) processing your claim.

Section V. GETTING HELP WITH WRITING YOUR LETTER

08-09. Organizations and Individuals. You do not have to do all of the work of gathering information and filling out forms by yourself. I recommend using one or all of the following:

a. State or County Service Agencies - Call information or look in your phone book for the closest “Veterans Service” agency. These agencies are almost always staffed by professional, well trained, dedicated personnel (mostly veterans themselves) that know the ropes. They can take you through the entire process including appeals, if needed.

b. Veterans Service Organizations. See Appendix D. Every major city has a chapter of Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), American Legion, and probably a Vietnam Veterans of America (VVA). There are approximately 40 Organizations Chartered by Congress and/or Recognized by the VA for Claim Representation by 38 C.F.R. Check your local phone book or call information for the phone number. The American Legion in my home town has a Veteran Service Representative (VSR), or Veteran Service Officer (VSO) available by appointment. You will need to call your local chapter and check. While there is no reason you cannot research and submit your own stress letter, the VSR is highly trained (they are required to have a great deal of experience, attend courses and be certified) and can improve your chances of success considerably. As mentioned earlier they have at their disposal the “Guide for the Preparation and Submission of Post Traumatic Stress Disorder Research Requests”.

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Depending on the size of your home town their may also be city or state Veteran Assistance offices. Call your nearest VA facility, 1-800-827-1000 or check your phone book for listings.

c. Fellow Vets. Consider talking with vets you may have stayed in touch with over the years or talking to vets at your local VA clinic or hospital or Vet Center. Even if you do not have a vet help you write the Stress Letter itself, I advise you to have one available, in case you need moral support. (See chapter 9, Section III, Finding an Active Duty or Retired Veteran)

d. Friends, Family, Community. You should get statements from friends, family members, community leaders (such as ministers and merchants), a current or former spouse, former employers, or anyone else who can attest to your actions or problems (this may include criminal records) since your discharge from the military.

Evidence of Record and Your Stress Letter

When you accomplish your Stress Letter it is important that at the end of the letter you put the phrase "These events took place during or as the result of a combat situation and occurred in action against an enemy of the United States. I swear the above information is true and correct to the best of my knowledge". If you have already written and submitted your stress letter you can send in an "addendum" stating the above.

SAMPLE LETTER

Date
Address of Regional Office
Reference: _____________ (Your file No.)
Subject: Addendum to Stress Letter
Dear Sir:
The following is an addendum to my Stress Letter dated __________.
Add as last paragraph:
These events took place during or as the result of a combat situation and occurred in action against an enemy of the United States. I swear the above information is true and correct to the best of my knowledge.
Respectfully,
Your Name
END OF SAMPLE LETTER

What you are doing here is establishing "evidence of record". VA Manual 21-1, Chapter 3, Part VI, says "No combat determination is to be made unless evidence of record clearly relates the disability to combat origin or acts of the enemy." In Part III of the M21-1, chapter 1, para 1.01 it says "Decisions on VA benefit eligibility and entitlement are based on the evidence of record. Evidence consists of documents, records, testimonials and information in other forms provided by, or obtained for, a claimant. VA has a duty to assist a claimant who files a substantially complete claim in obtaining evidence to substantiate his or her claim before making a decision on the claim. We are charged with granting every benefit supported by the law".

When you state that the stressor or stressors occurred in a combat situation, and it becomes a part of your claim, this is considered "evidence of Record".

Section VI. PERSONAL EXPERIENCE

08-10. Personal Experience. I took some time to review my life from the time I returned from Vietnam until the present, and I came up with some eye-opening facts. I remained in the Army for an additional seventeen years, eventually retiring. I changed assignments seven times, five of which I was responsible for (tired of a certain place or not able to get along with my supervisor). After retirement, during a time period of just over nine years, I changed jobs nine times. I made seven of those changes because I was unable to get along with persons in authority.

What has this got to do with you? One of the most common problems associated with PTSD is a problem of working for or around other people. In extreme cases this manifests itself as complete unemployability, however frequent job changes are a more common symptom. Take the time to make a list of your employment history as well as anything else listed in the C & P exam sheet above that applies to you. This may help you avoid memory problems when you go through the C & P interview.

In a special letter in The Post-Traumatic Gazette Newsletter, edited by Patience Mason, Mrs. Mason writes “Beyond taking a description of your traumatic experience in your war and your current symptoms to the interview, I also suggest taping the interview. Here in Gainsville, FL, the only time the VA Compensation examiner asks you about you experiences in the war or your symptoms is when you are recording the interview.”

SITREP - Vietnam Era (1969):
Man walks on the moon for the first time July 21 as U.S. astronaut Neil A. Armstrong steps out of the lunar module from Apollo 11; The Concorde supersonic jet makes its first flight March 2; Sesame Street debuts in November on PBS; Penthouse magazine begins publication at New York in September; The Saturday Evening Post ceases publication February 8 after 148 years; the book The Peter Principle by Laurence J. Peter is published; The Andromeda Strain by Michael Crichton is published; the movie Butch Cassidy and the Sundance Kid with Paul Newman and Robert Redford is released; other movies released were Midnight Cowboy, Wild Bunch, Easy Rider, and They Shoot Horses, Don't They; The New York Jets beat the Baltimore Colts 16 to 7 to win Superbowl III; The New York Mets beat the Baltimore Orioles in the World Series 4 games to 1.

Vietnam Era (1970):
Four students at Kent State University are killed by National Guardsmen during a antiwar rally; The Concorde supersonic jet exceeds twice the speed of sound for the first time November 4; the book Up the Organization by Robert Townsend is published; The French Lieutenant's Woman by John Fowles is published; Jonathan Livingston Seagull by Richard Bach is published; the television show The Mary Tyler Show begins; the movies Little Big Man, MASH, Patton, and There Was a Crooked Man were released; Kansas City beats Minnesota 23 to 7 in Super Bowl IV; the Baltimore Orioles win the World Series by defeating the Cincinnati Reds 4 games to 1.
Chapter 9
Documentation Sources

Section I. GENERAL

09-01. General. As you begin to work on your stress letter you will find that your memory is not what it use to be. This may be because many years have elapsed since you experienced the traumatic events about which you are writing or the memory lapses may be a symptom of PTSD. Either way you will need to locate a war buddy who can help you remember or you need to find some relevant data pertaining to the event or events that caused your extreme stress. What follows required months of research that included many letters and phone calls. I believe it to be the most extensive and accurate list of war material archives and related information available.

Section II. OBTAINING INFORMATION ON YOURSELF

09-02. General. Having been in the military you are aware of the mountains of paperwork created in peace and wartime. It may still be a problem to find historical data pertaining to your unit or individual operations because of carelessness by field commanders and clerks, as is the case for the early years of the Vietnam War, or because many records are still unavailable due to security classifications.

Listed below are archives and records depositories I have been able to locate where you can find information about your unit or a specific operation.

As you explore each of these archives, you may discover that distance makes the process slow and difficult. It may not be a bad idea to employ a professional researcher living near the archive. Considering what is at stake in financial gain/loss as a result of your stress letter it may well be worth the initial expense to engage one of these people. You can bet they are already familiar with the people and process at each depository.

Contact the phone company information operator in the area where the archive is located for a complete list.

09-03. Air Force. Former active-duty Airmen who retired or separated on or after Oct. 1, 2004 can request copies of records such as DD Form 214s, performance reports and other information by writing or faxing:

AFPC/DPFFCMP
550 C St. West, Suite 19
Randolph AFB, TX 78150
Fax: Commercial (210)565-4021

People requesting their own records need to send a signed note that includes their name, social security number, contact information and specific record requested. Those requesting a relative's record also need to provide their relationship to the former Airman.

Former Guard and Reserve Airmen who retired or separated on or after Oct. 1, 2004 can write:

HQ ARPC/PSDC
6760 E. Irvington Place, Suite 4000
Denver, CO 80280
Commercial (303) 676-7071

Your request will be assigned a number and you can expect to wait up to 6 months for a response, because of a constant backlog.

09-04. Army. Out of all the services the Army was the only one that did not answer my letter requesting information. I would recommend you contact:

National Personal Records Center
9700 Page Ave
St. Louis, MO 63132-5100

09-05. Marines. The US Marines maintain archives of USMC operational records, called command diaries in Korea, and command chronologies since 1965. These records are passed down from the battalion/squadron echelon (and above) when a unit is in combat. These reports contain very little personnel information, only the names of staff officers (see address further down for personnel rosters).
1. Obtaining Information Other Than In Person Try the following:

National Personal Records Center
Military Personnel Records
9700 Page Ave
St. Louis, MO 63132-5100

Current policy will allow them to copy 2 months’ records, or 100 pages, for free. After that you will be charged $.15 per page and $25 per hour for labor. As a minimum you will need to include the name of the unit, the months involved, and a statement of agreement to pay the above mentioned fees. Requested documents are usually completed within 1 week, at which time you will be billed, if required. When payment is received, documents are shipped.

2. Obtaining Information in Person. If you plan to go to the center in person they are open, without appointment, Monday thru Friday, from 8am to 4pm. There is a self-service copier available at $.15 per page, payable by cash or check. Korean and Vietnam war records are readily available and Gulf War documents, while still being processed (as of the time of this writing), may be seen if prior arrangements are made.

Authors note: Also see Appendix J, section VIII, for an address used by USASCRUR to obtain Marine Corps “Unit Records”.

09-06. National Archives. The National Archives is the single largest depository of retired military records. The archive consists of more than a hundred thousand cubic feet of documents. Although these records are stored in several locations we will mainly be concerned with those records (World War II and later) housed at the College Park, Archives II branch, location. In addition to printed records the national archives house a vast collection of Electronic records (electronic being defined as only available via some form of software; not printed on paper) as well as the “NARA” Archival Information Locator (NAIL) system, explained in the Internet section below.

b. Obtaining Information in Person. The Center’s research room, #6050 in the Steny Hoyer Research Complex, is open upon demand. You will need to call ahead between 8:45 a.m. and 5 p.m., Monday through Friday to arrange for use and to allow service staff time to pull the records you require, in advance of your arrival. You may purchase copies of records on open reel 9-track magnetic tape, 3480 - class tape cartridge, CD-Riteables, or when appropriate, 3 ½” diskette (DOS compatible).

a. Obtaining Information Other Than In Person. You can take a long shot and write to College Park, providing as much unit information (Company, Battalion, Regiment, Brigade and Division) as possible along with the region (I, II, III Corps, etc.) and dates of actions you are interested in and hope for the best (see chapter 10, application procedures). Mail your request to:

National Personnel Records Center
Military Personnel Records
9700 Page Avenue
St. Louis, MO 63132-5100

If they locate anything, based on the data you provide, they will mail you a NABT Form 72, National Archives Order for Reproduction Services, in duplicate, along with a cover letter and reproduction fee chart. As of this writing you can get from 1-20 copies for $10.00, 21-40 for $15.00, all the way up to 1000 copies for $255.00.

If you wish to order the document/s listed on the Form 72 return the “Order” copy along with Credit Card information, check or money order for the amount requested.

b. Obtaining Information in Person. The best way to know if you are getting the exact information you need is by visiting the College Park Textual Reference Branch and looking at any documents before copying them. As of the writing of this manual the Research Room hours (except legal holidays) are 8:45
1:30 a.m. to 5 p.m., Monday and Wednesday; 8:45 to 9 p.m. Tuesday, Thursday, and Friday; and 8:45 a.m. to 4:45 on Saturday. You can call (301) 713-7250 to confirm these times, particularly if you will be coming in from a long distance. Records are "retrieved" at certain times during the day and if you wish to narrow your research time down even further call (301)713-6775 to see what time your specific records will be available. Here are a few more useful items to know:

a. Researchers must be at least 16 years of age.
b. Report to room 1000 and see a consultant archivist to arrange for an orientation and for registration.
c. Pencil and paper is provided and you may bring approved loose paper, research notes, hand-held wallets and/or coin purses into research rooms, but these items are subject to inspection upon entering or leaving the research center.
d. You may NOT take briefcases, boxes, valises, purses or other large containers into the research rooms, however lockers are available for use at the cost of $.25, which is refunded when the key is returned.
e. You will be under electronic surveillance at all times while in the research room.
f. Paper to paper copies are available from self-service copies for $.10 per page. Microfilm, etc., copies will cost you $.25 each. They even have self-service Polaroid cameras available at $8.50 a print.
g. Special equipment such as personal computers and even scanners may be used if an approval tag is obtained from a staff member. I would recommend you call (301)713-7250 and ask ahead of time about special equipment you wish to bring with you.
h. There is also a local and toll free 800 connection jack available in room 1000 along with public use fax machines.
i. Free parking was available at the time of this writing.

09-07. National Personnel Records Centers (NPRC). There are fourteen (14) different custodian locations where you can obtain a part or all of your military personnel records. You must mail a SF 180 (Request Pertaining to Military Records) to the custodian responsible for your type of records. See the later part of appendix E for a list of all addresses. (see Appendix H for sample of SF 180, and chapter 10, Section IV, for Application procedures).

The VA will routinely request and review your 201 file as part of their determination process, as they do with your military medical records.

09-08. Navy. The Navy forwarded my request to the “U.S. Armed Services Center for Research of Unit Records”.

09-09. VA (Department of Veterans Affairs). Starting in 1992 the VA began taking control of all retired medical records (If you left the military before that date see chapter 10, Section III, for the correct address). If you can remember the location and name of the last medical facility you received treatment at, you can write to that location for assistance. You will find a sample request for medical records in Chapter 10, Section III, under “Medical and Clinical Treatment Records”.

09-10. General. At some point in the writing of your stress letter you may need to obtain different types of information (names, units served with, collaboration, etc.) about a fellow veteran who was present or killed during the traumatic event(s). These individuals may be deceased, still on active duty, or retired.

09-11. Deceased Soldiers. Besides a few Internet pages and history books the only way I could find to obtain data on WW II personnel was through scattered records located in the different archives (good luck). Korea and Vietnam both have an extensive database available and a Gulf War casualty list is available several places on the Internet. You may attempt to obtain personnel records on any veteran from the NPRC by means of the FOIA sample letter provided in chapter 10, section II. There are a few reasons the government may not wish to release records on deceased soldiers but requesting such records under the Freedom of Information Act (FOIA) cuts through most of these.

1. World War II -
   a. The Internet - Try “Phil’s World War II” page (http://www.secondworldwar.co.uk/) for some excellent information.

2. The Korean War -
b. National Archives - The Center for Electronic Records has custody of casualty records as part of RG 330 (known as the Combat Area Casualties Current File (CACCF). They have been compiled by state and can be ordered alphabetically by last name. You receive name, rank or grade, branch of service, home of record, and date of casualty for each person. Make certain you identify your request as part of the Korean War holdings. Each state list is $4.50, with a minimum charge of $10.00. Make check out to “National Archives Trust Fund” and send it to:

References Services
Center for Electronic Records
The National Archives at College Park
8601 Adelphi Road,
College Park, MD 20740-6001

You can call (301) 713-6645 for additional information.

3. Vietnam -
   a. The Internet - The “A Vietnam Veteran’s Memorial Wall” page maintained by “The Vietnam Veterans Memorial Fund” (thewall-usa.com/index.html) has a great search engine that you can enter either first name, last name, home town, home State, branch, age, birthday, service/ssn, or rank and look through a list of matches for that item. There are a lot of other interesting things available at this site. Another page (www.no-quarter.org), maintained by an organization called “no-quarter” offers a quick search by last name, branch of service, hometown, or state.

   b. National Archives (GR 330) - You can order the same type of list available explained in the Korean War GR 330 section above (by State) plus:
      1) Full Print Outs - You can order a printout sorted by up to three of the following variables: Military service, country of casualty, type of casualty, reference number, name, date record processed, social security or service number, military grade, pay grade, date of death (MM/DD/YY), home of record, state, service, occupational code, date of birth, reason, aircraft or not aircraft, race, religion, length of service in years, marital status, sex, citizen code, posthumous promotion, date tour in South East Asia began (YY/MM/DD), body recovered or not recovered, age at time of casualty, component, province, and a comments field. Mail $48 to the Center for Electronic Records address listed above.
      2) Electronic Data File - You can order the complete casualty file on the following media: 9-track magnetic tape at 1600 or 6250 bpi, on 3480-class tape cartridge (37,871 bpi), EBCDIC-OS labeled or EBCDIC-unlabeled or ASCII-unlabeled, and at any block size up to 32, 760 characters, and possibly on CD-R, with ASCII coding and DOS files names. Mail $90 for the 9-track magnetic or CD-R or $80.75 for 3480-class tape cartridge to the Center for Electronic Records address listed above.
      3) Specific Identifiable Person - Upon request the Center for Electronic Records will provide information on up to 3 individuals at no charge. I believe all variable fields are included. Call (301) 713-6645 for additional information.

   c. National Archives (GR 407) - Known as the “The [Army] Adjutant General’s Office Causality Information System (TAGCEN), these records are maintained by The Center for Electronic Records. This database was intended to incorporate information on casualties (deaths and wounds) suffered by U. S. Army personnel and their dependents, worldwide, during the period 1961-81. The printouts are sorted alphabetically by last name, home of record, major organization, and date of casualty. Also included on the printout will be:
      - Country of casualty, category of casualty, social security or service number (the SSN and SN will probably be blanked out), grade, military classification, major attributing cause, vehicle type involved, vehicle ownership, sex, date of birth and some dozen other categories. Mail $90 for a 9-track magnetic tape or CD-R or $80.75 for 3480-class tape cartridge and documentation to The Center for Electronic Records listed above. Information on a single individual may be provided free of charge, upon request.

Granada (Oct 83 – Dec 83) KIA 19
Panama (Operation Just Cause (Dec 89 – Dec 99) 23 KIA
Beirut (Apr 93 – Oct 93) KIA 265
Afghanistan (Operation Enduring Freedom) Oct 2001 –
The Internet - several sites offer useful information. The first is entitled the “Gulf War Debriefing Book” page (www.leyden.com/gulfwar/). The site provides general information but has no direct casualty information. Next we come to Scott O’hara “Desert Storm Homepage (www.desert-storm.com/Services/) which give direct access to casualty information. Another page belonging to Mr. O’hara is “The Gulf War veteran Memorial” (www.desert-storm.com/soldiers/memorial.html) which gives you access to Gulf War casualties by name, rank, age, city/state, and cause of death. Also use:

National Personnel Records Center
Military Personnel Records
9700 Page Avenue
St. Louis, MO 63132-5100

09-12. Active duty soldiers. Active duty soldier locators will not directly provide you information on individuals. They will however forward correctly and completely filled out requests for assistance to any active duty soldier. See chapter 10 for a sample letter and mailing instructions. Enclose a check or money order for $3.50 made out to “Finance Officer” for each request. Below you will find the address and charges for each service (the locator can forward your letter to located individuals but there is no guarantee the individual will answer your inquiry).

1. U. S. Air Force - They will forward one letter per request:
   Air Force Worldwide Locator
   AFPC/MSIMDL
   550 C. Street West, Suite 50
   Randolph AFB, TX 78150-4752

2. U. S Army - You can also get a verbal address by calling (703) 325-3732, Monday through Friday 7:30 am to 4:00 pm, at no charge IF you can provide the full name and social security number or date of birth of the individual in question:
   World-Wide Locator
   U.S. Army Enlisted Records
   and Evaluation Center
   8899 East 56th Street
   Indianapolis, IN 46249-5301

3. U.S. Coast Guard - They will provide ship or station of assignment and telephone numbers at no charge by calling (202) 267-1340, or:
   Commandant
   (CGPC - ADM - 3)
   U.S. Coast Guard
   2100 Second Street, S.W.
   Washington, DC 20593-0001
   Internet Address - NA

4. Marine Corps - Write to the following:
09-13. POW/MIA. I was unable to locate information on WW II POW/MIA’s. The Korean War is not much better but you might try the “Korean War Project” at “www.koreanwar.org/html/pow_mia.html.” The Vietnam Era POW/MIA data base maintained by the Library Of Congress “Federal Research Division” is located at “lcweb2.loc.gov/pow/powhome.html.”

09-14. Retired Soldiers. See chapter 10 for a sample letter and mailing instructions. Enclose a check or money order for $3.50 made out to “Finance Officer” if required, for each request.

1. U.S. Air force (Active duty, Reserve, or National Guard) - All information same as for Active duty above.

2. U. S. Army (Active Duty, Reserve, or National Guard) - During the first quarter of 1998 the Army Reserve Personnel Command (formerly the U.S. Army Reserve Personnel Center) discontinued the practice of forwarding requests for contact to retirees. They offer the following alternatives:
   a. Military associations or reunion groups (see appendix D)
   b. Ads in publications such as Army Times
   c. The Internet such as:

Authors note: See Index for other possible locator alternatives.

3. U.S. Coast Guard (Active Duty or Reserve) - No fee Required to:
   Commanding Officer (RAS)
   U.S. Coast Guard Pay and Personnel Center
   444 S.E. Quincy Street
   Topeka, KS 66683-3591

   Internet Address - NA

4. Marine Corps (Active Duty or Reserve) - No processing fee to:
   CMC (MMSR - 6)
   HQ U. S. Marine Corps
   2 Navy Annex
   Washington, DC 20380-1775

   Internet Address - NA

5. U.S. Navy (Active Duty or Reserve) - Do not put a return address on the letter to be forwarded. Fee of $3.50 is required to:
   Commanding Officer
   Naval Reserve Personnel Center
   4400 Dauphine Street
   New Orleans, LA 70149-7800
Last ditch - If all else fails in trying to reach a retired person you can ask the Retired Pay section to forward a letter for you. I have done this and it works. They do not charge a fee. Try calling (800) 321-1080. Sometimes they can give you an address over the phone if you provide the name and SSN. If not, ask for instructions for forwarding.

I would also like to recommend the book *How to Locate Anyone Who is or Has been in The Military* by Lt. Col. Richard S. Johnson. The book offers help on gathering information for Reunions, locating women veterans, and locator services. Cool.

Section IV. CIVILIAN ARCHIVES

09-15. General. Private and public libraries house literally tons of material about every war the U.S. has been involved in, and particularly the Vietnam War. My guess is that you can locate some information in ANY local library. Start by giving them a call.

1. California - University of California at Berkeley, Berkeley, CA.
   143 History of the Vietnam War (MFR 4342). One of the largest existing collections of non-classified documentary materials on the Vietnam War. Collection includes materials from all of the governments and organizations directly involved in the war including respective military forces. On microfiche.

   144 The NYPL has copies of the *History of the Vietnam War* from the University of California on microfiche, the *John M. Echols Collection* from Cornell University on microfiche and the *Oral Histories of the Johnson Administration, 1963-1969* from the Lyndon Baines Johnson Library on microfiche.

3. Tennessee - Middle Tennessee State University, Murfreesboro, TN.
   145 Armed Forces in Vietnam, 1954-1975 (MFM 1167). This collection is divided into four parts. Part one - Indochina Studies (4 Reels) - contains studies from the U.S. Army center of Military History written by Indochinese. Part Two - Vietnam: Lessons Learned (8 reels) - contains detailed Department of the Army studies on individual aspects of the war as well as an eight-volume work on strategic lessons learned. Part Three - Vietnam: Reports of U.S. army Operations (95 reels) - is a chronologically arranged set of reports on certain individual operations. Part Four - Vietnam: U.S. Army Senior Officer Debriefing Reports (4 reels) - contains reports of debriefings from 1968-1973. Microfilm - (21 reels). The Vietnam War - Microtext Collections. (Middle Tennessee State University Microtext Collections Internet Page)

4. Texas - The Lyndon Baines Johnson Library, Austin, TX.

Authors note: There are copies of many of the microfiche/microfilm items listed above in libraries around the country and some can be transferred between libraries. Check with your local area library and ask if there are in charges for this service.

Section V. ADDITIONAL SOURCES

09-16. General and Internet Resources. See Appendix E.

09-17. Books. See Appendix F.

Section VI. PERSONAL EXPERIENCES

09-18. General. Always figure it will take longer than you think to receive the requested material. Be as specific as you can in with every agency and for all types of information. I have had to request several items more than one time because I did not know what to call the information or how to ask for it. I hope this manual will help eliminate most of those problems for you.

I can say, without exception, that every letter I received in answer to my requests for information was polite, helpful, and offered more than I asked for. Patience, politeness, and persistence are the key words here.
SITREP - Vietnam Era (1971):
Roles-Royce, Ltd., declares bankruptcy; the “Pentagon Papers” are excerpted in the New York Times; the nonfiction book Bury My Heart at Wounded Knee by Dee Brown released; the book Winds of War by Herman Wouk released; Woody Allens movie Bananas released; the movie The Last Picture Show with Timothy Bottoms is released; Baltimore beats Dallas 16 to 3 in Super Bowl V; the Pittsburgh Pirates win the World Series by defeating the Baltimore Orioles 4 games to 3.

Vietnam Era (1972):
The Watergate affair has it beginnings; Federal Express is founded in Memphis, TN; Ms magazine begins publication; the nonfiction book The Foxfire Book by Eliot Wigginston is released; the book The Needle’s Eye by Margaret Drabble is released; the book Watership Down by George Adams is released; the Polaroid SX-70 is unveiled; the television show MASH begins; the movie Deliverance with Burt Reynolds is released; the song “American Pie” by Don McLean is released; the song “Operator” by Jim Croce is released; Dallas beats Miami 24 to 3 in Super Bowl VI; the Oakland Athletics win the World Series by defeating the Cincinnati Reds 4 games to 2.
Chapter 10
Letters, Forms, Notices, and Statements

Section I. GENERAL

10-01. General. As with anything you do that concerns the government there will always be a pile of forms to fill out. A quick reference list is followed by sample letters, forms, notices, and simplified instructions for all of the forms (the forms themselves can be found in appendix H) that may be required when filing for initial disability, claims, records, appeals, etc.

You should ALWAYS make copies of any letters or forms you send to the VA. To be safe I would advise you to send any documents by registered mail.

Most of the veterans I have spoken with submit all of their letters and forms through their local benefits counselor or national Service Organization Representative. I recommend you do the same as they already know the ropes, and their association with your material will lend it some additional credence.

Using FOIA. If there is any doubt that the information will be released on your signature alone include the statement “This information is requested under the FOIA”. USASCRUR points out that requesting documents under FOIA may cause your request to slow down because of additional administrative requirements. Your call.

Section II. QUICK REFERENCE

10-02. A list of All documents provided in this chapter. Listed alphabetically then numerical:

Located in Section III:

147 Air Force Historical Research Agency Request for Microfilm Titles
148 Air Force Historical Research Agency Request for Microfilm
149 Claim file request under the Freedom of Information Act (FOIA)
150 Freedom Of Information Act (FOIA) Request, Personnel Records
151 Medical and Clinical Treatment Records
152 National Archives Request for Textual Material
153 Notice of Disagreement (NOD)
154 Statement of Illness
155 Stress Letter Package
156 World Wide Locator Request for Forwarding

Located in Section IV:

157 SF 180 (Request Pertaining to Military Records)

Located in Section V (SSA Forms):

- HA-501 (Request for Hearing By Administrative Law Judge)
- HA-520 (Request for Review 0f Decision/Order of ALJ)
- SSA 3441-BK (Claimant’s Statement When Request for Hearing is Filed and the Issue is Disability)
- SSA-561-U2 Form (Request for Reconsideration)
• SSA-3368-BK Form (Disability Report - Adult)

158 SSA-3369-BK Form (Work History Report)

159 SSA-7050- (Request for Social Security Earnings Information)

Located in Section VI:

160 VA Form 1-646 (Statement of Accredited Representative)

161 VA Form 9 (Appeal to Board of Veteran’s Appeals)

162 VA Form 10-10EZ (Application for Health Benefits)

163 VA Form 10-5345 (Request for and Consent to Release of Medical Records)

164 VA Form 21-526 (Veteran’s Application for Compensation or Pension)

165 VA Form 21-527 (Income Net Worth and Employment)

166 VA Form 21-2545 (Report of Medical Examination for Disability Evaluation) -

167 VA Form 21-8940 (Veteran’s Application for Increased Compensation Based on Unemployability)

168 VA Form 28-1901 (Counseling Record – Personal information)

169 VA Form 28-8872 (Rehabilitation Plan)

170 VA Form 22a (Appointment of Attorney or Agent as Claimant’s Representative)

171 VA Form 0220 (Notice of Appellate Rights Following Denial of Motion For Reconsideration)

172 VA Form 4107 (Your Rights to Appeal our Decision)

173 VA Form 4597 (Board of Veteran’s Appeals Notice)

Section III. LETTERS: ACTIONS NOT REQUIRING FORMS

10-03. General. These documents are presented Alphabetically.

174 Air Force Historical Research Agency Request for Microfilm Titles - This is a sample letter requesting a list of microfilm titles and roll numbers:

DATE

HQ AFHRA/RSA
600 Chennault Circle
Maxwell AFB, AL  36112-6424

Subject: Request for Microfilm list

Dear Sirs:

I was assigned to the ________________________________ during the
period _____________ and am seeking a list of Unit History Microfilm Roll numbers that would cover that time period.

Thank you in advance for your assistance.

NAME (Typed and Signed)  
SSN  
ADDRESS

175 Air Force Historical Research Agency Request for Specific Microfilm - This is a sample letter asking for copies of a specific roll microfilm that may assist you in writing your stress letter:

DATE

ATTN: Microfilm Orders  
AFHRA/RSA  
600 Chennault Circle  
Maxwell AFB, AL  36112-6424

Subject: Request for Microfilm Required for Disability Application

Dear Sirs:

I am filing for a PTSD disability as the result of my combat service in ______.

Specific microfilm information, if possible:
   a. Subject or Document Title (Call Number)  
   b. Inclusive dates  
   c. Roll number  

I have enclosed a (check, money order) for $30.  
I sincerely appreciate your assistance in this matter.

NAME (Typed and Signed)  
SSN  
ADDRESS

176 Claim file request under the Freedom of Information Act (FOIA) - If you have never filed a claim with the VA you will not have a “C” file. If you have you might be surprised at what might be in your file. Submit this request to your local or regional VA office. Try the following:

Department of Veterans Affairs  
(STREET ADDRESS)

Attn:  Freedom of Information Act Request

Gentlemen:

Pursuant to the Freedom of Information Act, 5 U.S.C. sec. 552(a)(3), I hereby request a copy of my Claims file. (If you know of treatment you received related to PTSD ask for the records pertaining to that time frame only as your “C” file may be quite large).

I am willing to pay the costs of searching and copying these records. I request a reply to this request within a reasonable period of time and am aware of my administrative appeals rights if this request is denied. If additional information is needed please advise me. I can be reached at [phone number].

Sincerely yours,

NAME (Typed and Signed)
177 **Freedom Of Information Act (FOIA) Request, Personnel Records** - The following letter is modeled after a sample provided by the “Friends of the Vietnam Veterans Memorial”.

Public Affairs Office  
National Personnel Records Center  
9700 Page Boulevard  
St. Louis, Mo. 63132-5360

Attn: Freedom of Information Act Request

Gentlemen:

Pursuant to the Freedom of Information Act, 5 U.S.C. sec. 552(a)(3), I hereby request records on the following individual:

[Provide as much info. as you can, for example, "All record pertaining to Samuel L. Spade, U. S. Army, SSN, Service No., Rank, last unit of assignment, etc.".] I would like to have this record because

[state a reason, for example, "I have applied for a PTSD disability and this individual was in the same unit when a traumatic event occurred"].

I understand that the FOIA does not require an agency to disclose personnel, medical or other files "the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." However, since the records I have requested relate to someone who is dead, this exemption should not apply. The information I am requesting should fall under the 1974 amendments to the FOIA, which requires release of reasonably segregable portions of records.

I am willing to pay the costs of searching and copying these records, however, I do request that these fees be waived, given the nature of my request. I request a reply to this request within a reasonable period of time and am aware of my administrative appeals rights if this request is denied.

If additional information is needed please advise me. I can be reached at [phone number].

Sincerely yours,

NAME (Typed and Signed)

SSN

ADDRESS

178 **Medical and Clinical Treatment Records** - Submit a VA Form 10-5345 to the last facility which had responsibility for the treatment records (the last place of assignment), the year and type of treatment (be as specific as possible or be prepared to pay a service fee if you need you entire file).

Send request to the following if veteran was discharged, retired, or released from active duty AFTER the following date:

- Army - October 16, 1992
- Navy - January 31, 1994
- Air Force & Marines - May 1, 1994

Department of Veterans Affairs  
Records Management Center  
P.O. box 5020  
St. Louis, MO 63115-5020

All veterans discharged, retired, or released from active duty BEFORE the above dates send request to:

National Personnel Records Center  
Military Personnel Records
Allow up to 90 days before calling to inquire on the status of your request and remember that the VA will request your medical records when you file for any medical benefits, i.e., disability.

179 National Archives Request for Textual Material - This is a sample letter, similar to a successful one I sent, asking for copies of records that may assist you in writing your stress letter. I used the following format:

DATE

National Archives at College Park
8601 Adelphi Road
College Park, MD  20740-6001

Subject: Request for Textual Records Required for Disability Application

Dear Sirs:

I am filing for a PTSD disability as the result of my combat service in ______. Request any information you may have on the following:

Event:   Search and Destroy mission having taken place on 5 June 1966.
         General Area of Event:   III Corps
         Unit of Assignment:   B Company, 4th Battalion, 3rd Brigade of the 1st Infantry Division.

(authors note:  Repeat this as many times as necessary.)

Request you provide a NABT Form 72 with a list of documents found and cost of reproduction.

I sincerely appreciate your assistance in this matter.

NAME (Typed andSigned)
SSN
ADDRESS

180 Notice of Disagreement (NOD) - This is a simple letter sent to the VRO that disapproved your claim for disability or awarded you a lower percentage of disability than you feel is warranted. Something similar to the following will do:

DATE

ADDRESS OF VA REGIONAL OFFICE

SUBJECT:  Notice of Disagreement
RE: Claim # __________
Date of Claim approval letter __________

Dear Sirs:

I am in receipt of your letter dated _______ in reference to my claim for a PTSD disability. I disagree with your decision to deny my claim for disability (or you can disagree on the percentage of disability granted) and wish to file an appeal based on (new material, etc.).

Request that my claim first be reviewed by a Decision Review Officer (DRO), then if a favorable decision can not be made, Request a local hearing, in front of a local hearing officer, so that you might grant my claim of disability for PTSD (or so that you might increase my percentage of disability for PTSD to ______ %).
181 **Statement of Illness** - Because your benefits depend on the date you submit your claim it is important that you notify the VA as soon as possible of your condition. If you have already filed a claim concerning this problem but failed to take action up to this time, add “REOPENING OF CLAIM #___________” to the right of or following “STATEMENT OF ILLNESS”. If you do not know where your VA Regional Office (VARO) is call 1-800-827-1000 for assistance. The following is a sample letter to accomplish this task. It is recommended you send this letter by registered mail:

**DATE**

VA Regional Office (VARO)
STREET
CITY, STATE, ZIP

**STATEMENT OF ILLNESS**

Dear Sirs:

I have been experiencing problems with my nerves that are a direct result of my service in the __________(put your branch of service here). I am submitting this letter because I am unable to apply in person at this time.

Request you confirm receipt of this statement by return letter at your earliest convenience.

Sincerely,

NAME (Typed and Signed)
SSN
ADDRESS

**Stress Letter Package** - As stated in Chapter 8 this is a four part package. Below you will find a sample Cover Letter, Stress Events description paper, Supporting Material and Attachments. Here is a sample Cover Letter:

**DATE**

VA Regional Office (VARO)
STREET
CITY, STATE, ZIP

RE: (Put your Name and SSN here)
C: (Put your Claim # here)

Dear Sir:

I served in ___________________ from the month of _______19__, to the month ___________19__. (add additional dates if more than one tour).

I request that the VA, in addition to the information given here, develop evidence of my duties while I served in ___________ pursuant to 38 C.F.R. 3.103 and 38 C.F.R. 3.159. Please send me a copy of the results of the development and notify me when the development has been completed.

If your development does not include contact with the U.S. Armed Services Center for Research of Unit Records (USASCRUR), formerly the Environmental Support Group (ESG) please let me know.

If you obtain advisory opinions or opinions of the General Counsel please provide me with copies.
Any reasonable doubt involving my claim should be resolved in my favor pursuant to 38 C.F.R. 3.102 and 38 C.F.R 3.303.

Sincerely,

NAME (Typed and Signed)
SSN
ADDRESS

Incl (3):
Stress Events Letter
Supporting Material
Attachment to Claim

(Next is a detailed description of stressful events. You can use the Form VA will send you or the Form and this letter):

STRESSFUL EVENTS

RE: (Name and SSN)
C: (VA Claim #)(Repeat these on every page in case the pages are separated)

November 16-18, 1966

Unit of assignment and all other known units involved - A Company, 1st Battalion of the 24th Infantry Division with support from the 24th Cavalry Bde. (If there was only one (1) unit of assignment list it on the “Attachment” portion of the package, if more than one (1) list above each event)

Duties Performed While Assigned to this Unit: I was a Infantry Rifleman

(WARNING FROM AUTHOR: THE FOLLOWING IS A GRAPHIC DESCRIPTION OF A FICTIOUS EVENT. UNFORTUNATELY YOU WILL HAVE TO PROVIDE SIMILAR INFORMATION IN ORDER TO CONVINCE THE VA OF THE VALIDITY OF YOUR CLAIM.)

I was a SP4 member of a search and destroy operation that took place just north of Pleiku in I Corps. During this operation 4 of our members were killed and two wounded. Two of the members killed, Pvt James Smith (SSN if Known) and PFC Sam Jacobs, were friends of mine. The deaths occurred as the result of a fire-fight on the second day out when we were ambushed by an estimated 30 VC. Pvt Smith was shot in the head and died immediately. PFC Jacobs was shot in the upper chest and leg and bled to death before we could get a Med. Evac. chopper to fly him out. The chest wound was pretty clean going in but ripped a big hole coming out the back. He must have been hit in a lung also as he sort of gurgled when he screamed, just before he passed out. The leg wound probably would have crippled him as it shattered the bone below the knee.

(For every event listed provide as much supporting material as you were able to find. See the appropriate Chapter and Appendix for obtaining supporting material)

(If you can remember a particular reaction to a particular event list it after the event, if not put a check mark to the left of the appropriate problem on the “Attachment”) I threw up that night and remember getting the shakes each time I went out on missions after that because of the fear of having the same thing happen to me. Each of us was in danger of being wounded or killed each time we stepped into the jungle, if not from bullets and shrapnel then from booby traps made of shit smeared pungi stakes.

(If applicable) I knew the following people in ___(War zone)_____ and they might be able to verify some of my experiences (provide Name, Grade, SSN, Unit of assignment, and dates of assignment if possible):

(If applicable) I knew the following people (provide Name, address, title, phone #) before and/or after going to ___(War Zone)______ and they may be able to verify how I was different after returning:
SUPPORTING MATERIAL

RE: (Name and SSN)
C: (VA Claim #)

The following supporting material is included with this claim:

<table>
<thead>
<tr>
<th>NAME OF ITEM</th>
<th>SOURCE OF ITEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning Report (Mar 67)</td>
<td>National Archives</td>
</tr>
<tr>
<td>After Action Report (Mar 4, 1967)</td>
<td>USASCRUR</td>
</tr>
<tr>
<td>Description of Firefight</td>
<td>Non Fiction Book, Title</td>
</tr>
<tr>
<td></td>
<td>“Ways of War”, by</td>
</tr>
<tr>
<td></td>
<td>John J. Doe, Random House</td>
</tr>
<tr>
<td></td>
<td>1981.</td>
</tr>
<tr>
<td>Letter From Local Minister</td>
<td>Rev. James P. Holy</td>
</tr>
</tbody>
</table>

(The next item in the stress letter package is an Attachment or Enclosure, whichever you prefer. The above Letter is used to establish the Stressor, the following is very important as it will help the evaluation officer award the AMOUNT of disability (remember your disability percentage will be based primarily on your PTSD C & P and your social (in)adaptability):

ATTACHMENT TO PTSD CLAIM

RE: (Name and SSN)
C: (VA Claim #)

1. (If this is your initial application) I hereby request service-connected benefits because the event(s) described in the attached “Stressful Events Letter” prohibit me from functioning normally in a family, social or work atmosphere based on the following:
   a. Employment - (Explain problems you have had with supervisors, other employees, customers, stress of driving to work, concentration, number of jobs held because of being fired or quitting, etc.)
   b. Marital problems - (Describe any marital problems to include number of divorces, inability to express emotions or get close to wife, etc.)
   c. Social - (Explain fear of crowds, social gatherings, vigilance in restaurants like sitting with back to wall, lack of friends, desire to be alone, etc.)

2. (If applicable) I request increased compensation based on unemployability if the service-connected rating is less than 100%. I have attached additional documentation to support this request.

3. I have received psychiatric or psychological treatment for my nervous condition or treatment for alcohol or drug abuse or counseling for my problems at the location(s) identified below (if you have not been treated describe your past or present drug or alcoholic problems):

   ___ in the military in (year) while stationed at ____________________________.
   ___ within one year following discharge from the service at ____________________.
   ___ more than one year following discharge from the service at ________________.

(End of stress letter packet)
World Wide Locator Request for Forwarding - Place the final draft of your letter in a letter sized, sealed, stamped envelope. Place your name and return address in the upper left corner. In the center of the envelope type or write the full name and Social Security number of the final recipient. Now place the above envelope, a check or money order for $3.50 and the following letter in a legal sized envelope and mail it to the appropriate service address given in chapter 9, paragraph 9-12:

DATE

Re: Request For Forwarding

TO WHOM IT MAY CONCERN

Request you forward the enclosed letter to:

(Fill in as much as you know)

Name -
Rank (If not know insert “Officer” or “Enlisted” -
Social Security Number -
Date of birth -
Sex -
Last Assignment -
M.O.S or Job Title -
Service Member is - (Active or Retired)

Thanks in advance for your assistance

NAME (Typed and Signed)
SSN
ADDRESS
PHONE NO. (WITH AREA CODE)

Section IV. STANDARD FORMS (SF)

10-04. General. These forms are presented in Numerical order.

183 SF 180 (Request Pertaining to Military Records) - The minimum information required is veteran’s complete name used while in the service, service and/or social security number, branch of service, and dates of service. (Items 1, 2, 5 a, b, or c). It is also helpful to include date and place of birth (Items 3 and 4).

You will find a copy of SF 180 in appendix H of this manual or you can call (301) 713-6905 for a Fax-on-demand copy (available as document number 2255), or call (314) 538-4261 (Army), (314) 538-4243 (Air Force), (314) 538-4141 (Navy, Marines, coast Guard) and leave your name and address and they will mail you a copy.

Make a copy of the form or letter and mail the original to the appropriate National Personnel Records Center (NPRC) custodian. See latter part of appendix E for the correct address.

It should also be noted that if for some reason you cannot send for the information yourself you may authorize a third party (lawyers, doctors, historians, etc.) to do it for you. Call 1-800-827-1000 to find out what is required on the authorization letter as no specific form was available as of the time of this writing.

Allow up to 90 days before calling to inquire on the status of your request.

(www.nara.gov/regional/mprpub1a.html)

Section V. SOCIAL SECURITY ADMINISTRATION (SSA) FORMS

10-05. General. These forms are presented Numerically.
• **HA-501 Form (Request for Hearing by Administrative Law Judge)** – This form is used for the second step in the appeals process. If you have a “Representative” then you and he/she both have to sign the form before it is sent in. Items 1 through 4 are self explanatory.

• **HA-520 (Request for Review of Hearing Decision/Order)** – This form is used to request a review of your ALJ hearing, if the need arises. Item 5 is where you state why you are requesting the Review. You will probably put “See Attached” in this space. You may also attach additional evidence to this form when you send it in and request additional time to provide your reasons for requesting a review of your claim. The small print says “If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.”

• **Form (Claimant’s Statement When Request for Hearing is Filed and the Issue is Disability)** – This is another one of the “catch up” forms. All of the questions pertain to events SINCE you filed your original claim. Make certain your information is consistent with previous forms.

• **SSA-561-U2 Form (Request for Reconsideration)** – This form is used for the first step in the appeal process. The first few blocks are self explanatory. In the block “I do not agree with the determination made on the above claim and request reconsideration. My reasons are:” enter SEE ATTACHED. Your attachment should look something like the following:

  Name – John Doe

  SSN/Claim # - 000000000

  I do not agree with your disability determination, and request a Reconsideration, because:

  Even though “Post Traumatic Stress Disorder” is not specifically listed in your “List of Impairments” my diagnosed and persistant problems fall under five (5) of the seven (7) disorders listed in section “12.00 Mental Disorders” of the said List of Impairments.

  I would like to bring your attention to the introduction portion of your “List of Impairments”, section 12.00 which states: “An individual who is severely limited in these areas as the result of an impairment identified in paragraph A (found in each category of the particular Category of Impairments) is presumed to be unable to work.....The listings for mental disorders are so constructed that an individual meeting or equaling the criteria could not reasonably be expected to engage in gainful work activity.”

  I would also like to bring you attention to SSR 85-15: TITLES II AND XVI: CAPABILITY TO DO OTHER WORK -- THE MEDICAL-VOCATIONAL RULES AS A FRAMEWORK FOR EVALUATING SOLELY NONEXERTIONAL IMPAIRMENTS which states:

  "1. Mental Impairments
  There has been some misunderstanding in the evaluation of mental impairments. Unless the claimant or beneficiary is a widow, widower, surviving divorced spouse or a disabled child under the Supplemental Security Income program, the sequential evaluation process mandated by the regulations does not end with the finding that the impairment, though severe, does not meet or equal an impairment listed in Appendix 1 of the regulations. The process must go on to consider whether the individual can meet the mental demands of past relevant work in spite of the limiting effects of his or her impairment and, if not, whether the person can do other work, consideration his or her remaining mental capacities reflected in terms of the occupational base, age, education, and work experience. The decisionmaker must not assume that failure to meet or equal a listed mental impairment equates with capacity to do at least unskilled work. The decision requires careful consideration of the assessment of RFC.

  In the world of work, losses of intellectual and emotional capacities are generally more serious when the job is complex. Mental impairments may or may not prevent the performance of a person's past jobs. They may or may not prevent an individual from transferring work skills. (See SSR 82-41, PPS-67, Work Skills and Their Transferability as Intended by the Expanded Vocational Factors Regulations effective February 26, 1979.)
Where a person's only impairment is mental, is not of listing severity, but does prevent the person from meeting the mental demands of past relevant work and prevents the transferability of acquired work skills, the final consideration is whether the person can be expected to perform unskilled work. The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base. This, in turn, would justify a finding of disability because even favorable age, education, or work experience will not offset such a severely limited occupational base.

Example 1: A person whose vocational factors of age, education, and work experience would ordinarily be considered favorable (i.e., very young age, university education, and highly skilled work experience) would have severely limited occupational base if he or she has a mental impairment which causes a substantial loss of ability to respond appropriately to supervision, coworkers, and usual work situations. A finding of disability would be appropriate.

Stress and Mental Illness -- Since mental illness is defined and characterized by maladaptive behavior, it is not unusual that the mentally impaired have difficulty accommodating to the demands of work and work-like settings. Determining whether these individuals will be able to adapt to the demands or "stress" of the workplace is often extremely difficult. This section is not intended to set out any presumptive limitations for disorders, but to emphasize the importance of thoroughness in evaluation on an individualized basis.

Individuals with mental disorders often adopt a highly restricted and/or inflexible lifestyle within which they appear to function will. Good mental health services and care may enable chronic patients to function adequately in the community by lowering psychological pressures, by medication, and by support from services such as outpatient facilities, day care programs, social work programs and similar assistance.

The reaction to the demands of work (stress) is highly individualized, and mental illness is characterized by adverse responses to seemingly trivial circumstances. The mentally impaired may cease to function effectively when facing such demands as getting to work regularly, having their performance supervised, and remaining in the workplace for a full day. A person may become panicked and develop palpitations, shortness of breath, or feel faint while riding in an elevator; another may experience terror and begin to hallucinate when approached by a stranger asking a question. Thus, the mentally impaired may have difficulty meeting the requirement of even so-called "low stress" jobs.

Because response to the demands of work is highly individualized, the skill level of a position is not necessarily related to the difficulty an individual will have in meeting the demands of the job. A claimant's condition may make performance of an unskilled job as difficult as an objectively more demanding job, for example, a busboy need only clear dishes from tables. But an individual with a severe mental disorder may find unmanageable the demand of making sure that he removes all the dishes, does not drop them, and gets the table cleared promptly for the waiter or waitress. Similarly, an individual who cannot tolerate being supervised may be not able to work even in the absence of close supervision; the knowledge that one's work is being judged and evaluated, even when the supervision is remote or indirect, can be in tolerated for some mentally impaired persons. Any impairment-related limitations created by an individual's response to demands of work, however, must be reflected in the RFC assessment."

EFFECTIVE DATE: Final regulations providing the Medical-Vocational Guidelines were published in the Federal Register on November 28, 1978, at FR 55349, effective February 26, 1979. They were rewritten to make them easier to understand and were published on August 20, 1980, at 45 FR 55566. The policies in this PPS also became effective as of February 26, 1979."

(At the end of your request for Reconsideration put any new or different information you might have gotten a hold of and mention anything in their “Notice of Disapproved Claim” that you do not specifically agree with.)

Sign the document.
• **Form SSA-3368-BK (Disability Report - Adult)** – This form has 9 sections, section 9 being remarks. Section 1 will request personal information. Section 2 is VERY important as this is where you describe your “illness” and how this illness limits your ability to work. It further establishes the date you became unable to work, whether or not you are currently working and WHY you stopped working. Use the SSA guidelines for mental illness in their “List of Impairments” and the DSM-IV definition of PTSD to help establish your claim. Section 3 will ask you to list your work experience for the last 15 years (make certain this information matches what you listed on page 1 of Form SSA-3369-BK). Section 4 requests medical information and needs to be as accurate as possible. Section 5 Requests a list of medications you are currently taking and section 6 any tests you might have taken (be certain to list **mental tests** you have taken – since there is no space provided in section 6 simply write “SEE REMARKS” and list your tests in section 9. If you have copies attach them to the form before you mail it in.). Sections 7 and 8 are self explanatory. Reemphasize in section 9 that you are applying for a MENTAL disability. (Can also be accomplished on line)

• **Form SSA-3369-BK (Work History Report)** – This form tells the SSA what type of work you did and the skills you acquired in the past. This form and Section 3 of Form SSA-3368-BK must match. On page 1 you list every job you have had in the last 15 years and on the preceding pages you describe each of those jobs and describe the different physical requirements. The SSA will draw ammunition from this form when they seek to match you up with “work you are still able to perform”. Page 8, SECTION 3 is the remarks section. You will need to be prepared to explain how you are no longer able to perform these tasks or how they do not apply to your claim because you are applying for a MENTAL disorder.

• **Form SSA-3441-bk (Reconsideration Disability Report)** – This form is required to be filed along with the Form SSA-561-U2, even if the SSA does not inform you of such. This is why I asked you to keep track of everything that happens to you after you file your initially claim. Every question pertains to events that happened “since you filed your claim”. Part IV will ask you questions that you already answered for the most part in the “Personal Data Questionnaire”, submitted with your initial application. Make certain the information matches.

• **Form SSA-7050 (Request for Social Security Earnings Information)** – This form is used to request a print out of your past earnings to include the names and addresses of your previous employers. Item 1 is self explanatory. For item 2 put a check mark in the first box (Detailed Earnings Information), indicate the years you wish the information for (15 years, not counting the current year), and indicate that you need the information because you are applying for SSA disability benefits. The rest of the form concerns paying for the information requested and is self explanatory with the exception of the question “Do you want us to certify the information?” to which you will answer “NO”.

**Section VI. VETERAN ADMINISTRATION (VA) FORMS (Revised)**

**10-06. General.** These forms are presented Numerically.

184 **VA Form 9 (Appeal to Board of Veteran’s Appeals)** - This is the form that will go to the “Board of Veterans’ Appeals”, or more lovingly known as the BVA, if your claim is turned down or you feel you are entitled to more of a disability percentage than what was awarded. Instructions are normally attached so it is mostly a no brainer, however, you will need to give some consideration to item 7A, **Do you wish to appear personally at a hearing before a member of board of veterans’ appeals?** If you check NO your appeal will be evaluated on the documentation you enclose with the appeal. If you check YES you have two options; to appear personally in Washington, DC., before the BVA, or to appear before a BVA representative at the local VA office. The “local VA office” actually means a “Traveling BVA Board”. It could be up to a year before you stand before either board, but odds are it will take longer for the “Traveling BVA Board”. If you do not check EITHER YES or NO VA assumes that you do NOT wish to appear before a board at all.
If you are unable, or willing, to fill out the VA Form 9, you can submit the required information in a letter. You will need the following:

DATE

ADDRESS OF VRO
SUBJECT: Appeal to Board of Veterans’ Appeals

Dear Sirs:
The following is provided in support of my appeal of Claim File # ______________.

1. Name, Address, and Relationship of person other than Veterans filing appeal. (May require special documentation, call 1-800-827-1000, for instructions)

2. I DO (DO NOT) wish to appear personally at a hearing.
   a. I wish to appear personally in Washington, DC (at local VRO).

3. I hereby petition the board of veterans’ appeals for relief as set forth below: (State in specific detail the benefits sought on appeal and your reasons for believing that the action appealed is erroneous).

Sincerely,
NAME (Type and sign)
SSN
ADDRESS

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185 **VA Form 10-10EZ (Application for Health Benefits)** - Filled out the first time you go to your local VA facility for treatment. Read over the “Consent to Release Information” about mid-way down the page. You will be required to furnish “Emergency Contact” information and “Last year’s Estimated household taxable income” figures, which you may need to prepare ahead of time.

186 **VA Form 10-5345 (Request for and Consent to Release of Medical Records Protected by 38 U.S.C. 7332)** - Normally used by the veteran to allow a Service Representative to obtain medical records on his behalf when assisting with a claim, most VA facilities will also require the requesting veteran to fill out this form in order to obtain local records. It requires your name, SSN, and the name of the organization (other than yourself) requesting the records. There is a section to authorize the release of information on Drug Abuse, Alcoholism, HIV and Sickle Cell since this is considered sensitive and you may request this type of information NOT be released. You must also define the INFORMATION REQUESTED by selecting “Copy of Hospital Summary”, “Copy of Outpatient Treatment Note(s)” or “Other (Specify)” along with the dates covered by each. The form ends with a request for the PURPOSE of the information and AUTHORIZATION statement where you state that the request has been made voluntarily. A date and signature is required.

187 **VA Form 21-526 (Veteran’s Application for Compensation or Pension) Revised in 1999** - This is a typical government form with 7 pages of instructions and 10 pages to fill out. However, if you check a box other than "None" in item 9B you should not be filling out this form and you do not need to fill out items 33 through 41 as you will be applying for service-connected status. When complete this Form it may be mailed or taken to a VA Regional Office. Always make a copy. The 7 page instructions cover every block on the Form and if you still do not understand a question call 1-800-827-1000 for assistance.

Authors Note: You can save yourself some processing time by sending a VA Form 21-4142, release form, for each physician, hospital, or other persons who know about your sickness that you list in item 20 and 21.

You will need the following supporting evidence and/or documents:

a. Service Medical Records - If you have a copy of your own service medical records, submit them with the application (Take the time to make a copy, even if it is a large file).

b. Other Medical Records - Medical records to substantiate any and all treatment by private doctors and hospitals (Again make a copy to send and keep the originals).

c. Dependency Documents - Copies of birth and marriage certificates and copies of divorce/death record terminating all of your prior marriages and those of your spouse.

d. Military Discharge/DD Form 214 - (Copy 4 - Member Copy) Send a copy of all of your DD Form 214’s if you have them. VA will attempt to obtain verification from the service involved if necessary. (Be advised this will add significantly to your waiting time). (VA Internet www.va.gov/benefits/comp.htm).

188 **VA Form 21-527 (Income Net Worth and Employment)** - This is one of the most demanding forms you will need to fill out in the claims process. Call the VA facility you plan to visit to verify whether
this form will need to be filled out as marriage and dependent birth certificates may be required as well as a copy of your previous year income tax documents for you and your wife (if required). If you have an existing disability, this form should not be required. This is one of those forms you need to sit down with before you arrive at the VA because the information will probably not be readily available to you. You may have a VSO Representative or lawyer assist you and of course you may call 1-800-827-1000 for assistance. Be certain and ask if GROSS income or TAXABLE income is required. Pay attention to Part II, as unemployability may later become a major issue in your claim. Note in Part VI (Income Received and Expected from all Sources): you need to fill in items 20a thru 23c ONLY if you are applying for a non service-connected pension. These figures will determine your co-payment requirement for non service-connected medical treatment.

189 VA Form 21-2545 (Report of Medical Examination for Disability Evaluation) - This form is usually required only if you are applying for or upgrading an existing PHYSICAL disability. A copy will be provided by the C & P section of the VA facility performing whatever type of examination is requested.

You will be required to fill out parts 1 through 19. Parts 1 through 8 are self explanatory. Section A and B, parts 9 through 17, amount to supporting evidence of the disability you are claiming. You may need to reference attachments or add a continuation page. THIS IS VERY IMPORTANT and may well make the difference not only in whether the claim is approved by also the percentage of disability.

• VA Form 21-8940 (Veteran’s Application for Increased Compensation Based on Unemployability) – Items 1 through 23c will take some thought and time to complete. In item 24, Remarks, add the following, Provided That, if there is only one such disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more:

“If I am found NOT qualified for unemployability I am requesting you explain why 38 CFR 4.16 (b) does not apply.”

VA Form 22a (Appointment of Attorney or Agent as Claimant’s Representative) - This form is fairly self explanatory. If you are physically unable or just need help in the processing of your claim, have your service Representative sign, date and mail a copy of the form to the VARO and keep one for his files in case he needs to physically gather records or information. Pay attention to item 9 to be certain you wish your Representative to have this authority.

VA Form 28-1902 (Counseling Record – Personal Information) – On this form you fill out parts a – c. You will need to provide information on your education from Grade school through College. In items 11 and 18 you will need to provide a list of jobs or careers you might be interested in. Section C You will need to put down your last 4 jobs. Items twenty and 21 are self explanatory.

VA Form 28-8872 (Rehabilitation Plan) – Other than your name, claim and SSN, this is filled out by the counselor.

190 VA Form 0220 (Notice of Appellate Rights Following Denial of Motion For Reconsideration) - Nothing to be filled out. This is sent to you, along with the determination made by the BVA on a “Reconsideration” you have filed, so that you might understand your rights to appeal the decision to the US Court of Veterans Appeals (CVA). Note you must mail your appeal within 120 days of the date of the mailing of the notice from the BVA. Pay attention to who you are required to send and original and copy.

191 VA Form 646 (Statement of Accredited Representative) - This form is sent to the veterans Representative by the VA asking if all evidence has been submitted. Time sensitive. If no answer is returned or if the form is not returned by the date indicated the VA considers the appeal completed. Ask your Representative if he/she has received and returned the form.

192 VA Form 4107 (Your Rights to Appeal our Decision) - This Form will accompany the decision of the rating officer bearing the determination made on your claim. It pretty well speaks for itself. You
have one year to file a Notice of Disagreement (NOD). If you have questions, which you will, contact your Claims Representative immediately, to begin your appeal, if required.

VA Form 4597 (Board of Veteran’s Appeals Notice) - Nothing to be filled out. Sent to you by the BVA in answer to your initial, or first, appeal. Have your Benefits Representative explain your options if you do not understand them.

Section VII. PERSONAL EXPERIENCES

10-07. Personal Experiences. I have filled out all of the VA Forms except those pertaining to appeals. My local VA Clinic automatically mailed the necessary forms so I could fill them out prior to my first appointment. Ask you clinic to do the same or use the forms provided in appendix H of this manual.

SITREP - Vietnam Era (1973):
NCR (formerly National Cash Register) begins manufacturing automatic teller machines; Pablo Picasso dies at Mongins, France on April 8th; An energy crisis grips the world, an oil embargo by Arab nations exacerbates the problem; the book Fear of Flying is written by Erica Jong; the movies “Paper Moon” and “American Graffiti” are released; the songs “Tie a Yellow Ribbon Round the Ole Oak Tree” and “Bad, Bad Leroy Brown” are released; Miami beats Washington 14 to 7 in Super bowl VII; the Oakland A’s win the World Series by defeating the New York Mets 4 games to 3.

Vietnam Era (1974):
President Nixon resigns on August 9th; Word processors with cathode-ray tube displays begin to replace typewriters; “streaking” becomes popular at U.S. colleges; People magazine begins publication; the books Jaws and The dogs of War are released; the movies “Chinatown” and “Blazing Saddles” are released; the songs “The Way we Were” and “Behind Closed Doors” are released; Miami beats Minnesota 24 to 7 in Super Bowl VIII; the Oakland A’s win the World Series by defeating the Los Angeles Dodgers 4 games to 1.

Vietnam Era (1975):
Nationalist China’s Chiang Kai-shek dies on April 5th; Saudi Arabia’s King Faisal is assassinated on March 25th; Microsoft is founded in Seattle by Bill Gates and Paul Allen; the books Terms of Endearment and Humboldt’s Gift are released; the movies “Bite The Bullet” and “One Flew over the Cuckoo’s Nest” are released; the songs “The Hustle” and “Lyn Eyes” are released; Pittsburgh beats Minnesota 16 to 6 in Super Bowl IX; the Cincinnati Reds win the World Series by defeating the Boston Red Sox 4 games to 3.

Former Philippine senator Aquino, Jr. returns from exile to Manila August 21 and is shot dead upon arrival by an unknown gunman who is himself immediately shot dead. Israel’s ailing Prime Minister Menachem Begin resigns September 15. The book Iron Weed by William Kenney is released. Thriller released by Michael Jackson and Every Breath released by Sting. The Baltimore Orioles win the World series, defeating the Philadelphia Phillies 4 games to 1; Washington beats Miami 27 – 17 in Super Bowl XVII.

Panama (1989):
The 80486 microprocessor introduced by Intel; A Clear and Present Danger was released by Tom Clancy; San Francisco beats Cincinnati 20 - 16 in Super Bowl XXIII; Oakland Athletics win World Series by defeating the San Francisco Giants 4 games to 0.

Gulf War Era (Persian Gulf War, Desert Storm, (1990-1991):
Wall Street’s Dow Jones Industrial Average closes above 3,000 for the first time; Eastern Airlines ceases operations on January 18; The U.S. first-class rate goes to $.29; the books The Works of Nations and Immortality are published; the films “Bugsy” and “The Silence of the Lambs” are released; the song “Use Your Illusions” is released; The New York Giants beat Buffalo 21 to 19 in Super bowl XXV; the Minneapolis Twins win the World Series by defeating the Atlanta Braves 4 games to 2.

Beirut (1993):
Motorola ships its RISC Power PC Chips; Finnish computer programmer Linns Torualds, 25, uploads the Linux OS Free on the internet; Dallas beats Buffalo 52 to 17 in Super Bowl XXVII; The Toronto Blue Jays win the World Series beating the Philadelphia Phillies 4 games to 2.
Afghanistan (Operation Enduring Freedom) 2001 - :
A pill-size capsule camera gains federal Drug Administration (FDA) approval for use in endoscopy; The World Trade Center towers are destroyed on September 11 by terrorists.; Border Crossing was written and released by Pat Barker. The Baltimore Ravens win Super Bowl XXXV defeating the New York Giants 34 to 7; World Series Game between Arizona and New York, Arizona wins 4 games to 3. (Said to have been one of the best series ever played).

Iraq (Operation Desert Shield)( 2003 –):
Looters strip Baghdad museums of priceless artifacts amidst the chaos that follows the downfall of the Saddam Hussein regime; The Tampa Bay Buccaneers win Super Bowl XXXVIII at San Diago, defeating the Oakland Raiders 48 – 21; The Florida Marlins defeat the New York Yankees 4 games to 2 in the World Series.

THERE’S NOTHING LEFT TO FEAR

If you were there when the mortars fell and the ground shook...
There’s nothing left to fear.

If you saw the bodies rend and the blood and bones scatter...
There’s nothing left to fear.

If you shot another man and felt the soul of the Devil...
There’s nothing left to fear.

If you tripped a booby trap and watched a friend fall...
There’s nothing left to fear.

If you danced with a 50 caliber machine gun...
There’s nothing left to fear.

If you flew in a Huey with dead on the floor and the wounded screaming...
There’s nothing left to fear.

If you watched napalm consume a village of people...
There’s nothing left to fear.

If you lived through the madness and your mind is mostly yours...
There’s nothing left to fear
. By I. S. Parrish

CAN I FORGET?

Can I forget the screaming jets and low-flying choppers?

The smell of rotting jungle and stagnant water.

The sight of napalm exploding through and devastating a once beautiful countryside.

The bondbon beer and ice with cola caps inside.

The strangling rain storms and heat that burned the skin from my bones.

Can I Forget?

Can I forget the steady "thump" of VC mortars and starlight flares lighting up the night sky?

The reality of carrying my own bodybag in my backpack.

The bloody brown t-shirts and torn, twisted young bodies.

I might forget my own name, I will never forget Vietnam.

We were the forgotten patriots, yet only death will allow us to forget.

By I. S. Parrish

(This poem was published in the Annual National Library of Poetry book, 1995)
Chapter 11
The Past and The Future

Section I. GENERAL

11-01. General. I would like to close with a few thoughts on the past and offer hope for the future.

The long process of writing this manual has led me to rethink many aspects of my life. I have spent some time wondering what I would have done, where I would have gone, and who I would have met, had I not gone to Vietnam. I was 21 years old. I had already been married for 3 years, had two sons and my wife was 5 months pregnant with our third child when I left home for Vietnam. I was scared and excited at the same time.

During the first few months I was in Vietnam I thought many times of shooting myself, in some non essential part, so I could get the hell away from that hot, dangerous, miserable place. I do not remember thinking about whether the war was right or wrong, I only thought about getting home.

When I did get home there was no one to talk to about what had happened. The general community called us baby killers. Neither my parents nor my wife asked me any questions then, nor have they ever asked about what we did. Were they ashamed of my actions or concerned for my feelings? My parents can not ask me now; they are gone. My wife, the same one I had back then, has never wanted to know. How does that make me feel? How does it make you feel? Most of you went through the same thing.

You will never be welcomed home, except by your brothers, but you can shed some of the mental baggage by coming to terms with human nature.

Section II. THE PAST

11-02. A Combat Soldier. Dr. Aphrodite Matsakis released a book entitled I Can’t Get Over It: A Handbook for Trauma Survivors. In her chapter on “War and Combat” she writes “Unlike survivors of other trauma, if you were a combat soldier, you were not only powerless but powerful. You could have been killed at any moment, but you could also kill almost at will. You were given weapons and permission to kill and act out your aggressions.” And in the same chapter she explains that the statement “I feel guilty that I killed,” is a sentiment expressed by many veterans. Others say, “I don’t feel guilty that I killed, because that was my job, but I feel guilty that I enjoyed killing.” “It is not just what I saw,” says another, “It is what I became.” And finally “Yet to kill and enjoy killing is exactly what is encouraged by the military...As a result, war can pose a spiritual or moral dilemma for many soldiers...However, in instances where society does not provide such justification for killing, the moral pain of killing can be even more intense. Until most recently, for example, the Vietnam veteran did not receive much societal justification or forgiveness for the killing he was required to do.”

11-03. Fight or Flight. I do not know to what degree you were involved in your war. I do not know if you killed others or watched others die. I do not know if you were “in the jungle” or “stationed in Saigon”. It does not matter.

As civilized human beings we will never find adequate justification for the disposal of others. Whether it be political, self defense, intentional, unintentional, or just a matter of being at the wrong place at the wrong time, the justification will remain elusive. Again at this stage of our lives, it does not matter. We cannot change the past. I do know that every man and animal has a natural instinct to survive.

In her first issue of The Post-Traumatic Gazette, in 1995, Patience Mason, the wife of author and former Vietnam vet and Huey driver Robert Mason, says “As a person is traumatized, at least for the first time, the sense of personal safety is shattered. Two things start to happen immediately. The person will strive to survive using three available systems: flight, fight, or freeze...Military training is designed to get soldiers to always choose fight, but they wouldn’t have to train us to do that if we were natural born killers...Simultaneously, while survival is at stake, feelings will shut down and information taken in and processed will become very focused so the person can do whatever it takes to survive. (emphasis by original author).”

“Whatever it takes! This is not a polite, well behaved part of us. It pisses and shits in its fear. It scratches and bites and goes berserk, beating people to death with the rifle-butt when the bullets are gone. It kicks and gouges...It may freeze or follow orders that are against all the survivor personally believes in.”

Am I offering this information up in an effort to justify what we are capable of in time of war? No. What I want you to try and understand is that though what some of us did is often judged by others, and ourselves, to be morally unacceptable, it stems from what Mrs. Mason describes, when speaking of self preservation, as “God-given or evolution-given, depending on your point of view, but we all have it, and in traumatic enough situations, it will come out or we die.” (emphasis by original author).
11-04. Curable or non curable? After all the books I have read and all the people I have spoken with I am unable to give you a definitive answer to this question. Medical experts say PTSD is not curable. I have come to believe that trauma is similar to both alcoholism and grief. These are not entirely new realizations.

The first step in “curing” an alcoholic is admittance. Until you admit you got it, you can’t learn to live with it. PTSD works the same way.

Grief is the same, but different. Many years ago Dr. Elizabeth Kubler-Ross identified the five stages of grief as Denial, Anger, Bargaining, Depression, and Acceptance. Because of the trauma of combat, veterans spend most of their lives struggling with the first four steps. Sometimes one at a time, sometimes all at once. When the “all at once” happens, we are diagnosed with PTSD.

I wrote a poem (others are scattered throughout this manual) before I knew I had PTSD that goes like this…

“We walked in a place that was dark and presented no clear path to follow. There was beauty untold and dangers beyond understanding.

Most of us did not ask to go there but it was our destiny and duty to do so. It was that time when each breath and heart beat was precious.

The walk made us children borne of danger and raised on death. The walk also made us children loved by God and saved for his purpose.

Things were lost along the way that can never be found or felt again. Things were found that can never be removed from our memory.

If you walked not that path then you can not know our pain. Even those of us that did walk there do not always understand our feelings.

We have decided that we are not weak because of what we must remember. We have decided that if you were not there you cannot judge us.

If the truth be known it may have been the walk of our lives. If you cannot understand these feelings it is because your path has been different.

We pray that you never have to walk the path where we have been. May your thoughts and fears not come from whence ours come.

That walk is over and it is time for another one to start. This new path is better marked and there are signs along the way.

It is time to live with the memories instead of letting them live us each day. It is time to shed the guilt that was forced on us by those unknowing.

If we do not master the new path time will kill us and take away all that we love. If we cannot find our way on this easier path we will be lost forever.”

It appears that I knew at least some of the answer before I knew the question. I do not believe the issue to be the “cure”. The issue is admittance, acceptance and finally … forgiveness. Forgive your God, forgive your government, and forgive yourself. This will not be easy. I sincerely hope that you can come to terms with your demons and that this manual has helped in some small way.

Peace Brother and Sister ….
This author will be glad to speak at any gathering, schedule permitting, for the price of Travel, Food and Housing and permission to sell this Manual.

If you have recommendations or tips that may help other veterans with the PTSD claim process, Email me at “iparrish@ptsdmanual.com” with your comments and stop by my homepage at www.ptsdmanual.com for updates and new projects.
Appendix A

Bibliography

Books


Brochures


Guides

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Magazines

Pamphlets


The Internet


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*Your Health Page*, Kaiser Permanente Home Page (www.kpnw.org/~pfh/pfh97-hbits.html)

Newspapers


Appendix B

Glossary


Adrenal Gland - This is a triangular-shaped body near the kidney. The important thing to us is that it stores three “things” that have an effect on our nerves: dopamine, norepinephrine, and epinephrine (a fancy name for adrenaline). Adrenaline is the stuff that gets the heart pumping and provides an instant shot or energy.

Anhedonia - A psychological condition characterized by inability to experience pleasure in normally pleasurable acts

Antihistamine - Any medicine which counteracts the effect of a histamine (See histamine below).

Anxiety - A troubled feeling; experiencing a sense of dread or fear, especially of the future, or distress over a real or imagined threat to one’s mental or physical well-being (Taber’s Cyclopedic Medical Dictionary, 12th edition, Philadelphia: F.A. Davis Company, 1975, pp A-101)

Benzodiazepine drugs - Act as tranquilizers for the control of symptoms due to anxiety and stress and as sleeping tablets for insomnia. Act by interfering with chemical activity in the brain and nervous system. (The American Medical Association Encyclopedia of Medicine, New York: Random House, 1989, pp 164)

“C” File - Claim file. This file is maintained by the Department of Veterans Affairs (VA) and contains information on any and all queries and or claims you have ever submitted to the VA.

C & P - Compensation and Pension. An abbreviation used by the Department of Veterans Affairs (VA) when referring to physical or mental examinations in conjunction with a claim. For example you are required to take a C & P interview as part of the PTSD claims process.

Catastrophic - The final event

Chronicity - Marked by long duration or frequent recurrence

Cognition - Awareness, having perception and memory. The mental process by which knowledge is acquired.

Collateral - Situated or running side by side.

Concomitants - Something that accompanies or is collaterally connected with something else.

Contextual - The parts of a discourse that surround a word or part passage and can throw light on its meaning.

Cortical - Involving or resulting from the action or condition of the cerebral cortex in the brain.


Discourse - Verbal exchange, conversation.

Dulse - Any of several coarse red seaweed's.
**Duplicity** - Contradictory doubleness of thought, speech, or action, especially: the belying of one's true intentions by deceptive words or action.

**Dysfunction** - Impaired or abnormal functioning

**Efficacy** - The power to produce an effect

**Etiology / Etiological** - All the causes of a disease or abnormal condition

**Existentialism** - A chiefly 20th century philosophical movement embracing diverse doctrines but centering on analysis of individual existence in an unfathomable universe and the plight of the individual who must assume ultimate responsibility for his acts of free will without any certain knowledge of what is right or wrong or good or bad.

**Federal Benefits for Veterans and Dependents Manual, 1997** - The VA Bible on Benefits (for public use), also known as the *VA Benefits Manual*. It has 11 sections and approximately 66 pages of information.

**Fight or Flight** - What follows is a quote from the “New England Mindbody Institute” home page:

“There are two switches on your body's involuntary nervous system: one is for ordinary housekeeping chores; the other is for emergency situations.

When one switch is on, the other is off. The ordinary housekeeping switch controls the normal processes of your body such as breathing, digestion and metabolism. The emergency switch is designed to enable you to survive in the face life threatening danger by triggering your body's "stress response," also known as the "fight or flight response."

Keep in mind that your body's stress response is meant for short term use only. If it is triggered too often, and if it stays on for too long, you can develop serious health problems. How?

When the emergency switch is triggered, powerful hormones associated with stress biochemistry, such as nor-epinephrine and cortisol, are secreted in your body by a process set in motion by your reactive brain which cues the master gland of your endocrine system, the pituitary, to secrete a hormone called adrenocorticotropic. This hormone travels in your bloodstream, and when it hits the adrenal glands sitting on top of your kidneys, adrenaline is released and another phase of the fight or flight response is set into motion.”

[http://www.ne-mindbody.com/streskey.html](http://www.ne-mindbody.com/streskey.html)

**Hemispheric** - One of two half spheres formed by a plane through the sphere's center.

**Histamine** - A chemical found throughout the body released during an allergic reaction. Causes inflammation. *(The American Medical Association Encyclopedia of Medicine, New York: Random House, 1989, pp 540)*

**Hypotheses** - An assumption or concession made for the sake of argument, an interpretation of a practical situation.

**Inhibiting** - To prohibit from doing something, to hold in check.

**Malevolent** - Having, showing, or arising from intense often vicious ill will, spite, or hatred.

**Manual M-2** - A 24 part VA Manual maintained by the Veterans Health Services and Research Administration.
MAO - Monoamine oxidase inhibitor. Used to treat depression and anxiety. It is an enzyme (a complex protein, essential for growth and repair of tissue, capable if inducing chemical changes in other substances without being changed themselves) responsible for breaking down certain neurotransmitters (chemical messengers) in the brain.

Neuralgia - Acute paroxysmal (see paroxysmal below) pain radiating along the course of one or more nerves usually without demonstrable changes in nerve structure.

Neuron - A nerve cell, cell body.

Neurosis - A mental and emotional disorder that effects only part of the personality.

Neurotic - Of, relating to, constituting, or affected with neurosis, (see Neurosis).

Neurotransmitters - A chemical that transmits nerve impulses from one nerve cell to another.

Paroxysmal - A fit, attack, or sudden increase or recurrence of symptoms (as of a disease).

Pervasive - That which pervades or tends to pervade; to go through.

Psychodynamics - The psychology of mental or emotional forces or processes especially in early childhood and their effects on behavior and mental states.

Psychoneurosis - A neurosis based on emotional conflict in which an impulse that has been blocked seeks expression in a disguised response or symptom.

Psychoneurotic - A neurosis based on emotional conflict in which an impulse that has been blocked seeks expression in a disguised response or symptom.

Psychopathological - The study of Psychopathological and behavioral dysfunction occurring in mental disorder or in social disorganization.

Psychosis / Psychotic - Fundamental mental derangement characterized by defective or lost contact with reality.

Psychosomatic - Of, relating, concerned with involving both mind and body.

Reverie - The condition of being lost in thought.

Schizophrenia - A psychotic disorder characterized by lost of contact with the environment.

Shell Shock - Stress disorder in soldiers as a result of combat duty.

SITREP - Situation Report.

Somatic - Of, relating to, or affecting the body.

Stress Response - A physical, chemical, or emotional factor that causes bodily or mental tension and may be a factor in disease causation.

Symptomatology - The symptom complex of a disease.

Synapse - The point at which a nervous impulse passes from one neuron to another.

Synaptic - Of or relating to a synapses or synapse.

Trauma - Injury; wound may be physical or mental.

Tricyclic Antidepressant - Thought to effect the levels of the brain’s chemical messengers (neurotransmitters) and help in the adjustment of the brain’s response to the neurotransmitters.
**URL** - An acronym meaning Universal Resource Locator. This is a fancy computerese definition of any Web Page address on the Internet.

**VSR** - Veteran Service Representative.

**VVRO or VRO** - Veterans Administration Regional Office.

**Web Page** - This is also called a “Home Page” and is a location/address on the Internet created by an individual or company to provide general or product information.
Appendix C

Statistics

What follows is a cross section of statistics from various sources dealing with different eras and different wars/conflicts. Not all of it pertains to PTSD but will probably be of interest. I cannot vouch for the accuracy of the statistics shown. The authoring location/body/person follows each set of figures so if you do not agree with what is shown please contact the author not THIS author. Thanks.

TOTAL DEATHS, WWII THRU GULF WAR

<table>
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<tr>
<th>War (Conflict)</th>
<th>Total Served</th>
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<td>Korean War</td>
<td>5,764,143</td>
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<td>Vietnam War</td>
<td>8,752,000</td>
<td>58,193</td>
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<td>Iraq War (Desert Shield)</td>
<td>ongoing</td>
<td>4,210 (Ongoing)</td>
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<td>Persian Gulf War</td>
<td>467,939</td>
<td>299</td>
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<tr>
<td></td>
<td>31,337,741</td>
<td>502,724</td>
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</tbody>
</table>


VA INFORMATION (All of these figures were based on 2007 information)

- Number of Veterans receiving VA disability Compensation – 2.9 M
- Number of Veterans rated 100% disabled – 257,100
- Number of veterans compensated for PTSD – 308,402
- Number of veterans in receipt of IU benefits – 239,156

DEPARTMENT OF VETERAN AFFAIRS - US VETERANS

The present veterans population is estimated at 26.7 million, as of July 1, 1993. Nearly 80 of every 100 living veterans served during defined periods of armed hostilities. These 20.8 million wartime veterans accounted for 51 percent of all Americans who ever served in wartime.

Altogether, almost one-third of the nation's population -- approximately 70 million persons who are veterans, dependents and survivors of deceased veterans -- are potentially eligible for VA benefits and services.

Care for veterans and dependents spans centuries. The last dependent of a Revolutionary War veteran died in 1911; the War of 1812's last dependent died 44 years ago; the Mexican War's in 1962. There are widows and children of Civil War and Indian War veterans who still draw VA benefits. Some 2,190 children and widows of Spanish-American War veterans are receiving VA compensation or pension benefits.

Internet - http://www.va.gov/a:/stats/genstats.htm

AFTER-EFFECTS OF THE VIETNAM WAR EXPERIENCE

Between 1992 and 1994 DR. Roxane Cohen Silver, Ph D., University of California, Irvine, conducted a survey based on a questionnaire she mailed to Vietnam Veterans (This author participated in the survey). The following information was gleaned from the more 2000 replies received:

“The experience reflected in the questionnaires ranged from no combat exposure to extensive experience in active combat. Seventy percent said they had fired a weapon at the enemy at least sometimes, 72% said they thought they would not survive the situation at least sometimes, 70% said they saw our own soldiers dead, while 39% said they saw a close friend killed at least sometimes. Overall, 18% of our sample reported that they had no combat exposure. Another 52% of the sample reported having been involved in or exposed to combat in some way without having received injury, while 29% of the sample reported having direct combat
experience in which they were seriously injured. Independent of their exposure to combat, 98% of respondents considered their Vietnam experience somewhat stressful.

We found that exposure to intense combat was associated with higher levels of anger, hostility and violent behavior in veterans’ current lives….Upon reading the different descriptions of homecoming experiences, it became apparent that for many soldiers, returning home from the war was not what they had hoped for, as most were greeted with little fanfare…The majority (50%), however, rated their homecoming experience negative. Many respondents indicated that their transition to civilian life was abrupt. They reported going from the battlefield to their stateside homes in just a few days. Many veterans reported that upon their stateside return they were stigmatized, shunned, blamed, attacked or belittled by others, leaving them with feelings of abandonment and rejection by the American people. Those veterans who had negative homecoming experience reported current levels of distress on average 2 - 2 ½ times higher than those veterans with positive homecomings.

Over 90% of our sample report that Vietnam still affects their lives through unpleasant intrusive thoughts and mental pictures of the war….Seventy-nine percent of veterans reported being frequently affected by distressing and unwanted recollections during both their waking and sleeping hours.”

And finally “While experiences and reactions to the Vietnam War differed markedly from one veteran to another, the majority (85%) of respondents expressed their need to make sense of what they experienced. While 71% of our sample reported having tried, 30% of our sample reported that they had not been able to make any sense at all of their war-related experience. Over 68% of the respondents reported that Vietnam affected their beliefs about what they could expect from life, while 32% reported that Vietnam had not influenced their beliefs or expectations. The majority (87%) of our sample reported that their attitude towards the U.S. Government had changed because of the Vietnam War…59% of our sample reported feeling at least “somewhat” cheated because of their involvement in the war. While 57% felt that their participation in the war was at least “just a little unfair”, 43% of veterans expressed that their involvement was “not at all unfair.”

EPIDEMIOLOGICAL FACTS ABOUT PTSD

The following is taken from an Internet Web page, the author of which took it from a National Veterans Readjustment Study (NVRS), which was published in a book, Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Readjustment Study, by Richard A. Kulka. New York: Brunner/Mazel, 1990. Current means the data was taken between the years 1983 and 1988.

15.2 percent of all male Vietnam theater veterans (479,000 out of 3,140,000 men who served in Vietnam) are current cases of PTSD. [266]

8.1 percent of all female Vietnam theater veterans (610 out of 7,200 women who served in Vietnam) are current cases of PTSD. [266]

30.9 percent of all male Vietnam theater veterans have had full-blown PTSD at some point in their lives. 22.5 percent have had partial PTSD at some point in their lives. Thus a total of more than half of all male Vietnam veterans have experienced "clinically serious stress reaction symptoms." [267]

26.9 percent of all female Vietnam theater veterans have had full-blown PTSD at some point in their lives. 21.2 percent have had partial PTSD at some point in their lives. Thus a total of almost half of all female Vietnam veterans have experienced "clinically serious stress reaction symptoms." [267]

About 1,700,000 Vietnam theater veterans have experienced "clinically serious stress reaction symptoms." [267]

"40 percent of Vietnam theater veteran men have been divorced at least once (10 percent had two or more divorces), 14.1 percent report high levels of martial problems, and 23.1 percent have high levels of parental problems." [271]

"Almost half [of male Vietnam theater veterans currently suffering from PTSD] had been arrested or in jail at least once-34.2 percent more than once-and 11.5 percent had been convicted of a felony."
"The estimated lifetime prevalence of alcohol abuse or dependence among male theater veterans is 39.2 percent, and the estimate for current alcohol abuse or dependence is 11.2 percent. The estimated lifetime prevalence of drug abuse or dependence among male theater veterans is 5.7 percent, and the estimate for current drug abuse or dependence is 1.8 percent. [274]

(Internet - http://www.dartmouth.edu/dms/ptsd/Epidemiological_Facts.html)

HISTORY OF POST-TRAUMATIC STRESS
The following is quoted from an article posted by the “Emergency Support Network” on the Internet, which is quoted from “Shell Shock” by Roger J. Spillane, published in the May-June 1990 issue of American Heritage:

“WWI has many accounts of what we now know as PTSD. One example is a British Army report from the front lines at Boulogne that 7%-10% of all officers patients and 3%-4% of patients from the other ranks were suffering nervous breakdowns and by the end of WWI, the British army had treated more than eighty thousand front line men for a variety of mental disorders.

“On the eve of WWII, the British Ministry of Pensions was still paying two million pounds a year to shell-shocked pensioners from the 1914-18 war.”

WW2 was supposed to have been different. In the USA, of the 5.2 million men called to the recruiting stations after Pearl Harbor, 1.6 million were prevented from enlisting because of various 'mental deficiencies'. It was said that such a great screening effort was used to weed out mental defectives, so as to only select the bravest soldiers, who could withstand the rigors of combat. In the US Army alone, the enlistee rejection rate for WW2 was more than seven and a half times that of WW1, yet before the war was over, the psychiatric discharge rate soared to 250% of the earlier conflict.

In the 1943 North African campaign at Kasserine and Faid Passes, up to 34% of all casualties were described by medical personnel as 'mental'. Worst still, less than 3% of these soldiers were able to return to frontline duty.

While fighting in the Pacific at New Georgia, the US 43rd Infantry Division virtually disintegrated under fire. More than 40% of the 4,400 battle losses sustained by this division were diagnosed as psychiatric cases."

Another example comes from Europe. During a 44 day period of fighting along the Gothic Line in Italy, the 1st Armored Division of the US Army had psychiatric casualties amounting to a startling 54% of all losses.

Even towards the end of WW2, the US 6th Marine Division on Okinawa recorded 2,662 wounded in a ten-day period, plus... 1,289 psychiatric casualties.

By 1945, another 111,000 neuropsychiatric cases, then usually called combat fatigue, had been treated. These figures must be treated as the minimum credible figures.


TODAY’S SCIENCE PTSD ARTICLE
The following is reproduced from an article on the Internet entitled Post-Traumatic Stress Disorder which says the article is reprinted from “Today’s Science On Line”:

A 50-year study of 152 World War II veterans found that 30 out of 54 veterans who saw intense fighting contracted chronic illnesses and died by the time they were 65. Sixteen of those veterans had reported PTSD symptoms. The rates of disease and death were much lower among veterans who saw little or no action. The study’s results were published in the April 1995 American Journal of Psychiatry. Another study in that issue of the journal hinted that PTSD might not appear immediately. Researchers followed 62 Gulf War veterans. The soldiers were from two different National Guard units, one that saw little violence and one that worked in a medical unit treating injured and dying patients. Veterans in both units reported similar symptoms just after the war. However, two years later, medical unit veterans reported significantly more symptoms of PTSD.
PTSD AMONG VIETNAM VETERANS

The following information is reprinted from an article by Dan and Lynda King who reprinted the data from a government study entitled the “National Vietnam Veterans Readjustment Study (NVVRS)”: 

In the mid-1980s, the Congress commissioned a national study to determine the rates of PTSD in the Vietnam veteran population. That study, called the National Vietnam Veterans Readjustment Study (NVVRS) involved face-to-face interviews with Vietnam theater veterans, Vietnam era veterans, and non-veterans. The interviews lasted over four hours, on average, and much information was gathered. Regarding the primary question--what is the rate of PTSD among Vietnam veterans?--The NVVRS found the rate of PTSD for male Vietnam veterans as a whole to be 15.2%, and for female Vietnam veterans to be 8.9%. For those male veterans exposed to heavy combat, the rate was higher, about 30%. 

It is noteworthy that, although the incidence of PTSD in the Vietnam veteran population is high, not all veterans are suffering from it. Even among the heavy combat-exposed veterans, the rate was found to be 30%, not 90% or 100%.

(www.facts.com/tsf/tsf254.htm)
The following list of VSO’s is current as of 2008, according to the Department of Veterans Affairs, and chartered by Congress and/or by the VA for Claim Representation.

AFRICAN AMERICAN POST TRAUMATIC STRESS DISORDER ASSOC

NATIONAL HEADQUARTERS:
9129 Veterans Drive, SW
Lakewood, WA 98498
(253) 589-0766

AIRFORCE SERGEANTS ASSOC.

NATIONAL HEADQUARTERS
5211 Auth Road
Suitland, MD 20746
(301) 899-3500

AMERICAN DEFENDERS OF BATAAN AND CORREGIDOR

NATIONAL HEADQUARTERS:
John A. Crago
615 Lehmeyer Street
Huntington, IN 46750

AMERICAN EX-PRISONERS OF WAR

NATIONAL HEADQUARTERS:
3201 East Pioneer Parkway, #40
Arlington, TX 76010
(817) 649-2979

AMERICAN GI FORUM OF THE UNITED STATES

NATIONAL HEADQUARTERS
2870 N. Speer Blvd.
Suite 102
Denver, CO 80211
(303) 458-1700

AMERICAN GOLD STAR MOTHERS, INC.

NATIONAL HEADQUARTERS:
2128 LeRoy Place, NW
Washington, DC 20008-1893
(202) 265-0991

THE AMERICAN LEGION

NATIONAL HEADQUARTERS:
P.O. Box 1055
Indianapolis, IN 46206
(317) 630-1200

AMERICAN RED CROSS

NATIONAL HEADQUARTERS:
AMERICAN VETERANS COMMITTEE
NATIONAL HEADQUARTERS:
6309 Bannockburn Drive
Bethesda, MD 20817
(301) 320-6490

ARMED FORCES SERVICE CORPORATION
2800 Shirlington Road
Suite 350
Arlington, VA 22206
(703) 379-9311

AMERICAN WAR MOTHERS
NATIONAL HEADQUARTERS:
2615 Woodley Place, NW
Washington, DC 20008
(202) 462-2791

AMVETS
NATIONAL HEADQUARTERS
4647 Forbes Boulevard
Lanham, MD 20706-4380
(301) 459-9600

ARMY AND NAVY UNION, USA, INC.
NATIONAL HEADQUARTERS:
P.O. Box 608
Niles, OH 44446-0608
(216) 652-1612

BLINDED VETERANS ASSOCIATION
NATIONAL HEADQUARTERS:
477 H Street, NW
Washington, DC 20001-2694
(202) 371-8880

BLUE STAR MOTHERS OF AMERICA, INC.
NATIONAL HEADQUARTERS:
Post Office Box 555
Kensington, MD 20895

CATHOLIC WAR VETERANS, USA, INC
NATIONAL HEADQUARTERS:
441 North Lee Street
Alexandria, VA 22314
(703) 549-3622

CONGRESSIONAL MEDAL OF HONOR SOCIETY OF THE UNITED STATES OF AMERICA
NATIONAL HEADQUARTERS:
40 Patriots Point Road
Mt. Pleasant, SC 29464
(803) 884-8862

DISABLED AMERICAN VETERANS
NATIONAL HEADQUARTERS:  
3725 Alexandria Pike  
Cold Springs, KY 41076  
(606) 441-7300

FLEET RESERVE ASSOCIATION  
NATIONAL HEADQUARTERS:  
125 N. West Street  
Alexandria, VA 22314-2754  
1-800-FRA-1924

GOLD STAR WIVES OF AMERICA, INC.  
NATIONAL HEADQUARTERS:  
Post Office Box 555  
Kensington, MD 20895

ITALIAN AMERICAN WAR VETERANS OF THE USA  
NATIONAL HEADQUARTERS:  
115 S. Meridian Road  
Youngstown, OH 44509

JEWISH WAR VETERANS OF THE USA  
NATIONAL HEADQUARTERS:  
1811 R Street, NW  
Washington, DC 20009-1659  
(202) 265-6260

LEGION OF VALOR OF THE USA, INC.  
NATIONAL HEADQUARTERS:  
4706 Calle Reina  
Santa Barbara, CA 93110-2018  
(805) 692-2244

MARINE CORPS LEAGUE  
NATIONAL HEADQUARTERS:  
8626 Lee Highway, Suite 201  
Fairfax, VA 22031

MILITARY CHAPLAINS ASSOCIATION OF THE UNITED STATES OF AMERICA  
NATIONAL HEADQUARTERS:  
P.O. Box 7056  
Arlington, VA 22207-7056  
(703) 533-5890

MILITARY ORDER OF THE PURPLE HEART OF THE U.S.A., INC.  
NATIONAL HEADQUARTERS:  
5413-B Backlick Road  
Springfield, VA 22151  
(703) 642-5360

MILITARY ORDER OF THE WORLD WARS  
NATIONAL HEADQUARTERS:  
435 North Lee Street  
Alexandria, VA 22314-2301  
(703) 683-4911
NATIONAL ASSOCIATION OF COUNTY VETERANS SERVICE OFFICERS

NATIONAL HEADQUARTERS:
2768 Longboat Drive
Naples, FL 33942
(941) 649-8179

NATIONAL AMPUTATION FOUNDATION INC

NATIONAL HEADQUARTERS:
40 Church Street
Malverne, NY 11565
(516) 887-3600

NATIONAL ASSOCIATION OF COUNTY VETERANS SERVICE OFFICERS INC

NATIONAL HEADQUARTERS
2200 Wilson Blvd.
Suite 102-530
Arlington, VA 22301-3324
(910) 592-2862

NATIONAL ASSOCIATION FOR BLACK VETERANS INC

NATIONAL HEADQUARTERS:
40 Church Street
Malverne, NY 11565
(516) 887-3600

NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS (NASDVA)

NATIONAL HEADQUARTERS:
New Mexico Department of Veterans Services
P.O. Box 2324
Santa Fe, NM 87504-2324
(505) 827-6334

NATIONAL VETERANS LEGAL SERVICES PROGRAM, INC.

NATIONAL HEADQUARTERS:
1600 K Street, NW
Suite 500
Washington, DC 20006
(202) 265-8305

NAVY CLUB OF THE UNITED STATES OF AMERICA

NATIONAL HEADQUARTERS:
6134 South 375 West
Lafayette, IN 47909-9250
(800) 628-7265

NAVY MUTUAL AID ASSOCIATION

NATIONAL HEADQUARTERS:
6134 South 375 West
Lafayette, IN 47909-9250
(800) 628-7265

NON COMMISSIONED OFFICERS ASSOCIATION

NATIONAL HEADQUARTERS:
610 Madison Street
Alexandria, VA 22314
(703) 548-0311
PARALYZED VETERANS OF AMERICA
NATIONAL HEADQUARTERS:
801 18th Street, NW
Washington, DC 20006
1-800-424-8200

PEARL HARBOR SURVIVORS ASSOCIATION, INC.
NATIONAL HEADQUARTERS:
P.O. Box 1816
Carlsbad, CA 92016

POLISH LEGION OF AMERICAN VETERANS, USA
NATIONAL HEADQUARTERS:
P.O. Box 42024
Washington, DC 20015

SWORDS TO PLOWSHARES: VETERANS RIGHTS ORGANIZATION
NATIONAL HEADQUARTERS
1060 Howard Street
San Francisco, CA 94103-1605
(415) 252-4788

THE RETIRED ENLISTED ASSOCIATION
NATIONAL HEADQUARTERS:
1111 S. Abilene Court
Aurora, CO 80012

UNITED SPINAL ASSOCIATION
NATIONAL HEADQUARTERS
1060 Howard Street
San Francisco, CA 94103-1605
(415) 252-4788

U.S. SUBMARINE VETERANS OF WORLD WAR II
NATIONAL HEADQUARTERS:
6505 Camino de Luna
Rancho Murieta, CA 95683
(916) 354-2811

VETERANS ASSISTANCE FOUNDATION INC
NATIONAL HEADQUARTERS
P.O. Box 109
Newburg, WI 53060
(262) 692-6333

VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL HEADQUARTERS:
406 West 34th Street
(Broadway at 34th Street)
Kansas City, MO 64111
(816) 756-3390

VETERANS OF VIETNAM WAR
Veterans of the Vietnam War, Inc.
VETERANS OF WORLD WAR I OF THE U.S.A., INC.

NATIONAL HEADQUARTERS:
P.O. Box 8027
Alexandria, VA 22306-8027
(703) 780-5660

VIETNAM VETERANS OF AMERICA, INC.

NATIONAL HEADQUARTERS:
P.O. Box 109
Newburg, WI 53060
(262) 692-6333

WOMEN’S ARMY CORPS VETERANS ASSOCIATION

NATIONAL HEADQUARTERS:
P.O. Box 5577
Fort McClellan, AL 36205
(205) 820-6824

(www.va.gov/vso/index.htm) Department of Veterans Affairs
Appendix E

Other Resources - General

The Internet.

The following list is certainly not complete and by the time this book is printed it may not be accurate as Home Pages come and go every day on the Internet. There are also a number of Internet pages listed in Appendix A, Bibliography that may not be listed here.

American Psychiatric Association = www.healithyminds.org

Anxiety Disorders (NIMH) = http://www.nimh.nih.gov/publicat/anxiety.htm

Australian Trauma Pages = http://psych.psy.uq.oz.au/PTSD/


Department of Veterans Affairs Home Page = http://www.va.gov/va.htm

Emotional Trauma Info Pages = http://www.trauma-pages.com/


Federal Information Center = www.info.gov/

A kind of general information re-direction center. I called these people and they were very helpful. They can give you addresses and phone numbers for agencies dealing with:

- Copyright Information
- Default Student Loans Information
- Department of State Document Authentication Info.
- FCC Information
- Federal Income tax
- Federal jobs
- Federal Property for Sale
- Federal Publications
- Government Travel Info. (Passports, Visas, Per-Diem rates)
- Patent Information
- Savings bonds
- Selective Service Information
- Social Security issues
- Trade Mark Information
- Veterans Benefits

For Women Veterans = http://userpages.aug.com/captharb

Gateway to Post Traumatic Stress Disorder Information = www.ptsdinfo.org

Gulf War Illness Home Page (Gulflink) = http://www.dtic.dla.mil/gulflinkPersian

Gulf War Vets Resources Page = http://www.gulfwar.org/

International Society for Traumatic Stress Studies = http://www.istss.com/

KB Home = http://www.tehachapinews.com/home/ViewPost/29428


National Center for PTSD, Department of Veteran Affairs, White River Junction, Vermont = http://www.dartmouth.edu/dms/ptsd/

The Switchboard. For locating individuals. This is like a giant phone book and is located at
“www.switchboard.com”. There is a fill-in-the-blank type thing on their page where you type in first and last
name, city, state or as much of the afore mentioned data you know, and a list of possibles is produced. I tried this
out and actually located a friend of mine. There is no charge for this service at the time of this writing.

Understanding The Appeals Process (Published by the Board of Veterans Appeals) =
www.va.gov/vbs/bva/page1.htm

Vietnam Casualty Search Page. For locating deceased individuals. This is a data base using “The Wall”
information and is located at “www.no-quarter.org”. This is not the only “Wall” data base on the Web, but is one
of the easiest to use. You can search for a deceased buddy by Providence killed in, KIA date, branch of service,
last name, hometown and state, or combinations of them all.

Vietnam Vets Home Page = http://www.vietvet.org

National Personnel Records Center (NPRC) Custodians - For obtaining personnel records (if seeking medical
records see Appendix I, Application Procedures - Medical and Clinical Treatment Records). Match the
branch/status of individual with the address below: These addresses can be found on the back of Standard
Form 180, found in the Blank Forms section of this Manual.
Appendix F

Other Resources - Books


Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies by Edna B. Foa, Terence M. Keane, and Matthew J. Friedman. 2004


*PTSD: Pathways Through the Secret Door* by Timothy Kendrick. 2007.

*PTSD Research Quarterly*. The National Center for Post-Traumatic Stress Disorder, 1990- . q.


*Post-Traumatic Stress Disorder Sourcebook* by Glenn R. Schiraldi. 2000


PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms by Mary Beth Williams and Soili Poijula. 2002


**Books On Vietnam**

This list is an attempt to find titles that might provide information on individual or unit actions. The list is certainly not all inclusive and, if not entitled as such, may not contain any information on specific units.

**Listed by Title, Alphabetically**


*Air War over South East Asia: A Pictorial Record, Vols 1, 2 and 3.* Lou Drendel. Carrolton, TX: Squadron/Signal Publications, 1982-84.


Appendix G

Department of Veterans Affairs Treatment Facilities

The following is an up to date list of VA treatment facilities where you can get help with PTSD, either for treatment or claims assistance. See the first part of Chapter 7 if you are uncertain as to what each offers.

Since they change so often I have provided their Internet address

www1.va.gov/directory/guide/home.asp
Appendix H

Blank Forms

This is a listing of all of the Forms you might need in your quest for a PTSD Disability. Simply go to the Web Page listed, download the Form (Probably in PDF Format), and print the number of copies you will need.

**Standard Forms**

SF 180 (Request Pertaining to Military Records) - 3 Pages

**Veterans Administration Forms**

VA 1-646 (Statement of Accredited Representation in Appealed Case) - 2 Page

VA 9 (Appeal to Board of Veterans’ Appeals) - 5 Pages

VA 10-10EZ (Application for Health Benefits) – 5 Pages

VA 10-5345 (Request for and consent to Release of Medical Records.) - 2 Page

VA 21-526 (Veterans Application for Compensation or Pension) – 23 Pages

VA 21-527 (Income-Net Worth and Employment Statement) - 10 Pages

VA 21-4142 (Authorization for Release of Information) – 2 Pages

VA 22a (Appointment of Attorney or Agent as Claimant’s Representative) - 1 Page

VA 28-1901 (Counseling Record – Personal Information) – 2 pages

VA 28-8872 (Rehabilitation Plan) – 2 Pages

VA 0220 (Notice of Appellate Rights Following Denial of Motion For Reconsideration) - 1 Page

VA 4107 (Your Rights to Appeal our Decision) – 2 Pages

VA 4597 (Board of Veteran’s Appeals notice) - 2 Page

Find Forms at My homepage = WWW.PTSD.Com/Apph.htm
Find Forms at the VA Homepage = WWW.VA.GOV/vaforms/
Find a ADOBE reader at = WWW. Adobe.com/products/acrobat/readstep2.html
This information is accurate at the time this manual was published. Check with your local VA, VSO representative or call the VA “800” number to verify information.

38 C.F.R.

§ 3.102 Reasonable doubt.

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When, after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding service origin, the degree of disability, or any other point, such doubt will be resolved in favor of the claimant. By reasonable doubt is meant one which exists because of an approximate balance of positive and negative evidence which does not satisfactorily prove or disprove the claim. It is a substantial doubt and one within the range of probability as distinguished from pure speculation or remote possibility. It is not a means of reconciling actual conflict or a contradiction in the evidence. Mere suspicion or doubt as to the truth of any statements submitted, as distinguished from impeachment or contradiction by evidence or known facts, is not justifiable basis for denying the application of the reasonable doubt doctrine if the entire, complete record otherwise warrants invoking this doctrine. The reasonable doubt doctrine is also applicable even in the absence of official records, particularly if the basic incident allegedly arose under combat, or similarly strenuous conditions, and is consistent with the probable results of such known hardships.

(Authority: 38 U.S.C. 501)

§ 3.103 Procedural due process and appellate rights.

(a) Statement of policy. Every claimant has the right to written notice of the decision made on his or her claim, the right to a hearing, and the right of representation. Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government. The provisions of this section apply to all claims for benefits and relief, and decisions thereon, within the purview of this part 3.

§ 3.109 Time limit.

(a) Notice of time limit for filing evidence. (1) If a claimant's application is incomplete, the claimant will be notified of the evidence necessary to complete the application. If the evidence is not received within 1 year from the date of such notification, pension, compensation, or dependency and indemnity compensation may not be paid by reason of that application (38 U.S.C. 5103(a)). Information concerning the whereabouts of a person who has filed claim is not considered evidence.

(2) The provisions of this paragraph are applicable to original applications, formal or informal, and to applications for increased benefits by reason of increased disability, age, or the existence of a dependent and to applications for reopening or resumption of payments. If substantiating evidence is required with respect to the veracity of a witness or the authenticity of documentary evidence timely filed, there will be allowed for the submission of such evidence 1 year from the date of the request therefor. However, any evidence to enlarge the proofs and evidence originally submitted is not so included.

(b) Extension of time limit. Time limits within which claimants or beneficiaries are required to act to perfect a claim or challenge an adverse VA decision may be extended for good cause shown. Where an extension is requested after expiration of a time limit, the action required of the claimant or beneficiary must be taken concurrent with or prior to the filing of a request for extension of the time limit, and good cause must be shown as to why the required action could not have been taken during the original time period and could not have been taken sooner than it was. Denials of time limit extensions are separately appealable issues.

(Authority: 38 U.S.C. 501)

§ 3.159 Department of Veterans Affairs assistance in developing claims.
(a) Definitions. For purposes of this section, the following definitions apply:

(1) Competent medical evidence means evidence provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may also mean statements conveying sound medical principles found in medical treatises. It would also include statements contained in authoritative writings such as medical and scientific articles and research reports or analyses.

(2) Competent lay evidence means any evidence not requiring that the proponent have specialized education, training, or experience. Lay evidence is competent if it is provided by a person who has knowledge of facts or circumstances and conveys matters that can be observed and described by a lay person.

(3) Substantially complete application means an application containing the claimant's name; his or her relationship to the veteran, if applicable; sufficient service information for VA to verify the claimed service, if applicable; the benefit claimed and any medical condition(s) on which it is based; the claimant's signature; and in claims for nonservice-connected disability or death pension and parents' dependency and indemnity compensation, a statement of income.

(4) For purposes of paragraph (c)(4)(i) of this section, event means one or more incidents associated with places, types, and circumstances of service giving rise to disability.

(5) Information means non-evidentiary facts, such as the claimant's Social Security number or address; the name and military unit of a person who served with the veteran; or the name and address of a medical care provider who may have evidence pertinent to the claim.

(b) VA’s duty to notify claimants of necessary information or evidence. (1) When VA receives a complete or substantially complete application for benefits, it will notify the claimant of any information and medical or lay evidence that is necessary to substantiate the claim. VA will inform the claimant which information and evidence, if any, that the claimant is to provide to VA and which information and evidence, if any, that VA will attempt to obtain on behalf of the claimant. VA will also request that the claimant provide any evidence in the claimant's possession that pertains to the claim. If VA does not receive the necessary information and evidence requested from the claimant within one year of the date of the notice, VA cannot pay or provide any benefits based on that application. If the claimant has not responded to the request within 30 days, VA may decide the claim prior to the expiration of the one-year period based on all the information and evidence contained in the file, including information and evidence it has obtained on behalf of the claimant and any VA medical examinations or medical opinions. If VA does so, however, and the claimant subsequently provides the information and evidence within one year of the date of the request, VA must readjudicate the claim.

(Authority: 38 U.S.C. 5103)

(2) If VA receives an incomplete application for benefits, it will notify the claimant of the information necessary to complete the application and will defer assistance until the claimant submits this information.

(Authority: 38 U.S.C. 5102(b), 5103A(3))

§ 3.303 Principles relating to service connection.

(a) General. Service connection connotes many factors but basically it means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein. This may be accomplished by affirmatively showing inception or aggravation during service or through the application of statutory presumptions. Each disabling condition shown by a veteran's service records, or for which he seeks a service connection must be considered on the basis of the places, types and circumstances of his service as shown by service records, the official history of each organization in which he served, his medical records and all pertinent medical and lay evidence. Determinations as to service connection will be based on review of the entire evidence of record, with due consideration to the policy of the Department of Veterans Affairs to administer the law under a broad and liberal interpretation consistent with the facts in each individual case.

§ 4.130 Schedule of ratings—mental disorders.

The nomenclature employed in this portion of the rating schedule is based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, of the American Psychiatric Association (DSM-IV). Rating agencies must be thoroughly familiar with this manual to properly implement the directives in §4.125 through §4.129 and to apply the general rating formula for mental disorders in §4.130. The schedule for rating for mental disorders is set forth as follows:
<table>
<thead>
<tr>
<th>Rating</th>
<th>Schizophrenia and Other Psychotic Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>9201</td>
<td>Schizophrenia, disorganized type</td>
</tr>
<tr>
<td>9202</td>
<td>Schizophrenia, catatonic type</td>
</tr>
<tr>
<td>9203</td>
<td>Schizophrenia, paranoid type</td>
</tr>
<tr>
<td>9204</td>
<td>Schizophrenia, undifferentiated type</td>
</tr>
<tr>
<td>9205</td>
<td>Schizophrenia, residual type; other and unspecified types</td>
</tr>
<tr>
<td>9208</td>
<td>Delusional disorder</td>
</tr>
<tr>
<td>9210</td>
<td>Psychotic disorder, not otherwise specified (atypical psychosis)</td>
</tr>
<tr>
<td>9211</td>
<td>Schizoaffective disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Delirium, Dementia, and Amnestic and Other Cognitive Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>9300</td>
<td>Delirium</td>
</tr>
<tr>
<td>9301</td>
<td>Dementia due to infection (HIV infection, syphilis, or other systemic or intracranial infections)</td>
</tr>
<tr>
<td>9304</td>
<td>Dementia due to head trauma</td>
</tr>
<tr>
<td>9305</td>
<td>Vascular dementia</td>
</tr>
<tr>
<td>9310</td>
<td>Dementia of unknown etiology</td>
</tr>
<tr>
<td>9312</td>
<td>Dementia of the Alzheimer's type</td>
</tr>
<tr>
<td>9326</td>
<td>Dementia due to other neurologic or general medical conditions (endocrine disorders, metabolic disorders, Pick's disease, brain tumors, etc.) or that are substance-induced (drugs, alcohol, poisons)</td>
</tr>
<tr>
<td>9327</td>
<td>Organic mental disorder, other (including personality change due to a general medical condition)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Anxiety Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>9400</td>
<td>Generalized anxiety disorder</td>
</tr>
<tr>
<td>9403</td>
<td>Specific (simple) phobia; social phobia</td>
</tr>
<tr>
<td>9404</td>
<td>Obsessive compulsive disorder</td>
</tr>
<tr>
<td>9410</td>
<td>Other and unspecified neurosis</td>
</tr>
<tr>
<td>9411</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>9412</td>
<td>Panic disorder and/or agoraphobia</td>
</tr>
<tr>
<td>9413</td>
<td>Anxiety disorder, not otherwise specified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Dissociative Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>9416</td>
<td>Dissociative amnesia; dissociative fugue; dissociative identity disorder (multiple personality disorder)</td>
</tr>
<tr>
<td>9417</td>
<td>Depersonalization disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Somatoform Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>9421</td>
<td>Somatization disorder</td>
</tr>
<tr>
<td>9422</td>
<td>Pain disorder</td>
</tr>
<tr>
<td>9423</td>
<td>Undifferentiated somatoform disorder</td>
</tr>
<tr>
<td>9424</td>
<td>Conversion disorder</td>
</tr>
<tr>
<td>9425</td>
<td>Hypochondriasis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rating</th>
<th>Mood Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>9431</td>
<td>Cyclothymic disorder</td>
</tr>
</tbody>
</table>
## Bipolar disorder

- Code: 9432

## Dysthymic disorder

- Code: 9433

## Major depressive disorder

- Code: 9434

## Mood disorder, not otherwise specified

- Code: 9435

## Chronic Adjustment Disorder

### General Rating Formula for Mental Disorders:

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name</td>
<td>100</td>
</tr>
<tr>
<td>Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships</td>
<td>70</td>
</tr>
<tr>
<td>Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships</td>
<td>50</td>
</tr>
<tr>
<td>Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)</td>
<td>30</td>
</tr>
<tr>
<td>Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication</td>
<td>10</td>
</tr>
<tr>
<td>A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication</td>
<td>0</td>
</tr>
</tbody>
</table>

## Eating Disorders

### Rating Formula for Eating Disorders:

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least six weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding</td>
<td>100</td>
</tr>
<tr>
<td>Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of six or more weeks total duration per year</td>
<td>60</td>
</tr>
<tr>
<td>Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than six weeks total duration per year</td>
<td>30</td>
</tr>
<tr>
<td>Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of not more than two weeks total duration per year</td>
<td>10</td>
</tr>
</tbody>
</table>
or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to two weeks total duration per year

Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes

Note: An incapacitating episode is a period during which bed rest and treatment by a physician are required.

(Authority: 38 U.S.C. 1155)

**Hospital and Outpatient Care** - Eligibility for VA hospital and outpatient care is divided into two categories:

In the first category of veterans, VA shall provide any needed hospital and outpatient care to the extent and in the amount that Congress appropriates funds. In the second category, VA may furnish any needed hospital and outpatient care to the extent resources and facilities are available, if the veteran makes a copayment.

Category 1 is composed of the following: veterans in need of care for a service-connected condition veterans who have a compensable service-connected disability veterans whose discharge or release from active military service was for a compensable disability that was incurred or aggravated in the line of duty veterans who were former prisoners of war veterans of the Mexican Border period or World War I veterans who were exposed to Agent Orange in Vietnam, ionizing radiation, or environmental hazards in the Persian Gulf and veterans whose annual income and net worth is below the "means test" threshold. The threshold is adjusted annually and published in January.

Category 2 is composed of all other veterans, including nonservice-connected veterans with incomes and net worth above the "means test" threshold and zero percent service-connected veterans needing care for any nonservice-connected disability. These veterans must agree to make copayments. VA holds these patients responsible for the Medicare deductible for the first 90 days of care during any 365-day period. For each additional 90 days of hospital care, the patient is charged one-half the Medicare deductible. In addition to these charges, the patient is charged $10 a day for hospital care and $5 a day for VA nursing-home care. For outpatient care, the copayment is 20 percent of the cost of an average outpatient visit. *(Federal Benefits for Veterans & Dependents, 1997)*

**U.S. Court of Veterans Appeals** - A VA claim may be appealed from the Board of Veterans' Appeals to the Court of Veterans Appeals. This court is independent of the Department of Veterans Affairs. Only claimants may seek a review by the court VA may not appeal BVA decisions. To appeal to the court, the claimant must have filed a Notice of Disagreement on or after Nov. 18, 1988. The notice of appeal must be filed with the court with a postmark that is within 120 days after the Board of Veterans' Appeals mails its final decision. The court does not hold trials or receive new evidence. The court reviews the record that was considered by the Board of Veterans' Appeals. Oral argument is held only at the direction of the court. Either party may appeal a decision of the court to the U.S. Court of Appeals for the Federal Circuit and to the Supreme Court of the United States. Appellants may represent themselves before the court or have lawyers or approved agents as representatives. The court's decisions are published in West's Veterans Appeals Reporter, in the WESTLAW and LEXIS on line services and in the court's electronic bulletin board. The bulletin board can be reached at 202-501-5836. For information about the court's rules and procedures, contact the Clerk of the Court at 625 Indiana Ave. NW, Suite 900, Washington, DC 20004, or call 1-800-869-8654. *(Federal Benefits for Veterans & Dependents, 1997)*

**Manual M-2**

**2.09 PTSD (POST TRAUMATIC STRESS DISORDER) EXAMINATIONS**

Although the principles for all diagnoses are similar, the diagnosis of PTSD deserves special attention, particularly when the stressor is alleged to have occurred during military service. Documentation of the diagnosis and its relationship to military service must be in sufficient detail to facilitate the adjudication of disability benefit claims as well as the formulation of treatment.

a. The issue of service-connection is the sole responsibility of the rating board. The physician's responsibility is to present the clinical findings in a way that clearly demonstrates why the diagnosis of PTSD was made and, when applicable, why some other diagnosis was not made. Clinical findings which bear upon any relationship between military service and the diagnosis must be described. This diagnostic clarity should be present when the patient is found to have some diagnosis other than PTSD.
b. The diagnostic evaluation for PTSD includes review of the patient's C-file, a clinical interview and mental status exam designed to determine the presence or absence of diagnostic symptomatology and precipitants and, when indicated, psychological testing. Recent research has validated several instruments that may aid in diagnosing PTSD but do not substitute for a clinical diagnostic interview.

c. Interviews to establish a diagnosis, particularly for compensation, may be a stressful experience for the veteran, particularly for veterans with PTSD for whom issues of trust and feelings of alienation are often prominent. The veteran may be reluctant to experience the pain of relating fearful and threatening memories (e.g., of combat). For these reasons, it is vital that the interview be conducted in a sympathetic and understanding manner, and that the examiner make thorough review of the C-file and military records to provide information the veteran may not mention or to provide clues about areas or situations the examiner may wish to explore on interview.

d. The diagnosis of PTSD must be consistent with the criteria of the psychiatric diagnostic system approved by VHA (Veterans Health Administration), currently DMS-III-R (American Psychiatric Association's Diagnostic and Statistical Manual). NOTE: All criteria required for making the diagnosis must be met in order for a diagnosis of PTSD to be acceptable.

e. Specific aspects of the differential diagnosis of PTSD from other disorders, including personality disorders, substance abuse, depression, and schizophrenia, are well described in IB 11-56, Physician's Guide for Disability Evaluation Examinations. It is possible for PTSD to co-exist with other psychiatric disorders from Axis I and Axis II (e.g., major depression, substance abuse). In some instances, the other disorder may be secondary to or associated with PTSD, while in other cases, the two disorders may be unrelated co-morbidities. The nature of the relationship of PTSD to the other disorder(s) should be clearly stated.

f. The C&P (Compensation and Pension) Evaluation Report must include the following elements:
(1) Clear and complete documentation of the diagnostic criteria that have been met to make the PTSD diagnosis. The development of symptoms since the traumatic event and the absence of these symptoms prior to the event must be noted.
(2) Clear and concretely detailed description of the stressor(s) including:
(a) A description of the event;
(b) Location in time (as best it can be recalled: year, month, season, day if possible);
(c) Geographic location (military unit, providence, town, landmarks such as river or mountain); and
(d) If possible, names of others who may have been involved in the incident.
NOTE: Often there are multiple stressors.
NOTE: The claims file and military records as well as information from the veteran may be sources of this information.
NOTE: The foregoing detail should be provided for at least one event, and descriptions of others should be provided to convey the cumulative nature of the stressful experiences.
(3) Clear and specific demonstration of the linkage between the symptoms used to make the diagnosis and the in-service stressful event, e.g., content of intrusive recollection or re-experiencing of the in-service stressor which are similar to the actual stressors experienced. NOTE: Such recollections should be of in-service stressors rather than recollection of other stressors from before or after service.
(4) Detailed description of the manner and degree to which the symptoms affect the necessary functioning of the veteran, including the effects upon:
(a) Personal relationship with family members, friends and others in social, religious, work and recreational activities (if any);
(b) Productive activity, especially employment in obtaining and maintaining effective participation; and
(c) The utilization of health services.
g. It is essential that physician examiners recognize that the value of their examination of the patient for rating purposes depends specifically on their abilities to fulfill the requirements of items f. (1), (2), (3), and (4).
(1) Rating Boards have the authority and the responsibility to return as "inadequate for rating purposes" examination reports that do not satisfy these requirements.
(2) Accurate diagnosis is a primary clinical responsibility that has major impact on the quality of care provided veterans within and outside the VA medical care system.
Appendix J

Guide for the Preparation and Submission
of Post Traumatic Stress Disorder Research Requests

I have been unable to obtain an updated copy of this Guide. It is very closely held by the Department of the Army. You should be able to get a copy at your helping agency (DAV, Veterans of Foreign war, etc.)

Guide for the Preparation and Submission
of Post Traumatic Stress Disorder
Research Requests

Prepared and distributed by
U.S. Armed Services Center for Research
of Unit Records (USASCRUR)

Authors Note: To the best of my knowledge this guide has not been changed in any way other than the intentional omission of the documents between pages 24 to 49, the shortening of Section IX (AWARDS AND DECORATIONS), and the replacement of “U.S. Army and Joint Services Environmental Support Group (ESG)” with the new title of “U.S. Armed Services Center for Research of Unit Records (USASCRUR)” and the abbreviation “ESG” with “USASCRUR”.

RESEARCHING PTSD REQUESTS

INTRODUCTION

The U.S. Armed Services Center for Research of Unit Records (USASCRUR) is located at 7789 Cissna Road, Suite 101, Springfield, Virginia 22150. The USASCRUR conducts records research to assist Department of Veterans Affairs (VA) officials and veterans service organizations in verifying the stressing experiences described by veterans in Post Traumatic Stress Disorder (PTSD) claims. The purpose of this guide is to provide information to officials who are requesting USASCRUR to provide PTSD research assistance. Veterans are strongly encouraged not to attempt to develop their cases without the assistance of service officials. (authors note: I hope after the publication of this manual this will no longer be the case). The veteran’s Official Military Personnel File (OMPF) should be reviewed by the service representative assisting the veteran before a case is sent to USASCRUR.

Possession of awards and decorations can sometimes be an indicator of combat involvement. The Department of Veterans Affairs (VA) Regulatory Amendment to Regulation 38 CFR 3.304 (f), dated May 19, 1933, states that the receiving of such awards as the Purple Heart (PH), the Bronze Star with “V” Device, Combat Infantryman Badge (CIB), or other similar citations indicating combat involvement, satisfies the VA requirement that the veteran was involved in a combat stressor.

If a case presents special problems or circumstances, do not hesitate to call USASCRUR at (703) 806-7835 for assistance and guidance. Research requests should list a phone number (including area code) so the USASCRUR researchers may call to obtain information if necessary.
USASCRUR has no official role in the adjudication of PTSD claims. In addition, we are not notified how the cases we research are adjudicated. USASCRUR is committed to accomplishing the most thorough and comprehensive research possible to ensure veterans get the benefits they deserve and have earned.

Local reproduction and maximum dissemination of this guide to veteran service officers is authorized and encouraged.

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SECTION I
WHAT USASCRUR DOES AND DOES NOT DO

1. USASCRUR researches all available records of the Army, Navy, Air Force, and Coast Guard in attempting to document the stressing experience stated in PTSD claims.

2. USASCRUR conducts PTSD records research for all U.S. military personnel (except U.S. Marine Corps) who are attempting to document stressful events while serving in the U.S. Armed Forces.

3. USASCRUR researches records only if the veteran provides specific information concerning each stressful experience.
4. USASCRUR does not provide stressors since it is impossible for us to determine whom the veteran knew or what he or she personally witnessed.

5. USASCRUR does not provide general historical documentation nor copies of records for large periods of time without a specific incident.

6. USASCRUR does not do records research to establish service connection for medical problems that are unrelated to PTSD claims.

7. USASCRUR does not provide PTSD symptoms or treatment recommendations.

SECTION II
RESEARCH POLICY

USASCRUR researches all available military unit historical data related to the stressing experience stated by the veteran. USASCRUR will indicate clearly as possible whether evidence has been found pertaining to the veteran’s claim.

SECTION III
HOW RECORDS ARE ORGANIZED AND WHAT THEY CONTAIN AND DO NOT CONTAIN

1. Military records rarely chronicle the specific experiences of individual service members; therefore, much of the time, only circumstantial evidence can be found to support PTSD claims. Military records are organized by units (ships for Navy). Unit (ship) records are further organized by date. Therefore, USASCRUR must know the unit designation down to the lowest possible level and the most specific date(s) of the incidents. Records research is done manually. No master index of subjects or names exists. Contrary to popular belief, not everything occurring in the military is recorded. Events in combat, as they affect specific individuals, are not commonly recorded. Many records that are created are temporary in nature. They are retained for a short time, usually a year, and then disposed of according to regulations. The records that are available are often incomplete. Although such documents are passenger flight rosters, temporary duty orders, maintenance records and pay records could prove useful in PTSD research, they are destroyed after brief periods of storage. As a result, these types of records are not available to verify claims.

2. The Army has maintained several groups of historical records that are used for PTSD verification. To effectively research any Army record, the unit designation and most specific date of the incident are needed. The more specific the information provided, the more detailed the research can be provided.

   a. Daily Staff Journals (DJ’s) - DJ’s are the daily logs of a unit’s activities, normally maintained at hourly intervals. Locations, times, specific incidents, operations and occasionally names, are recorded. However, because these records can be quite voluminous, it is imperative that specific dates be provided when requesting DJ searches.

   b. Operational Reports - Lessons Learned (OR-LL’s) - These are quarterly reports concerning a unit’s significant operations and activities. They often include unit locations, strengths, operations, results of operations, casualty statistics, and recommendations for operational improvement.

   c. Combat Operations After Action Reports (COAAR’S) - These reports are compiled after major operations and describe the unit’s actions, strengths, weaknesses and recommendations for operational improvement. Some COAAR’s are written in great detail, while others are extremely sketchy.
d. **Situation Reports (SITREP’s)** - These are periodic narrative reports of brigade or division level activities covering a 24 hour period. They are primarily a summation of the DJ’s.

e. **Unit Histories** - These records document on the general activities of Army units for a particular period, normally six months or one year. The quality of unit histories vary greatly from unit to unit and may contain extremely detailed descriptions of battles to general unit activities.

f. **United States Army-Vietnam (USARV) Station List** - This record indicates where a unit’s mail was sent and the parent organization of the individual units.

g. **Military Assistance Command-Vietnam (MACV) - Strength Reports** - These records list units in Vietnam, their location, normally by province and town, and parent units.

h. **Morning Reports (MR’s) DA Form 1** - These documents can be used to verify daily personnel actions such as wounded in action (WIA), killed in action (KIA), missing in action (MIA), or transfers. It should be noted, however, that the Army ceased using MR’s in 1974.

i. **Casualty Records** - These records are arranged alphabetically by last name. To effectively research these records, full names and casualty dates are needed. Casualty research cannot be conducted using “NICKNAMES” or partial names.

j. **Aircraft Incident Reports** - These reports are arranged by date and usually identify the unit involved, crew members, witness reports, casualties involved, type mission, and cause of the incident. To effectively research these reports, the exact date and aircraft unit designation is required.

3. The Navy maintains historical records for ships such as:

a. **Command Histories** - These documents are maintained for ship and land units. These records can include special reports. They are normally in chronological order by year. The histories may or may not contain names of personnel.

b. **Decklogs** - These documents are maintained for ships only. Decklogs are a day by day account of the significant activities on board ship.

c. **Crew Rosters** - These documents are maintained for ship personnel only.

d. **Casualty Data** - These records are kept on individuals killed in action. Only. However, if a veteran can provide the complete unit designation, full name, and specific date, then, through other records, it may be possible to verify wounded in action.

The Navy does not publish Combat After Action Reports, Daily Staff Journals, Situation Reports, or Operational Reports-Lessons Learned.

4. The Air Force has maintained records such as:

a. **Quarterly Historical Reports** - These documents are maintained by major units. Each quarterly report is divided into functional areas, such supply, aircraft maintenance, civil engineering, security police, operations, etc.

b. **Morning Reports** - The Air force stopped maintaining Morning Reports in 1964.
c. **Casualty Reports** - These documents are arranged alphabetically by last name. To effectively research these records, full name and casualty dates are needed. Casualty research cannot be conducted using “NICKNAMES” or partial names.

d. **Aircraft History Record Cards** - These records list a planhs’s serial number, place of manufacture, and manufacturer’s contract number, and for each month that the plane was in service the place of assignment, cumulative flying hours, and any repairs or accidents.

5. The USASCRUR has discontinued all PTSD research on behalf of U.S. Marine Corps (USMC) veterans. Headquarters, USMC, is now conducting research for USMC PTSD claimants. Requests for USMC PTSD research should be directed to the USMC Historical Center, ATTN: Archives Section, Building 58, Washington Navy Yard, Washington, D.C. 20374-0580. They will reply directly to the requester.

### SECTION IV

**STRESS INCIDENT DESCRIPTION**

1. The single most important factor in USASCRUR’s ability to successfully research PTSD claims is how full and completely the stressing experiences are described.

2. A stress incident described in detail - one relating the who, what, when and where - will likely be within USASCRUR’s capability to verify by using the various available records. Stressors such as the “feeling of death” or the “smell of death” are not the types of events that are recorded in existing combat records.

3. The statement, “I saw my friend killed” may be true, but it is neither researchable nor verifiable. The statement, “I saw John Soldier killed during a fire fight in June 1969,” can be researched. When the veteran making the claim is not the one injured, the unit of the killed or wounded soldier should be provided.

4. To say, “I saw much action,” may be true, but again, is largely unverifiable. The statement, “I was in many mortar attacks during June 1968,” can more easily be researched. If the type of attack is known, and the number of casualties can be given, an USASCRUR researcher can frequently identify the incident if the records are available. If an incident happened aboard a Navy ship, the name, hull number, type of ship, and approximate date should be provided.

5. When researching casualty information, both the last and first names should be given. Dates and units are also helpful. Cases cannot be researched where only the first names or nicknames of individuals are provided. Common names need as much additional information as possible. No listing of casualties by units is currently available. Providing as much information as possible concerning the casualty will make research more effective. In addition to the name, type of injury or type of incident, will assist USASCRUR.

6. Anecdotal (unrecorded and unpublished) incidents are not researchable, even though they might be completely true. The following are examples of anecdotal incidents that cannot be verified through research: “The barber who cut my hair at the local barber shop was later found to be an enemy sapper,” or “A badly wounded soldier died in my arms.”

### SECTION V

**SPECIFIC PROBLEMS WHERE ADDITIONAL INFORMATION IS NEEDED**
1. **Prisoner of War (POW) claims.**

   If the veteran claims to have been captured or held as a POW, the veteran should provide as much information pertaining to the following questions as possible:
   
   a. Approximately when was the veteran captured?
   
   b. How was the veteran captured? (surrendered, aircraft shot down, position overrun, etc.)
   
   c. How long was the veteran held?
   
   d. Where was the veteran held? (jungle camp, POW prison, enemy city, etc.)
   
   e. Were other U.S. personnel taken prisoner at the same time?
   
   f. How was freedom obtained? (escape, POW exchange, release, etc.)
   
   g. Was the veteran declared MIA or POW by U.S. authorities?
   
   h. Was the veteran debriefed by U.S. authorities after release?

2. **When the veteran claims to have handled wounded.**

   If the veteran claims to have been actually involved with wounded service members, the following information should be provided:
   
   a. In what capacity did the veteran handle the wounded? (medic, buddy dare in the field, hospital corpsman, etc.)
   
   b. Did the veteran witness the wounded or did the veteran assist the wounded?

3. **When the veteran claims to have performed graves registration duties.**

   In an attempt to facilitate the research effort, the veteran needs to differentiate between actual graves registration duties and duties which are inherent to combat units, such as the bagging of bodies or transporting bodies to a graves registration point. As a minimum the following information is needed:
   
   a. Why is graves registration duty not shown in the veteran’s record? (temporary assignment, directed/voluntary additional duty, field expedient, etc.)
   
   b. Where were the graves registration duties performed? (hospital, mortuary, field unit, etc.)
   
   c. Approximately when and how long did the veteran perform graves registration duties? (whole combat tour, one day, etc.)

4. **When the veteran claims to have been in an aircraft crash.**
Numerous opportunities and reasons exist in a combat environment which allow for individuals other than pilots and crew members to be transported by aircraft. For claims involving aircraft crashes, as much information pertaining to the following questions is needed:

a. Was the veteran injured?

b. Were other passengers/crewmembers injured or killed?

c. What was the cause of the crash? (hostile fire, accident, weather, etc.)

d. What was the type or kind of aircraft? (fixed wing or rotary; C-130, UH-1, C-47, O-1, OH-1, etc.)

e. Was the aircraft destroyed?

f. Where did the crash happen? (jungle, runway, ocean, etc.)

g. What was the approximate date of the crash?

h. What unit was the aircraft from?

5. **When the veteran claims to have witnesses or participated in civilian atrocities.**

It is very rare when the intentional killing or wounding of civilians can be confirmed. The information pertaining to the following questions should be provided for PTSD claims involving atrocities against civilians:

a. What units participated in the alleged atrocity?

b. Was the atrocity reported to U.S. authorities?

c. What U.S. unit was it reported to?

d. Was there an investigation?

e. How many civilians were involved?

f. What were the circumstances of the incident?

Authors Note: My advice is to seek a legal opinion before submitting supporting evidence relating to atrocities against civilians.

6. **When the veteran claims to have witnessed or participated in the mistreatment of enemy prisoners.**

It is almost impossible to confirm from records instances of the mistreatment of the enemy. If the veteran makes such a claim, the information pertaining to the following question should be provided along with the basic facts and circumstances:

a. Was the incident reported to U.S. authorities?

b. Was there an investigation?

c. What unit was it reported to?

Authors Note: Once again, my advice is to seek a legal opinion before submitting supporting evidence relating to mistreatment of enemy prisoners.

7. **When the veteran claims to have been wounded or injured.**
There are numerous records in which a veteran’s wound or injury would have been recorded. However, some of the records may not have been retired or retained, for reasons mentioned earlier. It is imperative to provide as much of the following information as possible:

   a. Was the veteran awarded a Purple Heart? (check the veteran’s DD Form 214*)

Authors Note: While VA regulations stipulate that being in receipt of certain awards, of which the Purple Heart is one, automatically indicates a “stresser” has occurred, the percentage of disability will hinge on how many and how bad the wounds were. DO NOT just submit your claim based on receipt of an award with no other supporting evidence.

   b. What type of wound did the veteran suffer? (bullet, burn, shrapnel, etc.)
   c. Where on the body was the veteran injured?

   d. What type of incident was the injury incurred? (mortar attack, fire fight, accident, etc.)

   e. Was the wound reported? If the wound was not reported, it could not have been recorded, so it cannot now be confirmed.

Authors Note: I believe item “e” above could possible be proven wrong if a scar, medical records and statements of witnesses can be produced. I am certain non-critical wounds were treated in the field and either paperwork or the attending medic was lost.

   f. Was the wound treated? If it was treated, where was it treated? (hospital, clinic, aid station, etc.)

   g. Did the veteran lose duty time as a result of the wound?

   h. Was the veteran evacuated as a result of the injury?

Authors Note: You may be thinking that your medical records and official files should produce necessary evidence of wounds sustained in combat. Save yourself some grief, always provide the information requested and more, if possible.

(Some of the paging will differ slightly from the original pamphlet because of “Authors Notes”)

*On numerous occasions the DD Form 214 will not list all of the awards a veteran earned. The best source for verifying a Purple Heart Award is the Official Military Personnel File (OMPF). In addition to the qualification record which contains an awards section, the OMPF may also contain copies of general orders citing awards.

8. When the veteran claims to have had close friends killed and/or wounded.

I is not possible to determine “friends” from military records, but it is possible to frequently confirm the facts and circumstances of the death and wounding of U.S. personnel if the following types of information are provided:

   a. What were the first and last names of the casualty?

   b. What was the approximate date of the incident?
9. **When veterans with non-combat/combat support specialties claim extensive combat.**

It is not uncommon for veterans with non-combat/combat support specialties to claim extensive combat experiences. While such claims may be completely true, it is very difficult to confirm these cases from military records. Military personnel policy required that personnel perform within the designated specialties for which they were trained. Additionally, when they operated outside of their specialty, their records should have shown a change in duty specialty. Therefore, it is extremely important that claimants provide the following kinds of supporting information:

a. What were the circumstances behind the individual performing outside the assigned specialty?

b. Was additional training provided?

c. Were other individuals with non-combat/combat support specialties similarly exposed to combat?

d. How long or frequently did the veteran perform outside an assigned specialty?

e. Why doesn’t the veteran’s personnel record show a change in duty specialty?

f. Did the change in duty specialty involve a temporary or permanent change in unit?

10. **When the veteran claims to have been subjected to rocket and/or mortar attacks.**

All U.S. installations in Vietnam were within enemy rocket range, and most were within mortar range. It was uncommon for a veteran to have served in Vietnam without having been rocketed or mortared during the time he served there. Most major U.S. installations in Vietnam were many miles in size. A PTSD claim involving mortars and rockets must be put in the context of the personal involvement by the veteran. Therefore, the following information should be provided:

a. How frequent were the attacks (daily, weekly, monthly, etc.)

b. Were there casualties from the veteran’s unit?

c. Can the veteran provide names of casualties?

d. Was the veteran involved with the direct effects of the attacks? (barracks/duty section hit, etc.)

11. **When the veteran claims to have served as a door gunner.**

It is not uncommon for veterans to claim they served as door gunners when there is no evidence to substantiate that from the military records. Therefore, the following information should be provided to verify such claims:

a. Under what circumstances did the veteran serve as a door gunner? (emergency evacuation, daily duty, part-time between normal duties, etc.)

b. Did the veteran receive door gunner training? (in-country or stateside)
c. How frequently did the veteran perform door gunner duty? Approximately how many gunner missions did the veteran fly?

d. Was the veteran awarded the aircrew badge?

e. Did the veteran earn any flying decorations? (Air Medal or Distinguished Flying Cross - check the veteran’s DD Form 214 and OMPF.)

12. When the veteran claims to have participated in combat flights and the veteran’s record shows non-aircrew duty.

It is important to distinguish between true combat flights and those of an administrative nature which were flown over hostile territory. The following information is needed:

a. Under what circumstances did the veteran perform the aircrew duty? (emergency, part-time between regular duties, full time, etc.)

b. Did the veteran get aircrew training?

c. What function did the veteran perform? (observer, flight maintenance, gunner, cargo handler, flare kicker, leaflet dropper, etc.)

d. Approximately how many missions did the veteran fly?

e. Are aircrew orders in veteran’s military personnel record?

f. Did the veteran earn any flying decorations? (Air Medal or Distinguished Flying Cross - check the veteran’s DD Form 214 or the OMPF).

g. Was the veteran on flight orders and/or getting flight pay?

13. When the veteran claims to have been recommended for and/or awarded decorations for valor.

Verbal statements such as, “I am going to recommend you for an award,” did not always result into an actual award. Written recommendations with justification had to be sent through proper channels to the approving authority. If these procedures were followed, an audit trail of some sort can usually be found. As an aid, the following information is needed:

a. Does the veteran’s DD Form 214 or the OMPF show the awarding of decorations for valor?

b. What did the veteran do to merit the recommendation for an award?

c. What decoration was the veteran recommended for? (Bronze Star, Silver Star, etc.)

d. Who recommended the veteran for the award? (friend, first Sergeant, commander, etc.)

e. What headquarters processed the award?
f. Why was the veteran not awarded the decoration? (disapproved, administrative error, not submitted, recommendation lost, etc.)

g. What is the approximate date of the incident for which the veteran was recommended for an award?

14. **When the veteran claims to have been subjected to sniper attacks.**

Sniper attacks frequently did not merit mention in military records, so such claims are difficult to verify. However, information pertaining to the following questions should be provided for such claims:

a. Was anyone injured by the attacks?

b. Was counter fire employed to drive off the sniper?

c. Was the attack known to have been reported?

d. Under what circumstances did the attack occur?

e. Where did attack occur? (on patrol, at base camp, on convoy, etc.)

15. **When the veteran claims to have served in Vietnam, but there is no evidence of it in the individual’s military record.**

Occasionally some instances exist where veterans served in Vietnam and it is not shown in their military personnel records. Information pertaining to the following questions should be provided for such cases:

a. Under what circumstances did the veteran serve in Vietnam? (brief TDY, classified mission, fact finding visits, etc.) If it was a classified mission, it would normally have a code word which should be provided. Most Classified missions of the Vietnam War are now able to be declassified and successfully researched if the proper information is provided to USASCRUR.

b. When, where and for how long did the veteran serve in Vietnam, and with what unit?

c. Why is it not shown in the veteran’s military personnel record? (brief TDY, administrative error, emergency reassignment, etc.)

d. What was the veteran’s duty in Vietnam?

e. Does the veteran’s record contain temporary duty orders, hostile fire pay vouchers or any other evidence of service in Vietnam?

16. **“Almost Happened” Incidents.**

“Almost Happened” incidents are seldom verifiable. Claims such as “I almost shot a child,” or “My aircraft almost crashed,” or “I almost accidentally shot members of my own unit,” are not verifiable because they are not recorded. In order to research an “Almost Happened” incident, it must be clearly indicated that the incident was reported and recorded. USASCRUR will not attempt to research “Almost Happened” incidents unless it is indicated the incident was reported and which unit would have recorded the event.
17. **Convoy Guard and Driver Duty.**

Events that occur in convoys are rarely recorded and are thus largely unverifiable. If the veteran’s stressing experience involves convoy duty, the following should be provided:

- a. What was the date of the incident?
- b. Were there casualties? If so, how many? What were the names of the injured?
- c. How big was the engagement?
- d. What units were involved?

18. **When the veteran claims to have had civilian friends killed, wounded or executed.**

Civilian incidents are seldom recorded in military records. The accidental killing of civilians in combat is extremely difficult to verify. Incidents involving civilians, or civilian establishments, unless reported to Military Police (MP) units, are not normally found in combat records. If a report was written and filed with an MP unit, it may be possible to verify a particular incident. The same information required for Subsection 5, Page 11 is needed.

19. **When the veteran is on Temporary Duty (TDU)/Temporary Additional Duty (TAD) away from the home unit at the time of the incident.**

TAD/TDY orders are almost never maintained permanently, which makes it very difficult to confirm incidents when the veteran is away from home station. The veteran’s military personnel records should be screened for TAD/TDY orders, travel vouchers, or other evidence to validate the TDY/TAD. The following information should be provided for claims when the veteran was TAD/TDY:

- a. How long was the veteran TAD/TDY?
- b. To what unit/installation was the veteran TAD/TDY?
- c. What was the purpose of the TAD/TDY?
- d. Was the veteran part of a large or small group or alone?

20. **When the veteran refers to a base camp, fire support base, or other non-specific location.**

Place names are important only as they relate to specific stress incidents. Those names which identify the location of a stress incident should be included. If possible, the type location - base camp, hamlet, fire support base, landing zone - should also be included. Such information is important if the veteran’s unit of assignment as no records available for the period in question. In such instances, other units located at the same location may be reviewed for possible verification. What is not needed is a list of all places the veteran visited or traveled through. Start and end locations of convoy routes may be necessary in order to identify a particular convoy.

Examples of what is needed are listed below:

- a. Names should be as specific as possible. Statement such as “my base camp” should be “my base camp at Bearcat or Camp Martin Cox”; not a “hot landing zone” but, if possible, “landing zone Baldy.” If the
stress incident occurred during a convoy, such information as convoy between “Tay Ninh and Cu Chi” is more helpful than just saying “we were running a convoy along a major route”.

b. However, even with place names, the approximate date of an incident is still required.

SECTION VI

FREEDOM OF INFORMATION ACT REQUESTS

1. Most requests addressed to USASCRUR involving the Freedom of information Act (FOIA) are not actually covered under the Act. The purpose of the FOIA is to allow individuals access to records that are either classified or not normally available to the general public. The majority of records researched by USASCRUR are unclassified or declassified and are readily available to the general public.

2. Various records are available to the public at the cost from other organizations. Such records are not covered in a FOIA addressed to USASCRUR. Most Vietnam era OR-LLs, for example, have been declassified and reproduced on microfiche and are available from the National Technical Information Service.

3. USASCRUR policy is to research all available records for specific stress incidents without charge to the veteran or the requester. USASCRUR does not provide general historical documentation or copies of records for large periods of time without a specific incident.

4. Requests to USASCRUR under the FOIA do not facilitate research or the providing of records to the requester. As stated, most military records are available to the public. Requests under FOIA, however, do slow the USASCRUR response time to the majority of veterans who write USASCRUR because FOIA requests require additional administrative suspense and report requirements. With a large operational backlog of cases, such additional administrative burdens hurt many veterans.

SECTION VII

DOCUMENTS TO BE FORWARDED WITH REQUESTS

ARMY, NAVY, AIRFORCE, MARINE CORPS & COAST GUARD

1. This section contains examples of the various documents from the claimant’s records which should be forwarded to USASCRUR. When a specific record is common for all services, such as the DD Form 214 (Armed Forces of The United states Report of Transfer or Discharge) only one example is provided.

2. because of the way each of the military branches lists the service data on their respective forms, no attempt has been made to provide either a detailed definition of each element, or an index of where on the form a particular element can be located. To those familiar with military personnel records, the specific sections and subsequent entries are self-explanatory. Those individuals not familiar with military documents or personnel record may request assistance from USASCRUR.

3. The following is a list of these documents which need to be included for PTSD claims for each military service:

**ARMY**
- a. Enlisted Qualification Record (DA Form 20)
- b. Office qualification Record (DA Form 66)

**NAVY**
- a. Enlisted record of “Transfer and Receipts”
- b. Enlisted record of “Administrative Remarks”
- c. Officer record, NAVPERS 1301/51, “Officer Data Card”

**AIR FORCE**
a. Airman Military Record (AF Form 7)
b. Officer Military Record (AF Form 11)
c. Performance Reports: Copies of the Performance Reports covering the period of the claim should be forwarded to USASCRUR for Air Force PTSD claims. These documents are self explanatory, so no examples are shown.

**COAST GUARD**
a. Enlisted Record, “Endorsement on Order Sheet” (DOT Form CG 3312B)
b. Officer Record, “Service Records Card” (CGHQ Form 3359)

**ALL SERVICES**

DD Form 214

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**SECTION VIII**

**POINTS OF CONTACT FOR VARIOUS RECORDS**

1. Inquiries regarding awards and decorations should be addressed to one of the following:

   a. **ARMY**
      1) U.S. Army Reserve Personnel Center (ARPERCEN)
         ATTN: Awards Branch
         9700 Page Avenue
         St. Louis, MO 63132-5200
         
         Awards Branch *
         Total Army Personnel Agency (TAPA)
         ATTN: DACP-PDA
         Hoffman II
         200 Stovall Street
         Alexandria, VA 22332-0471
         
         *The Awards Branch of TAPA should only be contacted after contacting ARPERCEN and obtaining copies of the veteran’s qualification record and any orders from the OMPF which indicate award authorization.

   b. **NAVY**
      Officer in Charge
      Personnel Support Detachment
      Anacostia, Bldg. 92
      Washington, D.C. 20374-0922

   c. **AIR FORCE**
      Air Force Military Personnel Center
      (AFMPC/DPMASA)
      Randolph AFB, TX 78150-6001

   d. **MARINE CORPS**
      Commandant of the Marine Corps
      (Code MMRB)
      Headquarters U.S. Marine Corps
      Quantico, VA 22134-0001

2. If copies of the veteran’s unit records are needed, write to the following:
a. **ARMY**
   - Daily Journals, Operational Reports-Lessons Learned (OP-LLs), Combat Operations after Action Reports (COAARs) and Unit Histories:

   National Archives and Records Administration (NARA)
   ATTN: Archives II Textual
   Reference Branch (NNR2), Room 2600
   8601 Adelphi Road
   College Park, MD 20740-6001

   - Morning Reports:
     National Personnel Records Center (NPRC)
     ATTN: NCPMR-O
     9700 Page Avenue
     St. Louis, MO 63132-5200

b. **NAVY**
   - Deck Log and Ship station Histories:
     U.S. Naval Historical Center
     Building 57
     Washington, D.C. 20374-0517

c. **AIR FORCE**
   -Quarterly History Reports:
     The Air force Office of History
     AF/CHO
     Bolling Air Force Base
     Washington, D.C. 20332

*(Authors Note: I wrote to the above address, Bolling AFB, and they said they did NOT provide Quarterly reports. They said to contact USASCRUR or Maxwell, AFB (See chapter 9, paragraph 09-03)).*

d. **MARINE CORPS**
   -Unit Records:
     Commandant of the Marine Corps
     (Code HDH)
     Headquarters, US Marine Corps
     Washington, D.C. 20380

3. If a veteran desires a copy of his/her personnel or medical records, the request should be addressed to the respective service representative (Army, Navy, etc.) at:

   National Personnel Records Center (NPRC)
   9700 Page Avenue
   St. Louis, MO 63132

Pages 23 through 49 (Forms not provided)
AWARDS AND DECORATIONS

I. DECORATIONS ISSUED TO INDIVIDUAL MEMBERS OF THE ARMED FORCES

A. INDIVIDUAL DECORATIONS DENOTING COMBAT PARTICIPATION

1. Medal of Honor
2. Distinguished Service Cross
3. Navy Cross
4. Air Force Cross
5. Silver Star
6. Distinguished Flying Cross
   a. Army
   b. Air Force
   c. Navy
7. Bronze Star Medal (Merit or Valor)
8. Air Medal (Merit or Valor)
9. Purple Heart
10. Joint Service Commendation Medal (Merit or Valor)
11. Army Commendation Medal (Merit or Valor)
12. Navy Commendation Medal (Merit or Valor)
13. Air Force Commendation Medal
14. Navy Expeditionary Medal
15. Marine Corps Expeditionary Medal
16. Combat Ribbon
17. Parachutist Badge with Bronze Service Star
18. Combat Infantryman Badge
19. Combat Medical Badge
20. Bronze and Silver Stars
21. Numerals
22. “V” Device
23. Arrowhead
24. Service Stars
25. Fleet Marine Force Operations Insignia

II. DECORATIONS ISSUED TO ENTIRE UNITS OF THE ARMED FORCES

A. UNIT LEVEL DECORATIONS DENOTING COMBAT PARTICIPATION

1. Presidential Unit Citation
   a. Army
   b. Navy
   c. Air Force
2. Air Force Outstanding Unit Award with “V” Device
3. Republic of Vietnam Gallantry Cross Unit Citation Badge with Bronze Star
4. Valorous Unit Award
   NOTE: The Department of Veterans Affairs (A) Regulatory Amendment to Regulation 38 CFR 3.304(f), dated May 19, 1993, states that the awarding of the Purple Heart (PH), the Bronze Star with “V” Device or the Combat Infantryman Badge (CIB) satisfies the VA Requirement that a veteran was involved in a combat stressor. (Either the DD Form 20 or DD Form 214 will verify the awarding of the above listed awards.)

APPURTENANCES FOR UNIT AWARDS

1. Oak Leaf Cluster
2. Citation Star
3. Commendation Star
4. Arrowhead Device

(Descriptions of awards are listed on pages 50 through 73 and have been omitted for sake of space).

SOURCES: Military Awards
Army Regulation AR 672-5-1
Effective 12 April 1984

Armed Forces Decorations and Awards
DOD P-17D/ DA Poster 360-99

Air Force Regulation AF Reg 900-48
Effective 25 March 1982

Navy & Marine Corps Regulation
### Appendix K

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