Critical Periods in the History of VA Psychology:
People, Events, and Stories[1]

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My presentation will include a description of people and events in the history of VA psychology which was established in 1946. I'll also be telling some stories since I've found in my brief historian career that people are more likely to remember stories that reflect facts rather than the cold facts themselves. Because of time limitations, I will confine my remarks to five critical periods in that history.

Beginning with 1945-1949, I'll spend about half of my time talking about the forces leading to the reorganization of the VA, the establishment of psychology, and the critical need for and beginning of the VA psychology training program.

I'll next describe the well-earned reputation of psychology for leadership in introducing innovations in VA treatment programming during the 1960s.

Following those comments, I will present some highlights of the 1970s and early 1980s when VA psychology began emerging as an advocacy voice for psychologists and their patients. The 1970s and early 1980s also marked a time period when a shift in VA funding priorities resulted in a focus on VA psychology internship training and APA accreditation.

I will also add a description of the difficult times for psychology and other healthcare professions in the VA from 1995-2005 when the VA moved to streamline its operations and focus on primary care.

And, finally, I conclude the presentation with some brief remarks about the resilience of VA psychologists and the value of psychology's health care contributions to the VA in the remarkable growth of psychology in the post-2005 time period.

Medical Care and Benefits for Veterans Prior to 1945

The VA that most of us recognize today got its start in 1946 when a massive restructuring and growth of the VA was needed to take care of millions of new veterans from WWII who would be eligible for healthcare in the VA. To fully understand the impact of some of the events I will be talking about, I would like to spend a few minutes describing what the VA looked like prior to 1946.

Before 1917, there was no federal legislation in this country that specifically provided healthcare benefits for veterans. As early as 1636, however, the colonies and later the states

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began providing pensions and supportive residential care for those who served and were wounded in the early Indian wars. In 1789, the first Congress of the United States took over responsibility for payment of pensions for veterans.

The first domiciliary for veterans was built in 1811 and The National Homes for Disabled Volunteer Soldiers began opening in 1865 after the Civil War, but medical care was essentially small health clinics operating within and as part of these residential care programs.

In 1917, federal legislation authorized the US Public Health Service to provide medical care for veterans, including hospital care. In 1930 President Herbert Hoover consolidated all federal programs providing services to veterans into one agency—that agency was named the Veterans Administration.

With the creation of the VA in 1930, the VA assumed responsibility for 54 hospitals, many subsequently converted into VA TB hospitals because of the prevalence of that disease among veterans and military personnel at the time. The organization of medical care was primarily delegated to each hospital with virtually no central oversight from Washington. Even as WWII was ending, the VA was not well-organized to focus on issues of quality of care. The situation is best illustrated when I tell you that, in 1945, the primary medical officer of the VA was organizationally placed in the office of construction supply and real estate in VA Central Office.

A. <u>1945-1949</u>

As WWII was ending in 1945, 16 million military personnel would be returning home. Most would be discharged and many would be expecting the VA healthcare benefits promised them. President Harry S. Truman knew he had a big problem on his hands in preparing the VA to provide that healthcare. He would need someone to "fix" the VA to take care of the huge increases in expected patient workload. In addition to improving quality of care, that person would need to attend to a number of issues.

--First of all, VA employees enlisted in the armed services as did millions of Americans from all over the country. During the war, the Army in fact had to send military doctors to work in VA hospitals to take care of patients. By 1945, three-fourths of the 2300 physicians in the VA were on active military duty and on loan to provide patient care in the VA. It was an accepted fact that most of these military physicians would be leaving the military (and thus the VA) and all predications were that there would be never be enough staff to handle even the older WWI veteran patients already in VA hospitals, not to mention the influx of new WWII veteran patients.

-In 1945, the VA had 81,000 authorized beds but many were closed due to staffing shortages, and 69% of the operating beds were filled with mostly long-term psych patients, most from

WWI with a psychotic diagnosis and most of those patients had average lengths of stay of 500 days.

--finally, after the end of the war in Europe and in Japan in 1945, applications for VA disability compensation from discharged military personnel were being received at rates of up to 400,000 per month with a significant growing backlog of unadjudicated claims. Sound like a familiar problem? To provide some perspective to those numbers however, the VA's annual report to Congress noted that in FY1946, more disability claims were filed than in any previous year. Actually, the number of claims filed in FY46 exceeded the number of claims filed in any two-year period since – the 2.7 million claims filed in 1946 compared with 2.5 million claims filed in both FY 2010 and FY2011, the only 2-year period that came close to meeting the one-year claim total submitted in FY46.

With the end of the war in Europe, President Truman asked General Omar Bradley to take on the task of getting the VA ready to provide the best care possible for the huge influx of patients the VA would see.

Bradley had been in charge of American troops in Europe and was a very popular general. He was given the nickname of "the doughboys general" or "the GI's general" because he listened to the concerns of his troops whether they were privates or generals. He was also was noted for never losing his temper. In one story told about Bradley, a difficult German prisoner of war was being interviewed and one of Bradley's aids nervously fingered his rifle and, accidentally, sent a bullet whizzing by the general's ear. Bradley was reported to have asked, calmly, "Can't you be a little more careful with that darn thing—please." That story probably passed as quickly among privates and generals alike in the Army in Europe as a YouTube story might reach our population today. Truman knew that General Bradley would be trusted by veteran patients to take care of them. Bradley accepted Truman's request and became the "veterans general."

In addition to his reputation for listening, Bradley was also well known for his organizational skills and for choosing good people to work with him. His first recruitment after being appointed the new VA Administrator was to ask General Paul Hawley to join him. Hawley had been in charge of 16,000 physicians and was responsible for all medical care for troops in Europe. Bradley wanted Hawley to take the same role of being in charge of medical care of VA patients.

Hawley, however, had been an Army doctor his entire medical career and knew he would need general acceptance by the AMA and the American Association of Medical Colleges. Especially needed would be acceptance for one of the key plans that he and Bradley were planning to improve medical care in the VA…and that was to establish training affiliations with the nation's medical schools. Hawley picked Dr. Paul Magnusson to help him, a respected leader of medicine and medical education in the country. The task of getting medical schools on board with medical training in the VA was turned over to Magnusson.

Meanwhile, Bradley and Hawley spent much of the late summer and fall of 1945 putting together a legislative package to reorganize the VA to improve patient care. The legislation had 3 major components:

--1st, they wanted the recruitment of doctors, dentists and nurses in the VA taken out of the cumbersome and lengthy Civil Service Commission recruitment process in order to hire doctors more quickly – and with salary based on quality of credentials and experience. As noted previously, Hawley had 16,000 doctors under his command in Europe who knew the medical care needs of veterans. Hawley was respected by them and knew they would want to work for him again if he could compete with the lure of starting a private practice after the war. The powerful Civil Service Commission would oppose their proposed use of the Title 38 legislative authority for hiring.

--secondly, Bradley and Hawley wanted authority for the VA to establish affiliation agreements with medical schools to train their medical students in the VA and to have had their training supervised by experienced faculty. They were convinced that bringing medical school faculty and students into the VA would bring the VA into the mainstream of patient care and lead to improved health care for veterans. Previous attempts to establish affiliation agreements in the VA were turned down a number of times by Congress, however, as opponents kept implying that our veterans would be subject to "experimentation" by the student doctors. Bradley and Hawley knew this would be a hard sell to Congress.

--and lastly, they wanted to create professional division offices in VA Central Office in such areas as medicine, surgery, neuropsychiatry, and rehabilitation with the division leaders reporting to a chief medical director who would in turn report directly to Bradley. These division heads would be responsible for developing treatment programs in VAs around the country as well as providing leadership and oversight for their discipline's activities in the VA hospitals. Of all of their legislative proposals, this was the only one that would be relatively easy to get support for.

By the way…the only organizational action available to Bradley without legislation was to move the VA's medical officer out of the office of construction supply and real estate and have him report directly to Bradley—a move he made when he brought Hawley on board in what would become the VA's first medical director.

The legislation Bradley and Hawley wanted was passed by Congress and signed into law by President Truman on January 3, 1946.

I will note with little additional comment the remarkable fact that the day after the bill was signed, Northwestern University and the University of Illinois placed 56 medical residents for training at the VA hospital in Hines outside of Chicago. I don't have time for that story, but obviously Magnusson had done his job in getting support from medical schools for the VA's

affiliation plan. By the end of 1946, 63 of the nation's 77 medical schools had affiliations with the VA.

The new Neuropsychiatry Division in VA Central Office that was formed under the reorganization had 3 sections—one for psychiatry, one for neurology, and one for psychology. James Grier Miller was given the job to organize and provide oversight for psychological services for VA hospitals. He was also given funding and authority to hire 500 psychologists for VA hospitals.

One of Miller's most far-reaching decisions was to recruit psychologists for the VA only if they had a doctoral degree AND had some clinical service or training experience. That decision also gave him his first major problem. The 500 psychologists with the doctoral degree and clinical experience he was authorized to hire represented close to two-thirds the total number of doctoral psychologists currently working in clinical settings in the entire country. He realized that he would have to train the psychologists he wanted to work in the VA.

Although the legislation to affiliate and train medical students in the VA strictly applied only to medical, dental, and nursing students, Miller found language in the legislation that would permit part-time employment of psychology graduate students with a training assignment to deliver psychological services to patients and be supervised by their university faculty. Miller convinced Bradley of this interpretation and was permitted to use some of the money he had to hire psychologists to hire psychology students and pay consulting fees to university faculty for their supervision.

The next problem Miller had in setting up the VA psychology training program was that most psychology graduate schools in the country were not providing any clinical service training for their students. In the 1940s, remember, APA and most universities considered clinical psychology an academic profession whose only legitimate professional activities were to teach and do research.

The VA asked APA to identify which universities were giving clinical service training to their students. Eventually 22 universities were identified and the VA planned to recruit and pay students only from those schools.

It can be noted that historians credit the VA's request of APA to identify those schools with clinical service training to have led to the eventual decision of APA to begin their accreditation program for graduate schools of psychology. It can additionally be noted that the VA decision to hire staff psychologists who had both academic and clinical training pre-dated the decision made at the 1949 Boulder Conference that established the scientist-practitioner model as the norm for training in clinical psychology.

Those of you who received part of your training in the VA and those interns and postdocs attending the conference will be interested in knowing that in 1946, universities and medical

schools were beginning to think of providing practicum training for psychology graduate…but were not planning to pay them any training stipend. They argued that the training would be best introduced as a high-grade learning experience and that providing a stipend might be considered a low-grade job and underrate the training aspect. The VA, however, was planning to pay a stipend to graduate students (many of whom would be married veterans using the G.I. Bill to fund their graduate training) to free them from economic concerns in supporting their families so they could better attend to their training. When the U.S. Public Health Service also announced that they would be paying stipends to graduate students in their new grant program, the universities and medical schools had no choice but to find money to pay a stipend to their students while doing practicum and internship training in order to remain competitive with the VA and Public Health Service.

In the fall of 1946, 215 graduate psychology students from 22 universities began their training and work with veterans in VA hospitals. The significance of the beginning of the VA psychology training program was not overlooked by APA who published the names of all 215 students and their universities in a 1947 issue of the *American Psychologist*.

Still another footnote to this story was that Miller thought psychologists should be included in the Title 38 recruitment and personnel actions used for physicians, dentists, and nurses…and Bradley agreed. Legislation would be required to make that change, however, and in the press to get the VA's treatment programs going, the legislation was never introduced. It would take another 50 years before psychologists were included in a modified Title 38 — and many today believe that full Title 38 recruitment and personnel authority should be pursued for VA psychologists.

As Miller was putting together the VA psychology training program, he also convinced VA management to require all VA hospitals to have a psychologist and psychology service. One of the first doctoral psychologists hired to start a psychology service was Roy Brener recruited by the VA hospital in Hines in 1946. Although Roy died before I could conduct an interview with him for the APA book on VA psychology history that I co-authored, his wife, Golda, told me some of the stories that Roy used to tell about his being hired at Hines.

One of Roy's favorite stories was that nobody knew how to spell psychology, and that they certainly didn't know what a psychologist was supposed to do. He also told the story that although he was chief, he had no staff. Some of you remember Charlie Stenger (still alive, by the way) who tells a similar story when he was hired as a chief of psychology with no staff – that nobody knew what psychologists were supposed to do. When Charlie tells his story, however, with a twinkle in his eyes, he will add what a wonderful opportunity it was to be given the chance to develop a psychology service the way he wanted it to function.

One final story that Roy Brener would tell is that when he was hired at Hines, there was only one office left for management to assign and that management was trying to decide whether to give it to Roy—or the barber. Roy finishes his story by saying that the barber got the office.

Roy, however, got the next office available and went on to develop one of the premier psychology services in the VA -- known both for the patient care services his staff provided as well as his development of one of the finest psychology training programs that trained many of the leaders who made a name for themselves in the VA.

Returning to the psychology training program…in the fall of 1946 when the training began for the first class, there were only 50, maybe a max of 60 doctoral psychologists in VA hospitals. The 215 psychology trainees, however, were assigned throughout the VA to hospitals closest to their university. Some went to VAs with a doctoral psychology presence. Some went to VAs with only a master's level psychology presence…and some went to VAs with no psychology presence other than from the weekly visits made by their university faculty for supervision.

One-fourth of VA hospitals at the time were designated as neuropsychiatric hospitals with as many as 3,000 long-term psych patients…and most of those had no doctoral psychology presence. The psychology trainees assigned to those latter hospitals had limited opportunities to use the assessment and other clinical skills for which they they were being trained in their university. The pre-Thorazine era of management of psychotic and aggressive patients in both the VA and non-VA psych hospitals included straightjackets, cold packs, and electroshock treatment. Trainees often sharpened their assessment skills with assessments based only on observation and interactions with patients.

Lee Gurel was an early VA trainee assigned to one of large neuropsychiatric hospitals with no psychology presence. He reported that trainees did what they could to help patients and essentially supervised each other by sharing and discussing their patient care experiences with other trainees. Gurel noted in a presentation at an APA convention that the university faculty of the students did in fact come to the hospital to provide weekly trainee supervision and seminars…but many of their faculty had never seen a schizophrenic patient and most had no experience working with active and aggressive psychotic patients. In fact, the university supervisors learned with their students and took that learning experience back to their classrooms.

In spite of the varied and diverse difficulties that faced many psychology trainees, they almost universally report in oral history interviews that their training was a positive one with valuable learning. They were young, enthusiastic, and saw the relevance and need for their training. They believed that they were helping patients. They were also veterans themselves, a requirement of the VA training program, and appreciated the fact that they were not only learning useful clinical skills…but were additionally motivated by having the opportunity to help

their fellow veterans. Early trainees further report that their enthusiasm and desire to help patients was respected by other VA staff and helped develop important working relationships with nurses and others.

If you are checking the clock, you will note I've already used half of my 45 minutes and that's intentional...I will finish on time. The first few years of VA psychology, however, set the stage for so much of VA psychology history. I also hope you appreciate the fact that the early history of VA psychology and the early history of the VA training program are virtually the same. It is difficult to imagine what VA psychology would be like today without having the VA psychology training program in place in 1946. In the first 10 years of the training programs, 85% of trainees came on board as VA psychology staff after receiving their doctoral degree. Miller had in fact gotten the clinically-trained psychologists he wanted in the VA using the psychology training program.

B. The 1960s

Let's jump to the 1960s for a few comments. In 1960, psychology trainees still outnumbered doctoral staff…775 to 750. However, trainees would only be assigned for training in VA hospitals with a doctoral psychology presence. By 1960, VA psychologists were recognized for both their treatment and assessment skills and had firmly established themselves as an important part of the VA treatment environment, including their leadership in and staffing of the VA's mental health outpatient clinics. Psychologists and their trainees were also the first to introduce group therapy programs in both inpatient and outpatient care. In 1960, the VA published the first-ever treatment manual for group therapy that focused on practical advice on running group therapy programs. That manual was co-written by VA psychologist Hal Dickman while chief of psychology at Roseburg, OR (again, some of you remember Hal — also still alive.) The manual provided important information that supplemented the mostly theoretical aspects of group therapy developed in academia. The manual included such topics as different kinds of groups, which patients received most benefit…and added suggestions for how to prepare the patient for group therapy and how to best handle hostile, despondent, silent, and talkative patients.

While psychiatry in both VA and non-VA settings was still mostly focused on psychoanalytic treatment, VA psychologists found that approach to be of limited usefulness for the mostly acutely disturbed psychiatric patient population in the VA and began introducing behavioral-health treatment programs in the 60s being used by other psychologists in the country. A conference was held in Chicago in 1965 to focus on trends and development of the programs VA psychologists were using, especially those non-traditional approaches. Presentations ranged from token economy programs to attitude therapy to therapeutic milieu

programs and added presentations on some of the behavioral work VA psychologists were doing with medical and surgical patients.

C. The late 1970s and early 1980s

During the late 1970s, VA psychology became more active in advocacy both for their profession as well as for their patients and the psychology training program.

…psychologists wanted membership on the hospital medical staff as well as clinical privileges,

…psychology chiefs needed and wanted more training in administrative skill areas that had never been introduced in their graduate school programs,

…psychology leadership started pushing for inclusion in Title 38 to improve the professional standing of psychologists in the VA's health care community,

…and VA psychology begin partnering with APA in advocacy to reverse drastic cuts in funding for the VA psychology training program that were being proposed by Congress in the 1980s.

Oakley Ray at the Nashville VA and other VA psychology leaders began promoting the formation of an association of VA psychology leaders to support this advocacy and the Association of VA Chief Psychologists was formed in 1978 with Oakley as its first president. In its early days, the association was successful in getting VACO to publish a model VA staff membership and clinical privileging policy that included psychologists, helped reverse proposed funding cuts for psychology training proposed by Congress in the 1980s, and started an administrative training program for new VA chiefs of psychology.

It was also during the early 80s when the VA decided it would put its professional training dollars only in training programs that had a national accreditation status. Prior to this time, VA training programs were given a pass and were considered to meet accreditation status by APA if they recruited students only from APA-approved universities. With the shift in VA training policy, VA training programs now needed independent accreditation to continue to receive funding. APA was not really prepared financially nor did they have the manpower to conduct accreditation visits for over 80 VA hospitals doing psychology internship training, but the VA had become the largest funded training program in the country and APA noted the importance of getting these programs accredited. Eventually, things worked out and the psychology training program at Topeka, Kansas became the first VA training program to become APA-accredited in 1974. By the fall of 1977, 13 VA psychology training programs were accredited.

In 1982, new requirements for employment as a psychologist in the VA were established in legislation. In addition to a doctoral degree from an APA-approved graduate program, applicants must have had an APA-approved internship and obtain licensure within two years as a condition for continued employment. The requirement for an APA-approved internship credential for

employment further stimulated psychology services in the VA for obtaining APA accreditation for their training programs. By 1985, just 11 years after the first VA psychology training program was accredited, 84 VA psychology internship programs had received APA approval and were being funded by the VA. In 1991, the APIC Directory indicated that over one-third of all APA accredited training programs were in VA hospital settings. 1991 also was the year that the VA began funding post-doctoral training in psychology, and in 1999, the VA in San Antonio became the first VA training program, and only the 3rd in the country, to receive APA postdoctoral accreditation. The VA quickly assumed leadership in accredited post-doctoral training. In 2005, the APA accreditation website showed that almost half of the accredited postdoctoral training programs were housed in VA medical centers.

D. 1995-2005

No account of the history of VA psychology can overlook the difficult organizational time period that began in the mid-1990s when the VA decided to make major changes in its patient care delivery system. Motivating the decision were the challenges to remain viable in a fluctuating, competitive, and demanding healthcare market. The goal was to transform the VA into a performance-based, outcome-driven healthcare organization with a strong emphasis on primary outpatient care.

As part of the goal to improve efficiency and patient care coordination, many VA medical centers chose to replace the traditional professional service structures (such as independent psychology services, independent psychiatry services and nursing services) with a grouping of professional services working together for a particular patient care population. These structures were generally called product or service lines, and psychologists and psychiatrists were often merged into a mental health service line, sometimes with other professionals such as psychiatric social workers and psychiatric nurses. The service line would have a single chief or director, more often than not a psychiatrist. But surveys at the time, however, indicated that psychologists filled roughly one-third of these new service line management roles.

The loss of independent psychology services in many medical centers, accompanied by the parallel loss of two-thirds of the psychology chief positions in the VA, had a devastating impact on morale in the field. Together with severe budget constraints and pressures to increase time spent in patient care activities, this was not a good time for VA psychology.

This Leadership Conference was born in the early days of that change period. I'm always reluctant to credit someone for an event in history, especially recent history, because there are usually so many people that are responsible for any significant event. I am confident, however, that anyone here who was involved in creating this conference would not mind if I mentioned

Russell Lemle, chief of psychology at the San Francisco VA, as the person who must be given major credit for starting this conference in 1998.

Russell was not seeing any movement to help VA psychology deal with the major negative impact the reorganization was having. He came up with the idea of a national VA leadership conference to find ways to move VA psychology forward and began talking with other psychology leaders. With Russell's leadership, the now-named Association of VA Psychologist Leaders approached the APA Practice Directorate for their guidance and support. These discussions resulted in the scheduling of the first leadership conference in Dallas in 1998 jointly funded by the Association of VA Psychologist Leaders and APA's Practice Directorate.

The first leadership conference brought together close to 100 psychology leaders from more than 50 VA medical centers and was a somber event as workload, budget, and reorganization problems in the field were discussed.

To reverse some of the feelings of loss and impotence among psychologists, an important conference planning decision for the first years of the conference was to ask participants to develop planning interest groups around some of the critical problems facing psychology in the VA. Interest groups began working during and after the first conferences on such issues as promotion and advancement for psychologists, developing leadership credentials, and promoting the psychologist role as value-added providers. The conference began reversing some of the earlier morale problems and became an annual event that continues today, serving an important function in energizing psychology in the field in dealing with the current demands and issues facing VA psychology.

The other event having a major impact on the viability of psychology in the VA was the 2005 mental health strategic plan.

E. Post 2005

The APA book on the history of VA psychology that I co-authored went to press in 2006 and ended with a description of the development of the VA's mental health strategic plan. This plan introduced a blueprint for the VA to establish mental health services for the future and respond to the need to provide the needed staffing to implement the plan. The plan had been approved by the VA with funding by Congress in early 2005.

The mental health strategic plan provided for significant increases in psychology staffing and other mental health profession positions to meet the needs of patients with mental health problems.

In 2006, I could only note that, quote, "the 2005 mental health strategic plan took an important step forward in closing the gap between needed resources and the mental health treatment needs of veterans."

I am pleased to be around to give a follow-up report that the mental health strategic plan was responsible for almost tripling the number of VA psychologists from a count in 2005 of 1,685 to today's number close to 4,400 psychologists. The plan also resulted in a major growth and importance of mental health services for veterans in the VA.

F. Conclusion

If my comments today have given you any interest in learning more about the rich heritage of VA psychology, I invite you to consider reading some of references I included in my Resource Materials on the conference website. I would especially like to call your attention to the stories of 27 VA psychology leaders who describe their careers in the VA, many beginning with stories of their early VA psychology training experiences. The stories include both accomplishments and frustrations and span the entire history of VA psychology from 1946 through today. These stories are contained in two books I edited, one in 2007, and one just published this year. The books and the career stories of the authors also provide an entertaining, first person perspective that expands the reader's understanding of the formal history of VA psychology. Some highlight of the second book, for example, are the career stories of Toni Zeiss and Steve Cavicchia who had major roles in the creation of the 2005 mental health strategic plan and career story of Kathy McNamara who yesterday received the Pat DeLeon Advocacy Award. The descriptions and availability of both books are described in a flyer available at the registration table. They are simply entitled *Stories From VA Psychology* and *More Stories From VA Psychology*. If you can't wait to order the newest stories book, I have a few copies with me at the conference.

No one can say what the future will bring, but if past history is an indicator…I am confident that later VA psychology historians will tell the story of the continued importance of psychology in the VA and in the lives of veteran patients served by psychology. The rich heritage of VA psychologists that was begun in 1946 will continue with many of you in the audience today adding to that heritage.