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The Legislative Response to PTSD in the United States (1989–2009): A Content Analysis

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Although knowledge about posttraumatic stress disorder (PTSD) has grown over the past 40 years, PTSD policy research is undeveloped. This gap in knowledge warrants attention because policy is among the most powerful tools to prevent and mitigate the effects of PTSD. This study provides a content analysis of all bills introduced in U.S. Congress that explicitly mentioned PTSD. All bills and bill sections mentioning PTSD were coded to create a legislative dataset. Bills that addressed traumatic stress, but did not mention PTSD, were also identified as a comparison group. One hundred sixty-one PTSD explicit bills containing 382 sections of legislative text were identified, as were 43 traumatic stress, non-PTSD bills containing 55 sections (the 2 categories were mutually exclusive). Compared to traumatic stress, non-PTSD sections, PTSD explicit sections were far more likely to target military populations (23.6% vs. 91.4%) and combat exposures (14.5% vs. 91.4%). PTSD, as a discrete diagnostic entity, has been largely defined as a problem unique to combat exposure and military populations in federal legislation. Research is needed to understand knowledge and perceptions of PTSD among policy makers and the public to inform science-based advocacy strategies that translate the full spectrum of PTSD research into policy.

Despite exponential growth in the depth and breadth of PTSD research over the past 40 years, PTSD policy research is relatively underdeveloped. Questions regarding how public policy has been and can be used to address PTSD have been the subject of relatively little scholarship and even less empirical research. This gap in knowledge warrants attention because policy is among the most powerful tools for improving population health and preventing PTSD (Institute of Medicine, 2012; Sorenson, 2002).

Although scholars have theorized about the implications of individual pieces of legislation for specific populations with PTSD (Bursztajn, 1993), critiqued Congressional responses to PTSD (Duhart, 2011), and advocated for more Congressional action to address PTSD (Shea-Porter, 2009), there exists little empirically grounded guidance about how PTSD research can effectively be translated into public policy. The field of traumatic stress studies would benefit from such guidance because policy is made through complex sociopolitical processes in which problem framing and political feasibility often trump the merits of scientific evidence (Herman, 1997; Oliver, 2006).

Policy mapping studies have recently been conducted in the field of public health law research to address this challenge and help researchers successfully navigate political environments (Burris et al., 2010). These studies employ systematic and replicable methods to document how policy has and has not been used to address specific issues. In doing so, mapping studies produce menus of policy alternatives, identify policy gaps, develop policy research agendas, and generate empirically grounded recommendations regarding how researchers can strategically advance public policy that is both politically feasible and evidence based. The results of mapping studies can be particularly instructive when little is known about the policy terrain around a specific issue (Burris et al., 2010), as is the case with PTSD.

The purpose of this study was to systematically investigate the response to PTSD in one area of public policy—federal legislation in the United States. This study's primary aim was to describe the federal legislative response to PTSD. The secondary aims of this study were to describe (a) trends in this legislative response, (b) which populations have been the targets of legislation, (c) the types of events that have been implicated as capable of causing PTSD, (d) the policy instruments used by federal legislators to address PTSD, and (e) how the content legislation explicitly mentioning PTSD compares to the content of legislation aimed at addressing traumatic stress but not mentioning PTSD. By mapping the contours and boundaries of the legislative response to PTSD, this study aimed to serve as a foundation for future traumatic stress policy research and to

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inform advocacy efforts that translate traumatic stress research into effective and equitable public policy.

It is essential that readers are aware of the scope and aims of this study from the outset. This study aimed to describe the federal legislative response to PTSD, not the broader concept of psychological trauma. PTSD is only one of many disorders that people are at risk of developing after exposure to traumatic events and many people develop serious psychological sequelae, but do not meet the criteria for PTSD or other disorders. This study was also limited to legislation introduced at the federal level and not designed to capture administrative policies made in the executive branch of the federal government or policies made at state and local levels.

The rationale for the decision to limit the parameters of the current study to PTSD and federal legislation was at least twofold. First, federal legislation is among the most impactful types of public policy due to the mandate it carries and magnitude of financial resources at the discretion of Congress. Given the dearth of PTSD policy research, federal legislation provided an appropriate starting point for investigation. Second, although PTSD is only one possible outcome of traumatic exposures, it is a clearly defined construct that allows for systematic inquiry and is likely the consequence of trauma most widely recognized among policy makers and the public. Although this study was limited in its focus, it provided a methodological framework for future traumatic stress policy research that explores other sequelae of trauma across different domains of public policy.

Content analysis is well suited for producing a replicable, systematic, and objective description of a body of text (Krippendorff, 2013). The methodology involves coding units of textual data according to discrete categories and analyzing the distribution of categorical assignments using statistical methods. As textual data are often voluminous, this process serves to reduce data while retaining information about attributes that are relevant to research questions. Coding units can vary in size, ranging from sentences to entire documents, must have clearly delineated boundaries, and should be conceptually meaningful (Krippendorff, 2013). Coding categories may be defined a priori or identified during the research project. Content analysis has been widely used in public health policy mapping studies.

Method

Sampling and Data Collection Procedures

The methodology of content analysis was used to analyze the texts of bills introduced to address PTSD in the U.S. Congress between 1989 and 2009. Between 1973 and 2009, the Congressional Research Service (CRS) of the U.S. Library of Congress assigned Legislative Indexing Vocabulary (LIV) subject terms to every bill introduced in Congress (CRS, 1996). The LIV index contains both popular and technical terms and was developed by the CRS as a tool to assist with legislative research tasks. The term "post-traumatic stress disorder" was added to the LIV index in the 101st Congress and first assigned September 27, 1990. The term was then assigned to all proposed legislation containing the term post-traumatic stress disorder until the LIV term was discontinued in 2009 when CRS adopted a new legislative indexing vocabulary (CRS, 2013).

All bills assigned the LIV term post-traumatic stress disorder were identified using THOMAS, a comprehensive online database of legislative information maintained by the U.S. Library of Congress (2013). Using the Subject Terms search function within the Browse Bills and Resolutions feature of THOMAS, all information pertinent to each PTSD bill was identified. For each bill, its full text, legislative history, and other information (e.g., bill sponsors, Congressional committees referred, coassigned LIV terms) were exported from THOMAS and aggregated in a Word document. Only the most recent version of legislative text was exported for each bill.

Bills assigned the LIV term "Stress (psychology)" were also identified using THOMAS and exported using the procedures described above. The term was first assigned to a bill on February 2, 1989. The inclusion of Stress (psychology) bills served two purposes: identifying bills that explicitly mentioned PTSD but were introduced before the PTSD LIV term was added in September 1990; and allowing the content of bills that explicitly mentioned PTSD to be compared to bills aimed at addressing traumatic stress, but did not explicitly mention PTSD.

Coding and Analysis Procedures

The Word document for each bill was imported into NVivo 10 (QSR International, Doncaster, Victoria, Australia) for coding. Both entire bills and individual sections of legislative text within the bills served as coding units of analysis. Bill-level coding units consisted of the bill's legislative text in its entirety. Section-level coding units consisted of the sections of legislative text that explicitly mentioned PTSD and/or trauma or stress in addition to a traumatic event according to the Life Events Checklist (Blake et al., 1995). Section-level units were identified by conducting word searches within the text of each bill for PTSD, trauma, and stress. The boundaries of each section-level unit were delineated by the heading "Sec." at the beginning of the sections and the heading Sec. at the beginning of the subsequent bill section.

Each piece of proposed legislation was coded at bill and section levels. At the bill level, variables were defined a priori. Variable selection was informed by guidelines for analyzing health-related legislation (Tremper, Thomas, & Wagenaar, 2010). Bill-level variables consisted of chamber of origin (i.e., House of Representatives or Senate), name of bill sponsor, number of bill cosponsors, date the bill was introduced, and the bill's last major action (e.g., became law).

At the section level, each section unit was coded according to a priori variables selected from traumatic stress and policy science literature. Section units mentioning PTSD were coded as PTSD explicit and units mentioning trauma and/or stress in addition to a traumatic event, but not PTSD, were coded as Traumatic stress, non-PTSD. The Life Events Checklist

(Blake et al., 1995) was used to code section-level units according to the traumatic stressor implicated as causing PTSD/traumatic stress. Section-level units were additionally coded according to the population that was the target of the legislative action to address PTSD/traumatic stress (e.g., active duty military personnel).

Section-level units were further coded according to the type of policy instruments used. Policy instruments are the techniques and means by which governments can alleviate problems (Howlett, 2011). For the policy instrument variable, coding categories were derived from Howlett, Ramesh, and Perl's (2003) policy instrument typology. Each section-level unit was first coded as using a symbolic or material policy instrument. Symbolic policy instruments signal aspirations to address an issue, whereas material instruments involve an actual change in distribution of resources or a process. All section-level units entitled Findings, Sense of Congress, or Purpose—sections that often serve as a preamble to justify why a bill was introduced but include no material instrument—were coded as symbolic. All section-level units coded as material were subsequently coded as being procedural or substantive. Procedural instruments affect the implementation of a process, whereas material instruments affect the delivery of goods and services (Howlett, 2011). Lastly, all section-level units using material instruments were coded according to the governing resource being used.

Each section-level unit was coded, and thus counted, as a single unit regardless of the number of times that PTSD/traumatic stress were mentioned. With the exceptions of target population and PTSD explicit/Traumatic stress, non-PTSD, the coding categories for each variable were not mutually exclusive and section-level units could be coded at multiple categories within the same variable. The coding processes created a legislative dataset in which all bill and section-level units were coded dichotomously (0/1) according to the presence or absence of each coding category attribute for all variables.

This dataset was exported from NVivo (QSR International, Doncaster, Victoria, Australia) into SPSS 20.0 for analysis. Frequency distributions were produced for all coding categories within each variable. The proportions of bill and section-level units coded at each category were calculated using the total number of bill and section-level units, respectively, as denominators. The data were further stratified by different variables and coding categories to explore variations in the presence and absence of legislative attributes and trends over time. There were no margins of error because the legislative dataset included the entire population of bills ever assigned the LIV terms PTSD or Stress (psychology).

Results

Between 1989 and 2009, 161 bills introduced in U.S. Congress mentioned PTSD. Of these PTSD explicit bills, 85 (52.8%) were introduced in the House of Representatives and 76 (47.2%) were introduced in the Senate. Within these 161 bills, 382 sections of legislative text mentioned PTSD (*M* number of section units per bill: 2.37, $SD = 3.47$, mode = 1, range = 1–22). The bill with the most PTSD section units was the Comprehensive Assistance for Veterans Exposed to Traumatic Stressors Act of 2004. Fifteen (9.3%) bills containing 32 PTSD section units ($M = 2.13$, $SD = 1.85$, mode = 1, range = 1–7) became law.

Within this same period, 55 sections of legislative text in 43 bills assigned the LIV term Stress (psychology) mentioned trauma and/or stress in addition to a traumatic event, but did not mention PTSD (*M* number of section units per bill = 1.28, $SD = 0.73$, mode = 1, range = 1–5). Twenty-four (55.8%) of these Traumatic stress, non-PTSD bills were introduced in the House of Representatives and 19 (44.2%) were introduced in the Senate. Three (7.0%) of these bills, containing three Traumatic stress, non-PTSD sections became law. The bill with the most Traumatic stress, non-PTSD section units was the National Resilience Development Act of 2003, intended to improve mental health preparedness planning for terrorist attacks.

The trend in the number of bill sections introduced to address PTSD fluctuated between 1989 and 2009 (Figure 1). An early spike in activity coincided with the end of the Persian Gulf war. Twenty-seven PTSD explicit section units were introduced in the first 6 months of 1991, one of which became law—a bill mandating a needs assessment and plan to treat PTSD among members of the Armed Forces serving in Operation Desert Storm (Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act of 1991).

Following the introduction of two versions of the Veterans PTSD Treatment and Psychological Readjustment Act of 1993 in September 1993, which together contained 18 PTSD section units, there was a lull in legislative activity to address PTSD. Between January 1, 1994 and July 1, 2004, an average of 1.8 (mode = 0, range = 0–5) PTSD explicit sections were introduced every 6 months. A dramatic increase then occurred between July 1, 2004 and June 30, 2005. One-hundred three PTSD sections, 12 of which became law, were introduced during this period. Many of these bills included provisions to improve the quality of PTSD services for members of the Armed Forces returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The majority (52.9%) of section units in this period addressed issues relating to the diagnosis and treatment of PTSD. The provision of quality PTSD treatment for OEF and OIE military personnel was also a prominent theme in the 80 sections introduced in 2007, the focus of 48.8%, but themes such as PTSD research (19.5%) and prevention (13.4%) also emerged.

Trends in the number of Traumatic stress, non-PTSD section units introduced did not correspond with fluctuations in the number of PTSD explicit section units introduced. The first Traumatic stress, non-PTSD section appeared in June 1996 and the most (nine) were introduced in 1999. Although the number of PTSD explicit sections introduced did not increase following mass casualty events such as the terrorist attacks of September 11, 2001, the National Resilience Development Act[s] of 2003 (2003, 2004) contained nine Traumatic stress, non-PTSD section units. Neither of these bills, however, explicitly mentioned PTSD.

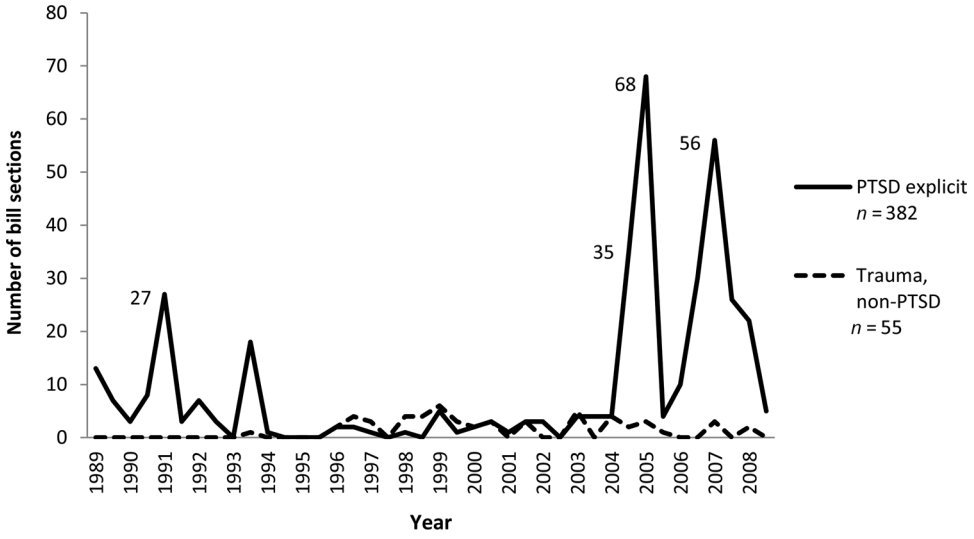

Figure 1. Number of sections of bills introduced in the U.S. Congress: 6-month intervals between 1989 and 2009.

Federal legislation explicitly introduced to address PTSD focused primarily on the needs of military personnel (Table 1). Military personnel were the exclusive target population of 349 PTSD explicit section units (91.4%), whereas 21 section units (5.5%) were exclusively focused on civilians and 12 (3.1%) targeted both military and civilian populations. A proportion of section units targeting military personnel were focused on specific subgroups within this population such as families (8.4%), women (5.0%), and racial and ethnic minorities (2.9%). Military personnel were the exclusive target population of all 32 of the PTSD explicit section units that became law.

Among the PTSD explicit section units exclusively targeting civilian populations, eight (38.0%) were focused on populations outside of the United States—such as women and girls in Afghanistan and civilian victims of landmines (e.g., International Disability and Victims of Landmines, Civil Strife and Warfare Assistance Act of 2001)—and eight (38.0%) were focused on youth. Sections that targeted both military and civilian populations consisted of initiatives aimed at increasing awareness about PTSD among military personnel, their families, as well as the general public, such as through the creation of websites and public awareness campaigns (e.g., Comprehensive Assistance for Veterans Exposed to Traumatic Stressors Act of 2004). With the exception of one bill, the Persian Gulf War Veterans' Assistance Act of 1991 that proposed to create a toll-free phone number for members of the military and general public experiencing symptoms of PTSD resulting from exposure to media about the Persian Gulf war, civilian populations were not the target of any PTSD explicit sections until 1999.

Table 1
Number and Proportion of Bill Sections Introduced in the U.S. Congress Between 1989 and 2009 by Target Population

Population	Total $N = 437$		PTSD explicit $n = 382$		Traumatic stress, non-PTSD $n = 55$	
	n	%	*n*	%	*n*	%
Only military	362	82.8	349	91.4	13	23.6
Only civilian	62	14.2	21	5.5	41	74.5
Both	13	3.0	12	3.1	1	1.8

Note. PTSD = posttraumatic stress disorder.

Compared to PTSD explicit sections, Traumatic stress, non-PTSD sections were far more likely to target civilian populations. Civilians were the exclusive target population of 41 (74.5%) Traumatic stress, non-PTSD sections compared to 5.5% of PTSD explicit sections. These sections targeted civilian subpopulations such as survivors of crime (27.3%) and disaster survivors and first responders—such as a bill that proposed to mandate that 10.0% of all Hurricane Katrina disaster relief funds be allocated to "the treatment of stress, trauma, and other mental health conditions arising out of, or complicated by, such Hurricane and its aftermath" (Hurricane Katrina Mental Health Relief Act of 2005). The 13 (23.6%) Traumatic stress, non-PTSD sections targeting military populations largely comprised provisions aimed at addressing combat stress.

The overwhelming majority (91.4%) of PTSD explicit bill section units addressed the consequences of combat exposure (Table 2). Sexual assault was the second most common event, identified in 17 section units (4.5%), 8 of which were focused on military sexual trauma. Natural disasters were identified as the traumatic event causing PTSD in only six section units (1.6%) and terrorism in five (1.3%). Ninety-five percent of PTSD explicit sections addressed direct exposures to traumatic events. The event causing PTSD was not specified in 13 section units (3.4%), such as in a bill (Mental Health Equitable Treatment

Table 2
Number and Proportion of Bill Sections Introduced in the U.S. Congress Between 1989 and 2009 by Traumatic Event

	Total $N = 437$		PTSD explicit $n = 382$		Traumatic stress, non-PTSD $n = 55$	
Event	*n*	%	*n*	%	*n*	%
Degree of exposure						
Direct	405	92.7	363	95.0	42	76.4
Indirect	31	7.1	10	2.6	21	38.2
Event not specified	13	3.0	13	3.4	0	0.0
Traumatic stressor						
Combat exposure	357	81.7	349	91.4	8	14.5
Sexual assault	24	5.5	17	4.5	7	12.7
Domestic violence	18	4.1	7	1.8	11	20.0
Physical assault	16	3.7	7	1.8	9	16.4
Terrorism	18	4.1	5	1.3	13	23.6
Natural disasters	10	2.3	6	1.6	4	7.3
Torture	6	1.4	0	0.0	6	10.9
Community violence	8	1.8	4	1.0	4	7.3
School violence	7	1.6	4	1.0	3	5.5
Technological disasters	7	1.6	3	0.8	4	7.3

Note. PTSD = posttraumatic stress disorder.

Act of 1999) that proposed to amend the Employee Retirement Income Security Act of 1974 to add PTSD to a list of "severe biologically-based mental illnesses." Traumatic stress, non-PTSD sections were far more likely to address indirect exposures than PTSD explicit sections (38.3% vs. 2.6%) and noncombat stressors, such as terrorism (23.6%) and domestic violence (20.0%).

Overall, 13.9% of PTSD explicit section units were symbolic and 86.9% used at least one material policy instrument (three sections contained both a symbolic and material policy instrument; Table 3). At least one procedural policy instrument was identified in 150 section units (39.3%). Evaluations (45.3%), such as assessments of the effectiveness of PTSD treatment for female members of the Armed Forces (e.g., Dignified Treatment of Wounded Warriors Act, 2007), and advisory committees and commissions (15.3%), such as provisions involving the Department of Veteran Affairs' (VA) Special Committee on PTSD (e.g., Veterans Benefits and Health Care Amendments of 1991), were among the procedural policy instruments most frequently used. At least one substantive policy instrument was identified in 247 section units (64.7%). The substantive policy instruments most frequently used included (a) tax expenditures (25.9%), such as those to improve the diagnosis and treatment of PTSD among members of the Armed Forces (e.g., Dignified Treatment of Wounded Warriors Act, 2007); (b) administration (17.5%), such as VA policies pertaining to presumptions of service connection for PTSD disability claims (e.g., Wounded Warriors Commission Implementation Act of 2007); and (c) training (8.9%), such as for primary care providers to identify risk factors for PTSD (e.g., Military Domestic and Sexual Violence Response Act, 2007). Traumatic stress, non-PTSD sections were more likely to use treasury policy instruments than PTSD explicit sections (40.0% vs. 30.1%), such as grants (21.8%) to provide "instruction on coping and dealing with stressful experiences of childhood and adolescence (such as violence)" (Telehealth Mental Health Services Act, 2001).

Discussion

The federal legislative response to PTSD between 1989 and 2009 in the United States was overwhelmingly focused on combat exposures and military personnel. Compared to sections of trauma-focused legislation that did not mention PTSD, sections explicitly mentioning PTSD were far more likely to address combat exposures (91.4% vs. 14.5%) and far less likely target civilian populations (5.5% vs. 74.5%). Although trauma-focused legislation not mentioning PTSD is fully capable of addressing issues related to the disorder, the total number of Traumatic stress, non-PTSD and PTSD explicit section units targeting civilians was relatively small (62, 14.2%). The results of this study suggest that PTSD has been addressed as a war-specific problem in federal legislation.

This inference is supported by the content of the Congressional resolution that designated June 27th National PTSD Awareness Day (S. Res. 455, 2012). The resolution extensively describes the prevalence and effects of PTSD exclusively among military personnel and makes no mention of PTSD existing among civilians. Although a strong focus on military personnel is to be expected given the unique responsibilities

Table 3
Number and Proportion of Bill Sections Introduced in the U.S. Congress Between 1989 and 2009 by Policy Instrument and Governing Resource

	Total $N = 437$		PTSD explicit $n = 382$		Traumatic stress, non-PTSD $n = 55$	
Variable	*n*	%	*n*	%	*n*	%
Policy instrument						
Instrument symbolic	60	13.7	53	13.9	7	12.7
Instrument material	381	87.2	332	86.9	49	89.1
Material procedural	163	37.3	150	39.3	13	23.6
Material substantive	291	66.6	247	64.7	44	80.0
Governing resource						
Authority	26	5.9	24	6.3	2	3.6
Information–knowledge	144	33.0	127	33.2	17	30.9
Organizational structure	168	38.4	147	38.5	21	38.2
Treasury	137	31.4	115	30.1	22	40.0

Note. PTSD = posttraumatic stress disorder.

of the federal government in providing medical care for this population and the high incidence of service-connected trauma exposures, the paucity of federal legislation introduced with the explicit intent of addressing PTSD among civilian populations is inconsistent with epidemiological research demonstrating the burden of the disorder among civilians. Policy research is needed to elucidate the dynamics through which PTSD research translates into public policy.

Theory from the field of policy science has utility in helping explain the results of this study and shaping a traumatic stress policy research agenda. How a problem is defined determines the range of policy solutions that are considered to address it (Burstein & Bricher, 1997). Policy scientists have found that problems are rarely redefined in the public policy arena and that elected officials are particularly slow to adopt new problem definitions because doing so may be politically risky (Schneider & Ingram, 1988). As Scott (1990, 1993) describes, awareness of PTSD largely emerged out of a military context and was primarily defined by policy makers and the public as a problem distinct to combat exposures and military populations when it first entered diagnostic nomenclature. The results of this study suggest that this problem definition has gone relatively unchanged in the federal legislative realm. Consequently, federal legislation may not have been proposed to explicitly address PTSD among civilians because PTSD among civilians has not been defined as a problem among elected officials.

There are at least two reasons why PTSD's original problem definition may have endured, both of which represent avenues for future research. First, elected officials, and the public they represent, might not be knowledgeable about the burden of PTSD among civilian populations. Mainstream media is a major source of information that influences public policy decisions about psychiatric disorders (Wahl, 2003). In the absence of targeted awareness initiatives, mainstream media may be the primary source of elected officials' information about PTSD and leave them unaware of the burden of PTSD among civilians.

Second, the distribution of political power among populations, and public perceptions of populations with PTSD in the United States, could play a role. Schneider and Ingram's (1993, 2005) theory of the social construction of target populations posits that policy makers' responses to problems are influenced by public perceptions about the population a problem affects and that population's political power. Although military personnel were a politically powerful and positively perceived population between 1989 and 2009 (Schneider & Ingram, 2005), many segments of the U.S. civilian population most affected by PTSD and trauma (e.g., low-income racial and ethnic minorities exposed to violence in urban settings) lack political power, and have been negatively perceived (Hurwitz & Peffley, 1997). Elected officials may be reluctant to introduce legislation aimed at addressing PTSD among civilian populations because doing so could be seen as a politically risky maneuver with little payoff—especially if the voting public is unknowledgeable, or unconcerned about, the burden of PTSD among these segments of the civilian population.

Both these reasons, however, are purely speculative given the dearth of empirical evidence about how elected officials and the public perceive PTSD and other issues related to traumatic stress. The results of this study highlight a significant need for research that explores these dynamics. Mixed-methods research designs that combine in-depth interviews with survey research are well suited to investigate such questions among policy makers and the public (Creswell & Zhang, 2009). Research that explores representations of PTSD in the popular press would also be valuable to inform traumatic stress policy-advocacy initiatives. A content analysis of stories about PTSD in major Korean newspapers, for example, found broad

discrepancies in the accuracy of information that was presented (Jeong, Kim, Oh, & Park, 2013).

Traumatic stress policy-advocacy initiatives would also benefit from an understanding of how federal funds have been allocated to research issues related to PTSD. Research funding—as distributed by Congress or the discretionary authority of executive branch agencies such as the VA, Department of Defense, and National Institutes of Health (NIH)—is one of the primary ways that the federal government addresses issues related to PTSD. A review of NIH's funding of research on issues related to lesbian, gay, bisexual, and transgender (LGBT) populations, for example, discovered disparities in funding allocations and identified priority areas for federally funded LGBT research (Coulter, Kenst, & Bowen, 2014). A similar analysis of the federal research portfolio on PTSD would provide empirical grounding for a federal PTSD policy agenda.

This study had a number of limitations that must be considered when interpreting its results. The parameters of this study were restricted to bills introduced in the U.S. Congress. Legislation is only one type of public policy. Administrative policies enacted by executive branch agencies (e.g., VA) and federal court decisions can also have substantial impacts on PTSD within the U.S. population. Myriad administrative policies and initiatives, not captured in this analysis, have addressed the needs of military and civilian populations affected by PTSD. This study was also limited to the federal level in the United States. Given differences between federal and state governments in authority and responsibility, the legislative response to PTSD presumably looks quite different at state levels. Furthermore, the quantity of bills and section units introduced to address PTSD is not an indicator of quality. No attempt was made to rate bills or sections according to the magnitude or direction of the impact they might have on issues related to PTSD.

It should also be re-emphasized that this study focused on the federal legislative response to PTSD and did not attempt to answer the broader question of how legislation has been used to address the needs of people who survive traumatic events. The decision to select bills on the basis of whether they explicitly mentioned PTSD, trauma, or stress—as opposed to selecting bills on the basis of whether they mentioned a traumatic event—was made because of the mandate this legislative language carriers. Bills mentioning PTSD or traumatic stress, if passed, ensure that some action will be taken to address mental health needs. For example, funds from a bill that provides financial assistance to a disaster-affected region, but includes no mention of PTSD, trauma, or stress, could be solely used for rebuilding physical infrastructure and not necessarily used to support the provision of trauma-focused activities that would directly address the psychological consequences of the event. A study that samples bills on the basis of whether they mention traumatic events would be a valuable, but different, study.

In 1996, reflecting on progress that had been made in recognizing the burden of traumatic stress among different populations in a society, Judith Herman (1997) wrote that the "observance of distinction between civilians and combatants in war has widely been broken down" (p. 237). Within the context of PTSD, this distinction may have disappeared among traumatic stress researchers, clinicians, and people working in the executive branch of the federal government (e.g., employees of the VA, Substance Abuse and Mental Health Services Administration, National Institute of Mental Health), but the results of this study suggest that it remains firmly intact among elected officials in the halls of Congress. The results of this study highlight the need to raise awareness about the burden of PTSD among civilian populations and consequences for society if left undressed. Knowledge about how to effectively communicate and translate research about PTSD and other trauma-related disorders into public policy is critical to continued progress in the field of traumatic stress studies.

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