

Remarks by Thomas J. Berger, Ph.D.
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before

The U.S. Medicine Institute for Health Studies
Interactive Roundtable Discussion
*“Mental Health Care for Returning Veterans:
Maximizing Professional Resources”*

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Good morning, ladies and gentlemen – my name is Tom Berger, Chair of the National PTSD & Substance Abuse Committee for Vietnam Veterans of America (VVA). I am a Vietnam combat veteran, having served as a Fleet Marine Force Navy corpsman with the 3rd Marine Division, 1966 – 68. I am also a recovering academic.

On behalf of Vietnam Veterans of America, I thank you for the opportunity to share our views on the availability of care for our nation’s veterans. Obviously “availability of care” can be applied to a broad spectrum of elements, including for example, specific medical conditions resulting from substance abuse and addiction, to more generalized ones such as homelessness, compensation and benefits, and employment issues. But as we don’t have enough time today to cover all the elements that can be linked to “availability of care”, I shall try and limit my remarks to – surprise – mental health, as PTSD in particular, played such a pivotal role in the helping establish VVA as a congressionally chartered veterans service organization.

First, however, VVA wants to recognize the efforts of both DoD and the VA to address the physical and the mental health care needs of our military personnel - - for example, the military services’ attempt to address combat stress at pre-deployment through such cognitive awareness programs as “Battle Mind”, the use of innovative “combat stress teams” for soldiers in the combat zone, and of course, the centers of excellence such as the burn center in San Antonio devoted to treating specific physical wounds suffered in these wars. In addition, through an unprecedented infusion of funds, the VA has added new Vet Centers, community-based facilities (CBOCs), implemented a 24/7 veteran suicide hotline, and is recruiting additional, much-needed clinical staff, particularly in the area of mental health.

Despite these commendable efforts, however, VVA believes that access to, and the availability of, effective, evidence-based mental health treatment and recovery programs especially for PTSD, remains problematic and highly variable in both the military and VA health care sectors. Stigma, discrimination, and the shortage of trained, clinical mental health workers all contribute to these problems, but they are especially acute for active duty women and for veterans and women veterans who reside in western and rural states. Moreover, the demands to meet the mental health needs of OEF and OIF veterans in many localities around the country is simply squeezing the VA's ability to treat the veterans of WWII, Korea and Vietnam.

As we are gathered here today after five years of combat in Iraq and Afghanistan, VVA is again sadly compelled to repeat its message that no one really knows how many of our OEF and OIF troops have been or will be affected by their SW Asia wartime experiences.

Furthermore, despite the increased availability of behavioral health services to deployed military personnel, the true incidence of PTSD among active duty troops may still be underreported. A recent retrospective report on PTSD documented what most in the military already know: specifically, that of those whose evaluations were positive for a mental disorder, only 23 to 40 percent complained of, or sought help for, their mental health problems while still on active duty, primarily because of stigma and/or discrimination. Thus no one knows whether those with PTSD who remain undiagnosed and so untreated will fail at reintegration upon their return to civilian life.

What is beyond argument is that the more combat exposure a soldier sees, the greater the odds that our soldiers will suffer mental and emotional stress that can become debilitating. For example, Colonel Charles Hoge, M.D. and his mental health researchers at Walter Reed have reported that the incidence of PTSD is over 30% in troops serving three combat tours, a number that is very close to that obtained for Vietnam veterans in the original National Vietnam Veterans Readjustment Study conducted in the 1980's, some years after the end of the war that put PTSD on the reality map. Our troops now are seeing both more and longer deployments, with at least four Army Brigade Combat Teams (CBTs) now in their fourth deployment cycle. Without proper diagnosis and treatment, the psychological stresses of war never really end, increasing the odds that our soldiers will suffer mental and emotional stress that can become debilitating if left untreated. This places them at higher risk for self-medication and abuse with alcohol and drugs, domestic violence, unemployment & underemployment, homelessness, incarceration, medical co-morbidities such as cardiovascular diseases, and suicide.

Despite the shortcomings and gaps noted above, the one piece of good news is that since 1980, when the American Psychiatric Association (APA) added PTSD

to the third edition of its “Diagnostic and Statistical Manual of Mental Disorders (DSM-III)” classification scheme, a great deal of attention has been devoted by the VA to the development of instruments for assessing PTSD [see Keane et al., (1)], as well as to therapeutic PTSD treatment modalities [see Foa et al., (2) and the National Center for PTSD’s Fact Sheets (3)] to assist veterans with managing or even overcoming the most troubling of the symptoms associated with PTSD. The range of treatment modalities utilized in VA services and programs includes cognitive-behavioral therapies (i.e., CBTs) such as exposure therapy, pharmacotherapies such as selective serotonin reuptake inhibitors (i.e., SSRI antidepressants) and mood stabilizers (e.g., Depakote), and other treatment modalities such as cognitive restructuring, group therapy, and coping skills.

However, as you may recall, back in October 2007 the National Academies’ Institute of Medicine’s Committee on Posttraumatic Stress Disorder issued a report (4) which found that “most PTSD treatments have not proven effective”, with one exception for “exposure therapy”.

According to IOM Committee Chair Alfred O. Berg, Professor of Family Medicine at the University of Washington School of Medicine, “At this time we can make no judgment about the effectiveness of most psychotherapies or about any medications in helping patients with PTSD. These therapies may or may not be effective -- we just don’t know in the absence of good data. Our findings underscore the urgent need for high-quality studies that can assist clinicians in providing the best possible care to veterans and others who suffer from this serious disorder.”

So VVA strongly supports the IOM Committee’s recommendations that the “VA and other government agencies that fund clinical research should make sure that studies of PTSD therapies take necessary steps and employ methods that would handle effectively problems that affect the quality of the results” and that “Congress should ensure that resources are available for VA and other federal agencies to fund quality research on treatment of PTSD and that all stakeholders -- including veterans -- are represented in the research planning.”

In addition to whatever scientifically rigorous treatment modality used, VVA also believes that it must be integrated into an effective, evidence-based treatment program that incorporates psychosocial elements and services (e.g., symptom management, recovery strategies, housing, finances, employment, family and social support, etc.) in the manner developed by the Substance Abuse and Mental Health Services Administration (i.e., SAMHSA) and is tailored to the individual’s needs for achieving the goal of successful PTSD treatment and recovery. And of course, for individuals suffering from co-occurring disorders, an integrated evidence-based dual diagnosis treatment model must be utilized. For PTSD the standard medical model is severely flawed because it only provides

treatment in the hope of reducing symptoms and thus approximating some notion of “normality” – when in reality, “normal” is only a setting on your clothes dryer. Recovery exists, or can exist within the context of the disorder. Reduce the stigma and discrimination, increase the clients’ social roles and participation which provides them a reason to get better in the first place and then you provide treatment and support

Nevertheless, integrated treatment programs take time and cost money – and with the large number of veterans involved, lots of money, along with accountability for its expenditure.

VVA is also very concerned about traumatic brain injury, or TBI, the so-called “signature wound” of the war in Iraq because it presents a most puzzling challenge, especially in mild to moderate cases. Symptoms can be hidden or delayed, diagnosis is difficult, and evidence-based treatments are as of yet largely undetermined. And if left untreated over time, even mild TBI can cause epilepsy/seizure disorder. Very few medical facilities in the U.S. are capable of providing even the most minimal level of specialized care for brain-injured patients, forcing most survivors to find treatment hundreds of miles from home, if they can find it at all -- and over forty percent of our military deployed in Afghanistan and Iraq come from rural America.

In addition, the most commonly utilized current treatment modality for epilepsy/seizure disorder is medication. However, we must remember that epilepsy/seizure disorder caused by either a concussive or contusive brain injury, is never just an isolated incident. Over time without proper diagnosis, treatment and care, it can affect nearly everything associated with the survivor including one’s cognitive, motor, auditory, olfactory, and visual skills, perhaps resulting in behavioral modifications, not mental illness. Epilepsy/seizure disorder treatment, recovery services and programs can also collapse a family and its finances. Of all the medically challenging injuries, brain injuries require the most involvement and cost over time.

Finally, last fall this institution convened a roundtable discussion of TBI. Like today, it was attended by representatives of federal agencies, Congressional staffers, professional organizations, academia, and a number of other interested parties. Among its recommendations were the designation of a single individual in charge of TBI programs across all federal agencies, the creation of a single research clearinghouse for TBI, the call for a TBI partnership among DoD, the VA and the National Institutes of Health, and making greater use of technology to focus on access to TBI care. With DoD and the VA together spending billions of dollars on medical care for our wounded warriors, it seems reasonable to ask what specific efforts have been undertaken to implement those recommendations, and whether the same will occur after this conference.

This concludes my remarks and thank you again for the opportunity to offer VVA's views on these important issues. I shall be happy to answer any questions you might have.