

**POST TRAUMATIC STRESS DISORDER  
TREATMENT AND RESEARCH:  
MOVING AHEAD TOWARD RECOVERY**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED TENTH CONGRESS  
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## **POST TRAUMATIC STRESS DISORDER TREATMENT AND RESEARCH: MOVING AHEAD TOWARD RECOVERY**

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**TUESDAY, APRIL 1, 2008**

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

The Subcommittee met, pursuant to notice, at 10:01 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Snyder, Hare, Doyle, Berkley, Salazar, Miller, and Brown of South Carolina.

### **OPENING STATEMENT OF CHAIRMAN MICHAUD**

Mr. MICHAUD. I would like to call the hearing to order. I would like to welcome everyone here to the Subcommittee on Health's hearing. We are here today to talk about Post Traumatic Stress Disorder (PTSD) treatment and research in the U.S. Department of Veterans Affairs (VA).

Post traumatic stress disorder is among the most common diagnoses made by the Veterans Health Administration (VHA). Of the approximately 300,000 veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) who have access to VA healthcare, nearly 20 percent, 60,000 veterans have received a preliminary diagnosis of PTSD.

The VA also continues to treat veterans from Vietnam and other conflicts who have PTSD.

With the release of the 2007 Institute of Medicine (IOM) report, we learned that we still have much work to do in our understanding of how to best treat PTSD. I hope that my colleagues will continue to work with me in supporting VA's PTSD research programs.

I look forward to hearing testimony today from several organizations that are working to provide comprehensive and cutting-edge treatment for PTSD.

The Subcommittee recognizes that this is an important issue and one that we will be working with for a long time to come. We are committed to ensuring that all veterans receive the best possible treatment when they go to the VA.

That is one of the reasons why we are having this hearing today. We will have several more hearings dealing with PTSD because

this is an important issue, an issue that there are still a lot of unanswered questions. So I look forward to the testimony here today.

I would like to recognize Mr. Brown for any opening statement he might have.

[The prepared statement of Chairman Michaud appears on p. 42.]

#### **OPENING STATEMENT OF HON. HENRY E. BROWN, JR.**

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman, for holding this meeting today. And this is a continuing of several meetings we have had dealing with this issue. It is certainly an important problem, important issue that we need to face. Thank you for your leadership on this.

Following every war in history, what we now call post traumatic stress disorder or PTSD has sadly affected the lives of many brave men and women who have worn the uniform.

This Committee, over the years, has held numerous hearings to bring to the forefront the emotional toll the trauma of combat can lay on our veterans and the need for us as a nation to effectively care for those who suffer with military-related PTSD and experience difficulty reintegrating into civilian life.

In response to the Congressional mandate, VA established a national Center for PTSD in 1989. This center was created to advance the well-being of veterans through research, education and training, and the diagnosis and treatment of PTSD.

VA has since moved to expand its program and currently employs over 200 specialized PTSD programs in every healthcare network. Available care includes omission behavior therapy, which has shown to be the most effective type of treatment for PTSD.

Many servicemembers who develop PTSD can recover with effective treatment. Yet, PTSD is still the most common mental disorder affecting OIF and OEF veterans seeking VA healthcare. About 20 percent of all separated OIF and OEF veterans who have sought VA healthcare received a PTSD diagnosis.

Even more alarming, a recent study conducted by VA shows that young servicemembers between the ages of 18 and 24 are at the highest risk of mental health problems and PTSD to be 3 times as likely as those over 40 to be diagnosed with PTSD and/or other mental health problems. Clearly PTSD remains a very prominent injury that our veterans endure. That is precisely why today's hearing is so critical.

We must continue to focus on how best to strengthen research and rapidly disseminate effective clinical care in all settings so that we can finally understand this illness, break through it, and move forward with complete recovery, bringing relief to the many heroic veterans who still fight daily battles no less harrowing than the ones they fought in combat.

On that end, I want to thank our witnesses for being here today and to present their expert views on what may cause and, more importantly, preclude PTSD from emerging among our veterans.

Again, thank you and I yield back, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Mr. Brown.

Mr. Salazar, do you have an opening statement?

### **OPENING STATEMENT OF HON. JOHN T. SALAZAR**

Mr. SALAZAR. Thank you, Mr. Chairman. First of all, let me thank you and Ranking Member Brown for having this important hearing. I appreciate your dedication to our veterans and your hard work.

We are fortunate to have this opportunity today to discuss the impact of PTSD and what effect it is having on our returning troops, veterans and their families. And I look forward to hearing the testimony of the experts that are joining us.

I want to thank you, Colonel, for your dedication to our service men and women and thank you for your service to our country.

I think an important part of our discussion today will be to hear about the research on PTSD cases regarding Vietnam, OEF and OIF soldiers. I think it is important to look at them both individually and in comparison to one another.

I also look forward to hearing about the research that is done on exposure therapy. Innovative and new treatments are essential to the health of our veterans and our current forces.

Our veterans deserve to know that once they leave the battlefield and return home that we have programs in place to take care of them.

Mr. Chairman, I want to thank you and the Members of this Subcommittee for being so dedicated and giving us the opportunity to discuss construction authorizations.

Thank you, Mr. Chairman, and I yield back.

[The prepared statement of Congressman Salazar appears on p. 43.]

Mr. MICHAUD. Thank you.

Mr. HARE.

### **OPENING STATEMENT OF HON. PHIL HARE**

Mr. HARE. Thank you, Mr. Chairman, and thank you very much for holding this hearing today. And I thank the Ranking Member also for being here with us this morning.

Today is the third hearing that this Subcommittee has had examining mental health for our veterans. And I find today's hearing on PTSD particularly poignant. We can all agree that PTSD is the signature wound of the current conflict and that the need to provide treatment is key.

Unfortunately, we have over 22,000 brave men and women who will not have access to VA treatment because they were discharged from the military because of a so-called preexisting personality disorder, not PTSD, from their service.

The Secretary of Defense is today required to submit a report to the Armed Services Committee evaluating the efficiency and fairness of this practice. And as we talk about the different treatment and research being done, I would ask that all the Members of this Subcommittee, all the people here today, all the panel members keep those soldiers in mind who are fighting their battle against PTSD alone without access to the benefit of VA healthcare that they have earned.

I spoke to a young man named Louie in Chillicothe, Illinois, who had severe problems when he came back. And he was asked and ordered, I should say, to have his reenlistment bonus with interest

paid back. This is a young man who gave everything he had to this Nation and is now, because of the conditions that he has, working 2 days a week at a Subway sandwich place because he cannot hold full-time employment.

We can do much better than that, Mr. Chairman, for our veterans. We owe it to them. And as I told Louie, I have asked him every month when he receives that bill to send it to my office and I will forward it with an appropriate response because Louie is not going to pay that bill.

He was screened four times prior to deployment and he does not have, I do not believe, personality disorder preexisting conditions. It was a terrible way to treat somebody.

And to think that there are an additional 22,000 people like Louie out there, I think, is a disgrace and something we have to address and fix. And clearly this is something that I think we owe to the best and the brightest that we put in harm's way.

So I thank you, Mr. Chairman, for having this hearing today and look forward to listening to the panel and asking questions. Thank you.

Mr. MICHAUD. Thank you very much.

Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. I understand that Mr. Brown was so kind as to already read my prepared statement and I will enter further the statement into the record. Thank you.

[The prepared statement of Congressman Miller appears on p. 43.]

Mr. MICHAUD. Thank you.

Ms. Berkley.

#### **OPENING STATEMENT OF HON. SHELLEY BERKLEY**

Ms. BERKLEY. Thank you very much, Mr. Chairman, and welcome. We are very appreciative that you are here for our third hearing on this particular issue.

Mr. Chairman, I want to thank you for holding this hearing on a very important issue that this Committee recognizes finally that it is important. And I think that our Nation has truly ignored this issue for many, many years and for many, many wars.

There are 3,070 veterans enrolled in the VA's southern Nevada healthcare system with a diagnosis of PTSD. As we know, nationally 1 in 5 veterans returning from Iraq and Afghanistan suffers from PTSD. Twenty-three percent of members of the Armed Forces on active duty acknowledge significant problems with substance abuse.

I do not think it is lost on anybody that our veterans need to receive the help that they need to deal with these issues.

A constituent of mine, and I have mentioned this before, but it bears mentioning again, Lance Corporal Justin Bailey returned from Iraq with PTSD. He developed a substance abuse disorder. His family, his loving parents insisted out of desperation that he check himself into a VA facility in west LA. After being given five medications on a self-medication policy, he overdosed and died. That is just horrific having survived his time in service to our country and then coming home and dying under the care of the VA.



I have introduced the “Mental Health Improvements Act,” which aims to improve the treatment and services provided by the Department of Veterans Affairs for veterans with PTSD and substance abuse disorders. In the interest of time, I will not read the different sections of this bill, but I would like to urge all of my colleagues on this Committee to co-sponsor the legislation. It is imperative that we not only provide healthcare for our veterans, but mental healthcare as well. I believe this bill and others that have been introduced will help in my opinion.

I had dinner last night with an old friend of mine from northern Nevada who is a Vietnam vet. I have known him since we were in high school in different parts of the State. He talks to this day of having flashbacks and problems. We know it exists.

And I told him I thought that it should be mandatory when people leave the Armed Forces that they are interviewed and then followed up with periodically and make it mandatory that they do so. He thought that would be a very good idea and would, in fact, prevent a lot of mental health issues that veterans in years gone by have suffered, but nobody recognized as PTSD.

And I thank you very much.

Mr. MICHAUD. Thank you very much, Ms. Berkley.

Once again, Colonel, I would like to thank you for coming today. On our first panel is Colonel Charles Hoge, who is the Director of the Division of Psychiatric and Neuroscience at Walter Reed Army Institute of Research.

We look forward to hearing your testimony and appreciate all the service that you have given this great Nation of ours. And without further ado, you may begin, Colonel.

**STATEMENT OF COLONEL CHARLES W. HOGE, M.D., USA, DIRECTOR, DIVISION OF PSYCHIATRY AND NEUROSCIENCE, WALTER REED ARMY INSTITUTE OF RESEARCH, DEPARTMENT OF THE ARMY, U.S. DEPARTMENT OF DEFENSE**

Colonel HOGE. Thank you, Mr. Chairman, Ranking Member, Members of the Committee, thank you so much for the honor of being here. I think this is my third testimony before this Committee.

And I was thinking about, you know, what is new since the last time that I testified and wanted to share a little bit about 3 different efforts that we have recently published just in the last 6 months that answer some fundamental questions about the importance of PTSD in our servicemembers coming home.

I am going to focus my comments on the wonderful work of my very dedicated team at Walter Reed Army Institute of Research, but I want to acknowledge up front and thank you and other Members of Congress for the appropriation, fiscal year 2007 appropriation of \$300 million for PTSD and TBI research which is now in the process of being distributed through grant mechanisms managed by Medical Research and Material Command at Fort Detrick to a variety of VA, civilian, and U.S. Department of Defense (DoD) researchers.

So I think that in the next few years, the hope is that we will see significant advancements in our understanding and ability to treat soldiers and veterans with PTSD.

The first thing I would like to mention is we have been doing some continuous assessments of the lessons learned from our post-deployment health assessment programs within the Army. And the PDHA, the post-deployment health assessment, is completed when servicemembers initially return and then the post-deployment health reassessment (PDHRA) 3 to 6 months later.

And we have looked at now longitudinally at the relationship of answers that they gave on the first assessment with the answers they gave on the second assessment. And I think that, you know, we have clearly confirmed the importance of that second assessment, particularly for our Reserve component servicemembers.

Twenty percent of our active component servicemembers were referred for mental health treatment or evaluation from the PDHA and PDHRA process and about 40 percent of our Reserve component members. And that difference that develops between active component and Reserve, it is not apparent when they first return. They look exactly the same. But about 6 months later, you see this difference emerge and there is a variety of possible reasons for that.

The second thing I would like to comment on has to do with the multiple deployments and the dwell time. We have just recently released our MHAT5 report, the Mental Health Advisory Team 5. This is an unprecedented effort to survey and assess the well-being of troops while the war is going on.

We have done assessments every year in Iraq since the beginning of the war and two assessments in Afghanistan. And the two things that we learned this year are that multiple deployments, that there is a direct relationship between the number of deployments and the psychological well-being of servicemembers.

So those non-commissioned officers (NCOs) who are on their third deployment in Iraq, had a nearly 30 percent rate of significant combat stress or depression symptoms compared to about 20 percent of those NCOs on their second deployment to Iraq compared to 12 percent of those on their first deployment to Iraq.

So there is a clear linear relationship. It is a little bit more difficult to show that relationship after they return from deployment because there is an attrition, there is an association of mental health problems with attrition from service. And so the linear relationship between multiple deployments was very clearly evident in the MHAT5 data that we collected this past year.

The second thing we learned from the MHAT5 was that those soldiers serving in Afghanistan in brigade combat teams are experiencing rates of combat and mental health rates very comparable to those soldiers serving in brigade combat teams in Iraq. So that is a fairly new development in the last year.

The third study that I would like to comment on briefly is the publication we just published January 31st in the New England Journal of Medicine having to do with the relationship of mild traumatic brain injury (TBI) to PTSD. And there has, I think, been a bit of confusion and I want to clarify terminology. Mild traumatic brain injury is exactly the same thing as concussion.

What is often reported in news media, for instance, is up to 20 percent of servicemembers coming back from Iraq have traumatic injury and often they show a seriously injured, seriously brain in-

jured individual. And it is often not made clear that the vast majority of those soldiers and servicemembers being labeled as having traumatic brain injury, in fact, have had concussions, what soldiers refer to as getting their bell rung or athletes refer to as getting their bell rung.

A concussion is an injury where there is a blow to the head or a jolt to the head that results in brief loss of consciousness or a brief alteration or change in consciousness. There may be a memory gap that lasts for a few hours.

But there is expectation of full recovery after concussion and that is very different than moderate and severe traumatic brain injuries which almost always result in evacuation from theater and sometimes long-term care needed to rehabilitate servicemembers with moderate and severe TBI.

There has obviously been a lot of concern lately about mild traumatic brain injury and about potential long-term effects of mild traumatic brain injury possibly in association with blast exposures. And some of the types of symptoms that servicemembers have coming back are things like headaches, irritability, concentration problems, memory problems.

And so our study looked to see what the relationship of those types of symptoms when servicemembers came home to having a concussion in theater. And what we learned was that, it was a somewhat surprising finding to us, was that PTSD and depression was actually what we could attribute the symptoms to. It is very difficult to attribute the symptoms in soldiers with concussions directly to the concussion.

What we found was that the vast majority of these physical health symptoms and post-concussive symptoms occurred in soldiers with PTSD and there was a very strong relationship between having a concussion in Iraq and developing PTSD. Almost half of soldiers who had a concussion developed PTSD, met the criteria for PTSD when they came home.

What the implications are of this is, the unfortunate truth is that we really do not have a definitive diagnostic test that can tell us definitively who had a concussion or whether symptoms that soldiers are having in the post-deployment period are, in fact, due to that concussion. And that makes it very difficult to do screening and know with accuracy what the cause of the symptoms are.

The major implication or finding is the soldiers coming back and getting post-deployment screening that there is a risk that they may get misdiagnosed as having brain injury when, in fact, the real problem is post traumatic stress or depression.

PTSD and depression, I think a lot of people do not realize are biological, physiological disorders that cause a variety of physical health symptoms and consequences. And I think what is happening in Iraq is when a soldier suffers a concussion, that is a very life-threatening experience in that context of concussion on the battlefield, that very life-threatening traumatic experience then sets up the potential for PTSD and depression and then PTSD and depression can lead to the physical health consequences through a variety of mechanisms.

I guess I am a little bit over time, but I just wanted to mention that one of the issues with multiple deployments and the dwell

time when soldiers come back, we have learned from the research that we have done that 12 months is not sufficient for soldiers to “reset” and be ready to go back for another deployment. In fact, we see rates of PTSD rise as soldiers come home.

And there is sort of a paradox. We are asking soldiers to, when they come home, to reset and transition home and those very things that we label symptoms when they come home and can get them in trouble and can interfere with their functioning when they come home and their relationships when they come home, those symptoms of PTSD are, in fact, often necessary adaptive mechanisms that they need in combat, you know, the deprivation, the ability to the hyper-alert state that they have to maintain for long periods of time.

So we are asking a lot of our servicemembers when we ask them to transition and sort of turn on and turn off these skills and it is, I think, a little bit unrealistic and, in fact, our data have shown that rates of PTSD increase over the first year. They do not decrease. They do decrease for a certain percentage of individuals, but then there are other individuals who manifest the symptoms as the year goes on.

So I think that the key lessons that we have learned have to do with this relationship of PTSD and mild TBI and some things about multiple deployments and dwell time and some lessons learned from post-deployment health assessment.

Thank you very much for the opportunity to discuss this with you.

[The prepared statement of Colonel Hoge appears on p. 43.]

Mr. MICHAUD. Thank you very much, Colonel, for your testimony this morning and your rundown of current DoD PTSD research programs.

Do you see any gaps in the current research programs and, if so, where are those gaps and what future research regarding PTSD does the Department of Defense have planned, if any?

Colonel HOGE. Yes, sir. I think the biggest gap in research has to do with clinical trials of the efficacy of psychotherapy and medication trials and understanding exactly what the elements of psychotherapy are that are effective and what works, what does not work, establishing group therapy practices that are effective. We have not been able to show necessarily the effectiveness of group therapy the way we have for individual therapy.

So there is a lot of questions within the psychotherapy and medication treatment arena. There are huge gaps in that area. And I think that to some extent, the funding that has been allocated, you know, hopefully will fill some of those gaps, but I think the gaps remain.

Mr. MICHAUD. What about the future research? Does DoD have any future research planned on PTSD?

Colonel HOGE. Within my own institute, I think one of the key studies that we are planning, we have done a lot of work with helping soldiers to transition through an educational program called Battle Mind. And we show that to be moderately effective, particularly for those soldiers with the highest levels of combat experiences.

But, you know, it did not have the effectiveness that we would like to see. And so we are working, my team is working on developing an advanced version of that that we hope to be able to test in a field trial in the coming time period.

I actually do not know to what extent how many clinical trials are going to be funded out of the appropriation, the fiscal year 2007 appropriation that is being managed by Medical Research and Materiel Command (MRMC), but I know there are clinical trials included in that as well.

Mr. MICHAUD. Thank you.

You had mentioned TBI screening sometimes being mislabeled. Can you tell us some of the recommendations that your research group made to leaders of the Army in this regard.

Colonel HOGE. There were 3 areas of recommendations that we made. One pertained to modifications to our post-deployment screening to assure that all health problems are addressed and symptoms that are identified that need to be addressed, while at the same time minimizing the risks involved. There are, I believe, enormous risks and mislabeling individuals as being brain injured. And so we have provided some specific recommendations about how we might structure the post-deployment screening in a way to minimize those risks.

The second set of recommendations pertain to risk communication and/or education. It is how we communicate about the disorder. And I think even just the term mild traumatic brain injury, which is a synonym of concussion, for some reason, mild traumatic brain injury has sort of caught on as the term, you know, that is being most widely used.

I think that is unfortunate. I think that soldiers and family members understand the word concussion much better and concussion is a lot less stigmatizing than the term brain injury. So I have been advocating for communication strategies that promote the expectation of recovery and even to include just simply using the term concussion.

And so risk communication, the screening, and then I think the key focus of caring for soldiers with traumatic brain injury is getting the word out there. The education strategy that is most important is that soldiers learn that they need to come in and get seen when they have a concussion on the battlefield and not blow it off as soldiers sometimes tend to do and athletes tend to do as well, you know, get them in, get them seen right there on the battlefield because that is really the time to be evaluated. Once they come home, it becomes a lot murkier and difficult to sort out what the etiology of particular symptoms are.

Mr. MICHAUD. Thank you. I appreciate that.

I have no problem with trying to call it what it is. My only concern is if you look at, for instance, disability ratings, the VA tends to be higher than the Department of Defense because they look at the individual holistically.

I just hope that changing the name does not necessarily prevent the Army from taking care of our men and women who served in uniform because that, I know, is a concern with a lot of veterans out there is trying to shift the burden back on to the veterans

themselves versus taking care of it. So I just hope the research that you are doing is not trying to not take care of our veterans.

I think it is very important that we do take care of our veterans regardless of whether we call it a concussion or TBI and that is the bottom line for myself in that critical area.

Colonel HOGE. Absolutely, sir. Agree completely.

Mr. MICHAUD. Thank you.

Mr. Miller.

Mr. MILLER. Thank you very much, Mr. Chairman, and I associate myself with many of the questions that you asked the witness because I think that we are all concerned and focusing from the same angle.

You mentioned \$300 million that was appropriated in 2007. I am interested in knowing a couple of things. How are we doing with spending the money, can you elaborate a little bit on the programs? This is a question that is loaded when I ask it, but was it enough and what else do we need to do?

Colonel HOGE. Sir, I am not really the person in a position to comment on the expenditure of those funds because I run the research program at Walter Reed Army Institute of Research and I am not in charge of the program. That is at a higher level.

So I will have to take that for the record, but that has certainly been information readily available. And my understanding, you know, the processes have been put in place and the grants are now in the process of being awarded. So I do not think there will be any issues with spending the full amount of that for the research.

[The following was subsequently received from DoD:]

**Fiscal Year 2007 (FY07) Psychological Health and Traumatic Brain Injury Research Program Investment Strategy**

The Department of Defense's (DoD's) investment strategy for the FY07 \$150 million (M) post traumatic stress disorder (PTSD) and \$150M traumatic brain injury (TBI) appropriations included multiple highly competitive Intramural (DoD and Veterans Affairs [VA]) and Extramural award mechanisms. Intramural funding mechanisms were dedicated to supporting only research aimed at accelerating ongoing PTSD- or TBI-oriented DoD and VA research projects or programs. Intramural proposals were solicited under two PTSD- and two TBI-focused funding mechanisms, the Investigator-Initiated Research Award, which supports basic and clinically oriented research, and the Advanced Technology—Therapeutic Development Award, which supports demonstration studies of pharmaceuticals (drugs, biologics, and vaccines) and medical devices in preclinical systems and/or the testing of therapeutics and devices in clinical studies. Approximately \$35M each of the PTSD and TBI appropriations has been approved for funding ongoing DoD and VA research projects or programs.

The opportunities for funding research in PTSD and TBI through the Extramural award mechanisms were open to all investigators worldwide, including military, academic, pharmaceutical, biotechnology, and other industry partners. The competition was open but rigorous, and the process ensured that the best and brightest are funded to provide solutions to the problems of those impacted by PTSD and TBI. Applicants were encouraged to collaborate with military investigators to ensure that solutions will be military-relevant. The Extramural award mechanisms solicited included the Investigator-Initiated Research Award and the Advanced Technology—Therapeutic Development Award, along with the Concept Award, which supports the exploration of a new idea or innovative concept that could give rise to a testable hypothesis; the New Investigator Award, which supports bringing new researchers into the fields of PTSD and TBI; the Multidisciplinary Research Consortium Award, which is intended to optimize re-

search and accelerate solutions to major overarching problems in PTSD and TBI; and the PTSD/TBI Clinical Consortium Award, which combines the efforts of the Nation's leading investigators to bring to market novel treatments or interventions that will ultimately decrease the impact of military-relevant PTSD and TBI within the DoD and the VA. The Clinical Consortium is required to integrate with the DoD Psychological Health and Traumatic Brain Injury Center of Excellence (DCoE). Further, outcomes from all Intramural and Extramural awards focused on treatment and interventions will be leveraged to support the DCoE's efforts to expedite fielding of PTSD and TBI treatments and interventions.

Congress mandated that the Program be administered according to the highly effective U.S. Army Medical Research and Materiel Command two-tier review process, which includes both external scientific (peer) review, conducted by an external panel of expert scientists and programmatic review. After scientific peer review has been completed for each proposal, a programmatic review is conducted by a Joint Program Integration Panel (JPIP), which consists of representatives from the Departments of Defense, Veterans Affairs, and Health and Human Services. The members of the JPIP represent the major funding organizations for PTSD and TBI and as such are able to recommend funding research that is complementary to ongoing efforts. Four rounds of peer and programmatic review have been completed, occurring between June 2007 and April 2008. The final round of peer and programmatic review are slated for May and June 2008, respectively.

Mr. MILLER. Do you think that the current timing of the post-deployment health re-assessment study, the 6 months, is the appropriate timeframe within to do that study?

Colonel HOGE. Yes. Yes, sir. Clearly when they first come home, when servicemembers first come home, the screening only identifies a small percentage of individuals who will then go on to develop problems. So we need that second assessment.

And there is about a two- to threefold increase in rates of reporting mental health problems at that second assessment time point. Three to 6 months seems to be about right. We could go as early as 2 months or, you know, as late as 6 months, but somewhere in that range is certainly reasonable.

Mr. MILLER. I think in the beginning of some of your testimony, you were talking about a 12-month timeframe, not having enough time to reset when they are redeployed. I am wondering if 6 months is too soon or does there need to be, you know, a second risk assessment?

Colonel HOGE. Some units are actually conducting the second assessment or conducting the second assessment 3 to 6 months and then they are doing it again shortly before redeployment to theater. But I am not advocating that that be done, but I know that some units are in the process of—

Mr. MILLER. Do we have any numbers that quantify that second risk assessment at all? Is there a spike between the 6 and the 10 months or—

Colonel HOGE. Not really. The 6 month and 12 month figures are very, very comparable to one another from the data that we have seen in a different context. We have studied soldiers with surveys that use similar instruments on them at 3, 6, and 12 months and we found that 6 and 12 months are very similar in prevalence rates.

Mr. MILLER. Thank you. That is all, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Colonel, just a couple of questions here. Do you believe that there is a stigma that surrounds PTSD and other mental health conditions that stops soldiers from actually seeking help?

Colonel HOGE. Absolutely. Our surveys have indicated that over half of soldiers who have significant mental health symptoms do not receive treatment. They do not come in and get any help at all. And we know that based on some of our survey data that concerns about perceptions within their unit, perceptions by their leaders, et cetera, are some of their concerns.

Now, we have been working ardently since the start of the war to destigmatize through education programs and the Battle Mind training, for instance, and other types of education programs. And I think the word is getting out there. We have a slight decrease in perceptions of stigma during this last visit to Iraq that my team took. The perceptions of stigma seemed to improve slightly compared to previous years.

But we are not seeing, you know, huge changes in perceptions of stigma. Small changes in perceptions of stigma from the work that we have been doing.

Mr. HARE. It would seem to me one of the ways we could really handle this would be to—in my State of Illinois, I know particularly with the Guard, every returning person coming back is screened and, I would hope we could get to the point at some point where every person who serves is screened so that they do not have to say, I think there might be something wrong here or this may not manifest itself for some period of time.

The other part is, I have a Vet Center right by my district office and a lot of times the family members will come over. They will say we do not know what happened to him. Why is he hitting the child or why are things going wrong. And so it is that being able to not have to cross the line and say, I think I have a problem here.

And I just would like to know from your perspective what happens to these people, who do not identify and you do not get the chance or people do not get a chance to help them?

They are out there and, I am wondering, from your perspective, what happens without that treatment and how long a person goes. They need this treatment, as you said, while they are over there. If they cannot get it, we try to get it for them when they are here. What happens to these men and women?

Colonel HOGE. There is universal screening, you know, in the PDHA and PDHRA. So everyone does go through a systematic routine screening process. But the screening processes themselves are somewhat inaccurate.

In fact, one of the publications that we published in November when we looked at the relationship of referral or treatment for PTSD symptoms from the first screen when they initially come and the subsequent screen 6 months later, we found no direct relationship in improvement in symptoms, which was somewhat of a counterintuitive finding. We were not expecting that.

And there a lot of potential reasons. Part of that may have to do with the inaccuracy of the screening. These are not 100 percent, you know. There is no way to 100 percent identify individuals. And



we have a lot better screening, I can guarantee you, for PTSD than we have for mild TBI. But that is kind of another topic.

So that is one inherent problem. And then when we identify problems, it is still voluntary. We cannot force a soldier to receive mental health treatment. We can encourage them to. We have a limited ability to get a soldier help if there is overt threats to self or others. But aside from that, you know, it is a voluntary process. We can encourage individuals to go in and get help and they can choose not to. And that is an individual thing.

And then there is the stigma, which is not just in the military. It is a stigma in society in general of receiving mental health treatment. So there is stigma and there are barriers, depending on where a person lives, how close the clinic is, how accessible the doctor is.

You know, in units, for instance, doctors rotate frequently and so sometimes there is a lack of stability. You know, a person might develop a relationship with a physician and then 3 months later, the physician has been deployed. And so that can affect the person's desire to continue with treatment.

So there are a lot of factors and it is a tough question that you ask in terms of what is going to happen to these individuals because, you know, this is part of, you know, sort of what we have recognized since the beginning of the war. There is going to be a significant psychological cost.

Mr. HARE. Mr. Chairman, my time is up.

But, Colonel, first of all, thank you for your service to the country. But, I was struck by the multiple deployments, the 30 percent, 20 percent, 12 percent, and, those figures. I hope a lot more people are listening to those figures than the people sitting in this room.

And also when you said the 12 months is just not enough for a person to be able to reset. We have been talking about getting people when they come back the opportunity to have some time to be able to, but then, some of these deployments and redeployments are happening so quickly that we are just asking—this is a recipe for disaster.

So I really appreciate your sharing those figures with us. And, again, thank you very much.

And thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Mr. Hare.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Colonel. I appreciate your testimony and appreciate your service.

I noticed in your testimony that you alluded to the \$300 million that is going to be, I guess, spread around between Department of Defense and the VA and also some private providers.

Could you share with me how that effort is actually taking place and if, in fact, the private sector is also contributing dollars to this effort?

Colonel HOGE. Sir, I work at the Walter Reed Army Institute of Research and that program is managed by the command above me, the Medical Research and Materiel Command. There is a very systematic process that involves putting out grant invitations to have grant proposals submitted and then those are all peer reviewed and there is a peer review process that establishes which ones get

funded based on the science and also based on the needs of the military and the VA.

So there is a very systematic process in place to determine which proposals should get funded and which do not get funded and how the money is distributed. And I will be happy to take the question for the record in terms of the details and specifics on how that is being done.

[The response was provided in the followup information provided by DoD, in response to Mr. Miller's earlier question.]

Mr. BROWN OF SOUTH CAROLINA. Okay. I would appreciate that, sir. How about the National Institutes of Health (NIH)? Are they contributing to this research too?

Colonel HOGE. They have also had their own grant funding mechanisms, so they are also actively involved, participated in the planning, the meetings that were held to prioritize how the money should be allocated, and have also had the opportunity to apply for the funding in a collaborative manner with other investigators within DoD and VA. So—

Mr. BROWN OF SOUTH CAROLINA. And at the conclusion of this study, what do you hope to be able to accomplish?

Colonel HOGE. The grants, again, this is a little bit outside my area because I am not responsible for this, but I know that the grant process spans the domain of basic science and applied research and clinical trials research. My hope is that there will be sufficient lessons learned at sort of the upper end of that in terms of clinical trials and that is what I hope, you know, sort of would be my priority. I think the biggest gap is in the area of clinical trials, new therapeutic modalities for the treatment of PTSD.

Mr. BROWN OF SOUTH CAROLINA. I guess one of my greatest passions is the homeless veteran and how he sort of, you know, fell out of the system. And I think most of those homeless veterans are suffering from some sort of mental disorder, PTSD or similar form.

And I am hoping that we could find, at the end of the research, that we could find a way to diagnose those people that maybe have the problem or the potential of developing that problem later because by the time they come with the problem, they do not have the wherewithal to be able to find help.

And so, I would hope as part of research that we would address, you know, the homelessness problem, we find ourselves with a lot of our veterans.

Colonel HOGE. Yes, sir.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. I yield back.

Mr. MICHAUD. Thank you, Mr. Brown. The homeless veterans' issue actually will be a full Committee hearing on April 9th on homeless veterans.

Ms. Berkley.

Ms. BERKLEY. I will be very anxious to participate in that hearing as well, but let me remind my colleagues it takes a little bit of money to be able to care for these people.

Let me ask you a couple of questions, if I may. Something that you said struck a cord with me when you said that there have been studies that demonstrate that if people are called back up to serv-

ice before a year or even after a year, that it is just not enough time in between tours of duty.

Did I hear you correctly?

Colonel HOGE. Yeah. Well, what we have found is that, yeah. That is what I said. What I said is that the 12 months is insufficient, appears to be insufficient based on the data that we have, ma'am.

Ms. BERKLEY. Now, it is my understanding, and correct me if I am wrong, that our Armed Forces are so stretched right now that people are being called back to duty in a far shorter time than 12 months. Twelve months is recommended. But in many instances, they have a 90-day stay at home and they are back in the theater of war.

Is that your understanding as well?

Colonel HOGE. I do not know actually, you know, how many units have rotated back before 12 months. So I would have to find that out for you.

[The information from DoD follows:]

In general, the Army does not require soldiers to violate individual dwell and has systems in place to honor the soldiers' dwell time. Army policy is in place to honor dwell or adjust for the instances where soldiers are at risk for violating dwell. There are instances where soldiers may volunteer to break dwell and some instances where they may be required to break dwell due to their having a critical skill. HRC understands how this affects the soldiers life and requires General Officer level approval any time this course of action is taken.

When assessing how many soldiers have deployed prior to receiving their earned dwell we find that the cause is often more patriotic and selfless. As an example we had a unit this week that had greater than 100 personnel non-deployable due to their dwell time being too short. When queried by their leaders, forty of the soldiers volunteered to break dwell. This demonstrates selflessness of our heroic Army.

Additionally, our dwell numbers have increased in some instances due to soldiers voluntarily reenlisting specifically for a unit that is deploying. Once the soldier arrives at their chosen unit they of course deploy with the same.

For example, in units that are deploying in the near future there are a total of 33,862 soldiers. Of these soldiers 33,246 (98.2 percent) have no dwell issues. Of the remaining 616 soldiers, nearly half of them have volunteered to deploy short of their authorized dwell periods.

The system is not perfect and there are soldiers, in the end, that are placed in situations where they must deploy repetitively and violate their dwell. It is up to the individual Commanders and Leaders to ensure that soldiers are afforded their earned dwell time. Army Human Resources Command knows that this issue is important to the soldier and has made strong efforts to prevent this sort of issue from occurring.

Ms. BERKLEY. I would appreciate it because it is my understanding that it is a much shorter period of time in many instances.

And I am going to share with you another Nevada story. A young man from Pahrump, Nevada, had done his tour of duty. He was back home in Pahrump. He had been raised by his grandmother, so he went back to his grandmother's home. He was called back. He did not want to go back. He told his grandmother he would rather kill himself than go back.

He was interviewed by a psychologist or a psychiatrist. They said that he was depressed and gave him Prozac. He was sent back. He was on suicide watch and the day after he was taken off of suicide watch, he killed himself.

Now, it seems to me that we ought to be doing a better job of screening people and fully appreciating when they are not capable mentally of handling the strain of war.

Do you agree with that?

Colonel HOGE. I agree completely in the sense that, you know, if we had the ability to accurately identify who will do well in combat and who will not—I mean, the fact of the matter is that—

Ms. BERKLEY. Forgive me for interrupting.

Colonel HOGE. Yes, ma'am.

Ms. BERKLEY. But don't you think if the military put this young man on suicide watch that they had a pretty good inkling that he was not doing well mentally?

Colonel HOGE. Yeah. I cannot comment on the specifics of the case. Presumably, you know, when they took him off suicide watch, you know, I am sure they, you know, had good reasons to do that, you know, based on what he told them.

But unfortunately there are tragic situations that happen and, you know, there has been an increase of suicide rates in theater because everyone has access to firearms. And so impulsivity that normally, you know, might not lead to suicide, in that circumstance where they have easy access to firearms can be a catastrophic event and a very unfortunate one.

Ms. BERKLEY. Let me ask you another question on a different issue. If you have a serviceman who gets a gunshot wound and he is bleeding profusely, do you have to ask his permission to treat him or do you just treat him? And if we just treat him, why is it if somebody has a mental wound that we have to tread carefully?

It would seem to me that somebody's mental problem is just as serious as somebody's physical wound and we ought not to have to get permission from that person in order to treat them. Why is it that we make this distinction?

Colonel HOGE. There are lots of answers to that and the first one that comes to mind is simply that the only way to get better is in part to have the desire to do so and to make that commitment. And we cannot force people to get better with psychiatric problems. The reason why therapy works is because of the alliance that we form between the doctor and the patient, between the counselor and the patient.

Ms. BERKLEY. Well, what if it was mandatory? What if we determined that it was part of getting out of the service that you are interviewed by a mental health expert and then 6 months later and a year later and maybe 5 years later, but have it mandatory that they must, in fact, get this counseling, just to be able to keep track of the problems because I agree with you, unless you recognize you have a problem, it is very difficult to overcome it, but I surmise that a lot of these young men and women do not even recognize that they have the problem?

Colonel HOGE. I agree with you, ma'am, that many of them do not recognize that they have a problem. And sometimes when they do, they are not necessarily willing or interested in treatment. There are options available to them to get treatment through other means.

For instance, Military OneSource, which is a separate track that is not part of the medical system. They can get care in the VA sys-

tem or Vet Centers. They can get help from chaplains. There is a huge amount of counseling that is provided by chaplains. And a lot of individuals actually do get better on their own, you know, with or without treatment.

But I think that in terms of requiring mandatory counseling, I think that I could see it might seem valuable on the surface, but I think the second order of consequences, you know, would be enormous, draining much needed resources, which are already overstretched and overtaxed away from those who most need it would be one, for instance.

And also I just do not think that by and large if we force—we cannot. We cannot ethically do that, force individuals to get better. And they are not going to get better if we do. They will find every way to rebel against that.

Ms. BERKLEY. Okay. Could I ask one more question? Thank you.

There is something else. I am getting a lot of calls from medical doctors in Las Vegas saying that the VA is not paying them on a timely manner, in a timely manner. And they are becoming very reticent to renew their contracts with the VA, which could create a pretty big crisis in the VA healthcare system if the doctors that we are contracting with do not get paid.

I am wondering if you have heard anything from mental health experts, doctors, psychologists, psychiatrists. I would assume that it is a challenge to find enough doctors, psychologists, psychiatrists that are trained to deal with mental health issues as it is and if we are not paying them in a timely manner, I would believe it would become even more challenging to get them to contract with the VA.

Are you hearing anything like that?

Colonel HOGE. I cannot comment on the VA situation. But within DoD, there was, as you know, I am sure, the Mental Health Task Force was a comprehensive self-assessment, very, you know, critical, you know, self-assessment by DoD to look exactly at that question of whether the resources were sufficient and available and accessible within particularly our remote operational, you know, locations, where the deployment platform locations, and it showed that there are some very significant challenges. That report came out in June, last June, challenges in terms of having sufficient resources and personnel trained, you know, mental health professionals at our remote locations.

Ms. BERKLEY. Thank you very much.

And, Mr. Chairman, I would hope that this Subcommittee or perhaps the Committee would look into this issue of compensating these doctors or lack thereof because we are going to end up with a real problem if they do not renew their contracts because they have not been paid by the VA.

Thank you.

Mr. MICHAUD. Very good point.

Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman, and I apologize to you and the Colonel that I missed your testimony. I have a simultaneous Telecommunications Subcommittee hearing going on.

Colonel, I was reading through your testimony as the questions were being asked, and the one thing that really just sticks out here

is you see for the first time you have had a sizeable number of soldiers studied that were on their third rotation to Iraq.

And it is really striking to see how the increased risk goes up with each deployment. And I hope that is something that the Department of Defense is taking a close look at, at what we are doing to these young men and women as we put them through third rotations and that it should only be done when absolutely necessary.

I had a couple representatives from the American Legion in my office earlier, and I heard you talk about the stigma of being identified as someone with post traumatic stress disorder or just having mental health issues. And they brought up another interesting point, not just from the medical side, but how it seems to be affecting our veterans on the employment side, too, that a lot of employers are a little bit nervous about maybe hiring people that are just coming back from this war because they are hearing so much in the media about, you know, traumatic brain injury and post traumatic stress disorder and that it is also affecting our veterans on the economic front.

So, as you embark amongst this campaign to educate people about PTSD so that they get treatment and help, I think it might also be, you know, a good idea if DoD in some way can help educate employers as to the treatments that are available and that these vets once they are treated, you know, should not be stigmatized when they go look for a job just because they have received this treatment, that employers have a responsibility to take a look at our young men and women that served the country and not use this as a reason not to hire them. I know they would not do that overtly, but it seems like it is causing some problems.

But the only question I have and maybe you could just educate me on this, the representatives I had from American Legion were talking about, you know, the distinction between regular military and National Guard and Reserves with regards to treatment.

And they were under the impression, I do not know if it is correct or not, maybe you can tell us, that when you have somebody that is in the National Guard and Reserve and they have a mental health issue coming back from combat, PTSD or the like, they can get treatment obviously. They have the benefit to get treatment, that their family members are not able to receive counseling.

A lot of time, as you know, these issues are issues within the family with marriages breaking up. We see the high divorce rate taking place in the National Guard and Reserve that seems to get worse as these young men and women are deployed and have multiple deployments.

What assistance is there that is available to families of National Guard and Reservists that are also going through tough times, trying to understand how they should be helping the veteran or responding to some of the things they are seeing at home when this happens and is it available to them?

Colonel HOGE. Yeah. I can comment, you know, from my perspective within DoD. There are a variety of different services for family members and counseling both within the medical system and outside of the medical system through the support, family support programs on——

Mr. DOYLE. Vet Centers and——

Colonel HOGUE. Yeah. And through Military OneSource, for instance, which is an employee assistance model program that has a strong focus on marital and family therapy. So there is different—

Mr. DOYLE. And this is available to families of National Guard and Reserves?

Colonel HOGUE. Yes, sir. I believe so. I am a little hesitant there, but, yes, I think that is the case.

Mr. DOYLE. Very good.

Colonel HOGUE. Yeah. And I can find out for sure, but I believe that is the case.

Mr. DOYLE. Well, thank you very much, Colonel.

Mr. Chairman, I yield back.

Mr. MICHAUD. Thank you very much.

Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

I appreciate your written testimony here today, specifically referring to research projects. Most of the time, our discussion at this Committee is about how to fund more research and we do not actually get a full presentation about some of the results.

We have been told, Colonel, that there are an abundance of good research projects that could still be done out there if there was funding available for that.

Do you agree with that statement?

Colonel HOGUE. Yes, sir. And, again, in the clinical trials arena, I think that is a true statement for sure.

Mr. SNYDER. Clinical trials, meaning the kind of studies where you need to have 5,000 or 10,000 or 30,000 people participating which takes a lot of staff time and labor and recordkeeping. Is that the kind of trials you are talking about?

Colonel HOGUE. No. What we need actually are smaller randomized controlled studies—

Mr. SNYDER. Of therapies?

Colonel HOGUE. Of therapy, yeah, to break down what specific elements of therapy work, you know, how can we improve therapy, can we create group therapy processes that work as effectively as individual therapy, which would have implications in terms of resources, and medications. There is a variety of new medication opportunities that need to be tested in randomized trials as well.

Mr. SNYDER. I would like to give you a softball question, if I could, and just let you take whatever time I have remaining on it. In your written statement on page six, you say both PTSD and depression are biological disorders that are associated with a host of chemical changes in the body's hormonal system, immune system, and nervous system.

I would just like you to amplify on that with the remaining time I have because we have a lot of discussions here about somehow the division between mental health and physical health and it comes up in a lot of context as mental health parity bills and that kind of thing.

But would you just take the remaining 3 or 4 minutes I have and just discuss in a little more detail those kinds of changes that you are talking about?

Colonel HOGE. Yeah. I mean, this is an important, a hugely important topic because we, you know, still within society, we think of PTSD as a mental disorder and, you know, other problems, TBI, for instance, mild TBI as a physical disorder. And that is just a very artificial distinction.

The fact of the matter is that there are a host of changes that happen within the nervous system, endocrine system, even in the immune system as a result of stress, traumatic stress, persistent stress in the combat environment, and these types of changes can lead to a host of physical health problems.

So we know, for instance, that individuals who have PTSD and depression are much more likely to use medical services, to miss work due to illness, to have more pain, to have more headaches, even to have more post-concussive symptoms. In fact, it is one of the strongest risk factors for the persistence of symptoms after a concussion is the presence, the coexistence of some sort of mental health problem like depression or anxiety or PTSD.

So the degree to which we can, you know, help people understand that this is—and the other thing is that these are normal biological processes that are adaptive and necessary in combat. Being hyper-alert is a survival mechanism that soldiers need in combat and they are not going to let go of that when they come home because that is, in fact, their body, you know, their Lindex System, the part of their brain that has to do with response to threat has been altered as a result of their training and, you know, what they have done as part of the professional duties in combat.

So they are not going to necessarily let go of that. And the reactions that they have, while other people may perceive them as being abnormal are, in fact, things that are adaptive, that as soon as they go back into combat for their next rotation, they have to turn it all back on again.

So we can look at some of these biological changes both in the context of what is normal reactions to stress and then also in the context of at what point do those reactions become abnormal and really interfere with the person's life. And those are, you know, questions which are active focus of research now.

Mr. SNYDER. I will take my last 15 seconds. I think there is also a lot of research going on now in young children who are raised as babies, who are born into very stressful environments, whether it is a home with abuse or a home with poverty, and that chronic stress month after month, year after year leads to some kind of permanent changes in the brain because of the development of a baby's brain. But this aspect of stress as somehow just being a mental thing is an incorrect, I think, application of the term.

Thank you.

Colonel HOGE. Yes, sir. Just a quick comment. The vast majority of individuals who are exposed to very significant traumatic events either in combat or in other settings do not develop PTSD. The vast majority do not develop PTSD. And that is a real active, you know, very important area of interest is what is it that, you know, causes some individuals to develop PTSD and others to not develop PTSD.

Mr. MICHAUD. Thank you very much. Once again, Colonel, thank you very much for appearing today, but also thank you for your service to this country. We appreciate it. Thank you.



Colonel HOGE. Thank you, sir. Thank all of you. Thank you.

Mr. MICHAUD. I would ask the second panel to come forward. And while they are coming forward, we have Carolyn Baum, who is the immediate past President of American Occupational Therapy Association (AOTA); Dr. David Matchar, who is the Director and Professor of Medicine at the Center for Clinical Health Policy Research at Duke University Medical Center; and Dr. Mark Wiederhold, who is President of Virtual Reality Medical Center.

I want to thank all 3 of you for coming here today. We appreciate it and look forward to your testimony. And we will start with Dr. Baum.

**STATEMENTS OF CAROLYN M. BAUM, PH.D., OTR/L, FAOTA, IMMEDIATE PAST PRESIDENT, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, AND PROFESSOR, OCCUPATIONAL THERAPY AND NEUROLOGY, ELIAS MICHAEL DIRECTOR OF THE PROGRAM IN OCCUPATIONAL THERAPY, WASHINGTON UNIVERSITY SCHOOL OF MEDICINE, ST. LOUIS, MO; DAVID MATCHAR, M.D., MEMBER, COMMITTEE ON TREATMENT OF POSTTRAUMATIC STRESS DISORDER, BOARD ON POPULATION HEALTH AND PUBLIC HEALTH PRACTICE, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES, AND DIRECTOR AND PROFESSOR OF MEDICINE, CENTER FOR CLINICAL HEALTH POLICY RESEARCH, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, NC; AND MARK D. WIEDERHOLD, M.D., PH.D., FACP, PRESIDENT, VIRTUAL REALITY MEDICAL CENTER, SAN DIEGO, CA; ACCOMPANIED BY GERALD M. HAASE, M.D., FOUNDER AND CHIEF MEDICAL OFFICER, PREMIER MICRONUTRIENT CORPORATION, NASHVILLE, TN**

**STATEMENT OF CAROLYN M. BAUM, PH.D., OTR/L, FAOTA**

Dr. BAUM. Thank you, Mr. Chairman, Members of the Subcommittee, for giving me the opportunity on behalf of the American Occupational Therapy Association to discuss issues regarding post traumatic stress disorders.

You introduced me, so I will bypass that. I also am the Professor of both Occupational Therapy and Neurology at Washington University School of Medicine.

Occupational Therapy (OT) has had a rich history providing services to veterans dating back to World War I. Occupational therapists help wounded warriors return to their military responsibilities or transition into civilian life. We do this by helping them set goals, develop strategies to accomplish their goals, and gain the skills that allow them to achieve the maximum level of participation and independence.

Occupational therapy perhaps is best known for its work in rehabilitation services after stroke, loss of vision, physical injury, including amputations, and traumatic brain injury, but occupational therapists also treat individuals with stress-related disorders that result in mental and cognitive impairments as well.

OT plays a unique role in helping veterans recover from PTSD as they serve as key members of the team, that along with physicians and psychologists who use medication and counseling, the occupational therapist employs performance strategies that support

the veterans in achieving success in their performance in daily activities.

Actually, it is in these daily activities that it is possible to observe the problems veterans are having with multi-tasking, with sequencing of tasks, with their safety, with their judgment, and actually identifying the cognitive fatigue which has a very important need for consideration. These are all problems that require strategies for individuals to overcome.

The effective treatment of PTSD and the return of veterans back into their work, their family, and community lives really requires an integrated system of care that includes assessment, goal setting, treatment, and learning to self-manage life with PTSD.

Rehabilitation does not stop when veterans are discharged from hospitals or medical care. It must be provided along a continuum addressing community reintegration, social reconnections, and work accommodations. All these are areas in which occupational therapists play an important role.

Veterans with PTSD often have difficulty in their daily lives and avoid activities because they result in anxiety or fear or even anger. Consider, for example, a soldier who is driving on routine patrol when a road-side bomb explodes. Upon returning home, the veteran might experience flashbacks of that event triggered simply by driving.

The therapist might use simulated or virtual reality driving experiences or even actual driving experience in a controlled environment to help the veteran extinguish or reframe the negative stress reactions.

Therapists also work with veterans to help them manage issues related to PTSD such as depression, mild head injury, or concussion, and substance abuse by helping them develop strategies to re-engage in daily life that are meaningful for them and their families. Having the families involved is particularly important because we know the importance of social support to individuals recovering from PTSD.

The unique contribution of occupational therapy is highly valued by the Army for their combat stress control. The Army model deserves additional attention from the Veterans Administration and the Subcommittee because it fully recognizes occupational therapy's contribution as a member of the team by adding the performance component to the medication and counseling provided by other team members. We recommend the VA consider and adopt the Army model.

The Veterans Administration has made significant strides in preparing to meet the needs of veterans, but work remains to be done. There are only 750 occupational therapists in the entire VA system. While both the Veterans Administration and the Department of Defense guidelines for PTSD exist and include occupational therapy, it is the experience of our members that the inclusion of occupational therapist varies from site to site. This variation does not ensure full access to effective treatment.

The American Occupational Therapy Association encourages the Committee to look at this issue. From the consultation with AOTA's members within the VA, we have heard that they are struggling to maintain the quality of care for which they are known

because of increased demand for rehabilitation services and gaps in staffing.

The most important issue is to ensure that veterans receive the services they need to recover and reenter community life, able to care for themselves and others, able to work and make contributions to their families and communities. If the VA has staffing problems, they should look for, and contract with, community programs to provide the services that the veterans need.

Just as you discussed earlier with Colonel Hoge, there is also a need to study the effectiveness of complex interventions, medications, counseling, and I would ask for consideration to add the third leg to the stool, the importance of daily life performance.

Research should seek to understand the relationship of quality of life to PTSD symptom severity, disability, treatment outcomes and cost. The problem begs for an interdisciplinary translational clinical study.

Mr. Chairman, I have made additional recommendations in my written testimony, but I want to highlight a couple of issues for your Subcommittee's consideration.

To increase the numbers of occupational therapists within the Veterans Administration, we would urge that the Subcommittee consider expanding the Student Loan Repayment Program to ensure that the VA remains an attractive employment option because there is a real supply and demand issue for OTs right now and that would draw people to the VA services.

Salaries in the VA appear to be lower than other healthcare settings. The Bureau of Labor Statistics estimated in 2006 that the average salary in California for occupational therapists was \$73,000. Right now the Palo Alto Polytrauma Rehab Center is offering \$50,000 for two new positions that have been vacant since last July.

New positions continue to be added across the country, but salary will continue to be an issue, and AOTA urges the Subcommittee and the VA to attend to salary, recruitment, and retention issues.

Mr. Chairman, in conclusion, I want to reiterate that occupational therapy has expertise in the treatment of functional impairments resulting from a broad range of conditions faced by veterans, including PTSD. Occupational therapy should be explicitly included on treatment teams to address the every-day life issues of veterans and their families through the phases of recovery and community reintegration.

Thank you very much for the opportunity to provide testimony to the Subcommittee. AOTA looks forward to working with Congress and the VA to meet the needs of our veterans. And I would be happy to answer any questions. Thank you.

[The prepared statement of Dr. Baum appears on p. 45.]

Mr. MICHAUD. Thank you very much, Dr. Baum.

Dr. Matchar.

#### **STATEMENT OF DAVID MATCHAR, M.D.**

Dr. MATCHAR. Good morning, Mr. Chairman and Members of the Committee. My name is David Matchar. I am Director and Professor of Medicine at the Center for Clinical Health Policy Research

at Duke University Medical Center and served as a member of the Institute of Medicine Committee, which produced the report "Treatment of Post Traumatic Stress Disorder and Assessment of the Evidence." This study was sponsored by the Department of Veterans Affairs.

The VA charged the Institute of Medicine Committee with several specific tasks. To respond to its main task, which is making conclusions regarding efficacy, the Committee developed methods using generally accepted international standards for conducting a systematic qualitative review.

The Committee's conclusions were ultimately based on its judgments of the sufficiency of the body of evidence for each category or class of treatment. The Committee was not asked to recommend what therapies clinicians should use or not use.

The Committee's assessment winnowed down the nearly 2,800 articles identified in our search to 89 randomized control trials, 37 studies of treatment with medications, such as Selective Serotonin Reuptake Inhibitors or SSRIs and anticonvulsants, and 52 studies of treatments with psychotherapy. I would be happy to provide details about the criteria the Committee used and about how we evaluated the methodological quality of the studies we reviewed.

The evidence on pharmacotherapy in general was limited with relatively few studies meeting inclusion criteria and free of significant methodological limitations. Even among the SSRIs with the most substantial evidence base, the Committee was struck by inconsistencies in the results and serious methodological limitations.

The Committee found the evidence for SSRIs and all other drug classes for which randomized trials were identified inadequate to conclude efficacy.

The Committee reviewed studies on several types of psychotherapy. The Committee judged the evidence for exposure therapy sufficient to conclude efficacy. Exposure therapies are a family of therapies that include confronting trauma-related memories or stimuli and may be used in combination with other therapeutic approaches. The evidence for all but one of the remaining psychotherapy categories was inadequate to conclude efficacy.

The Committee's conclusions of inadequacy regarding evidence for most treatment modalities should not be considered clinical practice guidelines. Finding that the evidence is inadequate is not a determination that the treatment does not work.

The Committee recognizes that clinical treatment decisions must be made every day based on many other factors and considerations such as patient preference, availability, ethical issues, and clinical experience that we were not asked to address and we did not.

The Committee was struck by the lack of evidence on treatment efficacy in one population compared to another. The Diagnostic and Statistical Manual criteria recognizes only one type of PTSD. Yet, reasonable people might question whether all PTSD is the same and whether one can expect a treatment shown effective in one group, for example, earthquake survivors, to also work for U.S. combat veterans.

However, we found no evidence either that PTSD is the same or that it is different in veteran or VA populations compared with civilian populations.

A minority opinion on the report was based on the belief that there are subgroups and the evidence should be examined separately for them, but the Committee majority concluded otherwise.

The Committee found that PTSD needs more attention from high-quality research, including in veterans. The Committee highlighted several research-related issues in the report, including methodological quality, investigator independence, and special populations.

We recommended that funders of PTSD research take steps to ensure that investigators use methods to improve the internal validity of research, for example, the use of blinding and adequate patient followup.

The Committee also noted that the majority of drug studies have been funded by the pharmaceutical manufacturers and the majority of psychotherapy studies have been conducted by the individuals who developed the techniques or their close collaborators.

The Committee recommends that a broad range of investigators be supported to conduct replication and confirmation studies.

The research literature is not informative on the issue of patients who have PTSD and other health problems, such as substance abuse, other anxiety disorders, or traumatic brain injury, or about special veteran populations, such as ethnic and cultural minorities, women, and people with physical impairments.

We recommend that the most important subpopulations be defined to design research around interventions tailored to their special needs.

Finally, the Committee made two general recommendations about research and veterans. First, recommend that Congress require and ensure that resources are available to fund quality research on the treatment of veterans with PTSD with involvement of all relevant stakeholders.

Second, we recommend that the VA take an active leadership role in identifying the high impact studies that will most efficiently provide clinically useful information.

The Committee is grateful to have the opportunity to be of assistance to the VA and hopes that the Department and Congress find the report useful in moving ahead to strengthen PTSD research.

Thank you for the opportunity to testify, and I would be happy to address any questions the Committee might have.

[The prepared statement of Dr. Matchar appears on p. 50.]

Mr. MICHAUD. Thank you very much, Doctor.

Dr. Wiederhold.

#### **STATEMENT OF MARK WIEDERHOLD, M.D., PH.D., FACP**

Dr. WIEDERHOLD. Mr. Chairman, Members of the Subcommittee, I am pleased to be here today to discuss a new innovative technology currently undergoing testing in the Veterans Administration and Navy facilities that has promised to speed and improve effectiveness of PTSD treatment.

We thank the Committee and you, Chairman Michaud, for your active interest in PTSD research.

My company, the Virtual Reality Medical Center, is currently testing virtual reality (VR) therapy to treat PTSD in five VA hospitals with requests from six additional facilities for the technology.

We have been treating patients with VR therapy for the past 12 years and have an overall success rate of 92 percent. This is defined as a reduction in symptoms, improved work performance, or the successful completion of a task which was previously impossible.

Our centers and clinics have broad experience in treating patients with VR therapy. The technology that my company and others have been studying is virtual reality or virtual reality exposure therapy for PTSD. The research protocol works by allowing the therapist to gradually expose the combat veteran to distressing stimuli in the virtual scenarios while teaching the study participant to regulate breathing and physiological arousal. After a number of sessions, the fighter flight response to distressing stimuli is extinguished.

Use of virtual reality technology helps veterans of the current engagement to overcome the reluctance they have in coming forward for help.

Virtual Baghdad, which is shown in Exhibit A, is a realistic environment consisting of a single map that allows the user to navigate seamlessly through a suite of different but thematically connected virtual scenarios. I can see myself in the village or the marketplace said one of the Navy Corpsman who participated in our study.

Virtual reality exposure therapy is an investigative treatment modality for PTSD that has been in existence for about 10 years. It has been used successfully with Vietnam era veterans and with survivors of traumatic events such as motor vehicle accidents, earthquakes, bus bombings in Israel, and 9/11 survivors.

A panel of academic and government experts have published a consensus opinion that exposure therapy is the most appropriate therapy for PTSD. While exposure might sound counterintuitive, it is necessary for treatment success.

In virtual reality, PTSD patients who normally avoid reminders of the trauma are systematically exposed to combat-related stimuli. This allow for individually paced emotional processing and desensitization to occur.

Current research funded by the Office of Naval Research is focused on determining the optimal treatment protocol for Iraqi war veterans with different co-morbidities. For example, those with mild traumatic brain injury and PTSD may require more treatment sessions than those with mild depression and PTSD.

Results to date show that the virtual reality protocol is successful in decreasing symptoms of PTSD, depression, and anxiety.

Study investigators are currently conducting 3-month followup visits to ensure that the treatment is lasting. Investigators are also performing physiological assessments to help design a study that would construct a profile of veterans who might do especially well with VR technology.

One of our systems is in Iraq right now and could be used in such research. In fact, we have just received strong interest from the Navy in advancing research in just this context.

However, we are here to speak about our experience and success with the VA and leave you with 3 additional advanced technologies which could significantly help improve the lives of veterans with PTSD.

First, it is important to correlate the progress of VR therapy not only with psychophysiology but also with brain imaging. In collaboration with other researchers, we have postulated that there may exist a functional Magnetic Resonance Imaging (fMRI) or functional brain imaging signature for PTSD, the discovery of which could lead to more targeted treatment.

Second, VR can be used both alone or in combination with neuroprotective agents such as antioxidants to conduct stress inoculation training pre-deployment. It is important to track how well both technologies work to avert PTSD.

Third, VR may be an important piece of the puzzle as tools are developed that can assess and treat the many co-morbid conditions that accompany PTSD. For example, virtual reality can be useful both in cognitive rehabilitation for TBI as well as physical rehabilitation for veterans with amputations.

Mr. Chairman, I thank you for the opportunity to present this important technology today. I would be pleased at this time to answer any questions you may have.

[The prepared statement of Dr. Wiederhold appears on p. 53.]

Mr. HARE [presiding]. Thank you all very much.

Dr. Baum, you talked about your concern that the VA does not effectively integrate occupational therapists into multi-disciplinary post traumatic stress disorder and treatment teams.

I was wondering if you might share with us what you think the reason is for the fragmented way the VA integrates occupational therapists into the treatment teams, and also, how can the VA do a better job to integrate occupational therapists into these teams?

Dr. BAUM. Thank you.

It may be a volume problem. I think the VA is having such an increased number of patients with many, many needs, with traumatic brain injuries and the polytrauma and the amputations that they may not have enough manpower assigned to that. And they have, as I mentioned, vacancies in the VA system that need to be filled.

So I think that by making the critical need to have the VA respond with training teams of professionals to address this issue, that bringing the occupational therapist into that does bring that performance piece into the management of the patients' lives.

Mr. HARE. Thank you.

Dr. Matchar, you talked about the IOM's findings regarding the current state of research on post traumatic stress disorder in combat veterans.

So as we move forward, what specific areas do you think the VA should invest research resources to close some of the gaps in research on treatment for PTSD?

Dr. MATCHAR. Well, first of all, the research that should be funded should be focused on methodologically high-quality studies so that at the end of the day, whatever therapies are being evaluated, that we can make reasonable inferences that these are going to work and who they are going to work for and that we also have understandings of the context in which they work, how long they should work.

So it is those kinds of issues that are really key. The specific therapies, personally I have no opinion about. I mean, there are

certainly some promising therapies out there, but it is really more a question of how it is studied as opposed to what is being studied from my perspective, but that is only because I am more of a methodologist than a scholar in this field.

Mr. HARE. How do you think the VA can work with other Federal research organizations such as the NIH to advance different areas of research?

Dr. MATCHAR. I think that the most important thing that could be done, again in my opinion, is that they establish a coordinated effort, that there are a lot of questions that need to be asked and answered and asking them in a coherent way, a systematic way, allocating research so that you are maximizing your bang for the buck, so to speak, in the research endeavor, making sure that the outcome measures and the methodological approaches are uniform across groups, so NIH, Department of Defense, and VA. I think one of the Committee's recommendations was that the VA take a leadership role in establishing that kind of coordinated agenda.

Mr. HARE. Just to be fair and pick on all 3 of you, Dr. Wiederhold, in your testimony, you talked about how neuro-protection might further enhance the utilization of virtual reality exposure therapy and provide a benefit for combat veterans.

What exactly do you mean by neuro-protective?

Dr. WIEDERHOLD. Can I refer that question to somebody in the audience or—

Mr. HARE. Sure.

Dr. WIEDERHOLD. Dr. Haase.

Dr. HAASE. I am Gerry Haase from Premier Micronutrient Corporation.

As we heard this morning from Colonel Hoge, there are some key biochemical issues that are involved in PTSD. It is not just a mental issue. And, in fact, excess free radicals and chronic inflammation have been implicated in most of the serious psychological illnesses as well as dementias.

In fact, very high levels of free radicals such as peroxynitrite and products of inflammation such as interleukin 6 and tumor necrosis factor alpha have been measured in PTSD patients. So if you can abrogate those processes, you can probably block those effects that would cause symptomatology and PTSD.

We also know that these pro-inflammatory cytokines, when they are mixed with oxidative stress, actually turn on the glutamate pathway which is exactly one of the biochemical pathways that Colonel Hoge was talking about. And this pathway can, in fact, be blocked by the use of proper neuro-protective agents such as formulations with antioxidants.

We also know that in virtual reality therapy, which is a very effective exposure therapy as Dr. Wiederhold talked about, the fear response mechanism is actually turned on. This arousal response is turned on to get the effect of the VR. That also turns on the glutamate pathway which is toxic to neurons and that can be blocked by the proper neuro-protective agents.

Now, what is the evidence that these neuro-protective agents might work? We actually have 3 pieces of evidence that we have been working on. One was in human civilians where we could



prove that the proper antioxidants would, in fact, block this oxidative damage.

The second was in a rodent model of Parkinson's disease where we actually could show that the proper antioxidants could block the Parkinsonian symptoms in this rodent model that were turned on by not only something called MPTP, which not only works in a rodent model for PTSD, but, in fact, is a contaminant of some drugs that are recreational drugs and causes Parkinson's in humans. So we can block that.

And, most importantly, since Colonel Hoge told us about the overlap between TBI and PTSD, we did a randomized prospectively blinded study in returning Marines from Iraq that had mild TBI and they had neuro-cognitive damage and they had focus problems and balance problems.

And in this blinded trial using the methodology is so important, as was pointed out by Dr. Matchar, we found that the antioxidant treated group did much better in all the domains measured at 12 weeks compared to a standard therapy.

So it appears to us that if you use neuro-protection on a chemical basis in addition to the other therapies, we will probably have a good effect in PTSD and this should be tested.

Thank you.

Mr. HARE. Thank you.

Let me thank this panel very much for taking the time to come before us today. I appreciate your testimony very much. Thank you again for coming.

Our next panel is Dr. Thomas Berger, who is the Chair of the National Post Traumatic Stress Disorder and Substance Abuse Committee for Vietnam Veterans of America (VVA) and Todd Bowers, who is the Director of Government Affairs of the Iraq and Afghanistan Veterans of America (IAVA).

Let me welcome both of you. Thank you so much for taking the time to come by.

Dr. Berger, we will start with you, if you do not mind.

**STATEMENTS OF THOMAS J. BERGER, PH.D., CHAIR, NATIONAL PTSD AND SUBSTANCE ABUSE COMMITTEE, VIETNAM VETERANS OF AMERICA; AND TODD BOWERS, DIRECTOR OF GOVERNMENT AFFAIRS, IRAQ AND AFGHANISTAN VETERANS OF AMERICA**

**STATEMENT OF THOMAS J. BERGER, PH.D.**

Dr. BERGER. Mr. Chairman, other distinguished Members of the Subcommittee, Vietnam Veterans of America thanks you for the opportunity again to present our views on PTSD treatment and research, moving ahead toward recovery.

VVA also thanks the Subcommittee for its concern about the mental healthcare of our troops and veterans and your particular leadership in holding this hearing today.

However, as we are gathered here today after 5 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 wartime experiences.

To be sure, there have been some attempts by the military services to address combat stress at pre-deployment through cognitive awareness programs as Colonel Hoge mentioned such as Battle Mind and the use of innovative combat stress teams. Yet, no one can really say how serious any individual soldier's mental and emotional problems will become after actual combat exposure or the resulting impact that these wounds will have on their physiological health and their general psychosocial readjustment to life away from the battle zone.

VVA would like to ask DoD if the Armed Services have developed any combat stress resiliency models that were referenced earlier and if they have, what is their efficacy and by what measures do they judge the efficacy?

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 unreported as was hinted at earlier today.

As Colonel Hoge mentioned, a recent retrospective report 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 discrimination.

Thus, no one really knows whether those with PTSD who remain undiagnosed and so untreated will fail at reintegration upon their return to civilian life, but is beyond speculation, and we have heard mentioned several times today 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. And our troops are seeing both more and longer deployments.

Without proper diagnosis and treatment, the psychological stresses of war will never really end.

Upon separation from active military service, our male, and increasingly so our female, veterans face yet other obstacles in the search for mental health treatment and recovery programs, particularly within the VA healthcare system.

In spite of the infusion of unprecedented amounts of money, the addition of new Vet Centers, community-based facilities that we call CBOCs, and the VA's efforts to hire additional clinical staff, the access to and availability of VA mental health treatment and recovery programs remains problematic and highly variable across the country, especially for women veterans and veterans in western and rural States such as Montana.

Moreover, the demands to meet the mental health needs of OEF and OIF vets in many localities around the country is squeezing the VA's ability to treat the veterans of World War II, Korea, and Vietnam.

But despite the shortcomings that I have mentioned, one piece of good news is that since PTSD was added to the third edition of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-III at the time, a great deal of attention has been paid by the VA to the development of instruments for assessing PTSD as well

as to the therapeutic treatment modalities used to manage them or even overcome the most troubling of symptoms. And we have heard some of those mentioned today.

We have also heard, however, that the National Academy's Institute of Medicine's Committee on Post Traumatic Stress Disorders about their report which found that "most PTSD treatments have not proven effective" with the one exception for exposure therapy.

Therefore, VVA strongly supports the IOM Committee's recommendation 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 of these studies" and that, again, "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."

For mental illness, the standard medical model is seriously flawed because it 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 illness. Reduce the stigma and discrimination against the folks, increase their social roles and participation which provide them a reason to get better in the first place. And then you provide the treatment and support services along with that.

Therefore, the issue is not so much making them normal, but helping them get their lives back together. In other words, recovery means living with the illness, managing it, and getting better, recognizing there might be limitations.

Most major psychiatric illnesses are episodic, but chronic. So recovery involves both coming to terms with the symptoms and finding a meaningful life in the midst of these.

Finally, the need for timely, effective, evidence-based psychiatric, psychological, pharmacological, if necessary, interventions along with effective evidence-based psychosocial treatment programs as here.

With the conflicts in Afghanistan and Iraq continuing and no immediate end in sight, VVA believes it is time to address the issues now rather than later.

That concludes my testimony. Thank you very much, and I will be glad to answer any questions you might have.

[The prepared statement of Dr. Berger appears on p. 54.]

Mr. HARE. Thank you, Dr. Berger, and thank you for that very compelling testimony.

Mr. Bowers.

#### **STATEMENT OF TODD BOWERS**

Mr. BOWERS. Mr. Chairman, on behalf of the Iraq and Afghanistan Veterans of America and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding this important subject.

I would also like to point out today that my testimony is as Director of Government Affairs for the Iraq and Afghanistan Vet-

erans of America and does not reflect the views or opinions of the Marine Corps Reserves which I am currently a member of.

During the Iraq and Afghanistan wars, American troop mental health injuries have been documented and analyzed as they occur and the rates are already comparable to Vietnam. But thanks to today's understanding of mental health screening and treatment, the battle for mental healthcare fought by Vietnam veterans need not be repeated.

We have an unprecedented opportunity to respond immediately and effectively to the veterans' mental health crisis. Mental health problems among Iraq and Afghanistan veterans are already widespread. The VA has given preliminary mental health diagnoses to over 100,000 Iraq and Afghanistan veterans, but this is just the tip of the iceberg.

The VA's Special Committee on PTSD concluded that 15 to 20 percent of OIF/OEF veterans will suffer from a diagnosable mental health disorder. Another 15 to 20 percent may be at risk for significant symptoms short of a full diagnosis, but severe enough to cause significant functional impairment.

These veterans are seeking mental health treatment in historic numbers. According to the VA, OEF/OIF enrollees have significantly different VA healthcare utilization patterns than non-OEF/OIF enrollees.

For example, OEF/OIF enrollees are expected to need more than eight times the number of PTSD residential rehab services than non-OEF/OIF enrollees. With this massive influx of veterans seeking mental health treatment, it is paramount that we ensure the treatment they are receiving is the most effective and will pave a path to recovery.

But before I speak about the specifics of PTSD treatment and research, I would like to talk about two of the barriers that keep veterans from getting the proper treatment in the first place.

The first step to treating PTSD is combating the stigma that keeps troops from admitting they are facing a mental health problem. As Colonel Hoge mentioned, approximately 50 percent of soldiers and Marines in Iraq who test positive for a psychological problem are concerned that they will be seen as weak by their fellow servicemembers and almost 1 in 3 of these troops worry about the effect of mental health diagnosis on their career. Because of these fears, those most in need of counseling will rarely seek it out.

Recently my Reserve unit took part in completing our post-deployment health reassessment, which includes a series of mental health questions. While we underwent the training, one of my Marines asked me about post traumatic stress disorder. He said, and I quote, "If there is nothing wrong with it, then why is it called a disorder?" I could not have agreed with him more.

To destigmatize the psychological injuries of war, IAVA has recently partnered with the Ad Council to conduct a 3-year public service announcement campaign and to try and combat this stigma and ensure that troops who need mental healthcare get it. Our goal is to inform servicemembers and veterans that there is treatment available and that it does work.

As the Colonel mentioned, there is also a problem with stigma in regards to society. That is what we hope this campaign will also

address. It will let people know that Marines like myself who have served are not damaged goods. We merely have an injury and we can be treated and step back into service.

Once a servicemember is willing to seek treatment, the next step is ensuring that they have a convenient access to care. On this front, there is much more that must be done, particularly for rural veterans. More than one-quarter of veterans live at least an hour from a VA hospital. IAVA is a big supporter of the Vet Center system and we believe it should be expanded to give more veterans local access to the Vet Centers' walk-in counseling services.

The problems related to getting troops adequate mental health treatment cannot be resolved unless these two issues, stigma and access, are addressed. However, once a servicemember suffering from PTSD has access to care, we also need to ensure they receive the best possible treatment.

Currently a variety of treatments are available. Psychotherapy in which a therapist helps the patient learn to think about the trauma without experiencing stress is an effective form of treatment. This version of therapy sometimes includes exposure to the trauma in a safe way, either by speaking or writing about the trauma, or in some new studies through virtual reality.

Some mental healthcare providers have reported positive results from a similar kind of therapy called eye movement desensitization and reprocessing.

In addition, there are medications commonly used to treat depression or anxiety that may limit the symptoms of PTSD, but these drugs do not address the root cause of the trauma itself. IAVA is very concerned that in some instances, prescription medications are being seen as a cure-all that will somehow fix PTSD or replace the face-to-face counseling from mental health professionals that will actually help the servicemembers cope effectively with their memories of war.

And I will address this briefly too. When I returned from my second tour, I faced the same reintegration issues that most servicemembers face. I had a hard time sitting in class, was scatter brained, had a very difficult time sleeping. When I sought some assistance from my school health center, I was given a whole slew of drugs. That lasted about 4 days when I realized I was needing to take two pills for sleep, two pills which I call super Ritalin, if you will, for adults during the day.

It did not effectively help me until I was able to sit down and actually talk with someone and they told me the steps I could take to help get myself settled down. It worked incredibly well, the face-to-face treatment, but there are, we are finding from our membership, a lot of issues with dealing with medication to try and treat PTSD.

A recent Institute of Medicine study entitled, "Treatment of Post Traumatic Stress Disorder and Assessment of the Evidence," that we have heard a lot about today outlined the many gaps in current research. Among the problems they identified, many studies lack the characteristics of internal validity. That means too many people were dropping out of these studies, the samples were too small, or followup was too short.

The Institute of Medicine Committee also identified serious issues with the independence of the researchers. The majority of drug studies were funded by pharmaceutical manufacturers and many of the psychotherapy studies were conducted by individuals who developed the techniques.

Finally, the Committee concluded that there were serious gaps in the subpopulations assessed in the studies. Veterans may react differently to treatment than civilians, but few of the studies were conducted in the veterans populations.

There is also not enough research into care for suffering from comorbid disorders such as TBI or depression.

The solution is more and better research. To respond to the IOM findings, IAVA wholeheartedly supports more funding for VA research into PTSD and other medical conditions affecting Iraq and Afghanistan veterans.

Thank you for your attention and your work on behalf of Iraq and Afghanistan veterans. If the Committee has any questions for me, I will gladly answer them at this time.

[The prepared statement of Mr. Bowers appears on p. 56.]

Mr. HARE. Thank you both very much.

Let me just say, before I ask a couple questions of you both here, I represent 23 counties in west central Illinois, much of that rural. You would swear that the only people that ever have a problem, if somebody gets sick or needs help, that they live in Chicago or Rockford or Peoria. If you come from Carthage, Illinois, and Hancock, Illinois, right on the river, you have veterans that serve and it is a very difficult process to get those vets to the places where they can get the help.

So I could not agree with you more that we need to do more in terms of rural healthcare for veterans because these are people who have served this country and do not have the resources, whether it is CBOCs or whatever for them to go. It makes it pretty hard to treat somebody when they have no place to go.

Dr. Berger, much of what we are hearing during this hearing about PTSD is focused on OEF and OIF veterans and obviously, that is part of the reason we are here.

But with that said, there is also, I am sure, a significant number of Vietnam vets who are suffering from post traumatic stress. I would like, if you would not mind, just maybe sharing some of the unique needs that the Vietnam vets with PTSD have, and specifically how these needs differ from OEF and OIF veterans? The second part of this question would be what specific steps do you think the VA can and should take to ensure that the needs of Vietnam veterans are being adequately addressed?

Dr. BERGER. Well, first, Mr. Chairman, thank you for asking the question.

There are significant differences in the types of warfare given even the four decades between them. The troops nowadays are serving longer deployments and more frequently, whereas in Vietnam you served a 12-month tour if you were in any Armed Services unit with the exception of the Marine Corps in which you served 13 months.

There are other significant differences in the makeup of the Armed Forces themselves. Today's Armed Forces, of course, are a

volunteer service, whereas a great number of the women and men who served in Vietnam were not only volunteers, but a large majority of them were draftees.

Lots of major differences, but the fact of the matter is that when we came back, and now I speak on behalf of Vietnam veterans, we did not have a lot of the resources available. In fact, there was a lot of stigma and discrimination directed against us.

I mean, PTSD did not exist as we know it now. At the time, it became known, of course, as post-Vietnam stress syndrome and it has been known for thousands of years. But, I mean, given the nomenclature of post—there are lots of differences.

Our principal concern is that with the lack of or reduced organizational capacity, and I mean that across the board in terms of resources, personnel, that sort of thing within the VA, and the priority being given to treating the OIF/OEF veterans, that our vets and vets from Korea and World War II are being squeezed out.

We have lots of anecdotal information to indicate that is happening around the country. I just took a call last week from a fellow out in southern California that said his Vietnam veterans support group, which was meeting in the VA and there was a licensed clinical social worker that has been working with this group for over 10 years, they were told they could no longer meet there, okay, and the social worker was taken off there because they do not have the resources to handle everybody at this time.

That is just outrageous. And I am sure as you indicated in your rural districts or parts of your district that are rural, the troops are not getting the help that they need and that includes the Vietnam vets.

Mr. HARE. You are right, Mr. Berger. It is outrageous and we have to do something quickly to fix that. To walk out on people like that makes absolutely no sense.

Mr. Bowers, you talked about several barriers to treatment faced by OEF and OIF vets with PTSD. And just two quick questions.

What specific actions do you think the VA can take to help eliminate the barriers to treatment and also do you feel that most of these vets know that they are even eligible for treatment for PTSD for 5 years at VA medical facilities? I mean, is that option given to them? Are they aware that they even have that?

Mr. BOWERS. I can answer both of those in one response. My drill before last when I went in for my weekend duty, we underwent, as I mentioned, our PDHR assessment where we filled out the PDHR. I then had a one-on-one meeting with a counselor who then could give us a referral slip whether we needed to go see someone or find out what other resources were available.

At that point, we then took all the Marines, lined them up, and they registered with the VA right there on the spot. They were given information to know what VA programs were available, what resources were available.

Then they took the Marines and they lined them up at the Vet Centers. They had approximately six representatives there from local Washington, DC, area Vet Centers who let them know what resources were available. It was textbook. I do not think we could do it any better. The problem is that was my unit taking initiative. It is not mandated that way. And this was the first time that I

have seen out of our 3 deployments that we have had service-members come back and had it organized in this fashion.

So until it is required that for Reservists and National Guardsmen to when they return as they are conducting these assessments to have the VA there as a resource, we are going to continue to see people fall through the cracks.

And I am very proud of my unit for what they did. But, again, it is not something that is done DoD or VA-wide.

Mr. HARE. Thank you.

Mr. Miller.

Mr. MILLER. Thank you very much.

Doctor, we all know we cannot force people to seek medical attention.

Dr. BERGER. Yes.

Mr. MILLER. And probably rightfully so, but how can VA better reach out and find the people who need the most help?

Dr. BERGER. Well, I am not a marketing strategist by any means, sir. But I think that there has to be more marketing efforts directed at outreach efforts, particularly in our rural areas. I think that would help a great deal.

I know that there are efforts being made around the country as part of the TAP Program, the Transition Assistance Program, because I do participate in one myself where administrators from the VA occasionally show up to talk to the Guard members and inform them of the services, but it is not, at least in the Midwest it is not as widespread as I think it should be.

So I think it is more a marketing kind of thing in the sense of getting the word out. Plus, I think also that there needs to be encouragement by their colleagues such as Sergeant Bowers here.

And if I may, sir, I know this is highly unusual, but I would like to recognize Sergeant Bowers for not only his two tours in Iraq, but I learned today that he has been called up for a third time.

Mr. BOWERS. He is correct. But I am not going to the desert this time. I am going some place relatively tropical, but I do not think there will be any umbrellas in our drinks or anything else. So it will be a change of scenery, but I will be leaving next month.

And it is with that, that I thank this Committee for the opportunities you have provided me with testifying before you and I look forward to seeing you next winter.

Mr. MILLER. Thank you very much, Sergeant, for your service. If we can find out where you are, maybe I will bring an umbrella personally.

Mr. BOWERS. I will bring the coconut, sir.

Mr. MILLER. Doctor, thank you for your testimony today as well.

Mr. HARE. Well, let me thank this panel. Just before you go, Sergeant Bowers, we wish you God's speed on your third deployment.

I want to thank both of you for your service to this Nation. I know you have been here before and testified before this Subcommittee and others and you are wonderful examples of what we can do and what we can expect from our veterans. I thank you so very much for that. So thank you for stopping by.

Mr. BOWERS. Thank you, sir.

Mr. HARE. You are welcome.



Our last panel is Dr. Ira Katz, who is the Deputy Chief Patient Care Service Officer for Mental Health for the Veterans Health Administration. He is accompanied by Dr. Matthew Friedman.

I welcome you, Dr. Katz. Thank you for coming.

**STATEMENT OF IRA KATZ, M.D., PH.D., DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MATTHEW FRIEDMAN, M.D., PH.D., EXECUTIVE DIRECTOR, NATIONAL CENTER FOR PTSD, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Dr. KATZ. Mr. Chairman, Ranking Member, I am pleased to be here today to discuss VA's treatment and research programs in PTSD.

I am proud to be accompanied by Dr. Matthew Friedman, Director of VA's National Center for PTSD, and one of the Nation's foremost clinician and citizen scientists.

In his introductory remarks, Mr. Michaud focused on the 120,000 returning veterans who have come to VA medical centers and clinics and been diagnosed with a mental health condition and the nearly 60,000 who have been diagnosed with PTSD.

The 60,000 figure makes PTSD the most common of the mental health problems, but it is by no means the only one, with depression a close second.

However, these numbers, as substantial as they are, underestimate the scope of VA's mental health services for returning veterans.

Our Vet Centers provide care to a substantial number of OEF/OIF veterans. To date, they have provided care to an additional 7,000 returning veterans with PTSD and a far greater number with readjustment problems without specific diagnoses.

As has been mentioned, it has been since the Vietnam War that we have learned about PTSD as a distinct mental health condition that we have developed criteria and strategies for diagnosis and have done research and established effective treatment.

It is important to recognize that most of the 400,000 veterans seen for PTSD in VA last year were Vietnam era veterans. Returning veterans represent an opportunity to apply lessons that we have learned since Vietnam to prevent the chronic course for PTSD that was all too common among Vietnam veterans.

At the same time, we cannot lose sight of the ongoing need to develop better treatments for all veterans with PTSD, OIF/OEF veterans and those from Vietnam as well as other eras.

VA has responded to the challenge of returning veterans and to the opportunities created by scientific advances with dramatic enhancements to our mental health programs. The budgets increased from \$2 billion in 2001 to over \$3½ billion this year. The number of mental health professionals has also grown. Over the past 2½ years, we have hired 3,800 new mental health staff for a total of nearly 17,000.

This has allowed VA to establish PTSD specialty care programs in each of our medical centers and in many of our larger community-based outpatient departments. There are also major expanses

in Vet Center programs with ongoing increases in the number of centers from 209 to 232.

VA's approach to PTSD is to promote early recognition and treatment. There is community outreach including collaborations in virtually all of the post-deployment health reassessments as well as screening for all veterans seen in our system. When there are positive screens, veterans are further evaluated and referred to mental health providers as needed.

Evidence from research suggests that the most effective forms of treatment for PTSD are certain forms of psychotherapy, specifically prolonged exposure and cognitive processing therapy.

It has been somewhat over a year since publication of findings from a landmark VA cooperative study demonstrating the effectiveness of prolonged exposure, the work of Dr. Friedman and his colleagues. Completion of this research was a major event.

However, of comparable importance even before the findings were published, VA began large-scale training programs for mental health staff so they could deliver these treatments in real-life clinical care.

Other research is ongoing. Two specific projects are large-scale clinical trials as has been mentioned earlier. One follows up on early small-scale studies by VA investigators, suggesting that prazosin, an inexpensive generic drug already used by millions of Americans for high blood pressure, could improve sleep and reduce nightmares in PTSD. Currently a large-scale multi-site trial is being implemented to evaluate its effectiveness.

Another trial is based on both clinical exposure and smaller clinical trials suggesting that newer antipsychotic medications may be effective in reducing symptoms in service-related chronic PTSD.

VA is currently conducting a large randomized clinical trial to determine if this drug risperidone is effective in veterans with chronic PTSD who continue to have symptoms despite receiving standard medications.

Other VA research is focusing on mechanisms underlying stress responses and resilience, longitudinal studies on deployment and its consequences, genetic risk and protective factors, novel therapeutics, effective strategies for rehabilitation of those with persistent symptoms and new strategies for the delivery of care including another study of Dr. Friedman looking at primary care management of PTSD.

Mental health is an important part of overall health. VA is committed to providing the highest quality of care possible to our Nation's veterans. Because VA researchers are also clinicians caring for veterans, VA is uniquely positioned to move scientific discoveries from investigators' clinical trials into patient care. This, in fact, is the primary goal of our research program.

Thank you again, Mr. Chairman. Dr. Friedman and I will be pleased to answer questions.

[The prepared statement of Dr. Katz appears on p. 58.]

Mr. HARE. Thank you, Doctor.

Just a couple of questions. In your testimony, you mentioned that if a veteran is reluctant to seek care for post traumatic stress disorder or other mental conditions that you watch over them for a period of time.

What does that exactly mean? Are there follow up appointments to assess the progression of the symptoms? Do you do it by phone calls or how do you watch over these folks?

Dr. KATZ. Yeah. I will respond and also ask Matt for his sense of this.

For those who come to VA, those who are screened and evaluated, some very obviously have PTSD, some very obviously don't. Many people are somewhere in between. If they prefer to be treated, they should be treated. If they are reluctant, we should keep an eye on them. If they get better on their own, terrific. If not, if they remain symptomatic or if their symptoms worsen, we should reapproach them and teach more about the benefits of treatment.

This sort of watchful waiting is a very important part of care, especially for people in the mid range where the doctor does not necessarily know whether or not treatment is necessary the first or second or even the third time we see the patients.

Matt.

Dr. FRIEDMAN. Thank you, Ira.

I think that one of the more important things that is happening with the current war and our attempts to provide treatment for veterans is that we know a lot more what to expect than we did following Vietnam. And, I think as a result of the experience that we have had for the past several decades is we have been able to educate the public. This is really a kind of a preventive public health approach trying to get information out to the veterans, to their families, to the communities, to their employers so that should there be difficulties readjusting and reintegrating, people will know what to look for, what to expect.

As Dr. Hoge emphasized, the expectation is that most people are going to have a few speed bumps along the road to reintegration, but they are going to get past it. I think that is why the watchful waiting that Dr. Katz mentioned is such a reasonable and important approach.

But for those people who do run into trouble, and we know that there is going to be a sizeable minority that either they will know themselves, their families will know, their employers will know, their loved ones will know, and then we can get the information out, where do you go for help. So this is a new development, a very important one.

Mr. HARE. Since there is no particular timetable with a person who has been diagnosed with post traumatic stress disorder, how long do we watch them? I mean, how long should we be, making sure that, we are communicating with them and their families to see that if there is some way we can do intervention because this, as I understand, is something that can manifest itself down the road?

Currently how long are we monitoring them and how long should we monitor them? Should this be an ongoing thing for years or from your perspective, what is the best way, because, as I said, I do not think there is any particular timetable where we can say, well, in 6 months if it is not there, it is just not going to happen?

Dr. KATZ. You are absolutely right. We screen annually for the first 5 years after people are discharged and then every 5 years afterward.

If they are suffering, if there is impairment, we urge treatment sooner. If it is very mild and marginal, deferring to the veteran's preference makes sense as long as the symptoms do not worsen.

Dr. FRIEDMAN. One of the problems or major characteristics of PTSD is that there can be a delayed onset. I mean, Colonel Hoge testified that just in terms of the newly returned veterans, many of people's expression of PTSD symptoms was not apparent at the point of demobilization and did not become apparent until 6 months later.

Well, our experience with Vietnam veterans and some of the research coming out of Israel indicates that the onset may be delayed for many, many years. And so as Dr. Katz said, we need to keep the word out there. We need to keep our partnerships with the veterans services organizations like VVA so that if something happens down the road, they will know what it might be and they will know where to go for help.

Dr. KATZ. At the risk of double teaming you on this and—

Mr. HARE. I am the only one here. That is fine.

Dr. KATZ. One of the findings that has gotten me thinking from Dr. Hoge's work is that half of the people with symptoms apparent on the PDHA assessments were no longer symptomatic by the time the PDHRA came around. So there can be delays in the onset of symptoms, but also there can be offset for symptoms during this time without doubt, many veterans are vulnerable to the delayed onset of PTSD, but in addition, a good deal of resilience is apparent after people return home.

Mr. HARE. My time is up, but I wanted to ask Dr. Friedman one last question before I let you go.

In your experience with PTSD, do you think at some point in the future, the VA will be able, to a certain extent, provide clinical guidelines to help mental health professionals with the VA tailor plans to treat soldiers with PTSD and, if so, what in your opinion are the strongest treatment solutions that have been discovered so far?

Dr. FRIEDMAN. That is a complicated question. Let me chip away at it. You know, first of all, there are VA/DoD practice guidelines based on the best evidence. And as the research continues, and you have heard from many people about this today who have emphasized the importance of the need for new research, and as the new results come in, obviously the practice guidelines will need to be tailored accordingly.

Again, repeating some of the answers that some of the other people have said, I think that there is a tremendous need for new research. We do have, as Dr. Katz and others have emphasized, we have very, very effective cognitive behavioral treatments such as prolonged exposure and cognitive processing therapy.

And Dr. Katz has been very, very visionary in supporting efforts to disseminate these treatments. One of the problems that we have, not just in VA because VA is kind of a microcosm of the Nation in general, there is something wrong with the picture in that the most effective treatments are utilized by a minority of the therapists. So that thanks to Dr. Katz's support, we are now out there training hundreds of VA practitioners in these new treatments so that when people come knocking, we will be able to provide the best treatment

that is available. These are going to be self-sustaining programs and so we will be able to increase the reservoir of qualified people out there.

There is the possibility that there are other psychotherapeutic approaches. There is one approach for treating dually diagnosed people that have both substance abuse and PTSD. One of our national Center for PTSD investigators, Dr. Lisa Nagivitz, has been pushing that and we are doing that both in VA and in the DoD.

As for medications, I think that the results of the IOM report reflect the fact that to date, the medications that are out there have not been designed with PTSD in mind. They are antidepressants that have been retested in PTSD patients and they have had moderate success.

But what is more exciting as I look to the future, as we understand more about the pathophysiology about PTSD, about how brain function is altered as a result of exposure to traumatic stress, that we can look down the road for new and much, much more effective pharmacological agents that will really attack the problem at its core.

Mr. HARE. Let me thank Dr. Katz and Dr. Friedman for coming by this afternoon and to all of our witnesses, let me thank you. This has been a very informative hearing.

At the end of the day, I know that all of us want to do the very best we can to make sure that not just the service person but their families can get some treatment and some relief in this. They have given us everything and that is the bare minimum we can do. I appreciate all of you for being here today. Again, thank you very much.

With that, this hearing is adjourned.

[Whereupon, at 12:15 p.m., the Subcommittee adjourned.]

## A P P E N D I X

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### **Prepared Statement of Hon. Michael H. Michaud Chairman, Subcommittee on Health**

I would like to welcome everyone to our Subcommittee hearing. We are here today to talk about PTSD Treatment and Research in the Department of Veterans Affairs.

Post-traumatic stress disorder is among the most common diagnoses made by the Veterans Health Administration. Of the approximately 300,000 veterans from Operations Enduring and Iraqi Freedom who have accessed VA health care, nearly 20 percent—60,000 veterans—have received a preliminary diagnosis of PTSD. The VA also continues to treat veterans from Vietnam and other conflicts who have PTSD.

With the release of the 2007 IOM report “Treatment of Post Traumatic Stress Disorder: An Assessment of the Evidence”, we learned that we still have much work to do in our understanding of how to best treat PTSD. I hope that my colleagues will continue to work with me in supporting VA’s PTSD research programs.

I look forward to hearing testimony today from several organizations that are working to provide comprehensive and cutting edge treatment to those with PTSD. The committee recognizes that this is an important issue and one that will be with us for a long time to come. We are committed to ensuring that all veterans receive the best treatment possible.

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### **Prepared Statement of Hon. Jeff Miller Ranking Republican Member, Subcommittee on Health**

Thank you, Mr. Chairman.

Following every war in history, what we now call Post Traumatic Stress Disorder or PTSD has sadly affected the lives of many brave men and women who have worn the uniform.

And, this Committee over the years has held numerous hearings to bring to the forefront the emotional toll the trauma of combat can lay on our veterans and the need for us as a Nation to effectively care for those who suffer with military-related PTSD and experience difficulty reintegrating into civilian life.

In response to a Congressional mandate, VA established the National Center for PTSD in 1989. This Center was created to advance the well-being of veterans through research, education and training in the diagnosis and treatment of PTSD. VA has since moved to expand its programs and currently employs over 200 specialized PTSD programs in every health care network. Available care includes cognitive behavioral therapy, which is shown to be a most effective type of treatment for PTSD.

Many service members who develop PTSD can recover with effective treatment. Yet, PTSD it is still the most common mental disorder affecting OIF/OEF veterans seeking VA health care. About 20% of all separated OIF/OEF veterans who have sought VA health care received a PTSD diagnosis. Even more alarming, a recent study conducted by VA shows that young service members between the ages of 18 and 24 are at the highest risk for mental health problems and PTSD, being three times as likely as those over 40 to be diagnosed with PTSD and/or another mental health problem.

Clearly PTSD remains a very prominent injury that our veterans endure and that is precisely why today’s hearing is so crucial. We must continue to focus on how best to strengthen research and rapidly disseminate effective clinical care in all settings so that we can finally understand this illness, break through it and move forward with complete recovery—bringing relief to the many heroic veterans who still fight daily battles no less harrowing than the ones they fought in combat.

On that end, I want to thank our witnesses for being here today to present their expert views on what may cause, and more importantly, preclude PTSD from emerging among our veterans.

Again, thank you, and I yield back.

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**Prepared Statement of Hon. John T. Salazar**

Good morning Chairman Michaud, Ranking Member Miller and distinguished members of this subcommittee.

We are fortunate to have the opportunity to discuss the impact that PTSD is having on our returning troops, veterans and their families.

I look forward to hearing the testimony of the experts that join us today.

I thank them for their dedication to our servicemen and women.

An important part of our discussion today will be to hear about the research on PTSD cases in Vietnam and OEF/OIF soldiers.

It is important to look at these two individually and in comparison to one another.

I also look forward to hearing about the research done on exposure therapy.

Innovative and new treatments are essential to the health of our veterans and our current force.

Our Veterans deserve to know that once they leave the battlefield and return home, we have programs in place to care for them.

Mr. Chairman, I thank you and the members of this committee for giving us the opportunity to discuss construction authorizations.

**Prepared Statement of Colonel Charles W. Hoge, M.D., USA Director  
Division of Psychiatry and Neuroscience,  
Walter Reed Army Institute of Research,  
Department of the Army, U.S. Department of Defense**

Mr. Chairman and Members of the Committee, thank you for this opportunity to discuss the Army's research on Post-Traumatic Stress Disorder (PTSD) at Walter Reed Army Institute of Research (WRAIR). I will focus on research initiatives at WRAIR but want to first acknowledge and thank Congress for the tremendous increase in funding for PTSD and Traumatic Brain Injury (TBI) research. The \$300 million dollars allocated to PTSD and TBI research in the FY07 appropriation is in the process of being awarded to numerous Department of Defense (DoD), Department of Veterans Affairs (VA), and civilian research organizations under the management of the U.S. Army Medical Research and Materiel Command's Office of Congressionally Directed Medical Research Programs (CDMRP).

I would like to briefly discuss the findings of three studies published since my last testimony to this Committee in September 2006, which highlight both the successes and challenges in addressing the mental health needs of our service members.

The first is a study reported this past November in the Journal of the American Medical Association (JAMA) involving nearly 90,000 Soldiers who completed both the post-deployment health assessment (PDHA) and the post-deployment health reassessment (PDHRA) after return from deployment to Iraq. Soldiers completed the PDHA immediately upon their return and they completed the PDHRA six months later. The study confirmed that many mental health concerns do not emerge until several months after return from deployment, highlighting the importance of the timing of the PDHRA, particularly for Reserve Component Soldiers. Twenty percent of Active Component and 42% of Reserve Component Soldiers were identified as needing mental health referral or treatment, most often for PTSD symptoms, depression, or interpersonal conflict. About half of Soldiers with PTSD symptoms identified on the PDHA showed improvement by the time of the PDHRA, often without treatment. However, more than twice as many Soldiers who did not have PTSD symptoms initially became symptomatic during this same period. One counterintuitive finding was that we could not demonstrate any direct relationship between referral or treatment for PTSD as identified on the PDHA and symptom improvement six months later on the PDHRA. The difficulty in demonstrating the effectiveness of the PDHA assessment may reflect, in part, the inherent limitations in screening or the fact that mental health services remain overburdened with the current operational tempo, despite the extensive efforts to bolster services and training. An encouraging finding was that many Soldiers sought care within 30 days of the PDHA and PDHRA even if they were not referred, which suggests these assessments may be encouraging individuals to seek help on their own following discussion of mental health issues with a health professional or participation in concurrent Battlemind education.

The second study I'll discuss is the recently released Mental Health Advisory Team 5 (MHAT-V) report. We have conducted MHAT evaluations every year in Iraq since the start of the war, and twice in Afghanistan. The MHATs have shown that longer deployments, multiple deployments, greater time away from base camps, and combat intensity all contribute to higher rates of PTSD, depression, and marital

problems. The MHAT-V included for the first time a sizable number of Soldiers on their 3rd rotation to Iraq. The study showed that with each deployment there is an increased risk; 27% of Soldiers on their third deployment reported serious combat stress or depression symptoms, compared with 19% on their second, and 12% on their first deployment. The MHAT-V also showed that Soldiers in brigade combat teams deployed to Afghanistan are now experiencing levels of combat exposure and mental health rates equivalent to those experienced by Soldiers deployed to Iraq.

Soldiers encounter a variety of traumatic experiences and stresses as part of their professional duties. The majority cope extraordinarily well and transition home successfully. However, surveys in the post-deployment period have shown that rates of mental health problems, particularly PTSD, remain elevated and even increase during the first 12 months after return home, indicating that 12 months is insufficient time to reset the mental health of Soldiers after a year-plus combat tour. Many of the reactions that we label as “symptoms” of PTSD when Soldiers come home are, in fact, adaptive skills necessary in combat that Soldiers must turn on again when they return for their next deployment.

The 3rd study I’ll discuss is one that we just published in the *New England Journal of Medicine* pertaining to the relationship of PTSD to mild traumatic brain injury (or “mild TBI”). It is important to clarify terminology. Reports have indicated that as many as 20% of troops returning from Iraq and Afghanistan have had traumatic brain injuries, but what is not always made explicit is that the vast majority of these are concussions. “Mild TBI” means exactly the same thing as “concussion,” which athletes or Soldiers also refer to as getting their “bell rung” or being “knocked out.” I advocate using the term “concussion” because it is less stigmatizing than the term “brain injury,” is better understood by Soldiers and Families, and is less likely to be confused with moderate or severe TBI. A concussion is a blow or jolt to the head that causes a brief loss of consciousness or change in consciousness, such as disorientation or confusion. Full recovery is expected, usually within a few hours or days. This is very different from moderate or severe TBI, where there is an obvious injury to the brain that almost always requires evacuation from theater. Although most Soldiers are able to go back to duty quickly after concussions, there has been concern that concussions in combat, particularly from blasts, may have lasting effects that are not immediately visible. Some Soldiers report persistent symptoms (termed “post-concussive symptoms”), such as headaches, irritability, fatigue, dizziness, problems concentrating, sleep disturbance, balance problems, and cognitive or memory difficulties. Our study involving 2,500 infantry Soldiers was one of the first to look at the relationship between concussions Soldiers sustained while deployed to Iraq and these types of physical and mental health outcomes three months after their return.

There were three key conclusions from this study:

First, the study highlighted a problem that we face with not having an accurate diagnostic tool in the post-deployment period. We are not aware of any questionnaire or test that can accurately tell us who had a concussion while deployed, or which symptoms were caused by a concussion that occurred months earlier, as we are attempting to do with post-deployment screening. In our study sample, 15% of Soldiers reported a concussion while deployed based on the questions currently being used on the post-deployment assessment forms. However, only one-third of these, or 5% of the Soldiers, reported an injury in which they were knocked unconscious, usually for just a few seconds or minutes. The rest had injuries that only involved being briefly “dazed or confused” without loss of consciousness, and it was not clear how many of these were true concussions. We found that this type of injury did not confer much excess risk of adverse health effects after redeployment.

The second important finding was that having a concussion was strongly associated with PTSD. Forty-four percent of Soldiers who lost consciousness met the criteria for PTSD, compared with 16% of those who had other types of injuries and 9% who had no injury.

Third, and the most important finding, was that the symptoms that we thought were due to the concussions were actually attributed to PTSD or depression. If a concussion was the cause of the post-concussive symptoms we should have been able to confirm an association of these symptoms with a concussion, both in those Soldiers who had PTSD and in the larger group of Soldiers who did not. We did not see this in either group. Instead, all the physical health outcomes and symptoms were associated with PTSD or depression. Both PTSD and depression are biological disorders that are associated with a host of chemical changes in the body’s hormonal system, immune system, and autonomic nervous system. Many studies have shown that PTSD and depression are linked to physical health symptoms, including all of the symptoms in the “post-concussion” category, to include cognitive and memory problems.



This study allowed us to refine our knowledge about what distinguishes concussions in combat from concussions in other settings. Concussions on the football field, for example, are not known to be associated with PTSD. It is possible that there is an additive effect in the brain when a soldier who is already seriously stressed in combat sustains a blow to the head, or there may be something unique about blast exposure, as many people are speculating. However, a hypothesis that is better supported by our data as well as other medical literature is the life threatening context in which the concussion occurs. Being knocked unconscious from a blast during combat is about as close a call as one can get to losing one's life. There are frequently other traumatic events that occur at the same time, such as a team member being seriously injured or killed, all of which can precipitate PTSD or depression.

The most important implication of this study is that current post-deployment TBI screening efforts may lead to a large number of service members being mislabeled as "brain injured" when there are other reasons for their symptoms that require different treatment. The optimal time to evaluate and treat concussion is at the time of injury, and it is my opinion that post-deployment screening efforts months after injury may actually lead to unintended harmful effects. As a result, my research group has provided recommendations to medical leaders at Army and DoD to refine the post-deployment screening efforts to assure that all health concerns are addressed in a way that minimizes potential risks. These recommendations are now under consideration. In addition to screening and treatment, our study has important implications for educating Soldiers and Families about mild TBI (i.e. concussion).

Thank you so much for your attention and I look forward to your questions.

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**Prepared Statement of Carolyn M. Baum, Ph.D., OTR/L, FAOTA  
Immediate Past President, American Occupational Therapy Association, and  
Professor, Occupational Therapy and Neurology,  
Elias Michael Director of the Program in Occupational Therapy,  
Washington University School of Medicine, St. Louis, MO**

Mr. Chairman and Members of the Subcommittee, thank you for giving the American Occupational Therapy Association (AOTA) the opportunity to testify before the Subcommittee to address the challenges of providing optimal identification and treatment of Post Traumatic Stress Disorder (PTSD). My name is Dr. Carolyn Baum. I am the immediate past President of AOTA. I am also a professor of occupational therapy and neurology and the Elias Michael Director of the Program of Occupational Therapy at the Washington University School of Medicine in St. Louis, Missouri.

**AOTA and the Profession of Occupational Therapy**

AOTA and I are grateful to the Chairman and Members of the Subcommittee for your leadership in addressing the healthcare needs of the approximately 8 million veterans enrolled in the U.S. Department of Veterans Affairs (VA) health care delivery system. As the professional association representing occupational therapy, AOTA has more than 38,000 members dedicated to providing the health care and rehabilitative services that help people recover and gain the skills needed to return to family, work and community life.

The goal of occupational therapy is to enable individuals with functional impairments, regardless of the cause, to attain their maximum level of participation and independence. With injured veterans, this can mean helping the veteran learn how to manage activities necessary for maintaining a household—everything from cooking and washing laundry to handling financial affairs; it can mean learning to manage medications; it can mean coping with triggers to prevent anxiety or anger and learning strategies to manage the health conditions associated with their injuries. Occupational therapists help wounded warriors return to their military roles and responsibilities or transition into civilian life; we do this by helping them to develop or regain the skills and strategies that allow them to be successful in all areas of their lives.

Our purpose in this statement is to share the unique role that occupational therapy plays in helping veterans recover from Post Traumatic Stress Disorder (PTSD). We also want to provide recommendations for improving the system of care for this all-too-common disorder among our veterans. This is particularly true in today's environment as many of the returning veterans from Iraq and Afghanistan have sustained serious injuries and been exposed to operational conditions that make PTSD a natural reaction to these extraordinary stresses. While immediate focus is nec-

essary on veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), it must also be noted that the effects of PTSD, if unidentified and untreated, can be delayed and can impact people many years after the trauma took place. Experience with WWII veterans reaching the age of retirement and their increasing identification and struggle with PTSD raises a flag of caution for Korean war and Vietnam veterans. The importance of followup screenings to identify individuals who are living with delayed-onset PTSD can't be overemphasized. This need alone provides a strong argument for the full use of occupational therapists for the ongoing assessment of PTSD signs and symptoms for all those who may be affected.

Mr. Chairman, we at the American Occupational Therapy Association are aware that the conflicts in Iraq and Afghanistan continue to increase the Veteran Administration's patient workload. From consultation with our members within the VA, we have heard that they are struggling to maintain the quality care for which they are known as a result of the increased demand for rehabilitation services. Of concern to AOTA and our members is the need for an increased focus on rehabilitation that will meet the needs of the veteran as he or she faces serious problems that require comprehensive rehabilitation services. There must be a continuum of rehabilitation in hospitals, outpatient clinics, and community rehabilitation centers. Because of the severity of their injuries and conditions, many injured veterans need rehabilitation in their home environment, in order to assess the modifications needed for them to be functional in their homes. Many who are in wheelchairs need an occupational therapist's help to work with building contractors to design and build an accessible route into and out of their homes. Rehabilitation does not stop when veterans are discharged from hospital or medical care; the process continues with post-rehabilitation fitness, community reintegration, social reconnection and work accommodations. All of these are areas in which occupational therapists play an important role.

Occupational therapy rehabilitation can be viewed developmentally and includes four phases: biomedical, client-centered, community-based and independent living. All four phases of rehabilitation may be necessary, as recovery occurs across time. The focus moves from medical treatment to assistance with recovery, to helping people achieve their goals and finally to helping them return to their roles in service, in families and communities, and learn to live with a disabling condition. To determine the specific rehabilitative needs of each veteran, it is necessary to conduct a multidimensional assessment of the person, of the environment and the occupational needs of the individual, to choose the most effective approach (Christiansen, Baum, 2005).

The effective treatment of PTSD and the return of veterans back into their family and community life requires an integrated system of care that includes assessment, goal setting, treatment, and learning to "self-manage" life after injury.

### **The Role of Occupational Therapy in PTSD Treatment**

Occupational therapy is probably best known for the rehabilitation of individuals after illness or injury, for example, stroke, loss of vision, traumatic brain injuries (TBI), and physical burns, wounds, and amputations. However, occupational therapists treat individuals with functional impairment regardless of the specific cause and go beyond the range of physical injury or illness to include the mental and cognitive impairments that can cause disabling conditions. (Gerardi, Newton, 2004).

Occupational therapy's approach to addressing health needs stems from a body of knowledge that is translated from neuroscience, occupational science and environmental science and from evidence-based interventions that recognize the importance of engagement in life and activities in maintaining and restoring health. Occupational therapists and occupational therapy assistants use a body of knowledge and evidence-based interventions that identify the causes of difficulties that are limiting participation. In the case of veterans, these are obstacles that limit their ability to reintegrate into military or civilian life.

In brief, occupational therapy is based on the following evidence-based constructs: (1) Health is linked to engagement in occupation (Haapanen et al, 1996; 1997; Blair & Connelly, 1996; Samitz, 1998, Dorn et al, 1999 and Pennedo & Dahm, 2005). (2) A healthful, balanced lifestyle is maintained by habits developed and sustained from engagement in daily occupations (Wilcock, 1998). (3) Lack of occupation leads to physiological deterioration and the loss of ability to perform competently in daily life (Kielhofner, 1992). (4) People need to make use of their capacities through engagement in individually motivating and ongoing occupations, and if they pursue this need, they will, enhance their health (Wilcock, 1993).

Occupational therapy uses a client-centered approach to rehabilitation that differs from traditional biomedical therapies. The approach and expertise of occupational therapy practitioners enables them to consider the client's needs, the environmental

factors and the family concerns to help the veteran develop and implement effective strategies to overcome disability and maximize quality of life. In client-centered rehabilitation, the strengths and desires of the patient are significant tools for recovery and the therapist is engaged by the veteran to assist them with the achievement of personal goals that will help them return to family, work and community life (Christiansen, Baum, 2005).

The unique perspective of occupational therapy is highly prized by the Army for combat and operational stress control and that model should inform the use of occupational therapy within the VA. AOTA understands the variations in the nature of combat stress and the deeper aspects of PTSD, but the Army model deserves additional attention from the VA and the Subcommittee because occupational therapy brings a third dimension to the system of care commonly employed for PTSD treatment within the VA. Pharmaceutical intervention and counseling are essential aspects of PTSD treatment but they do not use therapeutic activity nor focus as specifically as occupational therapy does on the reduction of functional impairment and the maximization of function and performance. Medication, counseling, and engagement and participation in social and therapeutic activities are all critical tools in helping veterans to recover from PTSD.

Veterans with PTSD have difficulty performing their daily life roles and activities because they reexperience events, and avoid certain activities because they are numbing and/or result in a state of hyperarousal, anxiety or even anger. Consider for example, a soldier who is driving on routine patrol and when a roadside bomb explodes under the vehicle. The soldier might experience a life-threatening injury, or witness the death of a unit member in the vehicle. Upon returning stateside, the individual with PTSD might experience disturbing flashbacks of the event triggered simply by getting behind the wheel of a car, or by driving in general. The individual might then avoid driving altogether, creating a negative spiral that affects his or her ability to engage in important activities involving everything from employment to community and social participation. But occupational therapy can help.

A study by Erica Stern, at the University of Minnesota, compared the driving behaviors and driving related anxiety of 150 soldiers who had returned from OIF to 49 soldiers who had not been deployed. Returned soldiers' reporting on their past 30 days of American driving, reported significantly worse driving behaviors (with a large percentage of OIF soldiers reporting that they sometimes or always fell into combat driving behaviors, e.g., drove through stop signs (25%), drove in the middle of the road or into oncoming traffic (23%), drove erratically in a tunnel (11%), made turns or lane changes without signaling (35%). Nearly a third of the group had been told that they drove dangerously. These soldiers were a general sample, without known PTSD, yet in addition to their slips into combat driving behaviors, they also reported significantly more frequent anxiety than their non-deployed comrades. Twenty percent were anxious when driving at any time, with larger numbers being anxious in specific civilian driving situations that mimic combat threats associated with driving, e.g., when driving near roadside debris (31%), near parked cars (25%), through tunnels/underpasses (19%), in slow or stopped traffic (41%), at night (28%), and when passed by other cars (31%), or another car approached quickly or boxed them in (49%). These soldiers were a convenience sample without known PTSD or head injury. When we hear how their driving is effected, we can easily understand the ways that driving and other daily activities are likely to be changed in soldiers with PTSD.

An occupational therapist would work with the veteran to address the functional impairment caused by the PTSD symptoms. The therapist might use simulated or virtual reality driving experiences in a safe and controlled environment in order to help the veteran extinguish or reframe negative mental or physical reactions.

Overall, an occupational therapist would help the veteran with PTSD through a graduated series of desensitization experiences *within the context of daily activities*. This is done by grading the individual's reactions to traumatic associations at baseline, and a variety of techniques (i.e., relaxation exercises, guided imagery and visualization) to counteract and reduce the reaction to disturbing thoughts and images. Strengthening a person's general coping skills can be addressed by identifying the activities and behavior associated with positive outcomes. Therapists also work with veterans with PTSD to engage in activities that will help them manage or ameliorate depressive symptoms and/or excessive anxiety, and address issues of substance abuse.

For a person with PTSD, occupational therapists might address issues of cognitive executive function, such as memory, planning or organizational skills, that are limiting the individual's performance. They address this by using cognitive behavioral strategies and assist the individual with learning and developing compensatory strategies to improve performance and maximize independence. Another approach

used by occupational therapists in task analysis; breaking down complex tasks into manageable parts. This strategy can be effective with activities as basic as bathing and dressing to something as complex as balancing a checkbook or even returning to a particular job.

Such an approach is important for the treatment of PTSD as the person must not only address the issues they experience during acute episodes, but they must also learn strategies to use at a later time when they have recurrent episodes. It is also important to include the families in this process as they can be instrumental in the recognition of problems that require professional attention. They also need to understand what their loved one is experiencing. Occupational therapy's unique approach is to work with the person in regard to the interaction of all aspects of their life and environment.

### **Occupational Therapy in the Veterans Administration**

The VA has made significant strides in preparing to meet the needs of returning OIF/OEF veterans but work remains to be done. AOTA urges Congress to continue to monitor how the VA uses occupational therapists and other professionals to assure that quality care is provided and that the full scopes of practice of all professions are brought to bear to meet veterans' needs. Veterans deserve every service and intervention that professionals have been trained to provide. But they should receive services only from qualified professionals.

Throughout the VA system, but particularly within the Polytrauma Rehabilitation Centers, there should be a special focus on appropriate training and on evidence-based practice. Monitoring how each profession is integrated into the team should be done to provide for continuous quality improvement in these facilities.

Additionally, AOTA is concerned about the fragmented way the VA integrates or more problematically, does not integrate occupational therapists and other professionals into multidisciplinary teams for assessment and treatment of PTSD. While VA and Department of Defense (DoD) treatment guidelines for PTSD exist and include occupational therapy, it is the experience of our members that the inclusion of occupational therapists varies from site to site. This variation does not ensure full access to effective treatments and AOTA encourages the Committee to look at this issue in detail. It is also our concern that because of the primary role occupational therapy plays in the assessment and treatment of other conditions like TBI, low-vision and traumatic amputations, veterans with PTSD are not getting the access to occupational therapy they need. Occupational therapists are simply not as readily available as they need to be to address PTSD because their workload is so high in other areas. Additional therapists are needed to address PTSD because the unique, activity-based focus of occupational therapy is so critical to recovery from PTSD, particularly during the community reintegration phase of recovery.

It is possible for the private sector to supplement the Veterans Administration. Occupational therapists at Washington University School of Medicine in St. Louis are currently contracted to provide services with three of our community based programs. Veterans referred to us are evaluated by the *Community Practice Program* in their home to determine the issues that may be limiting their ability to care for themselves or others, get in and out of their homes if they are using mobility devices; and to determine if their home arrangements support them in daily tasks like toileting, bathing, preparing meals and maintaining the household. Their needs and goals are determined based on real life needs. If they have unmet mobility or work needs they are referred to either the *Washington University Enabling Mobility Center* (EMC) where they are evaluated and receive mobility and other equipment that will maximize their independence. If needed, they begin a program of post rehabilitation fitness (similar to what is provided at the Intrepid Center at Fort Sam Houston). It is in the fitness program where the veteran can re-build their strength and endurance while socializing with other persons with mobility limitations on equipment designed for people in wheelchairs. If the veteran has a cognitive impairment and needs additional rehabilitation to be able to work or return to school they are referred to our *Occupational Performance Center* (OPC) where they learn strategies to perform work tasks and are assisted in maximizing their work potential using both simulated and then actual work tasks. The OPC team works with employers to create the right environmental fit to use the capacities of the worker. In this program people have gone back to complex jobs like nursing, teaching and the law in addition to trade jobs.

### *Considerations for the Committee's Attention*

1. In order to increase the numbers of occupational therapists within the VA, AOTA urges the Subcommittee to *consider expanding loan repayment programs to ensure that the VA remains an attractive employment option.* This is particu-

larly important because salaries in the VA do not tend to be as high as salaries in other healthcare settings. The Bureau of Labor Statistics (BLS) estimated that in 2006, the last year for which data is available, the average salary for an occupational therapist was \$62,510. This month, there are two positions at the Palo Alto Polytrauma Rehabilitation Center that are offering \$50,599 and have been open since last July 2007. This variation in salary and subsequent inability to fill the positions is troubling. It is even more alarming when placed in the context of California salaries for occupational therapists for 2006, which averaged \$73,120. That represents a more than \$20,000 salary gap between what is being offered by the VA for a highly complex position treating veterans with polytrauma compared to the statewide average salary. To add to our concern Mr. Chairman, there are additional occupational therapy and rehabilitation positions that were recently posted at that facility as well. The need is not being met by these salary differentials.

2. The BLS data indicates that occupational therapists and occupational therapy assistants are two of the fastest growing professions, with a projected 33% increase in overall positions by 2017. *AOTA urges the Subcommittee and the VA to vigilantly attend to recruitment and retention issues as the market for therapists becomes increasingly competitive.*
3. *AOTA encourages the VA to conduct a thorough, system-wide salary survey to ensure that the VA remains competitive and able to attract the quality, experienced staff necessary to ensure the best care for our veterans.* Sites like the four Polytrauma Rehabilitation Centers and the 17 Polytrauma Network sites require the highest quality staff with significant training and experience in treating veterans with multiple injuries and illnesses, often including PTSD. In hearing from our members from the Polytrauma Network and from others across the country, continuing education is an area that requires additional attention. This is particularly true in relation to the most severely injured veterans where expertise in multiple areas of practice is necessary. Veterans deserve best practices based on current research and evidence.
4. In discussions with the VA National Office, AOTA has offered to work with the VA to develop and implement training modules related to some of the areas of greatest need. This training would be developed with civilian and VA participants to benefit from their collective knowledge, experience and expertise. AOTA is ready to collaborate again with the VA, as we have in the past and we urge the VA to partner with AOTA to help meet the continuing education needs of occupational therapists and occupational therapy assistants within the VA.
5. AOTA encourages the Committee to hold a hearing on rehabilitation and reintegration of veterans and invite participation of the national associations, like AOTA, that represent the professions most involved in these phases of recovery in the VA. Such a panel would address best practices, multidisciplinary communication and service coordination to ensure veterans receive the highest quality and most efficient care. The hearing would inform the Subcommittee on the way various professionals are being used by the VA to meet veterans' needs and provide suggestions for improvement and enhancement of current systems of care.
6. Finally, I would like to address the importance of coordination between the VA and the Department of Defense (DoD) in regard to the transition from active duty to veteran status. It is essential that the VA and DoD ensure continuity of care for all veterans, but especially for those with PTSD and TBI. While the roles and responsibilities of each organization are different, the service member does not process the immediate transformation of their change in status as quickly as the paperwork is done. For service members becoming veterans because of injuries sustained on active duty, the transition can be overwhelming. The Army and other services have established Warrior Transition or similar units to allow recovering soldiers to engage in treatment in familiar circumstances and surroundings. During this stage, VA rehabilitation counselors can meet with soldiers to help create a continuous transition. These counselors often collaborate with the occupational therapists caring for the soldiers in the Warrior Transition units. This is particularly relevant to PTSD because of the prominent role occupational therapists play in Army Combat Stress Control units.

Mr. Chairman, in conclusion I want to reiterate that occupational therapy has expertise in the treatment of functional impairment resulting from a broad range of conditions faced by veterans and should be explicitly included in systems of care or treatment teams established to treat veterans and their families during the acute stages of recovery through the rehabilitation and community reintegration phases.

It is the unique treatment focus contributed by occupational therapy—not the replacement of other services—that can help veterans regain control of their anxiety and their future so that they can return to relationships and activities of meaning and purpose in their lives.

Roughly 750 occupational therapists are currently employed by the VA, but many more will be necessary to meet the needs of the new generation of veterans. Occupational therapy allows veterans with PTSD to return to activities of meaning that deliver a sense of normalcy and belonging to veterans and their families.

Thank you for the opportunity to provide testimony to the Subcommittee. AOTA looks forward to working with Congress and the VA to ensure that the profession of occupational therapy is doing everything in its power to meet the needs of our veterans. Mr. Chairman, I would be happy to answer any questions you or the Subcommittee might have. Thank you.

- Blair, S.N., and Connelly, J.C. (1996). How much physical activity should we do? The case for moderate amounts and intensities of physical activity. *Research Quarterly for Exercise and Sport*, 67 (2), 193–295.
- Christianson, C.H. and Baum, C.M. (Eds.) *Occupational Therapy: Performance, Participation, and Well-Being*, Third Edition. Thorofare, NJ: SLACK 2005.
- Haapanen, N., Miilunpalo, S., Vuori, I., Oja, P., Pasanen, M. (1996). Characteristics of leisure time physical activity associated with decreased risk of premature all-cause and cardiovascular disease mortality in middle-aged men. *American Journal of Epidemiology*, 143: (9), 870–880.
- Haapanen, N., Miilunpalo, S., Vuori, I., Oja, P., Pasanen, M. (1997). Association of leisure time physical activity with the risk of coronary heart disease, hypertension, and diabetes in middle-aged men and women. *International Journal of Epidemiology*, 26 (4), 739–747.
- Gerardi, S. and Newton, S. (2004). The role of the occupational therapist in csc operations. *Army Medical Department Journal*. PB 8–04–7/8/9 Jul/Aug/Sep.
- Kielhofner, G. (1992). *Conceptual foundations of occupational therapy*. Philadelphia: F.A. Davis.
- Kramer, A.F., Bherer, L., Colcombe, S.J., Dong, W., & Greenough, W.T. (2004). Environmental influences on cognitive and brain plasticity during aging. *Journal of Gerontology: Medical Sciences*, 59A(9), 940–957.
- Peneddo, F.J. & Dahn, R. (2005). Exercise and well-being: a review of mental and physical health benefits associated with physical activity. *Current Opinion in Psychiatry*, 18: 189–193.
- Samitz, G. (1998) Physical activity to decrease cardiovascular and all-cause mortality. A public health perspective. *Weiner Klinische Wochenschrift*, 110 (17), 589–596.
- Wilcock, A. (1998). Reflections on doing, being and becoming. *Canadian Journal of Occupational Therapy*, 65(5), 248–256.
- Wilcock, A. (1993). A theory of the human need for occupation. *Occupational Science: Australia*, 1(1), 17–24.
- World Health Organisation (2001). Introduction to the ICDH-2: The International Classification of Functioning and Disability. <http://www.who.int/icidh/>.
- Zimmer, Z. Hickey, T., and Searle, M.S. (1995). Activity participation and well-being among older people with arthritis. *The Gerontologist*, 35, 463–471.

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**Prepared Statement of David Matchar, M.D.  
Member, Committee on Treatment of Posttraumatic Stress Disorder,  
Board on Population Health and Public Health Practice,  
Institute of Medicine, The National Academies, and  
Director and Professor of Medicine, Center for Clinical Health  
Policy Research, Duke University Medical Center, Durham, NC**

Good morning, Mr. Chairman and members of the Committee. My name is David Matchar. I am Director and Professor of Medicine at the Center for Clinical Health Policy Research at Duke University Medical Center and served as a member of the Institute of Medicine committee which produced the report *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence*.<sup>1</sup> The Institute of Medicine was chartered in 1970 as a component of the National Academy of

<sup>1</sup>The report may be viewed on the Web site of the National Academies Press: [http://www.nap.edu/catalog.php?record\\_id=11955](http://www.nap.edu/catalog.php?record_id=11955).

Sciences. This study was sponsored by the Department of Veterans Affairs as part of an ongoing series of reports on the health of veterans.

The Department of Veterans Affairs charged the Institute of Medicine committee with several specific tasks. We were asked to: (1) review the evidence and make conclusions regarding the efficacy of available treatment modalities; (2) note restrictions of the conclusions to certain populations; (3) answer questions related to treatment goals, timing and length; (4) note areas where evidence is limited by insufficient research attention or poorly conducted studies; and (5) comment on gaps and future research.

To respond to its first task, making conclusions regarding efficacy, the committee developed methods using generally accepted international standards for conducting a systematic qualitative review. This included developing key questions, specifying the literature search strategy, inclusion and exclusion criteria, key quality criteria (such as assessor blinding or independence, and treatment of missing data), and judging the weight of the body of evidence. The committee's conclusions were ultimately based on its judgments of the sufficiency of the body of evidence for each category or class of treatment. Here, I should make an important distinction between what the committee did, which was to evaluate the evidence, and clinical practice guidelines. The committee was not asked to recommend what therapies clinicians should use or not use. Making such recommendations is the work of professional associations (such as the American Psychiatric Association) and guidelines are also developed by government agencies such as the VA. Clinical practice guidelines have different purposes and frequently include a very broad range of considerations.

The committee focused its review on randomized controlled trials (RCTs) because their design is most bias resistant to answer questions of efficacy, and because the statement of task asked that we review the highest level of evidence available, which was RCTs in most cases. Application of the committee's inclusion criteria (such as, studies that were published in English, were based on Diagnostic and Statistical Manual criteria, and included a PTSD outcome measure) narrowed the list of nearly 2,800 articles down to 89 RCTs, 37 studies of treatment with medications, and 52 studies of treatment with psychotherapy. Among the medication studies, the committee found studies of drugs such as selective serotonin reuptake inhibitors (SSRIs) and anticonvulsants.

The evidence on pharmacotherapy in general was limited, with relatively few studies meeting inclusion criteria and free of significant methodological limitations. Even among the SSRIs, with the most substantial evidence base, the committee was struck by inconsistencies in the results of studies, and serious methodologic limitations. The committee found the evidence for SSRIs (and all other drug classes for which RCTs were identified) inadequate to conclude efficacy. The report provides comments on several of the drug classes indicating areas where evidence might be suggestive in important subgroups.

The committee grouped the psychotherapy studies empirically into categories as actually examined in the literature, and did not attempt to enter the debates in the field about how the various therapies may be related at the level of theory. Among the psychotherapies, the committee identified studies where the therapy being investigated was exposure therapies alone or in combination with another component, cognitive restructuring, one or more types of coping skills training, Eye Movement Desensitization and Reprocessing (EMDR), other psychotherapy, and group format therapy. (The term exposure therapies refers to a family of therapies that include confronting the trauma-related memories or stimuli.)

The committee judged the evidence for exposure therapy sufficient to conclude efficacy. The evidence for all but one of the remaining psychotherapy categories (including the broad "group therapy" category) was inadequate to conclude efficacy. The evidence on other psychotherapies, such as hypnosis and brief eclectic psychotherapy was so limited that the committee did not form conclusions at all.

The committee's conclusions of inadequacy regarding evidence for most treatment modalities should not be misinterpreted as if they are clinical practice guidelines. Finding that the evidence is inadequate is not a determination that the treatment does not work. It is an honorable conclusion of scientific neutrality. The committee recognizes that clinical treatment decisions must be made every day based on many other factors and considerations, such as patient preference, availability, ethical issues, and clinical experience, that we were not asked to address, and we did not.

Next, the committee considered the issue of whether conclusions may be drawn about treatment efficacy in regard to population, provider, or setting. The committee was struck by the lack of evidence on this important issue. The Diagnostic and Statistical Manual criteria do not recognize more than one type of PTSD (such PTSD distinguished by trauma type), yet reasonable people might question whether all

PTSD is the same and whether one can expect a treatment shown effective in one group, for example earthquake survivors, to also work for U.S. combat veterans. Rigorously speaking, a study only applies to the population actually studied unless there are data showing the data applies to other groups. We found no evidence either that PTSD is the same or that it's different in veteran or VA populations compared with civilian populations. A minority opinion in the report was based on the belief that there are subgroups and the evidence should be examined separately for them, but the committee majority concluded otherwise.

VA asked the committee to comment on what the literature tells us about the meaning of recovery, the effect of early intervention, and the impact of treatment length (e.g., brief vs. prolonged therapy). The committee found no generally accepted and used definition of recovery in PTSD. We recommend that clinicians and researchers work toward common outcome measure that are valid in research, allow comparability between studies, and are useful to clinicians.

We interpreted early intervention to mean keeping cases of PTSD from becoming chronic. Intervention before the diagnosis of PTSD or before the possibility of meeting the definition of PTSD (generally, early intervention in the literature occurs immediately post-trauma, referring to a condition that's a precursor to PTSD, such as Acute Stress Disorder) was not part of our scope, because it refers to people who do not yet have or may never develop PTSD. We could not reach a conclusion on the value of early intervention, and recommended that further research specify time since trauma and duration of PTSD diagnosis. Interventions should be tested for efficacy at clinically meaningful intervals.

On length of treatment the committee found that the research varied widely in length of treatment even for a single modality, and was not able to reach a general conclusion. We recommend that trials focus on optimal length of given treatments, and that trials of comparative effectiveness between treatments should follow. There is also a need for longer term followup studies after treatment concludes.

Our last two tasks were to address areas inadequately studied and recommendations for further research. Our overall message here is that PTSD needs more attention from high-quality research, including in veterans. The committee highlighted several research-related issues in the report, including internal validity (for example, was there blinding in the study, was there adequate followup of patients, were missing data handled with appropriate analyses?), investigator independence, and special populations.

As outlined in our methods and in a technical appendix, the committee found much of the research on PTSD to have major limitations when judged against contemporary standards in conducting randomized controlled trials. While recognizing that PTSD research perhaps presents special challenges, we know that high quality studies are possible because we found them in our search, and there are authorities in the field of PTSD research who have called for more attention to methodologic quality. We recommend that funders of PTSD research take steps to insure that investigators use methods to improve the internal validity of research.

The committee also noted that the majority of drug studies have been funded by the pharmaceutical manufacturers, and the majority of psychotherapy studies have been conducted by the individuals who developed the techniques or their close collaborators. The committee recommends that a broad range of investigators be supported to conduct replication and confirmation studies.

The committee recognized that PTSD is usually associated with other problems such as comorbid substance abuse, depression, and other anxiety disorders. More recently, there's been growing concern about people with PTSD and traumatic brain injury. The research literature is not informative on this issue of patients who have PTSD and other disorders. It also does not address PTSD in special veteran populations such as ethnic and cultural minorities, women, and people with physical impairments. We recommend that the most important such subpopulations be defined to design research around interventions tailored to their special needs.

Finally, the committee made two general recommendations about research in veterans. First, the committee found that research on veterans with PTSD is inadequate to answer questions about interventions, settings, and length of treatment. We recommend that Congress require and ensure that resources are available to fund quality research on the treatment of veterans with PTSD, with involvement of all relevant stakeholders. Second, the committee found that the available research is not focused on actual practice. We recommend that the VA take an active leadership role in identifying the high impact studies that will most efficiently provide clinically useful information.

In closing, I would like to highlight the three key messages of this report.



1. Many of the studies that have looked into the effectiveness of PTSD therapies have methodological flaws and therefore do not provide a clear picture of what works and what does not work.
2. Various pharmaceuticals and psychotherapies may or may not be effective in helping patients with PTSD; we simply do not know in the absence of good data in most cases. To strengthen study quality, we need: larger studies, longer and more complete followup of all participants (including those who discontinue treatment before the study is over), and better selection of which treatments to study and which to compare to each other, with priority given to the most widely used therapies. Also, greater focus on veteran populations and special subpopulations (e.g. those with traumatic brain injury, substance abuse).
3. Given the growing number of veterans with PTSD and the seriousness of this disorder, the VA, Congress, and the research community urgently need to take steps to ensure that the right studies are undertaken to yield scientifically valid and generally applicable data that would help clinicians most effectively treat PTSD sufferers.

The committee is grateful to have had the opportunity to be of assistance to VA, and hopes that the department and Congress find the report useful in moving ahead to strengthen PTSD research.

Thank you for the opportunity to testify. I would be happy to address any questions the Committee might have.

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**Prepared Statement of Mark D. Wiederhold, M.D., Ph.D.,  
FACP President, Virtual Reality Medical Center, San Diego, CA**

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss a new and innovative technology, currently undergoing testing in Veterans Administration and Navy facilities, that has promise to speed and improve effectiveness of PTSD treatment. We thank the Committee and you, Chairman Michaud, for your active interest in PTSD research.

My company the Virtual Reality Medical Center is currently testing virtual reality therapy to treat PTSD in 5 VA hospitals with requests from 6 additional facilities for the technology. We have been treating patients with VR therapy for the past 12 years, and have an overall success rate of 92%. This is defined as a reduction in symptoms, improved work performance or the successful completion of a task which was previously impossible. Our centers and clinics have treated more patients with VR therapy than any other center in the world.

The technology that my company and others have been studying is virtual reality, or VR, exposure therapy for PTSD. The research protocol works by allowing the therapist to gradually expose the combat veteran to distressing stimuli in the virtual scenarios, while teaching the study participant to regulate breathing and physiological arousal. After a number of sessions, the "fight or flight" response to distressing stimuli is extinguished. Use of the virtual reality technology, helps veterans of the current engagement to overcome the reluctance they have in coming forward for help. Virtual Baghdad (which is shown in exhibit A) is a realistic environment, consisting of a single "map" that allows the user to navigate seamlessly through a suite of different but thematically connected virtual scenarios. "I can see myself in the village or the marketplace," said one of the Navy corpsman who participated in our study.

Virtual reality exposure therapy as an investigative treatment modality for PTSD has been in existence for about 10 years. It has been used successfully with Vietnam era veterans and with survivors of traumatic events such as motor vehicle accidents, Earthquakes, bus bombings, and 9/11.

A panel of academic and government experts has published a consensus opinion that exposure therapy is the most appropriate therapy for PTSD. But traditional exposure therapy requires that veterans relive the experience in imagination, which is what they are trying to avoid. When our clinician informed a study participant that he wouldn't have to relive his experiences every session, he said, "I sure hope not." One advantage of virtual reality is that it helps make it safe for the veteran to engage emotionally, thus allowing the fear structure to be accessed and the abnormal response to be extinguished.

Current research funded by the Office of Naval Research is focused on determining the optimal treatment protocol for Iraqi war veterans with different comorbidities. For example, those with mild traumatic brain injury and PTSD may require more treatment sessions than those with mild depression and PTSD. Results

to date show that the virtual reality protocol is successful in decreasing symptoms of PTSD, depression, and anxiety. Study investigators are currently conducting 3-month followup visits to ensure that the treatment is lasting. Investigators are also performing periodic physiological assessments to help design a study that would construct a profile of veterans who might do especially well with VR technology. One of my company's systems is in Iraq right now and could be used in such research. In fact we have received strong interest from the Navy in advancing research in just this context.

However we are here to speak about our experience and success with the VA and to leave you with three additional uses of advanced technology which could significantly help improve the lives of veterans with PTSD.

First, it is important to correlate the progress of VR therapy not only with psychophysiology, but also with brain imaging. In collaboration with other researchers, we have postulated that there may exist an "fMRI signature" or functional brain imaging signature for PTSD, the discovery of which could lead to more targeted treatment.

Second, VR can be used, both alone and in combination with neuroprotective agents such as antioxidants, to conduct stress inoculation training pre-deployment. It is important to track how well both technologies work to avert PTSD.

Third, VR may be an important piece of the puzzle as tools are developed that can assess and treat the many comorbid conditions that accompany PTSD. For example, VR can be useful both in cognitive rehabilitation for TBI and in physical rehabilitation for veterans with amputations.

Mr. Chairman, I thank you for the opportunity to present this important technology today. I would be pleased at this time to answer any questions you may have.

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**Prepared Statement of Thomas J. Berger, Ph.D.,  
Chair, National PTSD and Substance Abuse Committee,  
Vietnam Veterans of America**

Mr. Chairman, Ranking Member Miller, Distinguished Members of this Subcommittee, and guests, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on "PTSD Treatment and Research: Moving Ahead Toward Recovery." VVA also thanks this Subcommittee for its concern about the mental healthcare of our troops and veterans, and your leadership in holding this hearing today.

However, 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 wartime experiences. To be sure, there have been some attempts by the military services to address combat stress at pre-deployment through such cognitive awareness programs as "Battle Mind" and the use of innovative "combat stress teams". Yet no one can really say how serious an individual soldier's emotional and mental problems will become after actual combat exposure, or how chronic both the neuro-psychiatric wounds (e.g., PTSD and TBI) may become, or the resulting impact that these wounds will have on their physiological health and their general psycho-social readjustment to life away from the battle zone. VVA would like to ask if the armed services have developed any combat stress resiliency models and if so, what is their efficacy and by what measures?

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. 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 speculation 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, and our troops are seeing both more and longer deployments. 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, unemploy-

ment & underemployment, homelessness, incarceration, medical co-morbidities such as cardiovascular diseases, and suicide.

Upon separation from active military service, our male (and increasingly) female veterans face yet other obstacles in the search for mental health treatment and recovery programs, particularly within the VA healthcare system. In spite of the infusion of unprecedented funding, the addition of new Vet Centers and community-based facilities (i.e., CBOCs), and the VA's efforts to hire additional clinical staff, access to, and the availability of, VA mental health treatment and recovery programs remains problematic and highly variable across the country, especially for women veterans and veterans in western and rural states such as Montana. Moreover, the demands to meet the mental health needs of OEF and OIF veterans in many localities around the country is squeezing the VA's ability to treat the veterans of WWII, Korea and Vietnam.

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.<sup>1</sup>], as well as to therapeutic PTSD treatment modalities [see Foa et al.<sup>2</sup> and the National Center for PTSD's Fact Sheets<sup>3</sup>] 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 Post Traumatic Stress Disorder issued a report<sup>4</sup> which found that "most PTSD treatments have not proven effective," with one exception for "exposure therapy".

The IOM Committee reviewed 2,771 published studies conducted since 1980 (when PTSD was added to the DSM-III), and identified only 90 studies (53 psychotherapeutic and 37 pharmacological treatments) that met its criteria for trials from which it could anticipate reliable and informative data on PTSD therapies. Several problems and limitations characterized much of the research on these PTSD treatments, making the data less informative than expected. Many of the studies had problems in their design, how they were conducted, a low number of veteran participants, and high dropout rates—ranging from 20 percent to 50 percent of participants—reducing the certainty of several studies' results. Moreover, the majority of the drug studies were funded by pharmaceutical firms, and many of the psychotherapy studies were conducted by individuals or their close collaborators who had developed the techniques.

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."

Therefore 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."

<sup>1</sup>Keane, T.M., Wolfe, J., & Taylor, K.I. (1987). Post Traumatic Stress Disorder: Evidence for diagnostic validity and methods of psychological assessment. *Journal of Clinical Psychology*, 43, 32-43.

<sup>2</sup>Foa, E.B., Keane, T.M., & Friedman, M.J. (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Publications.

<sup>3</sup>National Center for PTSD Fact Sheets. U.S. Department of Veterans Affairs. National Center for PTSD (Matthew J. Friedman, M.D., Ph.D., Executive Director). On-line access at [www.ncptsd.va.gov](http://www.ncptsd.va.gov).

<sup>4</sup>"Treatment of Post Traumatic Stress Disorder: An Assessment of the Evidence" (2007). Committee on Treatment of Post Traumatic Stress Disorder Board on Population Health and Public Health Practice. Institute of Medicine of the National Academies.

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.

But such 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*—an area where the VA has had problems in the past. For example, according to a GAO report issued in November 2006, the Department of Veterans Affairs did not spend all of the extra \$300 million it budgeted to increase mental health services and failed to keep track of how some of the money was used, even though the VA launched a plan in 2004 to improve its mental health services for veterans with post traumatic stress disorders and substance-abuse problems.

To fill gaps in services, the department added \$100 million for mental health initiatives in 2005 and another \$200 million in 2006. That money was to be distributed to its regional networks of hospitals, medical centers and clinics for new services. But the VA fell short of the spending by \$12 million in 2005 and about \$42 million in fiscal 2006, said the GAO report. It distributed \$35 million in 2005 to its 21 healthcare networks, but didn't inform the networks the money was supposed to be used for mental health initiatives. VA medical centers returned \$46 million to headquarters because they couldn't spend the money in fiscal 2006. In addition, the VA cannot determine to what extent about \$112 million was spent on mental health services improvements or new services in 2006.

In September 2006 the VA said that it had increased funding for mental health services, hired 100 more counselors for the Vet Center program and was not overwhelmed by the rising demand. That money is only a portion of what VA spends on mental health. The VA planned to spend about \$2 billion on mental health services in FY 2006. But the additional spending from existing funds on what VA dubbed its Mental Healthcare Strategic Plan was trumpeted by VA as a way to eliminate gaps in mental health services now and services that would be needed in the future.

With the infusion of so many new dollars to strengthen the organizational capacity of VA in mental health programs and services (particularly PTSD), VVA wants to make certain that America's veterans get the "bang for the buck" in the expenditures of these taxpayer dollars. VVA encourages this Committee to get an accounting of all of the funds allocated out to the Veterans Integrated Service Networks (VISNs) to determine who received these funds, what did they do with the funds (e.g., how many clinicians hired, who did what with how many veterans served for what period of time), and what is the overall analysis of how effectively the VISNs used the funds for both short term (1–2 Years), and what appears to be the medium term or possibly permanent effect (e.g., more than two years).

Finally, the need for timely, effective evidence-based psychiatric/psychological and pharmacological (if necessary) interventions along with integrated psychosocial treatment programs is here. And with the conflicts in Afghanistan and Iraq continuing with no end in sight, VVA believes that the time to address these issues is now, rather than later.

I thank you again for the opportunity to offer VVA's views on this important issue and I'll be glad to answer any questions you might have.

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**Prepared Statement of Todd Bowers,  
Director of Government Affairs, Iraq and Afghanistan Veterans of America**

Mr. Chairman, ranking member and distinguished members of the committee, on behalf of Iraq and Afghanistan Veterans of America, and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding this important subject. I would also like to point out that my testimony today is as the Director of Government Affairs for the Iraq and Afghanistan Veterans of America and does not reflect the views and opinions of the United States Marine Corps.

During the Iraq and Afghanistan Wars, American troops' mental health injuries have been documented and analyzed as they occur, and rates are already comparable to Vietnam. But thanks to today's understanding of mental health screening and treatment, the battle for mental healthcare fought by the Vietnam veterans

need not be repeated. We have an unprecedented opportunity to respond immediately and effectively to the veterans' mental health crisis.

Mental health problems among Iraq and Afghanistan veterans are already widespread. The VA has given preliminary mental health diagnoses to over 100,000 Iraq and Afghanistan veterans. But this is just the tip of the iceberg. The VA's Special Committee on PTSD concluded that:

"Fifteen to 20 percent of OIF/OEF veterans will suffer from a diagnosable mental health disorder. . . . Another 15 to 20 percent may be at risk for significant symptoms short of full diagnosis but severe enough to cause significant functional impairment."

These veterans are seeking mental health treatment in historic numbers. According to the VA, *"OEF/OIF enrollees have significantly different VA healthcare utilization patterns than non-OEF/OIF enrollees. For example OEF/OIF enrollees are expected to need more than eight times the number of PTSD Residential Rehab services than non-OEF/OIF enrollees."* With this massive influx of veterans seeking mental health treatment, it is paramount that we ensure the treatment they are receiving is the most effective and will pave a path to recovery.

But before I speak about the specifics of PTSD treatment and research, I'd like to talk about two of the barriers that keep veterans from getting the proper treatment in the first place.

The first step to treating PTSD is combating the stigma that keeps troops from admitting they are facing a mental health problem. Approximately 50 percent of soldiers and Marines in Iraq who test positive for a psychological problem are concerned that they will be seen as weak by their fellow service members, and almost one in three of these troops worry about the effect of a mental health diagnosis on their career. Because of these fears, those most in need of counseling will rarely seek it out. Recently, my reserve unit took part in completing our Post-Deployment Health Reassessment, which includes a series of mental health questions. While we underwent the training, one of my Marines asked me about Post Traumatic Stress Disorder. He said: "If there is nothing wrong with it, then why is it called a Disorder?" I could not have agreed with him more. To de-stigmatize the psychological injuries of war, IAVA has recently partnered with the Ad Council to conduct a three-year Public Service Announcement campaign to try and combat this stigma, and ensure that troops who need mental health care get it. Our goal is to inform service members and veterans that there is treatment available and it does work.

Once a service member is willing to seek treatment, the next step is assuring that they have convenient access to care. On this front, there is much more that must be done, particularly for rural veterans. More than one-quarter of veterans live at least an hour from a VA hospital. IAVA is a big supporter of the Vet Center system, and we believe it should be expanded to give more veterans local access to the Vet Centers' walk-in counseling services.

The problems related to getting troops adequate mental health treatment cannot be resolved unless these two issues—stigma and access—are addressed. However, once a service member suffering from PTSD has access to care, we also need to ensure they receive the best possible treatment.

Currently, a variety of treatments are available. Psychotherapy, in which a therapist helps the patient learn to think about the trauma without experiencing stress, is an effective form of treatment. This version of therapy sometimes includes "exposure" to the trauma in a safe way—either by speaking or writing about the trauma, or in some new studies, through virtual reality. Some mental healthcare providers have reported positive results from a similar kind of therapy called Eye Movement Desensitization and Reprocessing (EMDR).

In addition, there are medications commonly used to treat depression or anxiety that may limit the symptoms of PTSD. But these drugs do not address the root cause, the trauma itself. IAVA is very concerned that, in some instances, prescription medications are being seen as a "cure-all" that can somehow "fix" PTSD or replace the face-to-face counseling from a mental health professional that will actually help service members cope effectively with their memories of war.

Everyone knows that counseling and medication can be effective in helping psychologically wounded veterans get back on their feet, and IAVA encourages any veteran who thinks they may be facing a mental health problem to seek treatment immediately. But we are also aware of the limitations of current research into the treatments of PTSD.

A recent Institute of Medicine study, entitled "Treatment of Post Traumatic Stress Disorder: An Assessment of the Evidence," outlined the many gaps in current research. Among the problems they identified:

- “Many studies lack basic characteristics of internal validity.” That means too many people were dropping out of these studies, the samples were too small, or followup was too short.
- The IOM Committee also identified serious issues with the independence of the researchers. “The majority of drug studies were funded by pharmaceutical manufacturers,” and “many of the psychotherapy studies were conducted by individuals who developed the techniques.”
- Finally, the Committee concluded that there were serious gaps in the subpopulations assessed in these studies. Veterans may react differently to treatment than civilians, but few of the studies were conducted in veteran populations. There’s also not enough research into care for people suffering from comorbid disorders, such as TBI or depression.

The solution is more and better research. To respond to the IOM findings, IAVA wholeheartedly supports more funding for VA research into PTSD and other medical conditions affecting Iraq and Afghanistan veterans.

Thank you for your attention and your work on behalf of Iraq and Afghanistan veterans. If the Committee has any questions for me, I’ll gladly answer them at this time.

Respectfully submitted,

TODD BOWERS  
Director of Governmental Affairs,  
Iraq and Afghanistan Veterans of America

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**Prepared Statement of Ira Katz, M.D., Ph.D.,  
Deputy Chief Patient Care Services Officer for Mental Health,  
Veterans Health Administration, U.S. Department of Veterans Affairs**

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss the Department of Veterans Affairs (VA) treatment and research for post traumatic stress disorder (PTSD). I am accompanied by Dr. Matthew Friedman, Director of VA’s National Center for PTSD.

From the beginning of Operation Enduring Freedom in Afghanistan until the end of Fiscal Year (FY) 2007, nearly 800,000 service men and women separated from the armed forces after service in Iraq or Afghanistan. Almost 300,000 of them have sought care in a VA medical center or clinic. Of these, about 120,000 received at least a preliminary mental health diagnosis, with PTSD being the most common seen diagnosis—nearly 60,000. Although PTSD is the most frequently identified of the mental health conditions that can result from deployment to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), it is by no means the only one. Depression, for example, is a close second.

Care for OEF/OIF veterans is among the highest priorities of VA’s mental health care system. For these veterans, VA has the opportunity to apply what has been learned through research and clinical experience about the diagnosis and treatment of mental health conditions to intervene early and to work to prevent the chronic or persistent courses of illnesses, especially PTSD that have occurred in too many veterans of prior eras. Since the Vietnam war, PTSD has been recognized as a medically distinct mental disorder; strategies for diagnosing the illness have been validated, and effective treatments have been developed. Although rates are high among OEF/OIF veterans, most of the 400,000 veterans seen in VA last year for PTSD are Vietnam era veterans.

VA has a number of intensive programs to ensure mental health problems are recognized, diagnosed, and treated. We do outreach to bring veterans into our system, and once they arrive, we screen for mental health conditions. For those who screen positive for mental health conditions, we conduct evaluations to recognize urgent needs, followed by comprehensive diagnostic and treatment planning evaluations.

If a veteran comes to VA concerned they may have PTSD, or if a veteran screens positive for PTSD symptoms, we are very much interested in whether PTSD is the correct diagnosis, since the veteran may have another condition, such as depression. Alternatively, a veteran may not have any mental health condition at all and may be experiencing a normal reaction to traumatic events related to deployment and combat. Our responsibility is to respect the strength and resilience of our service men and women, and follow their preferences in helping them to readjust to civilian life. When veterans are having difficulties, we must intervene early and effectively. At VA, care is available and treatments work.

### *Overview of Mental Health Care in Medical Facilities*

VA provides mental health services to veterans in all our medical facilities, and mental health services are provided in specialty mental health settings in all medical centers. VA also provides services for homeless veterans, including transitional housing paired with services which address the social, vocational, and mental health problems that contributed to becoming homeless. VA works very closely with the Department of Labor (DoL) on combating homelessness among our homeless veteran population. We are also increasing the scope and scale of programs conducted jointly with the Department of Housing and Urban Development. In addition, mental health care is integrated into primary care clinics, rehabilitation programs, and nursing homes.

Specific care for PTSD is provided in multiple settings. Last year, approximately 35 percent of veterans with PTSD were treated by PTSD Clinical Teams or Specialists; 55 percent were treated in general mental health settings; and 10 percent in primary care. Treatment settings depend on the symptoms and severity of the illness; response to prior treatment; and the presence of coexisting mental health or medical conditions.

PTSD Clinical Teams or Specialists are in each of our medical centers and in many of our larger Community Based Outpatient Clinics (CBOCs). VA offers inpatient and residential rehabilitation options across the country. Veterans with serious mental illnesses are seen in specialized programs, such as mental health intensive case management; psychosocial rehabilitation; and recovery day programs and work programs.

VA employs full- and part-time psychiatrists and full- and part-time psychologists who work in collaboration with social workers, mental health nurses, counselors, rehabilitation specialists, and other clinicians to provide a full continuum of mental health services for veterans. The numbers of these mental health professionals have grown steadily in the last two and a half years, as a result of focused efforts to build mental health staff and programs. We have hired over 3,800 new mental health staff in that time period, for a total mental health staff of nearly 17,000.

OEF/OIF has brought many new patients into our system with illnesses that are more acute than those of veterans from prior eras, and VA has responded with major increases in staffing. Addressing increases in acuity and ensuring that new staff are aware of military and VA culture, as well as the latest advances in clinical science, requires education. I am pleased to report that as we speak, in San Antonio, VA's National Center for PTSD has gathered the leaders of each of our specialty care programs in PTSD for a mentoring program. The goal is to ensure that all programs in all our facilities are delivering safe, effective, efficient, and compassionate care in similar ways.

VA is committed to enhancing the mental health services it provides to address the needs of returning veterans and veterans from prior eras. This commitment is reflected in increases in funding from \$2 billion in 2001 to a projected amount of over \$3.5 billion this year. VA views this level of funding as an investment, recognizing that appropriate attention to the mental and physical health needs of veterans will have a positive impact on their successful re-integration into their families, their jobs, their communities, the economy, and our society as a whole.

### *Access to Mental Health Services Through Vet Centers*

In addition to the care provided in medical facilities and CBOCs, VA's Vet Centers provide counseling and readjustment services to returning war veterans. It is now well-established that rehabilitation for war-related PTSD and other military-related readjustment problems, along with the treatment of physical wounds of war, is a central aspect of VA's continuum of health care programs for war veterans. Vet Center's mission goes beyond medical care to providing a holistic mix of services designed to treat the veteran as a whole person in his or her community setting. Vet Centers provide an alternative to traditional access for mental health care because some veterans may be reluctant to access medical centers and clinics. Vet Centers are staffed by interdisciplinary teams which include psychologists, nurses and social workers, many of whom are veterans themselves.

VA is currently expanding the number of its Vet Centers. In February 2007, VA announced plans to establish 23 new Vet Centers, increasing the number nationally from 209 to 232. This expansion began in 2007, and is planned for completion in 2008. Some Vet Centers have established telehealth links to VA medical centers that extend VA mental health service delivery to remote areas to underserved veteran populations, including Native Americans on reservations. Vet Centers address the psychological and social readjustment and rehabilitation process for veterans and support ongoing enhancements under the VA Mental Health Strategic Plan.

From early in FY 2003 through the end of FY 2007, Vet Centers have provided readjustment services to 268,987 veteran returnees from OEF and OIF. Of this total, 205,481 veterans were provided outreach services, and 63,506 were provided substantive clinical readjustment services in Vet Centers.

#### *Interventions for Post Traumatic Stress Disorder*

VA's approach to treating PTSD is to promote early recognition of this condition for those who meet formal criteria for diagnosis, as well as those who may be experiencing symptoms. Our goal is to make evidence-based treatments available early to prevent chronicity and lasting impairment.

Screening veterans for PTSD is a vital first step toward helping veterans recover from the psychological wounds of war. Veterans are screened on a routine basis through contact in Primary Care Clinics. When there is a positive screen, our patients are further evaluated and referred to mental health providers for further follow-up, as necessary.

If a veteran first enters the system through a clinical program other than primary care, screening for PTSD will be done in that setting. Screening also occurs for traumatic brain injury, depression, substance use disorder, and military sexual trauma. VA evaluates all positive screens and conduct timely follow-up. When the follow-up reveal either a likely diagnosis or early signs a veteran is having increasing mental health problems, VA begins timely treatment for those problems.

Medications can be effective treatments for PTSD. Specifically, several antidepressants that act on the neurotransmitter serotonin have been found to be effective and safe for the treatment of PTSD. A number of other medications are currently being studied.

The available evidence, however, suggests that the most effective forms of treatment for PTSD are certain types of psychotherapy. Specifically, there is compelling evidence, much resulting from VA supported research, that two types of cognitive-behavioral therapy for treating PTSD are effective: prolonged exposure therapy and cognitive processing therapy. In prolonged exposure therapy, patients are asked to re-experience traumatic events repeatedly in a safe, therapeutic environment. While a therapist provides reassurance, they may be asked to tell the story of their trauma during each session or even have it taped. They would then be asked to listen to the tapes between sessions as homework. By providing repeated but safe exposures to the trauma, the treatment is able to extinguish fear responses and to decrease symptoms. Cognitive processing therapy also includes elements of exposure, but it emphasizes the importance of describing the trauma verbally, and understanding it. The goal is to develop a mastery of trauma-related stimuli and memories.

Last year, VA investigators reported that findings from a randomized clinical trial of psychotherapy demonstrating that prolonged exposure therapy was effective. Even before these results were published, we were developing plans to implement the treatment throughout our system. To make both cognitive processing therapy and prolonged exposure treatments broadly available, VA has implemented extensive training programs for providers in our system. We are partnering with the Department of Defense (DoD) to make these training opportunities available to DoD mental health staff.

Other forms of psychotherapy treatments are also highly promising. One treatment, "Seeking Safety" appears to be effective for treating PTSD complicated by alcohol use disorders or other forms of substance abuse. VA is currently implementing this treatment, while at the same time conducting further research on its effectiveness.

In addition, there is increasing evidence of the effectiveness of psychosocial rehabilitation. Treatment is available to veterans for whom there may be residual symptoms after several evidence-based treatments to help them function in the family, in the community, or on the job.

Sometimes mild to moderate PTSD symptoms without a full diagnosis represent normal reactions to highly abnormal situations. Many returning veterans will recover without treatment, supported by their families, communities, and employers. In fact, what is most striking about our service members and veterans is not their vulnerability, but their resilience. When people prefer treatment, we encourage it. When they are reluctant, we watch them over time, and urge treatment if symptoms persist or worsen.

#### *Mental Health Research*

VA continues to support a strong behavioral and psychiatric disorders research portfolio focused on further understanding and treating mental health problems in veterans. Investigations are directed toward substance abuse, PTSD, adjustment and anxiety disorders, psychotic disorders, dementia and memory disorders, and re-



lated brain damage. Many laboratory studies are being conducted to better understand the changes that take place when someone is suffering from adjustment problems or mental illness. Clinical trials are underway to test new drug and therapy treatments specifically targeted to help veterans. VA also has a strong program for developing and implementing better mental health care, including enhancing collaborative care models, improving access to mental health care through innovations such as telemedicine and the Internet, and reducing barriers to veterans seeking mental health care. Several ongoing projects are investigating how veterans with mental illness might benefit from rehabilitation approaches, including vocational rehabilitation, skills training, and cognitive therapy to improve everyday functioning and work performance. Future research will enable VA to determine how to care for veterans with mental illness so that they can return to their highest level of functioning.

In a landmark ongoing study, VA researchers, collaborating with DoD, are collecting risk factors and health information from military personnel prior to their deployments to Iraq. These soldiers will be reassessed upon their return, and several times afterward, to identify possible changes in their emotions or thinking following combat duty in Iraq and to identify predisposing factors to PTSD and other health conditions. To date, researchers have reported that troops who served in Iraq showed mild deficits in some tasks involving learning, memory, and attention compared with non-deployed troops, but scored better on a test of reaction time. The researchers have proposed longitudinal followup studies to determine if these neuropsychological effects might fade over time, or be a precursor to PTSD (*Journal of the American Medical Association*. 2006; 296(5):519–529). An additional goal for this research is to examine the neuropsychological associations of traumatic brain injury (TBI) with the development of PTSD at long-term follow-up.

Veterans with PTSD commonly experience nightmares and sleep disturbances, which can seriously impair their mood, daytime functioning, relationships, and overall quality of life. In an exciting new treatment development, VA investigators have found that prazosin, an inexpensive generic drug already used by millions of Americans for high blood pressure and prostate problems, improves sleep and reduces trauma nightmares in a small number of veterans with PTSD (*Biological Psychiatry*. 2007; 61(8):928–934). Plans are underway for a large, multi-site trial to confirm the drug's effectiveness.

In addition, VA investigators are currently conducting the first ever clinical trial of a medication to treat military service-related chronic PTSD. It will also be the largest placebo controlled double-blind study (the most rigorous type of clinical trial) of its kind ever conducted. It will involve 400 veterans diagnosed with military-related chronic PTSD at 20 VA medical centers across the nation. The main objective of the study is to determine if risperidone is effective in veterans with chronic PTSD who continue to have symptoms despite receiving standard medications used for this disorder. Risperidone is being studied since it has been shown to be safe and has received a good deal of preliminary study in the treatment of PTSD patients.

In 2006, VA launched the Genomic Medicine Program as part of its Personalized Medicine Initiative. A PTSD Genetics Working Group was established to explore and define a research program to identify the genes which are important in determining how an individual responds to the experience of deployment, especially their response following combat exposure. By carefully characterizing those affected by combat-related PTSD and conducting genetic analyses, VA will be in a position to identify genetic variants contributing to PTSD and other post-deployment adjustment disorders, such as major depression. Once this program is established, this resource will be available for continued research including studying the genetic relationship to treatment response.

Other research on PTSD, related disorders, and coexisting conditions is being conducted by the National Center for PTSD, the Mental Illness Research Education and Clinical Centers, and the new Centers of Excellence in Mental Health and PTSD. These studies include investigations on stress and resilience; deployment and its consequences; novel therapeutics; and new strategies for the delivery of care, including primary care management.

### Conclusion

Mental Health is an important part of overall health. VA is committed to providing the highest quality of care possible to our nation's veterans. Because VA researchers are also clinicians caring for veterans, VA is uniquely positioned to move scientific discoveries from investigators' laboratories into patient care. One of the major medical advances resulting from World War II was the translation of penicillin from a laboratory curiosity to a medicine that could be produced in sufficient quantity to be delivered to soldiers with battlefield injuries. Although the basic re-

search had been done earlier, the translation of laboratory findings to the bedside and clinic came from the war. In a similar way, the spotlight on PTSD and its treatment has stimulated VA to translate evidence-based therapies from interventions delivered primarily in research clinics to real treatments for real patients. We believe this work will have a profound impact on mental health care, not only in VA, but throughout the country.

VA takes great pride in the research that keeps it at the forefront of modern medicine and health care. We expect to see further remarkable discoveries, and the translation of these discoveries into care in the coming decades.

Thank you again, Mr. Chairman, for having me here today. I will answer any questions you or the other members may have.

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**Prepared Statement of Joseph L. Wilson, Deputy Director,  
Veterans Affairs and Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's views on Post Traumatic Stress Disorder (PTSD) Treatment and Research. While the Department of Veterans Affairs (VA) continuously treats those who suffer from PTSD, more resources are required to ensure that the growing numbers of veterans and patients are evaluated and accommodated respectively.

***VA Research***

According to research from the National Center for PTSD, Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) combat veterans are at higher risk for PTSD. The VA has reported that approximately 25 percent of the 300,000 separated veterans have received a diagnosis of a probable mental health disorder.

VA states that due to the enhancement of body armor and exceptional medical care on the battlefield, many soldiers are surviving major blast-related injuries and will require long-term, specialized care; For those new veterans readjusting to civilian life, mental health challenges, such as PTSD, may be their most critical issue.

Currently, VA researchers are working to improve mental health care by developing screening methods for mental problems; it has been proven that early recognition and treatment results in better patient outcomes. VA is also leading the way in conducting studies on both drug and psychosocial/behavioral therapies; and studying treatment for women veterans, who may experience trauma differently than male veterans.

VA also reports that many soldiers diagnosed with PTSD respond well to standard treatments, while others do not; it is based on individual needs. The American Legion applauds VA on making strides through current research and for establishing new programs; however, the aforementioned suggests that every veteran isn't receiving adequate care to accommodate his or her needs. While effective treatment is being utilized, the overall results also warrant more research, to include the funding to support PTSD research.

Usually, there are questions that prompt studies and research. Currently, one question includes, "Can VA identify biological markers that might help guide psychological evaluation, treatment selection, and outcomes?" To assist with answering this type question, VA researchers are testing whether a computer-simulated "virtual reality" can be used to deliver a controlled type of exposure (to combat) therapy.

VA is also developing various ways to provide care to veterans residing in rural areas, to include videoconferencing, delivery of health information and services by telephone, and Internet. Lastly VA is attempting to ensure evidence-based, state-of-the-art care is available to all veterans with PTSD by rapidly transferring scientific breakthroughs from the laboratory into patient care.

The rapid integration of scientific breakthroughs into patient care is extremely critical because it may interrupt the deterioration of the patient's mental health, as well as halt other issues that arise within the veterans' community, such as family problems.

***Specialized PTSD Services***

VA recently extended health care services to OEF/OIF veterans through its health care system from two years to five years following the veteran's discharge or release from active duty. According to VA, there are veterans whose condition cannot be maintained in a primary care or in a general mental health setting and therefore are managed within a specialized environment by clinicians who have concentrated their clinical work in the area of PTSD treatment.

These specialized programs are outpatient treatment programs, to include a PTSD clinical team, substance use and PTSD team, Women's Stress Disorder Treatment Team/Military Sexual Trauma Team, and PTSD Day Hospital. There are also inpatient treatment programs, to include an Evaluation and Brief Treatment Unit, Specialized Inpatient PTSD Unit, PTSD Residential Rehabilitation Program, Women's Trauma Recovery Program, and PTSD Domiciliary.

Although these programs are located throughout the nation at various VA medical facilities, The American Legion suggests that adequate funding must be provided to ensure these programs are consistently in place throughout the entire VA system. This will ensure a more proactive approach as more veterans seek treatment upon their return from combat.

#### ***National Institute of Mental Health***

The National Institute of Mental Health (NIMH), over the years, has gradually strengthened its connection to VA and Department of Defense (DoD) to obtain more knowledge regarding the extent and nature of mental health needs related to war related trauma, and to accelerate the discovery of fundamental knowledge needed to improve treatment, and to ensure that all veterans who may benefit from treatment such as PTSD actually receive it. The American Legion supports the collaboration between these organizations and urges Congress to provide adequate funding to ensure such research efforts continue.

According to NIMH, their investment in overall PTSD research went from \$15 million in Fiscal Year (FY) 1997 to approximately \$45 million in FY 2006. During FY 2006, NIMH and VA awarded approximately \$1.2 million to support new projects targeting mental health needs of Active Duty, Guard and Reserve personnel returning from Iraq or Afghanistan. New initiatives proposed by NIMH for FY 2008 include projects to advance the prevention of post-deployment mental health problems among members of high-risk occupations who regularly encounter traumatic situations, to include those who suffer from combat related trauma and military sexual trauma (MST).

The American Legion supports these proactive initiatives proposed by the NIMH. We also believe such proposals may enable veterans to recover more effectively from conditions that trigger PTSD. We therefore urge Congress to ensure such initiatives remain a priority in researching for the advancement of PTSD treatment.

These new initiatives include exploration of new treatments, to include new medications that appear to selectively affect the encoding of traumatic memories. In partnership with VA and DoD, NIMH is actively attempting to create effective psychosocial treatments, such as cognitive behavioral therapy; making them more widely available along with Internet-based self-help therapy and telephone assisted therapy. Other research by NIMH is attempting to enhance cognitive, personality, and social protective factors, as well as minimize factors that ward off full-blown PTSD after trauma.

The American Legion applauds all efforts made on behalf of organizations and their researchers to administer treatment to prevent PTSD and maintain research into this vital issue among America's veterans. However, we also must remain mindful to ensure veterans from every era are not subject to undue stress such as unreasonable frequent evaluations that call for veterans to report to facilities periodically within the month.

#### ***Institute Of Medicine (IOM)***

The IOM's Committee on Treatment of PTSD, in its charge from the VA, recently undertook a systematic review of PTSD literature and subsequently recommended that Congress require and ensure that resources are available for VA and other relevant Federal agencies to fund quality research on the treatment of PTSD in veteran populations and to ensure that all stakeholders are included in research plans. The American Legion supports the call for funding of quality research on treatment of PTSD in veteran populations. We also ask that an equal emphasis be placed on veterans residing in rural communities throughout the nation.

Upon reviewing the issue of PTSD interventions, which as previously stated, has not systematically and comprehensively addressed the needs of veterans with respect to effectiveness of treatment and the comparative efficacy of treatments in clinical use, the Committee recommended that VA take an active leadership role in identifying research priorities for addressing the most important gaps in evidence in clinical efficiency and comparative effectiveness.

The Committee also pointed out possible areas for future research, to include, comparisons of the use of psychotherapy and medication, evaluation of individual and group formats for psychotherapy modalities, and evaluations of the effectiveness

of combined use of psychotherapy and medication; the effectiveness of the aforementioned were tested within individual and group environments.

According to the VA, available research continues to leave significant gaps in assessing the effectiveness of interventions within subpopulations of veterans who suffer from PTSD, as well as ethnic and cultural minorities, women, and older individuals. In response to this issue, the Committee recommended that VA assist clinicians and researchers in identifying the most important subpopulations of veterans with PTSD and designing specific research studies of interventions tailored to these subpopulations.

### **Conclusion**

Mr. Chairman, The American Legion agrees that gaps continue to remain in PTSD treatment of the veteran population. During The American Legion's System Worth Saving Task Force site visits to Vet Centers in 2007, management stated that the uppermost form of outreach was a mere conversation among veterans (word-of-mouth). The American Legion believes relying on veteran to veteran word-of-mouth outreach is inadequate. VA must promote its readjustment and mental health programs more effectively in order to help the veteran move ahead toward their recovery.

While there are various effective outreach tools in place, to include Global War on Terrorism Counselors or GWOTs, the concern also remains that research findings are not being expedited to clinical mediums within the VA. We support the continuous efforts of VA research to treat and/or accommodate this nation's veteran. Therefore, we urge that every measure be taken to ensure these advances are communicated and implemented within the most rural corners of this nation to ensure all veterans receive timely, adequate, and up to date mental health care.

Mr. Chairman and members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues to continue to ensure all veterans are informed, evaluated, and/or receives the best quality treatment for PTSD. Thank you.

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### **Prepared Statement of Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans**

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV), an organization of more than 1.3 million service-disabled veterans, to submit this testimony for the record of this hearing on posttraumatic stress disorder (PTSD) treatment and research. We appreciate the opportunity to offer our views on the Department of Veterans Affairs (VA) specialized programs for this condition.

Current research indicates combat veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans are at higher risk for the anxiety disorder PTSD and other mental health problems, including substance use disorder, as a result of, or consequent to, their military experiences. VA reports that veterans of these current wars have sought care for a wide range of possible medical and psychological conditions, including mental health conditions, such as adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. Through January 2008, VA reported that of the 299,585 separated OEF/OIF veterans who have sought VA health care since fiscal year 2002, 40 percent, or a total of 120,049 unique patients, had been diagnosed with a possible mental health disorder. Nearly 60,000 of these enrolled OEF/OIF veterans had a probable diagnosis of PTSD, and 40,000 have been diagnosed with depression.

The increasing rate of OEF/OIF veterans seeking VA health care, and the emerging trends in health care utilization of this group drive the need to ensure access to, and make available, robust services for: depression; stress and anxiety reactions, including PTSD; individual or group counseling; specialized intensive outpatient treatment for severe PTSD—including cognitive behavioral best practices; services for relationship problems (including marital and family counseling); psychopharmacology services; and, substance-use disorder interventions and treatment, including initial assessment and referral, brief intervention and/or motivational counseling, traditional outpatient counseling and intensive outpatient substance-use disorder care.

In its 2001 report, "Crossing the Quality Chasm: A New Health Care System for the 21st Century," the Institute of Medicine (IOM) put forward six aims that now underpin the standard of care for U.S. medical care providers. The IOM aims that health care will be *safe* (avoiding errors and injury), *effective* (based on the best sci-

entific knowledge), *patient-centered* (respectful of, and responsive to patient preferences, needs and values), *timely* (reduced waiting time and harmful delay), *efficient* (avoiding waste), and *equitable* (unvarying, based on race, ethnicity, gender, geography, or socioeconomic status).

VA has embraced these aims and consistent with them, VA's offices of Health Services Research and Development and Rehabilitation Research and Development are focusing on a number of important areas including PTSD. The complex and unique injuries sustained by troops serving in Iraq and Afghanistan have created the need for new research and treatment strategies focused on addressing the unique needs of the newest generation of combat disabled veterans. Furthermore, because of VA's long history in providing effective readjustment counseling services that are culturally sensitive to veterans and their unique military combat experiences, unquestionably VA is the optimum source for readjustment services for our newest veterans. VA provides the range of post-deployment mental health services veterans from current and previous wars may require, and provides services that are evidence-based which integrates the best research evidence, clinical expertise and patient needs.

Though clinical practice guidelines initially evolved in response to studies demonstrating significant variations in risk-adjusted practice patterns and costs, VHA has embraced the use of evidence-based clinical practice guidelines as one strategy to improve care by reducing variation in practice and systematizing "best practices." Like any other tool in medical care, these guidelines set out to improve the processes of care for patient cohorts, to reduce errors, and provide more consistent quality of care and utilization of resources throughout the system. Researchers had correctly hypothesized that establishing criteria for the appropriate use of procedures and services might decrease inappropriate utilization and improve care outcomes. Since guidelines also are cornerstones for accountability, and facilitate learning and the conduct of further research, they are subject to continual review and necessary revisions.

While clinical practice guidelines have been developed since the early 1990's, the VA took the important step to promote the use of evidence-based approaches by initiating development of a joint VA–Department of Defense (DoD) Practice Guideline for Management of PTSD. The guideline advocates application of a variety of evidence-based practices for treatment of veterans with PTSD. In addition, the National Center for PTSD (NCPTSD) in collaboration with Walter Reed Army Medical Center (WRAMC), developed an Iraq War Clinician Guide (now in its second edition), to guide treatment of returning personnel with PTSD, and generally better prepare VA mental health providers to receive and effectively treat returning veterans.

Despite the clear articulation of best practices in the PTSD clinical practice guideline and the Iraq War Clinician Guide, many of the recommended practices are not widely implemented in the VA health care system. Staff awareness about PTSD and efficacious treatments, knowledge and skill deficits, clinician attitudes, and institutional barriers all prevent widespread dissemination of recommended practices. DAV has, and will continue to call for improvements to better disseminate the information in the field to increase awareness, ability and knowledge, in addition to decreasing both clinical and institutional barriers, to implementing these guidelines.

### Research

The aforementioned limitations notwithstanding, DoD and VA share a unique obligation to meet the mental health care and rehabilitation needs of veterans who are suffering from readjustment difficulties as a result of combat service. Both agencies need to ensure that appropriate research is conducted and that federal mental health programs are *adapted* to meet the unique needs of the newest generation of combat service personnel and veterans, while continuing to address the needs of older veterans with substance abuse problems, PTSD, other combat-related readjustment issues, and other mental health challenges. Congress must remain vigilant to ensure that research and treatment programs are authorized and sufficiently funded to ensure these needs are met.

In our October 2007 testimony before this Subcommittee, the DAV urged VA to continue research that is veteran-centered and specifically focused on rehabilitation of veterans with physical and cognitive impairments related to military service, and to establish studies to identify and promote effective and efficient strategies to improve the delivery of health-care to veterans. We believe these research priorities should include:

- A study to objectively and systematically measure the expectations of OEF/OIF veterans to help VA better serve this population. These veterans are younger, have family and community support systems in place, and are frequently deal-

ing with complicated post-service readjustment, employment, education and other issues. VA should conduct health services and other research to identify services to meet their mental health needs.

- Studies to address access issues for this new population including tracking of OEF/OIF veterans to learn what services they utilize. VA should also examine barriers to care, especially those that relate to attitudes of veterans and their families toward being treated in the VA, and any breakdown in access this may cause.
- VA should quickly disseminate and deploy resources to make evidence-based PTSD treatment easily accessible. In particular, for women veterans across the country, and explore options for providing child care for those needing it to enable them to achieve access to treatment.
- VA should conduct research to fully understand the dual burden of military sexual trauma and combat-related PTSD, and develop the best treatment practices and programs for this population.
- DoD should fund a prospective, population and gender-based health study of veterans who served in OEF/OIF. An epidemiologic study with at least a ten-year follow-up period is needed. This study should be carried out by DoD, VA and academic researchers in a collaborative manner.

#### ***Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence***

As this Subcommittee is aware, VA contracted with IOM to study the ramifications of PTSD in the veteran population. IOM established three Committees to address the various aspects of PTSD: a Committee on PTSD Diagnosis and Assessment which submitted its report in June 2006; a Committee on Compensation for PTSD which submitted its report on May 08, 2007; and a Committee on PTSD Diagnosis and Treatment which submitted its report on October 17, 2007.

Based on a review of literature on best treatment practices, types and timing of specific interventions, and comment on the prognosis of individuals diagnosed with PTSD (including co-morbidities), the most recent IOM report indicates few studies have been conducted on the efficacy of treatments for veterans suffering from PTSD. In addition, no conclusion could be made about most treatment modalities, save exposure therapy.

The report reveals most of the evidence supporting the use of medications and psychological therapies for PTSD is supported by evidence compiled by researchers with conflicts of interest in the outcome of the studies or funded by pharmaceutical companies that make the drugs used in the therapies. In addition, the report could not highlight evidence showing any medication such as Selective Serotonin Reuptake Inhibitors (SSRIs) were effective in treating PTSD. There was insufficient evidence to determine the value of early intervention and an optimal length or treatment. Moreover, there was insufficient evidence to support the use of a range of psychotherapies known as cognitive restructuring, coping skills training, eye-movement desensitization and reprocessing therapy, and group therapy.

With formidable challenges in conducting high quality research, the report suggests many studies had design or methodological flaws, inadequate control for confounders, high dropout rates of 20 to 50 percent, and possible conflicts of interest among researchers. Additionally, discussion during the committee meeting noted that the diagnosis of PTSD itself has a high degree of overlap with other conditions, and therefore efforts to determine efficacy of therapies may suffer from a lack of specificity. We note however, that despite using a high threshold for inclusion and evaluation of PTSD treatment studies into this IOM report, it underscores the need for rigorous studies of all treatment modalities that will address major limitations of available research in finding optimal PTSD treatment when judged against contemporary standards. Moreover, the fact that the committee found literature that met the reliability requirement to determine efficacy,<sup>1</sup> means it is wholly within the realm of possibility for VA or others to conduct research that will allow a more definitive assessment of the effectiveness of PTSD treatment modalities.

While clinical trials take years to plan, conduct, and complete, and well-designed randomized clinical trials are costly in both time and resources, treatment still must be provided, and the DAV is concerned if the effectiveness of available treatment is questionable, some veteran patients may become frustrated and discontinue seeking VA mental health services. For example, the IOM committee report noted that while there were more clinical trials of SSRIs than of other drugs, outcomes were

<sup>1</sup>2,771 identified but narrowed down to 90 studies that were either randomized controlled trials, placebo-controlled pharmacotherapy trials, or controlled psychotherapy trials. Chosen studies met the criteria for Level-1 evidence in accordance with evidence-based medicine standards.

split in the seven most useful studies. The largest study fossil showed no improvement in primary PTSD outcomes and saw many patients drop out. The American Psychiatric Association's Clinical Practice Guideline for the Assessment and Treatment of Patients with Acute Stress Disorder and PTSD and VA's National Center for Posttraumatic Stress Disorder recommends SSRIs. SSRIs are a class of antidepressants used in the treatment of anxiety disorders and depression as first-line medications for PTSD pharmacotherapy in veterans suffering from PTSD.

The DAV believes that this report should be used as a guide to facilitate high quality research and not decrease access or treatment options. Particularly since this IOM report is the third in a series requested by VA asking for guidance in diagnosing, treating, and assessing disability in veterans with PTSD, and that the report indicates research gaps in regard to special veteran populations.

In light of the October 2007 IOM report, we applaud VA's actions regarding the efficacy of exposure therapy by initiating training of VA mental health providers in the use of exposure-based therapies, starting with cognitive and most recently including prolonged exposure therapy. In addition, VA had announced plans for a "consensus conference" with DoD and National Institutes of Health to exchange knowledge and work toward shared state-of-the art approaches for research in PTSD. In the interim, VA staff has been directed to work with DoD to evaluate early interventions such as the Army's "BATTELMIND" training and the "Marine Operational Stress Surveillance and Training Program," designed to help combat troops transition back to non-deployed civilian status.

The DAV is a strong advocate and believer of research as it provides the evidence base for effective treatment for veterans. We urge this Subcommittee to continue to conduct regular oversight on the entities charged with conducting research to ensure a comprehensive high quality evidence base for the veteran population suffering from PTSD and its effect on the improvement of PTSD treatment.

#### ***The Recovery Model***

As part of a larger social movement of self-determination and empowerment, the recovery movement calls for a fundamental transformation of the mental health care delivery system to one that is evidence based, recovery focused, and consumer and family driven, and where recovery from mental illnesses and emotional disturbances should be the common and recognized outcome of mental health services.<sup>2,3,4</sup> These changes were prompted in the President's New Freedom Commission on Mental Health, in its report entitled "Achieving the Promise: Transforming Mental Health Care in America."

The resulting December 1, 2003, VA Action Agenda, "Achieving the Promise: Transforming Mental Health Care in the VA," involves 82 system-wide changes and includes a number of recommendations to successfully adopt the recovery model in VA mental health programs nationwide. Some of those recommendations include educating VA staff on recovery, developing a strategic plan for mental health research that supports VA recovery-based mental health care, initiating a national Recovery and Rehabilitation Task Force, developing a manual on establishing a peer-support program, providing supported employment programs to promote recovery and the ability of veterans to live productively in the community, and promoting the integration of mental health into primary care services.

The VA Mental Health Strategic Plan Workgroup developed a five-year strategic plan to eliminate deficiencies and gaps in the availability and adequacy of mental health services that VA provides across the nation. The plan includes a number of action items that build on the recommendations of the President's Commission and the VA Secretary's Mental Health Taskforce recommendations.

As with other public health systems that are implementing pilot projects in several states to transform their mental health systems to emphasize the recovery model, concerns have been raised with respect to the VA mental health delivery system. There is a general concern over the use of the evidence-based medical model, which involves the elimination or reduction of symptoms and return to pre-morbid levels of function, and the recovery model, which, "enables a person with a mental health problem to live a meaningful life in a community of his or her choice while

<sup>2</sup>Nat'l Recovery Consensus Statement: <http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>

<sup>3</sup>SAMHSA's Nat'l Transformation Agenda: [http://www.samhsa.gov/Federalactionagenda/NFC\\_TOC.aspx](http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx)

<sup>4</sup>Surgeon General's M.H. Report: <http://www.surgeongeneral.gov/library/mentalhealth/home.html#preface>

striving to achieve his or her full potential.”<sup>5</sup> Although both the medical and recovery models can influence what treatments are provided, the recovery model emphasizes *how* the treatment is provided. Having a greater emphasis placed on peer support and personal experience has the potential to be a source of conflict particularly in a paternalistic health care model. Moreover, the inclusion of caregivers and family members as partners in treatment planning for the veteran is a necessity in the recovery model and current VA authority may prove to be insufficient for successful implementation throughout the continuum of VA mental health services.

We are aware of, and applaud VA for actively promoting the recruitment of peers as mental health service providers, and hiring over 3,700 of the 4,347 authorized new mental health professionals since the beginning of implementation in 2005, for providing program funding to integrate mental health and primary care in over 100 sites, and for large-scale training for VA providers on the delivery of evidence-based psychotherapies. However, this new emphasis of recovery and the requirements needed to reach its goals require additional resources, equipment, and space. For example, in fiscal year 2007, \$347 million was transferred from Medical Services to Medical Facilities to increase infrastructure capacity through three initiatives: \$58 million for appropriate clinic space; \$130 million for additional leased space and equipment for VA medical centers, Community Based Outpatient Clinics (CBOCs) and nursing homes; \$159 million for non-recurring maintenance projects to provide a safer environment.

Additionally, VA recovery programs have had difficulty becoming established and program managers have not made consistent efforts to involve veterans and family members locally. In order for VA to fully adopt the recovery model, it is imperative that its mental health care system be patient- and family-driven in addition to being focused on recovery. Despite some progress as reported earlier in this testimony, the current level of effort and provision of PTSD treatment remain challenging.

In closing, the DAV urges Congress to ensure that veterans’ needs for quality mental health care are met, so that the promise of recovery can be achieved. Moreover, we encourage this Subcommittee to continue conducting regular oversight on the progress of VA’s Mental Health Strategic Plan and the 2003 VA Action Agenda to ensure that your expectations about effective treatment and recovery are met.

Mr. Chairman, this concludes our statement and we appreciate the opportunity to express our views on this important topic.

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**Prepared Statement of Christopher Needham,  
Senior Legislative Associate, National Legislative Service,  
Veterans of Foreign Wars of the United States**

**MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:**

On behalf of the 2.3 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I thank you for the opportunity to present our views on this most important topic. It is clear that the mental health care of our returning servicemen and women is of utmost importance.

The battles may end when the last bullet is fired, but for the hundreds of thousands of men and women who have separated from the military after having served in Iraq and Afghanistan, the impact of the war continues. It is an impact that is felt not just by the veteran, but also his or her loved ones, and it is an impact that affects each individual differently. Some are able to pick up their lives and move on. Others have great difficulty dealing with the emotions and reactions they have. This grateful nation must see to it that every one of these brave men and women has the services they need—the helping hand—to overcome these difficulties, easing the transition into civilian life and becoming as whole as possible. No veteran should suffer untreated for what happened to him or her while serving this nation.

The mental health issue that has received the greatest attention—and the subject of today’s hearing—is posttraumatic stress disorder, PTSD. PTSD is an anxiety disorder that sometimes develops following stressful and traumatic events. For veterans serving in a war zone, surrounded by death and destruction, traumatic events are difficult to avoid.

Nobody goes into a war zone and returns the same. Everyone is affected to some degree. Some service men and women return to normal after a short time. Others have problems that linger. Still others have problems that get worse. This is important because a one-size approach to mental health care is likely not going to work.

<sup>5</sup> Substance Abuse and Mental Health Services Administration. *National Consensus Conference on Mental Health Recovery and Systems Transformation*.



We need an emphasis on approaches to treatment that are tailored for an individual's needs and what will work best for him or her.

Therein lays one of the bigger problems with PTSD. There is still much we do not know about its causes and optimal treatments for its conditions. The VFW urges more research into these important issues so that past and present generations of veterans can have the care they need to become whole, but also so that future generations will not have to suffer from its effects.

We know that exposure to stresses and traumas can lead to PTSD, but we do not know why some suffer from it more than others. Are there groups of veterans that are more susceptible? Are certain ages or sexes more likely to suffer? What background factors, if any, contribute to the illness? The more information we have about its causes, the better treatment options should be. Better information about those veterans more inclined to have PTSD could lead to earlier treatment and better screening, vastly improving the military's and VA's outreach efforts.

We need to study the conditions such as depression and substance abuse that are often co-morbid with PTSD. How are they related? Will treating the one condition improve the others? What else must health-care practitioners be aware of?

The questions yet to be answered also include treatment options. There is still no consensus on what treatment options provide the best chance for improvement. An October 2007 Institute of Medicine report, "Treatment of PTSD: An Assessment of the Evidence," showed that there is inadequate evidence to assess the efficacy of most PTSD treatments, including many antidepressant pharmaceuticals, group therapies or coping skills training. The report did find that exposure therapy—one of the courses of treatment that VA uses—is effective.

The report laid out eight key recommendations for future study on which it believes VA and other research organizations must concentrate. These include the need for research into interventions, settings, and lengths of treatment; studies of the effects of treatment in subpopulations of veterans with PTSD, especially those with traumatic brain injury, major depression, other anxiety disorders, or substance abuse, as well as ethnic and cultural minorities, women, and older individuals; and, research into the optimal length and duration of treatment, especially over the long-term.

The key with this report is that it did not find that these other forms of treatments are ineffective, just that the current research is not sufficient to determine this one way or another. Accordingly, we strongly urge VA to continue using all treatment methods, as well as attempting to innovate by finding new solutions that may work just as, if not more, effectively.

We also strongly believe that more needs to be done to remove the stigma of mental illness. PTSD can affect anyone, and it is not a sign of weakness to seek treatment. Too many service men and women have reported fears of losing standing among their peers or potential for career advancement as barriers to care.

We also must have improvements to the mental-health screening programs. In some cases, especially among returning National Guard members, there is a strong disincentive to seek treatment in that self-identifying would delay their separation as they are treated for their condition.

To combat this, we believe that mental health screenings should be included as part of a routine health care examination, especially among those groups—such as separating service members—more at risk of PTSD and other mental health issues. By screening everyone, no individual is isolated or made to feel weak, and all can then have further access to treatment for any problems identified.

There are a few other areas of concern we all need to be mindful of.

First, we need to ensure that the growing number of women veterans is being served by VA. Female veterans of OEF/OIF are experiencing conflict and situations that no other previous generations of women veterans have faced. They are involved in a conflict with no true frontline and in a high-stress situation with almost no respite. Since these situations are so new, VA must actively monitor and assess the level and types of treatment women veterans need and VA must conduct proper outreach so that they understand the benefits and services VA provides.

Second, we need to see continued improvement in mental health care options for families. We need new models of support that help OEF/OIF veterans overcome these mental health challenges. Families are an essential component of recovery, providing a support network, but also serving as eyes and ears for veterans who are truly in crisis and need more help.

The difficulties many veterans have dealing with these issues are putting an extreme strain on families, eroding this crucial base of support. Divorce rates are growing and the number of veterans reporting difficulties or strains with their families has increased too.

DoD needs to do a better job educating families on what to expect from a returning service member, and also give them tools to care for their loved ones when dealing with the difficult transition out of a combat zone. We need both DoD and VA to provide meaningful family and marital counseling, too. Ensuring the stability of the family and support structure can only help the service member improve.

As part of those efforts, we have been pleased to see VA expand the number of Vet Centers throughout the system. We are strongly supportive of Vet Centers, feeling that the relaxed, less formal, drop-in approach is conducive to encouraging veterans to seek the care they need. As part of their mandate, Vet Centers provide family counseling, which can be of great aid to our veterans. We have heard many compliments about the types and quality of service Vet Centers provide, but our concern remains with the staffing levels. Most Vet Centers have handled the increased demand for care relatively well, but with the number of OEF/OIF veterans returning and reporting some degree of mental health issue, the demand is sure to dramatically increase. Accordingly, we need VA to ensure that the centers are fully staffed, and we need Congress to use its oversight power to ensure that VA is meeting the demand for care and services.

Mr. Chairman, this concludes my testimony. I thank you for the opportunity to present the VFW's views, and I would be happy to answer any questions that you or the committee may have.

