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Matthew J. Friedman M.D., Ph.D
Executive Director
National Center for PTSD
VAM&ROC White River Junction, VT
&
Professor of Psychiatry and Pharmacology & Toxicology
Dartmouth Medical School

My name is Matthew J. Friedman, MD, PhD. Since 1989 I have been Executive Director of the VA's National Center for Post-Traumatic Stress Disorder (NCPTSD). The Center consists of seven divisions, located at VA facilities extending from Boston to Honolulu which are dedicated to advancing research and education on the causes and treatment of PTSD and related disorders among veterans exposed to warzone-related PTSD. I have also been Professor of Psychiatry and Pharmacology & Toxicology at Dartmouth Medical School since 1988. I have worked to provide and improve VA treatment, research, and education for veterans with PTSD since 1973.

In 1984, while serving as Chief of Psychiatry at the VA Medical and Regional Office in White River Junction, VT, I was appointed Chairman of the Chief Medical Director's Special Committee on PTSD. This Congressionally mandated committee was charged to report to congress about VA's capacity: 1) to provide treatment for veterans with PTSD; 2) to support research on scientific questions concerning the etiology, clinical course and treatment of PTSD; 3) to provide education and training to VA professionals in order to improve their clinical skills regarding PTSD-related problems; and 4) to adjudicate PTSD disability claims in a timely manner. I served for 5 years (from 1984-1989) as Chairman of the Special Committee which submitted annual reports to congress concerning the status of VA PTSD programmatic capacity. Since 1989, when I was appointed Executive Director of the National Center for PTSD, my focus has primarily been on research and education. In short, I have been treating veterans with PTSD for 32 years, and have had a national perspective on VA's clinical, research, and educational programs for 21 years.

The Committee has requested my testimony on a number of topics: [1] an overview of PTSD with respect to etiology, epidemiology, diagnosis, functional limitations, its impact on families and available treatments; [2] comparisons between PTSD among Vietnam as compared to OIF/OEF veterans; [3] treatment issues from the perspective of VA practitioners (others are better suited to comment on treatment issues from a VA system perspective; [4] my current concerns about the clinical needs of OIF/returnees; and [5] collaborative research and educational initiatives between NCPTSD and DoD. Given time limits, I will address each topic briefly but will be happy to elaborate during the question period.

I. Overview on PTSD

In the interest of time, I have appended to this testimony a brief overview of PTSD, which is available on the National Center's website, www.ncptsd.va.gov (Attachment 1). Briefly, PTSD occurs when an individual has been exposed to an overwhelming stressor (such as warzone trauma, sexual/or physical assault, a terrorist attack, or a natural disaster) involving actual or threatened death or injury, or a threat to the physical integrity of him/herself or others. During such traumatic exposure, the survivor has had an intense emotional response such as fear, helplessness or horror.

I'd like to emphasize that most people exposed to such events do not develop PTSD. Most will cope with the traumatic event(s) successfully without any psychological problems. Others will exhibit behavioral or emotional difficulties for a brief time from which they recover completely. These are Adjustment Reactions. However, a significant minority of survivors may develop PTSD. Among Vietnam veterans, for example, 30% of male and 26% of female veterans developed PTSD at some point following service in Southeast Asia. PTSD prevalence was lower, approximately 10%, following the Gulf War, and 8% following the Somalia deployment. Colonel Hoge is currently monitoring PTSD prevalence among OIF/OEF veterans. It will not be clear for some time how much PTSD will be related to current deployments to Iraq and Afghanistan. As I have noted in a recent editorial in the *New England Journal of Medicine* (Attachment 2), it is too early to project the eventual magnitude of PTSD prevalence that will emerge among OIF/OEF returnees.

People with PTSD exhibit three different types of symptoms.

1. Re-experiencing Symptoms represent symptoms in which the traumatic experience remains a dominating psychological event, sometimes lasting decades or a lifetime. Intolerable traumatic memories provoke panic, terror, dread, grief or despair as daytime recollections, traumatic nightmares or PTSD flashbacks.
2. Avoidant/Numbing Symptoms represent behavioral or cognitive strategies by which the person with PTSD attempts to ward off such traumatic memories. These include avoidance of thoughts and activities that might provoke reexperiencing symptoms or an emotional shutdown, "psychic numbing," through which PTSD patients attempt to control the intolerable emotions associated with such memories.

3. Hyperarousal Symptoms include insomnia, irritability, inability to concentrate, excessive jumpiness known as the startle reaction, and hypervigilence in which PTSD patients are constantly concerned about personal safety.

To qualify for a PTSD diagnosis, individuals must exhibit these symptoms for at least one month and must be significantly distressed or functionally incapacitated by the aforementioned re-experiencing, avoidant/numbing and hyperarousal symptoms. Domains in which such functional incapacity may be expressed include marital, family, social, or occupational function. It is clear that marriages and family well-being are frequent casualties in households where one member has PTSD. This is why outreach to families will be such an important component of any efforts to help OIF/OEF returnees with PTSD.

Finally, it should be noted that PTSD rarely occurs alone. It is often accompanied by other psychiatric disorders, especially depression, other anxiety disorders, and alcohol/substance abuse. We all believe that early detection and treatment is the best way to prevent the development of such co-morbid conditions. Early detection and treatment is also the best way to prevent treatable PTSD from escalating into a chronic and permanently incapacitating state that may last for decades or a lifetime. Finally, recent research indicates that PTSD is a risk factor for comorbid medical as well as psychiatric illnesses. This is why primary and specialty medical practitioners need to screen for PTSD in their clinics since many PTSD patients seek medical rather than mental health care when they become symptomatic.

II. Comparisons between Vietnam vs. OIF/OEF veterans with PTSD

Current research findings suggest that among people who develop PTSD, the syndrome looks the same no matter what the cause. This statement does not merely apply to veterans of different wars but to people who develop PTSD as a result of rape, assault, torture, traffic accidents, and natural disasters. It is not simply the pattern of symptoms or functional impairment that appears similar from one PTSD patient to the next; there are significant biological and psychological alterations, as well. Research involving brain imaging shows that people with PTSD exhibit similar abnormalities in brain structure and brain functioning. Psychophysiological reactivity is altered. Hormonal balance is changed. Cognitive processing and memory function are altered. The capacity to cope with every day stressors is compromised. And marital, family, and social functioning is adversely affected, as noted previously.

As I've stated in a the *New England Journal of Medicine* (Attachment 3), the biggest differences between the post-Vietnam and current era concern the American public's support for its veterans and the advances in PTSD diagnosis and treatment since the 1970's. As for public reaction, OIF/OEF veterans are returning to a nation that recognizes their heroism and sacrifice. Despite deep political divisions about national policy concerning the current conflicts, Americans remain united in supporting veterans. This is crucial since the homecoming is a decisive event for any veteran and returning to a supportive nation can facilitate readjustment to civilian life. Unfortunately, most

Vietnam veterans returned to a divided, if not hostile, public. Such an adverse homecoming appears to have exacerbated PTSD in many cases.

III. Treatment Issues

There has been great progress in the treatment of PTSD. Whereas there were no evidence-based treatments for returning Vietnam veterans with PTSD, we now have treatments that work. The recently developed joint VA/DoD clinical practice guidelines for PTSD (www.oqp.med.va.gov/cpg/ptsd/ptsd_base.htm) to provide state-of-the-art guidance for any practitioner wishing to provide optimal treatment for patients with PTSD. There are both psychotherapeutic and pharmacological evidence-based options available for practitioners. A number of cognitive-behavioral therapies (CBT), Prolonged Exposure, and Cognitive Processing Therapy, have met the most rigorous scientific criteria for efficacy. Other psychotherapeutic techniques are also being tested. Two medications, sertraline and paroxetine, both SSRI antidepressants, have received FDA approval as indicated treatments for PTSD. A number of other promising medications are at various levels of testing. In other words, VA and DoD practitioners have a number of effective treatments available at this time while several other treatments are in the pipeline.

Finally, VA has initiated a Best Practice initiative to ensure that veterans receive the best evidence-based treatments. I am please to tell you that PTSD has been selected as the first disorder to be addressed by this initiative. This should accelerate the pace at which VA clinicians can upgrade their skills in order to provide state-of-the-art PTSD treatment.

Other important advances (cited in my March 11, 2004 testimony before this Committee) include: [1] state-of-the-art assessment and diagnostic capability; [2] the sophistication and motivation of VA practitioners; [3] the availability of PTSD training programs, mentoring and web-based materials for VA practitioners; [4] the Iraq War Clinician Guide developed jointly by the National Center for PTSD and Walter Reed Army Medical Center (available on our website www.ncptsd.va.gov and as a CD-ROM); [5] development of the aforementioned VA/DoD clinical practice guidelines; and [6] a number of exciting collaborative projects between VA and DoD regarding OIF/OEF returnees.

I'd like to emphasize, at this point, that VA has maintained its position as the world leader in PTSD. It is only because of ongoing VA support for PTSD clinical programs, research, education, and for centers of excellence such as the MIRECCs and the National Center for PTSD that we have been able to continue to make such progress in this field.

IV. My current concerns about meeting the needs of OIF/OEF returnees with PTSD

As a longtime VA practitioner, it is heartening to observe the joint VA/DoD efforts to make PTSD services available to OIF/OEF returnees and to make every effort to make sure that people don't fall into the cracks. I have a number of concerns, some of which are elaborated in my two *New England Journal o f Medicine* editorials

(Attachments 2 and 3) or were mentioned during my March 11, 2004 testimony before this Committee:

1. As noted by Col. Hoge's data, stigma appears to be a major barrier to seeking treatment among military personnel. Furthermore, those who are most severely affected are those who are least likely to seek help. This is especially unfortunate, in view of our current ability to provide effective treatments for veterans, if we can just get them into our offices. I believe that stigma will also adversely affect requests for VA treatment among OIF/OEF returnees but not to the extent it is affecting active duty personnel. A number of potential strategies are currently being considered to counteract the impact of stigma, such as: integrated primary/behavioral health clinics, patient and family education, outreach, sensitizing primary care practitioners to screening for PTSD, and strategic use of technology such as telemedicine and web-based information. It is encouraging that both VA and DoD have begun to implement a number of these approaches, especially periodic PTSD screening in VA primary care settings, but all of these initiative s are at an early stage.
2. There is great concern that active duty OIF/OEF returnees will not avail themselves of VA follow-up once they have left military service. There is even greater concern that National Guard and Military Reserve personnel will neither seek VA treatment when symptomatic nor will even be aware of their eligibility for VA services. Data from the Gulf War indicate that PTSD prevalence is higher among Guard and Reserve than among active duty troops, so we consider them a major priority for outreach and follow-up, when indicated. One important advantage that DoD practitioners have over their VA counterparts is the availability of services for military families. Given the importance of family involvement in PTSD treatment, it would be very helpful if VA practitioners had similar clinical options. At present, only the Vet Centers have this flexibility.
3. Military sexual trauma is recognized by VA as one cause of PTSD among men and women. The stigma of such trauma is compounded by peer pressure, unreceptive leadership, or fear of jeopardizing one's career. This can only be overcome if safety and confidentiality can be ensured for victims who wish to disclose such events and if timely treatment can be provided.
4. An unprecedented number of wounded troops - 90% - are surviving their injuries, sometimes with loss of limb(s), eyesight, or other long-lasting medical problems. Veterans with war injuries rank among those at highest risk for PTSD and should be among those with the highest priority for consistent follow-up care.
5. Efforts to support VA clinicians through provision of adequate resources and, when necessary, to upgrade their skills must remain a major priority. The key to VA's pre-eminence in PTSD is the sophistication of its clinicians and the spectrum of treatment options extending from Vet Centers, to community based outpatient clinics, to primary care clinics, to mental health services, to specialized PTSD outpatient and inpatient programs. Since the post-Vietnam era, VA has developed the best, most extensive and most sophisticated

spectrum of clinical programs for PTSD in the world. It must be sustained and fortified to meet the new demand from OIF/OEF returnees.

6. A new challenge for many VA clinicians is the acuteness of symptoms among veterans with adjustment reactions or PTSD. During the post-Vietnam era, most veterans with PTSD were much older and had much more chronic PTSD before they sought or received VA treatment. With the vast improvement in VA/DoD collaboration, an increasing number of OIF/OEF returnees are requesting care at a much earlier stage in their post-traumatic clinical course. This is an important challenge that can be met with a large-scale system-wide training program to address this matter. I am pleased to report that a joint VA/DoD initiative has been set in motion for this purpose.

V. Collaborative Research and Educational Initiatives between NCPTSD and DoD

There are many ongoing collaborative activities between the National Center for PTSD and different DoD components. They fall into three categories. I will list some major initiatives.

1. Gathering the best information available and disseminating it to as many clinicians at as many locations as quickly as possible. This was accomplished by development of the Iraq War Clinician Guide in collaboration with Walter Reed Army Medical Center (available on our website www.ncptsd.va.gov or as a CD-ROM). The Guide covers general topics such as psychiatric treatment of military personnel, assessment guidelines concerning OIF/OEF returnees and a chapter on treatment. Special topics include: treatment of medical casualty evacuees, treatment of amputees, treatment in the primary care setting, military sexual trauma, traumatic grief, substance abuse, family issues and caring for clinicians who treat traumatically injured patients.
2. Training and support: consulting with active duty military personnel. NCPTSD has responded to requests for training on PTSD treatment from many DoD sites. At last count we were actively collaborating with 15 Army, Navy, Marine, and Air Force facilities. In addition, there has been a close working relationship between NCPTSD and the Uniformed Services University of Health Sciences (USUHS) in Bethesda, MD.
3. Collaborative NCPTSD/DoD research
   a. Research on resilience has been conducted at Ft. Bragg to understand biological and social factors that distinguish troops who perform well under high stress conditions from those who do not.
   b. The Parris Island Attrition Study has shown that Marine recruits who had been sexually or physically traumatized prior to enlistment were 1.5 times more likely to drop out of recruit training.
   c. A project with troops deployed to Kosovo, in conjunction with Col. Hoge's staff at the Walter Reed Army Institute of Research (WRAIR) showed that Critical Incident Stress Debriefing provided no benefit with regard to PTSD, depression, well-being, and other factors. Over 1,700 troops entered the study and over 1,000 were assessed 9-10 months later. This study will be repeated with OIF troops.

d. A prospective pre- post-deployment assessment of PTSD has measured neuropsychological and psychological outcomes related to combat theater assessment. This study will follow over 1,500 troops deployed from Ft. Hood and Ft. Lewis. It will also follow several hundred guard and reserve troops. It is a joint effort by the US Army, VA, and VISN 16 MIRECC.
e. DE-STRESS, a brief internet intervention for PTSD, is currently being tested at Walter Reed Army Medical Center.
f. Functional brain imaging, psychophysiological, neurohormonal, and genetic assessment is being carried out on troops from Ft. Drum with and without PTSD.
g. A medication trial is also being carried out at Ft. Drum.
h. Dissemination of evidence-based PTSD treatment is being provided o military mental health professionals at Wilford Hall and Lackland Air Force Base.
i. Integrated primary/mental health care for PTSD is being tested in a pilot project at Ft. Bragg in which Col. Engel has played a leading role.

At this point, I would welcome any questions. On behalf of all my colleagues at the National Center for PTSD, as well as key supporters and collaborators in both VA and DoD, I thank the Committee for this opportunity to testify. I believe we have a remarkable opportunity to learn from past experience, current actions, and ongoing research to provide more help for veterans and military personnel with PTSD than has ever been possible in the past.