



VISN 6 Mid-Atlantic MIRECC Post Deployment Mental Health

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Focus on the VISN

Invited Lectures

Dr. Mira Brancu (MIRECC Registry Managing Director) was a presenter in the webinar *“Developing Resilience in Trauma Workers”* on July 11, 2013. The webinar was hosted by the APA Division 56 (Trauma) Early Career Psychologists Committee.

Dr. Robin Hurley (Associate MIRECC Director, Education Component) presented *“Windows to the Brain: Update on VHA Polytrauma and Neuropsychiatry of Brain Injury”* at the VISN 6 Mental Health Service Line annual meeting in Durham NC, August 15, 2013.

Dr. Harold Kudler (MIRECC Associate Director, Clinical) presented *“Recognizing the Reserve Component: Needs, Access and Treatment Issues Facing National Guard and Reserve Members”* on July 8, 2013 as part of the CBOC Mental Health Rounds sponsored by the South Central MIRECC. His presentation is also now available in TMS.

Dr. Jason A. Nieuwsma (MIRECC researcher) presented *“Integrating Chaplaincy and Behavioral Health Care: Findings From a Mixed Methods Study in the US Departments of Defense and Veterans Affairs”* at the Duke University Center for Spirituality, Theology and Health Research Seminar, July 2013.

National Service

Dr. Robin Hurley (Associate MIRECC Director, Education Component) will serve on the recently re-chartered VA/DoD Health Executive Council Psychological Health I Traumatic Brain Injury Work Group, providing expertise in TBI education and research.

Dr. Harold Kudler (MIRECC Associate Director, Clinical) is part of the national team supporting implementation of the Community Mental Health Summits each VA facility is hosting.

Dr. Jennifer Runnals (MIRECC Repository Managing Director) has been appointed to a 90-day detail to serve as the Interim Director of the VA Heart of Texas Health Care Network (VISN 17) Center of Excellence for Research on Returning War Veterans. The center is considered to be a “sister” center to the VISN 6 MIRECC with its similar focus on post-deployment mental health of Iraq and Afghanistan era Veterans. Dr. Runnals succeeds Dr. Brancu (MIRECC Registry Managing Director), who completed her tour as Acting Director in July.

Clinical Component Update

What is PTSD ... And Who Is It For?

TIME - Military Mental Health - July 26, 2013

<http://nation.time.com/2013/06/26/what-is-ptsdand-who-is-it-for/>

Dr. Harold Kudler's (MIRECC Associate Director, Clinical) recent commentary on controversies in PTSD was based on his presentation in the *Military and Veterans Track* at the last American Psychiatric Association Annual Meeting. He submitted his talk to Time magazine's *Battleland* blog at the request of Dr. Cam Ritchie, Chair of the session. The resulting column is reprinted here.

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Journal Articles

Crawford EF, Fulton JJ, Swinkels CM, Beckham JC; VA Mid-Atlantic MIRECC OEF/OIF Registry Workgroup, Calhoun PS. *Diagnostic efficiency of the AUDIT-C in U.S. veterans with military service since September 11, 2001.* *Drug and Alcohol Dependence.* 2013; 132(1-2): 101-106.

Drescher K, Nieuwsma JA, Swales P. *Morality and moral injury: Insights from theology and health science.* *Reflective Practice: Formation and Supervision in Ministry* 2013; 33:50-61.

Hunter S, Hurley RA, Taber KH. *A Look Inside the Mirror Neuron System.* *Journal of Neuropsychiatry and Clinical Neurosciences* 2013 Summer; 25(3): iv, 171 - 175.

Liu Y, Rimmler J, Dennis MF, Ashley-Koch AE, Hauser MA, the Mid-Atlantic Mental Illness Research, Education and Clinical Center Workgroup, Beckham JC. *Association of variant rs4790904 in protein kinase c alpha with posttraumatic stress disorder in a U.S. Caucasian and African-American veteran sample.* *Journal of Depression and Anxiety.* 2013; S4, <http://dx.doi.org/10.4172/2167-1044.S4-001>.

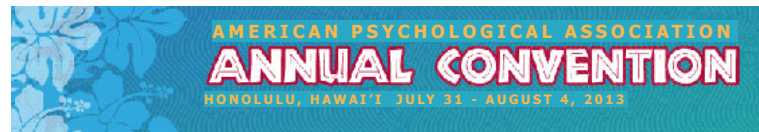
Plaut SM, Brown JK, Brancu M, Wilbur RC, Rios K. *Characteristics of health professionals in a mandated ethics tutorial after violating sexual boundaries with patients.* *Journal of Health Care Law & Policy,* 2013; 16:353-374.

Sripada RK, Marx CE, King AP, Rajaram N, Garfinkel SN, Abelson JL, Liberzon I. *DHEA Enhances Emotion Regulation Neurocircuits and Modulates Memory for Emotional Stimuli.* *Neuropsychopharmacology.* 2013; 38(9): 1798-807.

Strauss JL, Zervakis JB, Stechuchak KM, Olsen MK, Swanson J, Swartz MS, Weinberger M, Marx CE, Calhoun PS, Bradford DW, Butterfield MI, Oddone EZ. *Adverse Impact of Coercive Treatments on Psychiatric Inpatients' Satisfaction with Care.* *Community Mental Health Journal.* 2013; 49(4):457-652.

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Meeting Presentations



American Psychological Association

July 30-August 4, 2013, Honolulu, Hawaii.

Symposium: ML Kelley (Chair), **M Brancu** (Discussant)
Iraq and Afghanistan Era Women Veterans' Mental Health

Curry J, Aubuchon-Endsley N, Brancu M, Runnals J, VISN 6 MIRECC Women Veterans Research Workgroup, VISN 6 MIRECC Registry Workgroup. *Lifetime depression and co-morbidity in women veterans.* [Presidential Theme].

Kelley ML, Runnals J, Pearson MR, Miller MM, Brancu M. *Alcohol use and trauma exposure among male and female veterans.* [Presidential Theme].

Report of the Committee of Professional Practice and Standards:

Brancu M, Hunter S, McDaniels-Wilson C, Wong J. *Do professional practice guidelines truly matter? Issues and strategies in guidelines development, education, and dissemination.*



Association of Professional Chaplains

June 27 - 30, 2013, Orlando, Florida

Nieuwsma JA, Meador KG, Fitchett G. *Navigating a course for chaplaincy in mental health waters: Findings and suggestions from a joint initiative between VA and DoD.* Workshop presented at the APC Annual Conference, June, 2013, Orlando, FL.

Outreach to Providers: Group Supervision for Clinicians Listening to Trauma Histories

Therapists treating PTSD often find themselves in parallel turmoil, as they react to the patient's inner and outer worlds. Good clinical supervision is essential. In addition to receiving guidance and support from an experienced colleague, having the opportunity to share one's often turbulent emotions and learning how these can be used to better understand the case are also important.

Facilitator: Dr. Harold Kudler, Psychiatrist & MIRECC Associate Director - Clinical

Purpose: Assist presenter in processing a case that is particularly disturbing and hard to let go of.

Audience: Trauma clinicians and staff who routinely hear disturbing trauma histories

Objectives: As a result of participating, the attendee will be able to:

- Develop new personal and professional strategies and new clinical understanding;
- Recognize the potential effects of trauma narratives on therapists and staff;
- Identify the importance of on-going clinical supervision in work with trauma

Outcome: By building on the experience of peers and senior clinicians, the attendee will increase his/her effectiveness in serving Veterans, strengthen his/her clinical skills and improve self-care.

Upcoming sessions: September 11 October 9 November 11 December 18

Participation available in person (Durham VA) or by audio-teleconferencing. Register to participate or present a case at an upcoming session by contacting Harold Kudler (harold.kudler@va.gov; 919-286-0411 ext 7021).



CBOC Mental Health Rounds

September 11 from 9-10 am ET

Behavioral Interventions in Dementia Care

Ali Asghar-Ali, MD

You must register in TMS for these sessions in advance to receive credit.

Credits/Hours: 1

Accreditations: ACCME, ANCC, APA, ASWB

VANTS: 1-800-767-1750 Access code-26461#

October 9 from 9-10 am ET

Neuropsychiatric Side Effects of Medication

November 13 from 9-10 am ET

Gun Safety

December 11 from 9-10 am ET

Sleep Disorders

Contact Dr. Geri Adler with any questions:
geri.adler@va.gov or 713-794-8660

Journal Articles

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Swinkels CM, Ulmer CS, Beckham JC, Buse N, VA Mid-Atlantic MIRECC Post-Deployment Registry Workgroup, Calhoun PS. *The Association of Sleep Duration, Mental Health, and Health Risk Behaviors among U.S. Afghanistan/Iraq Era Veterans.* Sleep 2013 36:1019-1025.

Van Voorhees EE, Dennis MF, McClernon FJ, Calhoun PS, Buse NA, Beckham JC. *The association of dehydroepiandrosterone (DHEA) and DHEA sulfate (DHEAS) with anxiety sensitivity and electronic diary negative affect among smokers with and without posttraumatic stress disorder.* Journal of Clinical Psychopharmacology 2013, 33(4):556-560.

Visit our web site for more resources
<http://www.mirecc.va.gov/visn6.asp>

New Resources

MOVING FORWARD
OVERCOMING LIFE'S CHALLENGES

The VA and DoD partnered to develop *Moving Forward*, a free, on-line education and life coaching program that teaches problem solving skills to Veterans, Service Members and their families. This evidence-based program uses interactive exercises and video demonstrations to teach skills for overcoming life challenges such as relationship problems, financial hardship, and re-adjustment issues. Introduce your patients to this anonymous, always available, web-based resource and empower them to keep Moving Forward!

www.StartMovingForward.org

Educational Resources from the TBI Model Systems Carolinas Site

Heads Up - *An Ounce of Prevention*

Heads Up - *Fatigue*

Heads Up - *Irritability*

Heads Up - *Plans for the Future*

Heads Up - *Sleep Disturbances after TBI*

<http://www.carolinashealthcare.org/carolinas-rehab-heads-up-educational-resources>

Noon V-tel Lecture Schedule:

September 13 TBA

This series is presented by V-tel and audio conferences. We are having increasing participation from sites outside VISN 6, so our assigned numbers may change. The number that each VISN 6 site will use to dial in will be included in an email notification prior to each presentation.

If you wish to attend from a site outside of VISN 6, please contact Mary Peoples (mary.peoples1@va.gov; 704-638-9000 ext 2956).

★ Free ★ Web Courses for Providers

Treating the Invisible Wounds of War

www.aheconnect.com/citizensoldier

Click on **New Users** to register. You will then see the available web courses listed:

- 1 - *Post Traumatic Stress Disorder (english & spanish editions)*
- 2 - *A Primary Care Approach*
- 3 - *Issues of Women Returning from Combat*
- 4 - *Recognizing the Signs of mTBI during Routine Eye Examinations*
- 5 - *Understanding Military Family Issues*

These courses were developed by MIRECC faculty in collaboration with Citizen Soldier Support Program (CSSP) and North Carolina Area Health Education Center (NC AHEC). They are designed to help primary care physicians, case workers, mental health providers - who may see a veteran or family member on an unrelated issue - develop a better understanding of the culture in which veterans and their families live and work, and provide best practices for identifying, assessing and treating mental health problems that result from the trauma of war.

What is PTSD ... And Who Is It For? By Harold Kudler

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The light went on in my head during a debate over PTSD nomenclature last year. Then-president of the American Psychiatric Association, John Oldham, was chairing a session entitled *Combat-Related PTSD: Injury or Disorder?* A stellar panel of trauma experts — retired generals, senior researchers and key framers of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders — debated whether the term, post-traumatic stress disorder (PTSD) should be changed to post-traumatic stress injury (PTSI).

Supporters of the change to “injury” argued that it might help overcome the stigma that many military members and veterans associate with seeking treatment for PTSD. Service members aren’t happy to report “a disorder” but might be willing to admit an injury. Those in opposition argued that “injury” is too imprecise a term for psychiatric diagnosis and treatment.

As I sat through the heated session, it struck me that they were also implying that the term, disorder, is somehow “more scientific” and, therefore, “more psychiatric.” From the perspective of science, it seemed to me that the real question here was whether there is any evidence that changing the name of PTSD would actually promote health: neither side seemed interested in researching that very answerable question. This made me wonder if we were actually debating about science or, perhaps, whether we were arguing about something else.

Following up on this year’s APA session in San Francisco last month (and, in particular, its 45-session Military Psychiatry track organized by Elspeth Cameron Ritchie, M.D., MPH, retired U.S. Army colonel and now chief medical officer for the District of Columbia’s Department of Mental Health) triggered that recollection, and others connecting to the vexing challenge of PTSD, or whatever you want to call it.

Among the key questions that occurred to me was “*Who is DSM, the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, actually written for?*” If for patients, shouldn’t its language be crafted to serve them best (and shouldn’t we be doing research to find out how it might best serve them)? If for professionals, do we psychiatrists really believe that treating injuries is less consistent with science or with the practice. Don’t most physicians treat injuries? And might we be conflating medicine with science in worrying about being “precise” in describing mental disorders? While I’m all for precision, we don’t really know enough about the basic science of any mental disorder to be very precise in diagnosing or treating it. This is particularly so with PTSD, a complex clinical problem in which a stressful life experience perceived by the mind becomes an intricate and enduring problem of mind, body and society.

Stepping back a bit, these considerations raise the question of whether DSM is a clinical document or a research document. While based on a good deal of research, DSM is primarily meant to help clinicians make sense of their patients’ symptoms and signs by providing a basis for diagnosis and subsequent treatment. Am I a scientist or a clinician? For that matter, if I were ill, would I seek medical care from a scientist? Would anybody?

Controversy about DSM V

One of the highlights of the 2013 meeting of the APA was the release of DSM V, the long awaited, much debated revision of our diagnostic system. In the run up to the May meeting, many psychiatrists had noted the words of an April 29 blog post by Thomas Insel, Director of the National Institute of Mental Health (NIMH)

In a few weeks, the American Psychiatric Association will release its new edition of the Diagnostic and Statistical Manual of Mental Disorders... While DSM has been described as a “Bible” for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength... of DSM has been “reliability”... The weakness is its lack of validity. Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure... Patients with mental disorders deserve better. NIMH has launched the Research Domain Criteria (RDoC) project to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system... we cannot succeed if we use DSM categories as the “gold standard.” The diagnostic system has to be based on the emerging research data, not on the current symptom-based categories. ... We need to begin collecting the genetic, imaging, physiologic, and cognitive data to see how all the data – not just the symptoms – cluster and how these clusters relate to treatment response. That is why NIMH will be re-orienting its research away from DSM categories...

In this connection, it’s important to point out that when NIMH, one of the major funders of mental health research in the U.S. and around the world, says that it is going to shift away from research on the DSM categories, this means that a great many projects and careers are about to be affected. Since the 1980s, most psychiatric research has been cast precisely in terms of DSM categories — the ability to do so was the strongest argument for the modern structure of DSM. If the funds are about to follow another conceptual basis for grouping and understanding mental illness, this will be a sea change for psychiatry in America, and pretty much everywhere else.

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What is PTSD ... And Who Is It For? By Harold Kudler

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What happens to the concept of PTSD once it is deconstructed into its Research Domains? Is there room for understanding the personal meaning of the traumatic event: for grief, guilt, shame, moral injury, intergenerational history or any other dimension of human experience which clinical experience and abundant research demonstrate to have significant importance in understanding and treating PTSD? And what has become of the patient in this debate?

Where Does This Leave Psychiatry at the Beginning of the 21st Century? Pretty much where it was at the end of the 19th Century! For late-19th-Century psychiatrists, the study of mental health and illness was synonymous with the study of the brain. New technologies led to a cascade of neuroscientific discoveries which promised to reveal the nature of mental phenomenon and offer new treatments for debilitating disorders. New diagnostic systems reclassified mental illness. It was a time much like our own.

Still, for all the many breakthroughs in late-19th-Century psychiatry, perhaps the most revolutionary was Joseph Breuer and Sigmund Freud's 1895 declaration in their Studies on Hysteria that "...*psychical trauma — or more precisely the memory of the trauma — acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work...*" Thus Breuer and Freud identified traumatic memories as discrete agents of pathology in mental illness, much like a splinter under the skin, or a germ within its host. The idea that a memory could, in itself, be pathogenic, was a critical step beyond the then predominant brain degeneracy theory of hysteria and marked the beginning of modern psychiatry. Yet, although Breuer and Freud agreed that psychological trauma was provoked by overwhelming events, they differed decisively on how memories became pathogenic.

Biological Bias Then and Now

In early-21st Century psychiatry, many continue to think of psychological trauma as a pathogen (like a germ) inducing discrete changes in biological structures and processes that interact with genetic vulnerabilities to produce specific mental disorders. Following the disease model, modern psychiatry seeks the "antibiotic" which will eradicate the pathogenic memory. This underlying assumption is in operation whether we offer a drug meant to alter the activity of the amygdala, reset a receptor, or counter a gene in the aftermath of psychological trauma. It also applies in "body therapies" or EMDR, Eye Movement Desensitization and Reprocessing, therapy.

Freud, whose life ambition had been as a biological researcher and who had already made significant neuroscientific discoveries (including defining the neurological phenomenon, agnosia, and being the first to recommend the use of cocaine as a local anesthetic) had to leave neuroscience behind for the same reason that APA and NIMH now disagree on how to frame DSM V: science has yet to supply the missing links between the biology of the brain and the disorders of the mind. Lacking available neuroscientific tools but still needing to understand and treat his patients, Freud proceeded to work with mental disorders including posttraumatic disorders at the level of human experience (and with success).