For Veterans, a Surge of New Treatments for Trauma

By Tina Rosenberg  September 26, 2012 7:00 am

 Fixes looks at solutions to social problems and why they work.

Suicide is now the leading cause of death in the army. More soldiers die by suicide than in combat or vehicle accidents, and rates are rising: July, with 38 suicides among active duty and reserve soldiers, was the worst month since the Army began counting. General Lloyd Austin III, the army’s second in command, called suicide “the worst enemy I have faced in my 37 years in the army.” This Thursday, the Army is calling a “Suicide Stand-Down.” All units will devote the day to suicide prevention.

There are many reasons a soldier will take his own life, but one major factor is post-traumatic stress.

Anyone who undergoes trauma can experience post-traumatic stress disorder — victims of rape and other crimes, family violence, a car accident. It is epidemic, however, among soldiers, especially those who see combat. People with PTSD re-experience their trauma over and over, with nightmares or flashbacks. They are hyperaroused: the slam of a car door at home can suddenly send their minds back to Iraq. And they limit their lives by avoiding things that can bring on the anxiety — driving, for instance, or being in a crowd.

PTSD has affected soldiers since war began, but the Vietnam War was the first in which the American military started to see it as a brain injury rather than a sign of
cowardice or shirking. A study of Vietnam vets 20 years after the conflict found that a quarter of vets who served in Vietnam still had full or partial PTSD.

America’s current wars may create even more suffering for those who fought them. In the Afghanistan and Iraq conflicts soldiers have been returned to these wars again and again, and they face a deadly new weapon — improvised explosive devices, or I.E.D.’s — which cause brain injuries that, terrible in themselves, also seem to intensify PTSD. “We surmise PTSD will be worse,” said Dr. James Kelly, the director of the National Intrepid Center of Excellence, which studies and treats the intersection of PTSD and traumatic brain injury. “Some people are on their 10th deployment. Previously, people didn’t have those doses. And there are multiple blast exposures and other blunt blows to the head. This kind of thing is new to us.”

When we think about treating PTSD, we usually picture a single patient and a psychotherapist. The two treatments in widest use are, in fact, just that: cognitive processing therapy, where patients learn to think about their experiences in a different way, and prolonged exposure, in which the therapist guides the patient through re-experiencing his trauma again and again, to teach the brain to process it differently.

These therapies help a lot of veterans — about 40 percent of those who go through treatment are cured. But there are many, many more suffering veterans who are not helped. It’s not just that these treatments don’t work for everyone — no therapy does. More important, they are not broad enough. PTSD is often accompanied by and entwined with other serious problems — depression, sleep disorders, chronic pain and substance abuse. Sometimes these resolve if the PTSD does, but often they require specific attention — which the standard PTSD therapies don’t provide.

There is another way these treatments need broadening — they need to reach more people. The military and Veterans Affairs hospitals do not have enough psychotherapists to offer them on the necessary scale. And many soldiers are wary of psychotherapy and afraid of the stigma it carries.
Today, the military is fighting that stigma. The V.A. is trying to integrate mental health care into primary health care; soldiers are now routinely screened for issues like PTSD, depression or substance abuse. A public awareness campaign called AboutFace features dozens of vets talking about their PTSD and how they got better — the point is: they are people just like you. A new program called Comprehensive Soldier and Family Fitness builds in resilience training for all soldiers at every phase — pre-deployment, in theater, upon return. It seeks to make regular mental health exercises as routine for soldiers as physical training.

According to a recent report by the National Academy of Sciences’ Institute of Medicine, since 2005, the Pentagon and the V.A. have greatly increased funding for PTSD research. The V.A. has added 7,500 full-time mental health staff members and trained 6,600 clinicians to do cognitive processing and prolonged exposure therapies. Starting in 2008, all large V.A. clinics were required to have mental health providers onsite. The V.A. also added more centers that offer free, confidential counseling. Mobile centers bring counselors (themselves combat vets) to rural areas where other counseling is scarce.

All this effort however, is falling short. Only about 10 percent of those getting mental health care in the V.A. system are veterans of Iraq or Afghanistan — a vast majority of those treated are still Vietnam veterans. But some 2.4 million soldiers have been through Iraq and Afghanistan. The RAND Corporation’s Center for Military Health Policy Research did a telephone survey of vets from these conflicts and found that one-third were currently affected by PTSD or depression or report exposure to a traumatic brain injury — and about 5 percent had all three. RAND also found that only half of those who reported symptoms of major depression or PTSD had sought any treatment in the past year.

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Individual therapy is not the only way to treat PTSD. In January, a young man with the nickname of Trin (he asked that his real name not be published) sat down in a small, drab, room at a Veterans Affairs clinic in New Orleans with nine other men. All were veterans — of Iraq, Afghanistan, Operation Desert Storm or Vietnam; Trin
had served in Iraq. All had PTSD. The men took chairs facing each other around tables pushed into a square, along with two women, who were running the group.

The facilitators asked everyone to do three drawings: of how they felt, where they were and where they wanted to be. Trin drew himself with no facial features. The next week, the facilitators put on some music and everyone stood up, faced a wall, and bounced to it. At other sessions they took large sheets of paper and colored in their family trees, with different colors for divorces, early deaths, conflicted relationships. And at almost every meeting over 10 weeks, they practiced conscious breathing and mindfulness.

“When they asked us to draw and color, people were rolling their eyes,” Trin said. “We had older gentlemen, and some people might have thought this is kind of soft — not my lane.”

Trin was anxious, cold and short-tempered. He was drinking a lot. Before starting this group, Trin had tried individual therapy, with no success. “My psychiatrist would ask a question and I would answer it,” he said. “It was like talking to a wall. He didn’t understand what I had gone through.” He gave Trin a prescription for an anti-anxiety drug, which helped a little.

When Trin heard about the group, he quickly volunteered. By session five — the midpoint — he was sure it was helping. His sleep improved. The breathing exercises were things he could use to calm down. And having the group itself helped — men who had been through what he had gone through. On the last day, the group passed around stones — one for each participant. When your stone was passed around, each group member had to say something nice about you. “We put all that energy and kindness into each stone,” said Trin. He carries his in his pocket.

Trin’s program is a 10-week course designed by the Washington-based Center for Mind-Body Medicine. It is one of perhaps half a dozen different kinds of alternative therapies being tried for PTSD in military and V.A. hospitals.

You name it, and it’s being used somewhere in the veterans’ health system: The National Intrepid Center in Washington is one of many places using acupuncture to treat stress-related anxiety and sleep disorders; it has been shown to be effective
against PTSD. At the New Orleans V.A., the same clinicians who ran Trin’s group also did a small study using yoga. They found vets liked it and attendance was excellent. The yoga reduced the veterans’ hyperarousal and helped them sleep. There is even a group in the Puget Sound V.A. Hospital in Seattle that treats PTSD — including among Navy Seals — using the Buddhist practice of “loving kindness meditation.” (“We had a little bit of debate about changing the name,” said Dr. David Kearney, who led the group. “But we decided to keep it, and it worked out just fine.”)

One of the most promising techniques is mindfulness, inspired by Buddhist teaching, which emphasizes awareness of the present moment in order to choose how to respond to thoughts, feelings and events. Dr. Amishi Jha at the University of Miami is working with the military to develop mindfulness-based training for soldiers before they deploy, and Dr. Kearney has done a very small study of the effect of mindfulness on PTSD.

The Center for Mind-Body Medicine’s program — the one Trin did — is the most comprehensive of all of them, giving participants a variety of different strategies to choose from: breathing, meditation, guided visual imagery, bio-feedback, self-awareness, dance, self-expression, drawing. And it is the one with the strongest evidence that it works to cure PTSD. In a trial in a Kosovo high school, students with PTSD who did the 10-week program had significantly greater reductions in PTSD than a control group of students assigned to wait for the course. Other before-and-after studies (with no control group) in Gaza have found an 80 to 90 percent reduction in PTSD with the technique, and those results still held months later. This is significantly better than any currently used individual therapy.

The Mind-Body program is in use at various V.A. hospitals, military bases, and at the National Intrepid Center. In some places it is studied, as well. At the Minneapolis V.A. Health Care System, for example, the psychologists Beret Skroch and Margaret Gavian found that in a Mind-Body group of patients with numerous problems, about 80 percent showed improvement.

Trin’s group in New Orleans is part of the first randomized controlled trial measuring the program’s effect on PTSD among U.S. veterans. Researchers are still measuring whether the results lasted two months after the last session, but Dr.
James S. Gordon, the founder and director of The Center for Mind-Body Medicine, said that the patients’ improvement at the last session was “at least as good” as the individual therapies the V.A. uses, with significantly lower dropout rates.

If those results hold up, then mind-body medicine is a potentially valuable addition to the V.A.’s limited menu of widely used therapies. It is built for large scale: psychotherapists are welcome but not necessary. Some of the groups are run by lay people; in Kosovo, high school teachers ran the groups. In Gaza, Center staff have trained 420 group leaders and worked with 50,000 people. Gordon said the center is currently capable of giving 10-day training and support for 1500 group leaders a year.

Another advantage is that the program is broad-spectrum, showing success not only with PTSD, but depression, pain, sleep disorders and substance abuse. Dr. Barbara Marin, chief of addiction treatment services at Walter Reed National Military Medical Center, uses it there for patients with substance abuse problems. She calls it a “very effective” model.

Mind-body medicine and the other alternative therapies, moreover, may be more attractive to soldiers than the individual treatments, which have a 20 percent dropout rate. Both C.P.T. and prolonged exposure ask the patient to relive his trauma — an upsetting prospect for many soldiers. Some veterans avoid psychotherapy because they do not want to be singled out, judged and labeled deficient.

The alternative medicine groups, by contrast, have a dropout rate of virtually zero. Members can talk about their past trauma if they wish, but there is no pressure to do so. Instead, the groups are centered on the present, helping members to learn practical skills they can employ immediately. The facilitator does not sit in judgment — she’s a participant in the group, sharing skills she might use herself for better sleep or stress reduction. Everyone, after all, can use help dealing with the stress of re-entry to civilian life. Going to a skills group instead of psychotherapy could remove much of the stigma of treatment.

Despite the vast increase in research money, studies of these skills groups have been small and isolated. Only randomized controlled trials are persuasive enough to
get Washington to adopt a therapy on a wider scale, but these are too few and too slow, and starting new ones now would take years. It is time to take the most promising ideas and try them with thousands of people, not just a few dozen — and if they work, to expand them further. That is not cautious. But to continue with therapy as usual is to condemn hundreds of thousands of soldiers to a tour of duty without end.

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