

Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

**organized and edited by
The Erich Lindemann Memorial Lecture Committee**

hosted by William James College



**WILLIAM JAMES
COLLEGE**

Table of Contents

Foreward.....	3
Returning War Veterans: Meeting Health Needs of Veterans, Families, and Communities	4
Introduction by David G. Satin, MD and Nicholas A. Covino, PsyD	5
Jaine L. Darwin, PsyD.....	8
Introduction by David G. Satin, MD.....	8
Jaine L. Darwin, PsyD.....	8
Richard T. Moore, MA	14
Introduction by David G. Satin, MD.....	14
Richard T. Moore, MA	14
Jonathan Shay, MD, PhD.....	18
Introduction by David G. Satin, MD.....	18
Jonathan Shay, MD, PhD.....	18
Discussion	22
Questions and Answers.....	22

Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The insights and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this approach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated. For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE THIRTY FIRST ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE
IN MEMORY OF ELIZABETH BRAINERD LINDEMANN

Returning War Veterans: Meeting Health Needs of Veterans, Families, and Communities

We are faced with the mental health care of veterans returning from the destruction of war—again. How do we respond to humans reacting to inhuman experiences? How do we respond to the families and communities that are part of their lives and struggles? How do we deal with war, that public health hazard which produces these casualties? This Lindemann Lecture addresses these issues from clinical, political-administrative, and social-historical perspectives.

Speakers

Jaine L. Darwin, PsyD, Co-Chair, Strategic Outreach to Families of All Reservists, Clinical Instructor in Psychology, Harvard Medical School, Supervising Analyst, Massachusetts Institute for Psychoanalysis

Richard T. Moore, MA, Senator, Massachusetts General Court, Chairman Health Care Financing Committee

Jonathan Shay, MD, PhD, Staff Psychiatrist, Veterans Administration Outpatient Clinic, Boston; Author of *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (Scribner, 1994), and *Odysseus in America: Combat Trauma and the Trials of Homecoming* (Scribner, 2000)

Moderator

David G. Satin, MD, DLFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

Friday, June 13, 2008, 2:30 – 5:00 pm

*Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132*

Introduction by David G. Satin, MD and Nicholas A. Covino, PsyD

Dr. Satin:

I want to welcome you to part of the series on Returning War Veterans: Meeting the Health Needs of Veterans, Families and Communities.

This lecture in particular is dedicated to Elizabeth Brainerd Lindemann. Betty Lindemann was dedicated to community mental health. She was a social worker at community agencies, a teacher, a researcher at the Wellesley Human Relations Service, a mentor and friend to many graduate students, mental health colleagues and their family members, as well as a confidant and consultant to her husband Eric Lindemann. She was also mother to Beth, Brenda, and Jeffrey Lindemann and grandmother to Amy, Jamin, and Andrew. Betty lived a long and vibrant life. You can see her in one of her more vibrant postures at her summer home in Vermont. After declining in health for some years, she died on July 20, 2007.

Nicholas Covino:

This is a very important topic and your presence here shows us that this is a very important topic for us to be thinking about.

Somewhere on the order of 20 percent or 1.6 million people have flashbacks, depression, and post traumatic stress disorder syndromes. About an equal number had concussions and head injuries and neck injuries as a result of this Iraq war. It is also the case that a large number of families have been destabilized, have found themselves in very unfortunate situations where loved ones have died in the war or have been injured or even in a fortunate stressful situation of having to integrate somebody that they have been without for a period of months or years or longer.

When we have several hundred thousand people in a situation like that we have a significant public health crisis and we all need to think about how to bring our resources to bear about this because historically we have not done that very well. And so, Eleanor will tell me, as she is doing the public relations for this event, that she has received a dozen notes from Vietnam-era veterans that served who were worried about us and what is all this attention and what about us. Typically we either suppress or repress or deny or distance ourselves from the costs of war. This is what we do. We may equally make them overly heroic and also distance ourselves from the real stories of real people. But, we rarely listen and we rarely listen well. This is a problem that will lead a multi-disciplinary community focus to draw all of our resources to solve it. So, I welcome Senator Richard Moore who is an educator, a legislator and an expert on disaster relief who currently is the chair of the legislative healthcare finance committee; Dr. Jonathan Shay, who is a

clinician and an author who encourages us to aid Veterans reentry by being active listeners to their combat narratives; and Dr. Jaine Darwin, who I am pleased to say is one of our graduates and a psychoanalyst who saw the need of these families and worked with her peers to create a voluntary network of support for them that she will describe for you.

In addressing this mental health crisis- we really need legislative leadership, we really need guidance from clinical research and we are really going to need to find ways to be generously involved with each other to bring resources that we have to bear in an area of tremendous need. Thank you all for your generosity and for your leadership in this area and for coming today, welcome.

Dr. Satin:

Thank you. As you can see, this issue of love and war and struggles and that is going to key into a lot of experiences of people. The structure of the lecture will be that we will have presentations from our speakers: First Dr. Jaine Darwin on the services to military personnel and their families; then the Honorable Richard Moore on government and public health programs for the population, and then Dr. Jonathan Shay on the effect of war on mental health and preventative mental health approaches. After that there will be discussion among the speakers so please be a part of this Lindemann Lecture and not just an observer.

A couple of words of introductions since I have the microphone. The social sciences look at social institutions, values, and behaviors. The clinical disciplines look at the origins and correction of dysfunctional and destructive feelings, behavior and relationships. Community mental health and social psychology look at the mutual influence between social environment and the function of the individuals and small groups. We're used to dealing with life crises, destructive relationships, deprivation of essential needs and biological pathologies. Today, we expand to address a larger traumatic environment.

Eric Lindemann, who was one of the first to be interested in mass casualties, community relationships, open redevelopment, and the effects of rapid social change, once noted that if you have a little war this will have major effects on the mental health of large populations. Now, we have some wars at hand that demand that we pay attention to the mental health consequences. Today, we are fortunate to have 3 speakers experienced in different aspects of this issue of community mental health, the care of the individuals, the community's preparation for this public health problem, and ways of preventing and preparing for the mental health aspects of war. From a community mental health perspective, I am eager to hear primary prevention addressed, dealing with the causes and not just the consequences of the mental health problems.

We can struggle against sources of an infection, malnutrition, emotional deprivation, but how do we encompass the large forces that lead to war? I raise this as a background issue, a prospective on the more specific ones. I recently came across this paper written in 1964 by Jerome Frank, professor of psychology at John's Hopkins. It is called "Group Psychology and the Elimination of War." The elimination of war, he said, requires a modification of group standards supporting war and the development of alternative ways of defending one's society and one's values. The specific group beliefs that need to be changed are absolute national sovereignty, the idea that under certain circumstances war is both diffusible and a proper of way of pursuing the interests of one's group; the idea that arms strength is equated with determination and courage, and the tendency to reject and dehumanize the outsider. Efforts to eliminate war might include building a sense of world community, breaking the link between violence and courage, and attacking the defense of the morality of war. To address these larger issues, keep these preventive issues in mind as we discuss the mental health consequences of war.

Jaine L. Darwin, PsyD

Co-Chair, Strategic Outreach to Families of All Reservists; Clinical Instructor of Psychology, Harvard Medical School; Supervising Analyst, Massachusetts Institute for Psychoanalysis

Introduction by David G. Satin, MD

Our first speaker is Jaine Darwin, who received her doctoral degree from the Massachusetts School of Professional Psychology, has a certificate of psychoanalysis, and is a supervising analyst and member of the curriculum committee of the Massachusetts Institute for Psychoanalysis. She is a clinical instructor of psychology at Harvard Medical School, a clinical supervisor of the Victim's of Violence Program at the Cambridge Hospital, co-chair of SOFAR the Strategic Outreach to Families of All Reservists, and in the private practice of psychoanalysis of psychotherapy. Additionally, she has published among other things, "Wounded Warriors, Citizen Soldiers Changed Forever" and "PTSD: Its Symptoms How Families and Friends Can Help the Veterans," and the book *The War's Returning Wounded, Injured and Ill*.

Jaine L. Darwin, PsyD

I'm going to talk to you today about the real side of the war. In our community and in our clinical practices and about the many people who need, but do not or cannot access mental health services. The media talks of stories about the veterans who have returned from Iraq and Afghanistan- they are only one place as a problem and I hope to convince you that we are facing a public health crisis and to challenge you to respond to the needs I am about to elaborate.

Donald Winnicott, a British psychoanalyst said, "There is no such thing as a baby, there is a baby in someone." And, I would propose that "there is no such thing as a soldier, there is a soldier in someone." Actually, in each soldier, there are many people part of the soldier's service. The picture here is from a year in Iraq in August, 2006. So, when you think about how many people are impacted by in-service service, this is the best graphic example.

Since the beginning of Operation Enduring Freedom in Afghanistan, 1.7 million soldiers have deployed a total of 2.2 million times. Assuming each soldier has 7 people in their family- spouses, fiancés, children, parents, siblings, grandparents- there are approximately 11.5 million people impacted by the war. If we go out one more concentric circle further, and allow that most soldiers have at least 6 cousins, uncles, aunts, nieces, nephews, friends and neighbors- there are approximately 70 million people impacted by

war which is 2% of the population is living. One-third of this 70 million are between the ages of 0-18.

When a soldier deploys, the whole family serves. When a soldier returns home, the whole family is impacted. In this war, 410,000 serve in the National Guard. The National Guard are the military reserves or citizen soldiers. Their families are isolated in the community during the soldier's deployment. They are often isolated upon returning back to a civilian job. The National Guard reservists seem to suffer more severe mental health consequences than their colleagues in the active duty military and all soldiers are suffering serious consequences from the conflict. 300,000 soldiers returning have been diagnosed with PTSD or major depression, and 1 in 5 will be diagnosed with PTSD or Posttraumatic Stress Disorder. Three hundred and twenty thousand (320,000) soldiers have been diagnosed with a traumatic brain injury. Forty thousand (40,000) soldiers have been receiving treatment for substance abuse. Fifty percent (50%) of returning National Guard reserve come back with a diagnosable mental health condition- anxiety, depression, and transient stress compared to 41% of active duty military.

Now, this is different from the PTSD statistic. So, of the 50%, some of them will go on to develop PTSD and some of the are coming home and manifest itself and are diagnosed with the condition (PTSD). Suicide rates are sky rocketing. There are 1,000 suicide attempts each month. Today, the completed suicide in the civilian population is 8.9% per 100,000 people. Completed suicide in the military population is between 18.9 and 22.9 per 100,000. Based on the Rand Report recently commissioned by the military Dr. Thomas Insel, Director of the National Institute of Mental Health, said that it is possible that suicide and mortality "could trump combat death" and that 4,500 troops have died in Afghanistan and Iraq to date.

What are the costs of these mental health and cognitive conditions to the individual and society? I'm now quoting from the Rand Report, "Unless treated, each of these conditions has wide-ranging and negative implications for those afflicted. We considered a wide array of consequences that affect work, family, social functioning and we considered co-occurring problems, such as substance abuse, homelessness, and suicide."

Twenty-eight thousand (28,000) veterans have returned to Massachusetts at the conclusion of their military service. What are their needs and how are we going to help them? To answer this question, we have to think about what happened during each of them facing war zones and on the home front where their loved ones also served. Our soldiers spend up to 18 months in each of these war zones where because of improvised explosive devices (IEDs) and suicide bombers, no area is without risk.

The soldier bonds in combat because each depends on the other for safety and support. The soldier has two families- the family that he or she fights alongside and the family to whom he or she returns home. This is a particularly bigger issue for the families

to share their soldier with another family. The family, during the same period of time continues their activities of daily living without the help of the acting family member. Every parent has become a single parent. The family worries about the soldier's safety and of the dreaded knock on the door by the casualty officers who might announce the death of the soldier. Every time the family hears about a fatality, anywhere their soldier might be serving. They go through this white-knuckle period until they hear that their soldier is okay.

The family deals with area school problems, that carry with them a financial strain. Soldiers and families communicate by e-mail via Skype or cell phone. The soldier and the family worry about how much to share, what will burden the other. Is the soldier safe? Will the humvee blow up if they hit an IED? Does the family tell the soldier that a relative is gravely ill or that one of the kids was suspended for smoking in the school bathroom? The National Guard reservist- the family becomes what Time Magazine called semi-military families. They have no road map for this new family. I have heard military advise the families never to tell the soldier anything that could be a worry. But if you were a soldier related to a family member who always ran around yelling, "The sky is falling, the sky is falling!" Might he not spend more time worrying about what you are not being told, than dealing with whatever is wrong?

Parents of young soldiers are particularly taxed, as they struggle to integrate the image of the teenager who might not have been the poster child for responsible behavior and a young adult who is entrusted to save our country. These children and siblings are the only children in their school with serving loved ones. They may develop behavior problems, eating problems, and depression. Frighteningly, the rate child abuse or maltreatment rises by 42% or higher when the other parent is deployed.

A mother of three children ages 1-3 years-old was seriously depressed and was given an official psychiatric diagnosis so that the Family Action Center could petition to bring the husband home on emergency leave. She had moved to a community an hour from home when her husband deployed and could not get out of bed most days. I recommended that she immediately be evaluated at a small center. I spoke to her by phone, urging her to allow them to take her for evaluation at the local emergency room. After some pressure on my part I was able to cajole her to go to the emergency room, with the promise that it would hasten her husband's return. She was evaluated and admitted. When she was at the hospital several hours later, the process to return her husband had just begun. She is now properly medicated and her husband was able to arrange services during the week, but I tell this anecdote to put a real face on a statistic. Because it is very easy to think about these statistics and to forget that there are families behind them. A wife, whose husband was deployed during any part of her pregnancy,

suffers from 3 times the risk of developing postpartum depression compared to the civilian population.

Here's what happens when the soldier comes home. A soldier may return home, but the soldier's nervous system is still on high alert. As one family member said, "You get a soldier home first, but your husband may not come back for months." Soldiers are jumpy, they startle easily, and they may be uncomfortable in open spaces or crowds. One family took their soldier out to dinner after his return for a night. He wanted to leave the restaurant immediately, but consented to stay only after they found him a seat with his back against the wall, so that he would not fear ambush throughout the meal. You can imagine what it is like to go from a war zone to a place where business has been going on as usual and as Jackie so eloquently talked about- life has gone on without you.

They may stop 50 feet from where they need to stop in the road. He wouldn't let his family drive home from the return ceremony. They really traverse the road like this- to divert IED's. Smells and sounds may evoke memories of the war zone and cause panic attacks. They may feel unrelated in the family that learned to function without them. They would still have a period of readjustment. On the ground- everybody has changed. Daddy's little girl that he remembered has turned into an adolescent with the, "How stupid can you be?" and an eye roll. You know that look, and Mom has been used to this because she's has seen it for years.

Twenty percent (20%) of returned married troops are planning a divorce. According to a report that Army's Mental Health Advisory Team released in February- they surveyed mental health specialists working with soldiers in Iraq and Afghanistan. They quoted one worker as saying, "Fifteen month deployments are designed to destroy marriages."

Lisa Gorbaty, a doctoral student here at MSPP, whose dissertation committee I had the privilege of serving on, has just finished a ground-breaking study about the family integration of returning service members following a one-time deployment. It's a qualitative exploration of wives' experience. I hope Lisa will talk about her findings during the discussion period. We need research like this to help us build service delivery models that make sense to the people being served, not the hypothetical things that feed us ideas of what a family needs.

Since the summer of 2003, Ken Reich and I have co-directed SOFAR for continued outreach to families of all reservists. It is a mental health project that provides psychotherapy, psychoeducation, and prevention services to extend to the family of National Guard and reservists serving in Iraq and Afghanistan.

Our goal is to prevent and to treat trauma in the soldier and secondary trauma of the family member. We all know the effects of secondary psychological trauma. Sharing in the trauma of the soldier, seeing or hearing or imagining that it's happening, make

family members deal with the trauma too. This is called secondary trauma. SOFAR helps families cope with secondary trauma. About 2 years ago our program appeared in a magazine. (Inaudible). My husband is still at home and not away or not away physically anyway. One of the responsibilities my husband had was to care for the wounded that returned home as well as the soldiers killed in action. He visits them at the VA Hospital and visits them when they return home. He also visits the family of the soldier, often he is present when bodies return home and attends all funerals.

Recently a soldier who was killed in action was my husband's soldier. My husband was out of town when the family found out about their son's death. He asked me to go over and bring some flowers for the family and meet the parents. When my husband returned he met with them as well. He asked if I would go with him to the home and be present when the body arrived. I did so, it was difficult but I was glad that I could have helped comfort others. Now, more and more soldiers are wounded and my daughter has volunteered to make Purple Heart pictures to give to the soldiers, she is 8 years old. One soldier is coming home this afternoon and my husband wants our daughter to present the pictures and meet the soldier.

My present dilemma, since I helped with the reunion of that one soldier I cannot sleep very well, concentrate very well. I am very afraid of my daughter being exposed to the effects of war though when her father is called up and activated to Iraq she will be so worried and upset. Is it okay to tell my husband that I think that I am having an incredibly difficult time with the tragedy that I see around me? I never want to let this be my responsibility. The cost of having to deal with this- this is hell. I think that it would really be helpful for me to access mental health services. I just want to emphasize how much our families serve when the soldier serves.

By providing opportunity for families to come together and share concerns, they feel less isolated and then they realize that others share their feelings and concerns. It can be traumatizing, the hypervigilance, the nightmares, the flashbacks...I'm going to read to you the first paragraph of an article that appeared in the New Jersey Herald News in December, 2006, a story called "Casualties of War." It was written by a National Guard veteran who had been having numerous problems upon returning from Iraq and included a follow-up of the family for 6-months. He says that he does not remember any of this sitting in the apartment, daily fatigue, cradling a black plastic rifle, curling into a fetal position. His wife and 3 kids- walking in his 3-year-old son asking, "Why does poppy have his uniform on?" His startled wife answering. He practically treasures it.

(Inaudible)...this was a toy weapon. These are real veterans who are taking their real guns to bed with them. They are unaware of how impaired they are and drink or do drugs to calm themselves and they become withdrawn and isolated. Sometimes they talk to their family of comrades rather than the family who are awaiting the safe return.

Our third goal is to address intergenerational trauma. Unresolved trauma gets passed down to subsequent generations, leaving behaviors that no longer be adaptive. If it goes unacknowledged, it persists. Traits are handed down- self hatred, for example. In June 28, 2007 there was a story called “Father/Son Trauma” and it is the interview of father and son, Joe and Robert Brook, who both are being treated for PTSD. But Robert served during the Vietnam war and his son fought in the recent conflict. The reporter wrote that, “For years after returning from Vietnam he and his father held his (inaudible)...the need to survive, but also put a blank emotional space between himself and the world and above all his son. Michael finally found out that he wanted to serve his country and also earn a measure of respect from his father. “I guess I was hoping it might close the gap between us,” said Michael. A child is more likely to develop PTSD when they have a parent who suffers from PTSD. Our program began for mental health services to family members, many of whom do not come under any treatment mandates. But mental health continues to carry a stigma and we weren’t getting any calls from the family. We were targeting teachers to find families through children, those with behavior problems and complaints. Children are afraid to burden the rest of the family and they refuse to talk about their worries to those at home. They can be hyperactive and carry additional mental health diagnoses.

(Inaudible) Fortunately, a compassionate judge was persuaded by volunteers to give educational accommodations in school. In collaboration the educators, pediatricians, etc., SOFAR is beginning to helping children and youth help with the deployment and return of a parent in the National Guard and other military reserve. (Inaudible) This booklet can be downloaded from our web page which is www.serveourusa.org. We are working closely with the Massachusetts Department of Public Health and the Office of Veterans Affairs to help families to act as gatekeepers to identify veterans at risk. What would we recommend? Collaboration of all state and federal agencies; Veterans Services, Department of Public Health, Department of Education, Department of Social Services, Department of Mental Health, and others. We’d like to see them all at the same table because very often the right hand does not know what the left hand is doing.

Our vision is to ensure that the veteran and the family have the support they need. To do this we need to seek out not just the returning Veterans, but the numerous family members impacted by reintegration. I invite you; I challenge you; I implore you do the same.

Richard T. Moore, MA

Senator, Massachusetts General Court; Chairman Health Care Financing Committee

Introduction by David G. Satin, MD

Thanks Jaime, for a clear, but not very pleasant snapshot of the mental health casualties that come from war. If you wanted to create psychological damage, how would you go about it? You would teach people to make a commitment and investment in their families and their communities and to have a reverence for and protection of life, and then you would fragment those families and put people in the situation of danger, of killing and death. That is pretty well geared to making people very ill and that is the name of war.

Our second speaker is the Honorable Richard T. Moore, Massachusetts State Senator for the Worcester and Norfolk district since 1996. He is an Educational Administrator and Secretary of the Massachusetts Health and Education Facilities Authority, and a member of the Health Committee of the National Constance of State Legislators. He is also a Visiting Assistant Professor in Health Policy at the Masters in Public Health Administration Program at Bridgewater State College, a past Associate Director of the Federal Emergency Management Agency, and received the Distinguished Service Award for developing a strategy to mitigate damage from natural disasters. Presently, he is the Chair of the Senate Healthcare Financing Committee. In 2006, he was the Senate Chair of the Legislative Conference Committee on Healthcare Reform Legislation. He is here today to talk to us about public response to this public health problem.

Richard T. Moore, MA

Thank you to the previous presenters for setting forth the issues and the situation which we face across the country and in Massachusetts. I think that because of the heavy utilization of the National Guard in particular (inaudible)...We think of the veterans issues as being primarily a national concern and one that we would anticipate the present government would take care of, would do everything in that regard, but that isn't always the case. There has been some improvement, but a lot of times the folks, particularly in the National Guard, come back to their homes, their states, and their communities and to Veterans Administration programs. We (inaudible) legislative term 2007-2010 which we are in (inaudible) legislation to address mental health and the basic treatment of the Veterans and Massachusetts will be one of them.

Massachusetts really has a long and distinguished record for providing support for our National Guard and we are very fortunate, as I mentioned and I am going to recognize Tom Kelly. Tom is a (inaudible) following another congressional Medal of Honor. (Inaudible) It is, I think, a very good time for organizations as well as people who are interested in mental health, and the legislature attention has been focused on trying to help the Veterans. I think that this is the chance to really put together some important programs that will help strengthen our response to veterans, in particular, and sometimes that has the positive aspect of also improving our mental health programs generally for that population.

I am not going to spend a lot of time on the fact that you already talked about- the 1.6 million troops that have been deployed in Operation World Freedom, and the American freedom and the psychological toll that that has already produced is an indication of what we can expect. And that is, that 200,000 or so veterans, many of them are probably National Guard and Reservists who will need help. Sometimes the mental health issues do not present themselves until later in the community itself, it may be at any given state of the community we are going to need to pay particular attention and be sure that we have the resources available and the trained professional help available to reach out to all these men and women who have issues that they will face when they return. There are a lot of things going on (inaudible), for example someone mentioned that there is a project for traumatic brain injury. The other speakers have also mentioned it is important to consider issues of domestic violence and suicide occurring across the country and we certainly know of a few cases here as well. So, we need to be working on it and be prepared to do that (inaudible).

One of the major providers of services is actually to the developmentally disabled. We have been working on trying to develop a facility for people with traumatic brain injury (inaudible). They are finding some difficulty in locating services in Massachusetts that will meet the needs of this population. We are going to be looking at the needs and develop some kind of support that combines both mental and physical health issues that we need to address. There are copies of the bill that was recently signed into law by Governor Patrick which is an opportunity, I think, for this kind of policy. The prospects of something coming out of this I would say are strong. They will be looking for substantive ideas and programs that can be incorporated into their (inaudible), and so there is an opportunity to come up with ideas and proposals for what kind of programs we do need.

Also, there are 10 copies, I am not sure I have enough but there are some copies that are drafts of legislation that we are working on that we will present to the commission. I have incorporated material from a recently passed legislation with some suggestions of what we should be doing. There are some things that the VA should fund and should

handle and we should look to them to do more (inaudible) but not necessarily the disabled. We should be seeking federal assistance for (inaudible) have a responsibility to the Veterans, we think, and we just want to make sure that they live up to their responsibility. We need to look at it directly suicide prevention and domestic violence prevention with PTSD and all of that is part of the concept in the legislation.

(Missing part of audio file) We have several resources there, the top one is the DAV website connected to that. The third one down is Secretary Kelly's website which is, I think you will find if you want, a very good description of some of the (inaudible) now and it is an important thing to look at what the feelings are now. (Inaudible) But, in any case, the population that is here in Massachusetts and across the country, seem willing to come up with the resources and support efforts to really address the concerns and needs of the returning veterans as well as the efforts of the returning veterans that were service vets themselves have the proper armament protection and supplies and they seem to be getting them through the defense department. I think there are some excellent opportunities for any of you, and others who are in the field of mental health to take the concepts and ideas and turn them to actual public policy that would be helpful for these veterans.

When I was at the school a few years ago, I had the opportunity to take a number of courses in psychology and I was intrigued by the course of abnormal psychology and if any of you have taken that course, you know that we do the same thing as a medical student- that you start reading about symptoms and "Gee, I've got that." You know, "I might have that" and so it's important that we think of the opportunities that psychology can offer to a variety of direct service to this part of our population. I think that the point that Dr. Darwin mentioned is very good- one that we don't always think about- is that when we take care of the veterans that we have to understand that this type of war that we've had- the National Guard...Many of them signed up in Massachusetts because we have a very good program of education. We've got free tuition; we have actually expanded that now since tuition started to be less confused with (inaudible), another cost of going to school, so it's very attractive. And, especially when we are in peace time, even more attractive. But, you know, even then, I'm sure that most of them understood that it wasn't just a hand-out for college, but that they had an obligation to perhaps be called at some point to be called up to see some active duty.

I don't think they understood that it could be a long-term period- an extended period of time and that they were sent back for repeated return to the field. Nor did their families understand that and they have documented in the previous studies to some of the stresses and strains that that puts on the relationship between the service person and their family. So, many of the programs that we're looking at- we wanted to get the family

side as well. Now, I think that given the attitude- I think we have come a long way in our attitude towards mental illness, but we still aren't there yet.

And so, vets are supposed to be strong and are supposed to be very brave- so sometimes they are reluctant to go to a mental health clinic for treatment because it might be a sign of some kind of weakness. If they are still in the service, it might be considered that it is going to affect their continued opportunities to serve and be promoted. And so, I think it is very important that we work to develop some services in the department and its affiliates as kind of the focal point for a lot of where we want our planning to go and that let's figure out what we're trying to do in legislation and work with the Commission. And, I want you to think about what we do today, as you think about this issue as we go on into the future- I would encourage you that if you see anything that you want to do through me – I would be sure that I would address it at Richard.Moore@state.ma.us. I'm happy to collect that information and will forward it on to the committee. I suspect that the Commission will have its own website at some point soon. And, if you didn't pick up a copy of the working draft and you'd like that, if you give me your e-mail address or card or something, I'd be happy to send it to you and get your feedback from that basis as well. Thank you.

Jonathan Shay, MD, PhD

Staff Psychiatrist, Veterans Administration on Outpatient Clinic, Boston; Author of Achilles in Vietnam: Combat Trauma and the Undoing of Character (Scribner, 1994), and Odysseus in America: Combat Trauma and the Trials of Homecoming (Scribner, 2000)

Introduction by David G. Satin, MD

Thank you, Senator Moore. Your speech is a lovely example of community mental health- the community as a whole embodied in its government paying attention to mental health issues of the community and bringing together the resources that can do it and to my way of thinking, a proper use of government to help the society as a whole, rather than to stay out of society when it is in need. I am reminded that Senator Moore receives his distinguished service award for developing a strategy to mitigate damage from natural disasters. Now, he is developing a strategy to mitigate damage from unnatural disasters that is created by man- unless you consider war a natural aspect of human personality.

Jonathan Shay, MD, PhD

We have a bizarre phenomenon that the Secretary of Veterans Affairs in 2004, noisily announcing that there were going to be 100 psychiatrists hired to meet mental health needs for returning veterans. This is the last thing in the world that we need first, is more psychiatrists or psychiatric nurse practitioners, more psychiatric social workers, more PhD clinical psychologists. It is not that there is something wrong with having that credential; it is just that that credential is not enough by a long, long way when dealing with psychologically injured combat Veterans.

In my second book, "A Difference in America" I have a mock scene from an opera in which the psychiatrist singing, in the presence of a veteran, "See my credentials, see my credentials" and the Veteran singing in return, "They don't mean shit, they don't mean shit." The credibility that health professionals will acquire with veterans is unfortunately entirely personal through the veteran's personal testing of you and sometimes it can be borrowed if other veterans ask will say, "Go see these people, go see George Mendoza, he understands." George may be the only person in the room that I have personally met in this capacity, but it is a fact that trust is personal in that veterans will vouch for mental health professional so they can borrow trust.

Since this I have been officially certified from the (inaudible) saying that I am officially a geezer and the McArthur Foundation has designated me officially genius and I feel like I have to say something that people can take away and say, "Oh yeah." So

anyway, I want to read this particular part of the poem (inaudible)...the reminder that we are just one critter that at every instant your brain, your mind, we are society and culture and that at every instant that we are conscious and not in a coma. All four (4) of those are in play and none of them has ontologic priority in the sense that oh, this physical brain is (inaudible) real and all the rest is just platonic echoes on the wall or shinny bubbles on the sink. They all co-evolved in the full mycological meaning of the term in the upper Paleolithic and then the modern (inaudible) organ that we carry at the top of our necks, with that was first present also mind, brain, society and also mind society and culture were (inaudible) present at the same moment.

There was never a time when there was a quarter of a human being or a half of a language or an eighth of a society or an eighth of a mind it was all 100% present when they co-evolved at the same moment. This is not a mushy whatever syncretism of any mish mash that you want to introduce. Research still matters and actually this gives rise to incredible opportunities for research in much the same way as has been flowering in the evolutionary developmental biology which is where embryology and macular biology come together in very interesting and rigorous and mutually exclusive ways. These interchanges, these attritional changes I have talked about attrition. There are things that the mind has got to get rid of in a certain sense but that is part of it, we are biological creatures and this is a fully biological phenomenon that I'm talking about.

End of the genius thing and back to where we were. Now I want to shift the focus to the mental health work place. I expect that there are some mental health managers and administrators in the room and I won't ask you to identify yourselves. It is crucial that there be an awareness that secondary trauma is real and it is a real occupational health and safety issue and it is absurd to take the attitude of...well, there are 2 kinds of attitudes; people know enough to say, "Well if you can't stand the heat get out of the kitchen," they know enough to say that if this is hard for you, go sell shoes. People know enough not to say that but it is long tradition in mental health, but I am going to say that the psychoanalytic community has been one of the worst offenders in this. That if you are having trouble working with this traumatized patient you need to get yourself into therapy and there is a wonderful therapist that I can refer you to, a wonderful analysis, maybe you need a full psychoanalysis to be strong enough to do this.

Let's consider a coal mine operator who took the same position, that terrible black gunk you are coughing up from your lungs, "Oh, I don't want you to get black lung, you could die of that- it is terrible. There is this great respiratory therapy shop down the street and on your own time and at your own expense you go there and get them to pound the shit out of your back and get that stuff up." Well, we would look at this coal mine operator like he was a moral moron and he would be. This is an OSHA issue that the employer has to provide that respirator, has to install mixers in the mine gallery to

knock back coal dust from the air. At the employers expense the employer has to build that into their budgets. The mental health work place, the business model, if you are working with traumatized people the business model has got to have enough space and air in it for the lungs to fill in the community of the work place. People need to have to have time and place and structure to meet as professional colleagues to metabolize the constant (inaudible) that they are constantly accumulating when they try to work with the severely traumatized people. And, the cost of not doing this is incredible turnover.

One of the things that I sort of revel in pointing out about the program that I recently have retired from, is that after 20 years I was still the newcomer on the team. That's how little staff turnover there has been in the VIP program. Now, the staff has shrunk because of VA staffing cuts since 20 years ago, but in terms of turnover because of burnout or psychological injury. I was smart enough when I came, as a new psychiatrist, I could have destroyed that program but I could not have created it, and I take credit for the fact that I recognize that there is something special going on here, that I want to learn and I learned it and there is, no you don't have it as a handout, but it is a chapter that my colleagues Lynn Monroe and I had in the Saigh and Bremner text book of PTSD. If you are interested you could find that chapter, if you send me an email, I might, without too much risk of going to jail, send you an electronic copy of it.

Finally, I do want to say something about oxytocin. Oxytocin is fuel for the frontal lobe of the brain. When you are severely oxytocin-deprived, your frontal lobes are offline and you lose the capacity for ethical self-restraint, you lose the capacity for emotional self-restraint, you can not engage in even simple social judgment and as once more, there is a loss of what is known to the rat psychologists as fear of extinction. It turns out that even in a rat they are learning that going in the back corner of the cage no longer results in a painful shock. You can train rats rather quickly to avoid one corner of the cage by administrating a painful shock through the feet and when you turn the shock off and after a while this avoidance extinguishes because rats are curious and probably also forgetful and painfully wondered into that area. Well, it turns out that fear extinction is an act of process of suppression that is engineered in the frontal lobes. Now, how likely is it? I think the science has not yet been done that in humans the capacity to recognize that this is here and now and that fearful danger was there and then is also run in the frontal lobes and that if you are severely moxy deprived, as a veteran, your ability to extinguish that conditioned fear is slightly to severely impaired. So, I have become a complete nut case on sleep- that anything you can do to improve the sleep of a veteran is going to improve everything in that veteran's life. The famous short-temperedness of combat veterans- I don't pretend to know what percentage of that comes from sleep loss.

Again, in order to maintain the illusion that I really am a doctor- I do want to mention one medicine. You can count the medicinal breakthroughs in combat trauma on

one hand and still have fingers left over to wiggle. But, one of those breakthroughs- I have this perverse streak in me which is what I discovered that what really gives me jollies about it is that no one is making a nickel off this drug. It is maybe 50 years old, it's off patent. The drug is Prazocin. It started life as medicine for high blood pressure. It still has some use in that area but an alert VA doctor, I think an internist, noticed- he was listening to his patients what a concept, listening to his patients. He heard from many more than one of them, "Hey doc, you gave me that medicine for my blood pressure and my nightmares have gone away." About half of the combat veterans who take Prazocin who have suffered from repetitive combat nightmares report complete relief from that.

I have one of my patients who was a fireman after Vietnam whose lungs were burned in a fire, very fragile physiology, and his blood pressure dropped like a stone on just 2 mg, but 1 mg he could get relief from his nightmares and not drop his blood pressure. So, I want to leave you with that one, what some people will call clinical gem and it is a clinical gem and in case anybody is really wrapped around the axle on evidence base treatments, this has been subject to double-blind placebo controlled trials, again because some VA doctor with no money just put in the (inaudible) to bring it all together and got a little bit of money to finish up the trial and it is a part of the official VA DOD clinical practice guidelines for combat stress. That's it.

Discussion

Dr. Satin:

Thank you Dr. Shay. It is nice to be reminded of the importance of morale and the human context in psychological trauma. It is not something new as everybody (inaudible) to this Middle-East war in fact you will tell us the Peloponnesian war, it goes back to the Civil War in accounts such as The Red Badge of Courage, it goes back to WWII and the psychological studies of the importance of team and unit morale. And the treatment of physical and mental injuries in the combat context and not in another context which separates the soldier from his job and the interesting studies by Henry Beacher about the importance of the meaning of pain where pain means something good, like you are going to go home. You do not need nearly as much pain medication as you do when it means something bad, like you are going to lose your job and we have heard talk about the importance of these issues in the Middle-East Wars. Now is the opportunity for us to talk to one another and when the spirit moves you to hear of experiences, questions and comments from the audience.

Questions and Answers

Q:

I am just wondering (inaudible) that we were told that the reservists were more at risk than regular military, is that because of lack of support?

A:

That statistic showed that the Reserving Guard deal with some far greater level of impact. I am guessing that it is because of exactly what Dr. Shay was saying the lack of connection that when Reserving Guard come home they do not have to drill for at least 3 months, which would be a reasonable idea but they really are isolated in their community and that the Reserving Guard really have had to adapt to a new mindset of multiple deployments so that people who never expected to deploy at all are deploying 2 and 3 times, so I think that there is a lack of preparedness psychologically. I think that there is lack of some kind of structure where regular military leave their base, come back to their base and has a job. The Reserving Guard leave a civilian job, go, come back, and they can resume a civilian job but have to find a new civilian job so there is a great deal of isolation and I think that any of us who do trauma know that trauma occurs in isolation and heals in connection.

Unknown speaker:

I just want to make an additional comment to that, that we are already hearing of Guardsman especially but also Reservists, and these are not identical, Guardsman who have lost everything. They have lost their homes, they have lost their marriages, their wives have taken their children with them to some other place than they are now living, they sometimes have lost businesses that they have build, the wife sometimes has taken the car with her so he has no car which means in this society there are much more limited in (inaudible) for employment.

Q:

...community mental health I think one of the things that would be helpful and (inaudible) Secretary Kelley and Senator Moore (inaudible) position to help us do this, one is to all remember the impact (inaudible) people who are affected because they have to meet certain criteria the same as our (inaudible). We have a lot of people that also need this and we do have a community built service system but we need to find ways for us to connect to be able to provide these benefits in the communities where people live. Reimbursement structures are going to be the key for that. I think this is an important part of what I am hearing from (inaudible),

A:

I think (inaudible) legislation or budget activity to do (inaudible) the need for that maintaining some kind of contact with the peers (inaudible) not only from your own unit (inaudible) could be (inaudible) Massachusetts can go through on the system (inaudible) set up a similar system for (inaudible) classified to (inaudible) all kind of a web based way because they are so spread out. (Inaudible) but I think on an ongoing basis (inaudible) web based access of resource (inaudible) the family need as well as (inaudible) that there be a connection and we need to support that.

Unknown Speaker:

I want to point out the invisible presence in the room and that is the (inaudible) presence of the employer, the work place, the employer. It is wonderful that there is so much focus on supporting the family (inaudible) and so on but the family, as important as it is, cannot in fact hold up the whole world alone and in the absence of a good occupational adjustment and readjustment it is almost impossible for the family and the veterans employer. (Inaudible) we have to figure out imaginative and effective ways to educate employers, to support them, an employer hotline, (inaudible).

Unknown Speaker:

Actually there is an organization, ESGR (Employee Support Group Reserve and Guard) and that requires that peoples jobs be kept for them but (inaudible) operational but one of the things that ESGR does is to

Dr. Darwin:

I think that, you know- Charlie said it in the Globe and I spoke to him, maybe 2-3 years ago, he said something very interesting to me which was that the war correspondents feel particularly guilty because they felt that they had not done a clear enough job of indicating what was going on over there. And partly, I think it was because they were involved with the troops and the troops would convert them into...so you had an interesting notion and what he said to me was that he thought the war was a failure of planning and he did not want the return of the veterans to also be a failure of planning. And, I think part of that planning is the wonderful thing that is going in legislature, but the other part of it is, how do we make the .098% of society who are not serving in this war aware that they have a responsibility...

Unknown Speaker:

Because they do.

Dr. Darwin:

Because they do- exactly, and for me as somebody who grew up in the Vietnam era and you know really...I thought the Washington malls and protest marches were the social event of the season. What changed for me was meeting a good friend whose brother was killed in Vienam. And, I saw the Vietnam war memorial for the second time, because I had seen it already- there was name on there and I knew what had had happened to the family behind it. It was a very different experience. So, I think more often when I get up and speak, I try to be clear about the fact that these are people. You cannot say, "these are not me" which I think is something we tend to want to do and it puts faces, not names because we like to protect people's confidentiality, but to put faces on it so that we can't say, "Oh, this isn't about us." Because it is very much about us and when they talk about intergenerational transmission of trauma, it's going to be about us for years and years and years and if this society doesn't spend money now, we're going to spend it later.

Richard Moore:

Dr. Darwin mentioned the reference at the end of my slides. I put a plug, I don't get any money for this- a plug for Rob and Lee Woodruff's book about an incident that...it's interesting I happened to be with them about week ago at a McLean Hospital dinner, but he spoke about his experience as someone who had traumatic brain injury and severe

wounds and a recovery and now she went through a depression. Part of that, I think, because she was caring for two very young children and so it's a great read for kind of covering both the severe injury and other sides of it.

Unknown Speaker:

I don't know if you realize this, (inaudible) you said the first thing that you are going to, and it has the same statistics the (inaudible) offers now and talks about, I don't know- but 20 percent of them are on Ambien and another similar number being on Prozac and another antidepressant, and so I'm wondering if you think that being on these kinds of drugs is going to help with the PTSD later or make it worse? Or just what thoughts you have in terms of how this is going to effect therapy and readjustment when they come back?

Dr. Darwin:

I can give you a statistic which is that 19,000 (inaudible) them and one of the slides that I forgot (inaudible) and of course, what's it going to be like when they get home and is that a way that we then prolong people's exposure to combat- which is really the problem? Is it what they are going to be like when they come home or is it how much worse are they are going to be having gone back into the situation that they might have potentially needed to be out of?

Dr. Shay:

First of all, the research is unmistakable that there is a very powerful dose response curve- the more exposed you are to war, the more likely you are to get hurt. So, I share the worry about sending people back with already existing injuries is going to make the injuries worse. And, in the animal work and human work, there is likewise evidence that prior injury doesn't make you stronger, despite the (inaudible) terms that strong and grow complacent, etc. The fact is that prior injury, such as childhood sexual exploitation or surviving a prior criminal assault makes your more vulnerable, not stronger. And so, if you send somebody back to the war with existing psychological injuries, they are going to be more likely to be re-injured. Now, the use of the serotonin reuptake medicines is- I railed against credentialism, I think the (inaudible) as an example of the toxic overvaluation of number one, the diagnostic category PTSD. And number two, it's institutional Siamese twin, the FDA-approved indication for treatment of this diagnosis, of which I believe that Zoloft is the only manufacturer that went for that PTSD indication from the FDA and of course, got it. And, that creates an enormous illusion on the part of bureaucrats and legislators and (inaudible) that you are doing something because you are giving them an FDA-approved treatment for the condition. I'm going to stop there.

Unknown Speaker:

(inaudible) and there is a huge correlation between the sleep disorders and brain injury (inaudible) in terms of, if you are not sleeping, you (inaudible) brain injury (inaudible) and so I encourage people to not forget the (inaudible) brain injury and overlap that with the mental health because that really (inaudible).

Dr. Shay:

One of my other areas (inaudible) and also the fact that we've lost the folks that are in medical school residency who work weird hours, nurses sometimes as well, police officers, I fear that it happens in the military too. But you work- you're not doing eight hours shifts, you have no recovery time in between. The sleep medicine folks- it's kind of an area that we really don't (inaudible) sleep apnea that we never knew about before. It's a big area that needs to be connected, I think to this whole discussion.

Unknown Speaker:

This is a question for Dr. Shay. Sir, again the point is we have a (inaudible) survey that Iraq is still out and for the (inaudible) we filled that out. There are some with the stigma, that we were talking about earlier, that are afraid of losing their jobs. Maybe this is necessarily now for the purpose of (inaudible) now, for one, we have problems with (inaudible) and two, filled it out. There is a period of manifestation from their actual symptoms, (inaudible) and of course, the big ones are not encountered (inaudible) when it's going to happen. Our dilemma, our job is not to save the reserves, that, and yes it is true that for active duty, marines and soldiers would be (inaudible) the day, we interact everyday after deployment, we have the benefit of seeing them, how they react to deployment because we see them everyday and when we can- we have a kind of telltale difference from day one when they came from deployment to now two weeks or four months.

The (inaudible) with the reserves is that after they deploy, they leave the unit and as we talked earlier, that it is a critical time- it is a period of time that when they leave the unit, we don't see them and the only time we see them is at three months or six months. By then, a lot of things have happened. Especially if they don't get support from their families or the community. They may just be (inaudible), but the (inaudible) that we cannot see the difference because we don't see them everyday. The other ones- the challenges if they do seek medical help through the VA or other medical facility, they are bound to be either medical or (inaudible) get those medical documentations from any appointments they have had. So, again that's the challenge, not only from a medical standpoint, but as leaders, we want to be proactive in trying to help these young marines from going on the wayside, and get in trouble with the law or hurt themselves. Are there

any ways or any institutions out there that are available to help us out – at least try to piece together the manifestations as part of the problem?

Dr. Shay:

(inaudible) are injured and in trouble is there is one thing that I am aware of but if someone asks for help, and I need to mention that today, if you are a junior enlisted person and you say that you need help, it is more likely today that you will receive help as ever reported in history for within a military setting. That is a definite improvement. It is by no means where it should be but it is an unmistakable improvement if you were an enlisted service member who has no aspirations for staying in the service and advancement. And, that's worth celebrating. It's good, it's happened, it's real. I'm fascinated by your picture of the corpsmen having that kind of organic presence in say, a marine company or platoon, where it suggests you are billeted with them and perhaps in (inaudible) that is the case, a marine expedition or a unit.

I am sort of astonished by that as a general picture of the active component because my impression is that most of the corpsmen at a place like Camp Lejeune or Camp Pendleton are going to be not billeted with the battalions, with the infantry marines, and not seeing them on a daily basis. But, what you will be doing is going to the field with them. Woody Allen's law is the most important law for everybody to remember. And that is, showing up is 90%. If you aren't there with (inaudible) and their attacks with their live fire exercises and twenty-nine palms. If you're not with soldiers at the (inaudible) readiness training center at Fort Polk and then you just show up after something terrible has happened, either during a training exercise here or in theaters, you call, "I'm here from mental health, I'm here to help," they are going to look at you and say, "Who the fuck are you?" and you are going to be worthless.

But, if you have shown up and that's not purely the corpsmen decision, it is a man's decision and the prevention of psychological and moral injury in military service is a line leadership function. The medical personnel and the (inaudible) cannot billet with the goods on prevention. They simply cannot do it. But, they can do various (inaudible) things like making themselves known and getting out there with the troops. But that depends on the command giving them the helicopter list; giving them the other resources that are necessary and including them in going to the training exercises- including them in their budget and then do the training exercises. So anyway, again I feel a rant coming on, but let's be able to recognize it is critical.

Audience Member:

I'm a retired Marine Corps 1st Sergeant and I spent the majority of my career in the infantry and I just want to say the Navy corpsmen are drilling with the Marines, they are

deployed with the Marines. The Navy Corpsmen are an integral part and Marines, you room with a corps Marine, you are together 24/7. You can't actually do any kind of training or recon without the corpsmen. So, they're there. So you know, it's like bread and butter. (Inaudible)

Dr. Shay:

This is a huge subject and I think someone else here said using a different kind of language, that purification after battle is not something that you need- we need it. Purification after battle has to involve the whole community and part that is the development of the store of stories. It becomes community property. This is what happened at Fallujah and so the press plays an important role in this, artists play an important role in this, and some of purification after battle is unmistakably in the religious territory. But we have an enormous creative task as a culture in this society to arrive at acceptable and effective rituals and practices and ideologies of purification after battle that involves us all.

Unknown Speaker:

I was just going to say that I think the media needs to be (inaudible)- we did lose ourselves in this and you know, I just think that we need a better outreach program with more support to the families because our families. You really don't know how to react when your child is falling apart. You don't know what to do. So, I think it's really important that we give the program (inaudible), to do what we can to help the families with their veteran's and again, about stories. My son has a lot of stories that have been, kind of said that- the Marines have said, "That can't happen," but I truly believe my son. I think things that have come up, so you know we've been (inaudible). Also, I'm sorry, one other thing about deployment- my son did deploy also at Camp _____ and you get to that point where they say, "Well you keep going in that direction and we'll keep you here" and so I think a lot of Military don't want to say, "I want help" because they want to get home.

Dr. Darwin:

I think it's one of the reasons we're turning to a model of seeing families as gatekeepers is because the families see the soldiers and it is our feeling that if we can alert family members about when to be concerned, and we can alert mental health professionals just to simply ask, "Gee, has anybody in your family come home?" Because again, we're so into this nuclear model of family and we don't realize that grandmothers, aunts, and uncles can also be people who can be educated to reach out to the family- so that people are not alone with that. Because, I mean certainly this suggests unfortunately, has become the cluster of suicides in Massachusetts which is a horrible

thing to have gone through and to go to mental health visits- so it isn't as if one says, "If only you'd been where resources were available."

Dr. Darwin:

Well this is with kids and we're talking to pediatricians but we're also talking to primary care physicians.

Unknown Speaker:

(inaudible) Contact the first one, especially when they come out. I think this is very important and I hear this (inaudible) to more normalize and depathologize the stories of war. When I worked at the VA in the mid-80's we were in the middle of pathologizing PTSD, which I recall being very much a part of everyday as a psychologist in training and I think it has taken me these 20 years and this war that we're in now to realize that we have to undo some of the damage we did in pathologizing. And I think that if we can more normalize instead of trying to find people that are deeply pathologized, we'll include more people because I think that it would be hard for anyone to go through the experience of war and not to some extent, be experiencing traumatic effects. And, just to put a plug for more this team, this is not just something for the mental health professionals to be involved in but also as a public health issue.

Richard Moore:

I think these are very good suggestions that we should be normalizing the review of the mental health screening of returning veterans from the field. Not just to leave it to them and make it just part of the routine. And maybe this is overdue, but certainly when you come back then the follow-up at some point afterwards and it won't be just the mental health professionals, but it might involve some train the trainer sort of thing that some of the other veterans, that understand some of these issues to work with their comrades.