inSocialWork Podcast Series

Episode 32 - Dr. Harold Kudler: Helping Veterans and Their Families Succeed: Current Research and Practice Guidelines in Management of Traumatic Stress

[00:00:08] Welcome to LIVING PROOF A podcast series of the University at Buffalo School of Social Work at www.socialwork.buffalo.edu. Celebrating 75 years of excellence in social work education. We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to tell you about a new feature of living proof. In addition to listening subscribing to and sharing podcasts you can now rate and write a review of each episode of Living Proof rate or write a review of a podcast. Just go to our Web site at www.socialwork.buffalo.edu/podcast and click on that create your own review button. We look forward to hearing from you. I'm your host Peter Sobota in this podcast Dr. Harold Kudler provides an overview of his most current work and his current thinking about post-traumatic stress disorder traumatic stress both current and past returning veterans and research into the neurological frameworks and genetic markers for trauma. He addresses the limitations of current research as well as the evolving debate in the development of the DSM 5 and its classification of post-traumatic stress disorder in a wide ranging and informative discussion. Dr. Kudler describes his research and work with returning veterans and the similarities with the veterans of our previous conflicts in Vietnam and Korea.

[00:01:43] He also explains what he's learning about the differences inherent in our current veterans returning from Iraq and Afghanistan including issues around suicidality the impact of redeployment stress and how necessary it is to expand our view of trauma beyond the narrow lens of post-traumatic stress disorder. In one particularly thoughtful exchange Dr. Kudler notes differences he is finding in a rural and urban base veterans and the cultural competencies that are going to be necessary for service providers to improve access to care and adapt interventions to rural culture. He describes emerging ideas on how to reach out to vets and their families. Organize a community response to their unique needs and to build systems of care that reflect the challenges vets their families and their communities will need to grow. Dr. Harold Kudler received his M.D. from downstate Medical Center in Brooklyn New York and completed a psychiatric residency training at Yale University. He joined the Duke faculty in 1984 and as Associate Clinical Professor in its Department of Psychiatry and Behavioral Sciences. Dr. Kudler is the mental health coordinator for the veterans integrated service network. In this capacity manages the mental health service line for eight VA medical centers and the outlying facilities distributed across North Carolina Virginia and West Virginia. He represents the network's mental health programs at local and national levels. Dr. Kudler expertise in post-traumatic stress disorder stems from clinical and research work with combat veterans x prisoners of war survivors of other traumatic events and their families. He has reported on many aspects of PTSD including its diagnosis its biological and psychological characteristics and its treatment. OK let's join Dr. Barbara Rittner of the UB school social work where she's an associate professor and associate dean for external affairs as well as the director of our Ph.D. program. Dr. Rittner spoke with Dr. Kudler by telephone.

[00:03:48] I was trying to remember when we first met I think it was the Chicago IOPS DSS conference. And I was I know when I got interested in trauma work but I was curious when you got interested in trauma work well that was a long time ago when I started in my training in psychiatry. It was at the Westhaven VA and my first psychiatric rotation was on the intermediate stay ward of the Westhaven V.A. by the way and to me it day that meant about a year. Most patients on that ward were Vietnam veterans. It was 1980. So for most of the folks it was about 10 years more or less since they served in Vietnam and here they were on psychiatric wards. And you know we weren't trained to really think about a mental health problem coming right out of trauma. We knew

about schizophrenia. We knew about substance abuse but we didn't know we'd never heard of PTSD that came out that summer in 1980 in the DSM 3. It was all really new to me and it really shocked me that here was a whole major part of my work on something I'd never learned in medical school. Years later when I finished residency and I had a chance to start my career I was very pleased to find opening at the V.A. here in Durham North Carolina which is affiliated with Duke University right across the street. And so I could have a full time university job but work full time in a V.A. and I immediately picked up in work as part of a research and clinical team working with PTSD really doing some basic research but also doing a lot of of the early clinical work on PTSD.

[00:05:25] Do you find that there are similarities and and what are the differences related to the impact of the Iraqi Afghani war on veterans compared to what you were saying with the Vietnam population. I think that there are but you know it's what's so challenging is that when you see these very young people first back from the war in a way I feel like I'm getting a time capsule of what it might have looked like when the Vietnam veterans I met 10 years after they came home were coming home. I'm seeing already the beginnings of the stories I heard from the Vietnam veterans and for that matter from Korean War veterans and World War II veterans. When I first came home I didn't think I had a problem. I didn't want to think I had a problem. I started to drink. I burned through a marriage. Two marriages I had kids but I don't talk to them now. I think the problems that we're seeing of this new generation are very much with the older generation saw in terms of their response being combat which really intriguing for me and encouraging for me is I'm getting to see this now as if I had the chance to turn the machine backward and maybe have a chance to intervene before they become those people ten years down the road. Yeah. Who spent a year in hospitals. I don't know whether you saw this past weekend. There was an article in New York Times about the very high suicide rates in this population in particular the Iraqi and Afghani war veterans.

[00:06:48] Is that concerning to you or do you think it's probably always been there where it just become a more sensitized to it. Well you know really to put it in perspective the military rate of suicide has always been lower than the civilian rate of suicide partly because they select people partly because they have more support more training. So actually you know what shocked me is that now the military suicide rate has equaled and is just edging past the suicide rate for civilians so something truly remarkable is happening. I think we have a lot to learn about it and I think the first thing going into it is not to get caught up in any stereotypes. Certainly deployments stress is a part of it but which part of the deployment is the most stressful. A lot of what I've heard from DOD folks now is that you know what's triggering these suicides is not always a traumatic event that happens just then and then the suicide attempt was triggering them are people who are at a great distance from home under tremendous stress experiencing traumatic events certainly but then become aware of problems at home. A Dear John letter or Joan letter maybe now problems at home that they can't resolve a family member who's sick or have been diagnosed with terminal illness so that it's not really simple and it's not just trauma leads to suicide but it's probably trauma life stress. Young people and the way the proximity of firearms into a certain desensitization to their use all of these things add up. And so it's going to take a lot more research and more than likely a multi-modal approach to this problem before we can really like it.

[00:08:25] In essence it seems to me that part of what you're talking about is the sort of narrow perspective and PTSD versus the more recent stuff on complex trauma and how complex trauma begins to have these kind of sequential sequela. Exactly exactly right you know the way I look at it is that years ago we were happy if other people that heard of PTSD we wanted everybody to think about it. But now everybody thinks they know what PTSD is and they kind of stop with that DSM diagnosis and they don't think about the complexities including the fact that many trauma survivors have had earlier trauma. And that many trauma survivors are you know in the deployment cycle are prone to a lot of other life stress. It's not that simple. And within that context particularly in North Carolina I assume that you're struggling with sort of the urban and rural differences that get played

out. Are you seeing that. And can you talk a little bit about how you see that being played out. Well you know this is one of those kicking myself after all these years. Discoveries that I never thought much about rural mental health until the last couple of years. And I caught up around the time the VA was catching up and established its own office on rural mental health which only really got set up in the last several months. They've been working on it for a couple of years too. You know the fact is we don't know a lot about whether there's a major difference between people who say with PTSD who are rural and people with PTSD who are urban.

[00:09:57] However we do know that nationally about 38 percent of all veterans are rural or highly rural veterans. And in my network North Carolina Virginia a little bit west virginia fully half the veterans are rural or very highly rural really out there far from services. And one thing we're learning is number one it may be that combat veterans are that rural people are overrepresented among the combat veterans. It's probably true that rural veterans have less access to care in terms of the distance they have to go to get it. But finally there's an important cultural issue that I'm just becoming aware of. People who are rural from small towns often would not use big federal agency programs even if they moved into their backyard because the part of being rural is to feel like I want things of my community I want to see my local people I want people who I grew up with and who I know and I'm not going to go to those people down the street because they may be well-meaning but they don't get it and they don't understand me. So I think that each of these are elements and it's an onion I hope to help peel back over the next few years. Who are the rural veterans. Do they have the same problems are there differences. How do we most effectively reach them. How do we adapt our programs so that they're truly competent culturally competent for rural veterans. It would seem to me that you're also bumping up against a kind of rural mindset around self-sufficiency. It's one thing to need help. It's an entirely different thing to ask for help especially when you don't have anybody around you asking for help. Yes exactly.

[00:11:38] So you know it is an interesting paradox about the rural veteran on the one hand they have a very high volunteerism. Rural people believe in pitching in. And I don't think I'm trading in a stereotype. I may be proven wrong but my understanding rural people will pitch in and they will volunteer at a high rate which is one reason why they're probably overrepresented in our combat forces. On the other hand they believe in self-sufficiency and they always believe in letting the other guy go first. The fact is that there may be more of them proportionally who have been exposed and fewer of them who are willing to say you know I would like some help too. And that sort of makes me think about it. I've heard you talk about the painting a moving train project that you've been involved with at the Virginia wounded warrior program. Can you tell me a little bit about it. Well well yes it's actually part of sort of a system of programs that we've developed. The idea was first of all we have what's called a Mireck a mental illness research education and clinical center which is special V.A. program. It's one of 10 in the nation that's meant to do translational research not just to come up a good research but to make it work to implement it in everyday health care. Each of these Mirek's has its own theme and the one we have it's now been operating for five years. Our theme is deployment mental health not just PTSD but all the issues of stress trauma depression substance abuse family problems homelessness that can go with that and that's a very big bite.

[00:13:08] But we believe it's a functional bite and maybe a better bite than just setting up a PTSD clinic or a substance abuse clinic down the hall. So we did try to figure out how do we do this and what we've done is we partnered with states and communities to make this work. Actually our first partner was the state of North Carolina and back in 2006 we had a major meeting with about 500 people attending including the mental health folks of North Carolina but also members from Health and Human Services of all sorts people who helped veterans find jobs. People who help with housing. We started working very early with the community college system but also with school guidance counselors because the children of these veterans are in schools that really broad as many

stakeholders to get in under one tent. The governor came and he charged this group to come up with innovative ways to help veterans and their families in the deployment cycle to become not just healthy again but to become leaders based on all their experience to help them build stronger communities to see them as a resource. So that's been a big challenge. One of the things that came out of that is the idea that did succeed in this to reach all these people the V.A. And DOD couldn't do it by themselves. We used to think I used to think that if V.A. and DOD got their act together they would see every veteran they'd see me there before they became officially veterans while he was still in DOD or they'd see them in the V.A. system. But our numbers tell us something very different because we have national integrated computer systems.

[00:14:44] We know that of the roughly one point eight million men and women who have served in Iraq and Afghanistan only about half of them who are eligible to use VA services. That's about half of that one point eight million are already eligible to use VA services. Only half of them have actually used VA. So we're able to drill down and look at well OK the people who were using the VA what do they look like. What issues are they being diagnosed with. What what services are they requesting. Well about 22 percent of them are looking for PTSD help. This 22 percent seem to have some PTSD. Well it's a lot of new people with PTSD coming to VA. By the way similar numbers have various depressive problems a substantial number have substance abuse issues. So there's a whole it's not just PTSD. There's a whole range of post deployments mental health things that travel together. No surprise because you see the same thing in disasters you see the same thing. And veterans of other wars. So we're picking up a lot of new people through our systems. But if only half the people who could use us are coming to use us where are the other half. Now it could be that they're perfectly fine and that's why they didn't come to see us that only the people who need us combat truly doesn't need us doesn't come and I'd be fine with that. But one thing we learned from the Vietnam generation and this comes out of the National Vietnam veteran readjustment study which was commissioned by Congress back in the 1980s published in 1990.

[00:16:13] What they found is that when they went out and they actually did a careful job using a community sample not help seeking sample but a community sample gleaned from DOD records where you know find us Vietnam veterans in the community whether or not they ever used VA health care. What they found was that if you found those Vietnam veterans who actually had PTSD 80 percent of them had never come to V.A. for any mental health care. 80 percent of people actually had PTSD coming out of Vietnam in the years up until the late 1980s had never come to V.A. for mental health care. Interestingly 60 percent of them had gone somewhere but 80 percent had not gone to V.A. So that meant a lot of people coming out of a war. We're looking for mental health care had PTSD and probably related problems but would not go to V.A. that meant that to really do the job of reaching out to veterans and helping support their families which I think helped support the veterans. If we were really going to do that job we would have to somehow reach out to the community and engage members of the community including community providers and policymakers. So how to do that. We decided that we needed to create an educational program that would teach a number of things. It starts by kind of giving some detail some data about who these new veterans. Again we call them. OEFOIF as Operation Enduring Freedom Afghanistan Operation Iraqi Freedom. Who are OEFOIF veterans. Where are they. How many are they.

[00:17:52] What kind of issues have been identified by the DOD and VA about them. We then talk about military culture. We kind of explain how military people are different in a lot of ways live different lives than civilian people and how this is especially true of Guard and Reserve people who are sometimes military and sometimes civilian and they go back and forth between the two. So we explain who those people are and what their issues are and why they may present differently and have different needs and different requests of health providers when they do present. We then go on to talk about PTSD and traumatic brain injury as well as mention the other issues like depression and substance abuse to kind of get people thinking about well you know OK when you meet these

people and you understand a little bit better what are the issues you're looking for and how would you screen for those and we teach about assessments. We then provide some background information about treatment and we provide access to clinical practice guidelines and to other places where providers in the community can build their skill set. And finally we kind of charge them that you know we do this community by community. We charged them. Can we would they like to work with us to to build sort of a community response system. So you've got integration not just of the mental health system but primary care and mental health.

[00:19:14] The school counselors and mental health and primary care people on community college campuses is these new veterans and their family members used the new G.I. benefits and run into trouble because they've gotten a little TBI or maybe their PTSD makes them irritable or unable to attend in class as well as they'd like to. How can we create a system in which there is no wrong door. And one of the keys to this. It's worked very well both in North Carolina and now rolling out through the Wounded Warriors program in Virginia which is a similar state and community organization on behalf of veterans in which VA state and community leaders are all part the way we do this as we roll this out through the AHEC system. Area health education centers. A hack is sponsored by the federal government actually rehearse the Health Resources Services Administration. Their job is to get health information and other information frankly out into the community where providers and other stakeholders are so far from medical centers and traditional learning centers that they may not have access to this information. So AHEC people have been out there for years setting up these programs they know all the community providers they have mailing lists they accredit these programs they find venues in the community like the local agricultural center. It's big enough to hold 60 people for a painting a moving train meeting. They organize it. They get the lunch. They invite us they send out the brochures and we have one template so the syllabus is now rolled out through all of North Carolina. We've trained 2000 healthcare providers in North Carolina a number of them the rural folks. We're doing it in Virginia. We've done sessions in Florida Missouri. We're we're on the books to do it in Colorado and Arizona and Ohio. So it's a highly effective program and what I like about it is it doesn't just give some information.

[00:21:03] It begins to build systems of care. It sounds to me as if there is also some pretty robust research going along with this is that the case or not there's a great deal of research and that's kind of amazing. I mentioned the National Vietnam veteran readjustment study and if you want to know something about Vietnam veterans with PTSD or other post deployment issues you'll go to that that entire study only involved somewhere between three and 4000 veterans. That was a lot but it was the largest single epidemiological study ever done of a single mental health diagnosis. Up until that time. But all right three or 4000 Depart of Defense has already reported studies on 88000 soldiers coming back from Iraq and it's at a single point in time that's been done by the Walter Reed Army Institute of Research. And this kind of stuff isn't just being published in book form it's been coming out in military medicine in the Journal of the American Medical Association in mainstream journals that all of us read in all of us have access to. So DOD especially Walter Reed Army research are doing incredible work VA's National Center for PTSD. Our own Mireck and many other people across V.A. are doing a great deal of research on almost every aspect from neurobiology to public health.

[00:22:19] One of the things I find interesting about the way you are talking about trauma in this context is one that it's very complex too that it's a very systems impact kind of problem that is it's not just the person with the problem it's their family and their community and it's different rural and urban and that there are Prodromou set set people up that make them probably more vulnerable or the cumulative trauma that they have particularly folks who are on Frontline and are constantly dealing with a kind of intensity of these wars. And I find it interesting around the fact that there is some pretty interesting controversies going on right now and that discussion in the DSM 5 about what's going to happen with criteria PTSD. And it seems to me that part of what you're talking

about are some of the problems with the kind of current thinking about PTSD and in the DSM 5 but it's a great question. Barbara it's a really important one too and I think the DSM 5 committee needs all the feedback it can get on this. The fact is the DSM 5 is you know making progress in their work and they've been talking about just losing as you say criterion often known as the stresser criterion. The question is is the criterion that say that you have to survive an event that you in which there was real or at least threatened danger to your life to your physical integrity to that of someone you love someone you're you. Have you witnessed it directly. But something really horrible has to happen. And how do you know it's really horrible. The second part of a criterion. It was experienced with fear with helplessness with horror. It really is something that overwhelms you. Criteria A was developed and it's evolved over the course of DSM 3 DSM 3 are DSM for it's evolved to include both the objective it has to be truly dangerous and subjective you have to experience it in a way that shows that you responded to it as something that was overwhelming.

[00:24:25] So many people are saying well that's led us to a lot of confusion because how do you know when someone is truly overwhelmed. How do you decide if something is truly that stressful. Who decides if it was really that dangerous. Maybe it wasn't that dangerous. The fact is part of me would be really relieved if they lost criteria because I've known so many veterans who are asked by disability boards if you can you prove to me that you were blown off that bridge in the middle of the night in Vietnam. You know back in 1968 even though you were alone on patrol you know if you can prove to me that happened it didn't happen and if you can't prove that event happened then you don't have PTSD because you told me that that's what you dream about. That's what your flashbacks are about. If you can verify that point in time then you don't have PTSD even if you have all the symptoms. Part of me would be glad to see criteria a go for that reason. On the other hand I really wonder how meaningful PTSD would remain if you have a post-traumatic stress disorder with no effort to define what trauma is. I think the problem is the trauma turns out to be more complex than any of us thought for the reasons you mentioned. For instance the idea of cumulative trauma you know we've simplified it to say my PTSD is about being blown off a bridge in 1968 when in fact PTSD might be about that incident as well as a year of being in country six months of monsoons separation from family when a close family member was dying.

[00:26:08] The loss of a best friend a whole hoard of things trauma isn't easy to find. On the other hand again. I don't know the answer because I think if we lose the effort to at least try to address what trauma is we're going to lose the heart of PTSD and very soon PTSD might become so diffused that it becomes meaningless. I do worry I don't know the answer but I believe this is the time to get to get to work on it. Well it's interesting to me because as you know my area is more around children and some of the stuff coming out of work that actually I first was exposed to at the ISTSS org conferences has to do with differential experiences of children and adults. That is that a kid finds terrifying being abandoned in a mall for 10 minutes is mildly or at least somewhat irritating to an adult. And I agree with you I think that part of what we're doing is sort of trying to make a one size fits all age gender rural urban you know years ago. I remember learning that World War veterans who are mostly rural had a lot of trouble with the noise that occurred during the war because they had never been exposed to that kind of noise while urban people had less problems with it exists. So but I also add one or the other controversy isn't the DSM 5. That to me is concerning particularly as a social worker is this kind of medical reductionism that's occurring where there really is us focusing on the kind of neurobiological issues and almost abandoning some of the social interpersonal relationship components of it.

[00:27:47] Oh I think you're right. You know none of the ink is dry on that. A lot of it is only penciled in but I really do believe that there's a bias in the DSM 5 process. They would really like to be able to deliver a new taxonomy of mental health disorders. That was biologically based and they believe that genetics is going to offer the answer to this. No it's true there is not a single biological marker in the entire DSM 4. Nonetheless the people who are creating DSM 5 believe they want to

provide a paradigm shift and it's going to be based on science and they believe that science is going to be genetics. And you know I would like to believe that down the road genetics will be a very powerful tool in explaining a large part of the variance some of the risk and even telling us which medicines are going to work best for which people think all that will come. But I don't think that biological reduction is reducing PTSD to genetics is really going to help us understand people with PTSD be more effective in our outreach or in our treatment. And I really worry that you know in order to feel like real science is something psychiatry has been trying to do for many years people are going to really lose that broader clinical feel for patients that's so critical to doing the work we do every day. Frankly there isn't a lot more evidence that genetics are responsible for PTSD than there is that say leprechauns cause PTSD. And it really concerns me that we're going to go chase genes we might as well be chasing leprechauns.

[00:29:23] I don't feel like any more of a scientist when I say something I've never seen that I've never proven and I can't prove is the reason for this disorder. And yet I do think that there at least is a healthy cohort of people who really want to push that idea and say we'll find it later. Let's get it in writing now. Well it also seems to me that it really flies in the face about the successes that you were talking about in painting a moving train which is really looks at what the impact of these experiences are across the the person's total experiences not just their neuro biological. So it looks at and it works to address those issues across the family and the community components not just the neuro biological which I guess is partly what you're saying. Exactly. For instance you know you talk about predictors we don't really have strong biological predictors for PTSD but we do know that perceived social support from your family is one of the strongest predictors as to whether you're going to get PTSD or whether you're going to still have PTSD at some later point in time. So you know that's a really powerful finding. And you know why aren't we focusing on families not as causing PTSD by the way but as a mediator and a modulator of PTSD.

[00:30:39] That to me is strong size which is based on real scientific findings and it has clear clinical application in our everyday Yeah and certainly from a social work perspective if what we say is this is genetic and this is neurobiological and the person is going to get it one way or another or based on those assumptions then it also really flies in the face of what we call the strengths respect that as people have the capacity for resiliency. If we basically say Oh well you you've got this marker. You certainly are going to get PTSD. It really almost seems to me disrespectful of the potential that people have to in fact cope with pretty uncopeable situations. You know people have looked for those markers of various types character markers homosexuality is a marker for hundreds of years that we know in the military medical literature. I found that back to the Russo Japanese war and I understand that the Russians back in 1905 Russo Japanese war were using something the American Navy came up with to try to find people who were going to break down in combat not admit them to the military every effort that's ever been made to do this has failed. And I'll tell you the truth now this is just my hypothesis but I really believe that you know say we find a genetic marker that is related to PTSD in some way I bet we'll find that some of the people that marker are actually more robust and some of the people that marker are less robust based on other coexisting factors. I don't think the marker by itself is going to tell us who gets PTSD and who doesn't. But it may tell us something about how their biological systems are set and then we'll need to look at other aspects like the strength of their family like their perceived social support that will tell us which way that particular the person will respond in a combat situation.

[00:32:28] And it seems to me that one of the things that I've heard you talk about both in this conversation in other situations is that the multi disciplinary approach that is the bringing together of the practitioners as opposed to just treating this as a as a medical problem that we medicate has a lot going for it. And I guess I'd like to you to talk a little bit about your experiences with that because certainly the V.A. is one of the most interdisciplinary of all the organizations but also about what you see as the strengths of these kind of interdisciplinary settings and also organizations

especially as a psychiatrist. That's right. Because that endorsement matters. Well appreciate it. Well you know it's true psychopharmacology for PTSD is an exciting field you can make your whole career there but you'd be making a mistake to think that the treatment of PTSD begins and ends with psychopharmacology. You may remember the Institute of Medicine at the VA's request did a review of the evidence base for all treatments for PTSD that are included in our clinical practice guideline. The video the clinical practice guidelines for PTSD and they found that actually none of the medication treatments had a strong enough evidence base in combat veterans for V.A. and to say this is what combat veterans ought to do. That was kind of a slap in the face to all of us. But it's a slap in the face that wakes you up.

[00:33:54] We need more research in veterans a lot of data was based on other populations for instance rape survivors most of whom are women and you know are there gender differences are rape survivors different to combat survivors rape for instance is often but not always a single event is that different than living in Iraq for 15 months and being shot at. Most of that time. So you know it gets very confusing. But beyond the fact that psychotherapy by the way was exposure therapy had the strongest evidence based cognitive behavioral interventions that included exposure with a mix strongest. And that was it. Those are the only ones that were really had strong evidence base at the Institute of Medicine an Honors Society of clinicians and scientists were able to endorse I think it really speaks to the fact that you know we need to be practical in our approach to patients. We need to take all the things that we believe are helpful in that our research shows it can help and apply them all in a multidisciplinary and layered way in a phasic way. By the way this includes engaging people at the level they want to be engaged that some people will only want to tell other people only want medicine. We need to phase our treatment and engage people the way they want to be engaged. It's not as simple saying here's the right treatment and here's a wrong one. And to do this we need teams that are blended in that respect each other from the outset and each brings something to the table. Vitæ really has become a leader in developing those teams sometimes by fiat. Not long ago vitæ came up with a rule and said no PTSD program can deny a patient access because the patient is an active substance abuser. You know you know that barrier that often exists in many systems.

[00:35:36] Well for using substances don't expect me to treat your PTSD or depression come back when you're sober and of course that often means don't come back at all. Instead we insist and now we insist. By policy that you must treat these things in a coherent concerted effort you must workers in its disciplinary team. It's got to be coordinated. And I think the only way to work. And I do think V.A. has been a model for doing it. My hope. Because the V.A. is in every state V.A. reaches through over 900 community based outpatient centers into almost every community in America that we can sort of become partners and leaders helping our entire system to transform into this kind of multi disciplinary multi level care that meets people where they are in terms that they themselves you. Yeah and I think part of it is that there are now organizations that are springing up that are encouraging people across disciplines tecum and present on and have you know Frank and and challenging discussions about what we're beginning to better understand about how various interdisciplinary practitioners can have impact on these families and these individuals who are coming through the systems. Certainly as I said I asked you to assess as one of those organizations that you and I belong to in large part because it is us interdisciplinary and certainly at the practice level that's the case but it seems to me that in the research arena to some degree we're still fragmented a bit. That is you know social work researchers nurse practitioner researchers and medical practitioners are not necessarily working as collaboratively as possible. But are there ways that we can change that.

[00:37:28] I think one important way we can change that is for those who do qualitative research to become if you will advocate for qualitative research to their medical and research oriented colleagues sort of the quantitative research the people who believe that only randomized clinical

trials are the only they can tell us what works and what doesn't what we should do and what we shouldn't do policy and budgetary authority should follow from only randomized clinical treatment. You know the IOMS findings point out that we don't really have enough randomized clinical trials to really do evidence based care in PTSD the way we believed that we were doing it that most of what we were doing was not as evidence based as we were kidding ourselves it was. So you know and I know as a doctor that a great deal of what I do doesn't have that evidence base but I do it because I was taught to do it because I believe it works and I'll wait until the evidence comes through something better comes I think. And I think social workers in particular and more and more psychologists especially health psychologists are very good at qualitative research but they haven't really put their foot in the door with their medical and basic research colleagues to say this is an essential slice of the apple. This sometimes is the only way to get data about what works and what doesn't work where people want what they're suffering from and what they're not suffering from. So that we can design systems of care and decide which treatment approaches are going to help.

[00:39:02] So I think that is really kind of a call to arms for qualitative research has to step up and and I suspect that some of them are shy about doing that. But I think they have to step up and go toe to toe and the and the place to do that. Our national meetings versus national meetings national meetings of psychologists and social workers. I asked.

[00:39:21] ISTSS which you've mentioned the International Society for Traumatic Stress Studies. And by the way I say this with full disclosure I am the membership chair of ISTSS. So it's you know you could see my bias there. Nonetheless the reason I've been a member for over 20 years is that it's the world's largest interdisciplinary international program of not just clinicians and researchers but policy folks advocates and survivors and their families all working together to try to promote the field of traumatic stress. Places like that. People can say I want to give a talk about my issue in these terms and they can reach a very broad audience. I think we need many more people stepping into that breach and and sharing different perspectives. I couldn't agree with you more. I really want to thank you for having this conversation with us today. It will be exciting to see the responses to the podcast and I look forward to catching up on your latest research. Thanks very much. Barbara thank you very much. It's been a pleasure. We hope you enjoyed our podcast today and that you'll join us again for more conversations about topics of interest for social work practice and research and living proof. Hi I'm Nancy Smyth professor at Dean at the University at Buffalo a school of social work. Thanks for listening to our podcast.

[00:40:51] Our school is celebrating 75 years of research teaching and service to the community. More information about who we are our history our programs and what we do. We invite you to visit our Web site at www.socialwork.buffalo.edu. At UB we are living proof that social work makes a difference in people's lives.