Veterans and post-traumatic stress disorder

Epidemiology

Many of Canada’s nearly 500 000 surviving World War II veterans will be participating in Remembrance Day ceremonies next month. However, some will be too ill or feeble to attend, while others will simply try to forget their wartime experiences by staying away from the triggers that reactivate memories they want to avoid. A smaller number of young soldiers who have seen more recent conflicts, this time in the difficult role of peacekeeper, will also be present (page 1183).

It is normal to want to avoid painful memories, but if the avoidance is accompanied by hyperarousal, flashbacks, nightmares and a restricted range of emotions, the syndrome of post-traumatic stress disorder (PTSD) may be present.

The diagnosis of PTSD was not formalized until 1980. Earlier terms used to describe the chronic psychiatric casualties of war included “shell shock,” “traumatic war neurosis” and “combat exhaustion.” We are coming to understand PTSD as a long-term reaction to war-zone exposure that may linger, reactivate or even present as late as 50 years after exposure. Such factors as physical ill health, retirement, loneliness, anniversaries, service reunions and the use of psychotropic medications increase the risk of reactivation.

Estimates of the current prevalence of PTSD among World War II veterans range from 9% among those who have never sought psychiatric help to 27% among those who had been treated in a psychiatric hospital to 43% to 59% among veterans who were prisoners of war. Current estimates indicate that up to 40% of Canada’s returning peacekeepers will experience some form of PTSD (page 1183).

Clinical management

Patients with PTSD tend to avoid talking about it, so unless physicians deliberately take a military and trauma history, the diagnosis is likely to be missed. The most widely used diagnostic instrument is the CAPS (clinician-administered PTSD scale), but it is complex and takes 45 minutes to complete. Shorter screening scales are being developed, but their validity and reliability when applied to veterans, whose symptom complex is often muddied by comorbid depression and physical illness, has yet to be established.

Few treatments of PTSD have been rigorously evaluated, although well-controlled studies of the clinical efficacy of drugs are reportedly under way. According to the International Consensus Group on Depression and Anxiety, there are 3 aspects to the acute management of PTSD: education of the patient about the disorder and the normal stress response, psychological support and psychopharmacologic treatment. If at 3 weeks after exposure to the traumatic event there is no clinical improvement in the patient’s stress response, then referral to a mental health specialist or initiation of cognitive behaviour and drug therapy, or both, is indicated. The consensus group recommends the use of selective serotonin re-uptake inhibitors as first-line treatment, based on data from well-controlled studies.

Data on the risk of reactivation and the appropriate long-term follow-up of patients are lacking and have been identified by the consensus group as outstanding research questions. In the absence of data, experts agree that veterans have unique issues that are best ameliorated through peer counselling and active engagement in family and community.

Prevention

In a recent Cochrane review, single-session individual debriefing was not found to reduce psychological distress or prevent the onset of PTSD. Those who received the intervention showed no significant short-term (3–5 months) reduction in the risk of PTSD (pooled odds ratio 1.0, 95% confidence interval [CI] 0.6–1.8), and at 1-year follow-up one study showed that there was a significantly increased risk of PTSD among those receiving debriefing (odds ratios 2.9, 95% CI 1.1–7.5).

It sounds trite to suggest that the best primary prevention of war-related PTSD is the prevention of war itself. Many physicians see such work as beyond their purview, but the exceptional few, such as those who have fought to reduce the use of land mines and nuclear arsenals and who have been honoured with Nobel Peace prizes for their vision and efforts, do not. Our thoughts extend to the veterans and casualties of war on Nov. 11, lest we forget what they cannot. — Erica Weir, CMAJ