Review Articles

The diagnosis and medical management of chronic Posttraumatic Stress Disorder (PTSD) in military veterans (I)[1]

B White[2]

This is the first part of a two part series on the diagnosis and medical management of chronic posttraumatic stress disorder (PTSD) in military veterans. This article looks at the diagnosis and prognosis of chronic PTSD. The second part will look at the medical management of chronic PTSD.

Many treating professionals face the treatment of chronic PTSD with a sense of futility and hopelessness. Overall my clinical experience is that substantial improvement and stabilisation is the common outcome with comprehensive treatment but we do not see complete resolution or cure. This improvement indicates that the approach to PTSD can be one of realistic hope. The process of achieving improvement takes a prolonged time, often several months to two or three years to get to a significant level of stabilisation. This involves management across a range of approaches; biological, psychiatric, psychological, and social, and based on realistic aims and expectations.

Soldiers go to war for many reasons but for many underlying the desire for adventure, to be with their mates, to see the world etc., is a sense of serving their country. They seek to live up to the ANZAC tradition, even though this may seem an unfashionable sentiment at times, therefore less often stated , and certainly more selfless then the defence force recruiting advertising we see. Nevertheless this desire to serve their country is a major motivation.

At the commencement of his novel about the French military in Indochina and Algeria, Jean Larteguy quotes from a Roman Centurion writing to his cousin in Rome. [1] Part of this said, in effect, that they had been told on leaving their homeland that they were leaving to defend the rights of the citizens of their homeland and were protecting their civilisation.

Therefore they had not hesitated to spill their blood and sacrifice their youth and hopes. They did not regret anything untiltold of the treason in Rome and they couldnot believe that it might be true that thecitizens in Rome had abandoned them andvilified their actions. If this were to be so, ifthey had left in vain their whitened bonesin the desert, then take care of the anger ofthe Legions.

The experience of war has long been known to change a person. Men and women have come home from war with a changed outlook, becoming more withdrawn, moody, unhappy, and irritated with others unknowing, uncaring happiness and their thereby rejection of the soldiers suffering. The soldiers are resentful they bore the burden of fighting for their country and now suffer with the tortured nightmares and intrusive memories of the experience of war. They know, in a deep way of knowing based on experience, that life is cheap and precarious while most civilians are oblivious to the truth of the violence, ferocity, death and mutilation of war. An often unbridgeable gap between the veteran and the civilian community may be produced.

The contrast between the values and mores of warfare and those of peacetime civilian life, especially in such a stable country as Australia, further worsen the contrast with the persisting nightmares and

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Dr Brian White, MBBS, FRANZCP, is a consultant psychiatrist whose private practice consists largely of military veterans. former serving military personnel and current military personnel. This article is based on his clinical experience in treating range of military and ex-mili tary patients. Although the majority of veterans are Viet nam veterans, others have vaned from veterans of World War 2 up to the East Timor deployment.

memories of war and more alienate the military personnel. The resentment of the veterans towards this contrast is made worse when they have been rejected, abused and reviled. The very contrast between peacetime civilian life in Australia and the traumatic experiences in military service, for example in Rwanda, may actually contribute to the development of PTSD, since service personnel may not be conditioned and not expecting the degree of violence.

What is posttraumatic stress disorder?

PTSD is considered a form of anxiety disorder. It is based on the human response to exposure to a traumatic event involving actual or threatened death or serious injury to self or others. It can be considered the normal response in a human being to exposure to severe stress. In chronic PTSD there are Biological. Psychological and Social effects.

PTSD is mitigated and exacerbated by a range of interactive factors. On one axis the more severe and prolonged the exposure to trauma the higher the chance of developing PTSD. More moderate exposures to trauma may still induce PTSD but in such cases the pre-morbid experiences, strengths and weaknesses, and the exposure to stresses after the traumatic experience, have more significant impact on the onset and prolongation of PTSD. However the traumatic experience is still the crux and clear precipitant to the syndrome, as indicated by the content of the re-experiencing phenomena.

Chronic PTSD is a Complex Area

PTSD is a complex and interactive process, and the complete picture cannot be described in one article. Although the core of the symptoms are encapsulated by the DSM,[2] PTSD is much more complicated and involves the way human beings process traumatic experiences by a psychological process, the subsequent impact on their social structure, relationships and occupation. In the chronic condition, there is a process of inducing underlying biological change, at a probable neuronal level, and at a chemical level, including in the neurotransmitters and in the way the Hypothalamic Pituitary Axis is regulated. [3,4]

The core issue is that patients suffer from PTSD. This suffering also affects families, and friends, particularly spouse and children. The aim of management in a chronic medical condition is not a cure but effective and realistic management to alleviate suffering and to stabilise function. This includes specific management of different aspects of the PTSD, by medication, psychological therapies, family intervention and changes in lifestyle including the reduction in stresses in life.

PTSD is not the only psychiatric response to trauma, as trauma may induce almost any psychiatric illness, such as depressive disorders, other anxiety disorders, adjustment disorders, and psychotic disorders.

PTSD often occurs in patients who have had other physical injuries and illnesses, including wounds from military service. There may subtle degrees of brain injury which produce changes in apparent personality function. Hearing loss, often with associated tinnitus, is common from military service. Hearing loss has pervasiveeffects and will influence the clinical interview and the function at home and work. Many have learned to appear to hear when they do not. as a way of bolstering their failing self-esteem. Such self-esteem is often under threat due to their sense that their bodies and their minds are "failing".

PTSD is a much more complex and interactive process than a simple reading of the DSM diagnostic criteria. It is a syndrome with some lack of definition of the limit of what is and is not PTSD. It should be borne in mind that the diagnostic criteria for PTSD under the DSM are the result of deliberations by an expert committee. This inherently entails some compromises. The diagnostic criteria do encapsulate the major features of the core of the syndrome. It is not exclusive nor does the DSM intend this is so.

The most critical diagnostic criteria are the category A, exposure to traumatic experience, with a sense of fear, hopelessness, helplessness, and category B. re-experiencing phenomena.

Re-experiencing Phenomena

In clinical practice in military veterans recurrent distressing dreams relating to the traumatic experience, also termed nightmares, are one of the most common and enduring features of chronic PTSD. Many veterans are clearly dreaming, but have little recall of the content of the dreams.

The dreams in clinical practice are of two main types.

(l) recurrent repetitive dreaming of the actual incidents, which may undergo some distortions over time, and

(2) recurrent repetitive dreaming of what might have happened. This second form of dreaming is based on the subconscious processing of the fear at that time. A

common example in many infantrymen is nightmares of weapons failing to fire or running out of ammunition.

Distressing intrusive memories are often brought on by subtle reminders such as sounds and smells as well as the obvious reminders such as watching documentaries about the Vietnam War and movies such as "Saving Private Ryan".

Flashbacks are specific phenomena. where the patient has a sense of almost being back there and may involve sights, sounds, smells and even touch. They are therefore one of the more intense forms of re-experiencing symptoms. In my experience they are not particularly common. A lot of veterans who have heard the term "flashback" use this term when talking of their experience of having a flash of intrusive image of a traumatic experience, almost like seeing a photograph for a brief period. This is properly considered a form of intrusive memory.

There are other associated symptoms generally called avoidance and arousal symptoms. In military veterans sleep disturbance is salient. The most common pattern of sleep disturbance is early morning waking which is probably related to the effects of disturbing nightmares and depression.

Once present for any length of time this may become habitual as part of the established daily circadian rhythm. This is less responsive to simple hypnotic medication. Disturbed and restless sleep often has associated excessive sweating, talking and at times flailing of arms. This often encourages the spouse to sleep in another bed. The veteran may wake in a start and may come up fighting if woken.

In military veterans irritability, anger, agitation and short temper are common in PTSD and depression, while overt violence is much less common. This may be partly due to being desensitised to violence and the experience of warfare. Part of this experience is that most will have made a decision to kill first to protect themselves and their family and have a preparedness to carry out this intent. This is usually mitigated by their professionalism as soldiers and their military discipline. Furthermore they generally prefer to be socially isolated and less commonly become involved in situations that may bring out violence. Violence may be more likely with excessive use of alcohol.

Guilt may be common. This is a complex issue, and may relate to a wide variety of aspects of the traumatic experience, such as regret for not doing certain things, or for surviving when a mate did not.

Heightened Vigilance is common. One wife described her veteran husband as "patrolling the aisles" in the supermarket, very much as a forward scout looking out for the enemy.

Family Effects

There are commonly many family issues and disturbances in PTSD. Some of the family conflicts relate to the general military training and experience producing rigid expectations, based on a rigid military lifestyle.

The veteran is often at significant emotional distance from people including the family. This relates partly to the processof the syndrome itself and partly relates tothe experience of combat, as well as military training. The traumatic experiencesare therefore difficult for veterans to sharewith anyone who has not experienced similar conditions.

Diagnosis and Differential Diagnosis

Diagnosis itself formally is best based on the DSM system of diagnosis(for reliability). However, traumatic experiences produce changes in functioning that are not simply delineated by the criteria for PTSD.

Many of the superficially similar problems in veterans with PTSD may bedue to other conditions: the effects ofalcohol abuse alone, other anxiety disorders, depressive disorders and personality disorder. However, the effects of chronic PTSD often produce features of apparent personality disorder that are in fact a product of PTSD. Other traumas in life may also produce a PTSD.

Co-morbidity

Severe chronic PTSD is almost always found with Co-morbid, (existing in combination and often as a result of PTSD) anxiety and depressive disorders. Commonly these include Major Depressive Disorder, Agoraphobia, Social Phobia and Panic Disorder, Substance Abuse, including alcohol and more rarely illicit drugs and very occasionally anabolic-steroids. In the military veterans from Vietnam, alcohol abuse has been very common and to a significant extent part of an attempt to self-medicate. Psycho-somatic syndromes such as headaches, irritable bowel syndrome and bruxism are common. There is a risk of suicide in PTSD and co-morbid conditions.

War and military service related PTSD may be exacerbated or become overtly handicapping by the stress of other events in life. The onset of PTSD, and certainly exacerbation of PTSD, may relate to other

events and traumatic experiences in life.

Secondary depressive disorders may follow a range of medical conditions, such as chronic hearing loss and chronic persistent tinnitus.

Time Course of PTSD

PTSD is a variable condition with a fluctuating course, with symptoms fluctuating over weeks to months, and also over the life span.

In the overall life span it is common for PTSD to have some prominent symptoms emerge relatively soon after the traumatic experience, often to then settle or be suppressed. In many cases the symptoms become subdued, as the veteran uses a range of defenses to keep the symptoms at bay, commonly including alcohol and keeping excessively busy.

Symptoms may then re-emerge after many years, often after decades. This is partly due to the traumatic memory being processed in a different memory system, not based on time. We still see World War II veterans who remember incidents as though they happened yesterday, not 55 years or more ago. This process interacts with other stresses, other illness, and developmental stages of life.

In many cases the symptoms become accepted as part of normal life, such is the chronicity of these symptoms. It may be their veteran mates who identify they havea PTSD as they have often undergone a similar experience.

Why Now?

It is common in clinical practice for the most severe effects of PTSD to not emerge for some time and have an exacerbation in middle age, for many this is some 30 years after their war experience. There are various reasons for this. Common reasons for this later exacerbation are increasing age, being physically less robust, in some cases the intercurrent stresses of serious physical illness that become more common with increasing age, the developmental issues of aging and of being more aware of mortality, having children, and exposure to significant reminders of the traumatic event. Many become introspective as they grow older, which is a normal developmental process. In other words they tend to look back on their lives and try to seek meaning in their lives.

There are occupational and work stresses, including approaching redundancy or retirement. The alcohol intake used to suppress the symptoms may also contribute to the worsening of the PTSD by a range of mechanisms, including organ damage, mood disturbance and sleep disruption.

The effects of further stressful life events can contribute to the onset of exacerbation of the PTSD. For example further stresses in the police or in the military such as deaths in training. Such incidents on the television or news can be powerful reminders that exacerbate PTSD.

Many have children who are teenagers or young adults and are of an age where they remind the veterans of themselves at the age when they went to war. For many there is a determination that their children should not be exposed to be experiences that they had. In some cases they are asked by their children about their experiences in the war and this may bring back unwanted memories.

PTSD is far more widely known in the medical and psychology professionals and more likely to be identified, or at least sent for assessment. Another process is that of the effects of the veterans organisations. There is a process where veterans meet. often at a reunion, and veterans who know about their own PTSD condition recognise that mates have a similar problem. They encourage them to seek assistance, to receive a recognition of their condition and seek effective management and treatment.

PTSD fluctuates in severity often as a result of additional stresses, anniversaries such as being wounded, of a contact, or commonly with any other significant reminders. In Australia there are particular days in the year that often bring back memories: ANZAC Day, Remembrance Day and Vietnam Veterans Day- on 18 August- the anniversary of the Battle of Long Tan. The media frequently show documentaries and short news clips around such times. Units often have reunions at these times.

Reunions are a source of ambivalence; they provide mutualsupport and understanding, but also trigger distressing memories. The best way to handle this depends on the individual. On ANZAC Day many veterans only go to the Dawn Service. In Canberra, there can be 10,000 people around you but in the dark you can feel alone with your grief and do not feel embarrassed.

Many veterans with PTSD in milder stages work hard so as to keep busy all the time and not allow themselves time to think about the intrusive memories. They often present the image of being workaholic and driven. Therefore they are rarely home and this contributes to family disruption. They hope to also tire themselves out so as to help improve their sleep. However, years of poor sleep contribute to a process of being

chronically fatigued with consequent reduced drive and energy which contributes to the breakdown of the defence of keeping busy.

In many ways this process of being chronically fatigued combined with subtle cognitive changes, especially of poor concentration, and a reduced capacity to cope with any stress, is the most disabling aspect, and often least amenable to improvement with active treatment.

Why Vietnam?

PTSD is seen in serviceman who have been in a wide range of traumatic experiences in military service but Vietnam has had been of particular note. This is partly historical as the formal diagnosis developed as a result of the upheaval from Vietnam in the USA. The Vietnam War has particular significance due to a number of factors. For the infantry soldier the 12 month tour usually consisted of prolonged exposure to an environment where potentially one could come under attack at any time.

Most infantry units spent the majority of their time out in the bush. They were usually patrolling and moving under conditions where contact with the enemy might occur at any time and from any direction. A fraction of a second could make a difference to life or death, not only for oneself but for one's mates, for whom one felt responsible. Even in rear echelon areas, traumatic experiences still occurred, bombs exploded in Saigon, the local Vietnamese soldiers and police were often aggressive, threatening civilians and even their allies, and frequently shot suspects. It was often impossible to tell who was friendly and who was enemy. Many civilian casualties did occur. There were many atrocities perpetrated on the civilians, often by the Vietcong. This is part of the reality of war, which is not well understood outside of the military.

Of significance is the fact that the war was lost. The soldiers themselves were aware of the uncertainty about the political decisions that lead to the prosecution of the war. Of greatest significance for many was their treatment by the population of Australia including by friends and relatives. They certainly were given the message that they were not welcome. After Vietnam, the veterans had the common experience of being rejected and often were actively abused. They were called baby killers, murderers and rapists. Their return to Australia was anything but welcome. There are still cases of veterans who were rejected by their close family and parents who still have not resolved this. Therefore the veterans have learned to keep their emotional and psychiatric symptoms to themselves.

Prognosis

It is important to have a realistic understanding of the prognosis of chronic PTSD. The prognosis generally is similar to that of other medical conditions, that is if a patient has had, for example, asthma for 30 years then we would expect to continue to have asthma for the foreseeable future. The same prognosis is true for chronic PTSD. If the symptoms have been present for 30 years to some extent then realistically we can expect that symptoms will persist for the foreseeable future. However, in the same way that asthma can be better contained by appropriate treatment, management of PTSD will often produce significant improvement in the symptoms and quality of life for the veteran.

Military Significance: What is Different about PTSD in the Military

Post-traumatic stress disorder in the military is of significance as a large percentage have developed this after what are clearly severe and often persisting life threatening stressful experiences in hostile environments, especially service in a war, in peace keeping, but also in response to accidents in training. It is likely that if the stress is severe enough that anyone may suffer an Acute Stress Disorder. This is mitigated by many factors: leadership, morale, teamwork and mutual support, fitness, and training. This is a form of acute PTSD and needs a separate article to itself. Although the picture of the chronic Posttraumatic Stress Disorder is Jess clear there is certainly the pattern that the more severe the stress the higher the risk of a chronic PTSD in anyone no matter what their strengths or vulnerabilities are.

Remaining in the armed forces is protective as it provides structure, identity, and social support frompeers, but it is common for this to delay the onset rather than completely prevent the onset. The loss of structure, identity and support after discharge produces additional stress that may then exacerbate the PTSD.

It has been common in the military for personnel to not report symptoms of psychological distress during their service unless these symptoms are very severe. There is a range of reasons for this; these include a fear of being medically downgraded, of medical discharge, and the adverse effects on promotion and career prospects, and the fear of social ostracism

in the military environment. In past years personnel have presented to medical services with psychologically generated symptoms and have not been taken seriously, and service personnel have been fearful of the problems with confidentiality in the military.

Military personnel have difficulty in being close to people due to the military ethos, their training for combat, the experience of combat and the underlying psychological defenses against loss. Part of the military socialisation is that soldiers do not show emotion and are expected to cope with any problem. This helps reinforce or even induce a form of alexithymia, a process where the individual has difficulty in describing their emotions, even to themselves and therefore have difficulty expressing emotion. Further, people who join the military may often be already of a personality type where this is more common. Therefore, it is common that veterans may present appearing better than they really are.

The social setting of the military is also of major significance and poorly understood outside of the military. Because the language is ostensibly the same as the rest of the country and the military is assumed to be part of the broader society, there is often a presumption that military society is exactly what people expect in their own lives. This will lead to serious problems in understanding and communication.

Military social structure is different, with its own language with words which have meanings different from the same words used in civilian life. This confuses the unprepared clinician who does not understand the jargon. A knowledge of the language, or jargon, is a significant help; for example knowing what a "contact" or a "grunt" means.

Understanding these aspects of the military can quickly contribute to a good therapeutic relationship and more quickly lead to an orientation about the common significant problems in this group. It gives clues as to the questions that should be asked to obtain an accurate history.

Conversely an attitude that expresses disbelief or lack of understanding of a person's background and the values they hold dear will usually make patients reticent about discussing those things they find most difficult to talk about. One of the common features of PTSD is that the traumatic experiences are usually not discussed even with close family and friends. It is distressing to talk about many of the symptoms and experiences and it is therefore important to establish a therapeutic situation whereby they can discuss their experiences openly. Military veterans do not easily discuss their problems. Military veterans do not talk easily with people who do not understand the language or culture.

References

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