The victor as victim: stress syndromes of operational service

2: Post-traumatic stress syndromes

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THE TERM "POST-TRAUMATIC STRESS DISORDER" (PTSD) was first used in 1974;[1-3] and in 1980 it was formally included as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd edition).[1]

Post-traumatic stress syndromes are not exclusively disorders of service personnel or of professional civilian workers in the emergency services. They can occur as a complication of peacetime military training,[2] or in civilian life. Estimates of lifetime PTSD prevalence in the US civilian community are 1%–5% for men and 10% for women.[3,4] Thirteen per cent of American women report having been raped;[2] of these, 11% have chronic PTSD as a result.[5] The subject is thus of great significance to society as a whole.

Peacekeeping deployments as part of multinational United Nations forces have manifested differential risk rates for PTSD. Risks vary widely amongst different national groups and different operational deployments (Box 1).[6-9]

The post-traumatic stress disorders are protean and complex (Box 2). An understanding of their genesis and an appreciation of the different syndromes and their specific management may reduce long-term morbidity from this group of diseases. There have been no controlled trials of different medical, psychological or psychiatric interventions in acute combat stress disorders, or their effectiveness in preventing post-traumatic stress disorder.[9-12] Recognising, managing and preventing combat stress disorders is an important function not only of military medicine, but of the command and training personnel in all military units.

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Synopsis

- Identifying the post-traumatic stress syndromes remains a challenge to the ADF Health Service and Veterans' Health Services.
- Between 2% and 15% of formerly deployed servicemen and women require professional help for post-traumatic stress disorder (PTSD).
- The risks and costs are operation-specific. PTSD affected up to 30% of US veterans of the Vietnam War, with a point prevalence of 15% 10 years after the war. PTSD affected only 2% of Norwegian soldiers returning from UN peacekeeping deployments in the nations of the former Yugoslavia.
- There are 12 identified post-traumatic stress syndromes, each with specific risk factors, clinical features, management strategies and preventive options.

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1: Reported incidence and prevalence of post-traumatic stress disorder, by nation and UN deployment[6-8]

Nationality of troops	PTSD incidence	Deployment
Canadian	8%	UNPROFOR (Yugoslavia)
Danish	7%	UNPROFOR (Yugoslavia) March 1992–February 1999
Dutch	5%	UNIFIL (United Nations International Force in Lebanon) March 1978–current
Norwegian	2%	UNPROFOR (Yugoslavia) March 1992–1999
American	15%	Vietnam War
American	11.4%	UNOSOM I (Somalia) April 1992–April 1993

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2 Post-traumatic stress syndrome

Syndrome	Clinical features	Management
Post-traumatic stress disorder: Long history of more than a century,[15] and called by various names such as "shell shock", "war neurosis", "rape trauma".[16] PTSD first defined in 1974, and first accepted in DSM-III in 1980.[1]	Identifiable traumatic experience ("stressor criterion") required for diagnosis; plus evidence of three symptom clusters: (a) re-experiencing symptoms; (b) symptoms of effortful avoidance; and (c) increased arousal.[14] PTSD may not appear for several years after exposure to the initial stressor.	Critical incident stress debriefing,[16] hypnotherapy,[17] psychodynamic therapy (eg, group therapy),[18] cognitive–behavioural treatments, symptom treatment programs (eg, anxiety management), social support,[19] pharmacotherapy.
Post-traumatic depression	Classical psychiatric depression: lowered affect, loss of self esteem and motivation, feelings of gloom and unworthiness, intrusive paranoid thoughts, altered sleeping patterns, withdrawal, dysphoria, impacted grief, social isolation,[20] suicidal thoughts, and a high rate of achieved suicide.	Classical psychiatric management: drug therapy, psychotherapy, electroconvulsive therapy, social support.
Alcoholism and drug abuse: Recognised as a "veterans' disease" since the 19th century. Post-Vietnam epidemic among veterans of some nations who served in that campaign.	Classical features of physical as well as psychological dependence on the drug. Incremented dosage intake patterns. Alcohol and drug abuse are cognate symptoms of a number of other, more specific posttraumatic stress syndromes.[21]	Classical psychiatric counselling and organisational support, management programs (eg, methadone programs) for narcotic addiction, pharmacotherapy,[22] social support groups.
Somatisation syndrome: Known since the Crimean War, exemplified by Florence Nightingale's neuromuscular paralysis.	Chronic non-organic bodily symptoms, often organ- or system-specific. Somatisation features are co-morbidities for many post-traumatic stress syndromes.[22]	Psychodynamic therapy, cognitive–behavioural treatments; and hypnotherapy.[17]
Chronic fatigue syndrome: A long history of morbidity after wars, described variously as Florence Nightingale syndrome; lack of moral fibre (LMF); "shell shock"; "combat fatigue". Civilian counterparts include Tapanui disease, Royal Free disease and myalgic encephalomyelitis.[25]	Rigid diagnostic criteria specified by Centers for Disease Control, Atlanta, Georgia:[13] persistent overwhelming, recurrent fatigue unrelieved by rest, unrefreshing sleep. Exclusionary criteria are important, with confirmed absence of organic disease, poisoning,[23] Lyme disease.[24]	Management centres on decision-node to stop further investigation after diagnosis and to promote graded rehabilitation.[25] Development of infrastructure where secondary gain from illness is minimised, within boundaries of best-practice medicine. Social support networks.[23]
Gulf War syndrome: First described in the international literature in 1994,[28] extensive medical literature since then.[29]	A chronic fatigue syndrome complex (fatigue, non-specific rash, myalgia, headaches, memory loss),[13] with dispro-portionate respiratory and gastrointestinal symptoms.[26] Patients often have a fixed belief that the syndrome is caused by chemicals or drugs.[27]	Treatment as for CFS and PTSD. Social networks and support.[29]
Peacekeepers stress syndrome: First described in 1979 in the Nor-wegian military medical literature.[32] Subsequently reported from more than 10 multinational UN Peacekeeping deployments.[31,33,34]	Symptoms of fear of losing control over one's own aggression predominate.[30] Soldiers trained for combat, but forced to respond only in self defence, can experience guilt and stress at witnessing atrocities between warring parties without permission to intervene.[31] A syndrome of role-identity conflict compounded by longterm frustration, outrage, guilt and mortal fear.	Maintenance of a "forward psychiatry" doctrine, critical incident stress debriefing with emphasis on group cohesion, pharmacotherapy. Prevention by correct training and preparation for the unusual circumstances of peacekeeping in a foreign country.[35]
Lifestyle and cultural change syndrome: Permanent change of character after combat experience has been recorded since Homer's *Iliad*.[15]	Alienation from society: "most victims [of severe operational stress] find coming home harder than going away".[36] Those who leave the Services, or are medically discharged, then "drop out of life" or establish a counter-cultural lifestyle (eg, Vietnam Veteran biker groups, "post-Vietnam ferals").	By definition, a syndrome exhibited after permanent discharge from military ser-vice. If subjects do not exhibit comorbid-ities, there is nothing to treat and the concept of "treatment" is not legitimate.
Survivor's guilt syndrome	"I would never have continued as a soldier if there had been psychiatrists available to relieve my guilt at staying alive while so many of the men with me were killed".[33] May be exhibited as an acute or subacute syndrome; rarely with longterm morbidity.	Extensive counselling, peer and society support, psychotherapy, psychodynamic and cognitive–behavioural therapy.[18]
Independent psychiatric illness, co-incidental in a veteran	Many stressful situations precipitate or unmask hitherto unrecognised or newly-developed psychiatric illnesses such as schizophrenia, mania or depression.	Treatment is specific for the underlying diagnosis.
Complex PTSD syndrome: First included in the 10th edition of the *International Classification of Diseases* (ICD-10) as "enduring personality change after catastrophic experience".[38]	Victims exposed to prolonged, extreme or repeated stress,[38] often commencing in childhood (eg, sexual abuse, prolonged deprivation of liberty, maltreatment as a political prisoner). Clinical features include affect disregulation, altered ability to form interpersonal relationships, self destructive behaviour, preoccupation with the perpetrator, enduring feelings of revenge.	Early intervention with specialised professional therapy needed. Prolonged therapy usually required.[16] Re-education about normal interpersonal relationships.[16] Pharmacotherapy.[22]

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The Asia–Pacific Military Medical Conferences

WITHIN THE LAST DECADE, members of the Australian Defence Health Service have served on operations in Namibia, Somalia, Western Sahara, Rwanda, Cambodia, Kurdistan, Iraq, the Persian Gulf, Indonesia, Papua New Guinea and East Timor. Servicemen and women from all three Services have been involved, working as part of multinational teams. Similar commitments have been made by the defence health services of several Pacific nations. The Singapore Armed Forces Medical Corps served in Guatemala in 1997; New Zealand and Fiji sent military medical personnel to Bougainville in 1998; and the US is involved in several Pacific deployments, such as in Palau, and in rabies eradication programs in the Philippines.

The deployment of the Defence Health Service overseas has been a major exercise of Australia's strategic policy. This proactive and altruistic use of the Defence Health Service has been an expensive commitment, but the response in national and international opinion has been most favourable. Developing nations, in particular, see this commitment as appropriate for a nation with one of the highest standards of health in the world.

The Asia–Pacific Military Medicine Conferences provide an important annual forum for liaison between the Australian Defence Health Service and those of other nations in our region. The Conferences have been co-hosted since 1990 by the United States Army, Pacific Command (USARPAC) and another rotating host nation (so far including Thailand, Indonesia, India, Malysia, Australia and New Zealand). Each Conference allows military healthcare providers throughout Asia and the Pacific to exchange information about military medical issues common to all uniformed medical forces, such as preventive medicine, operational health deployments, combat surgery, malaria research, training injuries and medical ethics within the profession of arms.

The ninth Conference was held on 7–12 March 1999 in Bangkok. The tenth will be held in Singapore in May 2000.

Forty-three nations and over half the world's population are encompassed in the phrase "the Asia–Pacific region". Australia's principal strategic interests are in this region, where it is inevitable that there will be a continuing need to respond to natural disasters and military crises. Pre-deployment training for both uniformed and civilian groups and the interpersonal collegiate linkages that conferences help to create will make for improved effectiveness in multinational missions of the future.

A significant influence for the maintenance of a muscular peace is the enhancement of military-to-military relations. In peacetime, these can be promoted by international joint exercises, military personnel exchanges and conferences.

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