EDITORIALS

Acknowledging the Psychiatric Cost of War

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The data presented by Hoge and associates in this issue of the *Journal*[1] about members of the Army and the Marine Corps returning from Operation Iraqi Freedom or Operation Enduring Freedom in Afghanistan force us to acknowledge the psychiatric cost of sending young men and women to war. It is possible that these early findings underestimate the eventual magnitude of this clinical problem. The report is unprecedented in several respects. First, this is the first time there has been such an early assessment of the prevalence of war-related psychiatric disorders, reported while the fighting continues. Second, there are predeployment data, albeit cross-sectional, against which to evaluate the psychiatric problems that develop after deployment. Third, the authors report important data showing that the perception of stigmatization has the power to deter active-duty personnel from seeking mental health care even when they recognize the severity of their psychiatric problems. These findings raise a number of questions for policy and practice. I focus here on post-traumatic stress disorder (PTSD), because there is better information about this disorder than about others and because PTSD was the biggest problem noted in the responses to an anonymous survey among those returning from active duty in Iraq or Afghanistan.

The rigorous evaluation of war-related psychiatric disorders is relatively new, having begun with the National Vietnam Veterans Readjustment Study.[2] This national epidemiologic survey of male and female veterans of Vietnam was conducted in the mid-1980s. The veterans were therefore assessed 10 to 20 years after their service in Vietnam. The prevalence of current PTSD was 15 percent among men and 8 percent among women. The lifetime prevalence of PTSD was higher—30 percent among male veterans and 25 percent among female veterans.

A retrospective cohort study of veterans of the Gulf War that was conducted between 1995 and 1997[3] showed a prevalence rate of 10.1 percent for PTSD among those who had experienced combat duty, in contrast to a prevalence rate of 4.2 percent in a matched cohort of Gulf War–era veterans who had not seen combat. The adjusted odds ratio for PTSD for those who had been in combat was 3.1; this is similar to the odds ratios in the present study of 2.84 for soldiers and 2.66 for Marines after deployment to active duty, as compared with soldiers before deployment.

In a longitudinal study of New England veterans of the Gulf War, the prevalence of PTSD more than doubled between the initial assessment performed immediately after their return to Fort Devens, Massachusetts, and the follow-up assessment performed two years later. The rates increased from 3 percent to 8 percent among male veterans and from 7 percent to 16 percent among female veterans. Higher levels of symptoms have been reported among members of the National Guard and the Reserves than among active-duty personnel.[4]

Finally, a retrospective survey of American male and female soldiers deployed to Somalia between 1992 and 1994 showed an estimated prevalence of PTSD of approximately 8 percent, with no difference according to sex.[5] When the focus of this mission shifted from a United Nations' humanitarian peacekeeping operation to a more traditional military deployment to subdue the Somali warlords, there was greater exposure to traumatic situations and a higher prevalence of PTSD among the American troops.[6]

It is unclear at this time whether the prevalence of PTSD among those returning from Operation Iraqi Freedom or Operation Enduring Freedom will increase or decrease. On the one hand, it is en-

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couraging that the Department of Defense has been active in providing mental health care in the war zone and psychiatric resources in the United States and has demonstrated a commitment to monitor psychiatric disorders, as reflected by the present report. Furthermore, the findings of the National Vietnam Veterans Readjustment Study suggest that considerable recovery from PTSD among veterans is possible, as shown by the difference between the lifetime and the current prevalence of this disorder.

On the other hand, the National Vietnam Veterans Readjustment Study cannot tell us whether the onset of PTSD occurred while Vietnam veterans were still in uniform or at some time later, during the 10 to 20 years between their exposure to war and the survey for the study. Indeed, there is reason for concern that the reported prevalence of PTSD of 15.6 to 17.1 percent among those returning from Operation Iraqi Freedom or Operation Enduring Freedom will increase in coming years, for two reasons. First, on the basis of the findings of the Fort Devens study,[4] the prevalence of PTSD may increase considerably during the two years after veterans return from combat duty. Second, on the basis of studies of military personnel who served in Somalia, it is possible that psychiatric disorders will increase now that the conduct of war has shifted from a campaign for liberation to an ongoing armed conflict with dissident combatants. In short, the estimates of PTSD reported by Hoge and associates may be conservative not only because of the methods used in their study but also because it may simply be too early to assess the eventual magnitude of the mental health problems related to deployment to Operation Iraqi Freedom or Operation Enduring Freedom.

A recent reanalysis of the data from the National Vietnam Veterans Readjustment Study[2] and the Hawaii Vietnam Veterans Project[7] suggests that after the development of PTSD, the risk factors for persistent PTSD are "primarily associated with variables relating to the current time frame: current emotional sustenance, current structural social support, and recent life events."[8] This information is clearly useful for mental health policy and planning, because it raises the hopeful possibility that PTSD may be reversible if patients can be helped to cope with stresses in their current life.

There are obviously important distinctions between the period after the Vietnam War and the present. Americans no longer confuse war with the warrior; those returning from Iraq or Afghanistan enjoy national support, despite sharp political disagreement about the war itself. In addition, the field of study of PTSD has matured to the point where effective evidence-based treatment and practice guidelines are available for use by the Departments of Defense and Veterans Affairs and by civilian mental health practitioners. Cognitive–behavioral therapies have been successful in the treatment of PTSD, and two selective serotonin-reuptake inhibitors have been approved by the Food and Drug Administration.[9-11] Practitioners in the Departments of Defense and Veterans Affairs are sophisticated and strongly motivated to continue to improve their skills in treating PTSD. Collaboration between mental health professionals in the Department of Defense and those in the Department of Veterans Affairs is at an all-time high. For example, the Veterans Affairs National Center for PTSD and the Defense Department's Walter Reed Army Medical Center collaborated to develop the Iraq War Clinician Guide (available at www.ncptsd.org/topics/war.html) and to conduct a multisite, randomized trial of cognitive–behavioral therapy for PTSD among female veterans and female active-duty personnel.

In a best-case scenario, active-duty, Reserve, and National Guard personnel as well as veterans of Operation Iraqi Freedom or Operation Enduring Freedom with symptoms of PTSD will take advantage of the many mental health services available through the Departments of Defense and Veterans Affairs. Educational initiatives will be implemented to help veterans and active-duty personnel recognize that the loss of social support or the effect of recent adverse life events may precipitate a return of the symptoms of PTSD. Veterans and active-duty personnel will also be encouraged to monitor their psychological health and to seek treatment if and when it becomes necessary.

Alas, there is also a worst-case scenario that demands immediate attention. Hoge and associates report that concern about possible stigmatization was disproportionately greatest among the soldiers and Marines most in need of mental health care. Owing to such concern, those returning from Operation Iraqi Freedom or Operation Enduring Freedom who reported the greatest number or the most severe symptoms were the least likely to seek treatment for fear that it could harm their careers, cause difficulties with their peers and with unit leadership, and become an embarrassment in that they would be seen as weak.

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These findings are consistent with those in an earlier report that showed low use of mental health services among Navy and Marine Corps personnel.[12] In contrast to a rate of 28.5 percent among male civilians with a psychiatric disorder who sought treatment,[13] only 19 percent of servicemen with a psychiatric disorder sought treatment. Furthermore, among military personnel with PTSD, the rate of seeking treatment was only 4.1 percent, which is substantially lower than that for other psychiatric disorders. This finding may indicate that within the military culture, "succumbing" to PTSD is seen as a failure, a weakness, and as evidence of an innate deficiency of the right stuff.

Hoge and associates suggest that the perception of stigmatization can be reduced only by means of concerted outreach — that is, by providing more mental health services in primary care clinics and confidential counseling through employee-assistance programs. The sticking point is skepticism among military personnel that the use of mental health services can remain confidential. Although the soldiers and Marines in the study by Hoge and colleagues were able to acknowledge PTSD-related problems in an anonymous survey, they apparently were afraid to seek assistance for fear that a scarlet P could doom their careers.

Our acknowledgment of the psychiatric costs of war has promoted the establishment of better methods of detecting and treating war-related psychiatric disorders. It is now time to take the next step and provide effective treatment to distressed men and women, along with credible safeguards of confidentiality.

Dr. Friedman reports having served as a paid speaker for GlaxoSmithKline, Ortho-McNeil, and AstraZeneca.

The opinions expressed in this article are those of the author and do not necessarily reflect the views of the Department of Veterans Affairs.

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