c PTSD can remain unrecognised in a patient during several decades
d PTSD does not cause character changes
e PTSD cannot remain unrecognised for a long period of time.

4. Which of the following is correct? SSRIs:
a should not generally be used during psychotherapy
b are less effective with longer use, like benzodiazepines
c cause receptor hypersensitivity
d may facilitate introspection
e are insensitive to dose levels.

5. Post-traumatic nightmares:
a mainly occur during rapid eye movement sleep stages
b are indistinguishable from anxious dreams
c are nightly flashbacks
d occur preferentially during slumber sleep
e are phenomena of primary process thinking.

MCQ answers

1	2	3	4	5
a F	a F	a F	a F	a F
b F	b F	b F	b F	b F
c F	c F	c T	c F	c T
d F	d T	d F	d T	d F
e T	e F	e F	e F	e F

Commentary

Leigh A. Neal

It is a sobering fact that the average age of the surviving veterans of the Second World War is now close to 80 years. The available information indicates that the prevalence of post-traumatic stress disorder (PTSD) in all Second World War veterans is slightly higher than the 15% lifetime prevalence found in Vietnam War veterans, although there are few reliable studies on which to base this conclusion. It is, however, consistent with the finding that combat stress, based on casualty rates, during periods of the Vietnam War was equivalent to the severity of combat stress in the Second World War. There are several epidemiological studies (Beebe, 1975; Tennant *et al*, 1986) of more specific Second World War veteran groups such as Far East prisoners of war and, predictably, they show higher PTSD prevalence rates, ranging between 30 and 50%.

The case history clearly demonstrates the complexities of managing war veterans presenting with PTSD over 50 years after the traumatic event. The authors' emphasis on developing a therapeutic alliance and providing a flexible psychological intervention with adjunctive pharmacological treatment is a useful model on which to base a treatment strategy.

Many Second World War veterans, although exhibiting post-traumatic symptoms for most of their lives, have characteristically not allowed their symptoms to cause significant social or occupational impairment. They come from an era which encouraged the 'stiff upper lip' and this distinguishes them from the emotionally less inhibited veterans of recent conflicts. Patients in the elderly veteran group tend to present with an exacerbation of their symptoms at times of important anniversaries or during the development of comorbid psychiatric disorders, when their functional reserves are eroded. In fact, PTSD rarely presents as a unitary diagnosis and the presence of

Wing Commander Leigh A. Neal is Officer Commanding the Defence Medical Services Psychiatric Centre and the Tri-Service PTSD Unit, Duchess of Kent's Hospital, Horne Road, Catterick Garrison, North Yorkshire DL9 4DF.

https://doi.org/10.1192/apt.4.4.217 Published online by Cambridge University Press

comorbid disorders should be carefully elucidated and treated accordingly.

Clinicians should exercise caution when weighing up the authenticity of any combat history. It has been shown that human memory is unreliable when recalling combat trauma. Southwick *et al* (1997) demonstrated that Gulf War veterans, with more marked PTSD symptoms, amplified their memory of trauma severity over a two-year period. This effect may be multiplied in veterans recalling trauma memories from over 50 years ago. Additionally, the development of persecutory ideation as part of a late-onset paranoid illness can embellish the most uneventful military history with seductive stories of special forces operations and government cover-ups. However, in the UK it seems that factitious and malingered PTSD is more a phenomenon of conflicts post-dating the Korean War, for which personal injury litigation and disability compensation have become important motivating issues.

The necessity for treating the symptoms of elderly veterans with PTSD requires careful consideration. The PTSD symptom profile in Second World War veterans is enduring and more complex than in younger veterans and may have reached an accommodating homeostasis between symptoms and function. There are reports of exposure-based psychological treatment techniques exacerbating symptoms and precipitating depression or panic attacks in some younger patients. Therefore, the potential cost of behaviour therapy needs to be carefully balanced against the anticipated benefits in this very elderly population.

Although at least eight randomised controlled drug studies have been reported in the treatment of PTSD these are plagued by methodological difficulties, most importantly unrepresentative sample selection. The results are difficult to interpret either in rejecting the usefulness of medication in PTSD or in confirming its utility. However, there is some indication that monoamine oxidase inhibitors (MAOIs) and selective serotonin reuptake inhibitors (SSRIs) may have some clinical efficacy. Unfortunately, the SSRIs have the potential for anxiogenesis in the first few weeks of treatment, which has been reported in both panic disorder and PTSD. Since this may exacerbate the existing PTSD-associated hyperarousal, it can significantly impair compliance. Possible alternatives, not causing this undesirable effect, include the reversible inhibitors of monoamine oxidase-A (third-generation MAOIs) such as moclobemide, which has shown efficacy in one uncontrolled PTSD study (Neal *et al*, 1997). Sexual dysfunction, sometimes reported by PTSD patients taking an SSRI, may be reversed by changing to nefazodone, which acts both as an SSRI and a 5-HT_2 antagonist. Adjunctive treatment with the α_2-agonist clonidine, although useful in some younger patients, should probably be avoided in elderly veterans because of its hypotensive effects.

Attention to the social management of all veterans is a priority. In particular, it is important to ensure that they have the opportunity to contact a national ex-serviceman's welfare organisation such as Combat Stress[1] which can provide respite care as well as support in applying for disability payments. Veterans in receipt of a war pension should be informed that they are entitled to priority treatment for their attributable conditions. If they experience any problems or delays in obtaining treatment from the National Health Service, they can contact the War Pensions Welfare Office for further advice (War Pensions Agency, 1997).

References

Beebe, G. W. (1975) Follow-up studies of World War II and Korean War prisoners. *American Journal of Epidemiology*, **101**, 400–422.

Neal, L. A., Shapland, W. & Fox, G. (1997) an open trial of moclobemide in the treatment of post-traumatic stress disorder. *International Clinical Psychopharmacology*, **12**, 231–237.

Southwick, S. M., Morgan, C. A., Nicolaou, A. L., *et al* (1997) Consistency of memory for combat-related traumatic events in veterans of Operation Desert Storm. *American Journal of Psychiatry*, **154**, 173–184.

Tennant, C., Goulston, D. & Dent, O. (1986) Clinical psychiatric illness in prisoners of war of the Japanese; 40 years after release. *Psychological Medicine*, **16**, 833–839.

War Pensions Agency (1997) *Notes For People Getting a War Pension Living in the United Kingdom*. War Pensions Agency Leaflet 2. London: HMSO.

1. Combat Stress Head Office, Broadway House, Wimbledon Broadway, London SW19 1RL (tel: 0181 543 6333).

https://doi.org/10.1192/apt.4.4.217 Published online by Cambridge University Press