VETERANS' HEALTH AND WELFARE

CO-OPERATION INTERNATIONAL STEERING GROUP

FINAL REPORT

FEBRUARY 2008

VETERANS' HEALTH AND WELFARE CO-OPERATION INTERNATIONAL STEERING GROUP

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VETERANS' HEALTH AND WELFARE

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27 February 2008

1. Background

After a proposal from Israel to the WVF General Assembly in Johannesburg in December 2003, the Standing Committee on European Affairs (SCEA) on its 19th meeting in Zagreb in October 2004 called for the establishment of a Steering Group to advise SCEA on strategies to collect and disseminate scientific information relevant to veterans' health and well being. The purpose was to identify the real health and welfare issues facing veterans, and to stimulate exchange of information touching on the rights and benefits of veterans and their dependents, as well as to stimulate scientific co-operation between nations and, when necessary, to assist in building pressure on governments to develop adequate policies and to implement best practices on these related issues.

2. Mandate

The main tasks of this Steering Group were:

- to identify important and relevant issues with regard to the health and welfare of veterans in the affiliated European organizations and countries,
- to identify resources that can provide the members-affiliates with information about the results of research that has been carried out on these issues, as well with information on recommendations and strategies that have been developed on the basis of these results,
- to prepare recommendations for SCEA regarding the future co-ordination of these tasks.

3. Members

- Prof Avi Ohry, Israel, Professor of Rehabilitation Medicine, Sackler Faculty of Medicine, Tel Aviv University, Director of Rehabilitation, Reuth Medical Centre.
- Mr Jos Weerts, Netherlands, Head, Centre for Research and Expertise, Deputy Director Veterans Institute Netherlands.
- Dr Bjørn Bakke, Norway, Reserve Medical Officer (Retd) Norwegian Armed Forces, District Medical Officer and General Practitioner.
- Maj Gen (Retd) David S Jolliffe, United Kingdom, late Royal Army Medical Corps, from the 3rd meeting Brig (Retd) Robin Garnett, United Kingdom, Chairman Medical Advisory Committee (sub-committee of the British Members' Council) and Consultant in Rheumatology.
- Lt Col (Retd) Jeremy Hinton, United Kingdom, Secretary.

4. Meetings

- London, United Kingdom 29.07.2005
- Prague, Czech Republic 10.05.2006
- Doorn, Netherlands 11.10.2006
- London, United Kingdom 07.08.2007
- Kongsvinger, Norway 23.11.2007
- Doorn, Netherlands 02.02.2008

5. Area of work

5.1 The first two meetings focused on the terms of references, more in particular, on developing an agenda and a plan of activities for the Steering Group, based on the Terms of Reference. Following the meeting in Prague, a letter was sent to every European WVF member-organization, with a request to identify the most important and urgent issues regarding the veteran's health and welfare in the respective countries. Altogether, eight member-organizations responded, providing the Steering Group with input that was reviewed during the following meeting in the Netherlands. This meeting focused on identifying the most important and urgent issues that are relevant to veterans in (most) European countries, as well as on defining the way to proceed and complete the work of the Steering Group. These issues and the way to proceed were thoroughly discussed in 2007, and during its last meeting, in 2008, the Steering Group discussed and prepared the final report with the recommendations for SCEA, to be presented at the SCEA in April 2008.

5.2 The Steering Group decided to focus on four areas of major importance to veterans:

1. Post-traumatic stress disorder (PTSD).
2. Medical unexplained physical symptoms (MUPS).
3. Premature ageing and morbidity.
4. Veterans support veterans.

For each of these areas a brief overview of relevant aspects will be presented.

5.3 Post traumatic stress disorder (PTSD)

5.3.1 While most soldiers remain in good health, after returning from war or from an international operation, a minority develop psychological problems that affect their life and wellbeing in a serious way. This was an important issue in the feedback that the Steering Group received from various national member organisations.

5.3.2 Since its introduction in the psychiatric classification systems, PTSD became a central issue in clinical practice and in scientific research. However, one should keep in mind that this is not the only psychological disorder that can arise from wartime or war-like experiences. Mood disorders (depression), general anxiety disorders and abuse or dependency disorders (alcohol, drugs, gambling) are likewise frequently observed. Finally, there are also veterans who encounter social or existential problems, as a consequence of their experiences during war or during their service in an international operation.

5.3.3 PTSD is widely studied and there is a vast and broad amount of literature that is easily available from international sources and databases. Most prominent among these is the databank that has been developed and that is maintained by the National Center for PTSD in the United States, Published International Literature On PTSD (PILOTS, see http://www.ncptsd.va.gov/ncmain/publications/pilots/index.html). Also, the Australian Centre for Posttraumatic Mental Health presents an easily accessible overview of publications and resources (see: http://www.acpmh.unimelb.edu.au/resources/index.html).

5.3.4 In addition, various international professional organisations represent another important source of information. The European Society for Traumatic Stress Studies (ESTSS) is the European network for professionals in the field of psychotraumatology. Its website (see: www.estss.org) presents an overview, in the section resources, of important literature, research and training facilities. Several countries do have national organisations or national chapters, under the umbrella of the ESTSS (e.g. Britain and Ireland, Germany, France, Belgium, the Netherlands). The same applies for the International Society for Traumatic Stress Studies (see: www.istss.org). ISTSS has a special interest group on "Military". Finally, there are national centres for information and documentation in various European countries, which can serve as a resource for other countries or organisations as well. In Oslo there is, e.g. the Military Medical Competence Centre, affiliated with the Division of Disaster Psychiatry at University of Oslo, and in the Netherlands, there are Cogis, the Centre of Expertise in social and psychological consequences of war, persecution and violence, and the Veterans Institute, with its Centre for Research and Expertise.

5.3.5 A paper on the current state of knowledge surrounding PTSD was commissioned by the steering group and written by Dr Martin Baggaley . See appendix 1.

5.4 Medically unexplained physical symptoms (MUPS)

5.4.1 Physical symptoms that cannot be explained by a medical, biological or physical condition or disease, are called Medically Unexplained Physical Symptoms. These are sometimes included under the heading of Gulf War Illness.

5.4.2 In the past years, many veterans reported with physical symptoms that on one hand are rather common (e.g. fatigue, muscle or joint pain, concentration problems) and that are on the other hand serious enough to lead to a severe deterioration of health and wellbeing and that, in many cases, leads to functional disability. This, again, frequently leads to problems when the veteran applies for a (military) disability pension. Since his health problems do not fit into the concept of a known syndrome or disease, the possibility that his claim is rejected, is evident.

5.4.3 In recent times, this problem became apparent after the Gulf War, when vast numbers of veterans, in the United States and in the United Kingdom, reported these problems and applied for help. In the USA, the Research Advisory Committee was set up in 1998 to advise the Veterans Administration on research into health problems related to the Persian Gulf War (see: http://www1.va.gov/RAC-GWVI/). In the Netherlands, veterans who served in UNTAC, Cambodia, reported similar problems. Meanwhile, these symptoms have been reported by veterans from various missions and they can represent a major problem related to all kinds of war and operations.

5.4.4 The Veterans Institute in the Netherlands has prepared a fact sheet (see: http://www.veteraneninstituut.nl/media/med_view.asp?med_id=508) and a list of literature on MUPS. A translation of this fact sheet is at appendix 2, as well as a list of relevant literature.

5.4.5 Recently, the Ministry of Defence in the Netherlands has published a protocol to assess the disability and the relation with the military service among soldiers suffering from medically unexplained physical symptoms. This is available, in Dutch, at: http://www.mindef.nl/binaries/20080121_%20bijlage_%20MUPS_LOK_protocol_tcm15-79954.pdf.

5.4.6 Another valuable resource is the website on federal funded research into deployment related health problems from the Gulf War forward: (see: http://fhp.osd.mil/deploymed).

5.5 Premature ageing and morbidity

5.5.1 Starting with (clinical) observations among survivors of imprisonment, deportation and resistance during World War II, the clinical impression has been that people who underwent extreme stress age prematurely. In addition, somatic organic functioning seems to be impaired in various domains, leading to a large variety of diseases and disability, that as such are quite common, but that seem to occur, however, with high frequencies among traumatized people.

5.5.2 Normal ageing involves physiological modifications, the individual's changing role in family and society, and a different self realization. There are medical, functional, socio-economic and support problems. The rate of decline varies from person to person, depending on genetics, lifestyle and general state of health. In advanced age, physiological frailty increases. Its known mechanisms are: weakness, shrinking, low endurance, slowness, exhaustion and low activity. Frailty is caused by physiological changes of ageing not based on disease, such as sarcopenia and anorexia, and also by co-morbidity. Disability in the aged may result from the same causes, but equally from many other elements.

5.5.3 Thanks to better, comprehensive long term follow up systems, to legislation ensuring the rights of the disabled and to the constant improvement of rehabilitation technologies, disabled people now live longer. However, there are signs that they age prematurely, often facing more than only normal ageing processes. At least part of their functional reserves and capacities will be reduced. In view of this, all comprehensive rehabilitation efforts must be directed not only towards increased independence in Activities of Daily Living (ADL), but also towards preventing complications, limiting the extent of these reductions and improving quality of life.

5.5.4 This concerns especially the following groups:

- Veterans.
- Former POW's.
- Disabled persons.
- Relatives and family members of these people.

5.5.5 It is important to monitor the following parameters:

- Health status (hospitalization, medication, procedures, late appearance of diseases).
- Mental and behavioural status.
- Occupation.
- Education.
- Life style and habits (smoking, drinking, drug abuse).
- Other social issues (financial, accommodation, transport).

5.6 **Veterans support veterans**.

5.6.1 The Norwegian UN Veterans Association is a voluntary organization for personnel who are serving or have served in international operations, not UN operations only. Today the organization has about 6 000 members in about 45 branches nationwide.

5.6.2 The National Health Service provides support to veterans in need of professional help. Still there was a need of a low threshold support service in the local community. This observation is supported by research (e.g. in the Netherlands and in Israel) that only half of the veterans who need professional help, actually apply for professional help. In 1997 the veterans organized "a comrade support system", a network of veterans to be contacted by other veterans or their families. Soon the system spread across the country and today there are 31 groups at work. In the beginning there was just a local telephone number, but for almost three years now it has been organized with a national telephone number ("green number") that connect veterans to the nearest open telephone. Today these groups of unpaid volunteers receive about 1 000-1 500 calls a year.

5.6.3 The purpose is to have an easy accessible service where a veteran or his/her family has nothing to fear. You are not defined as a patient and there will be no record kept that could prejudice the veteran's career or opportunity to join a future mission. The service is free of charge. The main idea is to let a troubled veteran be able to talk to another veteran who knows from his/her own experiences what the veteran is really talking about.

5.6.4 The problems vary over a wide scale, from divorces and domestic problems, alcohol and drug problems, to suicide attempts and threats, night mares, "bad thoughts", periods of sick leaves, partial incapacity, unemployment, loneliness, queries and advice in general. Often not much is demanded. The main message is: We are interested in you and your difficulties, we want to listen to your experiences from your service, we can help you out of your isolation, we offer you friendship and support.

5.6.5 The service is meant to have a preventive effect. By giving support at an early stage it might reverse a situation before it becomes too serious. In other cases it is vital to assist the veteran or his/her family to get professional help as soon as possible. It is therefore important that the assisting veteran knows his/her own limitations, and that he/she knows where to find the right professional help. The veterans therefore started to arrange weekend seminars in 1999. Today The Norwegian UN Veterans Association arranges three seminars each year (level I-III). Each seminar has 12-20 participants. The topics are such as how the armed forces prepare and maintain contact with the personnel before, during and after international service, normal after-effects when returning home to everyday life, training in listening and conversation techniques, recognition of warning signals of acute suicide danger, post-traumatic stress disorder, debriefing, the health services and voluntary organizations relevant to the different problems. It also includes legal and economic advice and support after service.

5.6.6 Inspired by the Norwegian experiences Danish veterans established a similar system in 2001 in co-operation with the armed forces. In 2005 it was a well established system economically supported by the Ministry of Defence. Today there are two veterans on duty 24 hours a day. They receive about 100 calls each month. The Danish "comrade support system" also arranges group travels to former mission areas, to the Norwegian veteran rehabilitation centre, and other activities for veterans and their families. About 50% of the veterans participating are meant to be veterans with problems related to previous service. These activities then work as "group therapy". They have also established an active "family network" when the soldiers are in the mission area.

5.6.7 "Veterans support veterans" are now established by the veteran organizations in Sweden and Finland as well, and Lithuania and Latvia are planning similar systems.

6. Conclusions and recommendations

6.1 PTSD

PTSD, as well as other psychological problems resulting from serving in war or in international military operations is an important problem for veterans and a major concern for veterans organisations.

Ample research is conducted in various countries, the results of which are communicated via the international professional journals and through various international or national databases and centres for documentation.

The Steering Group recommends the following:

1. Prepare an overview of existing resources and distribute this to SCEA-members.

2. Prepare and distribute an overview of means of education, care and support.

3. Stimulate the adoption and implementation of international tools for screening and diagnosis.

4. Provide guidelines for effective treatment and follow up.

6.2 Medically unexplained physical symptoms.

Medically unexplained physical symptoms that occur after serving in war or in international military operations, represent a major area of concern. For many veterans, this constitutes a serious, often incapacitating condition. Because these symptoms can not be explained on the basis of the existing medical knowledge, this condition can easily lead to social, political and legal complications.

The Steering Group recommends the following:

1. Create a database of experts on MUPS in various countries.

2. Create a database of ongoing research on MUPS.

6.3 Premature ageing and morbidity

As a consequence of possible trauma they may have experienced, veterans seem to be at risk of premature ageing.

The Steering Group recommends the following:

1. Invite veterans for an annual screening by means of a questionnaire (Appendix 3).

2. Identify experts in various SCEA-countries and invite them to review the relevant literature and to share their reviews among the SCEA-members.

3. Identify centres for documentation and information in various countries and develop systems and structures to make this information available internationally.

6.4 Veterans support veterans

Contact among comrades and support from buddies is an essential asset in the military context. In line with this, veterans support for veterans is a cheap and effective first level of support for veterans in need. It is easily available and a valuable addition professional support from social work or mental health professionals.

The Steering Group recommends the following:

1. Distribute information about existing initiatives of "Veterans support veterans".

2. Collect and disseminate information on "Veterans support veterans.

3. Stimulate national veterans' organizations to organize a system of "Veterans support veterans" in their national or regional community.

4. Organize training and workshops for veterans who want to develop "Veterans support veterans".

6.5 General recommendations

In addition to the specific, thematic conclusions and recommendations above, the Steering Group recommends the following:

1. To extend the mandate of the Steering Group and to charge it with the implementation of the recommendations that are given for each specific area or theme.

2. To develop a website, preferably as part of an existing website, and to develop a structure and a first content for the databases as suggested above.

3. To develop a proposal for a digital newsletter to inform members and members organisation.

List of Appendices

1. Post Traumatic Stress Disorder (PTSD) – An update, at the request of the Steering Group, on the current state of knowledge. Paper written by Dr. Martin Baggaley, Consultant Psychiatrist and Lt Col (Retd).

2A. Fact sheet on medically unexplained physical symptoms by Jos Weerts.

2B. List of literature on medically unexplained physical symptoms.

3. Physical co-morbidity questionnaire.

Appendix 1 to
VHWCISG Report
Dated 27 Feb 2008

Post Traumatic Stress Disorder (PTSD) -
An update on the current state of knowledge

1) This is written as a brief guide to the important issues and state of knowledge of PTSD with a particular focus on military veterans.

Classification Issues

2) The classification of Post-traumatic stress disorder (PTSD) has remained unchanged in the last five years. The two main classification systems have slight differences but are broadly similar;

a) Category 309.81 of the Diagnostic and Statistical Manual of the American Psychiatric Association, Version IV, Text Revision (DSM IV TR).

b) Category F43.1 in the International Classification of Diseases, Version 10 of the World Health Organisation.

There are revisions due in both ICD 11 and DSM V. PTSD has always been unusual in psychiatric classification as there is a requirement for a specific trauma to enable the diagnosis to be made (Criteria A). Research and clinical experience has demonstrated that Criteria A is neither necessary nor sufficient to produce PTSD. It is therefore likely that in the revisions of the classification system Criteria A may be dropped or may become less restrictive.

Epidemiology

3) There have been no significant changes in the estimates of incidence and prevalence of PTSD over the last five years. Estimates for 12 month prevalence range from 1.3% (Australia: Cremer et al 2001) and 3.6% (USA Narrow et al 2002). Research over the years has suggested that between Seal et al 2007 reviewed over 100 000 US veterans of Iraq leaving the service from 2001 and found 25% had a mental health diagnosis and of these 50% had two diagnoses.

Risk Factors.

4) Brewin et al 2000 undertook a systemic review of risk factors for PTSD. The factors most associated with the development of PTSD were greater trauma severity, lack of social support and more subsequent life stress. Other factors include being female, previous and family psychiatric history, low educational achievement and intelligence, childhood adversity, a younger age, other previous trauma and being a member of an ethnic minority. In studies on a military population female gender was less important whereas younger age, greater trauma severity, lack of social support, being a member of an ethnic minority and low educational achievement were more important.

Treatment of PTSD

5) The area of greatest development in the last few years has been the publication of a number of guidelines in the UK, Australia and US which review the evidence for various treatment interventions. There is general consensus between the various guidelines and it is therefore clearer what treatment is recommended which is helpful for those planning services.

6) In the UK, the National Institute for Clinical Excellence (NICE) published a comprehensive guideline in March 2005. Interventions are classified according to differing levels of confidence in the evidence to support them (A at least one randomised controlled trial RCT, B no RCT but some good trials, C expert opinion).

a) Psychological Treatment.

i) All sufferers of PTSD should be offered a course of trauma focussed psychological treatment (trauma focussed cognitive behavioural psychotherapy or eye-movement desensitization and reprocessing, EMDR). These should be normally be given on an individual out patient basis. A

ii) This treatment should be offered regardless of the time elapsed from trauma to treatment B.

iii) The duration of treatment should be 8-12 sessions from a single event. Longer treatment is required for multiple events. B.

iv) There is little evidence to support other types of psychotherapy (supportive, psychodynamic etc) B.

v) If there is no improvement, either an alternative type of psychological treatment or anti-depressant medication should be considered. C.

b) Pharmacological Treatment. In general a variety of ant-depressants have shown some efficacy. Their availability varies to an extent from country to country, dependent on availability and licensing issues.

i) Drug treatments should not be used first line. A.

ii) Drug treatment should be considered if a sufferer prefers not to engage in trauma focussed psychotherapy. Mirtazapine or paroxetine for general use, phenelzine or amitriptyline for mental health specialists only. B.

iii) Drug treatments should be considered for sufferers who have gained little or no benefit from trauma focussed psychotherapy. C.

c) Debriefing and Early Interventions

i) Routine psychological debriefing after a traumatic event should not be offered A.

ii) Trauma focussed psychotherapy should be offered in the first month for those with severe symptoms of PTSD. B.

iii) Trauma focussed psychotherapy should be offered within three month for those who present with PTSD. A.

7) **Recent Conferences**.

Both the ISTSS and ESTSS hold annual conferences. The International Congress on Post Traumatic Stress was held in Leiria in Portugal in November 2004. This was an unique conference in that veterans, students, doctors and psychologists were all invited. It was set up by the veterans' organisation ADFA, the psychology group. UNIPSI and the Portuguese Ministry of Defence to which all the SCEA countries and veterans were invited

8) **Further Information**

a) **Useful Organisations**

i) National Centre for PTSD United States Veterans Association http://www.ncptsd.va.gov/ncmain/information/. This has access to the PILOTS database (a comprehensive database on PTSD research.

ii) International Society for Traumatic Stress Studies. http://www.istss.org/. This publishes the Journal of Traumatic Stress.

iii) European Society of Traumatic Stress Studies ESTSS http://www.estss.org

iv) King's Centre for Military Research. This is run by Professor Simon Wessely and has published some key research on Gulf War syndrome. http://www.kcl.ac.uk/kcmhr/research

b) **Guidelines**

i) **Effective Treatments for PTSD Practice Guidelines from ISTSS**. Edited by Edna B. Foa, PhD, University of Pennsylvania; Terence M. Keane, PhD, National Center for PTSD, Boston VA Medical Center; Matthew J. Friedman, MD, PhD, National Center for PTSD, VAMC White River Junction, VT; Dartmouth Medical School. Published by and available through *Guilford Publications, Inc.* *2007*

ii) Forbes D. **Creamer** M. Phelps A. Bryant R. McFarlane A. Devilly GJ. Matthews L. Raphael B. Doran C. Merlin T. Newton S. **Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder. [Review] [31 refs]** [Journal Article. Research Support, Non-U.S. Gov't. Review] *Australian & New Zealand Journal of Psychiatry. 41(8):637-48, 2007 Aug.*

iii) **Post-traumatic stress disorder (PTSD) Anxiety: Management of post-traumatic stress disorder in adults in primary, secondary and community care**. National Clinical Practice Guideline 26. Mar 2005. http://www.nice.org.uk/guidance/CG26.

c) **References**

i) **Brewin** CR. Andrews B. Valentine JD. **Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults.** [Journal Article. Meta-Analysis] *Journal of Consulting & Clinical Psychology. 68(5):748-66, 2000 Oct.*

ii) **Creamer** M. Burgess P. McFarlane AC. **Post-traumatic stress disorder: findings from the Australian National Survey of Mental Health and Well-being.** [Journal Article] *Psychological Medicine. 31(7):1237-47, 2001 Oct.*

iii) **Narrow** WE. Rae DS. Robins LN. Regier DA. **Revised prevalence estimates of mental disorders in the United States: using a clinical significance criterion to reconcile 2 surveys' estimates.[see comment].** [Journal Article. Research Support, Non-U.S. Gov't] *Archives of General Psychiatry. 59(2):115-23, 2002 Feb.*

iv) Seal KH. Bertenthal D. Miner CR. Sen S. Marmar C. **Bringing the war back home: mental health disorders among 103,788 US veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs facilities.** [Journal Article. Research Support, U.S. Gov't, Non-P.H.S.] *Archives of Internal Medicine. 167(5):476-82, 2007 Mar 12.*

d) **Other Publications**

i) **Gulf War and Health** Vols 1-6, produced by the Institute of Medicine of the US National Academies generally on the health effects of serving in the Gulf Wars. Volumes 4 Health Effects of serving in the Gulf War (2006) http://www.nap.edu/catalog.php?record_id=11729 and Volume 6 Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress 2007 http://www.nap.edu/catalog.php?record_id=11922 are the most relevant for PTSD.

ii) **Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War (Maudsley Monographs) (Hardcover)** by Simon Wessely (Author), Edgar Jones (Author) Psychology Press Ltd (25 April 2005). Highly recommended history of military psychiatry

iii) **Clinician's Guide to PTSD (Hardcover)** by Steven Taylor (Author) Guilford Publications; 1 edition (21 Sep 2006)

iv) **Neuropsychology of PTSD (Hardcover)** by Chris R. Brewin (Editor), Jennifer J. Vasterling (Editor) Guilford Publications (30 Jun 2005)

v) **Posttraumatic Stress Disorder: Malady or Myth? (Current Perspectives in Psychology) (Hardcover)** by Chris Brewin (Author) Yale University Press (1 Aug 2003)

vi) **Posttraumatic Stress Disorder: Issues and Controversies (Paperback)** by Gerald Rosen (Editor) John Wiley & Sons (20 Aug 2004)

vii) **A War of Nerves: Soldiers and Psychiatrists, 1914-1994 (Paperback)** by Ben Shephard (Author) Pimlico; New Ed edition (7 Feb 2002)

viii) **From Shell Shock to Combat Stress: Comparative History of Military Psychiatry (Paperback)** by Hans Binnevald (Author) Amsterdam University Press,Netherlands (Jan 1998)

ix) **Combat Stress Injury: Theory, Research, and Management (Psychosocial Stress): Theory, Research, and Management (Routledge Psychosocial Stress) (Hardcover)** by Jonathan Shay (Foreword), Charles R. Figley (Editor), William P. Nash (Editor) Routledge; 1 edition (1 Jan 2007)

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Fact sheet Medically Unexplained Physical Symptoms (MUPS)
Veterans' Institute, Doorn, the Netherlands (December 2006).

Nature and etiologogy.

Military personnel is exposed to health risks during deployment in conflict areas. In addition to the risks of infectious diseases, diseases caused by insects, exposure to environmental hazards or to (biological/chemical) weapons, the following may be the case: unfavourable hygienic conditions, long working hours and limited possibilities for recreation, and an increased state of alertness and tension. All these factors can lead to exceptional stress and strain.

Most military men and women do not experience any negative consequences of this after returning from their mission. Some veterans, however, do suffer from health complaints or develop symptoms. In many cases, these complaints are of a physical nature, without a clear cause that can be identified. These symptoms include: headaches, memory problems, joint- and muscle pains, fatigue, concentration disorders, sleep disturbances, skin problems, digestive problems, and/or dizziness.

Over the years, different names have been used to describe these symptoms. In general, medical terminology, these complaints have been summarized as: neurasthenia, functional disorders, myalgic encephalopathy (ME), somatoform disorders, or chonic fatigue syndrome. In the context of military personnel or veterans, these were indicated with names as: shell shock, combat exhaustion, or Gulf War Syndrome. Eventually, the medical community adopted the term "Medically Unexplained Physical Symptoms", as a neutral term, that bears no reference to a possible theoretical explanation for these symptoms, and because it indicates that no medical-organic reason, nor a psychological or social cause for these symptoms can be found.

Nevertheless, for the patient these complaints are very real and they often lead to a substantial impairment and to a serious deterioration in the quality of life. Research in the Netherlands, e.g., indicated that up to 17% of the personnel who have served in Cambodia, suffered from serious fatigue, 6 to 9 years after their mission.

Transient or chronic?

In general, MUPS become manifest a few months after returning from a mission. In some cases, the symptoms are rather mild and of a transient nature. In other cases, they are severe and can lead to functional impediments. A minority of veterans suffers from chronic symptoms and they are seriously disabled in their work and in their daily activities.

The literature indicates some risk factors for the development of MUPS, like: neuro-biological constitution, traumatic experiences in childhood and previous diseases. While these and other factors might increase this risk, the development of MUPS most likely can be explained by multiple causes interacting with one another. On the basis of research, the following, hypothetical causes are identified: precious infectious disease, multiple vaccinations, the use of insecticides, drugs applied to prevent malaria or to protect against chemical weapons, exposure to environmental hazards or to biological or chemical weapons, and work related stress, as well as traumatic stress.

Certain factors appear to increase the risk of chronicity of these symptoms:

- cognitive factors, like limited personal competences and limited capacities to act purposeful, attribution of the symptoms to somatic causes or a pre-occupation with one's health.

- factors that can play a role after the mission are: negative appraisal of the mission, disappointment in the (military) career, problems in adapting to life and work back home, and lack of recognition and support.

Treatment and support.

Treatment of these symptoms is difficult. High demands are placed on the confidence the veteran has in the physician, and vice versa, as well as on the attitude towards one another. The veteran can feel misunderstood, when the physician is prejudiced towards a psychological nature of the symptoms, or when he trivializes these symptoms Likewise, confidence will be damaged when the physician holds the opinion that the veteran is malingering, trying to obtain privileges like a disability pension.

When, after thorough medical examination, no cause is found, this can lead to feelings of helplessness and being misunderstood. On the other hand, this can create clarity, based on the results of the examination, that the veteran is not suffering from a serious, potentially life threatening disease.

There is no standard treatment that can make these symptoms disappear. Yet, there are strategies that can help the veteran to cope with them and to alleviate the consequences he experiences in his daily life. In the first place, information and education are essential. Secondly, courses, based on cognitive, behavioral therapy, can teach the veteran to improve his functioning and thereby to reduce the impact of the complaints to a minimum. In the third place, training can prove to be effective. In this, the veteran learns, with professional guidance and supervision, to use his physical capacities in an effective way,.

Understanding, empathy and acceptation are key elements to successful therapy: to the veterans, these complaints are very real, even if no cause can be identified.

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Dated 27 Feb 2008

Literature Medically Unexplained Physical Symptoms (English only).

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Appendix 3 to
VHWCISG report
Dated 27 Feb 2008

Physical Co-morbidity Questionnaire

Avi Ohry, 2006

Below is a list of different physical symptoms.

Please circle the number which best represents how often you experience each one. For any existing medical symptoms you have, please write down the year in which they began.

	Physical symptom	**Never**	**Once in a while**	**Often**	**Always**	**Year of onset**
1	Weakness / fatigue	0	1	2	3	
2	Tendency to faint	0	1	2	3	
3	Headaches	0	1	2	3	
4	Excessive sweating	0	1	2	3	
5	problems with digestive system (nausea, diarrhea, constipation, hemorrhoids, bleeding)	0	1	2	3	
6	Frequent *abdominal* aches	0	1	2	3	
7	Heartburn	0	1	2	3	
8	Appetite loss	0	1	2	3	
9	Increased appetite	0	1	2	3	
10	Sexual difficulty or dysfunction	0	1	2	3	
11	Weight gain	0	1	2	3	
12	Weight loss	0	1	2	3	

	Physical symptom	Never	Once in a while	Often	Always	Year of onset
13	Fever	0	1	2	3	
14	Rapid heartbeat /*palpitation*	0	1	2	3	
15	Breathing difficulties	0	1	2	3	
16	Chest pains	0	1	2	3	
17	Numbness of extremities	0	1	2	3	
18	Pain in extremities	0	1	2	3	
19	Paraethesias /*tingling sensation*	0	1	2	3	
20	Neck pain	0	1	2	3	
21	Problems with teeth or gums	0	1	2	3	
22	Weakness of limbs	0	1	2	3	
23	Dizziness	0	1	2	3	
24	Irregular heartbeat	0	1	2	3	
25	Lower back pain	0	1	2	3	
26	Allergies	0	1	2	3	
27	Tendency to have infections	0	1	2	3	
28	High blood pressure	0	1	2	3	
29	Hearing loss	0	1	2	3	
30	Kidney stones	0	1	2	3	
31	Eyesight problems	0	1	2	3	
32	Skin problems / eczema	0	1	2	3	
33	Impaired memory	0	1	2	3	
34	Sleeping problems	0	1	2	3	

Below is a list of medical illnesses.

Please mark down if you have suffered from one of these illnesses. If yes, please write down during which year the illness began.

	Illness	No	Yes	Year of onset
1	Joint diseases	0	1	
2	Fibromyalgia	0	1	
3	Infections or other disorders of the urinary tract	0	1	
4	*Peripheral -vascular disease*	0	1	
5	*Asthma / bronchitis/emphysema*	0	1	
6	Hepatitis	0	1	
7	Diabetes	0	1	
8	Heart disease / *Cardio-vascular diseases*	0	1	
9	TIA or CVA	0	1	
10	Bone fractures	0	1	
11	Nutrition problems	0	1	
12	Neurological disease (paralysis, epilepsy, migraines, Parkinson's)	0	1	
13	Surgery	0	1	
14	Neoplastic/*cancer* disease	0	1	
15	Disease of the digestive system (ulcer, *Crohn's* disease)	0	1	

Below is a list of medical related behaviors. Please mark the answer which is most correct for you.

	Behavior	Never	Hardly ever	Up to once a week	Twice a week	More then twice a week	Daily
1	Use of alcohol during past year	0	1	2	3	4	5
2	Use of hashish or marijuana during past year	0	1	2	3	4	5
3	Use of other un-prescribed drugs during past year	0	1	2	3	4	5

Do you smoke? 1. No 2. Yes

If yes, how many cigarettes do you smoke a day? _____

Below is list of illnesses. Please mark whether or not any of your immediate family members (parents, siblings, etc) suffer or suffered any of these illnesses.

	Illness	No	Yes
1	Vascular disease	0	1
2	Heart disease	0	1
3	Diabetes	0	1
4	High blood pressure	0	1
5	Other illnesses _____	0	1

Notes

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