



Is the war really over? A 20-year longitudinal study on trajectories of suicidal ideation and posttraumatic stress symptoms following combat



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ABSTRACT

Combat stress reaction (CSR) has widespread long-term consequences, including profound psychopathology in the form of posttraumatic stress disorder (PTSD). Studies have established the link between combat, PTSD, and suicidality. However, little is known about the temporal course of suicidal ideation (SI) in general, specifically among war veterans. We aimed to trace the trajectories of SI in the aftermath of war and to explore the role of CSR and PTSD in SI trajectories. Israeli veterans with CSR ($n=164$) and a matched control group (NCSR, $n=111$) were assessed, using self-report measures at three points over the course of 20 years. Veterans with CSR reported significantly higher levels of SI, compared to the NCSR group at all measurement points. Among veterans with CSR, SI increased 2 years after the war and then decreased 20 years following the war. This pattern was particularly characteristic of veterans with chronic PTSD. The results indicate that CSR is a strong predictor of subsequent PTSD and suicidality. These findings highlight the importance of prevention and treatment efforts for these traumatized veterans, who are at risk for suicide even 20 years after the end of the war.

1. Introduction

The intense pressures of war have long been recognized to produce both immediate (acute) and long-term (chronic and delayed) psychopathology (e.g., Kardiner, 1947). On the battlefield, the most common acute reaction is combat stress reaction (CSR), also termed battle shock and battle fatigue, among other designations (Isserlin et al., 2008). CSR comprises various polymorphic and labile psychiatric and somatic symptoms, with its diagnosis determined by soldiers' impaired functioning, as evaluated by clinicians on the battlefield. Symptoms characterizing this condition include paralyzing fear of death, emotional and physical numbness, withdrawal, severe depression, and impaired combat functioning (Kardiner, 1947; Solomon, 1993).

At the end of a war, the debilitating effects of CSR may abate, either spontaneously or by means of professional intervention (Solomon and Mikulincer, 2006). However, in other cases, CSR may have long-term psychological and physiological consequences. CSR often crystallizes into profound and prolonged psychopathological sequelae in the form of posttraumatic stress disorder (PTSD) (e.g., Solomon and Mikulincer, 2006). Recently, a plethora of research has been conducted on the adverse psychiatric effects of military service (e.g., Riviere et al., 2011), indicating high risk for suicide ideation and behavior (e.g., Stein et al.,

2010). However, little is known about long-term trajectories of suicidality after combat and, more specifically, about the predictors of these trajectories.

1.1. Suicidal ideation

Suicidal behavior is an important public health problem that results in significant morbidity and mortality worldwide (WHO, 2012). Suicide ideation (SI), comprising thoughts or plans about suicide, has been identified as one of the powerful predictors of completed suicide (Suominen et al., 2004).

A considerable body of research suggests that previous traumas in general and war-related traumas specifically are associated with an increased risk of suicidal behaviors (Jakupcak et al., 2009; Kemp and Bossarte, 2013). However, veterans' suicide rates reflect some variability in suicide behavior (e.g., Pietrzak et al., 2010; Hellmuth et al., 2012). Moreover, whereas some studies suggest that exposure to stress is a risk factor for SI (e.g., Dubow et al., 1989), others claim that the adjustment to stress, and not the exposure itself, predicts suicidal ideation (e.g., Warheit et al., 1996). Both CSR and PTSD are expressions of difficulties in adjustment to combat stress and may serve as predictors for SI. Surprisingly, the cross-sectional and longitudinal

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associations between CSR and SI have yet to be explored. The current study aimed to fill this gap.

1.2. PTSD and SI

Studies have repeatedly documented significant relationships between war-related PTSD and suicidal behaviors (e.g., Jakupcak et al., 2009). For example, Iraq and Afghanistan war veterans reporting symptoms of PTSD were more likely to report SI (Hellmuth et al., 2012) and a desire to harm themselves (Maguen et al., 2012), compared to veterans without PTSD.

Several longitudinal studies have shown that the course of PTSD fluctuates over time (Bonanno and Mancini, 2012). While some who develop PTSD following a war may recover, others who may have initially responded adaptively to combat stress develop delayed psychopathology, following an asymptomatic latency period (e.g., Dickstein et al., 2010). In other cases, PTSD takes a chronic course. Accordingly, research has identified PTSD trajectories, most commonly resilience, recovery, and chronic (Orcutt et al., 2004).

Whereas previous studies have showed that PTSD is associated with suicidal behaviors, to our knowledge there are no studies that have examined the association between different PTSD trajectories and suicidality.

1.3. Trajectories of SI

Similar to PTSD, SI may fluctuate over time. However, only scant longitudinal studies prospectively explored the temporal course of suicidal ideation. Recent studies have found that some psychiatric disorders, such as depression and anxiety, increased the risk for repeated SI over time (e.g., Soloff and Chiappetta, 2012). As most studies have relied on only two measurement points interpreting their results with regard to the long-term course of SI and its predictors is problematic. Moreover, to the best of our knowledge, no studies to date have examined predictors of the persistence of suicidality over time among veterans. Such information has importance for understanding the nature of suicidal behavior and for possible clinical implications of risk assessment and monitoring.

1.4. The current study

In this prospective study, we investigated the temporal course of SI over the course of 20years among combat veterans, with and without CSR. Specifically, we examined whether CSR, PTSD, and PTSD trajectories are implicated in SI trajectories among veterans. Three hypotheses are posited for the current study: 1) We expect CSR veterans to report higher rates of SI compared to veterans without CSR (NCSR), at all time measurements; 2) We expect different SI trajectories between these two groups; 3) We will explore the covariation between PTSD trajectories and SI trajectories, with the expectation of mutual simultaneous variation between PTSD and SI over time. As no previous studies have addressed CSR and PTSD with regard to SI trajectories, these hypotheses are exploratory.

2. Method

2.1. Participants

All participants were IDF male war veterans assessed at three time points: 1year (T1), 2-years (T2), and 20years (T3) following the 1982 Lebanon War. The data were based on the responses of participants who participated in all three assessments to assess the longitudinal trajectory of SI. Two groups of veterans were included:

a) CSR group: 164 Israeli soldiers who fought in the 1982 Lebanon War, identified by military mental health personnel as CSR

casualties. Inclusion criteria comprised four factors: 1) participation in frontline battles, 2) a referral for psychiatric intervention made by the soldier's battalion surgeon during the war, 3) a diagnosis of CSR given on the battlefield by clinicians trained and experienced in the diagnosis of combat-related reactions, and 4) no indication in the clinician's report of serious physical injury or other psychiatric disorders. Eligibility was determined by clinicians' diagnostic records made on the battlefield.

b) Comparison group: 111 soldiers who participated in combat in the same units as the CSR group, but were not diagnosed with CSR (NCSR). This sampling procedure was chosen to ensure similar exposure to the amount and type of objective stress. All soldiers in the CSR and comparison groups had undergone stringent physical and psychiatric screening prior to commencing their military service, and no indication of diagnosable premorbid symptoms was recorded in their medical files (for more details see Solomon and Mikulincer (2006)).

The soldiers' age in the first wave of measurement ranged from 18 to 37 (Mage=25.81, SDage=4.72, Medage=26). Sixteen percent of all participants completed only eight years of schooling, 27% partial high school, 39% completed high school, and 18% studied beyond high school. The subjects in both groups did not significantly differ in age, gender, education, military rank, and military assignment. Table 1 presents main socio-demographic characteristics in the two study groups. Men participating at all three time points did not significantly differ from those declining to participate at T2 or T3, in socio-demographic and military background, pre-military adjustment, intelligence, or mental and somatic health one year after the war.

2.2. Procedure

This research is part of a longitudinal study comprising Israeli male combat veterans from the 1982 Lebanon War, Israel's longest and most controversial conflict. It commenced in June 1982, with Israeli soldiers remaining in Lebanon, amid periodic flare-ups, until 2000. One and two years following their participation in this war, participants were asked to report to the Surgeon General's Headquarters to take part in this study. Participants completed a battery of questionnaires in small groups. Twenty years after the war, shortly after the Israeli Defense Forces (IDF) departed Lebanon, it was decided to approach participants again. In 2002, potential participants were contacted by telephone, and the aim of the current study was explained. In the CSR group, 323 veterans were located, and 286 of them (88.5%) agreed to participate in the current study. In the control group, 258 veterans were located, and 218 of them (84.55%) agreed to participate. Approval was obtained from both the IDF and the Tel Aviv University IRB committees. The participants' informed consent was obtained, and they were informed that the data would remain confidential and in no way influence their status in military or civilian life. For the 2002 (20-year) measurement, qualified research students, using the instruments from

Table 1
Distribution of socio-demographic variables in the CSR and NCSR groups.

	CSR		Control		
	M	SD	M	SD	
Age (1983)	29.6	8.28	30.29	9.14	t (n=669)=0.92 p=0.35
	N	%	N	%	
Education (1983)					
Less than 12 years	297	80.2	243	80.7	
12 years and more	71	19.8	60	19.3	χ^2 (2, n=671)=1.85, p=0.86
Family Status (1983)					
Single	108	29.7	91	30.5	
Married	253	69.5	203	68.1	
Divorced	3	0.8	4	1.3	χ^2 (3, N=662)=5.03, p=0.77

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