Battlefield blues

Ambivalence about treatment among military Veterans with depression

Norman Shields PhD **Michel White** MD FRCPC **Michael Egan** MSW

A 45-year-old woman Veteran presents to a family physician for a first visit. She lacks energy, sleeps poorly, says she feels "blah," and has little interest in socializing. Her husband prompted her to make the visit because he was concerned about her lack of interest in their family. Her symptoms started during service in the Canadian Forces while she was deployed in Asia several years earlier. While there, she missed her family and began drinking in order to get to sleep. She felt disconnected after returning to Canada. Without seeking medical help, she voluntarily released 7 years later at the rank of corporal, giving fatigue and lack of commitment to her unit as the reasons. Since she resigned from the forces, she has left numerous clerical jobs because she felt she was unable to cope with them. The income from her current job supports the family, and she fears losing it. She consulted a physician a year ago. That physician diagnosed depression, but she did not follow up with antidepressant treatment. At the visit today, the physician uses self-report screening tests and he detects moderate depressive symptoms and probable alcohol abuse. The woman denies having suicidal thoughts. With consent, he sends for her previous medical records, orders appropriate laboratory tests, and books a follow-up appointment in a few days to complete a physical examination and review results. The records show a thorough workup has been done to rule out the differential diagnoses of her symptoms. Using motivational interviewing, he addresses her ambivalence about modifying her consumption of alcohol and treating the depression. She accepts a prescription for an antidepressant and agrees to follow-up visits. He helps her to contact Veterans Affairs Canada (VAC) and sends a referral letter to VAC. The local VAC district office area counselor schedules a meeting with her to initiate applications for disability compensation and the VAC rehabilitation program, which includes referrals to mental health professionals.*

For many, military service provides opportunities for growth, personal reward, and a sense of purpose and community. Military duties are physically, psychologically, and socially demanding, and they sometimes overwhelm members' coping skills. When this happens, the mental health consequences can persist into postmilitary life.[1] This article suggests strategies family physicians can use to engage military Veterans who might be reluctant to seek help in pursuing investigation and treatment of depression.

*The case presented is fictitious.

Depression

The World Health Organization estimates that depression will become the second most common public health problem around the world in the next 20 years, following HIV and AIDS.[2] Depression is a multidimensional disorder with emotional, physical, and associated symptoms (**Box 1**[3]). The lifetime prevalence of depression in Canada is 12.2%.[4] Depression occurs more frequently in women and often has a chronic, recurrent course. The World Health Organization states that "Mental health care provided within general primary care services is the first level of care within the formal health system. Essential services at this level include early identification of mental disorders."[2]

Box 1. Diagnostic criteria for a major depressive episode

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning (exclude symptoms due to general medical conditions)

1. Depressed mood most of the day (ie, sadness) nearly every day
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
3. Substantial weight loss or gain when not dieting, or increase or decrease in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day
9. Recurrent thoughts of death, recurrent suicidal thoughts, gestures or attempts at suicide

At least 1 of the symptoms is either:

1. Depressed mood, or
2. Loss of interest and pleasure

The symptoms must cause clinically significant distress or impaired functioning. Other mood disorders, bereavement, or the effects of substances should be ruled out.

Adapted from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision.[3]

As in the general Canadian population, mental health conditions are not uncommon among members of the Canadian Forces. Major depression and alcohol dependence are the most prevalent conditions.[5] Mental health screening in Canada and the United States detected a greater incidence of depression, alcohol abuse, and other mental health symptoms after deployment, so it is important to ask about deployment history when interviewing patients.[6,7] In our experience, however, it is wise to proceed carefully at first in eliciting details of stressful exposures during deployment because bringing distressing situations up too soon might hinder Veterans' initial engagement in treatment.

Veterans' ambivalence about seeking help

Resistance to seeking help for mental health problems is not uncommon among civilians.[8] In a 2001 study of Canadian peacekeepers, Fikretoglu et al[5] found that more than half of those who reported having had mental health diagnoses 12 months before had not sought help during the previous year, and only a few acknowledged a need for services, perceiving various barriers. Since then, programs instituted by the Canadian Forces have improved access to mental health services and reduced the median delay in seeking care for mental health problems. Once in civilian life, Veterans might not recognize or respond to the need for mental health care after leaving service. This attitude likely influences not only Veterans' tendency to seek help but also whether they become and remain engaged in treatment. Ambivalence can lead to lower compliance with treatment or stopping treatment altogether. Addressing ambivalence about seeking help and treatment early is important for effective engagement and motivation.

Detection and feedback

Family physicians take over monitoring mental health when members of the forces transition from the military health care system to civilian health care. Evidence that brief mental health screening tools have added diagnostic value remains unclear[9]; however, screening tools can help detect mental health conditions, engage clients through personalized feedback, and provide busy family physicians with continuous monitoring. Short effective screening tests for depression exist,[10] but family physicians might consider using screening tools that alert them to other conditions as well.[11]

Motivational interviewing

Motivational interviewing with personalized feedback (**www.motivationalinterviewing.org**) is a brief intervention best suited to patients whose resistance to treatment stems from ambivalent feelings related to change. Motivational interviewing enhances patients' intrinsic motivation to change by exploring and resolving their ambivalence. Addressing resistance to change through motivational interviewing enhances patients' engagement in and compliance with treatment.[12,13] Motivational interviewing has become useful in time-limited settings, such as busy family medicine clinics, and the basic principles (eg, expressing empathy, supporting self-efficacy) and techniques will be familiar to most family physicians.

Diagnosis

Diagnosis starts with recognition, as depressed patients can present with somatic complaints. **Box 1**[3] lists the diagnostic criteria for major depressive disorder. A variety of treatable physical conditions can cause a depressed state. History, physical examination, and laboratory investigations are necessary to rule out differential diagnoses. Depression can interfere with reporting symptoms when patients have difficulty concentrating or are strongly ambivalent about being diagnosed. Hence, obtaining collateral information is important.

For members of the military, a mental health differential diagnosis includes posttraumatic stress disorder.[14] Comorbid psychiatric conditions are frequently associated with depression; anxiety is found in about half the people with major depression.[15] Substance misuse is associated with depression and is not uncommon in Veterans with mental health conditions. Risk of suicide is the most serious complication of major depressive disorder.[3]

Management

First-line treatments for depression include both psychotherapy and pharmacotherapy (**Box 2**[15]). Cognitive behavioural therapy and interpersonal therapy are most effective for mild to moderate depression.[15] Selective serotonin reuptake inhibitors and novel agents, such as venlafaxine, are recommended as a first-line approach for depression. Patients stop medication for many reasons, most frequently for a sense of improved well-being or for intolerable side effects.[16] More than half of patients stop medication less than 3 months after beginning treatment, and a third of those do not tell their physicians they have stopped. Education and continued monitoring for compliance are important.

A psychiatric consultation should be requested when there is doubt about the diagnosis, risk of suicide, severe symptoms, serious comorbidity, or initial treatment failure (**Box 3**). An interdisciplinary approach is recommended, particularly when substance use is an issue, to encourage continuity of care and minimize recidivism.[17] Physicians should manage substance withdrawal first and then reassess depressive symptoms and integrated treatment strategies.

Operational stress injury

Operational stress injury (OSI) is a novel concept that arose in the Canadian Forces to allow military

Box 2. Recommendations for management of depression

- Do a comprehensive evaluation to investigate the differential diagnosis of physical and mental health conditions
- Assess suicide risk at every visit
- Aim for full remission of symptoms and return to baseline psychosocial function
- Plan 2 phases of treatment: an acute phase (8-12 weeks) to achieve remission of symptoms, and a maintenance phase (of at least 6 months, but often longer) to prevent relapse or recurrence
- Maintain patients on antidepressants for at least 2 years if they have the following risk factors: older age, psychotic features, chronic episodes, recurrent episodes (3 or more in a lifetime), frequent episodes (≥2 in 5 years), episodes that are difficult to treat, and severe episodes
- Monitor response using validated outcome measures
- Reevaluate treatment at least every 4 weeks if there is no response
- Taper antidepressants slowly to avoid discontinuation symptoms

Adapted from the Canadian Psychiatric Association and the Canadian Network for Mood and Anxiety Treatments.[15]

Box 3. Suggested indications for referring military Veterans with depression to specialists

- Diagnosis or optimum treatment approach unclear
- Suicide risk, severe symptoms such as psychosis, or severe dysfunction
- Complex comorbidity
- Military context unfamiliar to clinician
- Partial or no response to initial antidepressant trial and counseling
- Need for specialized psychotherapy or electroconvulsive therapy

members and their families to normalize the mental health effects of stressful military service.[18] According to the VAC website (**www.vac-acc.gc.ca/clients/sub.cfm?source=mhealth/definition**), OSIs are "any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian military. [The term] is used to describe a range of problems that include diagnosed medical conditions, such as anxiety disorders, depression, and post-traumatic stress disorder, as well as other conditions that might be less severe, but still interfere with daily functioning."

VAC services: operational stress injury network

There are several levels of VAC care for Veterans suffering with mental health conditions. The process can start with a referral from a family physician to VAC. With the assistance of VAC area counselors, Veterans can receive expedited referral to contracted private mental health service providers in their communities, including psychiatrists, psychologists, and social workers. Area counselors actively monitor reports from providers regarding response to treatment and ongoing mental health needs. When a client's mental health difficulties require a more comprehensive approach, a Canadian network of OSI clinics provides interdisciplinary care to still-serving members of the Canadian Forces and Veterans, members of the Royal Canadian Mounted Police, and their families. The OSI clinics are staffed by nurses, social workers, psychologists, and psychiatrists. Services can be matched to Veterans' needs through outpatient care, an inpatient stabilization unit, and a residential treatment clinic. For substance dependency, residential treatment is available to manage withdrawal, to prepare patients for return to the community, and to provide respite care.

The peer support program, Operational Stress Injury Social Support (OSISS), can make the difference between a Veteran remaining withdrawn or reengaging in life. Including Veterans' families or peers improves treatment outcome. Peer support coordinators of the OSISS program are valuable sources of information about patient functioning and provide support to maintain treatment goals.

Family physicians play an important role in engaging and referring Veterans with mental health conditions as well as in providing ongoing care. Family physicians

Resources

Resources for physicians

- Information on motivational interviewing: **www.motivationalinterviewing.org**
- Veterans Affairs Canada (VAC) website: **www.vac-acc.gc.ca**
- Senior District Medical Officer or Area Counselor in a VAC District Office: Telephone the VAC National Contact Centre at 866 522-2122 (English) or 866 522-2022 (French). If your patient is a VAC client, it helps to provide the patient's VAC client number
- VAC National Centre for Operational Stress Injuries (NCOSI) promotes partnerships in treatment, research, and education. For more information, contact the NCOSI Clinical Expertise Sector at 866 750-0422

Resources for Veterans

- VAC telephone: 866 522-2122 (English)
  866 522-2022 (French)
- VAC website: **www.vac.gc.ca**
- Peer Support Network of the Operational Stress Injury Social Support (OSISS) program: contact the nearest Peer Support Coordinator at 800 883-6094 or visit website **www.osiss.ca**
- Publications for patients and professionals at the Centre for Addiction and Mental Health in Toronto, Ont: **www.CAMH.ca**
- *Antidepressant Skills Workbook*[19] and **www.comh.ca/antidepressant-skills/adult/** for patients ready to change behaviour on their own

are encouraged to collaborate with VAC area counselors, OSI clinic staff, and OSISS members. The OSI clinics, VAC area counselors, and OSISS members can provide family physicians with information about the military context of mental health care to assist them in meeting their patients' needs.

Dr Shields is a psychologist, and **Dr White** is a psychiatrist, at the National Centre for Operational Stress Injuries for Veterans Affairs Canada in Sainte-Anne-de-Bellevue, Que. **Mr Egan** is National Manager of the Mental Health Directorate for Veterans Affairs Canada in Charlottetown, PEI.

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Competing interests
None declared

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References

1. Pranger T, Murphy K, Thompson JM. Shaken world. Coping with transition to civilian life. *Can Fam Physician* 2009;55:159-61.
2. World Health Organization, World Organization of Family Doctors. *Integrating mental health into primary care: a global perspective.* Geneva, Switz: World Health Organization, World Organization of Family Doctors; 2008. Available from: **www.who.int/mental_health/policy/en/**. Accessed 2008 Jun 23.
3. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders.* 4th ed, text revision. Washington, DC: American Psychiatric Association; 2000.
4. Patten SB, Wang JL, Williams JV, Currie S, Beck CA, Maxwell CJ, et al. Descriptive epidemiology of major depression in Canada. *Can J Psychiatry* 2006;51(2):84-90.
5. Fikretoglu D, Guay S, Pedlar D, Brunet A. Twelve month use of mental health services in a nationally representative military sample. *Med Care* 2008;46(2):217-23.
6. Zamorski M. *Evaluation of an enhanced post-deployment health screening program for Canadian Forces members deployed on operation APOLLO (Afghanistan/SW Asia)* [PowerPoint presentation]. Ottawa, ON: National Defence; 2008. Available from: **www.forces.gc.ca/health-sante/pub/rpt/apollo/epdp-dmpd-eng.asp**. Accessed 2009 Apr 10.
7. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med* 2004;351(1):13-22.
8. Mojtabai R. Americans' attitudes toward mental health treatment seeking: 1990-2003. *Psychiatr Serv* 2007;58(5):642-51.
9. Gilbody S, Sheldon T, House A. Screening and case finding instruments for depression—a meta-analysis. *CMAJ* 2008;178(8):997-1003.
10. McIntyre RS, Konarski JZ, Mancini DA, Fulton KA, Parikh SV, Grigoriadis S, et al. Measuring the severity of depression and remission in primary care: validation of the HAMD-7 scale. *CMAJ* 2005;173(11):1327-34.
11. Dennis ML, Chan YF, Funk R. Development and validation of the GAIN Short Screener (GSS) for psychopathology and crime/violence among adolescents and adults. *Am J Addict* 2006;15(Suppl 1):80-91.
12. Miller WR, Rollnick S. *Motivational interviewing: preparing people for change.* 2nd ed. New York, NY: Guilford Press; 2002.
13. Hettema J, Steele J, Miller WR. Motivational interviewing. *Annu Rev Clin Psychol* 2005;1:91-111.
14. Jetly R, Cooper K. PTSD: the symptoms and how to treat. *Can J Contin Med Educ* 2008;20(2):45-8.
15. Canadian Psychiatric Association, Canadian Network for Mood and Anxiety Treatments. Clinical guidelines for the treatment of depressive disorders, Canadian clinical practice guidelines. *Can J Psychiatry* 2001;(Suppl 1):1S-92S. Available from: **https://ww1.cpa-apc.org/Publications/Clinical_Guidelines/depression/clinicalGuidelinesDepression.asp**. Accessed 2009 Jun 23.
16. Maddox JC, Levi M, Thompson C. The compliance with antidepressants in general practice. *J Psychopharmacol* 1994;8(1):48-53.
17. Health Canada. *Best practices: concurrent mental health and substance use disorders*. Ottawa, ON: Health Canada; 2002.
18. Richardson D, Darte K, Grenier S, English A, Sharpe J. Operational Stress Injury Social Support (OSSIS): a Canadian innovation in professional peer support. *Can Mil J* 2008;9(1):57-64.

BOTTOM LINE

- It is important to be sensitive to the attitudes of active military members and Veterans toward mental health treatment and to use tailored brief interventions to deal with their ambivalence about treatment.
- Continuous screening for a range of mental health conditions, including addictions, is encouraged. Feedback using brief interventions, such as motivational interviewing, can improve engagement in treatment.
- Veterans Affairs Canada supports a national network of specialized clinics for managing operational stress injuries incurred by members of the military and the Royal Canadian Mounted Police. These clinics work collaboratively with family physicians, Veterans Affairs Canada district office area counselors, and families.
- Engaging families and peers of military Veterans at the outset can inform treatment plans and provide additional support to maintain treatment gains.

POINTS SAILLANTS

- Il est important d'être sensible aux attitudes des militaires actifs et des vétérans face au traitement de santé mentale et de recourir à de brèves interventions adaptées afin de surmonter l'ambivalence relative au traitement.
- Le dépistage continu de diverses maladies mentales, dont les dépendances, est important aussi. Un feedback à l'aide d'interventions brèves, comme l'entrevue motivationnelle, peut améliorer l'engagement au traitement.
- Anciens Combattants Canada appuie un réseau national de cliniques spécialisées de traitement des traumatismes liés au stress opérationnel à l'intention des militaires et de la Gendarmerie royale du Canada. Ces cliniques travaillent conjointement avec le médecin de famille, le conseiller de secteur du bureau de district d'ACC et les familles.
- La participation de la famille et des pairs des vétérans, dès le début, peut être incluse dans le plan de traitement et fournir un soutien additionnel afin de maintenir les gains associés au traitement.

19. Bilsker D, Paterson R. *The antidepressant skills workbook: self-care depression program.* 2nd ed. Vancouver, BC: Centre for Applied Research in Mental Health and Addiction; 2005. Available from: **www.comh.ca/antidepressant-skills/adult/workbook/**. Accessed 2009 June 23.

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