LETTERS TO THE EDITOR

RE: “IS GULF WAR SYNDROME DUE TO STRESS? THE EVIDENCE REEXAMINED”

This letter is in response to the recent article by Robert Haley (1) in which he reviews the published literature on Persian Gulf War health issues and post-traumatic stress disorder (PTSD).

Dr. Haley is correct in his review when he states that virtually all studies done to date involving Persian Gulf War veterans have assessed PTSD using psychometric scales rather than clinical psychiatric interviews. He has also pointed out some of the potential biases associated with using psychometric scales to determine PTSD prevalence in studies of Persian Gulf War military personnel. However, we question the general applicability of the equation correcting for the sensitivity and specificity derived from clinical studies of Vietnam veterans with a high base rate of PTSD. For example, given a specificity of 90 percent, any study in which the observed prevalence of PTSD is ≤10 percent will yield 0 percent for the estimated “true” prevalence, because the numerator will always be negative. We disagree with the implication that the estimated “true” prevalence of PTSD is 0 percent in Persian Gulf War veterans. Validation studies of the psychometric scales are necessary for the study of PTSD in Persian Gulf War veterans specifically. We have been studying a cohort of Persian Gulf War veterans since the spring of 1991 (2); subjects were first surveyed at Ft. Devens, Massachusetts, within 5 days of return from the Gulf (time 1, n = 2,949). As such, the Devens cohort represents a sample of US Army troops from New England-area units who were processed through Ft. Devens. Analysis of initial participating unit members indicated no discernable selection bias. The Devens cohort included US Army active, reserve, and National Guard veterans from over 80 different units. The most prevalent unit duties involved medical, military police, transportation, and engineering activities. Cohort members were deployed to many different locations in Saudi Arabia, Kuwait, and Iraq. The cohort was largely male (92 percent) and Caucasian (83 percent) and served in the National Guard (52 percent). In some respects, this differed from the troop duty status and ethnic breakdown of the total US Gulf force, which was 17 percent reserve and Guard troops and 68 percent Caucasian (3).

For the recently completed third phase of the study (time 3), we selected a stratified, random sample from the larger cohort and recruited subjects to complete a comprehensive study protocol that included several psychometric scales (e.g., Mississippi Scale for PTSD adapted for Desert Storm, M-PTSD-DS) and clinical diagnostic interviews for PTSD (Clinician Administered PTSD Scale, CAPS) and Axis I disorders (Structured Clinical Interview for DSMIII-R, SCID). A total of 141 persons completed the CAPS, as well as the M-PTSD-DS.

Based on time 3 data, the rates of current and lifetime PTSD as diagnosed by the CAPS are low in this particular Persian Gulf War cohort (5.0 percent current PTSD; 7.8 percent lifetime PTSD). The lifetime rate is comparable with the 7.8 percent rate obtained for a US community sample in the National Comorbidity Study reported by Kessler et al. (4). When measured by psychometric means using the M-PTSD-DS with a cutoff score of greater than 89, the rate of PTSD in this sample was 17.0 percent (sensitivity = 71.4 percent, specificity = 85.8 percent); when measured using a cutoff score of greater than 107, the rate of PTSD was 5.9 percent.

Even with the low prevalence of PTSD in this sample, we cannot conclude that the “true” rate of PTSD is 0 percent. Furthermore, the effect of PTSD on health outcomes should not be discounted. Research (5) and clinical experience suggest that it is essential to control for PTSD status in any analysis of health symptom reporting or neuropsychologic test performance, in studies of veterans’ health status and illnesses. In the time 3 study, those persons with PTSD (n = 7) reported significantly higher rates of health symptoms (chi-square = 8.1 (1, n = 141, p = 0.004)). However, an appreciable number of persons reporting higher numbers of health symptoms (n = 60) do not meet criteria for PTSD. The findings suggest that increased health symptom reporting does not appear to be fully explained by PTSD status (or other psychiatric diagnoses), and other explanations must be explored.

REFERENCES


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