

Speaking for Myself

Post-traumatic stress disorder: Psychiatric management, atonement and justice

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Post-traumatic stress disorder (PTSD), initially described in Vietnam war veterans, is now a standard psychiatric diagnosis and used across cultures, contexts and around the globe. It is incorporated in the American Psychiatric Association's Diagnostic and Statistical Manual-5 (DSM-5)¹ and is to be a part of the WHO's International Classification of Diseases-11.²

Despite its widespread acceptance as a disease label, there are many unresolved issues related to the category.³⁻¹⁰ Many of the problems of facing psychiatric diagnoses and classification also plague PTSD. Unpleasant feelings (e.g. anxiety, dreams and memory) within the normal range of emotions and purposive responses of people who are stressed (e.g. efforts to avoid thoughts, feelings, conversations, activities, places associated with the traumatic event) are considered pathological.^{4-6,7} The reasonable reactions to specific contexts (e.g. hyper-vigilance or numbing) are labelled aberrant.

The lack of pathognomonic symptoms, marked overlap of symptoms with other categories (e.g. major depression, specific phobia, generalized anxiety disorder, dissociative disorder, etc.) and absence of diagnostic laboratory tests add to the confusion.^{3,4,6,7} Psychiatry employs symptom checklists for diagnosis and the process discounts the context; the diagnostic procedure does not examine the pre- and post-trauma setting, vulnerability and supports.

The 'atheoretical' approach adopted by the current psychiatric classifications essentially supports the medical model, which medicalizes personal and social distress.^{3,4,6,7} The PTSD category is now also used in people who are victims of violence in the civilian settings and who have survived rape, assault, accidents, communal pogroms, industrial disasters, tsunamis, etc.

The diagnosis also assumes that the trauma has past and that the current context is safe. While this may be true for war veterans who have come home, it may not be true for other civilian victims of assault, for women in patriarchal cultures, ethnic, religious and sexual minorities in traditional societies, where continued threats and violence are possible.^{6,7}

The concept discounts variation among different people and does not highlight the strength of the survivors or the meaning of the event.^{6,7,10} Problems in living, when viewed through the medical lens, are construed as mental disorders.³⁻⁷ The legal, insurance and compensation implications of the label are complex and influence the category and criteria. However, research evidence for the usefulness of psychiatric treatment after natural and manmade disasters is thin.¹¹ Similarly, the success of prevention and treatment programmes for veterans is limited.⁸

Nevertheless, recent articles about experience in wars have discussed different conceptualizations, opposed to the medical

model of disease.¹²⁻¹⁴ They highlight the ethical and moral aspects of armed conflicts. They cite the fact that the traditional duty of soldiers to defend homelands is replaced by having to fight 'just wars' far away from home. They describe the loneliness, personal guilt and shame of killing people, which erode the soldier's humanity and highlight their moral bankruptcy. They emphasize the need for atonement and focus on the difficulties in getting back to civilian life. These articles raise significant ethical issues faced by soldiers and question the wholesale medicalization of reactions of people to the horrors of war.

PTSD AND INDIA

A PubMed search, using the terms 'PTSD' and 'India' retrieved 35 articles. The articles, which diagnosed PTSD, essentially applied 'western-international' criteria to the Indian population. None of these articles interrogated the category, discussed its historical and political origins, dissected its social links, examined its genealogy or elaborated its cross-cultural significance. As with the DSM system as a whole, this category has been adopted by psychiatry in India with very little debate or discussion. The pressure to adopt the DSM as both the Indian and universal standard or be 'left behind' and considered 'unscientific' was tremendous.^{6,7}

The PTSD label seems to be used in clinical psychiatric practice in India for patients who present with symptoms after a traumatic event.^{6,7} While there are no systematic studies on the prevalence of the condition in different hospital settings in India, mental health professionals do not seem to be averse to using the label.

The category has been used in the literature related to natural and manmade disasters in India. A review⁶ identified articles, which did not refer to soldiers or war contexts, but included cross-sectional studies of the condition in the civilian environment. The Indian Council of Medical Research collected data on psychiatric morbidity from clinics and from community surveys after the industrial accident at the Union Carbide plant in Bhopal and described anxiety, depression and adjustment reaction after the disaster but made no mention of PTSD.^{15,16} The PTSD category had not yet reached the consciousness of the Indian psychiatric fraternity in the 1980s.

However, studies which examined symptoms and experiences of people affected by the riots in Gujarat in February 2002¹⁷ and among Kashmiri Pandits forced to leave their homes and livelihoods¹⁸ reported PTSD. Nevertheless, the Gujarat report failed to mention the role of the government, if any, in the riots nor the persistence of threats and violence against the people who were traumatized, the majority of whom are unable to return to their homes to restart their livelihood and resume their lives.^{6,7} The study from Kashmir recorded the targeting, sudden and forcible displacement, the separation of families, loss of livelihoods, poor

facilities in the camps and the lack of opportunities to return to their homes and resume their lives, and acknowledged these factors as causal.¹⁸

Psychiatrists who visited the coastal area in Tamil Nadu immediately after the tsunami in 2004 did not report PTSD among the survivors.^{19,20} Many reasons have been attributed to the absence of the condition including differences in culture, religion, prior poverty and hardship, concerted community response, that it was a natural rather than manmade disaster, the lack of compensation for persistent symptoms, and the disadvantages of a sick role. However, research studies in the area using internationally developed instruments and criteria report PTSD with variable prevalence.^{21,22} A detailed evaluation of these reports reveals that many subjects with PTSD also satisfied criteria for major depression, and had lost property and family members and would also qualify for the label 'normal grief'.^{6,7} A mechanistic application of PTSD criteria without accounting for the process of bereavement will result in pathologizing normal grief.

PTSD has also been reported among children and adults after cyclones and earthquakes, among Tibetan refugees, and among those who suffer intimate partner violence.^{6,7} It has also been reported after witnessing road traffic accidents, suffering from physical injuries, physical disease and its treatment.

Modern psychiatric classifications, supposedly 'atheoretical', essentially count symptoms sans context, view mental illnesses through the disease lens, assume a biological core, employ a biomedical model for diagnosis and prescribe medication for management.^{6,7} The Diagnostic and Statistical Manual-III (DSM-III)²³ argued that symptom counts sans context allow for high inter-rater reliability. It also suggested the need to sub-classify clinical presentations. It implied that such reliable diagnoses will result in the identification of valid biological categories. Thirty years later, the DSM-5¹ admits that further sub-categorization is futile and many biological psychiatrists²⁴ refuse to endorse the DSM-5 and its phenomenological approach, and consider it a failed strategy.

Psychiatry acknowledges the role of sociocultural norms in defining mental disorders.¹ It recognizes cultural idioms of distress to communicate suffering and cultural syndromes, symptom clusters recorded in particular groups and contexts, albeit with examples from non-Euro-American cultures. However, DSM-5 suggests that all identified mental disorders started out as cultural syndromes. It cites 'depression' as an idiom of distress, which is reflected in many diagnoses.¹ Nevertheless, the discipline does not accept PTSD as a sociocultural phenomenon. ICD-11 proposals for PTSD essentially follow the same lead, albeit simplified and with some differences.²

Yet, context, history and politics, all crucial to the formation of PTSD, are dismissed as non-essential and external to the disease. A category recently created, projected into the past and linked with description of other superficially similar conditions (e.g. Da Costa's syndrome, Soldier's heart, Shell shock),⁴⁻⁷ which had an entirely different context and meaning, and then gradually elaborated into its present form using a so-called scientific process. The label was introduced into civilian life, elaborated and universalized. The disparate settings under which the condition now exists are brought together as many strands, decontextualized and subsequently unified into a single disease label.^{6,7} Genealogical studies of PTSD reveal its heterodox formation; its historical and social links rendered invisible and its diverse strands brought together to seem natural and unchanging in their essence.^{6,7} The de-contextualization and the unification of the heterogeneous

situations where the label is now used to allow for equating the problems of perpetrators of violence (e.g. soldiers in the context of war) with the suffering of victims of trauma (e.g. rape) and shifts the blame for manmade disasters to the victims.^{6,7} The PTSD story is now authoritatively used across cultures, contexts and very different kinds of trauma experience.

Historians have shown changes in response to trauma over space and time.²⁵ Combat distress varies markedly and is dependent on the sociocultural context; different clinical presentations (e.g. 'debility', 'somatic' and 'neuropsychiatric' symptoms) have been linked to specific wars and to prevailing medical concepts.²⁵ For example, flashback, a symptom now considered classical of PTSD was not documented in earlier wars. Many critics recognize that PTSD as a diagnosis was born out of the political context of the Vietnam war and is now supported by the insurance-based health system of the USA.^{3,5-7} Elevating idioms of distress to disease status, decontextualizing clinical presentations and unifying diverse kinds of trauma are the limitations of current psychiatric classifications. Reifying certain symptoms, viewing them through the disease lens and arguing that they represent a universal response to trauma exposes the circularity of the current logic of psychiatric classifications.

The issues raise the question of relevance and validity of PTSD.^{6,7} Can medical jargon help paper over ethical and moral conflicts among soldiers? Will financial compensation settle ethical conflicts? Will antidepressants resolve them? Will atonement help? Should concepts such as justice for those killed and injured come into the equation for recovery? Can the category standardized to suit the context of the post-Vietnam war and the medical-insurance culture in the USA, be directly applicable to other kinds of trauma in different historical situations? Should the label be used to focus on the victims of riots and manmade disasters while remaining silent on the perpetrators of crimes against humanity? Can distressing re-experiencing of traumatic events where people have lost family members, be considered disease when they are part of normal grief and bereavement? Should perpetrators of violence and victims of crimes receive the same diagnosis?

Helping people cope with the trauma would necessitate understanding the context, focusing on their strengths, empowering them to handle the continued stressors in addition to practical solutions to re-engaging with life and with society.¹⁰ Recognition of grief, 'permission' to grieve, exploring the meaning of the traumatic events and relief for distressing symptoms will be useful.^{6,7} Atonement for those involved in violence and war seems to be beneficial.¹³

Social, political and legal solutions may be more effective in situations where grave injustice has been done to large sections of the community by bringing the perpetrators of crimes and of man-made trauma to justice.^{6,7} Evidence also suggests usefulness of practical solutions to re-engage with life and society rather than disease labels and psychiatric treatments.¹⁰ Livelihood issues for civilians, aiding assimilation back into society for war veterans and international mechanisms to bring national leaders, who often start wars on fictitious evidence, to justice would be necessary.^{6,7}

Psychiatry needs to acknowledge that it helps people in mental distress and with mental diseases; that their differentiation is often difficult and that symptom checklists do not distinguish them.^{6,7} It needs to accept that distress secondary to traumatic events is heterogeneous; context, stressors, personality, coping, supports and meaning of the event impact outcomes. While psychiatry in the 20th century focused on universal categories and diagnosis

with emphasis on reliability, the 21st century demands that the discipline understand variability (e.g. genetic, environmental, contextual, etc.). Psychiatry should not blindly attempt to help and manage people who are traumatized by providing labels and individual treatments; it should also be involved in examining the larger issues related to the context and justice. The issues raised demand a debate about the category and a rethink on the use of the PTSD label.

Conflict of interest. None

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