

# THE CONCEPT OF PTSD: A CRITICAL APPRAISAL

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Both Pakistan and India have faced enormous disasters in recent years in the form of earthquake on 8 October 2005 and Tsunami. The mental health professionals in these situations are invariably faced with the mental health consequences of such colossal disasters. It is crucial that our response is based on critical appraisal of the concepts and treatments which could be employed in these situations.

Post Traumatic Stress Disorder (PTSD) is frequently thought to be the natural consequences of these disasters in almost every setting. The assumed *universality* of PTSD has been strongly contested in recent times by sociologists, medical anthropologists and mental health professionals. It is interesting to note that the concept of PTSD had its origins in the aftermath of military campaigns as is discussed in more details in following paragraphs. However, recent critique of the concept is based more on discourse in disasters in non military settings. I would like to explore the dialectics of the concept in view of its history, literature from military Psychiatry as well as my three decades of experience as a military psychiatrist.

## Politics of PTSD

Conceived in the aftermath of the US defeat in Vietnam and initially christened *Post Vietnam Syndrome*, PTSD was included in DSM III by an effete American Psychiatric Association (APA) during 1980, following intense lobbying by the politically powerful Veterans Associations<sup>1-3</sup>. Even then, the motion was carried by a wafer thin majority. Following subsequent dilution of the diagnostic criteria, ambiguous to begin with, PTSD "became the *disorder du jour*, its meaning stretched to encompass practically all the population. In effect, PTSD is not conceptualized as an abnormal pathological response arising in particular circumstances, *but the pathological response is assumed to be the norm*. ... psychiatrists now say that it is *normal* to be traumatized by the horrors of war"<sup>4-6</sup>. The assumed *universality* of PTSD has been, however, strongly contested in recent times by sociologists, medical anthropologists and mental

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health professionals, who have flagged its cultural roots<sup>1,7-11</sup>.

## Origins of the PTSD Dialectic

The controversy surrounding PTSD raises critical scientific and historical issues which impact the credibility of psychiatry itself. The National Vietnam Veterans Readjustment Study (NVVRS), which is the most extensive ever evaluation of the ground realities arising from the genesis of PTSD as a DSM II diagnosis, reported the incidence as<sup>12</sup>:

- (a) PTSD= 30.9% (i.e., *twice* the number of those in combat roles!)
- (b) *Partial* PTSD= 22.5%
- (c) Combined= 53.4%

Surprisingly, however, there were very few *combat stress reactions* diagnosed in Vietnam itself and only 3.5% of all psychiatric casualties were diagnosed as *combat exhaustion*, which was not surprising as *only 15% of the men were assigned to combat duty*. Then how did twice that number develop PTSD? How to explain these puzzling data?

"It's different from shell shock (WW I) and battle fatigue (WW II)", protested the protagonists. "Delayed onset", explained others, echoing Penfield's landmark formulation, '*a silent period of strange ripening*', constructed half a century earlier in the context of post-traumatic epilepsy. But real life is different. Psychiatric trauma induced illness usually begins in the war zone itself, as documented in the annals of military medicine, through the two world wars and the Korean conflict. Burkett<sup>13</sup> advances a more rational thesis in a recent publication, appropriately entitled, *Stolen Valor*:

- (a) Dubious accuracy of data relating to both trauma and symptoms, as not all those supposed to have been exposed to trauma were from combat units.
- (b) *Oversampling* from combat units, treating deployment in the war zone itself as qualifying stressor.
- (c) Interviewers' *bias* towards false positives.
- (d) Artifact of retrospective appraisal (only 100 of the 1632 Vietnam veterans surveyed in the NVVRS had actual service connected disabilities), resulting from the reinterpretation of diverse problems/symptoms through the prism of war and wrongly attributing them to military service, whereas

- (e) Archival data, obtained from the files of 2000 Vietnam veterans using the Freedom of Information Act, indicated that 75% were, *a priori*, pretenders!

This damaging conclusion is reinforced by Frueh's study<sup>14</sup> of the personal records of 100 randomly selected Vietnam veteran's reporting *war trauma*, 94% of whom had been diagnosed as PTSD (!), which indicated that 59% had no credible record of exposure to any trauma at all and of the 41% who had such record:

- (a) 20% had served in Vietnam but had earned no combat medals,
- (b) 32% had no documented combat exposure, and
- (c) 7% had *never been in Vietnam!*

What, then, had happened? Fabrication, or highly improbable gaps in the data/ missed traumatic events? Doubts are strengthened by the fact that 28% of *non-combatants* had reported witnessing or participating in battlefield atrocities, compared to 12% of the combatants! Anthropologist David Marlowe sums up succinctly: "We are dealing with the *sequelae of post combat belief, expectation, explanation and attribution, rather than the sequelae of combat itself*"<sup>15</sup>. Simon Wessley<sup>16</sup> is more circumspect: "We should see war stories for what they are: complex narratives that serve many functions, functions that those of us who have never been to war are not best placed to interpret." Experience in the Indian context lends support to this view<sup>17</sup>.

### **PTSD and the Compensation Culture**

It is apparent from the foregoing that PTSD has become a *compensation driven* nosological entity in western cultures, like the US where the Veterans Administration is facing a grave fiscal crisis owing to a huge hike in PTSD compensation payments to Vietnam veterans over the past six years, at an annual cost of \$4.3 billion, with the number of beneficiaries having doubled over this period<sup>18</sup>. More surprisingly, this increase is not due to soldiers just returning from Afganistan and Iraq but due to Vietnam veterans in their 50s and 60s laying new claims to being *crippled* by PTSD arising decades after the end of the war. A 2005 study by the Department of Veteran Affairs (DVA) Inspector General on 2100 randomly selected PTSD cases from seven VA hospitals (mean age= 56 years, mean period from discharge to 100% PTSD rating= 24 years) revealed startling findings:

- (a) No evidence of trauma\* = 25.1% (Oregon=40.7%; Maine=11.0%)

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\* It must be stressed that this is Criterion 'A in the diagnostic criteria of PTSD i.e'- extreme traumatic stressor involving threat to life/safety/physical integrity, experienced or witnessed directly, or affecting someone close to the subject.

- (b) Subjects continued to make mental health visits until they received 100% disability compensation, and
- (c) Then they either dropped out of therapy, or reduced their visits by an average of 82%, while, on the other hand
- (d) No such decline was seen in other medical disability claim patients!

The report concludes that "Part of the problem is that the compensation programme has a built in disincentive to get well when veterans are reapplying to get their disability rating increased." Burkett<sup>13</sup> considers three possible constructs to explain the inexplicable:

- (a) Patients exaggerate, or even fabricate, the history of trauma to get compensation.
- (b) Treatment *toxicity* hypothesis, which postulates that putative treatments (e.g., "PD", psychological debriefing) *actually make patients worse*<sup>15,16</sup>.
- (c) 'Natural' history of the disorder, with putative treatments being *inert* and unable to reverse an inexorable downhill course.

In the aforesaid context, it will be justified to infer the need to triangulate trauma with multiple, independent (albeit, fallible) sources of data, self-report, archival, psychophysiologic, to evolve an integrated and credible paradigm.

### **PTSD and DSM: Internal inconsistencies and the subtle creep in**

The pernicious repercussions of PTSD, contextualized above to the post-Vietnam scene in the US, are directly traceable to internal inconsistencies in the DSM III diagnostic criteria for the disorder, as adopted by the APA in 1980, and since aggravated by subtle but significant dilutions in DSM IV. Originally, in the DSM III definition, *traumatic* stressors were distinguished from ordinary stressors as being:

- (a) Outside the bounds of everyday experience, though, in the context of war, many of the putative stressors fell within the range of the soldier's real life repertoire of almost routine combat phenomena<sup>17</sup>.
- (b) Able to provoke distress in almost everyone, thereby assuming a universal, aculturalised threshold of vulnerability which is under increasing attack in the context of post-disaster PTSD<sup>6</sup>.

The definition did, however, attempt to limit the boundaries of PTSD by identifying canonical stressors: combat (even though this rendered PTSD as an inevitable accompaniment of war), rape and confinement to

concentration camps. But DSM IV soon removed this token fig leaf by radically enlarging the diagnostic parameters as following:

*“Criterion A – (i) The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others.*

*(ii) The person’s response involved fear, helplessness, or horror, which, in children, may be expressed, instead, by disorganized or agitated behaviour.”*

The concept of the traumatic stressor has been, thus, vastly broadened and its boundaries blurred. Non-canonical stressors from within the bounds of everyday life now qualify, e.g., hearing about a traumatic event/death of a loved one and even non-traumatic life events<sup>19</sup>. Increasingly, more and more of contemporary life now counts as trauma, including being exposed to crude sexual jokes in the workplace (a Michigan lawsuit on these grounds resulted in a 21 million dollar settlement) and even *uncomplicated childbirth*: “Birth caused PTSD constitutes a serious mental health problem and accounts for 3000 new cases each year in the Netherlands”<sup>20</sup>. Does this make birth control a primary prevention strategy for reducing the incidence of PTSD? This would be considered laughable, but for the serious assertion in the same paper that nearly 90% of Americans now qualify as trauma survivors!

In effect, now, psychic trauma denotes an event that is traumatic by virtue of its meaning to the subject, rather than on the basis of any objectively definable canonical criteria. This trivializes trauma, with a traffic accident victim being assigned the same experiential value as survivors of the Holocaust. This trend undermines attempts at elucidating the psychological mechanisms underlying PTSD and as the causal relevance of the stressor is eroded, the emphasis shifts to a search for pre-existing vulnerability factors<sup>21, 22</sup>. Moving the causal burden away from the stressor (trauma) leads to a background-foreground inversion and thus destroys the very *raison d’etre* for inventing PTSD as a diagnostic entity in the first place. If anything and everything qualifies as a traumatic event, then trauma becomes the universal lexicon of distress or misfortune in modern life and PTSD will medicalise more and more of real-life human experience, shaping our culture in ways which will undermine our capacity for resilience in the face of adversity<sup>23</sup>.

### **Macro-level consequences**

The ideological malaise underlying the PTSD epiphenomena, which has the potential to inflict serious damage on organizations, governments and societies, has been subjected to critical analysis by Vanessa Pupavac in a seminal paper<sup>6</sup> and her comments in this regard merit being quoted verbatim:

“The cornerstone of the international psychosocial model is its assumption of the vulnerability of the individual. *Whereas earlier psychiatry assumed the general resilience of the population and sought to diagnose individual susceptibility to psychological breakdown, the PTSD assumes universal vulnerability.* Assuming universal vulnerability, metropolitan actuarial risk analysis then focuses on environmental risk factors. Hence *people in the South are deemed to be at greater risk of psychological dysfunctionality because of the economic, political and social insecurities they face.* However, *a history of insecurity should not be equated with a history of greater susceptibility to psychological breakdown,* a distinction that is lost in the international psychosocial model. If there is any correlation it may be reverse of that assumed by international policy makers, that is, *the background of communities used to hardship means that they are likely to be remarkably resilient in the face of adversity.* This factor explains why international aid workers, including trauma counselors, appear to be more susceptible to secondary or vicarious trauma, than the recipient populations who have experienced primary trauma.”

Pupavac’s landmark contribution has had profound impact across the globe and the World Health Organisation has decisively moved away from the PTSD-oriented approach in disaster management<sup>24, 25</sup>. In the US, experts in the ailing Department of Veteran Affairs have called in question the very utility/objectivity of the PTSD diagnosis and “whether the structure of government benefits discourages healing”<sup>26</sup>. Going one step further, the Bush administration has contracted the National Academies Institute of Medicine to “review the utility and objectiveness of the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and comment on the validity of current screening instruments and their predictive capacity for accurate diagnosis. ...also review the literature on various treatment modalities (including pharmacotherapy and psychotherapy) and treatment goals for individuals with PTSD”<sup>27</sup>.

### **The Implications**

It appears to me that our vision has been distorted by the pernicious prism of what Vanessa Pupavac terms *assumed universal vulnerability*. Like international aid workers and trauma counselors, we seem to have become *more susceptible to secondary or vicarious trauma, than the recipient populations who have experienced primary trauma*. The ethical dialectic was summed up by Simon Wessely, Honorary Adviser in Psychiatry to the British Army Medical Services in the course of the 15<sup>th</sup> Liddel Hart Lecture, given at the Kings College, London on 15 Mar 2004:

“Reducing risk is increasingly the purpose of public health, and indeed politics. Whenever anything is identified as ‘risk’, it is inevitable that this is closely followed by calls to remove it. However, there remains one

section of society whose *raison d'être* is to take risks: the armed forces. That is the nature of the military contract. So when men (and increasingly women) go to war, it remains the case, now and then, that some do not come back, some come back physically injured, and some come back with invisible but often equally damaging psychiatric injuries. The notion that a military operation could ever be free of physical casualties is something devoutly to be wished for but unlikely to be achieved, and so it is with psychiatric casualties."

I have dwelt in some detail on the dialectics of PTSD not only because it focuses attention on one of psychiatry's many self-inflicted injuries but also because it provides a useful prototype for illustrating the ideological pitfalls which have the potential to erode the credibility of psychiatry. We must resist the temptations of the bandwagon effect and learn to manage pseudo-idealistic counter-transference, which often tends to colour our vision.

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