Post-traumatic Stress Disorder:
a Response to Abnormal Circumstances

Michael Simpson

It has long been recognised that psychological and social trauma can cause psychological symptoms which persist long after the traumatic event. Victims of the 1666 Great Fire in London, the American Civil War, the Russo-Japanese War and the First and Second World Wars experienced very similar reactions. The 'victims' symptoms were variously called 'nostalgia', 'combat fatigue' and 'shell-shock' (the latter term was used because, for a time, it was mistakenly believed that damage was caused by some form of concussion from continuous artillery bombardment).

The recurrent tragedy is that many basic lessons about recognising these problems and aiding the victims have been forgotten or ignored. These have had to be learned again during each conflict, at great cost in human damage and suffering. There has been a tendency to ignore or deny the extent of such damage and to ignore the victims, because this seems to be the more comfortable response. This has compounded the misery of victims, who are often blamed for cowardice, weakness or lack of commitment to the struggle or nation, when they are merely normal individuals responding to highly abnormal circumstances.

The Abuse of Psychology

In most forms of conflict, war and political violence, the extent and duration of the psychological damage caused to combatants and civilians has been far greater than the more obvious physical damage. Moreover, it has become increasingly common to intentionally inflict psychological trauma on the opposition. Over thirty years ago, William Sargant wrote that the politico-ideological "struggle for the mind of man may well be won by whoever becomes most conversant with the normal and abnormal functions of the brain, and is readiest to make use of the knowledge gained".

In this country and many others, we have seen the planned use of the structured stresses of captivity, coercive interrogation and torture, deliberately designed to induce traumatic stress disorders in captives, in order to force them to reveal information, to change political polarity and to betray their former comrades, or to produce lasting psychological impairment. We have also witnessed the deliberate fostering of violence within communities, including those in Crossroads and Natal, and across South Africa's borders, for example, Mozambique.

Diagnosing PTSD

The American Psychiatric Association's Diagnostic and Statistical Manual (DSM-3) introduced a diagnostic term for the psychological damage following a traumatic event, namely Post-traumatic Stress Disorder (PTSD). The table below shows the criteria by which this diagnosis is made.

Diagnostic Criteria for Post-traumatic Stress Disorder (DSM-3R, 1987)

A. *The person has experienced an event outside the range of usual human experience that would be markedly distressing to almost anyone, for example: a* serious threat to one's life or physical integrity; a serious threat or harm to one's close relatives or friends; sudden destruction of one's home or community; the sight of another person who was recently, or was in the process of being, seriously injured or killed in an accident or by physical violence.

B. *The person persistently re-experiences the traumatic event in at least one of the following ways:*

1. Recurrent or intrusive distressing recollections of the event (in young children, repetitive play in which themes of the trauma are expressed);
2. Recurrent distressing dreams of the event;
3. Sudden acting or feeling as if the traumatic event were recurring, including a sense of reliving the experience, illusions, hallucinations and dissociative (flash-back) episodes, even those that occur upon awakening or when intoxicated;
4. Intense psychological distress at exposure to events that symbolise or resemble an aspect of the traumatic event, including anniversaries of the trauma.

C. *The person persistently avoids stimuli associated with the trauma or has a numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:*

1. Efforts to avoid thoughts or feelings associated with the trauma;
2. Efforts to avoid activities or situations that arouse recollections of the trauma;
3. Inability to recall an important aspect of the trauma (psychological amnesia);
4. Markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills);
5. Feeling of detachment or estrangement from others;
6. Restricted range of affect, for example,inability to have loving feelings;
7. Sense of a foreshortened future, for example, no expectation of a career, marriage, children or a long life.

D. *The person has persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:*

1. Difficulty falling or staying asleep;
2. Irritability or outbursts of anger;
3. Difficulty concentrating;
4. Hyper-vigilance;
5. Exaggerated startle response;
6. Physiological reactivity on exposure to events that symbolise or resemble an aspect of the traumatic event, for example, a woman who was raped in an elevator breaks out in a sweat when entering any elevator.

E. *The duration of the disturbance (symptoms in B, C and D) is at least one month.*

PTSD was previously thought to be fairly uncommon, but more recent studies have shown that there may be a high occurrence of PTSD, even in comparatively peaceful communities. We have seen that PTSD occurs as a result of war, torture and political violence within communities, but it is also caused by a wide range of other stresses, including rape, incest, child or woman abuse, crime and natural and other disasters. In South Africa, the social decay resulting from long standing repression and political violence has increased the incidence of many of these forms of social and familial trauma and thereby enhanced people's susceptibility to being damaged by them.

Many surveys have confirmed that 60 to 80 per cent (or more) of those exposed to severe traumas are likely to develop PTSD. Some follow-up studies of disasters found 80 per cent of young children had symptoms of PTSD one to two years later, compared with 30 per cent of adults, strongly suggesting that children are more vulnerable.

It has been recognised in cases of disaster, severe political violence and similar events that it is not only the direct victims who develop significant symptoms and problems. The structure and function of entire communities can be severely affected. There are also indirect victims among the helpers, including ambulance staff, doctors and nurses and body handlers.

Drugs and Psychotherapy

Early treatment, within the context of a supportive community, can provide effective and lasting relief. There is clear evidence that, although the trauma may be psychological in origin, the effects include definite chemical changes in brain function. Careful use of appropriate psychotropic drugs can be invaluable in

Funeral of massacre victims. The extent and duration of the psychological damage caused has been far greater than the more obvious physical damage.
Photo: Julian Cobbing

providing effective therapy. Such pharmacological treatment may enable the survivor's brain chemistry to return to their normal state, and thus enable them to fully participate in, and benefit from, psychotherapy, which can be ineffective if used on its own.

Individual psychotherapy can be most valuable. This should be provided by skilled and properly trained therapists, except in the simplest of cases. When therapy is simple, almost anyone can do it. But when there are setbacks, complications, and crises, the naive and self-accredited counsellor can be seriously out of his or her depth, and the consequences can be serious. Group therapy has also proved valuable. Expert consensus, however, is that for reliable benefits, such groups should be run by people trained in group therapy and with real experience in the trauma field.

Without treatment, PTSD may last for decades. Furthermore, severe trauma can lead to clearly noticeable effects in survivors, their children and perhaps even their grandchildren. It is also important to recognise that PTSD can begin long after the traumatic stressor. Survivors can become disabled after everyone has stopped paying attention to their situation.

Overcoming PTSD in South Africa

In South Africa, the combination of political, social and familial trauma has affected millions of individuals and, in many instances, entire communities. Some attempts have been made to assist the victims of trauma, but they have fallen well short of what is required.

During the 1980s, individuals and groups from the major democratic health organisations worked under repressive conditions to assist victims clinically and medico-legally. There was considerable risk to both the counsellors and the counselled. It was also very difficult to conduct evaluations of the effectiveness of our work and to develop new methods of helping victims. It is hoped that, once these conditions of repression have been fully overcome, better quality research, programme evaluation and care systems will be developed.

It is also clear that we can gain from effective collaboration and liaison with our many international colleagues. Experiences in other countries can be highly relevant to our own local needs. At a meeting on the issue in Amsterdam, it was obvious that far too little disciplined and expert work has been done in South Africa so far. The true individual and social healing this country needs will only be possible when respectful and effective attention is paid to the consequences of trauma, thereby helping the survivors of apartheid to be freed from its grip.

Michael Simpson is a psychiatrist and is an expert on PTSD.