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Is Torture a Post-Traumatic Stress Disorder?

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INTRODUCTION:

Although most disorders within the field of psychopathology rely upon some notion of stress, the notion of the stressor involved in any particular disorder is often vague and ill-defined. Nonetheless, nosologies retain the notion of stress, and DSM-III even provides a specific axis for classification of disorders in which stress is argued to occupy a dimensional existence, from "minimal" to "catastrophic", and the presence of a defined stressor is argued to be a good prognostic sign. Hence, Brief Reactive Psychosis, which requires a stressor, is argued to have a better prognosis than Schizophrenia, which has no stressor and has insidious onset. However, this assumption that a stressor is a good thing may be questioned, and the notion that insidious development of a disorder is a bad thing may reflect clinicians' ignorance rather than any real state of affairs. In some disorders, however, stress is clearly not a good prognostic sign, but the reason for the disorder itself, as is the case with Post-Traumatic Stress Disorder.

Post Traumatic Stress Disorder(PTSD) has been argued to be a useful classification in dealing with stressors of an extreme nature, specifically those of a "catastrophic" nature according to Axis IV of DSM-III and DSM-III(R). The stressor no longer forms part of the background theory of a disorder, as is the case for many disorders, but forms the rationale for the disorder. However, it is argued by some workers, largely those working with torture survivors, that the notion of stress-induced disorder is insufficient to deal with the extent and nature of the trauma caused to a person by torture and repressive violence. This paper examines this debate.

POST TRAUMATIC STRESS DISORDER:

Post Traumatic Stress Disorder(PTSD) came into existence in order to provide a description for disorders and symptoms in which the stressor seemed to be of a "catastrophic" nature, and was clearly demanded by a socio-political reality: the large numbers of soldiers who suffered disorders after the Vietnam War were difficult to ignore. There were, however, many previous attempts to give expression to the effects of trauma that were not easily covered by the existing nosologies. These earlier descriptions had been classified mainly by reference to the precipitating event, and "concentration camp syndrome", "post-Vietnam syndrome", and "rape trauma syndrome" are all well-known examples of this approach to classification (Rasmussen.1990). However, impetus for a specific classification for disorders caused by trauma came with the recognition that diverse forms of trauma seemed to produce similar clinical pictures in the sufferers.

This recognition, that diverse stressors could produce remarkably similar effects, was codified in DSM-III in 1980 with the invention of Post Traumatic Stress Disorder. This was quickly followed by clinical studies and research, and resulted, in 1987, in the amended definition and description given in the revised version of DSM-III (APA.1987). Some brief consideration should be given to these two descriptions and to the amendments that have taken place. There are also plans to further amend this last definition (McNally.1993).

Post Traumatic Stress Disorder: DSM-III	**Post Traumatic Stress Disorder: DSM-III(R)**
A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.	**A. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost everyone.**
B. Re-experiencing the event as evidenced by at least one of the following: (1) recurrent and intrusive recollections of the event (2) recurrent dreams of the event (3) sudden acting or feeling as if the traumatic event were re-occurring, because of an association with an environmental or ideational stimulus.	**B.The traumatic event is persistently re-experienced in at least one of the following ways:** (1) recurrent and intrusive distressing recollections of the event (2) recurrent distressing dreams of the event (3) sudden acting as if the traumatic event were re-occurring (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the event
C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following: (1) markedly diminished interest in one or more significant activities (2) feeling of detachment or estrangement from others (3) constricted affect	**C. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness(not present before the trauma), as indicated by at least 3 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 (psychogenic amnesia) (4) markedly diminished interest in significant activities (5) feelings of detachment or estrangement from others (6) restricted range of affect (7) sense of foreshortened future
D. At least two of the following symptoms that were not present before the trauma: (1) hyperalertness or exaggerated startled response (2) sleep disturbance (3) guilt about surviving when others have not, or about behaviour required for survival (4) memory impairment or trouble concentrating (5) avoidance of activities that arouse recollection of the traumatic event (6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event	**D. Persistent symptoms of increased arousal, as evidenced by at least 2 of the following:** (1) difficulty in falling or staying asleep (2) irritability or outbursts of anger (3) difficulty concentrating (4) hypervigilance (5) exaggerated startle response (6) physiological reactivity upon exposure to events that resemble an aspect of the traumatic event
	E.Duration of the disturbance (symptoms in B,C, and D) of at least one month. Specify delayed onset if onset of symptoms was at least six months after the trauma.

As can be seen from the figure above, there are several marked changes in both the definition and the descriptive criteria. Firstly, the stressor concept itself is amended, from "recognizable" stressors that cause "significant distress in almost everyone" to stressors that are "outside the range of usual human experience" that are markedly distressing to almost everyone". This marks PTSD off as a disorder in which the stressor would have to be at least "catastrophic" on Axis IV of DSM-III. It is not clear that this continues or alters the notion that stress is dimensional, and does not deal with the problem that the stressor is exceptionally difficult to define in objective terms (Feinsten & Dolan.1991).

Secondly, re-experiencing of the trauma (Criterion B) needs now to be "persistent", with the inclusion of intense distress at exposure to events that may symbolize the original trauma. Thirdly, numbing of responsiveness, Criterion C in DSM-III, is replaced by persistent avoidance, Criterion C in DSM-III(R), with a much expanded range of symptoms. Fourthly, there is the replacement of the range of allowable symptoms in DSM-III, Criterion D, with the notion of persistent increased arousal in DSM-III(R), Criterion D. DSM-III(R) adds a fifth criterion, Criterion E, which includes a time course of at least one month's duration, as well as allowing for a delayed course. These changes together indicate a much clearer definition and a disorder that is clearly more severe than had been previously assumed.

Accompanying these classificatory changes has been the validation of the disorder by epidemiological and clinical research. This work has been recently reviewed by McNally, who argues out the studies indicate that PTSD forms a coherent syndrome (McNally.1993). There is good reliability in diagnosis, and reliability coefficients range from 0.58 for unstructured interviews to 0.86 for research studies using trained interviewers. Reliability is thus good, but there can still be questions about validity.

Prevalence is rather variable, and has been assessed in two ways: one approach has been to examine prevalence in the general population, whilst the other has been to examine prevalence in "at risk" groups. The Epidemiological Catchment Area(ECA) Survey estimated the lifetime prevalence of PTSD at about 1.3% in the general population, and at 3.5% in persons exposed to civilan or military violence, whilst a rate of 20% was found for veterans wounded in Vietnam (Helzer,Robins & McEvoy.1987). The clear suggestion was that the rate was dependent upon actual exposure to violence, and this was bolstered by studies of at risk groups.

The National Vietnam Veterans Readjustment Study reported lifetime prevalence rates of 30.9% for males and 17.5% for females, whilst, for those exposed to high war zone stress, the current prevalence rates were 38.5% and 17.5% for men and women respectively (Kulka et al.1988). This again bolstered the notion that the stressor could be objectively determined, and that there was a continuum along which stressors could be ordered, and according to which the severity and prevalence of PTSD could be predicted.

The degree of exposure to violence seems to affect the course of PTSD, and an American study on children attacked by a sniper at school showed this clearly (Pynoos et al.1987). One month after the attack, 77% of the children who had been in the playground when it was attacked showed PTSD, whilst 67% of the children who had been inside the school also showed PTSD. 14 months later, 74% of the former group still showed PTSD, whilst only 19% of the latter were still suffering from the disorder.

There would therefore appear to be a dose-response effect due to the magnitude of the stressor, and, according to this argument, torture will represent the most severe of all stressors, and the prevalence of PTSD should be highest in this population. This would seem to support the dimensional conception of stress, but, as pointed out above, this argument is somewhat modified by a recent empirical study, which demonstrated that, although PTSD was a probable result of physical injury, it was more a consequence of the perception of injury than the actual severity of the injury itself (Feinstein & Dolan.1991).

Although there is little doubt that PTSD usually follows trauma, there has been some debate over the notion that there is a delayed subtype. This argument has been partially resolved by a recent study from Israel, examining veterans who sought psychiatric help between 6 months and 5 years after the 1982 Lebanon War (Solomon et al.1989). This study suggested that 40% of cases represented delayed help-seeking, 33% was exacerbation of subclinical PTSD, 13% was reactivation of old PTSD, and 10% was delayed onset PTSD.

The debate is complicated even further by recent studies of Holocaust victims, which demonstrate clinical disturbance in third-generation survivors (Hardi & Szilagyi.1993), but it is not clear that the disturbance measured in the grandchildren of concentration camp victims can be described as PTSD. The issues around the course of the disorder and its long-tern effects are yet to be clearly resolved.

All of this epidemiological work has been substantially supported by the more empirical work. Laboratory studies have shown PTSD sufferers to have marked and significant response to noxious stimuli, with sufferers showing both psychological distress and physiological reactivity to battle sounds, war imagery and the like, and marked avoidance of these stimuli: 80% of PTSD sufferers in one study terminated exposure to audiotaped combat stimuli as opposed to 0% healthy combat veterans (Malloy et al.1983).

Studies of sleep show traumatic dreams occurring in both REM and non-Rem sleep, as well as difficulties in both falling asleep and maintaining sleep. In general, the sleep studies show a wide range of differences between PTSD sufferers and other populations, both civilian and military. Other studies, investigating intrusive cognitive activity, have shown marked effects of intrusive cognitions, with

PTSD sufferers showing positive interference for Vietnam-related words (BODYBAG), but not for other intrusive words (GERMS) (McNally et al.1990).

Thus, some of the key features of PTSD, sleep disturbance, intrusive cognitions, psychological reactivity and physiological distress, seem to be supported empirically, and there is support for the notion of a specific disorder produced by trauma, and capable of being delineated from other disorders. It seems clear that exposure to violence has severe, persistent and delayed sequelae, with a dose-response effect, but there still remain some difficulties, and some critics. The major critics come from amongst those working with torture survivors, who are critical of many aspects of the PTSD definition, and suggest that there may still be such a thing as a "torture syndrome" apart from PTSD.

TORTURE:

Torture clearly represents an extreme form of exposure to violence, in that the effects are premeditated and designed, the process usually involves attacks of both a physical and psychological nature, and, most importantly, torture has an explicitly political purpose in a clear socio-political context. One estimate sees "government-sanctioned torture" as being present in 78 countries in the world (Jacobsen & Vesti.1992), whilst another estimate reckons that between 5% and 35% of the worlds refugees have suffered at least one torture experience (Baker.1993). So it is well to have an understanding of the scale of the problem, and to see that it has a particular socio-political value. In general, those who work with torture survivors argue that PTSD is an insufficient definition of the consequences of torture. This argument requires some brief consideration.

At the outset, it is worth noting several important features of modern torture, for it is clear that torture, as a socio-cultural phenomenon, may well have had different effects through history. Contrasting ancient and modern torture, Rasmussen notes that torture was an accepted practice in previous times, that it was practised publicly, and that it was usually carried out after legal proceedings, whereas today torture is clearly not acceptable, is invariably carried out in secret, and is mostly arbitrary in its infliction (Rasmussen.1990). This last point is not trivial, for it is well-established that torture is specifically used a political weapon in order to achieve political ends: the use of terror and torture as an arbitrarily applied means of political coercion is an increasingly common feature of modern life. Thus, the meaning of torture has altered over time, and it seems pertinent to remember that torture may differ from other trauma because of its meaning alone.

It may seem to be hair-splitting to raise the socio-political and meaning in a consideration of psychopathology, but it is obvious that it is just these aspects of torture that set it aside from disasters, catastrophes, wars, accidents and abuse. It is the specific purpose of torture that sets it aside from most other trauma. Torture and repressive violence are specifically targeted at individuals and groups with the specific intention of causing harm, forcing compliance, and destroying political will, frequently in the absence of war, but always in a situation of civil conflict (Somnier & Genefke.1986).

Thus, there is considerable debate over whether torture should be conceptualized in a narrow medical framework, or should be seen in some broader framework including the political. The deliberate and systematic attack on people, and the attempt to destroy personality and political will, are felt to be such intrinsic features of torture that a narrow definition, such as PTSD, may miss this. For this reason, many workers in the field prefer the concept of "Psychosocial Trauma" to PTSD, for it seems to specifically allow for links to be made between the causes of trauma and trauma itself (Pagaduan-Lopez.1994).

As Basoglu has pointed out, this means that there are problems involved in the classification of torture, and three main arguments may be identified (Basoglu.1993). Firstly, torture is a political phenomenon, and thus is not easily captured within a psychiatric diagnosis: this refers specifically to some criterion of meaning. Secondly, PTSD does not apply to torture since it does not reflect the understanding that torture is only one of a series of ongoing trauma affecting a survivor, and, thirdly, psychiatric labels are stigmatizing and should be avoided. The rationale behind each of these views can be given quite shortly.

The first point relates to the validity of psychiatric diagnosis, and, in particular, the validity of PTSD. As was pointed out above, it is not in question that the diagnosis of PTSD can be made reliably. Studies of the prevalence of PTSD in torture survivors clearly demonstrate high rates of PTSD in torture survivors. For example, In a study of Turkish prisoners, it was shown that 85% of the sample had been tortured (Paker et al.1993). Of the tortured group, 39% showed PTSD, whilst none of the non-tortured group had the disorder, and, of those who showed physical sequelae of torture, 71% had PTSD. A study from Gaza, showed that more than 70% of political prisoners had received more than one form of torture, with 30% showing PTSD (El-Sarraj & Salim.1993). So, it is not in dispute that PTSD can be found in torture survivors, nor that torture is not a cause of PTSD, but it can be argued that the meaning of torture is not well reflected in the current classification of PTSD.

The narrow classification of torture as PTSD also does not reflect the reality for torture survivors, and, in particular, the finding that torture is merely one of a series of stressful life events for the survivors. Survivors do not merely suffer psychic and physical injury, but they also lose families, jobs, educational opportunities, and suffer alienation, displacement from their communities, and frequently end up as refugees (Baker.1993). In fact, torture survivors suffer a wide range of adverse consequences, and this frequently means that

the process can carry on over a very extended time period. For this reason, many workers feel that "ongoing traumatic stress disorder" would be a much more accurate expression of torture (Straker.1987).

The problem of "labelling" is equally not trivial. Many workers feel that the reduction of torture sequelae to a psychiatric condition places a very unhealthy emphasis upon the victim, ignores the entire process behind torture, and can even ignore the likely probability of psychopathology in the perpetrators of torture. This criticism is only partially vitiated by the advantages of including torture in international classifications, and the recognition that torture is recognized as a cause of psychopathology.

From a theoretical and epistemological perspective, the criticisms about the narrow definition of PTSD are rather more serious. The deliberate infliction of harm seems to place torture in the position of a distinct form of stressor, and the specific purpose behind torture makes it very different from random violence or catastrophe, whether natural or man-made. Furthermore, the violence is decidely purposive, with the aim of the systematic destruction of individual and community identity, and it is very hard to know how to include in a definition what is surely a notion of "evil", however unpalatable this notion might seem to a scientist. But in the final analysis, the claims for torture as distinct must rest on empirical as well as logical and moral grounds, and thus it needs to be demonstrated that a torture syndrome exists separate from PTSD. Little such evidence exists, nor has the issue received much empirical attention, but the clinical work does suggest that a torture syndrome is more than a logical or moral construct, although there are dissenters from this view (Turner & Gorst-Unsworth.1990).

THE TORTURE SYNDROME:

At the outset, we should note that there are different methods for approaching this problem (Turner.1993). One approach, which has already been extensively described, is to examine the range of pathologies already shown, and then to construct a syndrome. This is the preferred approach of psychiatry, and is the explicit method behind the construction of the DSM-III definitions. The second approach is to generate hypotheses based on an understanding of current theory, and to then test these on the problem at hand. This is generally the favoured approach of psychology, and is effectively a hypothetico-deductive empirical method. Both have their advantages and disadvantages, but it should be pointed out that the former is frequently argued to have greater validity because of the strong observational base behind the description. Actually, this is a spurious claim, since it is evident that the observations are very rarely unpolluted by theoretical bias (Faust & Miner.1986), and, certainly, within psychiatry there can be no claim that a symptom exists independent of the measuring device (Reeler.1993).

If the second of the two approaches above is adopted, then it becomes possible to see the ways in which torture differs from PTSD. Turner has provided both interesting argument and clinical support for the view that torture has consequences not covered by the PTSD definition (Turner & Gorst-Unsworth.1990; Ramsay et al.1993). This theory argues that there are 4 themes common to torture survivors: incomplete emotional processing, depressive reactions, somatoform reactions, and the Existential Dilemma. The first covers many aspects included in the definition of PTSD, such as psychic numbing, re-experiencing of trauma, and avoidance, which can also be described as the attempts by survivors to split emotional and cognitive components of their being.

It also reflects ways in which many survivors coped with the torture process, which frequently is described as having to learn to dissociate in order to survive (Somnier & Genefke.1986).

The second theme is important, and relates to an important aspect of the definition of PTSD: that of its conceptualization as an anxiety disorder. As Turner points out, repressive violence usually leads to a wide range of losses, which are more frequent precipitants of depressive reactions than of anxiety (Turner.1993). Indeed, depressive symptoms are very frequently reported by torture survivors, and are not explicitly mentioned in the DSM-III definitions.

Somatoform reactions are equally important. Most torture requires that the sufferer learn very complex associations between physiological and psychological events, and these may be adaptive during torture, but turn out to be maladaptive subsequently. Thus, it is apparent that the survivors may have a very wide range of idiosyncratic conditioned and formerly adaptive responses, and this needs to be included in the understanding of the response to torture. The point here is that the range of reactions may be exceedingly diverse, and it may be doubtful that even the reduction behind this taxonomic category, somatatoform reactions, will be an adequate description.

The final criteria is perhaps the most important, because it rescues the four-dimensional model from a narrow and reductionist definition. The Existential Dilemma expands the theory away from mere consideration of conditioned responses, and reflects the ways in which the survivor's sense of Self and position in the world are affected. Alienation, shame, guilt, inability to trust, personal change, relationship difficulties, and sexual difficulties are all reported by torture survivors. There clearly must be difficulties in the operational definition of this dimension, but it does reflect some of the considerations that demarcate torture and repressive violence from other forms of trauma.

The model may be preferable to both PTSD and the single entity theory of a Torture Syndrome, but it too has difficulties. To relegate the meaning of torture to an existential dilemma is not clearly an improvement, nor an answer to the criticisms raised by Basoglu, for

example. Causing an existential dilemma in a person may be the intent behind torture, but it seems unlikely that torturers and educators are only distinguished by their methods: the intention to harm and the perception of this intent suggest torture and repressive violence must be described not only by behavioural and medical criteria, but also by moral, ethical, and political criteria.

Thus, it does seem that there are good grounds for thinking about torture as having unique consequences, and consequences that might not be easily covered by the PTSD definition. It is also clear that some kind of conceptual analysis is also necessary as a preliminary to the construction of any syndrome entity, and this will determine the kinds of observations that are made. This will not preclude the approach of existing epidemiology, that of examining persons in populations that have suffered repressive violence, but it may point out the limitations of the approach.

As Faust and Miner have commented in their analysis of the epistemological basis of modern psychiatric nosologies, purely descriptive observations do not exist in psychiatry, and all observations are theory-driven (Faust & miner.1986). It is crucial, therefore, to make explicit the theory behind the observation language, and this is as true for torture as it is for any other disorder. Thus, there needs to be an interaction between the two methodologies outlined earlier, and neither will be satisfactory alone.

The more difficult epistemological question, that raised implicitly by the concept of Psychosocial Trauma, has scarcely been addressed. As Basoglu has commented, torture (and repressive violence) are political acts, and conceptually this marks off these forms of trauma as distinct from disasters, accidents, and the like (Basoglu.1993). Vis maior may be the same as the hand of man, but this needs still to be established both empirically and logically. It is difficult to clinically and epidemiologically differentiate PTSD and a Torture Syndrome at present, but the problem is not merely a measurement problem, for there remain complex conceptual problems that are not simply solved by more complex models (Turner & Gorst-Unsworth.1990).

CONCLUSIONS:

Clearly no definitive remarks can yet be made about this debate at this point, but the problems and issues raised deserve serious consideration. The acceptance of PTSD as a psychiatric (and medical) disorder has lead to a focus upon the problems caused by man's violence to man, and to an increasing awareness that violence may be a cause of considerably more harm than is commonly accepted. It has lead, for example, to the understanding that the witnessing of violence may cause disorder no less than the experiencing of violence. It has also lead to the suggestion that the effects of violence can be long-lived, persistent, and even inter-generational. Here, we must of course consider too the perpetrators, and the possibility that, just as victims and survivors of repressive violence may rear damaged children, so too may the violent continue the cycle of their own violence in their children.

The definition of PTSD makes visible the consequences of organized violence, but it may equally make invisible many of the processes in the causation of the disorder as well as many of the consequences. Whether torture should be regarded as an "ongoing traumatic stress disorder", and hence distinct, or should be seen as the most severe form of PTSD remains to be seen. The reduction behind psychiatric definitions can have many positive effects: it can facilitate identification of formerly undetected disorders, can lead to necessary descriptive work, and can allow scientific communication. However, reduction is only useful where it encompasses all the relevant variables, which is the cause of the present debate.

The deliberate infliction of harm has powerful biological, social, and psychological consequences, and seems to place the stressor concept in torture in rather a different position to the other kinds of stressors known to cause PTSD. It seems to have the quality of evil about it, which may be a reason why it produces such pronounced counter- tranferential effects (Danieli.1988). Evil and politics may not be the common currency of the healing professions, but do we not need to consider whether the attempt to produce a definition by reduction takes the meaning out of torture and repressive violence?

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Post Traumatic Stress Disorder: DSM-III(R)
A.The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost everyone.
B.The traumatic event is persistently re-experienced in at least one of the following ways: (1) recurrent and intrusive distressing recollections of the event (2) recurrent distressing dreams of the event (3) sudden acting as if the traumatic event were re-occurring (4) intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the event
C.Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness(not present before the trauma), as indicated by at least 3 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 (psychogenic amnesia) (4) markedly diminished interest in significant activities (5) feelings of detachment or estrangement from others (6) restricted range of affect (7) sense of foreshortened future
D.Persistent symptoms of increased arousal, as evidenced by at least 2 of the following: (1) difficulty in falling or staying asleep (2) irritability or outbursts of anger (3) difficulty concentrating (4) hypervigilance (5) exaggerated startle response (6) physiological reactivity upon exposure to events that resemble an aspect of the traumatic event
E.Duration of the disturbance (symptoms in B,C, and D) of at least one month. Specify delayed onset if onset of symptoms was at least six months after the trauma.