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Biomedical Diagnosis of Post-Traumatic Stress Disorder and Implications for Care during Complex Emergencies

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Introduction

Complex emergencies expose not only the physical body and (its faculties) to extreme events and violence, but also people's way of life, the economic, infrastructure and social fabric are affected [1,2]. For example, over the twenty years of war in northern Uganda, people experienced extreme stressors, injuries, torture by fighters and deaths, abductions of children [3]. In addition, war displaced people from their livelihood, with subsequent resettlement in congested, insecure displaced persons camps [4,5].

In this context the biomedical trauma model guided interventions by many national and international aid agencies. Reference was made to trauma, traumatised people and mandates to alleviate wartime people's suffering through offering trauma-focussed psychosocial support. Because there was a discrepancy between what wartime persons regarded as needs, priorities and appropriate timely interventions for their suffering, I was drawn to explore how it is possible to redefine all the complex forms of suffering during war-in order to focus on the impact of violence on the physical body and more narrowly on the psyche [6].

To do this, over seven years of teaching medical students, I have listened to many case presentations where the main diagnosis is PTSD. Most of the cases involve mothers displaced from their livelihood who also lost close relatives to violence, former child soldiers and adults who return from armed combat. The central question I analyse is how students arrive at PTSD as the major presenting complaint and focus on the impact of stressors on the clients' psyche in management. By observation, students in our medical school are carefully taken through the biomedical lingua, the importance of focussing on biology and biological pathology over the five years. Another discourse is that patients only come to the hospitals when they are looking for medicines and a good doctor must prescribe medicines at the end of the interaction with the patient. Students often assert; if it was not clients' aim to seek a pharmaceutical intervention or any other biomedical procedure -clients would seek for help elsewhere. While there is some truth in all these areas of emphasis, it is not exactly clear whether patients seek medicare with the expectation of a diagnosis basing on physical complaints and subsequent expectation for pharmaceutical intervention.

Furthermore, whereas students show an awareness that in restoring normality, it is important to focus on the physical body, the psychological and social body [7], in the biopsychosocial model, their training puts hierarchy on the BIO-PSYCHO-SOCIAL approach. To put it in another way, routine practice first focuses on the physical body, then the psychology and -when-one-is able to, 'refer' the client for social therapy. Any attempt to retrain students to think otherwise for instance do a SOCIAL-PSYCHO-BIO approach or simultaneously handle all contributors to mental illness ends with so much debate. While my argument is that the moment biological factors are prioritised, and pharmaceutical prescribed, for major depressive disorders including Amitriptyline there is a danger of closing the practitioners' sight to any other approaches, which would be effective; rarely are students able to see this. For example, as soon as Amitriptyline is prescribed, lack of recovery will be reinterpreted as inefficacy of dosage, thereby giving no room for addressing other determinants to disease. Thus it is frequent to observe a client who has not recovered taken through an ever increasing dose from 25 mg, to 50 mg, 75 mg until a maximum of 120 mg Amitriptyline. To help me understand this dilemma, I frequently give fourth year students the case below for management.

Case Study

In 2005, Opiro was a 16-year old former child soldier who was abducted by the Lord's Resistance Army at the age of 12 years. His village of origin was in a resource poor and insecure –Pagak. Opiro preferred to be reintegrated in Limu - a suburb in Gulu Municipality with his uncle. Opiro was brought to the psychiatric clinic for assessment. He was dusty and exhibited bruises all over his body. He looked shaken and fearful owing to an ordeal to which he had just been exposed. He had been rescued from an angry mob, which responded to an alarm by his neighbor. It was early afternoon and Opiro had forcefully entered his neighbor's hut, claiming that he was hungry and had sensed that she was cooking. He demanded that she share her food, or else he would violate her. The concerned neighbour raised an alarm which attracted other neighbours, most of whom responded with violence against Opiro. Some shouted how Opiro was ill-mannered. Ever since he was reintegrated into that suburb by World Vision, Opiro apparently has been aggressive to many people. He beat children in the neighborhood without mercy. He stole. Neighbours initially feared attacking him, but wished for a day to come when they could do so. On this particular date, it seemed the police were aware of the hidden revenge. The police's response to rescue the offender from the violent community was remarkable.

Opiro's past notwithstanding, the, then Senior Psychiatrist remarked on his assessment form, that "there is no link between the current behaviour and his past experience of being abducted and trained as a child soldier".

With the signed form, he was taken to the police detention cells to await trial, when the district judge would be in court. About five months later, Opiro was brought back by the police officer for another assessment. This time, Opiro had severely assaulted the neighbour whom he claims led to his arrest and subsequent incarceration to a juvenile prison - until he escaped. The then, senior psychiatrist again

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found no link between the presenting crime and past traumatic experiences to which Opiro had been exposed during his abject captivity with the LRA.

In a recent class(and the trend is similar for past years), out of 35 students, 29 students diagnosed PTSD in view of past abduction, replay - forcing Opiro to attack the neighbour for food, and hyper-arousal when Opiro beats children in the neighbourhood. The intervention would be cognitive behavioural therapy and psycho-education. Only 6 students were able to recognise the physical bruises, the dustiness, and immediate mundane hungry presentation of Opiro during the psychiatric assessment. Their priority intervention then would include administering I.V, since the psychiatric unit does not have food, and investigating and treating of bodily injury during attacks by the community, before assessing mental faculties. How is it possible that the majority of students' assessment neglected the immediate priority needs of Opiro, with preference to assign the technical PTSD diagnosis? Is a narrow focus on biological pathology in biomedicine closing practitioners' expertise to patients' realities? How can biomedicine enable,-as-one-student asked, 'recognise and identify social factors in their clients? In other words, has biomedicine, in the way it is taught become so scientific that it closes students' sight to realities and suffering of their clients? What is more, when does a diagnosis like PTSD become meaningless and hence compromising patients' care, inspite of the fact that clients presented could be exhibiting symptoms of PTSD?

This brings me to the observation that the senior psychiatrist, tactfully did not diagnose PTSD in order to force stakeholders including international humanitarian agencies to see the realities at hand, including hunger, lack and gender based violence perpetrated by the 'traumatised former child soldier'. This then begs the question, when is it possible for that expert diagnoses contribute to social injustice and a neglect of social suffering and social determinants of disease? Scholars discuss how a PTSD diagnosis could harm both the community and the individuals affected [8,9]. Further, describe the foregoing phenomenon as medicalisation of social and economic problems [10,11].

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