

Psychosocial Transition in a Postsocialist Context:
Posttraumatic Stress Disorder in Croatian Psychiatry

by

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BA, University of Victoria, 2005

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of the Requirements for the Degree of

MASTER OF ARTS

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Abstract

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In this thesis I explore the effects of the recent introduction of posttraumatic stress disorder (PTSD) to the post-conflict and postsocialist discourse of Croatian psychiatry. In recent years, the diagnosis of PTSD is increasingly spreading among the population of veterans from Croatia's *Homeland War* that lasted from 1991 to 1995. To explore the effects of the introduction of PTSD to the discourse of Croatian psychiatry I am raising the following questions: (1) how was the diagnostic category of PTSD introduced; (2) what are the ways in which Croatian war veterans convey their war-related experience through the trauma discourse about PTSD; and (3) how are ideas about the effective treatment of PTSD reproduced, transformed, and resisted by individual medical practitioners? In the final analysis, I argue that PTSD in Croatian psychiatry is constituted in a way that makes it both a medically recognizable form of emotional suffering and an instrument in post-conflict governmentality.

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Note on Translation and Pronunciation

I have translated all the terms, phrases, institutional names, and excerpts from interviews from Croatian into English language myself. All italic words in parenthesis are in Croatian language unless otherwise indicated. Below is a short list of some of the letters and sounds that are specific to the Croatian language and their approximate equivalents in English.¹ The spelling is phonetic and each sound has its own corresponding letter.

a	as in <i>father</i>
c	ts as in <i>cats</i>
č	ch as in <i>cherry</i>
ć	ch as in <i>chile</i> (only softer)
đ	soft j as in the British <i>duke</i>
dž	j as in <i>jam</i>
e	e as in <i>get</i>
h	h as in <i>hot</i>
i	long e as in <i>he</i>
j	y as in <i>yellow</i>
lj	li as in <i>milieu</i>
nj	ny as in <i>Sonya</i>
o	o as in <i>not</i>
r	hard r rolled with one flip of the tongue
š	sh as in <i>she</i>
u	u as in <i>school</i>
z	z as in <i>zebra</i>
ž	zh as in <i>measure</i>

¹ I borrowed parts of this list from the “Pronunciation Guide” of the 2007 publication of “The New Bosnian Mosaic: Identities, Memories and Moral Claims in a Post-War Society”, edited by Xavier Bougarel, Ellissa Helms and Ger Duijzings.

List of Acronyms

APA	American Psychiatric Association
ECTF	European Community Task Force
DSM	Diagnostic and Statistical Manual of Mental Disorders
HFP	<i>Hrvatski fond za privatizaciju</i> (Croatian Privatization Fund)
HZZMO	<i>Hrvatski zavod za mirovinsko osiguranje</i> (Croatian Pension Insurance Institute)
ICD	International Classification of Diseases and Related Health Problems
MIORH	<i>Ministarstvo invalidskog osiguranja Republike Hrvatske</i> (Croatian Pension and Invalidity Insurance Fund).
MOBMS	<i>Ministarstvo obitelji, branitelja i međugeneracijske solidarnosti</i> (Ministry of Family, Veterans, and Intergenerational Solidarity)
MORH	<i>Ministarstvo obrane Republike Hrvatske</i> (The Ministry of Defense of the Republic of Croatia)
PTSP	<i>Posttraumatski stresni poremećaj</i> (Posttraumatic Stress Disorder – PTSD)
SFRJ	<i>Socijalistička Federativna Republika Jugoslavija</i> (Socialist Federative Republic of Yugoslavia)

UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USKOK	<i>Ured za suzbijanje korupcije i organiziranog kriminaliteta</i> (Office for the Prevention of Corruption and Organized Crime)
WHO	World Health Organization

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Chapter One

Introducing Posttraumatic Stress Disorder

One reason for the generally accepted language of trauma is its broad political and journalistic legalisation... That is the language in which debates are carried out in the newly founded parliaments, and it is the language of the media, the language of ordinary people.

Dubravka Ugrešić (1999:245)

In the Fall of 2005, I was standing in a lineup at a bank in Croatia and was amazed by a sign that read something like this: “if you are a person suffering from posttraumatic stress disorder please do not wait here, but call this number...” My friend later explained how this was one of the recent strategies used by some government agencies to divert the anger and frustration of veterans from the recent war in Croatia. I was not entirely convinced that this explanation captured the full complexity of social, political, and economic transformations that characterize the intersection of Croatia’s postsocialist and post-conflict reality. As a civilian witness and participant of the war in Croatia, I was well aware of the suffering it caused and I could instantly recall numerous occasions of people saying, “we are all traumatized here... we all need some sort of psychiatric treatment”.² I started asking myself where is the line between normal and abnormal suffering to be drawn? Is the sign suggesting an attempt to reintroduce discipline into a disorderly, postsocialist Croatian society and are the bodies of Croatian war veterans

² (*Svi smo mi ovdje traumatizirani... svima nama je potrebna psihijatrijska pomoć.*)

undergoing some sort of transformation from martyrs into hostile elements, or from perpetrators into victims? Is it suggesting some local attempt to separate the good citizens from the emotionally unstable and therefore less desirable ones?

Since the end of the “Homeland War” (*Domovinski rat*),³ which lasted from 1991 to 1995, more than 32,000 people (mostly men) have been diagnosed with posttraumatic stress disorder (PTSD) and since then new programs have been established to combat the effects of the war. The government set up one national and several regional centers for treatment of psychotrauma. PTSD quickly emerged as a new psychiatric disorder to be reckoned with psychiatrists, health care policy makers, state politicians and the general public. Local media made reports about increasing numbers of violent confrontations almost all of which had a direct connection to the population of war veterans and PTSD. In this context, I re-read the sign as reflecting a new constellation of links between the materiality of power in postsocialist Croatia and the post-conflict need for a medical protection of personal well being, as well as collective mental health. I wanted to explore this relationship.

³ *Domovinski rat* is the most commonly used Croatian phrase for the war of Yugoslav succession that was specific to the territory of the Republic of Croatia. Although the war officially lasted from 1991 to 1992, in reality armed conflicts continued until 1995. Initially the war was waged between the Croatian police force and local Serb populations who were opposed to the secession from Socialist Federative Republic of Yugoslavia (*Socijalistička Federativna Republika Jugoslavija – SFRJ*). With the help from the Yugoslav People’s Army (*Jugoslovenska Narodna Armija – JNA*), Serbs came to control approximately one fourth of the territory of the present-day Republic of Croatia. (Olujić 1998:32). The Croatian military regained control over this territory in 1995. During the war, there were approximately 20,000 people killed and 200,000 were forced away from their homes. These numbers are even higher when combined with the numbers of killed and displaced persons from the war in Bosnia-Herzegovina (1992–1995) and the war in Kosovo (1996–1999). Therefore, *Domovinski rat* is also used to distinguish between the conflict in Croatia and those in Bosnia-Herzegovina and Kosovo. The Serbian phrase for the same conflict is “war in Croatia” (*rat u Hrvatskoj*).

Approaching PTSD: Intersection of suffering, psychiatry, and governance

This thesis is about war-related trauma that is commonly categorized as PTSD and its role in the governing of traumatized subjects in the post-conflict and postsocialist Croatian society. My overarching aim is to explore how PTSD is constituted through the work of Croatian medical professionals and to explore their reflections about this country's social, political, and economic transformations, as well as individual and collective experience of emotional suffering that was propelled by the effects of the recent war and the establishment of the new postsocialist state.

The central argument is that PTSD in Croatian psychiatry is constituted in a way that makes it both a medically recognizable and manageable form of political suffering, as well as an experiment in post-conflict governmentality. In the course of medicolegal validation of war-related emotional trauma, medical practitioners reproduce, transform, and resist conventional narratives about the effective treatment of PTSD.

In order to explore the introduction of PTSD to the discourse of Croatian psychiatry and its effects on individual and collective experiences of suffering, I am raising the following questions: (1) how was the diagnostic category of PTSD and the need for institutional treatment of war-related psychological trauma introduced; (2) what are the ways in which Croatian war veterans convey their war-related experience through the trauma discourse about PTSD; and (3) how are ideas about the effective treatment of PTSD reproduced, transformed, and resisted by individual medical practitioners?

With the first question, I seek to explore the processes that allow for the creation and subsequent resurfacing of traumatic memory by asking when this new kind of memory begins to be regarded as psychotrauma in need of psychiatric attention. To answer this question, I will examine what “traumatic memory” signifies in the context of Croatian psychiatry and how it is defined and explained by local medical professionals. The second question investigates the specific ways in which individuals who directly participated in Croatia’s Homeland War lay claims to PTSD, and how local psychiatrists respond to these claims, which in turn aids the creation of a particular medicolegal “culture of trauma”. The third question is an attempt to investigate whether Croatian psychiatrists and other medical professionals diffuse, redraw, and blur boundaries that define the trauma discourse of PTSD. To explore this question, I analyse narratives about war-related trauma and PTSD that I recorded during interviews with psychiatrists and medical staff at a psychiatric department of a clinical hospital and centre for psychotrauma in Zagreb, Croatia where I conducted most of my fieldwork from May to October of 2007.⁴ The central focus of my analysis is on the perspectives offered by the medical staff and I do not include the experiences voiced by persons diagnosed with PTSD.

⁴ There are several centers for psychotrauma located within psychiatric hospitals and clinical hospital centers in Zagreb. In order to protect the privacy of the participants in this research project, when referring to the site where I conducted most of my fieldwork I will use the term “Clinic”. This is the term used by most of the people who work there.

Psychosocial intervention in postsocialist Croatia

In the aftermath of the fall of Yugoslav socialism and the establishment of the new state, the institutional organization of the Croatian health care system was changed. This period is characterized by the confluence of the post-conflict introduction of “psychosocial” programs promoted by international humanitarian agencies and postsocialist transformations in local political and economic landscapes through privatization of state-owned socialist enterprises, loss of common markets, and large-scale social and ideological restructuring.⁵

The term “psychosocial” was introduced to Croatian medical and humanitarian discourse by international aid agencies that draw on Euro-American trauma models and conflate the sense of individual emotional vulnerability with the challenges posed by shifting social, political and economic conditions common to post-conflict settings (McKinney 2007:266; Pupavac 2004:492; Stubbs 2005:55; Summerfield 1996:12). In this context, PTSD is explained and processed both as a new kind of emotional distress experienced by individual sufferers and a new psychiatric disorder which requires continuous support from the local medical community and different national and international health organizations. Therefore, the focus of my thesis is on psychiatric discourses about emotional trauma that seek to ameliorate the consequences of Croatia’s Homeland War through a form of psychosocial assistance defined as PTSD and how this reflects transformations in Croatian psychiatry and society in general.

⁵ I return to a discussion about the effects of postsocialist transformations in Chapter Four, “Processing PTSD in Croatian Psychiatry.”

Locating the context for my research

The context I am writing about is post-conflict, postsocialist Croatia, and the Clinic (*Klinika*) in which both patients and medical professionals reconfigure PTSD into a new diagnostic category in Croatian psychiatry. Within these contexts, I am interested in the role of medical professionals in articulating the need for the treatment of war-related emotional trauma and in their validating of the experiential realities of individual sufferers. In this way, I regard PTSD as a process propelled by social, political, and economic transformations, which is directly impacting the lives of individual sufferers, as well as reflecting the organization and function of the structures and institutions of Croatia's postsocialist political economy.

I approach the Clinic as an ethnographic site in which individual suffering is actively merged with larger, social, political, and economic efforts to deal with the effects of Croatia's most recent war. I selected this particular place for my fieldwork as a "clinic is both a major social actor and the site of intimate and painful exchanges [that] makes it possible to document how socio-economic events become registered at the level of normal or abnormal selfhood" (Skultans 2007:27).

Tracing the ways in which different forms of assistance are delivered and channeled through this site may expose the semantic domain that is coded in the relationship between PTSD as a new psychiatric category and the apparent post-conflict dismantling of the old socialist symbolic order. For this purpose, I approach PTSD as what Falk-Moore defines as a "diagnostic event", or a process that "reveals ongoing

contests, conflicts, and competitions and the efforts to prevent, suppress, or repress these” (Falk Moore 1987:730). In other words, I am interested in the points of fissure and disruption that characterize the introduction of PTSD and the responses to its treatment within the discourse of local psychiatry and Croatian society in general.

In order to explore the dynamic matrix into which PTSD was introduced and to create a framework for the analysis of its constitutive parts, I grounded my research in a context that is defined by a “complex of institutions, advocates, newspaper articles, lawyers, court decisions ... within which an idea, concept, or a kind is formed” (Hacking 1999:10). To investigate how the introduction of PTSD reflects larger transformations in Croatian society I will explore the organizational mandates of some of the programs for treatment of psychotrauma, as well as how PTSD is used by psychiatrists and war veterans as a means for consolidation of a new kind of vulnerable individual who can benefit from postsocialist reconfiguration of economic and health discourses. In addition, I will engage in a thematic content analysis of interviews with medical staff at the clinic in Zagreb where I conducted most of my fieldwork. Following Ryan and Bernard (2003:87), I will identify and interpret the common themes in the perception of what constitutes Croatian experience with PTSD.

From emotional distress into politicized suffering

The course of this research project has been informed by my readings of Foucauldian works on power, knowledge and governmentality, as well as studies of postsocialism.

Expanding on Foucault's notion of the "body politic", Ian Hacking (1996:73) argues, that the transfer from physiological memory to mental memory signals the emergence of "memoro-politics", which transforms human memories into objects of knowledge in service of power relations. In line with this, PTSD in Croatia is processed as an instrument in postconflict governmentality in which the state extends its authority and powers of surveillance over emerging categories of state beneficiaries, such as the population of war veterans. I approach "governmentality" as a process in which power is exercised through state laws and regulations and the application of psychiatric techniques for the management of human emotion. Following Nicolas Rose, I approach governing as a "genuinely heterogeneous dimension of thought and action [in which] to govern is to act upon action [and] to presuppose the freedom of the governed" (1999:4). Therefore, although individual subjects internalize techniques of governing, I make the assumption that people have a capacity to act and, to varying degrees, shape their own objectivities.

The reification of PTSD as an object of scientific inquiry in Croatian psychiatry is an example of the process of conversion of emotional distress into a politicized biomedical entity. Starting with initial categorization of illness and diagnosis, PTSD is an object of interest to many different stakeholders, including branches of international and national medical communities as well as local politicians. The appropriation of the Euro-American trauma models in Croatian psychiatry has allowed for the use of PTSD as a means to pursue the status of a medicalized victim entitled to social recognition and compensation. Furthermore, in the context of postsocialist transformations in Croatian health care PTSD is a sign of political and economic changes in which the population of

war veterans is regarded as traumatized and granted with moral forgiveness and the right to claim disability compensation. At the same time, the Croatian government is making attempts to implement recommendations of international health authorities and create a favorable image about its governmentality at a crucial time as it is making attempts to be granted entrance to the European Union.

Summary

In this thesis, I am interested in exploring the role of Croatian medical professionals in the process in which this country's post-conflict challenges and postsocialist transformations get coded into the local discourse about PTSD.

In the chapters that follow, I first locate myself – as a person who was born and raised in Croatia, and a Canadian citizen and student of anthropology – and provide justification for my choice of the research subject. I then outline a brief history of the emergence and development of PTSD as a psychiatric category and continue with an investigation of how it was initially introduced to the discourse of Croatian psychiatry. Finally, I highlight how local political and economic transformations are reduced to psychiatric discourse on trauma and how local psychiatrists use it to participate in the postsocialist re-organization of local social security arrangements.

Chapter Two

Site of Life and War, Site of Research

Ethnography is the eye of the needle through which the threads of imagination must pass.

Paul Willis (2000:x)

In this chapter, I explain the choice of my research project and begin to position myself in relation to the topic and the people who I worked with during my fieldwork in Zagreb from May to October of 2007.

The choice of subject in this research project was conditioned by my experiences as a Croatian and Canadian citizen and as a civilian participant in the war in former Yugoslavia, as well as by my post-war immigration to Canada, and my witnessing of the appearance of PTSD as a new form of traumatic memory and a psychiatric disorder in Croatia. I do not regard my childhood experience of growing up in socialist Croatia as a tool to build an authorial “insider” status. Likewise, my personal ties to the context should not be read as what Roberts (2002:788) described as “laying down of genealogical claims”, but as an attempt to approach the issue of positioning my own “voice” and gaze to explain my deliberate choice of context, ethnographic subject, and the specific sites and methods of inquiry.

Writing as a [identity label] versus self-conscious ethnography

I conducted my fieldwork in Zagreb, Croatia from May to October of 2007. Personal ties to local life-scapes made my entry into the field free of “culture shocks” associated with settling in, learning the local language, and struggling to make sense of local ways of being. However, after arriving to Zagreb, I soon began to realize that my insider experience of growing up in the region and my outsider experience as a novice, “western” anthropologist-in-training presented me with both advantages and difficulties in positioning of myself in relation to persons who were to become participants in this project.

This difficulty may be summarized as resting in my own experience of living and growing up in Croatia, witnessing the war, and my post-war emigration to Canada. In order to overcome any potential biases related to my growing up in Croatia and my leaving the country at the time of rising nationalist sentiments and social turmoil, I had to constantly remind myself about the complex and multiple roles of anthropologists working within their own “cultures” and how these relate to issues of representation of different experiential realities.

As an individual who may claim to share the experiences of both the insiders and outsiders, my position is reminiscent of Lila Abu-Lughod’s (2006:466) description of feminists and “halfies”⁶ who are responsible to multiple audiences, and who embody and unfreeze the anthropological separation between the self and the other. The post-war

⁶ ‘Halfies’ are “people whose national or cultural identity is mixed by virtue of migration, overseas education, or parentage” (Abu-Lughod 2006:466).

reality in Croatia, of which I am also a part, complicates this relationship further. The following vignette may help to illustrate this conflict.

Participation before and after: War, violence, and boundaries

In April of 2006 – a year before my fieldwork had officially started – I visited my family in Osijek, my hometown in the region of *Slavonija* (Eastern Croatia) where I was born and raised and in which many Croats and Serbs were killed during the war. One day, I accompanied one of my relatives to the local health clinic. He was experiencing hearing problems and was going to seek help from an audiologist. After arriving at one of the clinics, we lined up in a crowded hallway and waited for my relative to enter the doctor's office. After a while, it became obvious that we would have to wait longer than we expected so I went out for a walk. Just in front of the entrance, I found two men smoking. I joined them and a conversation immediately followed.

They commented on the reconstruction that was being done on the clinical centre and how it was hard for patients to walk around all that scaffolding. I said how that must be true, but that the place was overdue for a makeover and that it is good that all these scars (*ožiljci*) from the war will finally disappear from its walls.⁷ The brief mention of bullet marks was enough to turn our conversation into a discussion about the war.

⁷ One of the men commented on how much more is needed to fix the scars from the war and anyway, he remarked, you can never hide the real scars (*pravi ožiljci nikada se ne mogu skriti*).

I asked them what they were doing at the hospital. They both said to be experiencing a painful noise in their ears and believed that it was a direct consequence of their military service during the war. In addition to that, they both claimed to be diagnosed with PTSD. This sparked my interest even more and I wanted to learn as much as possible about their experiences with PTSD, which, it seemed, they did not mind sharing. However, I was not prepared for what was to follow. They both said how they easily get agitated and how they have problems with controlling their anger. One of them confessed how his frequent outbursts of anger distanced him from his spouse and his teenage son with whom he even got into a physical fight on several occasions. He said that he could not control himself at a given moment and that after his anger attacks end, he cannot admit to himself that those were his own actions. Every time after a fight with his spouse and son he would be overcome with a feeling of guilt and sorrow, but this did not prevent him from reacting the same way again.

The other man confessed how he had the same problem and that he often experienced difficulties in maintaining ordinary conversations, so he decided that it is best if he avoided talking to people. On a rare occasion when he felt like being in company of other people, he went to a local pub where he knew that he could always find someone to pick a fight with. Most of the time he preferred to walk alone in the forest and sometimes he brought his rifle and shot with it until all his ammunition was used up.

I asked them if they were members of any of the local veterans' support networks (*veteranske udruge*). They both replied affirmatively but also claimed this was not helping them. When I asked why that was the case, they began to complain about "the

system” (*kriv je sistem*) that did nothing to recognize their losses and the sacrifice they made for their country.

They claimed how the same people they were fighting against now infiltrated the government. What particularly revolted them was the fact that the Serbs who were shooting at them for all those years were now walking freely around the town. They started sharing, in much graphic detail, the pain-inflicting acts that they would like to do to these Serbs and at that point I stopped listening to what they were saying, but could only see how they were increasingly taken over by anger. Their overt expression of nationalist sentiment was created in relation to what they perceived to be their ultimate Other: the Serbs. This made me think of my Serbian last name – Dokić, and I suddenly felt that these two men might somehow find this out and decide that I was also one of the people they felt so strongly against. Suddenly I was apprehensive about the way I spoke, I was trying to sound and look more “Croatian.”⁸ I was afraid and I could not wait to put an end to this conversation.

⁸ In former Yugoslavia, Serbian and Croatian, although recognized as different dialects, were part of the same official language; in Croatia the variant was known as Croatian-Serbian (*hrvatsko-srpski*) and in Serbia Serbo-Croatian (*srpsko-hrvatski*). After the declaration of independence from SFRJ the new Croatian government, led by its first President Franjo Tuđman, started with language reforms and many new terms were added to the Croatian lexicon. Some of these newly added words are still in use while others were a source of ridicule and were never really added to everyday usage. Still, people living in Croatia can easily recognize regional dialects and they often construct entire ethnic identities based on the way some words are used or pronounced. The people living in the region of Slavonia (*Slavonija*), where I was born and raised, use a distinct Slavonian dialect that is easily recognizable in other regions of Croatia. It is the same with other regions, such as Dalmatia (*Dalmacija*), or Northwest Croatia (*Zagorje*). However, my Slavonian dialect is still slightly at odds with the present standard, because, although once regarded as standard Serbo-Croatian, it has changed considerably over the last decade (which I spent in Canada) and some of the words and sentence constructions that I still use are now regarded as archaic and sound closer to Serbian language. This was brought to my attention by some of my friends who grew up in the same region as me but are now living and working in Zagreb. On the other hand, I thought how my friends’ “new” Croatian sounds like a mixture of dialects that I can no longer attach to any particular region. However, being aware of these nuances made it possible for me (at least I felt that way at the time) to switch between what could have been perceived as different ethnic identities based solely on the region

This event made me think about my future double role as a researcher and a member of the local community. As a student of anthropology and as a person who was born and grew up in Croatia, I recognize conflicting perspectives on the violence. A part of the explanation, for me, lies in the local meanings of aggression and violence. In a setting where atrocities have been committed by all sides, people are still trying to come to terms with the aftermath and their experiences and concerns are quite often voiced using the language of violence. It is not uncommon that in post-conflict communities, people use violence as a form of communication and may even perceive openly aggressive behavior as prestigious (Schläube 2006:5).

In Croatia people often use a form of narrative discourse that closely resembles what Ries (1997:83) had observed in socialist Russia and described as “litanies” of suffering.⁹ These litanies provide a set of semiotic codes through which people process the meanings of social transformations of which they are a part. However, during my brief conversation with the two men, I was struck with my own resistance or inability to remain a part of it. Any anthropologist will recognize this situation as a kind of participant observation – the one method they are trained for and expected to engage in during fieldwork. However, in this instance I placed an end to it by simply walking away.

with which I was associated.

⁹ Nancy Ries (1997:83) uses “litany” to describe a specific speech genre used in Russia that was especially common during perestroika. It signified a range of value transformations where “suffering engendered distinction, sacrifice created status, and loss produced gain”. While using this speech genre to voice their concerns and suffering, people distance themselves from the political processes and may remain relatively powerless.

Although I genuinely attend to the suffering of the local population, I refused to observe and approve of the violence and the language of hate. To decide not to participate in a politicized encounter such as the one I described here is to claim a position of neutrality, as noted by Živković (2000:50) who experienced it in a similar way in 1990s during his fieldwork in Serbia. This course of (in)action carries its own set of dilemmas of whether one should actively assert their opinions or silently observe and record what one is witnessing. In fact, people who ask for semantic affirmation of their litanies may interpret silence as a kind of violent action aimed against them. When Achino-Loeb (2006:2) writes, “the semantic space of silence is marked by experience of presence” to argue how silence can be used as a “first step in the realization of power”, she speaks of how silence can be used as a strategy. However, for me the important question is who claims the power in a particular context? I think that to remain “silent” in the context where everyone is expected to voice opinions may itself be interpreted as an opposing political statement.

In retrospect, the juxtaposition of my respondents’ and my own personal anxieties reveals the significance in exposing the relationship of competing attitudes and ideas. The relationship between my own reactions and what on the surface sometimes appear as prevailing local attitudes toward violence and experience of suffering flashed out a crucial tension that uncovered an ethnographic event that is a significant source of “diagnostic data” (Falk Moore 1987:734). What is immediately visible in the foreground is the apparent local participation in violence and in the background are the emerging large-scale value transformations that characterize Croatia’s post-conflict society and

caught in the middle is the challenging messiness of daily interactions of which both my respondents and myself were a part. This situation resembles Olujić's (1995:200) description of the experiences that the "recorders of human suffering" commonly face. She argues that individuals entering post-conflict areas to conduct research must be made aware of the traumatic nature of collecting such experiences, as well as be mindful about the challenges of particular social and political conditions which shaped their informants everyday lives.

In the kitchen, reception, and therapy: Observing participation in Klinika

Qualitative researchers use a variety of interconnected methods, which allow for the studying of phenomena as it is occurring in its natural setting, and as people create meanings in a particular context (Denzin and Lincoln 1998:3). My choice of methods in this research was guided by the principle that there are at least two broad categories of data available: the verbal statements, or "what people say" and people's observed behavior, or "what people do" (Holy and Stuchlik 2006:162). The existence of various sources of information that are available in different social contexts required a research design that would make use of a combination of methods and gathering techniques (Spradley 1979:8). The methods of data collection that I used in this project consist of archival research, participant observation, and semi-structured interviews.

PTSD in documents, meetings, and organizations

Throughout my fieldwork and especially before my research at the Clinic, I collected legal information on the pension and health insurance system and investigated how these have changed over the last decade. Furthermore, I explored organizational mandates of several institutions that have a stake in the design and operation of psychosocial treatment programs for veterans diagnosed with PTSD. The most prominent of these is the Ministry of Family, Veterans, and Intergenerational Solidarity (*Ministarstvo obitelji, branitelja i međugeneracijske solidarnosti*)¹⁰ and several war veterans' centers. The latter is increasingly sharing the responsibility for the operation of the newly designed state-sponsored programs of psychosocial treatment and reintegration of PTSD patients into their home communities. Other sources of information were the National Library and the Library of the Medical University Zagreb, whose staff assisted me in searching for relevant regional publications on PTSD and post-conflict transformations in Croatian psychiatry. In June of 2007, I had the opportunity to attend the European Conference on Traumatic Stress Studies that was hosted by Croatian psychiatrists in Opatija, Croatia. I also attended several colloquia that were organized by psychiatrists at some of the other clinical hospital centres in Zagreb. Other sources of information included the local audio, print and video media. Finally, throughout the summer I took part in several commemorative services in Zagreb where I had a chance to meet individuals who are directly involved with various governmental and non-governmental initiatives related to

¹⁰ Most people refer to it as the Ministry of Veterans (*Ministarstvo branitelja*).

Croatian war veterans.¹¹ The combination of these sources made it possible to position my research subject against a backdrop of structures through which the discourse about PTSD is channeled and sustained.

Klinika as social field

In addition to being an important economic and political centre the Croatian capital Zagreb is the place of with the largest and most influential clinical and health care agencies in the country. From what I had learned from my preliminary inquiries about Croatian health care and war-related PTSD, almost every route from diagnosis to treatment leads to one of the clinical centers, or state ministries and veterans' associations in Zagreb. In addition to these obvious advantages, this is also the place where a large number of people from all over Croatia and other parts of former Yugoslavia settled during and after the war, creating a particular social dynamic that exposes some of the effects of the recent transformations in the region.

The Clinic is located within one of several health centers in Zagreb and is divided into several departments scattered across the large clinical hospital grounds. The professional hierarchy within each of the departments corresponds to the professional qualifications of the staff: at the top of the hierarchy is the Director of the Clinic

¹¹ Some of the commemorative services were particularly well attended and included screenings of films and presentation displays of different interest groups and organizations such as the prominent “Vukovar Mothers” – Association of the Families of the Imprisoned and Missing Croatian Soldiers (*Vukovarske majke – Savez udruga obitelji zatočenih i nestalih hrvatskih branitelja*) who have been active since the beginning of the war in Croatia. The most attended were the public commemorations held on the Zagreb Defenders' Day (*Dan branitelja grada Zagreba*), Statehood Day (*Dan državnosti*), and Victory Day (*Dan zahvalnosti*).

(*predstojnik*), then the individual Heads of departments (*pročelnici*) followed by psychiatrists (some of whom are also administrators), therapists, counselors, nurses, and the facilities management staff. During my stay a number of resident students of medicine were completing the practicum requirement for their specialization in psychiatry and were also present at the site.

I was initially introduced to a single department and over the next several months, this was where I spent most of my time observing the work and daily interactions between the psychiatrists, therapists, nurses, medical students, and other staff. As time went on I was introduced to the medical staff in other departments who would invite me to observe how the work was conducted within different psychiatric units. This arrangement in some ways mirrors the internal organization and interaction of the medical staff within the Clinic. In a typical week, some of the psychiatrists and nurses would attend meetings or be scheduled to work at different departments, however, most of the time they were working within their home department and resident unit.

The official start of the day at the site is 8:00 am. This is when the night shift ends and medical staff from all the departments get together during their morning briefing to discuss their plans for the coming day. The meeting usually lasts for approximately half an hour and then everyone leaves just in time to prepare for the regular 9:00 am doctors' daily visit to patients (*vizita*).

The part of the Clinic where I spent most of my time is located in the basement of one of the buildings. The hallways in this part of the building are long, there are no windows and its walls are painted in a yellowish shade of white and lined with drawings

made by some of the former patients. On a typical weekday morning, at 9:00 am the hallways are already crowded with people waiting for their turn to drop in for a consultation, or a scheduled check up with one of the psychiatrists. After *vizita*, at around 10:00 am, the crowd in the hallway is now mixed with outside visitors, doctors, and nurses in white or blue uniforms, as well as patients walking around in their pajamas, tracksuits, or just plain clothes. The rush usually calms down after lunchtime, at around 1:00 pm, and then again after 4:00 pm when all visitors, and most of the doctors and the regular daytime staff leave for the day.

Although I could in principle visit any part of the Clinic at any time, I spent much of my time at the nurses' reception room (*recepcija*). In fact, most of the doctors would frequently hang about the reception room and this is where I first met most of them. The room is a relatively small space located in the middle of the department. Beside it, on each side of the hallway there are doctors' offices and across from it are patients' sleeping rooms. Its central location and the fact that this is the place where the nurses distributed medication to patients meant that there was always a steady flow of people there, both patients and medical staff.

Often, the medical staff would get very busy, at which point I would get my chance to conduct observations of their standard daily procedures and interactions with patients and among each other. This would usually occur in the mornings and in the afternoons, the pace would typically be much slower. At this time the coffee breaks would start and the staff would get their chance to relax which made them more receptive to my never ending questions. The location where I spent a lot of afternoons and where I

had some of the most stimulating conversations was the departmental kitchen (*kuhinja*), which is located in one of the side hallways, away from the busy areas frequented by patients and their visitors. This is the place where the staff prepares their food and has their dinners together, as well as the only spot where they are allowed to smoke and have a cup of thick “Turkish” coffee. The room is set up like the living room of a large and busy family with a large sofa, dining table and a door that leads to a large kitchen in which there was always someone preparing food or taking a break from their day at work. The location and the setup of the room made it seem like an informal and intimate space for casual conversations that proved to be crucial for my learning about the site and the people working there.

Getting to know the staff

At the Clinic, I first had to learn where my presence was not regarded as an obstacle and I also had to be particularly careful not to offset the balance in the relationships between the patients and the medical staff. At the beginning I was introduced to the common areas where all patients and medical staff are welcome. Several doctors and nurses gradually introduced me to their colleagues and as I became more familiar with the language of clinical discourse and the staff became familiar with my presence, I was invited to attend some of the regular meetings and therapy sessions. At first these were group occupational therapy sessions with one occupational therapist and a large group of patients. After that, I was invited to weekly “indication” sessions (*indikacijski sastanak*) where two or more

psychiatrists and a nurse would interview a person who was usually seeking admission for some type of psychiatric treatment. Following this, I was invited to group psychotherapy sessions, where entire families would participate in the treatment.

All of this was happening gradually, and before I was invited to witness any of the therapies that would allow me to observe interactions between doctors and patients, I spent the first few weeks spending most of my time with the nurses. All of this happened gradually. I spent most of my first few weeks with nurses before I was invited to witness any of the therapy sessions that would allow me to observe interactions between doctors and patients. However, it was with the nurses that I learned most of the nuances about everyday life at the psychiatric unit of the Clinic.

Klinika and the daily medical time

The techniques of recording my observations at the Clinic depended largely on the nature of the particular setting and the event I was observing. In the Clinic I typically used a small notebook, and at home I would transfer information into a research log, field notes, and a personal diary.

The nature of the clinical setting often required that I use a small pocket-size notebook to quickly jot down pieces of information that later proved to be crucial in recalling elements of important conversations that I had no way of recording at the moment I heard them.

In the research log, I marked meetings and plans for the weeks to come. I would compare notes from my notebook to my field notes in order to determine what had changed in my schedule and what was the best way of adjusting it.

I used field notes in order to record most of what I encountered during daily life at the Clinic that had a descriptive or analytical value. Here the notes range from descriptions of daily interactions between the medical staff to my ideas about what particular practices might signify and how they added to my understanding of my research questions. Every night after fieldwork, I would add the information from the notebook into my field notes and in the process I would expand on those parts that were represented by only brief pieces of information. The field notes contained the bulk of my observations and recordings of a range of conversations I had with people at the Clinic, as well as outside of it.

I also used a personal diary to express myself in ways that often did not immediately benefit the analytical purposes of my research project. The information in the diary, even if not necessarily factual and without personal biases, added to the complexity of the moment and served me later as a memory trigger. What is even more important, ruminations from my diary added a dimension of messiness and complexity to my experiences, which later helped me to better understand some of the nuances about everyday life at the Clinic.

Interviews

In the initial research proposal, I outlined a tentative plan to tape-record ten one-hour sessions of semi-structured interviews with ten respondents at the hospital and the centre for psychotrauma. However, during the interviews several participants expressed a wish for their responses not to be tape-recorded. They explained how a tape recorder would negatively influence their ability to concentrate on the interview and share unbiased responses. In the end, seven participants agreed to have their responses tape-recorded, and three decided to opt out from using the tape-recorder and I recorded their responses by hand. In the final analysis, I used the responses from all ten participants.

All the methods I used in this project are based on qualitative research. The scope of the project required that the research be rooted in a strategy that would allow for the answering of a broad set of questions about different processes that shape the social reality and define the postsocialist discourse of Croatian psychiatry. As Holy and Stuchlik (2006:160) argue, “social reality is not unitary”. Therefore, differences in collected materials and recorded information should not be only viewed as products of different techniques of data collection but also as stemming from different contexts and aspects of social reality.

Although my research was context-dependent, I also had a choice of what to record, where, and at what times. However, I do not intend this kind of “self-reflexivity” to be read as an end in itself, nor should it be interpreted as an argument against the anthropologists doing research from within and inside their familiar contexts. Quite on

the contrary, but only if as Robertson (2002:788) suggests, the insider status is not used as a name-category for self-representation but to describe a careful and informed choice of the research subject.

My epistemological and methodological choices were guided by the assumption that all respondents will share their own personal ideas about what constitutes PTSD in Croatian psychiatry, as well as reproduce conventional psychiatric understandings about the disorder. Therefore, the central aim of this research is to identify and explore the processes within which medical staff at the Clinic reproduce and challenge conventional understandings about PTSD.

Summary

In this chapter, I positioned myself in relation to my research subject and described some of the elements that form the basis of my project, including the choice of my research site and the combined use of methods and techniques for gathering information. I provided information about my initial arrival at the Clinic where I conducted most of my research from May to October of 2007 and provided a brief snapshot into daily life at the site. Finally, I provided some justification for my epistemological and methodological choices.

In the following chapter, I explore some of the key elements in the development of the concept of “trauma” and PTSD. I provide some information about the effects of its

sustained expansion to different social settings and make suggestions about how the disorder found its path into Croatian psychiatry.

Chapter Three

PTSD as a Historical and Political Product

[PTSD] is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources.

Allan Young (1995:5)

In this chapter, I explore some of the historical developments that have led to the inclusion of PTSD in the official psychiatric nosology and trace its links to Croatian psychiatry. I hope to bring into focus some of the common debates that question its universal validity as well as to point out some of the qualities that allowed for its expansion across different localities.

Conceptualizing “trauma”

The basic assumption in psychiatry and biomedicine in general is that disease exists as an object independent of the scientific gaze (Bracken 1995:1075; Singer 2004:9; Summerfield 2001:61; Young 1995:5). Some researchers argue that certain aspects of trauma are universal regardless of the context and that symptoms of PTSD have always existed (Dyregrov et al. 2002:1; Jakovljević 2000:53; Wilson et al 2001:409).¹² Others

¹² Young points to the increasing medicalization of human experience by quoting studies that claim how there is evidence that PTSD was mentioned as far back in the past as in the time of Shakespeare’s *King*

take the opposite stand by claiming how the diffusion of PTSD has been ever widening and inclusive of increasing numbers of people in a variety of settings in which distress is equated with trauma and in need of biomedical attention. This in turn places serious strains on the effectiveness of treatment programs in social, cultural and political settings with healing traditions that are different from those associated with the “West” (Argenti-Pillen 2000:87).

Although it a social construct, there is no doubt about the empirical reality of PTSD and “trauma.”¹³ PTSD does have an objective existence in the sense that it is a consensual diagnostic category used by medical professionals to treat emotional distress. Furthermore, people universally experience different forms of suffering however, their experience is conditioned through diverse social and political realities. Therefore, the ways in which researchers explain, validate, and legitimate particular forms of human experience cannot be reduced to a single conceptual category. From this it follows that a thorough understanding of trauma needs a more nuanced engagement with different experiences, expressions and conceptualizations of suffering in various social, political, as well diagnostic and treatment contexts. To paraphrase Kirmayer, human prospects and predicaments vary across social, cultural, political, and economic contexts and constitute different constellations of meaning and experience across “cultures of trauma” (Kirmayer, et al. 2007:12).

Henry IV and the Epic of Gilgamesh. He argues however that claims of historical continuity of PTSD are untenable because none of these authors wrote about the same type of “traumatic memory” that is used by contemporary medical discourse (Young 1995:3-6).

¹³ In the “Canadian Oxford Dictionary”, (Barber, ed. 1998:1554), among several definitions, there is a distinction between the psychiatric meaning of “trauma”: “emotional shock following a stressful event, sometimes leading to long-term neurosis” and its general use: “a distressing or emotionally disturbing experience...” In this particular instance I am referring to the general meaning of trauma that does not necessarily imply existence of medically validated disorders.

In this way, I consider trauma as a process and a practice that spans across different localities and is shaped by the challenges of economic and political transformation, as well as different responses to treatment in the aftermath of war. It is during these periods, which typically characterize post-conflict settings, that trauma becomes an important issue for both the sufferers of PTSD and medical professionals whose work is conditioned by larger economic and political processes.

History of psychotrauma and PTSD

The American Psychiatric Association classified posttraumatic stress disorder (PTSD; APA 1980) as a disease for the first time in its third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III).¹⁴ Initially, PTSD served to treat traumatic experiences of the veterans from the Vietnam War. The disorder made it possible to link present symptoms of “trauma” to the experiences of past “traumatic event(s)”. Since then, it has been used to describe a multitude of human experiences, including torture, rape, disasters, and accidents (Summerfield 2001:95). By treating direct exposure to violence as the cause of the disorder, diagnosis of PTSD in effect simplifies the complexity of its causes (Kirmayer et al. 2007:6).

¹⁴ DSM is the official diagnostic manual for classification of mental illness and disorder and it is used both inside and outside psychiatry for processing of various administrative work, such insurance claims (Scott 1990:294). Several revisions of the DSM preceded the addition of PTSD to its official nosology: in DSM-I (published in 1952) Freud’s conceptualization of traumatic memory was included as “Gross Stress Reaction”; in DSM-II (published in 1968) PTSD was taken off the list and the closest entry was “Adjustment Reaction to Adult Life”; in DSM-III (published in 1980) PTSD was finally added to the list of anxiety disorders (Wilson 1994:689-90). The most recent is the fourth revised edition, DSM-IV-TR (APA 2000).

Emergence of traumatic memory

The concept of trauma and medicalization of the past through the idea of “traumatic memory” is closely linked to PTSD.¹⁵ In order to describe mental injuries, Pierre Janet, Sigmund Freud’s contemporary, first used the term “trauma” in 1890s. Janet described it as occurring in people with weak nervous systems who, after the initial “shock” become fragmented beings and who sometimes lost control over their conscious will and presented themselves through multiple personalities. Throughout the British and Western-European medical history the idea of “shock” has been closely linked to trauma. Just as it was understood that some forms of trauma to the body could cause severe physical injuries, links were made between trauma to the head or spinal cord and psychological malfunctioning (Kirmayer et al. 2007:5).

In his study of the introduction of PTSD into the discourse of Western psychiatry, Young (1995:13-14) describes how “traumatic memory” for the first time emerged at the intersection of somatic and psychological streams of scientific inquiry. The first cases of trauma that included damage to neural tissue were described as caused by “railway spine accidents”. These injuries emerged as a consequence of industrialization and reaffirmed the link between physical shock and injuries to the nervous system. John Erichsen, who was the physician diagnosing and treating symptoms of railway spine accidents, reported three categories of patients based on the severity of shocks and the visibility of damage to neural tissue. Although symptoms in all of the cases appeared to be the same, some

¹⁵ The concepts trauma and traumatic memory developed from the nineteenth century European neurology and later culminated in Freudian psychoanalysis (Kenny 1996:152).

injuries were less visible than others and this invisibility caused a growing concern about individuals fabricating symptoms to receive compensation. Furthermore, Erichsen could not identify specific mechanisms that caused these symptoms, or explain how a particular emotion, such as fear, produces effects that can multiply the consequences of physical trauma. Therefore, at the root of the problem was the effort to find a single cause for trauma, which was further complicated by attempts to separate the less visible psychological from the more visible physiological mechanisms.

“Railway Spine” was transformed into a syndrome for the first time by the French neurologist Jean-Martin Charcot who believed that patients were most likely suffering from “hysteria”, or “the Great Neurosis” that was caused by intense fear. During the late 1800s, it was taken for granted that hysteria was common only to women and that its origins were in the uterus (Herman 1992:10). In his experiments, Charcot moved away from somatic explanations and focused on searching for a psychoneurological cause. It can be argued that in this way mind was successfully distanced even further from the rest of the physical body.¹⁶ Herman adds how Janet and Freud, who were Charcot’s followers, took it upon themselves to find the cause of hysteria by actually listening and talking to patients. They both agreed that alterations in consciousness, or “psychological trauma”

¹⁶ Similarly, Oliver Sacks describes the inability of early neurologists to locate possible causes for the loss of speech function, or loss of memory and identity. He notes how all of the early attempts at treating the impairment of neurological function were based on the treatment of centers in the left hemisphere of the brain, while the ‘minor’ right hemisphere that controls the sense of reality, or what was termed as “direct consciousness”, was systematically ignored (Sacks 1998:4). The reason for this was, once more, the apparent invisibility of specific syndromes that would correspond to lesions in the right hemisphere of the brain.

caused the symptoms of hysteria (Herman 1992:12). The method of treatment of this condition was soon known as psychoanalysis.¹⁷

The World Wars

During and after the First World War the Western-European belief in “manly honor” was quickly shattered as mental injuries of “shell shock” represented around forty percent of all British casualties (Herman 1992:20). Charles Myers attributed these symptoms to the exposure to shock waves from exploding shells that were equal to striking a person’s head and spine and causing concussions (Young 1995:50). The disenchantment with the ideals of manly glory in battle once again stirred a debate about the moral character of the patients who were regarded by some military authorities as “constitutionally inferior beings” (Herman 1992:21). Others, such as anthropologist W. H. R. Rivers, had a more progressive view and brought back the use of the “talking cure” of psychotherapy.

During the Second World War, anthropologist Abram Kardiner published “The Traumatic Neurosis of War”, which became the standard reference material in the diagnosis and treatment of war neurosis and is still a source of the list of symptoms for PTSD (Young 1995:89). After the Second World War, the interest in war-related neurosis or “combat neurosis” waned. It was the Vietnam War and the social and political

¹⁷ Herman (1992:18-19) adds how this new method of uncovering past traumas proved to be effective at alleviating the symptoms of hysteria. However, it also led Freud to a discovery that sexual exploitation of women in their childhood was the major cause of hysteria. His explanation was met with fierce resistance and Freud himself faced the possibility of social ostracism after which he denied his findings and abandoned his female patients.

conditions faced by the Vietnam War veterans that were the major catalysts for the inclusion of PTSD in the official psychiatric nosology.

The appearance of delayed symptoms from the Vietnam War

The 1970s political push for systematic psychiatric research about PTSD came from individuals organized through numerous veterans' organizations that asserted "the rightness, the dignity of their distress" (Herman 1992:27). In effect, the Vietnam War left a permanent mark on the diagnosis of PTSD because it was suddenly possible to make a link between greatly delayed symptoms and the experience of past war traumas. In the early 1990s, the Gulf War marked a shift in focus to the somatic effects of war in "Gulf War Syndrome", or bodily experiences caused by psychological stress and medically unexplained somatic symptoms (Kilshaw 2009:4; Kirmayer et al. 2007:6).

Diagnostic criteria for PTSD

Diagnosis of PTSD depends on the use of standardized psychiatric criteria as set in the Diagnostic Statistical Manual, fourth edition (DSM-IV-TR) (APA 2000) and the International Classification of Diseases, tenth edition (ICD-10) (WHO 1992). To be diagnosed with PTSD, a person has to have experienced an extremely stressful and traumatic event that involved "actual or threatened death or serious injury, or a threat to

the physical integrity of self or others” to which they responded with “intense fear, helplessness, or horror” (Yehuda 2002:108).

According to Judith Herman, an expert in trauma studies and a clinical psychiatrist, “trauma” contains both subjective, inner experiences of the individual and objective aspects that are observable and measurable by others (Herman 1992:6). Each diagnostic condition is defined by several objective and subjective symptoms or events. For each condition to be objectively recognized, the individual must exhibit an agreed-upon number of symptoms from each category. However, in practice there are few criteria that can be objectively established.¹⁸

DSM-IV-TR specifies three clusters of signs and symptoms of PTSD: (1) Criterion B: Reexperiencing of the traumatic event in the form of flashbacks and nightmares; (2) Criterion C: Avoidance behavior toward the reminders of trauma and emotional numbing; (3) Criterion D: Hyperarousal in which the individual is in a state of constant and exaggerated physiological alert and irritability. Additionally, under Criterion E, the symptoms must persist for at least one month,¹⁹ and according to Criterion F, the symptoms must cause distress or impairment. However, a person can only be diagnosed with PTSD if he reports at least one of the symptoms under Criterion B (Reexperiencing) and if he satisfies Criterion A (Stressor), that is only if he has been exposed to and experienced what qualifies as a “traumatic event” (Brewin 2004:10; McNally 2004:2).

¹⁸ Timothy G. Black (personal communication, 2007).

¹⁹ There are three subtypes of PTSD: Acute PTSD is associated with symptoms that last less than three months; Chronic PTSD is characterized with symptoms that last three months or longer; Delayed-onset PTSD is associated with symptoms that begin at least six months after a traumatic event (Yehuda 2002:109).

The fact that not every individual exhibits the same symptoms or response to traumatic events is usually explained by evoking the interplay of several factors in the causation of PTSD: the severity of the traumatic event(s), the number of traumatic events the individual has experienced, the age of the individual (exposure at a younger age leaves a permanent imprint of the traumatic event and may affect normal brain and identity development), level of social integration and support, differential impact of interpersonal versus impersonal trauma, and personality type of the individual (Herman 1992:8).

In DSM-III a “traumatic event” is defined as causing significant symptoms of distress in “almost everyone” whose experience falls outside of the normal range for humans (McNally 2004:3). This definition was later expanded in DSM-III-R to include learning about one’s family or friends being exposed to a traumatic event. Finally in DSM-IV the definition includes learning about others’ exposure to a traumatic event regardless if they are related to the individual, as long as her response included intense fear, helplessness, and horror.

The expansion of Criterion A (Stressor) effectively broadened the conceptual boundary of what may be defined as a traumatic event. A person no longer needs to be directly exposed to a serious threat or injury, but can qualify as having experienced a traumatic event upon learning of another person’s experience of trauma. Furthermore, the existence of a traumatic event now serves to explain a whole range of otherwise unexplained and nonspecific physiological and behavioral symptoms, including

palpitations, shortness of breath, tremor, nausea, mood swings, insomnia, unexplained pain, and refusals of treatment (Yehuda 2002:108).

Because the concept of trauma is no longer confined to direct experiences of catastrophic events that fall outside the perimeter of normal, everyday human experience, the majority of people may be regarded as having been exposed to some form of PTSD-related traumatic event. There are many events that qualify as traumatic, such as experiencing or witnessing physical abuse or violence, sexual abuse, rape, assault, traffic accidents, natural disasters, terrorist attacks, war, and severe neglect.

Studies about the development of PTSD indicate that following a traumatic event, such as sexual abuse, most people show reexperiencing, avoidance, and arousal symptoms that would satisfy the diagnostic criteria for PTSD (Brewin 2004:31). These numbers drop over the first three months and people who exhibit the same symptoms after three, or six to eight months, will be diagnosed with chronic PTSD. Brewin (2004:32) adds that of those individuals who are eligible for diagnosis after the first month many will continue to recover “naturally” and those individuals whose symptoms do not start to decrease at three months are at increased risk of not recovering in the same way and will depend on psychiatric intervention.

Expansion of PTSD and its medicolegal application

Since its inclusion in the DSM-III, PTSD has become one the most common psychiatric disorders in the world (van der Kolk et al. 1996:417). The explanation for the expansion

of PTSD lies partly in its etiologic properties which link present symptoms with past traumas that can be used as credible medicolegal instruments for the purpose of legal mitigation, or service-related claims for compensation. In fact, as Breslau notes, “[PTSD] seamlessly connects observable psychiatric symptoms with particular antecedent events through the constitutive medium of memory” (Breslau 2004:116). In other words, the narrative connection between outside events and individual’s internal traumatic experience makes PTSD a particular form of suffering that can be validated by medical discourse. In turn, this kind of credibility allows for PTSD to be used both as the instrument and the object of interest for the international aid organizations and branches of the international health community. Furthermore, by connecting current symptoms and past events and because of its capacity to place the cause and attach “blame”, PTSD takes on a sociopolitical dimension (Kirmayer et al. 2007:2) that serves the interests of international and local political actors.

Another explanation for the expansion of PTSD is the continuous escalation of conflicts around the world. Since the end of the Second World War World there have been more than two hundred wars and armed conflicts (Kienzler 2008:1) all of which impacted the well being of individuals, as well as entire communities and systems of health support. During the same time, medical anthropologists, psychologists and psychiatrists developed various theories that question the application of psychosocial programs in post-conflict settings and the value of PTSD as a health concept (Bracken et al. 1995:1073; Pupavac 2004:491). However, since the early 1990s its universal spread has never been greater and it is now used to explain many experiences of suffering

regardless of the context in which it happened (Breslau 2004:113; Folengović-Šmalc 2000:42; Summerfield 2001:95).

This expansion resulted in numerous scholarly debates about PTSD, which roughly fall into either universalistic or relativistic perspectives (see Argenti-Pillen 2000; Breslau 2004; Caple James 2004; Dyregrov et al. 2002; French 2004; Han 2004; Salis Gross 2004; Zarowsky 2004). Proponents of the former may be described as searching for discrete disorders and arguing for their objective existence, while the latter argue that PTSD is a psychiatric construct that is suppressing local “idioms of distress” (Nichter 1981:379) and allowing for the spread of western biomedical categories (McKinney 2007:293; Summerfield 2000:232; Young 1995:5).

However, according to Kienzler (2008:8), later developments have led to the production of a “less radical” interdisciplinary field of medical anthropology and transcultural psychiatry, which acknowledges the existence of some universal features of trauma while being sensitive to socio-cultural, economic and political circumstances that condition local expressions of distress and responses to treatment.

Dealing with PTSD in different localities

Investigations of different contexts reveal how the discourse of trauma becomes one of the many ways of dealing with suffering (Argenti-Pillen 2000:89). In particular contexts, the ideas about the impact of trauma may refer to individuals, as well entire communities and societies. Furthermore, it can include political claims about how entire nations should

be considered as traumatized. In such cases, the influence of the Euro-American biomedical discourse and conceptualizations of trauma get introduced into local contexts through global humanitarian agencies and international epidemiological surveys.

Breslau (2004:117) reports how PTSD was rarely diagnosed in Japan before a team of PTSD experts arrived from the US to obtain survey materials about the psychological impact of the Kobe earthquake in 1995. In a similar process, a team of researchers from Netherlands inserted PTSD into a new local setting by making the disorder “visible” at a refugee camp in Nepal.

In a study of emotional distress among the Somali returnees to Ethiopia, Zarowsky (2004:189) found how local expressions of emotion do not fit the psychological analyses of PTSD. In fact, certain expressions of emotion that would, according to Euro-American models be characterized as traumatic, such as anger and the rhetoric of demoralization, are critical for the establishment and maintenance of social networks among Somali refugees. In the communities where Zarowsky worked, people linked individual and collective memories to the community experience, the Ethiopian and other states, war, dispossession, and survival in a complex natural and political environment. She argues that shame and guilt are still important, but are not expressed, instead anger and aggressiveness reinforces a sense of shared identity and commitment to survival (2004:191). Therefore, in this context, distress does not equate trauma in the biomedical sense of the word, rather it creates a connection between different individuals and forges links to the social and political landscape they inhabit.

The relation between the subjective and objective meanings of suffering in Somali refugee camps is in stark contrast to the experiences of trauma shaped by the discourse of the Swiss medical system. Salis Gross (2004) describes a context in which the state run bureaucratic structures define what is to be regarded as a traumatic experience that can be granted legal status in Switzerland. Several discourses exert the Swiss collective vision about what should constitute effective lawmaking practices regarding refugee immigration which Salis Gross labels as “humanitarian, control and market-regulated” (Salis Gross 2004:153-4). Depending on the political landscape of the particular canton at a given time, and because asylum seekers are guaranteed access to certain medical services, any of the three discourses may have a precedence in determining the effectiveness of a refugee’s narrative of suffering in access to social, political and economic resources. At the same time, both doctors and asylum seekers are caught in a relationship of mutual blaming and mistrust (Salis Gross 2004:162). The individuals seeking medical assistance make attempts to learn the language of trauma that is required of them to communicate their experiences of suffering in a way that can fit the approved biomedical categories. In the process patients express concerns about their emotions being objectified and some begin to question the intentions of the medical staff: “they make me sick with all this treatment and I wonder if they want me to be sick... this drives you paranoid and you get fearful if you realize that you have some of these problems” (Salis Gross 2004:161).

It follows that the medical interpretation of sickness becomes a template for framing the subjective experiences of individual political actors. In effect, the individuals

whose suffering is being legitimized and formulated for the purpose of medically validated inclusion into Swiss society become participants in a social practice that Petryna (2002:5) defines as “biological citizenship” in which individuals’ “damaged biology... has become the grounds for social membership and the basis for staking citizenship claims.”

Summary

In this chapter I explored some of the most important developments in the history of “trauma” and PTSD. I made links to the emergence of the works of Pierre Janet and Sigmund Freud and followed its path from “Railway Spine” to PTSD. Next I described the current diagnostic criteria for PTSD and explored some of the explanations for the recent expansion of the disorder. Then I listed some of the debates about its “universality” and provided some evidence about how it found its place in different localities. In the following chapter, I investigate how PTSD was introduced to Croatian psychiatry and how it became one of the most frequently diagnosed mental disorders following the Croatian “Homeland War.”

Chapter Four

Processing PTSD in Croatian Psychiatry

Politics, culture, irreversible harm, and scarcity combine to produce and normalize a particular vision of risk's social acceptability. In this model, risk is not something to be limited or simply denied... but rather something to be turned into resource and then parceled out.

Adriana Petryna (2002:117)

In this chapter, I investigate how PTSD found its place in Croatian psychiatry and postsocialist society through the introduction of international psychosocial programs that seek to ameliorate effects of recent wars in former Yugoslavia. I also explore how it is presently used as a new disorder in Croatian psychiatry as well as a new medicolegal category and a point of access to social assistance resources.²⁰

Traumatic states of postsocialism

The collapse of state socialism, subsequent wars, and the establishment of new nation states, caused a range of emotional reactions among the people living in the areas of former Yugoslavia. According to Maruška Svašek (2006:9–11) people across the postsocialist world reacted to social, economic, and political changes with initial euphoria, welcoming “transition” as an opportunity to express their ethnic and national

²⁰ The Homeland War is legally defined as the defense of the territorial sovereignty of the Republic of Croatia that lasted from August 5, 1990 to June 30 1996. A veteran is that individual who participated in the defense for at least 5 months until December 24 of 1991.

identities. However, these feelings of hope were soon replaced with skepticism and disillusionment after it became obvious that only a few would benefit from “western-style” prosperity, while most would have to face poverty, corruption, unemployment, and new class differences (Kalb 2009:209).

Although everyday life in Croatia is still strongly influenced by people’s memories of recent wars, their experiences are not entirely different from those of people living in other areas of the former communist bloc. Countries of the former Soviet Union and Eastern Europe were all parts of a larger socialist project characterized by a single-party political and economic monopoly. After the collapse of the one party rule they all faced challenges with privatization of state properties, rise in unemployment, and different degrees of uncertainty in political and economic “transitions” to the “West” (Berdahl 2000:2; Brunce 1999:756.) People in Croatia experienced similar problems with the disappearance of the “old” markets in Eastern Europe and the complete collapse of trade links with the former Yugoslav republics (Radošević 1994:490). However, in comparison to the peaceful “divorce” of countries such as the Czech Republic and Slovakia, the breakup of former Yugoslavia ended up in a series of extremely violent wars (Bookman 1994:176). Therefore, Croatian experience of postsocialist transformation must also be viewed against the backdrop of large numbers of killed and displaced persons, destruction of property, and subsequent political repression and rise in nationalisms. In line with this, Croatian responses to the collapse of the former Yugoslav federation and the dismantling of the Eastern bloc show elements of both “continuity and rupture in the legacy of socialism” (Yalçın-Heckman and Demirdirek 2007:11).

Re-conceptualizing Croatian memories

In the early 1990s the appropriation of “lost memories” from the Second World War signaled the replacement of the Yugoslav multicultural ideal of “brotherhood and unity” (*bratstvo i jedinstvo*) with emerging nationalisms. Much like for the individuals in what Han described as the “untimely discourse” of neoliberal Chile (Han 2004:172), the discursive landscapes in Croatia are allowing both for a skeptical and critical engagement of the past and the lamenting of the political and ideological present. Furthermore, in addition to changes in official politics and economic challenges, similar to experiences of people in other postsocialist countries, people in Croatia and other parts of former Yugoslavia, are faced with disruption in social relations, rewriting of history, and everyday “downsizing of [national] imagination” (Demirdirek 2006:45).

In this context, the introduction of PTSD and Croatia’s postsocialist transformation into a free market system influences people’s understanding about their own place in the emerging system of social and economic relations. During the era of Yugoslav socialism, the concept of psychotrauma did not exist as a diagnostic psychiatric entity (Cvitan 2003:112). In fact, it can be argued there were no victims in former Yugoslavia but only victors and perpetrators. Under the communist regime, the experiences of “Ustaša” soldiers who served in the fascist military forces of the Independent State of Croatia from 1941-1945 were not verbalized in state politics. On the other hand, the members of the communist guerrilla forces, “Partizani”, were valorized as

heroes and their war experiences were not regarded as traumatic, but were glorified by the public for establishing national order and safety.

Although the political apparatus of the former state overtly exploited the ideology of communist triumph over fascism in the Second World War, there were no reported cases of transgenerational trauma (Cvitan 2003:111). Furthermore, similar to the Soviet Union and most of the countries of the Non-Aligned Movement, Yugoslavia largely ignored the application of Euro-American psychological functionalism. In fact, treating war as psychological dysfunction was interpreted as an attempt to undermine the communist liberation movement (Pupavac 2001:359). This is one of the reasons why until recently Croatia was one of the only European countries without national programs for treatment of mental health.

New therapeutic interventions

The Homeland War had a great impact on health care and social support services in Croatia. Some health care units were seriously damaged and others were completely destroyed. During 1992 and 1993 the escalation of conflicts in Bosnia-Herzegovina further complicated the situation with many people fleeing their homes and seeking refuge in the country, particularly in the Zagreb area. In 1994, there were more than 380,000 registered migrants in Croatia²¹ (Soroya and Stubbs 1998:303).

²¹ At the time total population of Croatia was approximately 4.5 million (Government of Croatia Census 1991)

During this time several international aid organizations promoted the development of psychosocial programs and soon after that the local field of psychotrauma was developed. Since then, the Croatian government has organized national and regional centers for treatment of psychotrauma across the country.

Arrival of the psychosocial

The most influential psychosocial influences came from abroad and can be attributed to the European Community Task Force (ECTF) that funded many psychosocial projects led by NGOs of the EU member states; the World Health Organization (WHO) that aimed at protecting mental health and promoting the organization of national mental health services; United Nations Children's Fund (UNICEF) that was focusing on organizing psychosocial programs for child victims of war; and the United Nations High Commissioner for Refugees (UNHCR) that funded NGO psychosocial programs for refugees in Croatia and Bosnia (Stubbs 2005:55). All four of them organized and promoted psychosocial programs based on the assumption that trauma is a universal human experience, that there are large and increasing numbers of people suffering from trauma and that local populations needed immediate psychological intervention. In the *New York Times* an influential article appeared in 1995 with the title "In Croatia, Minds Scarred by War" that predicted a contagious spread of PTSD (Kinzer 1995:np).

Since then, based on Euro-American models of psychosocial development and to address problems with "ineffective spending [and] paraprofessionals running many

projects” (Kozarić et. al 2002:222) the Croatian government organized a network of psychosocial programs. In 1999, the network was redesigned into one national and several regional centers for treatment of psychotrauma in Zagreb, Rijeka, Split, and Osijek.

The local spread of PTSD

In recent years, local psychiatrists have been faced with a significant increase in the number of reported cases of mental disorders or social disorders, with PTSD appearing as the most frequent one (Kozarić-Kovačić and Borovečki 2005:180-1).

Over 32,000 individuals have been diagnosed with PTSD in Croatia.²² However, according to the new Law on Rights of War Veterans and Members of their Families (*Zakon o pravima hrvatskih branitelja i članovima njihovih obitelji*) all of these cases are now undergoing a process of revision. Since January 2005 approximately half of the PTSD claims have been reassessed and approximately 4,000 have been denied. Meanwhile all individuals whose PTSD claims have been reapproved and all those who are still in the process of revision continue to receive disability pensions from the Croatian government.

²² In comparison to Croatia, in the US there were 216,000 PTSD cases in 2006 and in Canada approximately 6,500 in 2008 (The Canadian Press 2008:np). This ratio becomes significant when measured against the relative population in each of the three countries: Croatia, 4.5 million (Central Bureau for Statistics 2006); U.S., 306.4 million (U.S. Census Bureau); Canada, 33.6 million (Statistics Canada).

Sale of PTSD diagnosis

In February of 2008, Croatian police raided psychiatric units at two major clinical centers and arrested individuals, six of whom were psychiatrists charged with selling posttraumatic stress disorder (PTSD) diagnoses. Over 10,000 PTSD claims have been brought under police investigation due to suspicion they were sold by psychiatrists who charged up to 8,000 Euros for a single diagnosis (Babić 2008:np; Rajčić and Kuzmić 2008:np). The arrests were part of a seven-month long undercover investigation by Croatia's police and the "Office for the Prevention of Corruption and Organized Crime" (*Ured za suzbijanje korupcije i organiziranog kriminaliteta – USKOK*), aptly named "Operation Diagnosis". The objective was to expose the long suspected chain of corruption among Croatia's psychiatric experts and other staff in charge of diagnosis and treatment of people suffering from war-related PTSD.

The process usually involved the falsification of medical records, approval of forged diagnoses and psychiatric reports, and in some cases, the same psychiatrist provided expert opinion on the disability claim that he or she had initially formed. On the basis of their newly acquired "disabled status", patients could then claim various benefits, ranging anywhere from government pensions, free education, and various tax breaks, to reduced interest rates for mortgage loans and complimentary shares from the "Croatian Fund for Privatization" (*Hrvatski fond za Privatizaciju - HFP*). Therefore, PTSD in Croatia has become the object of interest to many stakeholders including international humanitarian aid organizations and branches of the international medical community, the

local media and politicians, as well as particular segments of the population, such as Croatian war veterans.

Claiming disability pension

A person who participated in the Homeland War and who wishes to file a claim for disability pension or an increase on in the compensation that he is already receiving has to deal with a series of government offices and special experts commissions. The following outline will illustrate the complexity of this process. For the sake of clarity, I named the person filing the claim Ivan:

Ivan was wounded and presently he is experiencing emotional distress and because of that he finds it difficult to keep working. To file his claim for disability pension Ivan has to be on sick leave for at least a few months. Because he suffered direct physical injuries, and is experiencing emotional distress that is a consequence of his participation in the “defense of the sovereignty” of the Republic of Croatia (*obrana Republike Hrvatske*), he might satisfy the requirements for a 100 percent increase of his earnings, that is on top of the wage (or pension) that he is already receiving.

A family doctor or a GP refers Ivan to a specialist experts’ commission that will determine if his physical or mental injuries are a consequence of the Homeland War. Ivan will have to visit the commission every month for six months before receiving a “decision of the first instance” (*prvostupanjsko rješenje*). After he receives the first decision, the experts will send him to the Ministry of Defense of the Republic of Croatia

(*Ministarstvo obrane Republike Hrvatske – MORH*). Individuals who are not veterans of the Homeland War will be referred to the Croatian Pension Insurance Institute (*Hrvatski zavod za mirovinsko osiguranje – HZZMO*).

The Experts' commission at the Ministry of Defense determines which percentage of Ivan's disability was caused by his participation in the war and issues a "decision of the second instance" (*drugostupanjsko rješenje*).

If Ivan's claim had been assessed as a 100 percent disability, he would be granted with a full disability pension and would not have to take his claim any further, except to determine the exact amount of the compensation he would be entitled to receive based on his rank and military unit. However, Ivan's claim had been assessed so that 50 percent of his disability was legally recognized as caused by his exposure to the war and he received a certificate proving his "limited work ability" (*ograničena radna sposobnost*). Ivan is now expected to seek help from a job placement service at MORH (Ministry of Defense) that should find him a work placement that will match his level of education and his new work ability.

However, Ivan is not satisfied with the decision and he decides to file an appeal to the decision of the experts' commission at MORH. His case is forwarded to a higher commission that will reassess his work ability. Once Ivan's disability, or "limited work ability" is increased, he has to take his files to the Croatian Pension and Invalidity Insurance Fund (*Ministarstvo invalidskog osiguranja Republike Hrvatske – MIORH*). Another commission reassesses the claim and determines that Ivan may not be able to work at all. Once the percentage of disability has been established, the files are sent to the

National Centre for Psychotrauma in Zagreb. Here, members of another experts' commission will separate the percentage of Ivan's disability caused by his participation in the defense of the sovereignty of the Republic of Croatia from the percentage of disability that was not caused by the war. Veterans distinguish the two as war pension (*ratna mirovina*) and civilian pension (*civilna mirovina*). After Ivan's disability was reassessed and increased to 100 percent, his file is sent back to the Croatian Pension and Invalidity Insurance Fund (MIORH) and he will start receiving a 50 percent increase on his pension.

For most people, the appeal process lasts approximately three years. Furthermore, based on the 2005 Law on the Rights of Croatian War Veterans, all war-related claims to disability pension based on PTSD diagnosis have to undergo a process of revision. In the meantime, psychiatrists are predicting the appearance of secondary trauma among the families of people who are now diagnosed with PTSD.

“Trauma” materialized

It appears that at the same time as regulatory bodies of the Croatian health care and pension insurance system redefine the identities of Croatian war veterans through medicolegal validation of their psychological conditions, individuals adopt a “victimized identity” that is further sustained through different forms of state provisioning (Antze and Lambek 1996:vii). In the process, psychiatric explanations act as both a major catalyst in the diagnostic spread of PTSD and a transformative force that shapes local ideas about

what constitutes a healthy individual and how national health systems should be organized. Through their involvement in the design and operation of formal systems of psychosocial support, local psychiatrists actively (re) define the categories of state beneficiaries and allow for a creation of a new class of traumatized Croatian citizen.

Summary

In this chapter, I outlined some of the processes that have allowed for the introduction of PTSD into Croatian psychiatry, as well as contributed to its expansion outside of the clinical setting. I also describe some of the events that are particular to the Croatian postsocialist experience with PTSD as well as reflecting some of the larger ideological and social transformations that are common to most other postsocialist states. In the next chapter, I analyse the contents of my interviews with the medical staff at the Clinic in Zagreb, Croatia in order to explore what constitutes PTSD according to those who are directly involved in treatment programs.

Chapter Five

Specialists' Views

Understanding is about more than truth, since when we speak of understanding, we do not merely signal the presence of an abstract quality; we offer specific content, statements about the world as experienced, whether direct or reported.

Johannes Fabian (1995:41)

In this chapter, I engage in a thematic content analysis of the interviews in which medical staff at the Clinic shared their views about what constitutes PTSD in the Croatian psychiatry. The themes that I identified through analysis of the interviews reflect some of the most common ideas about PTSD that continuously emerged during my research at the Clinic.

An investigation of similarities and differences in people's perceptions about the role of PTSD in the lives of individual sufferers and its place in Croatian psychiatry will expose the symbolic domain that constitutes the Croatian post-conflict experience of PTSD. In the final analysis, these personal accounts will serve to map different ways in which the need for institutional treatment of war-related trauma was introduced and channeled through different institutions of Croatian healthcare, as well as reveal the processes in which ideas about the effective treatment of PTSD are reproduced, transformed, and resisted by individual medical practitioners.

Medical staff

During my stay at the Clinic, I observed daily interactions between the medical staff and attended some of the therapy sessions, as well as recorded ten semi-structured interviews. The people who volunteered for interviews have various positions within the Clinic. The ten consisted of five psychiatrists, one of whom is also a Clinic administrator with direct input in the design of treatment programs, two medical nurses, two occupational therapists, and a resident student. The interviews from these individuals form the core part of my research as they have different roles and experiences with PTSD and are directly contributing to the organization of treatment programs.

Their responsibilities range from participating in daily operations in the psychiatric unit, attending to people diagnosed with PTSD and other psychiatric disorders, to organizing and participating in different therapy sessions and providing administrative support. The ten of them are of different age, gender, class and status depending on their professional rank within the Clinic.²³ Five of them have been active within the Clinic for over twenty years, and three were present since the first treatment programs for people diagnosed with PTSD were introduced to Croatian psychiatry. All except one were present in the Clinic during the war and some were active within the military during the war, which means that they were working at the site when increasing numbers of persons were diagnosed with PTSD. All participants come from middle to

²³ Most of them moved to Zagreb from other parts of Croatia during late 1980s after completing their university degrees and all of them are proud of their active support of the Croatian military during the Homeland War. In terms of the professional rank, the roles of the persons who work at the inpatient ward are generally regarded as more prestigious from those of staff who work at the psychiatric dispensary.

higher class backgrounds and define themselves as Croatian. Each interview lasted for approximately one hour. Out of the ten interviews, I audio-recorded seven and, at the request of three individuals, recorded the rest by hand.

Generating themes

My analysis entails the task of locating and interpreting the use of common themes and the diversity of meanings attached to PTSD. Following Ryan and Bernard (2003:87-88), I regard themes as abstract constructs that link particular expressions about what constitutes PTSD in the context of Croatian psychiatry. In order to organize expressions into meaningful categories and generate themes, I performed three levels of analysis: (1) identifying expressions about PTSD in each of the ten interviews, (2) creating meaningful categories and comparing the appearance of patterns across interviews, and (3) generating and interpreting the use of common themes.

First, I identified key expressions about PTSD in each interview. For example, I marked expressions in which medical staff recalled their “first experience [with PTSD]”, used medical terms such as “reaction to stress” and “psychological trauma”, or talked about various administrative challenges and constraints in the process of diagnosis and treatment. Next, I created categories, such as “novelty [of PTSD]”, “social disorder”, and “objective existence”. Finally, I considered both the general temporal trajectory in which clusters of expressions were used to describe the experiences of medical staff and how these reflected the use of common themes about the Croatian experience with PTSD. At

this stage I excluded individual expressions about hardships and suffering of medical professionals during the war, such as references to intimate recollections of specific battles. Although some of these accounts revealed conflicting ideas about what constitutes individual resilience at times of war, the highly personal nature of these stories would reveal the identities of persons who participated in the interviews. In the last step of my thematic content analysis I was guided by the principle that generating themes is not a simple manipulation of data through coding and sorting, but an “imaginative work of interpretation” (Coffey and Atkinson 1996:6). In this way, I could situate the expressions about PTSD that were shared during interviews against the backdrop of my own fieldwork experiences and observations at the Clinic.

The one broad question that I would ask at the beginning of each interview was a variation of: “What is PTSD in Croatia?” From there, I would follow the natural progression of the conversation and at times I would ask for clarification of certain points.

On the whole, most of the interviews follow a similar course in which the medical staff first share their experiences with war-related trauma as they experienced it at the beginning of the Homeland War and then move to a discussion about the appearance of PTSD during the war, and its post-conflict expansion, both in terms of the increase in the number of diagnoses and the effect this had on their work in psychiatry. All of the medical staff expressed concern about the political appropriation of PTSD outside of their clinical setting and how this might affect the lives of people diagnosed with the disorder and the medical staff’s future work in psychiatry.

PTSD as a new addition to Croatian psychiatry

The relative novelty of PTSD is often evoked at the Clinic, as well as outside of the clinical setting. The medical staff frequently shared stories about its recent arrival and rapid transformation into a common diagnostic entity within Croatian psychiatry and expressed how they were quick to respond to the rapidly emerging need for the protection of people exposed to effects of the Homeland War. However, according to the following excerpt, although theoretical knowledge about PTSD existed before the war, Croatian psychiatrists seldom used it as part of their official diagnostic inventory.

GD: What is PTSD in Croatia?

Dr. DT: It is what everybody says it is. We were always talking about PTSD as some sort of exotic disease in our specialist exams. It was something sporadic, something that appeared only occasionally, but always in some extraordinary situations. There were traumatic experiences, but it was very rarely diagnosed until 1991; that is end of 1991 and beginning of 1992. In fact, during 1991 we used to diagnose a certain reactionary state, and we started using PTSD only later. That is, this diagnosis was brought into Croatia only later (Psychiatrist/male/45).

GD: But, it did exist?

Dr. DT: It existed only in the fine print of our theory books. We had this entity in our textbooks of clinical psychiatry, but this was something that never appeared in real life (Psychiatrist/male/45).

In order to describe PTSD, Dr. DT uses phrases such as “exotic disease”, that was “sporadic” and “rare”, appearing in “extraordinary situations” that “existed only in the fine print of our theory books”. These expressions reaffirm the theme about the sudden appearance of PTSD, which although present in specialist manuals and textbooks, was rarely diagnosed until after it was “brought in” to Croatian psychiatry during the war. This account confirms the widely held assumption in psychiatry that PTSD is a timeless disorder, or an “always-already-there” object in the physical world, independent of the diagnostic category (Scott 1990:245; Young 1995:5). The excerpt also suggests that what was once regarded as exotic and extraordinary, or a form of “reactionary state” by the psychiatric community in Croatia is now already an objectified form of knowledge normalized into the clinical discourse as a normal “traumatic” reaction to war. Dr. DT’s opening remark that “PTSD is what everybody says it is” hints that the disorder expanded outside of the confines of the clinical setting and that it already means different things to different people.

Adapting to war and post-conflict conditions

One of the most commonly occurring themes in all of the interviews was the successful adaptation of the local medical staff to the challenges of the war and rapid transformations in the clinical setting during the post-conflict period. PTSD is crucial to this experience and most individuals remember the arrival of the first “cases” to the Clinic.

GD: What was your first experience with PTSD in Croatia?

Ms. SA: I still remember our first case. He was a Croat from Serbia. He had some Hungarian last name. He was hungry and completely exhausted when he came in. You know, the military was very disorganized at the time. So, this was my first contact with someone who would later be diagnosed with PTSD. [During 1991 and 1992] we didn't call it PTSD yet. Everything was different then – we talked about some reactions to stress, but not about PTSD diagnosis (Occupational Therapist/female/50).

Ms. SA's recollection of the "first case" as a soldier who is a Croat from Serbia with a Hungarian last name is significant for at least two reasons. First, her assumption that this person is Croatian, although she recognizes the possibility of his mixed ethnic origin, points to the customary inclination to attribute PTSD to people of Croatian ethnicity. Second, although the war in Croatia is often described as "ethnic conflict", Ms. SA's statement is of one of the very few instances in which people of other ethnic groups were mentioned in connection to PTSD. For instance, during my entire stay at the Clinic, Serbs were mentioned only twice: one time in relation to a conflict between a war veteran diagnosed with PTSD and another patient who was listening to Serbian pop-folk music, and another time when one of the psychiatrists confided in me about his disappointment that one of his Serbian colleagues, his friend and one of the senior medical nurses at the Clinic left the place during the war without ever saying goodbye.

Ms. SA also remembers that the soldier was hungry and that he showed signs of exhaustion and makes the point that this was the person that would only later be diagnosed with PTSD. At the time, however, the medical staff at the Clinic would be

discussing these signs in relation to “some reaction to stress” and would not be making a customary connection to PTSD. Her comment that certain signs that were once explained as reactions to stress would presently be regarded as symptoms of PTSD, points to the importance of the disorder’s retrospective chronology – a quality which allows PTSD to be retroactively attributed to people and events that happened even before it was established as a part of the psychiatric discourse.

In his answer to the same question, Dr. TE remembered how at the beginning of the war there were only a few psychiatrists who could diagnose people with PTSD:

Dr. TE: Back in 1991 we had fewer psychiatrists. There were only two or three doctors checking people for PTSD. Soon we had all these conferences and trainings and today everybody is doing it. [...] During and just after the war, we used to record “comorbidity” much more often. Later on PTSD was used much more frequently (Psychiatrist/male/40).

Dr. TE also reveals that there was a rather rapid shift in how frequently PTSD was diagnosed. In fact, according to him, the increase in the diagnosis of PTSD is linked directly to the increase in the number of workshops that were organized for the medical staff at the site. His statement that before PTSD gained popularity, psychiatrists more often used “comorbidity” which may signal the appearance of a constellation of symptoms that was not recognized before the war. However, it also underscores the inclination to subsume a number of symptoms and otherwise discrete mental disorders within the psychiatric category of PTSD.

In most interviews, the medical staff reflected on specific battles of the Homeland War as crucial events that precipitated the appearance of PTSD and that acted as catalysts for later transformations in Croatian psychiatry.

Mr. DA: Patients started coming here since the fall of Vukovar in 1992. I have been working here for twenty years. I have been observing this [PTSD] since it first happened. I was also a participant in the war. Back then we knew very little about it. We heard about some “Vietnam syndrome”, but we never dealt with it here. After the Second World War, maybe they did not deal with it either since we have no information about it. Then it started after the fall of Vukovar. The first people from Vukovar who were coming to this Clinic were coming to this department. Our work here was very different until then (Occupational Therapist/male/45).

Although he was working at the Clinic for twenty years, Mr. DA states that he and his colleagues knew very little about PTSD other than it had a connection to the Vietnam War. In contrast to other medical staff, in this instance Mr. DA questions the disorder’s historical continuity since he has no knowledge about its appearance after the Second World War. At the same time, he recalls a specific traumatic event after which the numbers of people seeking psychiatric treatments at the Clinic greatly increased. The event that is most often used as a reference point in this regard is the battle for Vukovar, a town in Eastern Croatia that was under siege for over four months in November of 1991. During that time, the town was reduced to rubble and finally taken over by local Serbs and the Yugoslav People’s Army (*Jugoslovenska narodna armija – JNA*). After the siege many people were killed including some 200 civilians and soldiers who were taken from

the local clinical centre and killed by Serb militia (Sohn 2003:22). This event had a profound demoralizing effect on the Croatian military and “the fall of Vukovar” continues to serve as one the nation’s major sites of “chosen trauma” (Volkan 2001:87).

[No] need for training

During and after the Homeland War several international organizations promoted the development of psychosocial programs in Croatia (see chapter 4, page 52). Most of the persons who participated in my interviews attended some of the workshops and training programs that were organized at the Clinic. Still, almost all of them claim that they acquired most of their knowledge about PTSD “on the ground” while working with their patients and some claim they had no training at all:

GD: What kind of training did you have about PTSD?

Ms. SA: We had no training about this except from what we could find out for ourselves and then we learned about it as we went along, from our own mistakes (Occupational Therapist/female/50).

During one of our informal conversations that took place before this interview, Ms. SA told me that not all departments and therapy programs receive equal support from the Clinic administrators and that she does everything that she can to run her therapy groups with minimal financial and educational support. Although her statement is context dependent, it represents an exception to the claim that emphasis on credentials is one of

the defining characteristics of the clinical world (Miller and Crabtree 1993:296). However, her statement could also be read as a way to augment her personal dedication to provide for the patients with little or no assistance from the administrators.

A similar view was expressed by Dr. SR who participated in one of the first workshops about war related psychotrauma that was organized for the medical staff at the Clinic:

Dr. SR: In 1992 or 1993 we had a visit from a Dutch specialist who was the first to introduce this new idea [about treatment of psychotrauma] to our clinical setting. This was of course happening at the height of the war. At the time all major cities in Croatia were shelled daily and we had a lot of patients to deal with. Personally, I also had to take care of my young child. This was the situation that pretty much all of my colleagues experienced and were affected by. One of my colleagues came in with the Dutch specialist and this person was brought in to share her experiences and views and to introduce this Western institutional discourse and a “proper and experienced” [she makes the quotation signs with her fingers] way (*pravi i isprobani način*) of dealing with psychotrauma. This lasted for several days. We had workshops and discussion groups and most of the staff participated at some point during those several days although we were very busy with other things. On the last day, she decided to finalize her presentation and asked everyone who was present in the room, all the local staff, nurses and psychiatrists, to form a circle. Then she asked us to join our hands and think positive thoughts as to emit some sort of collective positive energy. This part was the culmination of my frustration. Please don’t get me wrong; I am thankful to my Dutch colleague for her effort and for coming here to help us at the height of the war. But I was, and I still feel this way, deeply offended by this act. This was completely inappropriate (*neprijemno*) for this situation. There we were, a room

full of psychiatrists – people who were dealing with war and fear on a daily basis. Lives were lost on a daily basis at the time and this was just not the way to deal with it. I could hear some people chuckle and laugh behind her back, but they tried to keep their appearance as professionals anyway just so they would not offend her. But, I can tell you, people still remember and talk about that event to this day (Psychiatrist/female/50).

Dr. SR's highly personal account about her experience with one of the workshops offers several important insights that are reflective of the general attitude among the medical professionals at the Clinic. Dr. SR's is at the same time welcoming the idea of foreign professionals running educational programs for the local medical staff, but also appears to be skeptical about the efficacy of what she calls "'Western' ... proper and experienced ways of dealing with psychotrauma." Her doubt about the positive outcome of this workshop was strengthened with what she recognized as a "completely inappropriate" behavior of her Dutch colleague. This was all happening at the time when the medical staff at the Clinic was under heavy pressure from both working with large numbers of patients affected by the war, as well as trying to live their civilian lives and take care of their families. However, over the years the event has been normalized into the discourse and has become a form of unofficial oral history of the Clinic that is readily remembered by Dr. SR and her colleagues.

Working with PTSD patients

Over a decade after the initial introduction of PTSD in Croatian psychiatry, the medical staff at the Clinic who participated in the interviews expressed a concern about not being in control of the disorder.

GD: How is it to work with people diagnosed with PTSD?

Ms. SA: There were pleasant experiences. Usually like, well... ha, PTSD... it's hard, it's hard to work with them and especially because I am not really educated in this field.

GD: But you have a lot of experience...

Ms. SA: After all these years, I guess all of us are already exhausted, so it's easy to generalize where this is not necessary. But, when I work with them... as you have seen in our group we have many people suffering from PTSD. Over the last two years, especially when all this with pensions had started, the number of people with PTSD has greatly increased. In this process they have to go through psychiatry if they want their rights to be recognized. (Occupational Therapist/female/50).

Although she expressed a concern about her lack of education making it harder to work with people diagnosed with PTSD, the underlying problem appears to be the increasing numbers of patients who, in the process of compensation seeking, have to undergo psychiatric examination. Dr. DT expressed a similar concern about this situation:

Dr. DT: Some of us, I think, are slowly giving up and there will be even less interest for treating these people. In some way, everybody thinks: “if society does not care why would I have to care.” I don’t think that everybody feels this way just yet, but I do hear some signs of that sort of perception. You work, work, work and you don’t get any results or you can’t even get near any results, you can’t cure anyone... I feel very bad – and everyone know this – when I see that I can’t do anything for my patient, and if I do attempt to make some progress, he will lose this minimum of welfare that he receives – those 1,000 or 1,200 Kuna of compensation that he gets for his illness. This is basically all that he has to survive. And he can’t get a job because he is an ex-soldier, veteran who is *crazy* and *aggressive* (*lud i agresivan*; his emphasis) and nobody wants to employ him (Psychiatrist/male/45).

Dr. DT’s statement that everyone knows about his dissatisfaction with the limits that are placed on the work of psychiatrists is significant because it points to a possibility that not all of his colleagues are ready to voice their concerns about their role in the processing of claims for social assistance. At the same time, he makes a direct link between therapy success and the delivery of social assistance by making a claim that the psychiatric diagnosis is sometimes the only guarantee that a person will receive the minimum compensation.

“Real” versus “fake” PTSD

The theme of malingering was often discussed at the Clinic. Although the medical staff would usually start answering my inquiries into this subject with laughter, and

lightheartedly suggest that I should first switch off my tape recorder, most of them would readily and vocally share their opinions about this matter.

GD: I heard a lot of talk about real versus fake PTSD, what do you think about that?

Nurse MA: I can smell them [the real PTSD patients].

GD: How is that?

Nurse MA: The real ones have something about them... some kind of recognizable something that is different from the rest (Nurse/female/50.)

Although she had no rational explanation how tell the difference between what constitutes “real” and what makes “fake” PTSD, GS expressed a similar ability:

GS: Oh, that is such a touchy subject [laughs]. That is purely subjective. Sometimes I start holding to that thought and I think to myself “this is not it”. So, I come to this conclusion because of a patient’s behavior. [...] There is something that you could call, transferable vibes. Of course, you come to this conclusion through conversations and everything together, but that doesn’t need to be correct (Occupational Therapist/female/50).

GD: Do patients think the same?

GS: Oh yes, they certainly do. There were even occasions when they fought about this, but then we would cover it up somehow. Even during the group meetings. [...] Sometimes if the discussion went too far, they would start pointing fingers and accusing each other and saying, “Where were you in this and that battle;

while I was fighting you were hiding in the rear and peeling potatoes.” Things like that would make all of them, and us look bad. However, I should say that most of the patients here are “returnees” (*povratnici*). You probably know that all of the deadlines for submission of all of those claims for their benefits have passed, but in the meantime all these revisions have started. Although, I said, there are those, as far as I know, who come here even though they have no material benefit from that. In fact, right now we have one patient who has nothing to gain from coming here, but he does come because he really does not feel well – he is experiencing all those symptoms that come with this disorder (Occupational Therapist/female/50).

Although GS regards her assumptions about what constitutes the “real” PTSD as “purely subjective, she nevertheless does not discount what she views as her personal capability to read the signs of the “vibe transfer” with her patients. In her experience, patients make the same judgments and sometimes even make attempts to exaggerate their suffering in relation to the suffering of other patients, which sometimes leads to confrontation. She also notes that most of the patients at the Clinic are “returnees”, or persons who are back at the site because they have to undergo a process of re-evaluation in order to keep their disability benefits.

In a similar way, Mr. DA also supports the claim about the existence of real and false PTSD patients, but he also brings forward several important points about organizational transformations in the Clinic that were caused by the rise in the number of persons diagnosed with PTSD. Furthermore he hints that there is a possibility that in the future persons who exhibit symptoms of PTSD might be diagnosed with depression:

Mr. DA: Some people were susceptible, or as we would say, had a “predisposition” for developing a psychological disease, but there was also a lot of simulating of PTSD [giggles]. As for that real PTSD, a doctor could learn about it through a sustained observation of the patient. And it was normal that, as the time went on and as those benefits were becoming more attractive to former fighters, then a lot of things started to happen – simulating of PTSD, and this and that. There were patients – that is, PTSD patients (*PTSP-ovci*) – who really went through all those horrors of the war and who felt a need to visit doctors during all those years. In reality, this department was organized in a different way and we were not supposed to treat real PTSD patients. We have a closed men’s and women’s section and they [PTSD patients] would come here when they were already in some way re-socialized. That is, we would get those mild cases. However, later we did start getting real PTSD cases; in reality this started because of the need to attend to increasing numbers of patients and because of the need to process their claims for benefits, which they get through that PTSD diagnosis. I am saying, not everything is the way it should be. Now, ten or fifteen years after the war new patients are still coming. The only difference is that now the law is organized in such a way that a person who did not begin with their treatment until the 1st of January 2006 cannot get that PTSD diagnosis, but he can be diagnosed with depression. There you go, now PTSD equals depression (Male/Occupational Therapist/40).

Mr. DA supports the view that “real” PTSD can be detected through close and sustained psychiatric observation (Kozarić-Kovačić 2005:197). Furthermore, he suggests that those patients who regularly visit the Clinic for longer periods of time are more likely to be suffering from real PTSD. He also mentions that his department at the Clinic was not meant to provide treatments for the persons diagnosed with PTSD and that the real reason for the introduction of therapies for people with PTSD was the increase in the

need for processing of veterans' disability claims. From my conversations with other medical staff, I learned that this is not entirely correct, primarily because the department is designed to provide therapy programs for persons diagnosed with a range of different mental disorders, including PTSD. However, everyone I spoke to agrees that the number of PTSD patients increased much more than what anyone had anticipated placing a serious strain on the effective delivery of programs for patients suffering from other mental disorders.

Mr. DA also speculates that since the new law was put into effect which prevents individuals from being diagnosed with PTSD if they already have not started with their therapy before a certain date, the diagnosis of PTSD will be replaced with the diagnosis of depression. His statement is misleading and not entirely accurate since people can still be diagnosed with PTSD, although not in connection to their involvement in the Homeland War. This means that those persons diagnosed with PTSD after the legal deadline can no longer file claims for war-related disability compensation. However, since depression, together with substance abuse and personality disorders have the highest rate of comorbidity with PTSD (Folengović-Šmalc 2000:43), his assumption about a rise in the number of diagnoses of depression might prove to be accurate. However, in my view, it is highly unlikely that depression will simply "replace" the diagnosis of PTSD.

Searching for the “cure”

In reflecting about their experiences in their work with persons diagnosed with PTSD, the medical staff revealed a crucial tension between the clinical delivery of different therapies and the possibility for a social recovery outside of the clinical setting. Although most of the medical staff continues to search for “trauma” within the individual, in search for the “cure” they acknowledge the importance of directing their gaze to the social environment.

GD: Is it possible to cure people from PTSD?

Ms. SA: [Laughs] I don't know that. I would prefer not to make any comments about that. [...] That you can work with them, and that they can feel better, that is certainly true. But this should not be happening only here. I mean at the Clinic they are all protected – not only those with PTSD, but everybody. This is especially true at our department where everyone is so actively involved in the treatments and where we are all connected. Well... but what can they do once they are out? They are once again facing all those frustrations of theirs, their problems. While they are here, they are functioning, more or less, just fine (Occupational Therapist/female/50).

Dr. TE: I would say that a large number of people couldn't be cured from PTSD.

GD: Why?

Dr. TE: Psychiatric treatment alone is not enough. You need some support from the environment in which the person is living. If there is no such support then we

have a problem. For example these days there are many armed robberies. If a person is a witness of something like that his employer may react in different ways. [...] A positive response would be to tell the employee to go talk to a psychiatrist, neutral response would be to tell him to take a sick-leave, negative way would be if they just told him “go back to work, you are fine” (Psychiatrist/male/40).

In response to my question whether it is possible to cure people from PTSD, Dr. DT follows the same logic as Dr. TE arguing for the transfer from a victim-centered focus on trauma to the focus on alleviation of social problems. What is more, he brings to the fore the important issue of existential and moral challenges that individuals face in a society that at the same time offers a form of gratification through financial compensation, as well as denies individual wartime experiences. I present his reflections in their entirety.

Dr. DT: [Laughs] it is certain that the traumatic experience will stay. [...] Some women who survived the trauma of rape may function in certain ways, but their experience will always stay with them. Traumatic experience is like a black hole that stays imprinted in us and it always puts a break to our psychological energy. We can develop some reparation mechanisms and function in a, more or less, sustained way, but this trace remains recorded somewhere inside us. You can go into a good remission, good functioning, however, what usually happens – and this is in a way a social critique – is that we do not provide adequate social support so that the person can function adequately.

GD: What does this mean in the context of Croatian psychiatry?

If they [PTSD patients] don't have a job, if they don't have normal life conditions, than we cannot expect that they will reach a level of a relatively adequate functioning. If they have a no place to go back to, if they have nothing to live off, if their family structure is damaged because of this extended leave of several years, then we can't expect that they will reach that possibility of a full recovery. There will always exist a possibility for a new re-traumatization. [...] Actually, the way I see it, there are two levels of messages here. On the one hand, in the beginning, during 1990s, [PTSD] was favored, but not its symptoms. Croatian soldiers who defended the country experienced some form of gratification – that they are worth something, that they have done something, fought; that they have invested themselves emotionally, psychologically and physically. Then, on the other end, the symptoms and psychological problems started to appear – which is normal. Next, the negative messages appeared: Croatian soldiers cannot have PTSD because they are defending something priceless, positive. Because they are defending their homeland they cannot have PTSD. This message was even backed up by some important political figures – Croats have a genetic predisposition, or structure which makes them immune to PTSD. On the one hand the soldiers are being gratified, and on the other they are very much stigmatized.

GD: What kind of effects did this have on your work in psychiatry?

Dr. DT: Both of those messages affected us in a negative way. Psychiatry is not defined with only pharmacology and medical treatments, but it has much wider implications. Protection of health is what I understand to be its purpose. Protection of mental health does not involve only the treatment of visible symptoms, but it is supposed to secure – and this is the primary definition of health according to the World Health Organization – a level of social well being

(*socijalno blagostanje*). I think that the role of psychiatrists is to point to those social problems. We found ourselves with a dilemma: on the one hand we had to and wanted to treat these patients – that was certainly necessary – and on the other hand we were in a very delicate situation. [...] We were asking ourselves “Am I allowed to cure them? What will happen if I cure them? He has no place to go back to. His basic needs are not satisfied. He will lose his welfare that he was receiving until now.” The patients who are cured lose that *economic status* (*ekonomski status*; his emphasis) and are left without anything. We found ourselves in a situation that, as far as I see it, we could not cure those patients. This is a very ungrateful position for a psychiatrist (Psychiatrist/male/45).

In addition to his reflections about the challenge of patients’ re-adjustment from a protected life at the Clinic to a life outside the institutional setting, Dr. DT shares a number of details about the politicization of PTSD and Croatian psychiatry in general. He quotes the WHO definition of health, while pointing to a range of social problems, which prevent his patients from achieving that proposed level of well being. Therefore, in his view, at the present time psychiatrists in Croatia can only cure their patients if they make sure to validate their need for compensation.

Postsocialist challenges in Croatian psychiatry

In the following set of excerpts the medical staff reflect on what they view as major challenges in Croatian psychiatry, and more specifically, what they regard as the main problems with treatment of people diagnosed with PTSD. Although this question could have been approached from many different aspects, most of them made a connection to

postsocialist transformations in Croatia as the main reason for the challenges faced by local medical professionals.

GD: Where do you see the main problems with treatment of people with PTSD?

Nurse BK: The problem started from above [points her finger upward]. No, I don't mean from God [laughs], but the Ministry of Health. They did not know where to place all those people who could not return to their pre-war jobs. Industry was put to a halt, and the whole system was in a state of collapse. Instead of making attempts to re-socialize people and give them jobs as soon as possible, efforts were concentrated on keeping them in check through the Ministry of Health. Put them into treatment and when the need arises, use them as parts of the system in the official political rhetoric of the new state. Once the cycle started, there was no turning back anymore. [...] These individuals were not patients who needed medical attention – at least not as much as administrative attention – and they soon became both assets and a burden to our health care system. [...] This entire problem was right at the beginning turned into a social and political one. This resulted in psychiatrists not having the tools to work with because how can you diagnose, treat, and cure someone who had a different agenda on their mind – an agenda that will succeed only if the person is not and cannot be cured – the underlying goal, of course, being compensation. This doesn't mean that there are no people out there who suffer from real PTSD. But, the real cure for a majority of people who are actually not real sufferers is to give them jobs of some sort. They have to function in a social setting that will require some creative effort for survival. Giving them pensions and forcing them to remain in constant check only deepens their alienation and constant reliving of traumatic episodes and strengthens their role as medical subjects (Nurse/female/35).

Dr. DT: I just had a visit from one of my patients suffering from heavy PTSD (*teški PTSP*). Together with some of his friends from some veterans' club he leased a plot of land and now they are building a fish tank. They go there and stay there for two or three days and then they go back home. This is something like a transition period for them. They are doing something, they feel useful, they are making some money and with all of this they are fighting off some of their symptoms. Unfortunately, cases like this are not heard about in our society. For instance, someone will decide not to help them with water for the tank, then there are some legal regulations that will prevent them from using this lake and some ministry that will not help them must approve this. Our society is re-traumatizing these men. They bought this land together using their own money, built a road, they were proactive and now they received some paper saying that they don't have the right to fill this tank with their fish. What can you say to this? I mean, it's absurd, but they can't solve this legally. This is re-traumatizing for them, it's pulling them back, they are again dissatisfied and their "hysterical" symptoms [his emphasis] are coming back. They are aggressive again. One of them said that the best thing to do is to throw a bomb over there. OK, fine, I have to admit that I am not a law expert; I am not a lawyer, so I don't know these [administrative] things. Still, all this seems pretty absurd to me that these formal matters cannot be easily solved (Psychiatrist/male/45)

Dr. MT: After the war attempts were made to solve the problem of soldiers. People were receiving loans to start businesses. The process of de-nationalization of state enterprises, or privatization, started in 1992. While some people were dying in the battlefields others were buying companies. The war ended and Croatian people were left with a huge emotional charge; now you are your own person on your own turf (*sad si svoj na svome*) – now you have your state²⁴, but

²⁴ TB's use of this particular phrase is significant because it was commonly used as slogan during and after the Homeland War to evoke the nationalist ideal that all Croats were expected to strive for – to live in their own nation-state.

this powerful energy was not utilized in a positive way. People were losing their jobs, their company was gone, or large numbers of people had been laid off. Those who were fighting in the war were not laid off, instead they would return and start working, but not at their old job and their company would soon fail... Then the situation changed and suddenly all those people are not getting jobs. As soon as you would say that you were in the battlefield you would not get the job. As a result, a number of people who were not treated during the war started to hide their suffering. There are still cases of hidden PTSD (Psychiatrist/male/55).

All of the views expressed in the above excerpts show a considerable overlap in terms of what has become a (re) traumatizing experience and what is presently posing challenges to the work of medical professionals both inside and outside of their immediate clinical setting. All four express and reaffirm their concerns about the postsocialist market transformation, collapse of pre-war industries and the subsequent loss of jobs. Furthermore, Nurse BK argues that in these conditions PTSD was turned into a political entity and a tool of post-conflict governmentality. In the same way, Dr. DT and Dr. MT share concrete examples of what they consider to be signs of a worsening social attitude toward war veterans who because of this face new possibilities for re-traumatization.

In the following excerpt Dr. BR and Dr. TE share some of their views and experiences of how postsocialist transformations and government policies have effected their own work experiences.

Dr. BR: This [Clinic] does not follow trends and psychiatry is needlessly divided into different departments. Actually, the entire problem is not in all these

departments, but in the staff who are not interested in the exchange of ideas and collaboration. [...] This is the legacy of the old system in which people only worried how to keep their seats for themselves and were not trying to be pragmatic and to improve the existing treatment programs. The amount of paperwork is too big and therapeutic and administrative channels are too complicated and creating unnecessary trouble and stress for patients. The path to validating disability may last up to five years. You can imagine how much this aggravates the experiences of people who suffer from PTSD and who are already shying away from the system and are not receiving help because of its inefficiency (Psychiatrist/male/50).

Dr. BR evokes the image of the socialist past, or the “old system” to make his point about the inefficiency of the bureaucratic apparatus within psychiatry and health care in general, which he says is evident in the amount of paperwork and the length of the process of re-evaluations of PTSD claims.

Dr. TE forwards the same argument, but also reflects on some of the major legal changes that he views as crucial to people’s experience with PTSD:

Dr. TE: In the beginning every person who participated in the war and who reported psychological reactions [to the war] could be diagnosed with PTSD. Scientists now claim that PTSD could appear much later, even ten years later. Then the official end of the war in Croatia was set for the 31st of December 1995. According to this, the ten-year period lasts until the 31st of December 2005. Those people who filed their claims during this period could be diagnosed with PTSD. At this time, special commissions were formed with a task to provide expert opinions in cases of people suffering from PTSD and filing claims for the status of Croatian Disabled War Veteran (*Hrvatski ratni vojni invalid* – HRVI). During

2005 there were approximately 35,000 [claims]. This created an absurd situation in which people use this disorder to materialize their, human, military, or veterans' rights. It is understandable that people will want to be diagnosed with PTSD. People who experience even more stress; people who were tortured, and are diagnosed with chronic PTSD may result in a permanent personality change (*trajna promjena osobnosti* – TPO). However, it is important to note that people with TPO could get a 60% disability. Later this was changed and now they can get only a 40% disability – the same as people diagnosed with chronic PTSD. Many patients talk about this and say: “Doctors told me that this should be enough”. [...] There are five experts' teams of the first instance with five people each – they are psychiatrists, neurologists, urologists, etc. – and there are two or three experts' teams of second the instance with five people, psychiatrists. A person has to have a 20–40% PTSD diagnosis and go through all these steps to get his permanent disability. He has to do this three times. This means that, if there are 35,000 cases, which are then multiplied by three, there are in fact 105,000 cases that have to be death with. That's a lot of work and pressure. Not to mention how much this costs. [...] All of those experts' teams, each member is paid a lot of money for each check-up and all of them are interested to continue doing this. There are also extra teams being formed and all these people are financially better off from the rest of us (Psychiatrist/male/40).

Although not all of Dr. TE's figures are completely accurate, he points to not only how legal changes conditioned the increase in the number of PTSD diagnoses and the subsequent need for re-evaluations, but also to what he regards as an entire new class of Croatian psychiatrists emerging within this system.

Future of PTSD in Croatia

During one of my informal conversations with a nurse at the Clinic, she made a remark how in her view my project is very important, but that I should return to it after several years because then I will be able to see the “real” effects of the introduction of PTSD to Croatian psychiatry. She expressed a concern that current preoccupation with PTSD does not allow for a more sustained focus on other mental disorders that could soon pose new challenges to Croatian psychiatry. This view is also expressed in the following excerpts:

GD: How do you see the future of PTSD in Croatia?

Nurse MA: This situation in Croatia only obscures the real problems, which could become a real burden. I am thinking here of what will happen with the younger generation of people who were born during or just after the war. When my nephew was born he was physically a healthy baby and was developing normally. However, just recently he started wetting his bed. There is a whole generation of young people out there that grew up during the war, but were not fighting. Many of them are potential victims, but there is no systematic research done to help them. This is because all the effort – administrative, psychological, and medical is going toward the war veterans (Nurse/female/50).

Ms. NA: Among PTSD patients there are many people with personality disorders, depressive disorders, and many who probably should not have been diagnosed with PTSD. This is very hard to fix now and will cause new problems... Another problem is that there is not enough attention being paid to the role of secondary and tertiary traumatization (Resident Student/female/30).

The Croatian experience: what to do with it?

In all the interviews, the medical staff acknowledge the objective existence of PTSD and the importance of a common psychiatric diagnostic criteria. However, they also quickly turn to a discussion about the local political, economic, and social transformations as crucial factors in the understanding of what constitutes their experience with PTSD.

GD: Are there any similarities or differences between what may be described as western and Croatian experiences with PTSD?

Dr. DT: Diagnostic criteria are identical. We use ICD-10 and DSM-IV as the criteria and patients satisfy those criteria. But, another thing is the problem: what to do with it? When you see that a patient is getting better, can you sometimes verify that?; leave the diagnosis over there... floating in the air?; do you let it exist and turn into a chronic form, so that he does not lose that help? In this case you are really re-traumatizing [the patient]. When he loses his job he is again in an acutely stressful situation.

GD: Is it then safe to assume that this classification is not always applicable in the Croatian context?

Dr. DT: Yes, it is not always applicable. I visited one veterans' center in the US. Over there they have one isolated group, which does not really communicate with the outside world; they are drug users. Luckily we still don't really have this problem here; we don't have veterans' hospitals, so we don't separate them, we don't stigmatize them, we don't close them up in some special institutions.

GD: But you do have the centers for psychotrauma...

Dr. DT: In reality these are only diagnostic-therapy departments and they are within hospitals. They are not separate. The Ministry of Veterans in part finances them, but they are all parts of clinics and psychiatric departments, so they are not separate outside of hospitals, or outside of the system. In a way, if you ask me, this is good. One of my colleagues just returned from Israel and I can tell you that we are not like the Israeli model either. [...] They keep their jobs for [the soldiers] and if they sometimes can't function they find them part-time jobs and in this way they are bringing them back to their society. We are not there however. (Male/psychiatrist/45.)

This excerpt summarizes the common view among Croatian medical professionals about the similarities and differences between the local and international experience with PTSD. Dr. DT's view that the problem is not the diagnostic criteria but "what to do with it" was also expressed during an international conference on trauma studies that was hosted by local psychiatrists and which I attended at the beginning of my fieldwork. In one of the sessions in which several medical experts in the field of trauma presented on their experiences with PTSD in Croatia, as well as Israel, and the US, one of the Croatian psychiatrists who I spoke to after the session remarked how learning about all these different experiences is very important, but at the end everyone will go home thinking that they are doing the best possible thing.

Interviews re-visited

All the interviews contain themes about the introduction of PTSD to the discourse of Croatian psychiatry, which are linked with individual expressions that reaffirm the objective existence of PTSD. Moreover, they contain a degree of skepticism about the ways the treatment programs are organized, as well as critiques about the “politicization” of the psychiatric knowledge outside of the clinical setting. In addition, all themes are introduced following a certain temporal course from reproduction through transformation to resistance.

I regard “themes of reproduction” as stories containing a degree of approval of the psychiatric diagnostic criteria, which is usually expressed in accounts referring to the earlier phase of the introduction of PTSD at the time during and immediately after the Homeland War. This is the time when many soldiers (still not veterans) were for the first time seeking help from psychiatrists. At the same time most psychiatrists had no concrete experience with PTSD and very few were actively involved in the actual diagnosis.

As the system of psychosocial support was being rapidly institutionalized, and immediately following the war, increasing numbers of psychiatrists were becoming involved in the process of diagnosis and the operation of the formal systems of support. However, although the war had at this point officially ended, this is also when the effects of post-conflict and postsocialist transformations were beginning to take effect and the process of social, political, and economic “transition” started placing an increasing strain on the formal systems of social support. The role of psychiatrists was abruptly altered

during this period and PTSD was increasingly recognized as a “social disorder” that was pulled outside of the confines of psychiatric discourse and was becoming an instrument of political rhetoric. The “themes of transformation” typically refer to this time as the period that left a permanent imprint on what was to become a constitutive quality of the “Croatian experience” with PTSD. This is the point at which, as one of the psychiatrists described it during our interview, PTSD became a “social problem more than anything else”.

“Themes of resistance” are mostly expressed in the form of, to again borrow the phrase from Nancy Ries (1987:83) “litanies” of complaint, but also outright criticisms about PTSD. In these narratives, PTSD is evoked as a disorder that is masking the multiplicity of its causes, and as obscuring the potential spread of the more “real” and emerging problems, such as drug abuse among Croatian youth, the effects of inadequate care for the growing population of elderly people, as well as problems which are regarded as direct byproducts of PTSD in its present form – the secondary and tertiary traumatization of the families and friends of war veterans who are also presently suffering from PTSD.

Although all of these three themes are expressed to varying degrees and do not always follow the same trajectory, they are all connected with a repertoire of perceived needs of the population of Croatian war veterans and they all contain certain “themes of resistance”. However, this is not a form of resistance that is directed against what has been suggested as a possibility of malingering, or “false” suffering, – in fact all agree that veterans’ suffering is real and in need of psychiatric attention – rather, resistance is

directed at PTSD as a sign of systemic deficiencies. Medical professionals find themselves in an awkward position in which they are expected to help but feel powerless because of systemic barriers, such as inefficiencies with the state and health care apparatus, widespread corruption, as well as inadequate social support networks outside of the protective environment of the psychiatric Clinic.

Summary

In this chapter, I analyzed the contents of interviews with the medical staff at the Clinic and identified some of the major themes about what constitutes PTSD in the context of Croatian psychiatry. Finally, I put forward the argument that local medical staff, to varying degrees reproduce, transform, and resist dominant ideas about the effective treatment of PTSD.

In the chapter that follows, I re-visit the main premises that have guided this research and situate my findings in relation to my initial arguments.

Chapter Six

Conclusion: PTSD in Croatia Re-examined

When physicians dismiss illness because disease is absent, they fail to meet their social responsibility

Leon Eisenberg (1977:9)

In this final chapter, I return to my central arguments and research objectives that I laid out in the opening paragraphs and re-visit some of the most common themes from my fieldwork that have guided the course of this thesis. In conclusion, I argue that by accepting PTSD as a medically recognizable form of war-related political suffering, local medical professionals allow for the creation of a new kind of traumatized Croatian citizen (cf. Petryna 2002). In the process, medical experts, war veterans, and various government agencies engage in the discourse of “memoro-politics” (Hacking 1996:73) in which certain groups of people retain preferential access to social security resources and yet also depend on the terms of state provisioning.

In the preceding chapters, I explored how PTSD is constituted through the work of Croatian medical professionals and traced some of the ways in which local postsocialist political and economic transformations have contributed to its expansion. The course of my inquiry was directed by the three questions that I outlined in the introductory chapter: (1) how was the diagnostic category of PTSD and the need for institutional treatment of war-related psychological trauma introduced; (2) what are the

ways in which Croatian war veterans convey their war-related experience through the trauma discourse about PTSD; and (3) how are ideas about the effective treatment of PTSD reproduced, transformed, and resisted by individual medical practitioners. With these questions in mind, I have attempted to delineate some of the processes through which the idea of traumatic memory was introduced to Croatian psychiatry, as well as to trace the ways in which PTSD became a point of access to welfare resources for a large number of local war veterans. Against this backdrop and through the content analysis of my interviews with medical staff, I was seeking to expose some of the ideas about what constitutes PTSD in Croatian psychiatry from the point of view of persons who are directly involved in the organization and delivery of therapy programs.

PTSD in hindsight

The introduction of PTSD through international psychosocial programs precipitated a new form of governmentality in which attempts were made to present psychiatric knowledge as nonpolitical and in need of being spread through humanitarian intervention. Aihwa Ong (2006:3) describes this process as a “new mode of political optimization, neoliberalism – with a small *n* – that is reconfiguring relationships between governing and the governed, power and knowledge, and sovereignty and territoriality.” Post-conflict and postsocialist Croatia is a case in point in which this process was set into motion with the introduction of PTSD to the discourse of local psychiatry.

Many of the international psychosocial programs that were active in Croatia during and immediately after the Homeland War were soon replaced with a state-funded network of psychosocial support that was designed to:

...improve coordination, evaluation, supervision [and prevent] ineffective spending, uneven distribution of psychosocial programs in the country, overlapping between projects, paraprofessionals running many projects because mental health professionals did not have the approval by the health authorities, and lack of cultural adaptability of some organizations. (Kozarić-Kovačić, et al 2002:222)

In the meantime, PTSD became a new link between war-related traumas and the emerging discourses of human rights and civil society of the postsocialist Croatian state. After the end of the Homeland War, people were faced with large scale social political and ideological transformations and, to again use the words of one of the psychiatrists, “[they] were left with a huge emotional charge; you are your own person now, on your own turf (*sad si svoj na svome*) – now you have your state, but that powerful energy was not utilized in a positive way.” Under these conditions, for many Croatian war veterans PTSD diagnosis became a way to re-assert their privileged position in the relationship to the new state.

At the same time, the inclusion of PTSD into the context of Croatian psychiatry contributed to a change in the attitudes of medical professionals about what they view as their role in the social projects of the new Croatian state. All of the medical staff who took part in the interviews expressed various degrees of approval and skepticism about

the usefulness of PTSD and about how it is processed in the context of Croatian psychiatry. In this regard, I observed the constellation of expressions in the interviews as corresponding to three overlapping themes, which I termed as themes of reproduction, transformation, and resistance to PTSD.

Although skeptical about the possibilities for recovery, majority of Croatian medical professionals accept and *reproduce* the language of the psychiatric discourse by treating PTSD as a disorder that was “always-already-there” (Scott 1990:245; Young 1995:5). Furthermore, they regard their quick adoption of the PTSD discourse as a sign of their successful professional adaptation to the post-conflict increase in war-trauma and the challenges of postsocialist transformations.

However, although the new language of trauma opened up new possibilities for the exchange of ideas with their international colleagues, many of them question their ability to provide adequate help for people diagnosed with PTSD. For this they blame the lack of support outside of the immediate clinical setting. As PTSD became increasingly politicized, it underwent a *transformation* and it finally became, as one psychiatrist explained it “a social problem more than anything else.” During this process, the attitudes of most medical staff toward the disorder, the patients, and therapy programs were transformed as well.

Finally, several persons expressed concerns about a new threat emerging in the form of social disorders, such as drug abuse and secondary traumatization that are presently neglected by the Croatian medical community because of the exaggerated focus on PTSD. In fact, increasing numbers of Croatian medical professionals seem to express

a type of *resistance* to war-related PTSD, which they increasingly consider to be the moving force for what they describe as rising deficiencies in the system of care.

Future research: beyond war-related PTSD

As one of the medical staff at the Klinika suggested, processing of PTSD in the context of Croatian psychiatry and the meanings that people attach to it are bound to take a turn in the coming years. Part of the reason for this is the change in government policies that now prevents people from filing claims for war-related disability compensation. Future research would benefit from the exploration of emerging disorders in Croatian psychiatry that appear to be pushed on to the margins of the psychiatric gaze. A focus on disorders such as depression, personality disorders, and substance abuse, as well as the by-product of PTSD – “secondary traumatization” may expose new ways in which local medical professionals conceptualize disease and organize programs for treatment.

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