Specific Aspects of Group Work with Torture Victims

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Abstract

Psychotherapeutic work with torture victims is already challenging and demanding for the therapist; I believe this is particularly true in the situation of group therapy. In this case there are some specific aspects related to this particular group - its members had been connected with each other even before the formal establishing of the group for therapeutic purposes. Unfortunately, this connecting factor was their common and simultaneous traumatic experience of war, captivity, torture and life in a new community after exile. During 54 sessions, 27 men with various levels of vulnerability and initial position of "permanent helplessness" have through several phases of group work successfully dealt with their paranoid anxiety, established and developed cohesiveness and certain group culture, thereby ensuring their own path towards the phase of opening, working through fears for their own psychophysical integrity by way of hypochondriac elaborations, and finally mustered the strength to voluntarily face again the trauma and torture they had suffered. They have managed to re-incorporate these experiences through the re-integration phase and finally through termination to wind up and attribute the meaning to their emotional turbulences brought by therapy and its closure. Support in the psychotherapeutic work with this group was provided by psychologists from the Centre for Rehabilitation of Torture Victims - IAN Belgrade. By conducting psychological testing they have helped in the diagnostic exploration of these people, while two other important services in IAN - legal department and medical unit with internal medicine and neurology experts - also provided important contribution.

ESTABLISHING THE GROUP AND CHOICE OF PSYCHOTHERAPEUTIC TECHNIQUE

One of the groups established in the field within the scope of activities of the Centre for Rehabilitation of Torture Victims - IAN Belgrade was also the group of tortured people temporarily settled in the towns of Hrtkovci, Ruma and Platicevo. Most of the group members lived in Hrtkovci.

All group members have had the experience of psychophysical torture during captivity (in most cases in the town of Bihac, Bosnia, for the duration of at least three months). In the course of combat activities during the war in former Yugoslavia they were taken prisoners when they had surrendered after several days of being surrounded by Muslim army troops. Members of their unit who refused to surrender "were never seen again". This moment was particularly important for their future psychological dynamics. Similar to the phenomenon described in Vietnam veterans, the death of a close friend was not experienced as the loss of a close person, but as the loss of a part of self (through narcissistic identification). This type of identification deprives one of the memory or representation of the dead comrade and constitutes the basis of most unresolved pathological grieving among war veterans. It is connected to deep feelings of grief and guilt (Shatan, 1973). Van der Kolk (1987) states that soldiers with PTSD experience the death of a fellow soldier as a narcissistic injury rather than as an object loss. In other words, they see their fellow soldiers as an extension of themselves and not as separate individuals. This results in the need to avenge the death of a fellow soldier even though concrete action against the enemy. One of the key benefits of group psychotherapy is that it enables the participants to renounce such pathological identifications.

Most of the group members were located in Hrtkovci, since they had exchanged apartments and houses with its former Croatian inhabitants. All group members but one (N.T.) had their housing issue resolved. In addition to having been prisoners of war and subjected to various types of torture, some of them also had the experience of ill treatment by the Serbian police (MUP) and paramilitary units. Namely, after they had fled to Serbia as refugees, they were arrested, treated as traitors and forcibly sent back to the frontlines in Bosnia and Herzegovina and Croatia. Those who were handed over to the paramilitary unit in the town of Erdut were detained and subjected to psychophysical torture by their compatriots and subsequently transported to the frontlines. This fact added to the confusion of these people. Many years later, some of them were still unable to accept the reality of having been tortured by their own compatriots and this fact was frequently repeated content in the therapy of these people. Besides group therapy, many of them needed additional individual discussions about this problem.

The group consisted of 27 members, all men between 45 and 55 years of age. Fifteen of them comprised the core of the group. According to the CRTV principles, in addition to psychotherapy and classical psychiatric assistance, they were also provided with legal and medical aid. One of the specific aspects was that the group members could also

have individual sessions if they wished to discuss particularly traumatic or intimate contents, which they couldn't reveal before the group. Meetings were held once a week for one and a half hours. The group has worked for 18 months and held 54 sessions. After the completion of the group work, its members were left the possibility to occasionally contact the therapist and other IAN experts (psychiatrist, psychologist, internist, neurologist and lawyer) depending on their need.

Some of the characteristics that should not be disregarded have distinguished this group from the usual ones and made the work with it more delicate, complex and challenging. Firstly, the group members did not some to seek help by themselves, but the initiative to assist them came from the IAN expert team. This partly fuelled the above-mentioned suspiciousness, distrust and reluctance of all members. On the other hand, the fact that during first contact they were in a passive position has to a certain extent supported the tendencies towards tertiary gains, which could be a much stronger obstruction in therapy for this profile of clients than in the population of "usual" psychiatric clients. Consequently it was necessary for me as therapist to invest additional effort in identifying such tendencies, their elaboration and attempts to have the group overcome them. Secondly, the selection of the group members was not done through screening and assessment of vulnerability and capacity for psychotherapeutic group work. It could be expected that as therapist I would face group members with various levels of vulnerability, which made my work even more complex. Nevertheless, I did not see this as too big an obstacle and relied on assessing the acceptance of group work by each member of the group. There I took into account the possibility of excluding from the group a member that would be drastically different in terms of anxiety level or severity of psychopathology, with recommendation and referral to a more appropriate form of therapy (such as individual supportive psychotherapy and pharmacotherapy). This, however, was not necessary.

In order to portray a clearer picture of the group and the everyday functioning of these people, I would like to go back to some characteristics that make their lives, as well as the group dynamics, somewhat special. Namely, they were all connected by the same traumatic experience in the same time and space dimension - they have lived through it together and watched each other during ill treatment in Bihac and Erdut. Most of them were captured together, since they have surrendered to the enemy troops that had surrounded them. Finally they came to live in the same community after surviving many traumatic experiences brought by war, captivity and exile. All this has created a kind of cohesion among them, but this cohesion also hampered their communication with the outside world and made the group somewhat autistic. They found it difficult to allow new people and women into the group (there is not a single woman in the group, although I have said on several occasions that their family members may join in), as well as persons who did not have a direct torture experience or had been detained in another prison camp. This is the case of N.T. who had experienced most severe types of torture, but not with this group in Bihac or Erdut, but in Zagreb. In the beginning he was isolated, had difficulties in communicating with others, the group ignored him in a way, to which he contributed by being passive. It was only later in the individual interviews that he presented psychotic contents (interpretative and auditive-halucinatory) after which the group branded him as the

least communicative and most disturbed. This was never openly shown in the group, but it was evident that N.T. has a status of special member. Although it seemed that the group was rejecting him, it was more obvious that some group members had a protective attitude towards him. They did not insist on communicating with him, they would accept when he would become engaged in conversation, but none of the members has confronted with him throughout the work of the group. During therapy I suggested that he should undergo additional medical examinations (neuropsychological testing and NMR) since I suspected he might have organic changes in the brain; he was subsequently diagnosed with unilateral parietal and occipital changes in terms of brain tissue atrophy. After several months in the group, N.T. became more communicative, he did not seem so isolated and, most importantly, he managed to stay in therapy despite his predisposition to abandon it.

Another impeding cohesive element was the fact that all group members have initiated court proceedings against the state. However, as the result of unrealistic expectations from the state and mutual discord, lack of cooperation and consequently reduced effectiveness, none of these cases have shown progress, the interest of the plaintiffs began to drop, and all of them were convinced that a positive outcome of the proceedings was impossible. The entire group was consumed with anger against the state and the system and this anger began to evolve into passive-aggressive behaviour model in most of them.

Freud (1919/1968) believed that the symptoms he had noticed in veterans from the World War One were related to the state he called "injured self-esteem". This point of view is used to explain the so-called "permanent helplessness" in many Vietnam War veterans, which rests on the disbelief that things might ever change. In most veterans this leads to narcissistic stress based on the opinion that the individual is unable to respond to the challenges posed by life and certain culture. This could explain our observation that motivation for work in this group had initially been linked primarily with legal redress and benefit, while the group itself was perceived as an instrument by which its members could more easily achieve a positive outcome of their complaints and obtain material compensation. The delicate nature of my work in this situation was to balance between supporting healthy parts by which the group members would be activated (care for somatic health, family, etc.) and maybe file complaints for redress on one hand, and on the other, the danger to support secondary and tertiary gains that could result in resistance to work on personal improvement and other aspects of self.

Another problem related to the diverse membership of the group (age, motivation, vulnerability, depth of psychopathology, comorbidity as well as internal and external resources of support) was the choice of work method. The conscious and unconscious influence of the therapist's theoretical orientation was inevitable, but this should not compromise the critical approach in assessing the choice of therapeutic technique. My greatest dilemma arose only after some time of group work, since initially I had thought that the only possible approach was the sociotherapeutic one. However, it became evident that the group also has capacities for the modified group-analytical approach. Thereby sociotherapy gradually gave way to the increasingly group-analytical approach, following the maturing of the group and manifest progress in improvement of each member's integrity. After 4 months of working with the group, I finally decided to maintain this

approach until the end, with necessary modifications, since this could not become a classic analytical group. I took a more directive approach, with interpretations "here and now", with plenty of supportive interventions, sustaining verbalisation of feelings and with occasional deeper interpretation addressed to the members that I believed could use them. Both of these components we continuously represented in the work and could not be separated. Similarly to the classic analytical work being accompanied by a cognitive aspect, here there was a high degree of complementarities between the sociotherapeutic and the adapted group-analytical approach. One of my main goals was to support the development of an appropriate group culture and try to maintain the setting as stable as possible (given that the work was done in the field in difficult conditions).

THE BEGINNING

First sessions were held in a rather unpleasant atmosphere. At the beginning all members were reserved, suspicious, wondering what they might get form and organisation such as IAN. I soon informed them about this, but they still expressed mistrust. Contents from the first sessions mainly related to expressing the anger against the system, the politicians and doctors who "did not provide adequate assistance". It was evident that these people, who expected assistance from the country where they sough refuge in a state of exhausted psychophysical resources and in a situation requiring adaptation to difficult external circumstances, had been gravely disappointed when they realised there was no help for them. Better said, no help was available in the form they had expected. While they were venting their frustrations with this regard, I had the impression that all this they were talking about happened recently and not several years ago. This counter-transference feeling has helped me significantly to understand how these people really felt. The experience of torture has led to the use of adequate psychological defence mechanisms with the view of discarding the depression, guilt, shame and helplessness. Affective regression and cognitive exhaustion lead to an increased use of primitive mechanisms such as denial, splitting and projective identification (Krystal, 1988; Ogden, 1982). Apitzsch (1987) defined torture as a psychological construction where the individual is thrown into a state of extreme infantile helplessness, faced with absolute ruthlessness and omnipotence of the persecutor. Although they were now far from the painful and tragic events, materially and existentially provided for, their fears remained the same - as if the trauma was still present. The only difference was that now they could express their anger, so that during first sessions my role was primarily that of a container for and enormous amount of anger and paranoid anxieties. They openly told me they had no reason to believe me, that they "have been cheated many times so far", that their lawsuits against the state have been on hold for years, that the society "only abuses them" and that doctors treat them with disrespect. When they seek help for somatic discomforts, "…they interpret this as an indirect message that we want retirement, they send us away from their offices without therapy...". I was of course uncomfortable listening to them attacking me, seeing in me various figures from their lives with which they associate neglect and manipulative behaviour. Nevertheless, I was satisfied with the fact that despite their aggressiveness they continued to come to the sessions, saying

that after the traumatic experience of captivity and torture it was difficult for them to maintain any relationship. I think that in the beginning they were completely unaware that this was what they were in fact achieving - maintaining a relationship and creating something as a group.

OPENING

After about ten sessions, progress in the group work became more evident and significant. Its members gradually ceased to attack the society and me and began to talk about themselves. First they openly said they have begun to have confidence in me, in the organisation I represented and - which was for me particularly gratifying - in the group therapy itself. They spoke about their experience of having lived together in the same town for years without meeting or communicating with each other like they do now in this group. They felt estranged, passing by each other and talking only "casually, briefly and superficially". Yalom (1970) described this phenomenon of experiencing the group as an integrating factor. The veterans finally felt they have found a place for empathic object reflection they had always needed, but were lacking until this group experience. The members were now able to empathically resound with their deepest fears, feelings of humiliation and narcissistic injuries, as well as help each other in establishing better self-confidence. It was very striking to feel how fixated they were on the idea that their lives could never spontaneously progress without extensive and special assistance from the outside. Their comment was that they "needed someone to get them together", which expressed their dependent needs. Whenever they would express such needs, they impressed upon me the feeling of how urgent these needs were, how the injustice was everywhere around them. It was clear to me that in the phase of "basic trust" (Erikson 1950) I was now becoming for them an omnipotent "archetypal figure of immeasurable authority and power, possessing magical healing capabilities" (Anthony, 1967, p. 60). Session went on, but none of them yet spoke about the traumatic experience of torture. I did not force the issue, but rather waited for the moment when the atmosphere in the group would become ripe for it. At first I was afraid whether it would ever become ripe, whether the group resistance would grow instead and preserve its members from elaborating the experience of torture, whether I would have to be the one to initiate discussion about the most painful topics, etc. However, having seen that the group culture was slowly developing and that cohesion was growing, I became confident that this group would be able to constructively participate in therapy. I was relieved and gratified seeing that the basic trust necessary for working on therapy of posttraumatic condition has been established (Truax & Carkhuff, 1967; Wilson, 1989.). Gradually such atmosphere developed where the problem of opening before one another, originating from the complex and perverse torturer-victim relationship, was slowly surmounted. Now there was enough space for me as the therapist to be accepted by them as someone in the role of benign authority (Horner, 1979), which would enable a catharsis devoid of prejudice and rationalisation. They became concerned for the group, they regularly called to announce the change of schedule if a technical problem arose, they

suggested we found more comfortable pre mises (with better heating), they called when they would be absent and inquired about those who were not present at the session.

HYPOCHONDRIAC ELABORATIONS

During the next phase, contents in sessions were filled with members expressing fears for their health. They all began to ask about medical institutions where they could undergo appropriate examinations. I took this opportunity to support the concern for health with those who really needed medical aid and help them become conscious of the auto destructive aspects of their behaviour. They were the ones who despite somatic problems refused to see a doctor, e.g. they ignored the long-term hypertension or resorted to the increasingly heavier alcohol abuse in order to ease the insomnia and increased anxiety, or would smoke excessively, up to several packs a day. In addition to the real concern for health, one part of the group had obvious hypochondriac elaborations. Even after many analyses and examinations that were within the scope of normal findings, they were still looking for illness. In this phase they readily accepted and obviously found useful the interpretations (both group and individual ones) that could be formulated as: "It seems that after a long period of real danger and threat from the outside, which is now gone, there seems to be a need to look for the danger in one's own body and hence the fear from illness". During several sessions we have elaborated hypochondriac fears, which subsequently opened the ground for one of the most significant stages in the work of this group - the elaboration of traumatic experiences from prison camps where they had been detained.

I would like to make a brief digression and compare this phase of the group therapy with confronting traumatic experience in the individual therapy conducted in IAN. Namely, a new IAN client almost immediately meets a psychologist for psychological testing. In the battery of tests there are many questions related to trauma and torture that the client had experienced. This inevitably leads to discussing the traumatic experience while the client is still relatively unprepared and this risk of re-traumatisation is increased, which makes the work of the psychologist particularly complex and requires certain tactfulness and skill. Even more delicate is the situation when the traumatic event is debated with the lawyer, since it frequently leads to re-traumatisation and very strong resistance to enter into therapy with the psychiatrist at a later stage. In some cases this has resulted in abandoning the therapy after several sessions and on a few occasions immediately after the first session. Torture survivors fear they would lose control over their psychological and moral integrity; the insistence by therapist to revive painful memories may be felt as persecuting and lead to the state of regression and loss of self-confidence. Although the process of catharsis and cognitive revision of trauma is undoubtedly useful, only the preparation through wider elaborating of traumatic experience could ensure an adequate therapy (Kalucy, 1988).

Concerning the group we have worked with in Hrtkovci, there was no insistence to discuss traumatic experiences at the beginning of the therapy; there was no testing, while discussions with the lawyer were held in the group. At first there was no mention of torture

experiences, but more general plans were made and further steps related to their complaints were discussed in a wider context. My intention was to leave the group enough time to grow and become ripe for expressing severe traumatic experiences. This ripening process required that members stop seeing the group as fragile and unable to withstand their own painful life stories. Over time, this was achieved and the group slowly sailed into the period of trauma elaborations.

TORTURE "REVISITED"

Consequently, following sessions were full of contents that were difficult to express and contain. Group members were not reluctant to express even the hardest details about their torture. Firstly they spoke about the conditions in which they survived in prison camps; how they slept on concrete floors or a little straw, how their food was bad, how they were exhausted by psychical work and how they were deprived of sleep. They have been humiliated in many ways - locked in doghouses and forced to bark, to eat grass, to beat each other and if they refuse, they were beaten themselves. The beatings were done with hand and feet, as well as with various objects - usually rifle buts, clubs and police truncheons. They would be tied and hung in an upside-down position, or their limbs would be tied with rope that the torturer would tighten occasionally. N.T. said that several people had beaten him on the head for hours continuously. They were threatened by death, as well as by death of their families, they were taken to mock executions, had to witness sexual abuse and even murders. Some of them had empty guns pressed on the temple and fired, without them even reacting to this.

Several members described in detail the feeling related to "learned helplessness", when after a while they became indifferent to how they would be treated next and whether they would be killed. Under the reformulated model of learned helplessness (Abramson, Seligman & Teasdale, 1978) persons who are prone to self-accusation and who believe that bad events would persist over time and affect many areas of their lives, run a significant risk of becoming depressive.

I mostly listened, occasionally linking the contents related to the earlier feeling of humiliation with the current feeling of humiliation and the fantasy that "all refugees are generally degraded" and that it seems everything depends on the outside factors. One of the manoeuvres I used for introducing the principle of reality was to compare their current way of life with the life of local inhabitants. It turned out that there were no differences between the two, and some of the group members actually had high quality lives. Thereby their fixation on trauma gradually weakened. They expressed satisfaction that they do not have to discuss these things with their families and openly expressed their bond with the group, stressing the "value of gathering". Many of them showed signs of evident progress with regard to their psychic discomforts.

B.Ž. is one of the members who benefited most from the group. At the beginning of therapy he was highly depressed, so I thought of suggesting to him a more intensive

treatment in a state institution. However, he soon showed his capabilities to use therapy and face his own anxieties, so that his condition became better and better each week. He soon revealed his conflict regarding the ambivalence towards waging war in general, killing "to which you are forced in war", towards what is conventional and justified and what is not, etc. On several occasions he mentioned that he had hurt his index finger on a machine. It was evident that his finger had been amputated. During one of the sessions he started talking about this injury again, quite casually at first. He left the impression that we would not hear anything new about it. But this time he told the whole story. While he was living in Croatia, at the outset of war, he was at risk of being mobilised by the army, like many others. Wishing to avoid mobilisation he broke his own finger and reported to a doctor who relieved him from the military obligation. Later, when the worst was over for him as regards the war and after he fled to Serbia, he "accidentally" cut off the same finger while doing something very simple on a wood-processing machine. I draw his attention to this: "B., this is the finger that pulls the trigger, that kills."

REINTEGRATION

The entire group hears everything that is said to an individual in the group. This was one of the interventions that, to my mind, the group has heard quite well. After clarifying the unconscious destruction of the "killer finger", the most important phase for the group began, which I was sincerely hoping for. In following sessions contents came up related to positive events during war and captivity. The group began to experience a contact with feelings related to such events and the pessimistic, black-and-white contents gradually gave way to more positive ones. They talked about all the good things that happened in the prison camp, one by one linking his associations to others. They described events when the enemy soldiers helped them, hen they occasionally protected them from exhausting work on a particular day if some of the prisoners was ill or injured. Some of the guards would smuggle a note from someone's wife, or undertake to pass a message to their family. They also secretly gave them food, sometimes helped them to change wet clothes or blanket they were sleeping on, etc. There were cases when a soldier would recognise a friend or acquaintance among the prisoners and protect him from the beating. Suddenly many of such examples appeared. Negative attitudes gradually gave way to brighter ones and the internal initiative was authentically started. This was evident in their everyday functioning - care for themselves, their health and families became more adequate, they invested more effort into getting proper medical assistance, their claims for compensation of damages for sustained torture were "revived", they were better informed and educated in terms of knowing legal facts that could help them resolve their current problems. Education in understanding medical problems that we conducted simultaneously with therapy also gave evident results. There were a dozen topics that the group worked on with IAN experts of various profiles (psychologists, physicians, lawyers). Some of the topics related to understanding the symptoms and problems within the PTSD, to the significance and adequate use of medication, to alcohol and substance abuse, to psychosomatic illnesses, emotions as a psychic function, etc. It was almost unbelievable that the group, which has

spent a year talking angrily about its tragedy, now had enough strength to notice that in all this tragedy in life there was something good going on, even if it was petty in relation to the hardship they've been through. When discussing this occurrence in war veterans, Parson (1988b, p. 295) said that this is about "reaching cognitive and emotional independence from Vietnam and strengthening the feeling of self". In other words, the trauma becomes integrated in the personal life history (Santini 1989). Finally, without remorse or pangs of conscience, they verbalised that "it's good they have survived the war".

TERMINATION

Termination of the group work was announced four month in advance. The group initially accepted this and commented the termination as something "normal", but they soon began to ask me "to prolong it for a little while". There were even ideas to send a letter to IAN as the organisation providing psychological and medical assistance to people from Hrtkovci and thereby advocate for the continuation of the group. This, however, did not come about, since I used all these needs as the material to work through termination of therapy. This was exceptionally important for these people, to be able to close something up and bring it to an end and thereby cease to be captives of their past. Termination of the group therapy was now a starting point from which to move on, particularly because it was also the platform from which one could turn around and remain in contact with the fact that things have gone by and nothing is the same as before. The closure of therapy certainly does not mean the end of assistance for these people. Commitments were made that they will continue to receive assistance in resolving their medical and legal problems and that this would depend on IAN's resources as well as on their needs and motivation. The IAN team continues to maintain contact with the group once a month.

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