Therapy with Torture Victims: An Integrative Model and the Importance of Pharmacotherapy

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Abstract

Pharmacotherapy with patients traumatised by torture has so far not been a subject of research and therefore no data is available about this issue in the existing literature. Based on the experience of therapy with torture victims in the Centre for Rehabilitation of Torture Victims – IAN Belgrade we have learned that psychosocial, legal and humanitarian assistance do not suffice for their rehabilitation. With the view of attaining an integrative therapeutic approach, we have included pharmacotherapy into therapeutic procedures. This paper reviews the range of medication prescribed in IAN for 429 patients during a six-month period. Most frequent psychopharmacological drugs were the antidepressants (26.8%), followed by anxiolytics and hypnotics (25.4%) whereas the least prescribed medicines were antipsychotics (4.2%). The complexity of torture syndrome sequelae is additionally confirmed by the high number of medicines prescribed for somatic disorders, such as cardiovascular (21.2%) and rheumatic (10.5%). In conclusion it could be said that pharmacotherapy for torture victims is an indispensable part of an integrative therapeutic approach and that efforts invested in implementing it within our centre have proven well justified.

CONSEQUENCES OF WAR IN FORMER YUGOSLAVIA

War in former Yugoslavia that began in 1991 has had all characteristics of a civil, religious and ethnic conflict. It broke out in Slovenia, subsequently spreading to Croatia, Bosnia and Herzegovina, as well as to Kosovo and Metohija in early 1999. The tragedy of this war is reflected in the fact that for centuries various nations have lived in this region and that there were over two million mixed marriages between them. Huge influx of refugees who survived the destruction of their homes, death or wounding of close persons, or have themselves been wounded, starved, tormented by fear and uncertainty, has led to a sudden dramatic increase in reactive stress related psychic disorders. Prolonged war and deteriorating economic situation have in turn led to serious mental health disorders not only among refugees, but among the entire population as well (Kalicanin, Bukelic, Išpanovic-Radojkovic & Lecic-Toševski, 1994).

According to data from the World Health Organisation in 1994, the number of refugees, internally displaced persons and persons living in war zones was 4 million, and due to war post-stress syndromes mental health of 800,000 people was seriously jeopardised to such extent that they needed urgent psychiatric and psychosocial assistance.

It is considered that in Serbia, or Serbia and Montenegro, there are currently over 700,000 refugees from other countries of former Yugoslavia and over 200,000 internally displaced persons from Kosovo and Metohija.

Its sheer brutality, bestiality, atrocity, unheard-of torture, suffering and tragedy of civilians and children, devastation in war zones, makes the conflict in former Yugoslavia a paradigm of traumatic experience. These traumas form an endemic hotspot of post-traumatic disorders whose victims will long after the war require psychiatric help because of severe consequences in the form of psychological, psychosomatic and psychosocial disorders in those who have lived through these traumas (Jovanovic et al., 1996; Samardžic, Mandic-Gajic, Alacov & Bosic 1998).

The piling up of war related stressors was further aggravated by the NATO air strikes in spring 1999. Consequences of these stressful experiences are still felt by many people in this country.

TRAGIC CONSEQUENCES OF THE EXPERIENCES OF CAPTIVITY AND TORTURE

Specificities of the civil war in former Yugoslavia have somewhat distinguished this conflict from other wars in recent history. Among other things, the combination of frontline and civil warfare, mass ethnic cleansing and expulsions of populace of different nationality have marked the traumatic experienced of survivors. Large numbers of civilians have

experienced some form of camp detention, regardless of whether these were civil prisons, military camps or even "private prisons". Treatment of the prisoners of war and civilians was almost identical. The only purpose of psychophysical torture to which both civilians and soldiers were subjected was to break down the bodies and souls of prisoners belonging to other nationalities. This has also determined the type of torture to which prisoners were subjected(Ilic, Jovic & Lecic-Toševski, 1998).

Captivity in prison camps represents one of the most severe traumatic experiences, which significantly affects the psychic and physical health of the victims. It is assumed that in Serbia today there are several thousands people who had been imprisoned in one of the camps in Bosnia and Croatia. Camp detainees lived in extremely difficult conditions, they were used as live shields and have been subjected to torture, both physical and psychological. Most of them are at risk of developing stress related disorders. Besides, their families are also at risk, due to the well known negative influence that the person with a psychiatric disorder has on his/her environment.

Our earlier researches have shown that 30% of refugees have manifested signs of chronic post-traumatic stress disorder, as well as 70% of camp detainees who have been subjected to torture. Besides, 11% of students we have interviewed showed indicators of the post-traumatic stress one year after the NATO air strikes (Lecic-Toševski, 2002).

PSYCHOTHERAPY OF TORTURE RELATED PSYCHIC DISORDERS

In a large number of clients who have come for assistance to the Centre for Rehabilitation of Torture Victims (CRTV) we have registered sequelae of torture or trauma they have survived, in forms of various psychopathological syndromes, most frequently the post-traumatic stress disorder.

The experience of torture often leads to many mental health problems such as anxiety, fear, paranoia and suspiciousness, sorrow, guilt feeling, despair, hopelessness, withdrawal, depression, somatisation, psychoactive substance abuse and alcoholism, anger and hostility. Together with the said psychiatric symptoms, there are also problems at work, in the family and marriage.

Psychosocial rehabilitation of torture victims involves also an integrative therapeutic approach through a combination of various types of psychotherapeutic techniques, pharmacotherapy and psychosocial support.

Psychotherapy with torture victims can be conducted through application of various methods and techniques, some of which are described in the existing literature, such as cognitive and behavioural approach (Basoglu, 1992), testimony method (Cienfuegos & Monelli 1983), psychodynamic and psychoanalytical techniques with emphasis on supportive and explorative techniques (Herman, 1992). In practice, various centres have developed different methods by combining cognitive and psychodynamic techniques particularly adapted for torture survivors. Many of these techniques have been developed

based on experience in treatment of various forms of post-traumatic disorders prompted by criminal acts or natural disasters (Horowitz, 1988; McCann, 1990).

Revealing the traumatic experience is the essence of therapeutic approach regardless of the applied techniques. However, it is important to take care about the amount of traumatic contents that is revealed during one session, because it could be overwhelming for the client. In therapy other aspects are often more important than the very contents of the traumatic experience of torture. Work on strengthening the therapeutic relationship with the client and establishing a good therapeutic alliance are often more important factors in therapy than the contents discussed and the interpretation or clarification.

Therapy with torture victims is difficult and breeds limited results, primarily because their "basic trust" had been destroyed, and they remain unable to verbalise and describe the traumatic situation. Torture victims block and suppress the traumatic experience that overwhelms them, by psychological mechanisms of "closing up", "affective anaesthesia", "psychic numbness", "psychic death", which significantly disrupt the therapeutic context.

Other problems stem from the clients' tendency to retroactively idealise their childhood, guilt feelings because they have survived, continued aggression that is a consequence of rigid, politically or religiously oriented super-ego.

Torture victims can identify with their torturers through traumatic attachment, in the desire to maintain their destroyed identities. This kind of "hate dependence" can create a new guilt feeling that distances them even more from other people, because of the fear from desire for revenge and retaliation. The therapist should be aware of this kind of emotional attachment and know how to protect himself/herself from it, since it carries a large potential for conflict. This can be achieved if the therapist remains strong and precise, knows how to establish boundaries, tactfully rejects the client's idealisation or accepts rejection filled with hatred. One needs to favour supportive techniques that aim at reorganising dynamic forces through experience rather than through insight. Therapeutic approach should offer something that the client lacks. The traditional analytical approach characterised by objectivity, patience and tolerance should be complemented with an approach that involves looking for a new meaning of existence together with the client himself.

With some clients the short-term therapy using abreaction and manipulative techniques has proven very effective. These techniques can lead to a quick release from symptoms, especially in clients with a healthy personality. However, with those more severely traumatised there could be such damages in the personality structure that need long term psychotherapy, which could only partly improve its functioning (Elsass, 1997).

Centre for Rehabilitation of Torture Victims within International Aid Network (IAN) was opened in September 2000 in Belgrade, with the aim of providing free of charge psychiatric, psychological, medical and legal assistance to people who have survived war related torture, to victims of civilian and political torture and violence, family members of torture victims, as well as to people traumatised by NATO air strikes.

In the Centre various types of techniques are applied within the individual and group psychotherapy. Types of therapeutic techniques applied depend on education, training and preferences of each therapist, as well as on conditions related to the characteristics of clients and their individual psychopathology.

Majority of therapists have adequate education and training in psychotherapeutic techniques they apply, as well as additional training in cognitive-behavioural technique EMDR (Eye Movement Desensitisation and Reprocessing). This training was conducted in IAN with a large number of therapists working in the Centre.

PHARMACOTHERAPY OF TORTURE RELATED DISORDERS

Until now there have been no studies that would examine the qualitative and quantitative differences between psychological effects caused by torture and those caused by other traumatic experiences.

While deliberating the diagnostic definitions of psychopathological reactions caused by trauma, several therapists have attempted to define and identify the "torture syndrome" based on their own experience, but without success (Goldfeld, Mollica & Pesavento, 1988; Hougen, 1988; Kosteljanetz & Aalund, 1983).

Others have claimed that similar reactions and long term sequelae could arise as a consequence of war, rape, kidnapping, camp experiences and incest (Horowitz, 1986; van der Kolk, 1987). Torture can, however, be differentiated from other severe traumatic experiences because it represents an extreme form of violence, both physical and mental, which has a specific social and political context, as well as a clear political aim in most cases. Torture is different from Holocaust both by meaning and sense. Torture is directed against individuals and groups, with specific intention of inflicting injury, forcibly obtaining a confession and destroying the political will, very often even when there is no war. Holocaust aimed at provoking a collective trauma and annihilation, whereas torture relates mainly to individual persecution and pressure that has a clear political context (Somnier & Genefke, 1986).

Although the post-traumatic stress disorder (PTSD) is the most frequent consequence of torture, many agree that it is insufficient for defining its sequelae. The PTSD diagnosis does not include torture syndromes leading to permanent personality change, because it excludes changes of identity as determination criteria (Reeler, 1994; Turner & Gorst, 1993).

In order to expand the PTSD diagnosis and encompass victims of extreme traumas such as those caused by torture, Herman and Lansen proposed a diagnostic entity called the "Complex PTSD Syndrome". This entity is characterised by the chronic nature of symptoms, prolonged depression, difficult regression of affects, anhedonia and alexithymia, as well as an inclination towards renewed traumatisation (Lensen, 1993).

Regardless of the conceptual model, aims of pharmacotherapy in PTSD cases, meaning the clients who have survived torture, are the same:

- reduction of intrusion symptoms and inclination to interpret the stimuli as the return of trauma;
- reduction in avoidance behaviour and in symptoms of numbness and distancing, with a tendency to improve the overall mood;
- reduction in physical and tonic irritation as a response to trauma reminders;
- reduction in impulsiveness and psychotic or dissociative symptoms, if those exist (Davidson & van der Kolk BA, 1996).

For this purpose various groups of drugs are used, the characteristics of which shall be presented briefly in this paper.

Selective serotonin re-uptake inhibitors - SSRI *(sestraline, fluoxetine, paroxetine, fluvoxamine)*

SSRI can be recommended as choice drugs for PTSD. They reduce the PTSD symptoms and lead to an overall improvement at the same time being effective against comorbid disorders and accompanying symptoms (van der Kolk, Dreyfuss & Michaels, 1994). These drugs have less unwanted effects than other antidepressants, but can cause insomnia, agitation, gastrointestinal symptoms and sexual dysfunction. It has been shown that their effectiveness in case of war veterans is more difficult to interpret, since the studies have been done on individuals who had severe chronic forms of this disorder (Brady 1997; Brady, Sonne & Roberts 1995). In studies on civilians affected by PTSD, however, the effectiveness of fluoxetine (Connor, Sutherland & Tupler, 1999; Malik, Connor & Sutherland, 1999) and fluvoxamine (Marmar, Schoenfeld & Weiss 1996) was proven.

Monoamine oxidase inhibitors - MAOI *(phenelzine, moclobemide)*

These drugs have shown effectiveness in overall improvement, in intrusion symptoms and somewhat less in avoidance symptoms, but have not been tested extensively. In three placebo-controlled studies the effectiveness of phenelzine was tested (17-75 mg/day) with war veterans with PTSD and significant effectiveness was discovered in relation to placebo (Kosten, Frank & Dan,1991). In a study where the effectiveness of moclobemide was examined on 20 patients with PTSD, 11 of these patients have shown no more symptoms afterwards (Neal, Shapland & Fox 1997). Limitations in usage are linked with the restriction in diet, and these drugs are also contraindicated with patients prone to alcohol

and other substance abuse. It is also necessary to follow up on cardiovascular, hepatotoxic and other undesired effect.

Tricyclic antidepressants - TCA *(imipramine, amitriptyline, desipramine)*

In two studies on Second World War veterans and Vietnam War veterans, amitriptyline was tested with the first group (50-300 mg/day) and imipramine with the second (50-300 mg/day) and both have shown significant reduction of symptoms in relation to placebo, this result being slightly higher in the case of imipramine usage (Davidson, Kudler & Smith, 1990). These drugs have a similar range of effect as the MAOI (reducing symptoms of intrusion and inducing general improvement) but are less effective. Besides, they have more unwanted side effects: they can lead to hypotension, heart arrhythmia, anticholinergic effects and sedation.

Antiadrenergic drugs *(clonidine, guanfacine, propranolol)*

These drugs reduce symptoms of increased irritativeness, intrusion, and possibly the symptoms of dissociation, although effectiveness of these drugs has not been studies in clinical research. On the whole, they are quite safe, although one should routinely follow up on blood pressure and pulse, especially with patients with hypotension and those on antihypertension drugs. Propranolol can occasionally cause depressive symptoms and psychomotoric deceleration.

Anticonvulsants *(carbamazepine, valproate)*

Both drugs can be effective in reducing symptoms of increased irritativeness, intrusion symptoms (only *carbamazepine*) and avoidance symptoms (only *valproate*). They have been tested in several open clinic studies, but never in randomized studies. Both drugs have proven effective in case of bipolar affective disorder and can cause significant undesired side effects, especially the *carbamazepine* (Davidson, 1992).

Benzodiazepines *(alprazolam, clonazepam)*

With patients who suffer from high anxiety, irritativeness, insomnia and vegetative instability, these drugs are a logical choice, although there is very little information about this. In a randomized, double blind study in which alprazolam and placebo were compared,

with 10 Israeli war veterans and victims of terrorism, it has been shown that alprazolam reduces symptoms of anxiety more than placebo, but to a limited degree (Braun, Greenberg & Dasberg, 1990). Discontinuation of therapy with short-term impact benzodiazepines can lead to abstinence problems and it is therefore recommended to use benzodiazepines with longer-term impact, such as clonazepam (Davidson 1997). Caution is needed in prescribing these drugs to patients who are prone to abuse or dependent on alcohol or used to have such an addiction.

Antipsychotics *(thirodazine, clozapine, risperidone)*

These drugs are also not recommended for PTSD therapy, because there is very little information published about their effectiveness. They could be recommended only for patients resistant to drugs from the first or second line but who manifest extreme hypervigility, paranoid symptoms, agitation or psychosis. These drugs have many unwanted side effects, some of which are quite serious.

REVIEW OF APPLIED PHARMACOTHERAPY WITH IAN CLIENTS

In order to implement the integrative therapeutic model for torture victims who came to seek assistance in our Centre and became our clients, it was necessary to also ensure pharmacotherapy. With additional efforts and assistance from a Danish humanitarian organisation, the O.A.K. Centre from Copenhagen, since June 2001 our clients began to receive pharmacotherapy as well.

It is well known that severe traumas, especially those caused by torture, also leave permanent neurobiological changes. These changes can be manifested through symptoms of depression and anxiety, as well as through somatophorm reactions and various other somatic symptoms and disorders, which is the consequence of dysfunctions of the immunological defence system.

With the view of providing medical assistance IAN has opened a small medical centre "Median", where clients can get free of charge general internist and neurological examinations. Until June 2002, among the examined clients we have determined a polymorph pathology. Most of them suffered from hypertension and related problems (31%), followed by rheumatic ailments (27%), gastrointestinal tract diseases (17%) and obstructive pulmonal diseases (11%) (Jovic, 2002).

Table 1. contains the list of most frequently prescribed drugs, both in the "Median" clinic and the Centre for Rehabilitation of Torture Victims, for 429 clients during the period from 1st August 2001 until 8th February 2002.

Table 1. List of prescribed drugs in IAN in the period from 1st August 2001 until 8th February 2002

Type of drug	No. of clients	**%**
Antidepressants	115	26.8
Amitriptilyne	*16*	*3.7*
Maprotilyne	*44*	*10.3*
Mianserine	*36*	*8.4*
Fluoxetine	*16*	*3.7*
Sertraline	*3*	*0.7*
Anxiolytics and hypnotics	109	25.4
Diazepam	*68*	*15.9*
Bromazepam	*24*	*5.6*
Prazepam	*6*	*1.4*
Lorazepam	*4*	*0.9*
Brotizolam	*7*	*1.6*
Antipsychotics (*Haloperidol, Thioridazine*)	11	4.2
Drugs for cardiovascular diseases	91	21.2
Drugs for pulmonal diseases	23	5.4
Antirheumatics	45	10.5
Drugs for gastrointestinal diseases	28	6.5
Total	**429**	**100**

The table shows that the most frequently prescribed drugs are from the group of antidepressants (26.8%), followed by anxiolytics and hypnotics (25.4%) and drugs for cardiovascular diseases (21.2%) and antirheumatics (10.5%), which confirms the complexity of torture syndromes sequelae, with consequences for psychic and somatic health of the victims.

DISCUSSION

War in former Yugoslavia during the last decade of twentieth century represents a paradigm of traumatic experience. Several hundred people who had survived war trauma have come to seek assistance in IAN Centre for Psychosocial Rehabilitation.

Since its opening the Centre has mainly provided psychological, psychosocial, legal and medical assistance. The concept of integrated therapeutic model soon proved to be insufficient because there was no pharmacotherapy to supplement it. Thanks to the Danish humanitarian organisation O.A.K. pharmacotherapy was included and the application of the integrative therapy model began.

The review of pharmacotherapy with IAN clients shows that various groups of drugs were used. Most of them were from the group of psychopharmacs, including antidepressants and anxiolytics. Antipsychotics were prescribed for 11 (4.2%) of clients, mostly chaloperidol and tirodazine, which shows that there were very few psychotic disorders among our clients.

Also interesting is the fact that hypnotics were prescribed only for a small number of clients, lendormine was given to only 7 of them (1.6%). It was probably possible to regulate their sleeping disorders by other psychopharmacs. It is also possible that the sleeping disorder was less prominent given the time that has elapsed since the traumatic experience. For this kind of conclusions we lack empirical data and evaluation of characteristics of the clinical picture of post-traumatic syndromes, which is not the aim of this paper.

Following the psychopharmacs, highly represented are drugs for cardiovascular and rheumatic diseases, and slightly less represented are those for gastrointestinal diseases.

Based on the said representation of prescribed drugs it can be concluded that mental disorders dominate among our clients, but that there also are somatic diseases that are most probably the consequence of the same etiological factor - the traumatic experience.

This paper gives a descriptive analysis of pharmacotherapy given to clients of the Centre for Rehabilitation of Torture Victims. Based on the number of clients who have received pharmacotherapy it can be concluded that the sequelae of traumatic experiences of torture are significant and that they encompass both mental and somatic health of clients. The choice of psychopharmacs prescribed was also highly influenced by the situation in the drug market, which has for years been affected by economic sanctions that caused a deficit in variety and possibility of obtaining appropriate drugs.

In literature there are no data on research about the impact of pharmacotherapy on torture experience, since most pharmacological studies relate to PTSD. Based on clinical experience we concluded that pharmacotherapy with clients who had survived torture has given positive results in terms of quicker reduction of torture sequelae symptoms. Valid conclusions about the effects of pharmacotherapy with torture victims could be given only

after an adequate empirical research, which is very difficult to perform in constrained conditions of this kind of assistance provision.

CONCLUSION

There is an increasing amount of data on lasting psychological, psychosocial and neurobiological changes that originate as a consequence of severe traumatic experiences, especially those caused by torture. In this paper we have described some aspects of therapy with torture victims in the Centre for Rehabilitation of Torture Victims and stress the importance of pharmacotherapy as an inherent part of the integrative therapeutic approach. The review of drugs that have been prescribed during a one-year period shows that the most frequent psychopharmacs were antidepressants, followed by anxiolytics, antipsychotics and hypnotics. High prevalence of drugs prescribed for somatic diseases indicates the complexity of torture consequences, as well as justifies the effort of IAN CRTV to employ pharmacotherapy alongside other therapeutic procedures.

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