

Treatment of torture survivors - influences of the exile situation on the course of the traumatic process and therapeutic possibilities*

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Abstract

Traumatized refugees often suffer from complex posttraumatic disorders with a high tendency of chronicity. This is due to severe and often repeated traumatization in the course of political persecution on one hand and uprooting and ongoing stress caused by leaving their home country and society and living under an adverse situation in exile on the other hand. This article shows how positive and negative factors going along with migration interfere with the course of the traumatic process and the therapeutic possibilities and how the therapeutic process can be adjusted to the situation.

Key words: torture survivors, traumatized refugees, treatment

1. The traumatic process under stress factors in exile

Refugees living in Germany have often suffered from severe and repeated man-made traumatic situations in the course of political persecution, detention and torture. Sometimes the trauma also included the circumstances of their flight. Depending on the country of origin, about 40% of refugees are suffering from PTSD by the time of their arrival in the country of exile.¹ An even higher percentage has gone through potentially traumatizing situations. These individuals are at risk of developing trauma sequelae later on, if preventive measures are not granted in the country of exile.

Having been uprooted and having lost their material and social basis of living, close and beloved persons, social support, their home country and their cultural and political context, refugees are weakened in their capacity to cope with the traumatic impact to which they have been submitted. In addition to severe trauma, refugees pass through a situation of loss and ongoing stress.

Getting to Germany or other European countries means to the survivors that they can finally feel safe from persecution. The anxiety due to external factors (“Realangst”) is reduced and the hope for a better future may alleviate depressive moods and pain.

But on the other hand – especially if the

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refugees are not granted asylum right after their first interview with the German immigration authorities (BAMF) – they will soon suffer from an exile situation with a variety of adverse factors such as:

- ongoing uncertainty (insecure residence status: asylum seekers, temporary permission to stay)
- lack of prospects for the future
- inactivity, interdiction to work/study, dependency on social aid
- subjection to degrading and incomprehensible bureaucratic acts
- housing in mass accommodations often far away from cities and exile communities
- restriction to leave their residence areas
- isolation within the German society and difficulties with communication
- sometimes violence with xenophobic context
- lack of access to adequate medical/psychological care²

About 90% of the patients treated annually at the Berlin Centre for the Treatment of Torture Victims (bzfo) do not have a secure residence status at the time of intake and sometimes for many years to follow. This

means that treatment will be under a situation of ongoing stress and uncertainty. Being forced into a passive role is one of the important factors that hinder refugees in developing coping strategies after a trauma; it weighs heavily on their self esteem and reinforces states of depression.

Migration always means a process of changes and adaption. Sludzki³ described the process of relocation as one in which the emotional needs of individuals increase markedly, while their support social network is severely disrupted. As a result, relocations are strongly associated with increased psychosomatic and interpersonal distress.

As Hans Keilson⁴ found out in his study of holocaust child survivors, the period after the traumatic incidents is crucial for the development of the traumatic process. His concept of sequential traumatization, which distinguishes three consecutive phases of stress, is still fundamental to understanding the traumatic process that is induced by traumatic experiences but influenced by many external and internal factors (Figure 1).

Refugees are very likely to experience an extremely stressful and depressing situation (“ongoing stress”) in the important third

1st phase	2nd phase	3rd phase
Repression Discrimination War Anxiety Isolation	Persecution/flight Torture, prison Lifethreat/agony, loss Traumatic events Anxiety	Exile Uprooting (new culture asylum situation) Uncertainty Anxiety Dissociation Chronicity of posttraumatic syndromes

Other influences: personal and social meaning of the trauma, consequences/losses age, sex, pre-traumatic resources of the personality, active modus, social support

Figure 1. *Sequential traumatization.*⁴

phase of their traumatic process. The ongoing exposure to situations that are adverse to a process of trauma compensation goes along with a high tendency of chronicity of posttraumatic stress disorders. The more severe the traumatization is and the longer the traumatic process under conditions of ongoing stress continues, the higher the tendency to develop complex posttraumatic disorders with persistent or periodic PTSD symptomatology accompanied by increasing comorbidity such as:

- alterations in the regulation of affect and impulses
- disorders of attention and consciousness
- depression
- somatization
- anxiety
- alterations in systems of meaning, enduring personality changes
- changes concerning the interpersonal area
- worsening of pre-existing mental and somatic disorders^{5,6}

Laban, Gernaat, Komproe, Schreuders and De Jong⁷ recently published a study of the impact of long asylum procedures on the prevalence of psychiatric disorders of asylum seekers. The overall prevalence of psychiatric disorders increased from 42% to 66.2% when the (Iraqi) refugees had lived more than two years as asylum seekers in the Netherlands.

A posttraumatic stress disorder, even if the symptoms are already in remission, can be reactualized (updated) by renewed stress and stimuli which are connected with the trauma. If the victim is confronted with a severe or long lasting stressful situation or a new loss of safety and coping possibilities or with reactualizing stimuli in a situation that is experienced as uncontrollable, there

is a risk for a so called retraumatization with acute crisis and eventually persistent exacerbation of the trauma related psychopathology. Unfortunately the life of a refugee bears a relatively high level of risk for retraumatization. We especially see such heavy decompensations when traumatized refugees are threatened with deportation to their countries of origin.

2. Adapted forms of treatment

2.1 Basic measures and necessary elements of health care

If we want to support torture survivors to overcome the traumatic impact that has shattered their lives, we have to try to minimize the risk factors for the worsening of the traumatic process on one hand and to increase protective factors on the other hand.

The initial treatment of torture survivors in exile is focused on secondary prevention in order to increase health promoting factors. What helps to overcome the traumatic impact and find a way into a worthwhile life after trauma and uprooting are basic measures in areas such as:

- security
- housing
- access to legal advice
- access to health care (with interpreters!)
- access to social support
- supporting autonomy wherever possible
- adequate physical conditions
- language skills, access to education
- occupation, access to work if there is ability
- respect, acknowledgement
- social contact, integrative activities
- developing future prospects (the survivors and their families)

Health care and the access to psychological care are important, but they are not the

only concern in the process of rehabilitation of torture survivors. There are many other factors playing an important role in the outcome of treatment for the traumatized refugees – some of them we can influence, others not.

Following the EU Council Directive laying down minimum standards for the reception of asylum seekers,⁸ adequate material conditions and the “necessary treatment of damages” should be granted to persons who have been subjected to torture, rape or other serious acts of violence. Taking into account the experience of the treatment centers for torture survivors and refugees, the access to, and the realization of, a “necessary treatment of damages” consists of various steps (figure 2).

Upon arrival in the exile country all refugees need basic medical care and access to psychological diagnostics if it is wanted and necessary. Traumatized refugees need appropriate living conditions and psychosocial support and the possibility to take part in

so-called low threshold offers. Some of the refugees need psychotherapy over a long period of time or at various times of the process after the traumatizing experiences.

2.2 What is offered by the Berlin Center for the Treatment of Torture Survivors

At the Berlin Centre for the Treatment of Torture Victims (bzfo) and the connected Center for Migrants and Refugees we offer: Diagnostics and medical reports, psychological and social counseling, language and professional training courses to support the process of integration in the country of exile, medical and psychiatric treatment, psychotherapy and psychotherapy. At the bzfo approximately 400 to 500 patients are treated annually.

Like other trauma centers, the bzfo works in an interdisciplinary, multi-professional and integrative manner, using elements of different forms of trauma oriented therapy. We have colleagues working psychodynamically and others who have a cognitive behavioral background and offer

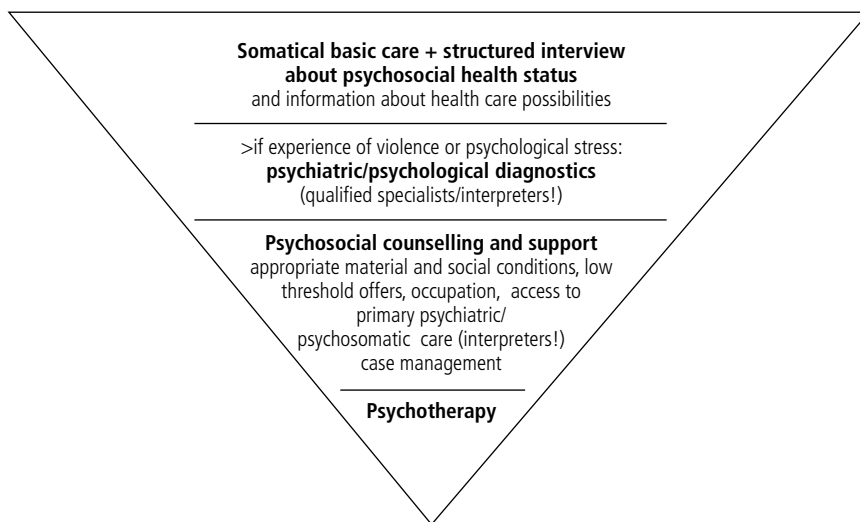


Figure 2. Elements of necessary health care.²

modules like psychoeducative groups with information and control focused elements or biofeedback programmes. There is a service for children and youth with specialized colleagues who work with a systemic approach with unaccompanied minors and families. Physiotherapy, body oriented psychotherapy, art therapy and music therapy and resource work in our “Intercultural Healing Garden” are offered as additional therapeutic approaches. We have an outpatient setting and also offer a day clinic program for survivors who are psychologically very unstable and who had frequently been admitted to psychiatric wards. Medical and psychiatric treatment is embedded in social therapeutic and psychotherapeutic processes. Interactions between psychic suffering and physical complaints and impairments require an integrative method, both in the diagnostic area and in the therapeutic area. The integration of the different views and approaches is possible through regular staff meetings and supervision where we evaluate cases, indications, the therapeutic relation, the long term course of treatment and necessary steps in the social area. A scientific service offers standardized diagnostics and evaluation. We work in close exchange with centers abroad (in Iraq, Ukraine, Uganda, Ethiopia and Kenya) especially on the topic of cross cultural diagnostics and treatment. Since in Germany there are not enough treatment opportunities specialized in diagnostics and treatment for traumatized refugees with a cross cultural approach, the bzfo also offers courses, counseling and supervision for colleagues that work in the public health sector.

2.3 Special aspects in the course of treatment

Due to the persistently stressful psychosocial situation of traumatized refugees, clinical social work often represents a main focus in the first phase of therapy. Giving social

support should strengthen the autonomy of the clients, thus avoiding the trap of creating new dependencies. But, as always in trauma therapy, it has to be “safety first”. Due to the restrictive asylum politics of Germany (and other European countries) about 90% of the patients do not have a secure residence status at the time of intake. That is why we have to provide medical/psychological reports for the asylum process of the torture survivors and traumatized war victims that we take in for treatment. We are also asked by courts to give expert opinions for refugees that are not in treatment at our center. For the medical report it is necessary to go through an initial narrative of the incidences of persecution and trauma. This means a difficult task for the refugees and a high responsibility for the therapists. It requires profound clinical experience with trauma in order to avoid destabilization or even retraumatization. On the other hand patients often feel relieved after overcoming their avoidance behaviour. They note that they start to control their PTSD symptoms and get encouraged to continue the treatment.

The form of treatment varies depending on the individual indication and the wishes of the patients. It can be merely supportive with medical psychosomatic or psychiatric treatment and stabilizing and social-therapeutic elements. In those cases, after an initial intensive phase of building trust and getting to know the patient and his/her former and current worlds, the frequency of sessions may be low, e.g. every two weeks or once a month, often accompanied by other measures such as physiotherapy or group activities. In most cases though, treatment consists of an intensive process of psychotherapy with individual sessions and sometimes group therapy. As we see a lot of traumatized families we offer family interventions, if necessary. The average time of the phase of in-

tensive therapy with at least weekly sessions is about two years.

Of central importance for the course of treatment are:

- a trusting and stable relationship between therapist and patient⁹
- sensitivity and openness for cross cultural encounters
- working with specially trained interpreters

The psychotherapeutic work may remain stabilizing and resource oriented or offer the opportunity to work more deeply in trauma focusing after a “good enough” stabilization of the patient. The course of psychotherapy has to be adjusted to the individual psychosocial and psychodynamic process. A schematic approach has turned out to be of limited practicability.¹⁰ However, a “phase model”, that shows the elements of treatment, is helpful (figure 3).

Following man made trauma and disruption of social connections patients prefer individual therapeutic settings because of the mistrust and shame induced by the traumatic experiences. However, additional psychoeducational¹³ and resource work¹⁴ can be done in a group setting, e.g. with art or music therapy or Concentrative Movement Therapy. Patients will meet others and learn that they are not the only ones who react this way after abnormal situations. Resource

work can be fruitful because it facilitates vivid input of good memories and cultural richness. The resource orientated treatment, including the reconstruction of the biography and the strengthening of good inner objects,¹⁵ often leads to a stabilization and reduces the posttraumatic symptomatology so that life can be confronted in a more positive and active way. Ongoing avoidance behaviour and dissociations often go together with persisting nightmares and pain.

Furthermore, to reduce the trauma related symptomatology it is important to look for symptom stabilizing psychodynamic aspects and cognitions like guilt or shame and to work on them. In order to reduce dissociations and the impact of the traumatic experience, trauma focusing and trauma related work is offered. Trauma focusing therapy, especially after such shameful events as sexual torture, normally has to take place in an individual setting. Due to the necessity for elaborate expert opinions for the asylum process (see above) in our institution, the first disclosure of the traumatic experiences usually takes place in an early stage of treatment. In most cases this will be during the first translation of the traumatic memories into a narrative. After this important and very *relieving* step of verbal, or at least symbolic communication, of traumatic experiences the further *processing of the trauma*, in most cases, ensues in a gradual process. For example, on the basis of the patient’s stressful dreams or thoughts, a repeated focusing

1. Orientation	2. Stabilization	3. Focus on past	4. Focus on future	5. Farewell
Security Trust building Diagnostics Support Goal setting	Information Control Resources Medication Mourning (Individual therapy)	Reconstruction Trauma focused Transformation	Perspectives Relationships Social contact Crisis intervention (possibly group therapy)	Integration Employment Aftercare – social

Figure 3. Elements of a trauma oriented treatment.^{11,12}

on traumatic experiences and the associated complexes from different perspectives takes place. If the patient feels up to the task at that particular point in time in her/his particular life situation to confront the traumatic experiences, then it can be possible to dissolve dissociations gradually and to assemble scattered fragments to integrate them into the patient's biographical context. Sometimes, though, it is not possible to work more intensively on trauma focusing because the patients are too unstable or decide that they want to stay in their avoidance behavior – which we have to respect. Trauma focusing work can only take place when there is sufficient outer and inner stability. The patient should have made a conscious decision after having being informed of the therapeutic steps.

In the later phase of therapy central points are questions of self-confidence, interpersonal relationships and prospects for the future and integration in the country of exile. A group setting can be very enriching in this later phase of therapy. The farewell has to be prepared as a gradual process.

Psychotherapy does not undo the trauma. Especially in those cases where people are already suffering from chronic trauma sequelae, one should not expect a full recovery. However, an important improvement in symptomatology, stabilization, development of coping strategies and the opening of new scopes of action (e.g. the ability to work and to have social contacts) usually is possible.

We offer aftercare for the patients. They can participate in self help groups that meet regularly or other activities offered by the bzfo. In crisis situations patients might come back for individual sessions.

3. Conclusion

Due to contextual factors and ongoing

stress, a schematic approach has turned out to be of limited practicability in the treatment of traumatized refugees even though trauma oriented modules are useful parts in the therapeutic work. The therapeutic process has to be individually adjusted to the living conditions of the victims as well as to their personal way of dealing and coping with the trauma.

Of central importance is a trusting and stable relationship between the therapist and patient and flexibility, sensitivity and openness to the cross cultural encounter as well as working with specially trained interpreters.

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The International Rehabilitation Council for Torture Victims (IRCT) has launched a comprehensive one-stop resource to assist health and legal professionals with the investigation and documentation of torture:

www.preventingtorture.org

Promoting awareness and encouraging the use of the Istanbul Protocol