Psychiatric treatment for extremely traumatized civil war refugees from former Yugoslavia

Possibilities and limitations of integrating psychotherapy and medication

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Abstract

Patients with a history of extremely traumatic experiences show a complex pattern of psychological and physical disorders which represents a special challenge for psychiatric care. This problem is described using the example of the psychiatric/psychotherapeutic treatment of 13 civil war refugees with a history of traumatic experiences from former Yugoslavia in psychiatric treatment at the Psychiatric Clinic of the University of Ulm. One substantial problem encountered by these patients is that, in addition to the original traumatization in their country of origin, the unstable psychosocial conditions of their legal exile condition can lead to re-traumatization which must be responded to with psychiatric treatment.

Key words: post traumatic stress disorder, Bosnia-Herzegovina, refugee, psychiatric treatment, re-traumatization

Introduction

Posttraumatic stress disorder (PTSD) is one of many possible psychological reactions to traumatic experiences. It is a diagnosis, only having been included in the major international diagnostic classification systems since 1980 (DSM-III) and in 1992 (ICD 10). A criterion for diagnosis, apart from the symptoms, is that the person must have suffered an actual traumatic event, such as armed combat or a violent attack. Similarly, having observed or somehow shared a life threatening event to another person may also represent such a trauma. Characteristic symptoms are recurrent memories or flashbacks of the traumatic event, a constant avoidance of stimuli which are associated with the trauma and a flattening of general activity level as well as constant symptoms of heightened arousal. In addition to these specific characteristics, an extreme trauma experience also involves intentionally inflicted bodily harm, which is often connected with strong pain. Beating, violent shaking or pulling body parts may over-stretch joints and connective tissue, and may lead to cerebral oedema or damage nerves to such an extent that the patients are faced with long lasting body symptoms. It is potentially misleading when in DSM-IV the physical consequences of extreme and man-made trauma are merely described by somatization, as it gives the impression that it is a mental phenomenon, i.e. that psychological damage is expressed on a somatic level.[1,2]

An extremely traumatic experience nor-

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mally strikes a person outside the realm of their previous experience and completely or partly overstretches the person's ability to cope with stress, which has developed throughout the person's life. The later consequences of the trauma are formed from several characteristics of the acute traumatic situation:

1. It can not be fully processed cognitively and behaviorally,
2. it is unavoidable, and
3. it disturbs all normal social bonds.

The lifetime prevalence of PTSD for both sexes is 7.8%-12.3%. Depending on the kind of trauma, the development of PTSD is thought to occur in 22.3-38.8% of men and 48.5% of women.[3-5] The occurrence of PTSD in risk populations has mainly been studied in refugees from South East Asia, where prevalence rates of between 10% and 86% were found.[6] An American study found that 13 of 20 Bosnian refugees suffered from PTSD.[7] In a Norwegian study[8] the prevalence of PTSD in 150 Bosnian refugees varied over the course of 12 months from 45% to 82%. Thulesius and Hakansson found a prevalence of between 18% and 33% in a cohort of 206 Bosnian refugees who sought asylum in Sweden in 1993, depending on which diagnosis procedure of the Posttraumatic-Symptom-Scale is used.[9] The disorder normally occurs within the first few months following the trauma. The time directly after the trauma is often characterized by a state of shock or acute stress.[10] Spontaneous recovery of PTSD has been reported in 30% of sufferers within the first 12 months, in 50% after about 4 years, and 30% showed symptoms of the disorder after 10 years.[3] An intensification of the symptoms can occur after critical life events or role change in the biographical context. A delayed onset of PTSD after a symptom-free period of months or years is rare. A chronic irreversible course is described in ICD 10 as personality change after extreme traumatization, e.g. concentration camp detention, torture, catastrophe, prolonged life-threatening situations.[11]

Controlled studies demonstrate the importance of the following psychoactive medication: Antidepressants of the SSRI type are indicated, also when no depressive symptoms are shown.[12] Tricyclic antidepressants seem to bring about improvement in depression and anxiety symptoms and in avoidant behavior but not in intrusive symptoms.[13] Benzodiazepines may be prescribed with the necessary caution and briefing in addition to an antidepressant if anxiety occurring spontaneously persists. Buspirone has been applied with the favorable result of significant reduction in all symptom categories.[14] Anticonvulsives (carbamazepine and valproate) and lithium have so far only been tested in uncontrolled studies.[15] The use of neuroleptics is treated with serious caution. They are indicated when psychotic symptoms (e.g. paranoia, visual or acoustic hallucinations of the traumatic experiences) or aggressive behaviors are present.[16,17]

Various psychotherapeutic interventions have proved their effectiveness: Confrontation with the traumatic memory images is the main constituent of the behavior therapy for PTSD. The goal is habituation, i.e. the decline of the PTSD symptoms through repetitive cognitive activation of the scene of the trauma. Special attention is paid to the patient imagining the traumatic event in all of its sensory and emotional qualities, i.e. with the accompanying visual, acoustic, olfactory and tactile properties as well as all forms of aversive feelings and altered bodily sensations. Only in this way can a comprehensive back-formation of the fear structure be achieved. Exposure treatments show positive effects in

the reduction of avoidant behavior, intrusions and over-arousal.[18] Cognitive techniques utilize a comprehensive anxiety management procedure, self assertiveness and stress inoculation training, as well as a cognitive therapy especially developed for PTSD and a cognitive technique directed at the intrusions. Techniques such as thought stopping for haunting memories, recognition of irrational thoughts, model learning, and cognitive restructuring are applied to identify and correct distorted perceptions and beliefs. Both therapeutic methods are often combined with each other and with relaxation training or breathing exercises. The integrative psychodynamic-cognitive therapy of Horowitz is based on an information processing theory, the focus of which is the processing of cognitive conflicts and ambivalent feelings related to changes in personal schemata. The aim of the treatment is the integration of (old and new) schemata and consequent reduction of the state of stress. The general techniques are fine-tuned depending on the personality dispositions (histrionic, obsessive-compulsive, narcissistic) of the patients.[19] Finally, self-help groups and group therapy can also be helpful in the reduction of the existential feelings of alienation towards others.[20]

All of the examined psychotherapeutic treatments cause sustained reduction in PTSD symptoms (as long as follow-up studies have been carried out). The most influenced symptoms were intrusions and nightmares, chronic hyperarousal and shock reactions as well as impulsiveness and anger. Less able to be mastered were the symptoms of emotional numbness, the feeling of alienation and restricted emotional scope. Generally, several treatments and techniques are combined in a patient-oriented, flexible procedure consisting of several phases.[21,22]

Examined and treated patients

Among other patients, a group of 13 severely and continually traumatized civil war refugees from former Yugoslavia were examined and treated at the Psychiatric Ambulatory Clinic of the University of Ulm in close cooperation with the Rehabilitation Center for Torture Victims Ulm. Among these patients were eight women aged between 26 and 50 and 5 men between 33 and 50, who fled to Germany between 1992 and 1995 (see Table 1).

Table 1. *Sociodemographic data of the patients with age, gender, marital status, level of education, social background and language.*

Patient	Age	Gender	Marital status	Level of education	Social background	Interpreter necessary: yes/no
M.S.	26	f	divorced	M	Bosn. Moslem, RS	no
B.S.	28	f	not married.	L	Moslem Federation	no
C.A.	32	f	married.	L	Moslem RS	yes
D.N.	33	f	widowed.	M	Moslem RS	no
S.S.	33	f	married.	M	Moslem RS	no
S.A.	35	f	married.	M	Bosn. Croat Federation	no
K.S.	36	m	married.	M	Moslem RS	no
S.N.	37	f	not married.	M	Moslem RS	yes
S.Z.	38	m	married.	H	Bosn. Croat RS	yes
J.M.	39	m	married.	M	Bosn. Croat RS	yes
B.R.	42	f	widowed.	L	Moslem RS	yes
H.K.	50	f	widowed.	M	Moslem RS	yes
K.M.	50	m	married.	M	Moslem RS	yes

Level of education: L (low) = secondary school without professional training, M (middle) = completed professional training and H (high) = tertiary education; RS = Republic of Srpska: Serbian part of Bosnia; Federation: non-Serbian Bosnia).

The diagnosis of these patients is difficult, as they have what is referred to in DSM IV as a particular cultural characteristic, but is more appropriately described as a particular behavior difficulty in the immigration situation: Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals.

All patients suffered from prolonged and repeated traumatic experiences (see Table 2). Two female patients did not experience violence directed specifically at them but were witnesses of abuse of close relatives and of the deaths of countless compatriots. One female patient had been held in a Croatian camp and was repeatedly raped; another was the victim of violent attacks by Bosnian Moslems; four patients survived Serbian extermination camps with the month-long abuse for which they are known; one patient was held prisoner in his own house by Serbian militia and his Serbian neighbors; one patient was witness to the abuse and abduction of her husband and victim of sexual violence; one patient was brutally raped in her house by two Serbians; one patient experienced the abuse and detention of her husband and soon after the life-threatening firearm injury of her eight-year-old son as well as the refusal of Serbian physicians to treat this Moslem child; and one female patient was repeatedly raped in Serbian camps.

Patients also showed high comorbidity with other mental disorders: According to DSM IV and ICD 10, as well as PSTD, the symptoms of a major depression episode and/or somatization disorder, an anxiety disorder and/or an acute psychotic disorder were diagnosed. They all showed a history of illness extending over several years with predominant somatic complaints such as headache, stomachache, back pain or heart complaints as well as persistent sleep disorders.

To examine the trauma-related symptomatology, we used the Serbo-Croation version of the Harvard Trauma Questionnaire (HTQ), which was developed specifically as a culturally universal instrument for use with victims of extreme traumatization, such as torture, and political persecution. It is a self-rating questionnaire which covers various traumatic experiences and symptoms, which were compiled by evaluation of clinical experiences and studies of the treatment results in various groups in the Indonesian Psychiatric Clinic[23] and is applied in various institutions for the treatment of traumatized people. Thirty trauma symptoms are evaluated according to their severity (total score), of these 16 correspond to the DSM-III-R criteria (PTSD score). Scores > 2.5 (with a maximum of 4) support the presence of PTSD (see Table 2).

General characteristics of patients and history of treatment

Most patients were admitted for psychiatric treatment via the Rehabilitation Center for Torture Victims Ulm. Three patients were admitted via the practice of a psychiatrist and three women on the initiative of social welfare services. At that time one patient had been treated with medication for pain by general practitioners and specialists. Two patients had been referred to a psychiatrist and treated there with antidepressants with the diagnosis of a reactive depression. In two cases a secondary benzodiazepine abuse was reported. Only six patients had alluded to the traumas in discussions with their general practitioner. Since their traumatization, all

Table 2. *Severity and type of traumatization in terms of PTSD symptomatology.*

Patients	HTQ (PTSD)	HTQ (TS)	Trauma exposure	Retraumatization
B.S.	3.3	3.6	Camp detention, rape, life-threatening event, physical violence, witness to violence	Questioning by police as a witness for the War Crimes Tribunal in The Hague, legal complications with residency status
H.K.	3.25	3.26	Physical violence, sexual violence, sexual abuse, witness to violence	Ordered to leave the country, problems with residency status
S.A.	na	na	Life-threatening event, physical violence, witness to violence	Ordered to leave the country, problems with residency status
D.N.	3.31	2.76	Camp detention, life-threatening event	Ordered to leave the country, problems with residency status
S.S.	3.43	3.10	Camp detention, life-threatening event, physical violence, witness to violence	Ordered to leave the country, problems with residency status
C.A.	na	na	Rape, life-threatening event, physical violence	Asylum court hearing, repeated conflicts in the community lodgings, ordered to leave the country, problems with residency status
K.S.	3.18	2.6	Camp detention, life-threatening event, physical violence, witness to violence	1998 ordered to leave the country, problems with residency status
S.N.	3.9	3.6	Camp detention, rape, life-threatening event, physical violence, witness to violence	1996 sexual abuse by official, problems with residency status
S.Z.	3.18	2.88	Camp detention, life-threatening event, physical violence, witness to violence	Problems with residency status
J.M.	3.37	3.2	Camp detention, life-threatening event, witness to violence	Ordered to leave the country
B.R.	3.45	3.37	Life-threatening event, witness to violence	Death of husband ordered to leave the country
M.S.	3.25	2.76	Life-threatening event, physical violence, witness to violence	Repeated physical violence by husband, divorce, ordered to leave the country
K.M.	2.56	2.93	Camp detention, life-threatening event, physical violence	Problems with residency status, Asylum court hearing

HTQ/TS = total score from 30 items, HTQ/PTSD-score of the 16 DSM IV items, na = not available.

patients had experienced intrusive symptoms, avoidance behavior and hyperarousal to varying degrees. Apart from five patients, all had found work and were determined to build a new future in their country of exile. The patients who were not working were counting on permanent residency status.

A pattern of symptom worsening emerged in all the patient histories between 1996 and 1998, a time at which the legal residence status of refugees in Germany changed. A law that made it compulsory for the patients to return to their country of origin was introduced and the residency status was changed to residency toleration. Renewal deadlines of 1 to 3 months lead to a clear increase in anxiety symptoms (Germany is a country with the possibility of

forced expulsion). The longer the uncertain situation of residency toleration persisted and the fear increased that they would be sent back to the place or to the vicinity of trauma with the danger of encountering those who abused them, the more the symptoms of the illness increased. In addition there are mental health effects of mandatory detention and subsequent temporary protection on refugees. An Australian study revealed the risk of ongoing PTSD, depression and mental health-related disability where longer detention was associated with more severe mental disturbance, an effect that persisted for an average of three years.[24]

Treatment concept

In abstract terms, the treatment proceeded in phases, which should not, however, be considered linear, but rather as a spiral-like process. Of special importance in the first phase of treatment is the conveyance of security and trust and the development of meaningful personal contact between the refugee and the therapist as well as developing a safe therapeutic environment.[25,26] In the second phase, the treatment of psychosomatic problems is central. In this phase, it is favorable to use interdisciplinary forms of treatment in which the patients learn relaxation and are also treated with physical therapy. The third and most difficult phase of therapy involves the supported confrontation with the experienced trauma. The fourth phase is designed to enable a reinterpretation of the experience (normalization of the abnormal) and attention is directed at social integration.[21,27]

Quantitative information on the various phases of the psychotherapeutic treatment (numbers represent total estimated time invested in hours, whereby there may be overlap between the categories of therapy) are given (see Table 3). In addition to the actual therapeutic work, a substantial part of the workload comprised the legal safeguarding and counseling of the patients, which involved at least 10 hours per patient.

Security: This phase involves recovery of control over the body, feelings, and thoughts. Therapeutic strategies must satisfy the patient's need for a feeling of security in all of these areas: physical means, medication, relaxation training and strategies for cop-

Table 3. *Quantitative information on the various phases of the psychotherapeutic treatment.*

Patient	Treatment since	Total hours	Feeling of security	Self control	Remembering and grief	Reintegration
S.A.	5/98	35	18	10	5	2
B.R.	5/98	17	11	3	3	0
B.S.	5/98	23	10	4	6	3
D.N.	7/98	15	10	3	2	0
C.A.	7/98	12	12	0	0	0
M.S.	8/98	18	12	2 plus 12 physical therapy	4	0
K.S.	6/98	17	10	5	2	0
S.N.	10/98	12	12	0	0	0
S.Z.	10/98	10	8	2 plus 12 physical therapy	0	0
K.M.	1/99	6	6	0	0	0
J.M.	1/99	6	6	0	0	0
H.K.	3/99	3	3	0	0	0
S.S.	10/98	8	6	2	0	0

Numbers represent total estimated hours, whereby there may be overlap between the categories of therapy.

ing with stress, cognitive methods for the recognition and naming of the symptoms, making concrete plans for obtaining a feeling of security, developing a trusting therapeutic relationship, social strategies in cases of social alienation, self help organization, mobilization of the social environment, creating a secure environment, and utilizing pre-traumatic resources.[25,28]

Self control: In this phase of the treatment the focus is on coping with pain and lowering the hyperactive level of arousal. The modern cognitive behavioral methods for coping with pain involve deep relaxation which can be learned well regardless of the cultural background of the torture victims and which represents a 'first aid' in coping with the physical pain.[29] In addition, the high level of arousal of the patients may be reduced, and in combination with physiotherapy, the patients begin once again to experience their body in a positive way. The introduction of relaxation techniques also offers the opportunity to develop a model of the reciprocity between physical stressors and bodily reactions together with the patient. Finally, these therapeutic experiences are important for the patients because they learn to become active rather than stay as a passive victim. Self control, active participation, and trust are the goals of this phase of treatment.

Remembering and Grief: Here too, the general principle of personality strengthening and special attention to the need for a sense of security is applied. Exploration of the life situation before the trauma and the circumstances which caused the trauma is carried out at this point. After that, the reconstruction of the trauma is essential. The trauma is not transformed during this stressful reconstruction work but rather it becomes more present and real. The transformation with the highly developed behavior therapy techniques of stimulus confrontation or the creation of witness accounts aims at taking the horror out of the events through repetitive and controlled reliving of one memory after the other. The process of grieving is accompanied by the processing of revenge fantasies, and reparation wishes, deep feelings of guilt and shame, but also the search for positive experiences and the strengthening of the bonding and relationship-forming capacity. This phase is of variable duration, and mostly takes longer than the patient (and the therapist) would wish.

The reconstruction of the trauma can not be fully completed in the therapy. Each new stage of life brings with it new conflicts and challenges, which unavoidably reawaken the trauma and expose a new aspect of the traumatic experience. The main body of work is completed when the trauma can be considered to be past in a time continuum and the patient participates in life with regained hope and energy.

Reintegration: Creating a future, development of a new "self", starting new relationships, searching for meaning and activities, and adaptation to a new situation are integral parts of this phase. In this phase, problems of the first phase are often approached anew, not defensively, but actively. The patient should be prepared for the fact that in new stages of life, and in times of high stress, posttraumatic stress symptoms can reoccur.

The psychotherapeutic treatment was complemented by medication or the precondition for psychotherapeutic intervention was established by the medication (see Table 4). Detailed information about the necessity for medication, about the type and effect spectrum of each of the substances allowed for good compliance. The initially strong and partly culturally rooted reservations about psychiatric and especially pharmaceutical treatment were overcome in this way. We

treated the patients with antidepressants of the SSRI (citalopram) or NaSSA (mirtazapine) types, partly in combination with an atypical neuroleptic (olanzapine) drug.

Treatment evaluation

The evaluation of the treatment was conducted in two ways. The therapy protocols were examined for signs of change. This was done with the use of an evaluation schema in which the reduction of PTSD symptoms, sleep disorders, pain and pain reducing medication, and improvement in self esteem, trust of other people, and general life satisfaction (feeling of security) were noted. This examination was complemented by post hoc interviews in the context of the psychiatric treatment. A quantification of the therapeutic evaluation was not attempted as no corresponding evaluation instruments in the patients' language is available and for this purpose the employment of an interpreter would only have produced a pseudo exactness.

All patients showed an improvement in sleep behavior with a shortened time to fall asleep and lessening of nightmares. Most patients also showed a reduction in intrusive symptoms and hyperarousal. Avoidance behavior was interpreted by us in this first phase of treatment as an active protection mechanism against intrusions and was

Table 4. *Pharmaceutical treatment with various substance classes.*

Patient	SSRI	Buspirone	NaSSA	Benzodiazepines and Hypnotics	Atyp. Neuroleptics	Typ. Neuroleptics
S.A.	Sertraline 50 mg					
B.R.			Mirtazapine 30 mg			
B.S.	Citalopram 40 mg				Olanzapine 5 mg	
D.N.	Sertraline 50 mg	30 mg		Zopiclone		
C.A.	Sertraline 100 mg			Lorazepam w.n.	Olanzapine 15 mg	
M.S.	Citalopram 40 mg	30 mg		Lorazepam w.n.	Olanzapine 5 mg	
K.S.	Fluvoxamine 150 mg				Olanzapine 5 mg	
S.N.	Citalopram 40 mg			Lorazepam 2 mg	Olanzapine 20 mg	Flupentixol 10 mg
S.Z.	Sertraline 50 mg				Olanzapine 2,5 mg	
K.M.	Fluvoxamine 200 mg			Lorazepam w.n.		
H.K.	Fluvoxamine 150 mg				Olanzapine 5 mg	
J.M.	Citalopram 40 mg				Olanzapine 5 mg	
S.S.	Sertraline 50 mg			Zopiclone		

Numbers are daily doses, w.n. = when needed, i.e. after consultation with the patients with flashbacks or overwhelming anxiety.

supported. The positive effect observed by patients of the antidepressant treatment normally started after several weeks and was described in terms of more liveliness, courage, and interest, which lead to a reduction in avoidance behavior (see Table 5).

Discussion

We offered the patients an examination and treatment atmosphere which unified a high degree of empathy with the necessary professional distance. The cooperation with the Rehabilitation Center for Torture Victims Ulm and our specialized trauma consultation session showed that an experienced trauma can be encountered and does not have to be made taboo. At the same time, the institution of a university psychiatric clinic allowed for the necessary competent diagnostic and differential diagnostic examination of the symptoms.

Professional, or at least experienced native speaking, interpreters (corresponding to the ethnic background of the patient) are necessary for the treatment if the patients and therapists cannot communicate in one language. However, interpreters without specials training are very often not able to function within a meaningful therapeutic relationship. Instead of translating they tend to speak with the patient. Summarizing to the therapist is also a problem. Another problem is that traumatic experiences and emotional responses are often difficult to put into words even in the mother tongue for the patients.[30] In such cases an interpreter is left alone with constructing the meaning to the therapist. Occasionally patients are accompanied by a relative for translation and they will not disclose some traumatic experiences because of emotional responses like shame or guilt. However the quality of the personal relationship between the refugee and the therapist is more important than correct translations.

The connection between the symptoms and the traumatic experiences was, if not spontaneously reported by patients, actively examined, e.g. "How long have the symptoms been there and in what context did they first occur? Have you got your own explanation for why you have suffered from them since then? Have there been events since then which have especially stressed

Table 5. *Evaluation information from the therapy protocols and post hoc interviews.*

Patient	Reduction PTSD criteria 2	3	4	Reduction sleep disorders	Reduction pain and visits to physician	Reduction pain medication	Improvement sefl esteem	Increase trust	Increase satisfaction
S.A.	Y	Y	Y	Y	0	0	Y	Y	Y
B.R.	Y	Y	0	Y	Y	Y	Y	Y	Y
B.S.	Y	Y	Y	Y	Y	Y	Y	Y	Y
D.N.	Y	0	Y	Y	Y	Y	Y	Y	Y
C.A.	0	Y	Y	Y	Y	Y	Y	Y	Y
M.S.	0	Y	Y	Y	0	0	Y	Y	Y
K.S.	Y	Y	Y	Y	Y	Y	Y	Y	Y
S.N.	0	0	Y	Y	Y	Y	0	Y	0
S.Z.	Y	Y	Y	Y	Y	Y	Y	Y	Y
K.M.	Y	0	Y	Y	Y	Y	0	Y	Y
H.K.	0	0	Y	Y	Y	0	0	0	Y
J.M.	Y	0	0	Y	0	0	Y	Y	0
S.S.	0	Y	0	Y	0	0	0	0	Y

No therapeutic success is indicated by 0, therapeutic success is indicated by Y.

you and which you often think about?" We always asked why the patients emigrated from their homeland to Germany and under what conditions. Of particular importance is that the interviewer must be sure that he or she can withstand the reports of the patients without being secondarily traumatized. The danger exists that the descriptions in their full horrible and gruesome nature with the accompanying emotional exasperation or petrification and the rage and helplessness which they cause, can lead to a kind of helpless therapeutic activity or a distancing defense mechanism manifesting itself in secondary traumatization, compassion fatigue or burn-out of the therapeutic personnel.[31]

Speaking about the events can only relieve the patient when the clinician directs attention to the fact that being emotionally overwhelmed can be avoided by encountering the traumatic memories. In this way the patients were asked to report only as much as they felt comfortable with, since this distinguishes the examination and treatment situation from the traumatic event (during the latter control and termination were not possible). Only then will the patient realize that another approach to the traumatic memories and to the combination of defense (avoidance = constriction) and uncontrollable emotional overload (flashbacks = intrusions) can be possible.

It is also important to look into the current social situation of the patient, including the legal and residency status related conditions, since this can be the source of intensive worry and the background to oppressive anxiety. Knowledge of the particular situation of foreign patients and their culture is helpful and should be present.

All patients profited in this setting from a pharmaceutical treatment embedded in an educative procedure, conducted with great care, informing the patients about the mechanisms of their suffering. The knowledge about the psychobiological nature of the connections between the symptoms and the traumatization lead to substantial relief. Mostly patients were very afraid of being or becoming crazy or of having obtained permanent organic damage from their abuse.

Limitations of the therapy

The uncertain external life circumstances of the patients did however set limits to our therapeutic efforts. For example, it could be observed that all symptoms of PTSD, which were receding during therapy, increased with respect to frequency of occurrence and severity when the residency toleration deadline was reached, even with constant or increased medication. The constant uncertainty as to whether the residency toleration would be extended or not represented subjectively for the patients a repetition of their trauma, and of their exclusion experience, their expulsion, and their self perception of worthlessness. It re-traumatized them and hindered the therapeutic process. Only when the immigration authority could be convinced that the above described special circumstances existed, thereby establishing secure life circumstances for the patients, was it possible to continue the therapeutic process unimpeded by this re-traumatization.

The creation of life circumstances which offer external security is a sine qua non for being able to conduct successful psychiatric treatment and offering a safe therapeutic environment for traumatized refugees, thereby substantially reducing suffering and preventing the development of chronic disorders. Returning to the patients' homeland, in which they were abused by neighbors, teachers and former friends, and where the risk of extreme stressful situations is high, should only occur voluntarily and can only be safe

for health if the patients are sure of their reaction to meetings with former perpetrators.

Under current German immigration policy it is often necessary that the treating physician takes active steps for the protection of his or her patient from mandatory expulsion or even worse, deportation. Unfortunately usual clinical medical certificates with etiology and diagnosis are not enough, and in addition to the diagnosis of PTSD, the causality between the disorder and the traumatization experienced in the patients' homeland must be included. This is possibly even a reason why the medical treatment is being carried out now and not on an earlier occasion. It is also advisable to point out that a treatment of this kind with a chronic course of illness could be a slow process and requires several years in order to prevent chronicity or re-traumatization. Such therapeutic complexities and extensions carry the risk of intra-role conflicts, particularly if exploiting or even deceiving (in rare cases) of helpers occur. Recently Pross[32] argued in this journal that among other means like supervision, solids professional training, and self-awareness, a proper professional distance must be maintained in order to prevent burnout and vicarious traumatization.

In summary, the examined group of extremely traumatized refugees with PSTD can profit from a specific psychiatric treatment in their country of exile which combines pharmaceutical and psychotherapeutic treatment.

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