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A NARRATIVE EXPOSURE TREATMENT AS INTERVENTION IN A REFUGEE CAMP: TWO CASE REPORTS

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Abstract

Psychosocial services in refugee camps need workable guidelines on how to treat posttraumatic symptoms that result from organised violence. In two severely traumatised Kosovar refugees living in a Macedonian refugee camp during the Balkan War, we applied a Narrative Exposure Treatment (NET). NET is a pragmatic short-term approach that integrates effective therapeutic components deriving from Cognitive Behaviour Therapy and Testimony Therapy. Success was evaluated by clinical examination and the Posttraumatic Stress Diagnostic Scale (PDS). In both patients one to three sessions of NET were enough to afford considerable relief, although some PTSD symptoms remained. Our experience indicates that Narrative Exposure is a promising and realistic approach for the acute treatment of even severely traumatised refugees living in camps. In addition, it can provide valid testimonies about human rights violations, without humiliating the witness.

Key words

Narrative Exposure Therapy, refugee camp, PTSD, Kosovo war, emergency psychotrauma-aid

Introduction

According to the United Nations High Commissioner for Refugees (UNHCR) the number of civilians who are fleeing from severe human rights violations or the consequences of war is rapidly increasing. Whole populations have been victims of mass expulsions, persecution, torture and genocide in different theatres of war, from Africa to the former Yugoslavia in Europe. In 1999 the so-called ethnic cleansing of Kosovo resulted in the flight of hundreds of thousands ethnic Albanians from their country. Humanitarian relief organisations that cared for refugees in camps near the Kosovo borders in Macedonia and Albania were confronted with widespread disease and injuries resulting from exhaustion, violence, deprivation of food and water, and bad hygienic conditions. Besides these degrading conditions, refugees report having witnessed and/or experienced atrocities and other extremely stressful events, and come to caregivers with severe psychological complaints including anxiety and depression (Agovino, 1999).

Faced with considerable psychiatric morbidity and a high proportion of somatic symptoms that are inexplicable physically, medical relief organisations have set up departments for the psychological assistance of their patients. Mental Health officers working with such patients are in need of concrete instructions on how to treat seriously affected survivors of severe psychological trauma. Current knowledge about consequences of violence of this kind is quite limited.

Several studies have investigated mental health in refugee camps near the borders of the county from which the refugees fled. Two of these studies (Mollica et al., 1993; Shresta et al., 1998) were carried out in developing countries in Asia, and found a high psychological morbidity among the refugees even several years after their escape. Mollica and coworkers (1999) examined the mental health of Bosnian refugees living in a camp in Croatia. Significant rates of PTSD (26%) and Major Depressive Disorder

(39%) were found. In a camp in Italy, half of the refugees from the former Yugoslavia suffered from PTSD (Favaro, Maiorani, Colombo, & Santonastaso, 1999) as did refugees in camps and settlements of Northern Uganda (Schauer et al. 2001).

So far, no study has investigated the nature and prevalence of acute symptoms among survivors of severe human rights violations immediately after persecution or fleeing. High rates of psychiatric morbidity found in survivors of the Holocaust, even several decades after the end of World War II, indicates that the psychological consequences of violent persecution can persist throughout life (Levav, 1997) and may even affect the next generation (Yehuda, R. et al., 1998; Lueger-Schuster & Dar, 1999).

It is unclear to what extent psychosocial interventions are useful for the treatment and prevention of chronic psychological disorders in refugees (Summerfield, 1997). There is evidence that some acute psychological interventions in the immediate aftermath of a civil trauma may be useless or even harmful (Rose & Bisson, 1998), so caution is warranted in the large-scale implementation of ad hoc psychosocial programmes in refugee camps. Further research is necessary to develop and evaluate methods appropriate to the special characteristics of individual refugee groups.

Research on therapy of PTSD following civil trauma and combat experience shows that exposure techniques, particularly procedures that are able to reactivate the survivor's traumatic memories in a controlled way, are successful in treating PTSD (Foa & Meadows, 1997). Recent studies have verified that Cognitive Behavioural Therapy (CBT) that includes an exposure element is successful in both treating PTSD and preventing the development of chronic PTSD in patients who present severe symptoms in the immediate aftermath of civilian trauma (Bryant, Harvey, Dang, Sackville, & Basten, 1998; Follette, Ruzek & Abueg, 1998; Foa, Hearst-Ikeda, & Perry, 1995a). Such exposure therapy was developed to separate the traumatic memory from the conditioned emotional response and abolish the latter. Following successful exposure

treatment, clients can confront these memories without having the recollections trigger intrusive and hyperarousal PTSD symptoms, and consequently avoidance symptoms are no longer relevant. This approach has proven to be the most effective treatment for PTSD so far (Friedman, 2000; Rothbaum, Meadows, Resick & Foy, 2000).

However, the exposure techniques applied to clients suffering from traumatic stress after rape or motor vehicle accidents cannot be easily transferred to survivors of severe human rights violations like massacres, atrocities and genocide. Here, it has to be taken into account that the exposure would be administered in the midst of a disaster-emergency setting. Psychotherapeutic intervention would take place only a short period after the person has got severely traumatised and was dangerously evacuated to a transient refuge. Taken together, it was unclear whether a brief and in addition confrontative measure, applied without considerable preparatory work (e.g. like establishing a stable relationship with the client), would result in equally reliable treatment effects.

Furthermore, in exposure therapy or other confrontative techniques the patient is continuously confronted with his or her memories of the traumatic event that caused the symptoms. Exposure to the traumatic stimuli is obtained through mental imagery of the worst events they clearly remember (Foa & Rothbaum, 1997). This is much more difficult to achieve with survivors of organised violence as most of them did not experience a single traumatic event, but a series of extremely stressful experiences during their persecution (Basoglu et al., 1994; Gorst-Unsworth & Goldenberg, 1998; Mollica et al., 1993). The length of time these survivors had been exposed to violence can span several years, and often the most stressful event among the sequence of traumas is impossible to identify.

Instead, survivors of torture and other severe human rights violations were found to respond very positive to a standardised procedure called Testimony Therapy (TT) that aims at the construction of a detailed and coherent report of the survivor's biography

including an explicit description of the traumatic events. The written testimony created by the patient in cooperation with a therapist can also be used for documentary and political purposes.

TT was created by Cienfuegos and Monelli (1983), for treating victims of the Pinochet regime in Chile. Although the efficacy of TT has not yet been proven in a randomised controlled trial, several case reports and group studies indicate that it can bring significant relief to severely traumatised survivors. In addition to political activists in Chile, TT has been applied successfully by Agger and Jensen (1990) to refugees coming from different cultures to Denmark, and by Weine, Kulenovic, Pavkovic, and Gibbons (1998) to refugees from Bosnia who resettled in the US.

As in CBT, prolonged exposure to the traumatic material is realised through reporting about it during testifying and may allow the habituation of emotional and physiological reactions to reminders of the traumatic events and reduce symptoms in this way (Foa & Kozak, 1986).

Foa, Molnar, and Cashman (1995b) explored the changes in trauma narratives during exposure therapy for survivors of rape. They showed that the decrease in fragmentation of the narratives was correlated with a reduction in PTSD symptoms.

Taken these findings together, there is evidence that the reconstruction of the autobiographic memory about stressful events may be an essential part of the processing of the experience. The Narrative Exposure Treatment (NET) applied in this study combined CBT elements with the testimony approach to reduce PTSD in survivors of organised violence.

The psychotherapeutic elements considered to be essential of the NET approach can be described as follows:

1. Prolonged exposure and repeated imaginative reliving of the traumatic situation as applied in CBT, in order to activate and modify the corresponding fear-structure (Lang, 1984, Lang, 1993) and to separate the traumatic memory from the conditioned emotional response.
2. Active reconstruction of the shattered autobiographic memories of the trauma through the process of completing a higher-order knowledge about the incident in the form of a comprehensive, meaningful and consistent testimony (report of witness).
3. Cognitive re-evaluation and re-interpretation of every more recent and more complete version of the trauma narrative in order to correct false thoughts and negative beliefs generated by the overwhelming stressor that affected healthy processing of traumatic memories.

An explicit human rights orientation of 'testifying' can be a significant advantage of this procedure. Psychotherapy for survivors of human rights violations has been criticised for neglecting the context of the violence and for 'medicalising' the consequences of war and repression (Bracken, Giller, & Summerfield, 1995). Since the testimonies created by the survivors can be used to document human rights violations, the NET procedure helps the person to regain dignity and satisfies the survivor's need for justice. Consequently a relatively high willingness to take part in this form of therapy has been reported (Weine et al., 1998; Neuner et al., 2001).

Narrative Exposure Procedure

The basic procedure of the Narrative Exposure can be outlined as follows.
In a relatively small number of sessions the client constructs a detailed and consistent narration of his biography in cooperation with the therapist. The focus of the therapy lies on the completion and integration of the initial fragments about the traumatic

events into its entirety, including the sensory, emotional and cognitive experiences of the incident. The testimony is written down and, pending on the acceptance of the client, also used for documentary purposes. This procedure was now adapted to the special demands of the situation in a refugee camp and has evolved to the following standard:

After the assessment of PTSD a psycho-educational introduction is given to the survivor, focusing on the explanation of his/her disturbance and suffering from symptoms, as well as an explanation about the United Nations World Declaration on universal human rights, followed by a preparatory introduction to the therapeutic approach.

Treatment starts immediately after a diagnostic assessment, which gathers demographic data, medical and psychiatric history, and current complaints. PTSD symptoms are quantified using a slightly modified form of the Posttraumatic Diagnostic Scale (PDS; Foa, Riggs, Dancu, & Rothbaum, 1993).

Using a semistructured interview, the following topics are explored in consecutive sessions:

- Individual and family history prior to the persecution
- Experiences from the beginning of persecution to the first terrifying event
- Terrifying events
- History of flight
- Life in the refugee camp
- Plans, hopes and fears concerning the future

The therapist structures the topics and helps to clarify ambiguous descriptions. S/he takes an empathic and accepting role. Inconsistencies in the client's report are gently pointed out and often resolved by raising in-depth awareness about recurring body-sensations or thoughts. The client is encouraged to tell the traumatic events in as much detail as possible and to reveal the emotions and perceptions experienced at that

moment, being assured that s/he is in control of the procedure at all times and will not be pushed to do anything against his or her will. A translator, oriented beforehand to the psychological goals, may be necessary.

The therapist writes down the client's narration (or the translation if necessary). In the subsequent session, this report is read to the client (simultaneously translated by the interpreter if necessary) and s/he is asked to correct it and to add further details. The procedure is repeated across sessions until a final version of the client's biography is reached.

In the last session, this document is read again and the client, the translator and the therapist sign the written narration. One copy of the signed document is handed to the client; another is kept for scientific purposes. With the agreement of the client, another copy is passed on to human rights organisations for documentary and advocacy purposes or published in another way.

The setting in the Macedonian camp

Narrative Exposure Treatment has been given a trial in a refugee camp in Macedonia in cooperation with an international humanitarian aid organisation. When the mass expulsion of ethnic Albanians from Kosovo begun in March 1999, non-governmental organisations (NGOs) conducted mental health programs, supporting refugees with outpatient clinics in tents in the refugee camps at border-crossing points. The mental health service in the camp, where over 20,000 refugees were sheltered opened its full service in April 1999. Key objectives of the psychosocial programme during the crisis included identification, first aid and short-term treatment, or referral of those not able to care for themselves, mentally or socially (De Jong, Ford & Kleber, 1999); and provision of back-up service for acute psychiatric conditions. In addition, the program treated traumatised survivors who were unconscious, depersonalised, in danger of

mutilating themselves or harming others in the camp, and cared for chronic psychiatric patients who had been expelled from hospitals and care institutions.

The team of mental health professionals in the camp was led by one of us (M.S.). Three to seven general practitioners, psychiatrists, and psychologists from Macedonia were employed. Further outreach workers have been recruited from the refugee population. This mental health team dealt with an average daily influx of fifty patients. Because of their numbers, most persons seeking help had to be attended in a single session, aiming to provide some relief from symptoms, stabilise the survivor and secure his/her functioning in the camp environment. This was mainly achieved by providing counselling and practical help. Emphasis was put on mobilising the client's social support network. Narrative Exposure was carefully implemented only when other methods of stabilising the client's personal or social situation had failed.

The Case of Aferdita

Aferdita (this and the following names are fictitious), a 24-year old student from Pristina, was carried into the medical health tent on a stretcher. She reported later, that she had had repeated episodes of loss of consciousness for several years. As the physicians could not find any reason for these episodes, she was referred to the mental health unit in April 1999.

The exploration by a mental health professional revealed that Aferdita had been experiencing fainting spells since 1993. The trigger for this referral was an investigation of an interviewer who worked for a human rights organisation. Aferdita described that this interviewer had urged her to report her recently witnessed atrocities.

In addition to the fainting Aferdita suffered from diverse dissociative symptoms, such as emotional numbness and out-of-body experiences. The fainting was possibly a dissociative phenomenon as well. Posttraumatic Stress Disorder was present as she

experienced marked intrusion, avoidance and hyperarousal symptoms. The fear of getting killed made her scream during flashbacks. She prevented herself from falling asleep by wandering around in the camp during the night because she feared nightmares. She was severely depressed and kept social contact with no one but her cousin (the only other member of the family in the camp). The PDS revealed maximum scores for each symptom except for partial amnesia (see Fig. 1a). Aferdita reported that the symptoms had persisted for five years.

In view of Aferdita's suffering, the outpatient department first attempted to treat her with psychoactive medication (diazepam). This brought no relief. Efforts to alleviate her suffering through counselling and symptom-oriented problem-solving failed as well. Notwithstanding Aferdita's negative experiences with the interview for the human rights organisation we suggested carefully exploring her traumatic experiences within Narrative Exposure. Therapeutic procedures, their purpose and limits of scientific knowledge about its effectiveness under the given circumstances were made fully transparent to her. For obvious reasons Aferdita agreed, because she wanted the truth about her persecution to be known.

The first session of NET revealed a long history of persecution of Aferdita and her family, including many potentially traumatic events. She could report her past without difficulty until she came to the following scene, the recounting of which visibly affected her.

„I was the first to see the paramilitaries forcefully entering our house. This happened in 1993. I fainted in that moment. Later I was told that they searched the house. When my consciousness returned, I was lying on my back on the ground in the backyard. A man in uniform stood on top of me pointing a gun to my forehead, screaming at my father: 'Give us weapons or money or you will lose your daughter!'"

After Aferdita reported this event the first time, she fainted. Some minutes later she regained her consciousness and therapy could proceed. The following exploration

revealed that her sudden breakdowns were connected to her previous experiences. Aferdita realised that fainting was triggered each time by seeing another person lying on the back or by thinking of this experience.

Aferdita told that she was often reminded of this event during her flight as she was regularly threatened with death and saw massacres and numerous mutilated corpses on the way. “At some point the flashbacks began, hitting my face like a fist. It was horrible. Suddenly I had to re-experience everything again and again. I felt as if my self was outside my body. It was as if I would have to die.“

Aferdita agreed to continue therapy and was bent on telling the whole story without fainting. Within three sessions (about 70 min each) she actually managed to create a nearly complete narration of her autobiography including several traumatic events. Therapy was not interrupted by fainting spells any more. After the third Narrative Exposure session, which took place within five days, Aferdita did not lose at all consciousness any more. Her mood improved dramatically. In view of the great number of refugees seeking help, therapy was concluded at this point.

A follow-up examination one week later (just before her evacuation to the US) revealed that Aferdita still suffered from mild PTSD including intrusive symptoms like incidental nightmares and flashbacks (Fig. 1a). But her marked dissociative symptoms had disappeared completely. She showed no signs of depression any more and started to relate to other peers the first time since five years.

-- insert Figure 1 --

Surprisingly, Aferdita phoned from her overseas exile about one year after the treatment. She happily expressed her satisfaction with the treatment and reported that she is "very good" because symptoms had remitted.

The Case of Ismaeli

Ismaeli, a 44 year old male teacher was brought to the mental health tent by his brother on his third day in the camp. Ismaeli was not able to talk. He displayed restlessness of both legs suggesting running movements even while he was sitting on a chair. He did not eat but drank unusually large amounts of water. He was breathing heavily. His appearance was reminiscent of the behaviour of a man on the run.

According to his brother, this condition had not changed since he had found Ismaeli in the Kosovar mountains five days ago, where he had been hiding for ten days. When the brother said this during the assessment interview, Ismaeli rose from his chair and tried to hide behind him.

The brother continued to describe Ismaeli's behaviour. He said that Ismaeli was continually shifting his attention, orienting to minor environmental stimuli. More intense stimuli produced a profound startle response. He was hyperalert and checked permanently to see who was around, being uncomfortable when turning his back to the entrance of the tent. Even in his family's tent he would try to hide behind his wife. His family members reported that he was sleepless ever since they found him in the mountains.

Psychological examination confirmed that Ismaeli suffered from PTSD with marked symptoms of hyperarousal. (PDS-scores are presented in Fig. 1b). Since various therapeutic approaches during the preceding two days including anxiolytica, sedatives and counselling had proved completely ineffective, a NET session was scheduled for the next day.

The procedure had to be modified, as this client was not able to put his experiences into words. We had to fall back on his brother and his wife to construct in Ismaeli's presence a verbal version about his traumatic incident. So we asked them to narrate his biography from his perspective as accurately and completely as possible. Ismaeli's

gestures made clear that he accepted to the procedure and his wife and brother serving as his current voice. He spontaneously pantomimed along the spoken words, highlighting which parts of the report were particularly relevant to him. He indicated with mimics and pointing at parts of his body where he felt which sensations. His traumatic events can be summarised as follows:

Ismaeli was a teacher of Kosovar children and had lost his job when paramilitary forces closed the school in 1991. He kept on teaching in private houses in the years following. Serbian police forces attacked the village in 1999. When troops began to shell the village, the family escaped to his sister's home village. But paramilitary troops with face masks and red scarves reached this village, entered the houses and divided men from women and children. The women hid and watched what happened to the men. The men had to raise their arms, stand with their face to the wall and the paramilitary men beat their backs.

The women, including his wife, took the children and escaped. According to other witnesses and survivors of the situation the Serbian forces lined up the men and massacred them by cutting one after the other into pieces. "They threw the cut-off parts, ears, eyes, heads, legs, arms over a wall." Thirteen men had already been killed each by each in the row where Ismaeli stood awaiting his mutilation. He was the next to be executed when just at that moment Serbian military forces arrived at the site. In the resulting confusion Ismaeli and the other men behind him in the line managed to flee by running as fast as they could. For the next ten days they hid in the mountains being under permanent threat from attacks by ground troops.

His brother concluded "I found him in the mountains in a terrible state; he didn't want to live anymore. So I took him to the nearest house, gave him water and food, but he only wanted a cigarette, and didn't speak anymore. He was only able to express himself by gesturing. Obsessively he repeated to imitate hitting his back with his fist, cutting his body parts off with a knife and throwing them in the air."

Ismaeli confirmed his relative's report with lively mimic and the described gestures of mutilation. Subsequently he progressively relaxed. At one point the continuous motion of his legs came to rest. He stretched, leaned back, and stopped trembling. Finally he accompanied his brother's report about screams of pain expelled by the dying victims with his own loud cry, the first sound he had vocalised since he had stopped talking.

A short follow-up was conducted on the next day. Ismaeli's relatives said that he still could not talk but they were better able to communicate with him now. He had calmed down and has been well sleeping during the night. The continual movement had disappeared completely. He had not been hiding any more and was beginning to participate in family life again.

The PDS reflected the change reported by Ismaeli's relatives. Of course he has not been cured but his state has considerably stabilised. As attempts to evacuate the family were successful soon afterwards, treatment could not be continued.

Discussion

In the transit camps near the Kosovo border there has been a great need for psychosocial assistance among the refugees. A considerable number of them have sought treatment for psychological or psychosomatic symptoms. The intrusive symptoms of acute and post-traumatic stress together with hyperarousal and dissociation seem to be common among this refugee population. Unfortunately there are no reliable guidelines on how to treat acute or chronic symptoms in survivors of extreme stress after severe human rights violations, particularly under conditions that do not allow an extended series of treatment sessions or a safe and comforting environment.

During these first hours and days after a man-made disaster including genocide, human rights interviewers need to approach the survivors to get hold of credible and genuine eye-witness testimonies.

Using NET we tried the combination of a testimony like approach as a procedure that has been developed especially for survivors of severe human rights violations together with CBT elements . However, since a confrontative treatment approach may have harmful consequences in the immediate aftermath of a trauma, NET was carefully applied to only a limited number of refugees who were resistant to any other help.

Several characteristics of the situation complicated our treatment attempts. Due to the high influx of refugees seeking treatment, only a very short time has been available for each client. The therapeutic environment consisted of tents, were privacy was unpredictably disturbed, and which were highly permeable for the level of surrounding noise (e.g. screaming of mentally handicapped and other survivors under acute shock, helicopters from the air, excavators and trucks on the ground, as well as the accumulating emission of over 20.000 humans moving in and out the transit camp). Frequently sessions had to be interrupted, because the therapist had to attend emergency cases.

Many refugees have presented symptoms that were unexpectedly severe even for therapists with experience in treating PTSD. And finally, because quite a number of eye-witnesses experiencing the worst human rights violations were chosen by the International Tribunal they were only one time allowed to talk about their traumatic events.

In spite of those difficulties our experiences with NET are promising. As presented above, in two very distinct cases, both patients were able to substantially profit from one or three sessions of NET, although they initially suffered from severe symptoms and substantial restrictions in social functioning. The two reports indicate that chronic (Aferdita) and acute symptoms (both cases) may be amenable to NET. The case of

Ismaeli illustrates that it may not be the report of the patient himself that is central but the reconstruction of the episode, be it by the patient or by witnesses. NET was superior to other treatment attempts in these and other victims of organised violence. No negative consequences of NET have been observed in any of the treatments so far.

Of course, no complete cure in all areas of functioning is to be expected particularly under these pressing circumstances. In most of our cases, a mild form of PTSD-related symptomatology was still present immediately after the treatment. But to our surprise Narrative Exposure turned out to be especially powerful for the therapy of the acute symptoms of dissociation and hyperarousal. The reduction or elimination of these symptoms enabled most patients to take care of themselves again. Perhaps after the autobiographic memory of the traumatic events is restored and dissociative and avoidance symptoms disappear, a precondition for further emotional processing of the trauma is met, making further remission of symptoms possible (Foa & Hearst-Ikeda, 1996; Friedman, 2000).

It is unclear if an extension of the treatment would bring about a further relief of symptoms. In further sessions the client would be encouraged to go through his traumatic memories repeatedly, presumably facilitating the habituation of emotional responses. But complete remission was not considered an attainable goal of a limited psychosocial intervention performed in a refugee camp, so how much improvement is possible with this approach was not studied.

We have confirmed that talking about traumatic experiences can be beneficial for the survivors of organised violence. But there may be exceptions. Many refugees have complained of harmful after-effects of testifying to a human rights organisation. There are some fundamental differences between these testimonial interviews and the procedure of NET. Human rights organisations aim at receiving tenable testimonies free of inconsistencies from credible witnesses. The proceeding of these interviewers sometimes resembles interrogations in court. In contrast, the main focus of NET lies on

the reconstruction of the client's autobiographic memory. The credibility of the client is never questioned in NET. Inconsistencies in the client's report are interpreted as inevitable features of traumatic memories and must be resolved gently. And finally the therapist accepts and encourages emotional responses during the session. Maybe these differences in the procedure determine whether talking about traumatic events has harmful or beneficial consequences. It needs further investigation, to validate whether testimonies gained through the NET procedure meet juridical demands.

Case reports like ours cannot prove the efficacy of a treatment. The effects we observed may be due to spontaneous remission, which is common for acute traumatic symptoms. Only a randomised controlled trial with long-term follow-up can clarify this question, which was not possible in the situation our clients were met. Considering the prevalence of severe human rights violations all over the world, such studies are badly and urgently needed. In the meantime therapists of survivors of severe human rights violations will have to fall back on the guidelines that are currently available.

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