Torture and Trauma: Humanity Lost and Regained

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1. Case Presentation of a Somali Man
2. Special Issues in Traumatized Refugees
3. Psychotherapeutic Approaches
Before Interview

- Somali, therefore Muslim
- Probably experienced war in 1991-1992
- Refugee in Kenya
- Refugee status in U.S.
Intake Interview (May 2008)
53-year-old married Somali refugee male

Major symptoms: poor sleep, nightmares, startle reactions, poor concentration, irritability, depression, loss of interest, for one year since out of work.

In 1991 – kidnapped and beaten. Saw many people killed, rebels broke into his home and killed his uncle and brother while he escaped out of the back window (much sadness and guilt), in refugee camp for 10 years.
THRESHOLD FOR SEEKING TREATMENT

- Loss of job with increased symptoms (loss of self respect and more self-preoccupation)
Symptoms:
- Depression
- Hyperarousal
- Intrusive
- Avoidance

Course of Trauma-Related Symptoms

Antidepressant ↑
Clonidine ↑
New Trauma with Reactivation ↑
Took medication not as prescribed (3x fluoxetine, ½ clonidine)
Did improve immediately
Very erratic follow-up – usually only made appointment when out of medicine
Any patient from any culture will take any medicine any way they want.
When patient doesn’t take medicine as prescribed

- A. If they get better, claim that is what you wanted
- B. If they get worse, blame the patient
Patient (with counselor) in August 2009
Patient Developed hypertension
- Related to living with angry wife
- New context became apparent
- New threshold for help
Patient’s Wife
Wife’s Story

- 3rd wife of patient
- Symptoms of hyperarousal (startle reaction, flashbacks), severe irritability, and anger
- 17 years prior to first clinic visit her father and brother were tied up and shot in front of her
- She and other women were raped
- Now working but angry much of the time
Patient with severe trauma and PTSD living with a wife with severe trauma and irritability and anger
- Increased symptoms
- Poor sleep
- Unable to find work
- Talked about children’s problems for the first time
Patient’s Children

- Age 12 – diagnosed with severe ADHD and Mental Retardation
- Age 9 – bright but severe ADHD
- Both treated by child psychiatrist in our clinic and on stimulant medicine
FRUSTRATED DRAWING OF ANYTHING
NEW CONTEXT

- Somali man with severe trauma and PTSD
- Living with a wife with severe trauma, PTSD and anger
- Living with two children, both with severe ADHD and one with mental retardation
- Patient unable to work
1. Refugee Trauma

- Refugees often have massive, multiple, prolonged, unpredictable physical and psychological trauma, which often continues in refugee camps and host countries. The clinical implications depend on the traumas, patient’s culture and personal history.
It is essential to do a thorough evaluation of the traumas and their meanings. With ongoing stress and traumas, there is no single event on which to focus therapy.

Exposure therapy is culturally related and is inappropriate to patients from some cultures: (Buddhist & Muslim)
Some traumas are so existentially profound (parents helpless as their children die) that a desensitization or reprocessing therapy is contraindicated.
2. In addition to trauma, refugees suffered multiple losses

- Loss of family members
- Loss of social network
- Loss of role within a culture
- Loss of country
- Loss of vocation and income
- Loss of respect

PTSD is usually associated with depression and sometimes psychosis in all ethnic groups.
It is essential to do a thorough psychiatric evaluation for symptoms of affective disorders and psychosis in addition to PTSD. Any model of PTSD biological or psychological, are of limited relevance clinically if they do not also consider depression. The PTSD-psychosis syndrome has been overlooked theoretically and clinically.
3. Chronic Course

- For massively traumatized individuals, the PTSD-depression and the PTSD-psychosis disorders are chronic, with high impairment, subject to exacerbation under stress.
Course of Trauma-Related Symptoms

Symptoms:
- Depression
- Hyperarousal
- Intrusive
- Avoidance

Course of Trauma Related Symptoms

Antidepressant ↑
Clonidine ↑
↑ New Trauma with Reactivation
Patients with PTSD (N=129)
Reaction to 9/11/2001

<table>
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<tr>
<th>Ethnicity</th>
<th>None</th>
<th>Somewhat</th>
<th>Moderate</th>
<th>Very Safe</th>
<th>Extremely Safe</th>
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<tr>
<td>Vietnamese (n=42)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Cambodian (n=37)</td>
<td>6.65</td>
<td>2.57</td>
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<tr>
<td>Somalian (n=17)</td>
<td>9.00</td>
<td>6.94</td>
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<td>Laotian (n=10)</td>
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<td>2.40</td>
<td></td>
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<tr>
<td>Bosnian (n=18)</td>
<td>9.22</td>
<td>4.56</td>
<td></td>
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</tbody>
</table>

*Affect you*:

*F* = 5.414, significance = .000

*Nightmares/Change***:

*F* = 9.274, significance = .000

*Flashbacks/Change***:

***F* = 4.303, significance = .003

*Depression/Change****:

****F* = 10.384, significance = .000
4. Hypertension & Diabetes

Traumatized refugees have a very high prevalence of hypertension and a high prevalence of diabetes.
Comparison of Prevalence of Hypertension in US norms versus IPP patients

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% of US Hypertensive</th>
<th>% of IPP Hypertensive (N/Total)</th>
<th>P value*</th>
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<td>20-44</td>
<td>10.3</td>
<td>21.6 (27/125)</td>
<td>.00001</td>
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<tr>
<td>45-64</td>
<td>38.3</td>
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<td>.03</td>
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<tr>
<td>65+</td>
<td>71.8</td>
<td>69.8 (44/63)</td>
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Comparison of Prevalence of Diabetes between U.S. norms and IPP group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% of US Diabetes</th>
<th>% of IPP Diabetes (N/Total)</th>
<th>P value</th>
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<tr>
<td>0-44</td>
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<td>11.2 (14/125)</td>
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<td>45-64</td>
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<td>17.0 (46/271)</td>
<td>.00001</td>
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<td>65-74</td>
<td>18.1</td>
<td>19.3 (11/57)</td>
<td>NS</td>
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Medical Issues

It is essential to do combined psychiatric and medical evaluation and treatment.

There are large public health implications for the diagnosis and treatment of hypertension and diabetes in traumatized refugees.
The treatment of massive trauma is neither simple nor formula bound and is accompanied by the therapists’ intellectual and emotional reactions.
Major Factors in the Cross Cultural Psychotherapeutic Relationship

1. Telling and listening to stories of massive psychological trauma
2. The effects of time; long-term relationships
3. The acts of giving and sharing
4. The search for meaning and the search for the sacred
Listening

- The patient’s need to tell the trauma story
- The therapist’s ability to listen
Long-term Relationship

- The patient’s need for constancy
- The therapist’s ability to stay
Give and Receive

- The patient’s need to give
- The therapist’s ability to receive
The Problem of Evil

- The patient’s search for the sacred
- The therapist’s ability to believe
1. A simple formulation of a complex psycho-social-cultural clinical problem is usually wrong.
2. A complex formulation of a complex psycho-social-cultural clinical problem is usually wrong.
3. There is no single context or threshold. Clinical situations are dynamic and changing and the clinical formulation and treatment need to change in response.
The optimal clinical approach to psycho-social-cultural disorders is to treat on the basis of known information and patients’ needs, but modify the formulation and treatment plans as more information is available.
What we have learned...

Treatment needs to counteract the trauma, loss, and “hell”. Treatment needs an authentic relationship, safety, continuity, long-term reduction of symptoms and attention to medical problems. Treatment is not simple, nor formula-driven.
What we have learned...

There is goodness just as there is evil in the world. Our job is to promote that goodness through our science and clinical skills. Our efforts are to reduce the suffering and restore hope of traumatized people from all cultures and all religions.