Torture and war traumas:
Wounded healers or the experience of the therapist

Clinical work with traumatized and torture victims is a great challenge for the therapists, especially if he/she experienced personally (directly or indirectly) the wounds of conflict. This brief survey is aimed to explore the perspective of the clinicians who worked and still works in the Kosova Rehabilitation Centre for Torture Victims KRCT in these years. In particular, it is explored the complex emotional intertwinement which creates between therapist and patient and in the context of the psychotherapeutic treatment of Post Traumatic Stress Disorder. As described in literature (Wilson, 2002), the empathic capacity and the counter transference of therapist could influence the outcome of therapy. Generally, clinicians have lived war events only indirectly, and they are able to adjust their empathic strain in an optimal way in relation to their professional experience. Counter-transference experience is described.
1. Coping with trauma

Since its foundation KRCT’s mission has been to contribute to the psychological and physical health rehabilitation of torture and trauma survivors. From the beginning in 1999, KRCT has been aimed to increase awareness of the general public and health professionals on the post-war issues and to reinforce the prevention of torture and other maltreatment forms of individuals. All the staff members have been trained in identification and treatment of traumatized and tortured persons, mainly from professionals from the International Rehabilitation Council for Torture Survivors, IRCT, based in Copenhagen.

Currently, the rehabilitation staff is composed of 4 psychiatrists, one psychologist, one gynaecologist/ general practitioner, one social worker and one lawyer.

Through the referral system, KRCT welcomes clients from several organizations and institutions such as the Family Medical Centres, Social Entities, schools, non-profitable organizations, Police Services, Kosovo Security Force of Kosovo. Since year 2003, the Centre’s services have become part of the public services vis-à-vis the official partnership with the Family Medical Centres in Prishtina and in municipality as Podujevë, Skënderaj, Suharekë, Gjilan, Drenas, Pejë and Deçan. From 1999 until 2005 KRCT has trained 177 medical doctors and nurses in identification of traumatized and tortured cases and in providing of psychosocial assistance. Besides the activity of the existing centers, KRCT has extended the activity in other municipalities such as Lipjan, Obiliq, Klinë, Mitrovicë and Malishevë. Actually, KRCT is present in almost all regions of Kosovo.

Rehabilitation activities

The rehabilitation service is organized in providing treatments according to a multidisciplinary approach. Medical, psychological, social and legal services are one of the main activities of KRCT. Before starting the treatment each member of the multidisciplinary team formulates a treatment plan. More than one specialist may follow the client at the same time.

The treatment is hold in sessions and the duration varies from 4 to 6 months, but in some case it may last for a year or more. Treatment is oriented according 3 dimensions:

1) Psychological-psychiatric rehabilitation: methodological approach for psychological and psychiatric treatments are counselling, support therapy, individual psychotherapy, group psychotherapy, family therapy, psychodrama, body therapy, cognitive-behavioural therapy, expressive-creative therapy, testimony and medication therapy. Decision on the appropriate method is based on the client’s needs, experience of the psychotherapist and client’s resources.

2) Medical rehabilitation: clients may have somatic symptoms which are the main reason why they approach the centre for help. The majority of the psychosomatic consequences
from trauma and torture are combined with pain symptoms in the body. Family doctors offer services like medical consultations, medication treatments and referrals to medical institutions and other specialist. The most frequent diagnosis of clients with somatic disorders are high blood pressure and gastrointestinal disorders.

3) Social rehabilitation: the decline of the economic and social aspect of the clients is one of the main factors that hamper the progress of treatment. Apart from the aggravated psychological status, the clients have problems such as unemployment and unstable economic and social situation. The social worker of the centre is engaged in finding employment opportunities, improving social relationships, finding preparation training for jobs, conducting social counselling and other legal issues. These activities are made possibly in partnership with other NGOs and social al legal institutions.

2. The treatment with tortured and traumatized clients: the therapist’s perspective

In order to react to the great deal of the collateral damages of war on the population, KRCT has established since 2001 a psychological and psychotherapeutic service system. At the beginning the service was aimed to guarantee care, support and specialized treatment of trauma victims, and when the capacities increased, the clinical activities have been extended to education and training services. Three types of psychological treatment are adopted in KRCT: 1) psycho-diagnosis; 2) counselling and psychological support; 3) psychotherapy. Since the most frequent diagnosis within the clinical population who seek help is of Post Traumatic Stress Disorder, the main therapeutic approach is clearly oriented to the traumatic experience.

The main goal of this research is to explore and assess the role and the experience of the therapists, who have been working or are still working with torture and war victims. The contribution of the therapists, who are listening to the client empathically, is definitely important for positive outcome of psychotherapeutic process. Nevertheless, taking in charge clients who suffered such extremes act of violence deliberately oriented to psychic annihilation and physical disruption, represents a challenge for the internal mental asset of the clinician. In particular, therapist who have been working in the post conflict Kosovo may have been involved personally in war events, including losses and traumatic experience, and certainly they have been deeply affect by war as witnesses. Consequently, the therapist could be influenced and limited in his/her empathic capacity of listening and helping clients. Discussing therapists’ experiential perspective results very important in order to improve at first, the effectiveness and the efficacy of psychotherapeutic intervention; second, to guarantee the
well-being and the inner capacity of clinician to be securely engaged in clinical activity; third, to prevent burn-out phenomena.

It will be illustrated a brief overview on the literature about the counter-transference\(^1\) of therapist in psychotherapies with torture victims. It will be also pointed out the main features of the interaction between clinician and client engaged in therapy of trauma. Then, will be reported the pilot study conducted on the group of psychologists and psychiatrists who worked for KRCT starting from 2001 until now.

### 2.1. Trauma therapy and therapist counter-transference

According to one of the most important researchers on trauma studies, traumatic experiences can be considered as archetypal in nature and having their own psychological structure and energy (Wilson, 2002), vary along many different stressor dimensions and have simple and complex effects on the human psyche (Wilson & Lindy, 1994), and are not only different qualitatively and quantitatively from each other, but are subjectively experienced in individual ways through the life history of the person, the filters of culture and language, and the nature of injury inflicted on the organism in all of its integrated wholeness (Wilson, 2002).

Traumatic experiences can lead to transformations of the personality, spirit, beliefs, and understanding of the meaning of life. In that same sense, traumatic experience can alter life course trajectories and have multigenerational legacies (Danieli, 1998).

In a broader perspective, massive or catastrophic trauma can permanently alter, eradicate, or damage entire societies, cultures, and nations (Lifton, 1967, 1993).

Indeed as archetypal form, trauma can be a psychic force of enormous power in the individual and collective unconscious species. Un-metabolized trauma of a violent nature caused by wars, terrorism, genocide, ethnic cleansing, and the purposeful abuse of others can unleash destructive forces within the fabric of civilization (Freud, 1917; 1928; Jung, 1929; Wilson, Friedman & Lindy, 2001). Trauma that is unhealed, unresolved and un-integrated into a healthy balance within the self has the potential to be repeated, re-enacted, acted out, projected, or externalized in relationships and gives rise to destructive and self destructive motivational forces (Wilson, 2002). Listening and observing carefully, the voices and faces of trauma are “snapshots” of the existential struggle to remain whole, vital, and to restore that part of the self damaged by trauma. The stories of the survivors are inevitably universal variants on the archetypal abyss of the trauma complex (Wilson, 2002).

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\(^1\) With the term of counter transference we indicate the complex of cognitive, emotions, behavioral and imaginative reactions of the therapist activated by patient’s communications.
For the therapist, counsellor and others in the healing role, the encounter with the voices and faces of the trauma patient that is difficult and painful: listening empathically to trauma stories is demanding and stressful.

Effective post traumatic therapy or treatment is more than the application of a clinical technique; it is the capacity to facilitate self healing by helping the patient mobilize and transform the negative energies, memories, and emotions of post traumatic stress disorder (PTSD) and associated conditions into a healthy self-synthesis, which evolves into a positive integration of the trauma experience.

In the role of a professional therapist there is a significant and certain risk of empathic distress, compassion, fatigue, burn out and more technically, counter-transference processes.

2.2. Empathy

It is noteworthy the fact that the encounter between therapist and traumatized individual is traumatic in itself, seeing the faces of trauma clients and listening to their voices: this phenomenon is named secondary traumatisation (Stamm, 1997) and is due to the empathic strain of trauma related reactions (Wilson & Lindy, 1994).

The term “empathic attunement” indicates the capacity to resonate efficiently and accurately to another’s state of being; to match self – other understanding; to have knowledge of the internal psychological ego states of another who has suffered a trauma.

The efficacy of Post Traumatic Stress Disorder therapy is related to empathic capacity and to empathic attunement of the therapist. Empathic capacity is considered a fundamental dimension of the psychobiology of empathy, which means the “signal detection” of the information transmission or “flow” in the transference (from client to therapist) and counter-transference (from therapist to client) matrix.

Rowe and Mac Isaac (1991) state, “empathic immersion into the patient’s experience focuses the analyst’s attention upon what is like to be the subject rather than the target of the patient’s wishes and demands “ (Wilson, p.18). Only counter identifications, is to say the capacity of therapist to put him/her self in the perspective of client’s experience, permit empathy with the patient’s ego state. The ego spatial configuration includes organization of experience into memory and functions as adaptation of self to others and to the world and also fluctuating dimensions of self reference, which includes cognitive functions affect regulation, ego identity, and a sense of well being (Wilson, Friedman & Lindy, 2001).

Post Traumatic Stress Disorder is based on four main symptomatic aspects:

1) Re-experiencing traumatic events and scenes;
2) Avoidance of stimuli and situation which can activate memories;
3) Hyper arousal;
4) The new ego identity, self processes and interpersonal attachment.
Describing the intertwinement between clients and therapist during therapeutic communication is very complex. The exchange of information, which occurs during the treatment, could be represented as a “flow” of information through different channels transmitted by the patient toward the therapist and vice versa. PTSD symptoms get transmitted during the process of psychotherapy in a specific kind of transference, which Wilson, Friedman and Lindy (2001) defined as “Trauma Specific Transference Transmission” (TSTT). On the one hand, patient is protected by a defensive screening of anxiety and vulnerability: PTSD symptoms re-experience phenomena, avoidance denial, physiological hyperactivity, ego states, interpersonal processes and unconscious projections of traumatic experience represent sender variables. On the other hand, the emphatic attunement that is function of the therapist’s capacity to decode, is composed by resonance, precision/accuracy, timing, connection to event, relation to history, self-object, counter-identification, translation of unconscious memory.

In a way that the authors call “psychobiological synchrony”, the therapist is “in phase” with the client, but the empathic strain is conceived as a continuum dimension of attunement ranged from optimal level to separation and detachment.

Therapist may react according to his/her personal style, with empathic disequilibrium or enmeshment, when tends to over-identify with the clients. In other cases may prevail a detachment strategy, which includes empathic withdrawal and empathic repression?

Working with traumatized patients could activate anxiety and defensiveness in therapists, with influences on the empathic strain. Coping mechanisms of therapists are very important for their clinical capacity and have significant consequences on the outcome of treatment.

3. The clinical experience of therapists in KRCT

In order to explore the perspective of clinical staff in KRCT and to evaluate their capacity and effectiveness, the Research and Documentation Unit jointly with the Rehabilitation Service Unit have conducted an in-depth interview.

Psychologist and psychiatrist currently employed in the KRCT throughout Kosovo have been interviewed.

The interview has been constructed on the basis of the studies on counter-transferential phenomena related to therapy with traumatized people and especially to treatment focused on Post Traumatic Stress Disorders (Wilson, 2000; Wilson & Lindy, 1994).

The interview consists of three main sections: the first is related to background information and aspects of clinical activity. The second part explores the concept of empathy of therapists, their attribution of relevance to the empathy in psychotherapy and usefulness. Counter-transferential experience also investigates, with emphasis on personal memories and episodes, coping
mechanisms and anxiety and defensiveness signs. The third and last part regards the therapist’s personal experience of the war and traumas.

3.1. Results

Professionals are psychiatrists (6) aged ($M=42.2; DS=10.2$), clinical psychologist (2) aged ($M=39.5; DS=17.6$). Background: psychiatrists have more than 10 years of experience, and their medical background plays an important role in treating patients. Clinical psychologist as profession has been introduced very recently in Kosovo, and it is a fundamental figure for providing integrated psychosocial treatments. Psychologists have an average of one year of clinical experience. All the staff has been trained in Cognitive Behavioural Therapy (CBT), which provide them many techniques focused on treatment of PTSD, but also methods for therapy of other disorders. In fact, the clients, who consult Family Centres, may seek help also for problems related to different mental disease, as psychosis or depression. The amount of work-load of the interviewed staff is ranged between 25-40 patients for week, dependently on part or full time. On the whole the work’s charge is considerably high, especially for psychiatrists.

Empathy is considered to be a basic aspect of the clinical communication, which helps and support therapist’s understanding and listening to the problems of the patient. It can be seen as the foundation of psychotherapy: “to be empathic is essential in our work”.

Nevertheless, working with traumatized people challenge the capacity to be always empathic: “Some time is really difficult to be empathic, it might be too painful, and you need to keep the attention on the patient without be overwhelmed” (Selvije, 27).

Work-load could also influence empathic capacity: “after nine patients your attention can decline and you cannot listen to your patient with intense participation” (Melita, 37).

It emerges a common pattern of regulation of the emphatic strain in the continuum between over-identification and detachment, which is related to the years of experience:

“When I was young I tended to become overwhelmed by the images and memories of patients […] but growing up and having more experience I became more detached, I mean, I am not more upset by that” (Melita, 37)

The same movement is reported when therapists describe a single session, along the temporal arch of 45 min. This could be related to the coping mechanisms that the therapist develops in order to obtain and optimal level of concentration, attention and emotional participation.

Counter transference is reported as a normal experience, which affect therapist deeply when the patient tells about dramatic and violent events. In these cases, dreaming about patient’s experiences and narratives is a central reaction.
“Once a patient told me about the massacre of his family, he described so many details and images that it was as if I could see the scene in front of me […] that night I dreamed that my family was killed and I recognized that it was the effect of the session I did ” (Selvije, 27).

Anxiety and defensiveness might be perceived as non-responsiveness to the emotional distress of patient, preoccupation for the patient outside office, problems with time management or being argumentative with the patient.

By this brief survey, two main points have emerged as being very noteworthy for therapists.

The first is the importance of supervision, individual and in groups, in order to exchange information, feelings, thoughts about patients and clinical activities or psychotherapeutic approach. Supervision can alleviate emotional stress of the therapist, support and relief their capacities and effectiveness. A clear view and authentic participation can be regained through supervision.

The second is related to training activities and updated learning of therapeutic techniques. This is directly related to the capacity not only to offer adequate treatments for many types of mental health problems, but also for interpreting and understanding the needs in the population, which is rapidly changing: “Work as therapist is a challenge, and you need being well equipped if you want to do your best” (Selvije, 27).

3.2. Conclusions

The aim of this work has been to point out some important issues related to the professional and therapeutic assistance with torture victims and with people who experienced war related events:

1) is necessary an organized and specific approach for interventions and psychosocial treatments (short and long term) of these population’s targets;

2) There is need of training for clinician and psychiatrist who have to implement many different kind of treatments;

3) Is strongly recommended supervision for therapist and caretakers, who could be affected by working with these particular clients;

4) there is need of coordination and support for health care centre and others social institution, in order to prevent burn out phenomena and guarantee more positive outcomes of psychosocial rehabilitation;

5) Intervention’s approach has to be multidimensional and oriented toward the psychosocial rehabilitation of individuals in the society.
After ten years from the war the major challenge is now oriented, not only to the rehabilitation, but also toward the growth and full development of collective resources within the population.

KRCT approach is aimed not only to the reintegration according to the individual dimension, but also toward the collective dimension, including families and social and cultural background as fundamental part of its mandate.

References


