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Clinical Pearl
A New Focus on Caring for Survivors of Extreme Violence
Richard F. Mollica, MD, MAR

Major depression and post-traumatic stress disorder (PTSD) are two of the most common psychiatric disorders associated with life experiences of violent conflict [1]. Extensive research has demonstrated a high prevalence of these disorders in combat veterans, survivors of torture, and civilian populations traumatized by mass violence. These diagnoses are well known, and their signs and symptoms are clearly defined in the *Diagnostic and Statistical Manual,* 4th Edition (DSM-IV) [2]. Yet despite the availability of explicit diagnostic criteria, persons who have experienced extreme violence are often poorly diagnosed and treated. Based on 25 years of clinical experience caring for patients traumatized by extreme violence, I believe the reasons for most poor care are related to three problems in clinical diagnosis and treatment: neglecting the trauma story, misuse of the psychiatric diagnosis, and overlooking the patient's natural resiliency.

Problem One: Neglecting the Trauma Story
It took me two decades to learn that obtaining the trauma story should have top priority in caring for patients affected by extreme violence [3]. Unfortunately, this principle is often neglected by the health professional who is afraid to listen to the suffering of the patient in detail, especially if he or she has no treatment plan or experience caring for these patients.

The trauma story is easier to obtain than most clinicians imagine. They simply need to ask the patients what traumatic events have occurred in their lives. If a trusting relationship has been established with the patient, he or she will readily respond with the story. It is unusual for patients to be overcome with grief and pain; they almost always retain emotional control. Many clinicians feel they cannot ask about the patient's traumatic life history because they only have a few minutes with their patients. Patients appreciate time limitations and titrate their stories to fit within the allotted time. Clinicians should thank their patients for their revelation of painful life events and pick up the story where the patient left off during the next visit. (Good record-keeping will facilitate this process.) In our clinic, this slow process is called "a little, a lot, over a long period of time." The clinician should not rush. In fact, some stories are so emotionally disturbing that revealing them over time is less traumatizing and more therapeutic. In almost every case, the patient is extremely grateful that the clinician has listened to the story.

Problem Two: The Misuse of Psychiatric Diagnoses

The trauma story sets the clinical stage for the patients' medical and psychiatric diagnoses and treatment. But the diagnosis of PTSD in, for example, an Iraqi civilian or an American soldier fighting in Iraq tells the clinician little about the psychological, social, spiritual, or medical problems related to violent events. The diagnoses of PTSD and depression can obscure the specific symptoms that are contributing to the patient's suffering. Most patients do not have the full PTSD diagnostic profile, nor do they meet all diagnostic criteria—but they are still suffering, and their psychological and physical pain are most likely affecting job performance and social relationships. So the next step is to discover each patient's specific symptoms.

We seek to identify the presence of nightmares and insomnia and treat these disorders in addition to the major symptoms of depression, intrusive thoughts and memories, and hyperarousal associated with PTSD. In our experience, the symptom clusters associated with the major diagnoses need to be individually evaluated and then treated if necessary. Rarely does a single medication or counseling approach relieve the pain caused by extreme violence. The trauma story, then, points the clinician in the direction of the psychological, social, and spiritual dimension of the trauma-related illnesses that need to be addressed. This approach also allows for the cultural aspects of symptom expression and health-seeking behavior to be entered into the therapeutic equation [4].

Problem Three: Overlooking Patient Resiliency

The recently published treatment approach for traumatized persons (see suggested reading) focuses on reinforcing the patient's resiliency and existing coping strategies and the enormous self-healing capacity of survivors of extreme violence [5]. It has been scientifically demonstrated that, at the time violence strikes, a biological, psychological, social, and spiritual self-healing response is activated that often leads to recovery without the help of health professionals. For some, partial relief from suffering leads to care-seeking within the health care system. Unfortunately, many clinicians do not appreciate the effort that patients have already put into their rehabilitation and recovery. In the days before modern medicine, self-healing was a major therapeutic force in the care of sick human beings. Ancient physicians knew how to work with the natural healing forces that begin after an injury or an illness, which they described with the term, *vis medicatrix naturae*.

Building on the care that has taken place between trauma survivors and healers, a clinical reform that relies upon scientific and culture-based evidence is now well advanced. Four simple questions summarize this therapeutic reform and provide a guide to the healing process. The patients' answers reveal what is being done and what still needs to be done in the recovery process. The questions are:

1. What traumatic events have happened?
2. How are your body and mind repairing the injuries sustained from those events?

3. What have you done in your daily life to help yourself recover?
4. What justice do you require from society to support your personal healing?

Mental health professionals, and indeed all health professionals, should use these questions in their treatment of traumatized persons. The fourth question often surprises clinicians because they have failed to appreciate the deep injustices associated with traumatic life experiences, especially during times of conflict. Justice is a major concern for victims of manmade violence and needs to be addressed clinically, even if the therapist is in no position to right a wrong or punish an aggressor.

After a quarter of a century addressing the identification and treatment of survivors of extreme violence, I am sure that we can confidently tell our patients who feel hopeless and full of despair at the beginning of treatment that they can and will recover. This prognosis is more than an opinion; it is based upon scientific evidence.

References

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Suggested Reading

Mollica RF. *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Orlando, FL: Harcourt; 2006.

Richard F. Mollica, MD, MAR, is a professor of psychiatry at Harvard Medical School in Boston, and director of the Harvard Program in Refugee Trauma.