TITLE: TRAUMA AND POST-TRAUMATIC STRESS DISORDER: APPROACHES TO TREATMENT FOR VICTIMS IN POST-CONFLICT COMMUNITIES IN NORTHERN UGANDA

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ABSTRACT

Best approaches to management of traumas and post-traumatic stress disorder (PTSD) in victims of a conflict which occurred more than 14 years ago have become the focus of attention in today's Uganda of 2020. Most programs have focused on resilience, posttraumatic growth, transitional justice and peace-building processes as well as psychotherapeutic and psycho-educational interventions. Treatment, however, must be individualized and the victim and their family's explanatory model for the trauma are key in help-seeking, reparation and determining one's best approach(es) to the treatment. Most work on trauma in victims of armed conflict has a reverse focus; looking at areas of vulnerability rather than strengths or resilience. Beyond the assessment and documentation of traumas and PTSD, (which is in and of itself potentially therapeutic through narrative exposure), a useful first step in management of delayed or prolonged trauma and PTSD is providing mental health sensitization to the families and psycho-education to the victims. This paper will focus itself on approaches to treatment for victims of post-traumatic stress disorder in post-conflict communities in Northern Uganda for traumas which happened decades ago.

INTRODUCTION

Not everyone who experiences trauma requires treatment. Some recover with the help of family, friends, clergy or tradition. But many do need professional treatment to recover from the psychological damage that can result from experiencing, witnessing, or participating in an overwhelmingly traumatic event or events. A number of direct and indirect mental health and psychosocial interventions to address the potentially long-lasting consequences of victimization exist, but most are not specific to PTSD. Most programs have focused on resilience building, transitional justice and peace-building processes as well as psychotherapeutic and psycho-educational interventions. We focus, here, on what works in the northern Ugandan context and approaches in Uganda.

Although a majority of the population living in conflict-affected areas will experience or has experienced a severe trauma at some point, the fraction of those who develop lasting psychiatric disorder reactions is in fact relatively small. There is evidence that psychotherapies work in the northern Ugandan context although not specific to PTSD (Nakimuli-Mpungu et al, 2013; Mutamba et al., 2018). So a principle treatment modality for PTSD would be some type of psychotherapy, such as supportive psychotherapy, narrative exposure, or interpersonal and counseling therapies that have shown promise in the Ugandan context, with medication used to augment the psychotherapy and help reduce symptoms. Best approaches focus on three goals of treatment:

- To help patients regain a sense of being worthwhile;
- To help patients again feel in control of themselves and their lives;

• To help patients re-work their shattered assumptions.

A PHASED APPROACH TO TREATMENT

While there are differences across disciplines and professional expertise in trauma treatment, in keeping with established research, such as work by Herman (1992), Van Der Kolk (1996), and others, our experience is that a phase-oriented model should be used to conceptualize group or individual treatment approaches that work in the Ugandan context. Best practices would have three phases:

Phase I: Establishing safety, stabilization, symptom reduction and the therapeutic alliance

Phase II: Dealing with the traumatic event; e.g., through remembering and abreaction, desensitization, deconditioning, mourning, etc.

Phase III: Restructuring personal schema and integrating the trauma into a meaningful life narrative; i.e., putting the trauma into perspective and moving forward in developing a positive life.

The first phase is devoted to establishing safety (which might be physical or emotional) in the actual environment as well as in memories. For instance, if the patient with PTSD is living in the same context with the perpetrator of violence, plans should be made to ensure safety; i.e. perform cultural cleansing processes such as mato oput help in peace building and reconciliation. Encourage the patient to improve self-care and to reduce self-destructive behaviors, e.g., by abstaining from alcohol and drugs of abuse. Educate the patient early about the signs and symptoms of PTSD, and teach them various coping mechanisms for mastering intrusive memories and flashbacks. Address social supports, and inform patients that important

people in their lives also should learn about the symptoms of PTSD. Finally, encourage patients not to let their symptoms stop them from functioning in everyday life.

In the second phase, the main task is the trauma narrative construction, also known as trauma story telling. Here information is often needed from collateral sources, such as other victims' accounts, eye-witnesses, police records, hospital records etc (given the propensity for traumatic amnesia). Affects should be identified as they are attached to elements of the story. Many people have great difficulty talking about a trauma because the feelings are so intense. Other approaches include desensitization to the trauma memories, controlled re-exposure and memory reactivation, and restructuring of trauma-related cognitive schemes. Patients must restructure their personal schema and integrate the trauma into a meaningful narrative within the continuum of their life, while putting the trauma into perspective.

In the third phase of treatment, patients must assimilate the trauma(s) into their belief systems, or accommodate their beliefs to better fit reality. Their basic assumptions about themselves and the world need to be re-thought. This will necessitate adjusting their sense of self and identity. They are forever changed, and as such need to re-negotiate relationships and make new ones. Patients need to become involved in activities that provide them with feelings of mastery and pleasure.

The victim and their family's explanatory model for trauma are key in help-seeking and determining best approaches to treatment. The way we construe our experiences of trauma and its behavioural and emotional problems depends on one's cultural and professional backgrounds. One's response draws on a set of explanatory models derived from one's experiences as well as empirically derived data. Other professionals, such as social workers, psychologists or psychotherapists, may apply a different set of explanatory models, leading to radically different formulations even if they see the same alleged victim and their family.

Nevertheless, it is clear that victims often have complex explanatory models that differ substantially from those of health workers and other professionals – as regards aetiology, phenomenology, natural history and treatment. In other words, victims and their families come to therapy and reparative processes with expectations that may differ radically from established practice. The only sensible way to find out what they believe is to ask them open-ended questions and listen carefully to their replies. Knowing about people's explanatory models gives the therapist a chance at the end of the assessment to present their views in the way that will be most relevant to the patient.

Resilience

Most work on trauma and negative life events in victims of armed conflict have a reverse focus, looking at areas of vulnerability rather than strengths or resilience- the ability to maintain a state of normal equilibrium in the presence of extremely unfavorable circumstances. Building resilience is a vital next step for those who need it, with factors such positive beliefs, attitudes, coping strategies, behaviours and good psychosocial support important in promoting resilience among victims. Whether it can be said that one has resilience depends on one's perception: does one conceptualize an event as traumatic or, or as an opportunity to learn and grow? Although it is possible to normalize the symptoms of trauma as an understandable reaction to the experience through sensitization or psycho-education, resilience building seeks to emphasize that events are not traumatic until we experience them as traumatic. The theory is that every frightening event, no matter how negative it might seem, has the potential to be traumatic or not to the person experiencing it, hence the term potentially traumatic events (PTE) .The experience isn't inherent in the event; it resides in how one interprets or constructs it psychologically. It is important to note that resilience building or positive construal of one's traumatic experiences can be taught as a set of skills, to reframe them in positive terms when the default response is emotionally distressing, to better regulate their emotions.

MANAGING TRAUMA AND DELAYED PTSD

Regarding the management of trauma and delayed PTSD as its associated features, we acknowledge that a significant number of victims are very resilient. However, mental health literacy and skills are often lacking for both the victims as well as their helping professionals. Beyond the assessment and documentation of traumas and PTSD, which is in and of itself potentially therapeutic, a useful first step in management of delayed or prolonged trauma and PTSD is providing mental health sensitization to the families and psycho-education to the victims. The aim, here, is to ensure an identity shift from victim to survivor to thriver. A key focus of attention is making the link between the experiences and reactions to the traumatic events and then to 'normalize' the reactions.

In cases of prolonged trauma and/or PTSD, the principal reasons for using medications to treat PTSD (if needed) are:

- Reduce PTSD specific symptoms:
  - Frequency and/or severity of intrusive symptoms,
  - Interpreting incoming stimuli as recurrences of the trauma,
  - Developing hyperarousal to stimuli reminiscent of the trauma, & generalized hyperarousal,
  - Becoming avoidant, Developing numbing)
- Treat depression and/or mood swings
- Treat anxiety and sleep disturbences
- Reduce psychotic or dissociative symptoms
- Reduce impulsivity and aggression against self and others.

Although no medications have been systematically studied in the northern Uganda context, our experience is that antidepressants such as fluoxetine, amitriptyline, imipramine etc may decrease symptoms of PTSD in addition to their benefits for depressive symptoms, with

benzodiazepines such as alprazolam and clonazepam appearing to decrease the autonomic hyperarousal and sleep problems associated with PTSD. Perhaps the best approach is to choose a medication based on the more problematic target symptoms. This may require a combination of medications, e.g., an SSRI to decrease numbing and depression, and a benzodiazepine and a beta blocker to decrease autonomic hyperarousal.

For victims who spent a long time under LRA captivity, the symptoms of PTSD may be more complex and therefore beyond the scope of ordinary caregivers and would require intense psychotherapy by a trained therapist. We propose that the goals of treatment can be thought of as being divided into three phases: early, middle, and late-stage treatment.

Goals of early-stage treatment include:

- Helping patients improve self-care. As children or young abductees, these victims were often forced into positions of taking care of an adult's needs, and did not receive appropriate care themselves. Thus, they did not learn to take care of themselves.
- Establishing a better sense of safety by helping them to reduce the suicidal ideations and behaviors as well as other self-destructive and self-defeating coping strategies.
- Reducing symptoms of PTSD, dissociation, anxiety, disrupted sleep and depression. Here, medications may be very helpful.
- Acknowledging that trauma played a central role in the development of their current symptomatology and dysfunction. Education about their disorder and its treatment is essential.
- Improving functioning in their everyday life, such as at work and play, in school, and in relationships.
- Teaching, training, and helping them to practice better coping mechanisms to assist them in managing their PTSD and dissociative symptoms.
- Helping them to improve their relationships and shore up their support systems.

The approach to achieving these early goals is largely directive and didactic in nature, using cognitive and behavioral techniques. Uncovering repressed traumatic memories, processing

traumatic memories and nightmares, and experiencing abreactions of traumatic memories is counter-productive at this stage, and usually leads to profound regression and dysfunction. Depending on the ego strength of the individual, the first phase of treatment may require months to years.

Goals of mid-stage treatment include:

• Talking about the traumas: This is if the patient is able to put words to the traumatic experiences. This involves understanding the meaning of what happened and correcting cognitive distortions as more important than the veracity of the memories per se. For instance, being forced to hurt others by the LRA may mean to the victim, "I was to blame for doing it," "I am bad," "I am not forgive-able," etc. The victim needs to construct as integrated a memory as possible of what happened to them and what it meant in reality, while experiencing the associated feelings. He or she needs to realize that the traumas happened a long time ago, were survived, and are not happening now. Victims need to realize that their mistreatment by their captors was not their (victims') fault. They need to put into perspective that the traumas did not destroy their self-worth.

• Bearing the pain: Through the relationship with the therapist, victims need to learn that they must and can bear the associated pain. It is only through the controlled and coordinated experiencing of these intense trauma-related affects that the victims can decrease the intensity of their fear and pain. The therapist then helps the patient to find words to describe these experiences and to make meaning out of them. Nonverbal techniques can be very helpful to patients who can describe their traumas in words.

• Relationship with the therapist: Having a secure, trusting and safe relationship with a therapist. It is only through the relationship with the therapist that the victim can face memories in a controlled and coordinated manner.

• Reality re-orientation: Reassessing former understanding of how the real world operates. Before therapy, the patient's perceptions were fraught with misconceptions and distortions about themselves and the world. This can include issues regarding identity, competence, trust, power and control, autonomy, and value systems.

Goals of late-stage treatment include:

• New Self: To coalesce a new sense of self based on the patient's real strengths and weaknesses.

• Forgiveness: To forgive, let go of, and grieve the past. The patient will never have the parents or the childhood that was wanted, and for this they must grieve.

• Relationships: To make and maintain new healthier relationships.

• Termination: To finally terminate therapy and grieve the loss of the therapist.

At the end of therapy, the patient should not be encumbered with memories and feelings from past traumas, allowing them to live in the here and now. They should be able to give up their preoccupation with their symptoms and focus on the challenges of the outside world and future.

CONCLUSION

In sum, there is a paucity of data regarding best approaches and treatment facilities for the LRA traumas and delayed PTSD in northern Uganda. The most feasible approaches would require, at the barest minimum, a public-private partnership with the Ministries of health and local government health facilities to ensure continued access to and utilization of an established trauma mental health service as well as a sustainable referral system (Nakimuli et al, 2013). Community based group rather than individual approaches to treatment are imperative to help bridge the human resource gaps as well as providing the much needed social capital to help victims improve their livelihoods. This can all be engulfed in the proposed and well tried out Group Support Psychotherapy (GSP) approach (Nakimuli et al, 2015)

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