Conflict and Health

Short report

The Colombian conflict: a description of a mental health program in the Department of Tolima

Elisabeth Sanchez-Padilla1, German Casas*2, Rebecca F Grais1,3, Sarah Hustache1 and Marie-Rose Moro2,4,5

Address: 1Epicentre, 8 rue Saint Sabin, 75011, Paris, France, 2Médecins Sans Frontières France, 8 rue Saint Sabin, Paris, France, 3Harvard Humanitarian Initiative, Harvard University Cambridge, 14 Story Street, Cambridge, MA 02138, USA, 4Hôpital Avicenne, Assistance Publique Hôpitaux de Paris, Université de Paris 13, 125 rue de Stalingrad, 93009 Bobigny, France and 5Hôpital Cochin, Maison des adolescents, Université de Paris 5, 97 Bd de Port Royal, 75679, Paris cedex 14, France

Email: Elisabeth Sanchez-Padilla - Elisabeth.Sanchez@epicentre.msf.org; German Casas* - casasgerman@hotmail.com; Rebecca F Grais - Rebecca.Grais@epicentre.msf.org; Sarah Hustache - Sarah.Hustache@epicentre.msf.org; Marie-Rose Moro - marie-rose.moro@cch.aphp.fr

* Corresponding author

Abstract

Colombia has been seriously affected by an internal armed conflict for more than 40 years affecting mainly the civilian population, who is forced to displace, suffers kidnapping, extortion, threats and assassinations. Between 2005 and 2008, Médecins Sans Frontières-France provided psychological care and treatment in the region of Tolima, a strategic place in the armed conflict. The mental health program was based on a short-term multi-faceted treatment developed according to the psychological and psychosomatic needs of the population. Here we describe the population attending during 2005-2008, in both urban and rural settings, as well as the psychological treatment provided during this period and its outcomes.

We observed differences between the urban and rural settings in the traumatic events reported, the clinical expression of the disorders, the disorders diagnosed, and their severity. Although the duration of the treatment was limited due to security reasons and access difficulties, patient condition at last visit improved in most of the patients. These descriptive results suggest that further studies should be conducted to examine the role of short-term psychotherapy, adapted specifically to the context, can be a useful tool to provide psychological care to population affected by an armed conflict.

Findings

Colombia has been seriously affected by an internal armed conflict for more than 40 years. The “guerrillas,” the Revolutionary Armed Forces of Colombia (FARC) and the National Liberation Army (ELN), paramilitary groups and the governmental military, control different aspects of the social and political landscape. Civilian populations are the main victims of this conflict, forced to displace, suffering kidnapping, extortion, threats or assassinations.

Due to the security problems, very few medical actors are present and even less mental health professionals are able to work in the region. Médecins Sans Frontières-France (MSFF) has been working in mental health support pro-
grams in the department of Tolima, Colombia, since 2002. Tolima, which groups 47 municipalities, is considered a strategic corridor in the armed conflict in Colombia, and has been occupied for more than 30 years.

The MSFF mental health program in Tolima was based on a short-term multi-faceted treatment developed according to the psychological and psychosomatic needs of the population. Here, we describe the population attending during 2005-2008, as well as the psychological treatment provided during this period and its outcomes.

Between 2005 and 2008, MSFF provided psychological care and treatment in Ibague, the capital of the department of Tolima, and in various rural villages. Three mental health teams provided services: two were mobile within the rural areas and one was based in Ibague. They were comprised of expatriate and local psychologists or psychiatrists working jointly with the medical officers.

The population attended differed in these two settings. In Ibague, everyone considered internally displaced by the conflict and health conditions not in relationship with the internal armed conflict. In case of exclusion, the patient was referred to the local health system. For those patients admitted, severity of the condition was assessed considering the number and intensity of the signs and symptoms of the disorder, and any resulting impairment in occupational or social functioning. Two types of psychological treatment were offered: individual psychotherapy and therapeutic groups. Individual psychotherapies were based on a short-term psychotherapy model. A rigorous treatment schedule was used in order to assure adherence to the treatment and the fulfillment of the objectives. During each 45-minute session, the psychologist performed therapeutic interventions in order to help the patient understand the relationship between the traumatic events and the current symptoms. Patients were invited to describe their personal history and visual or hearing memories. Group sessions were developed based on a psychotherapy group model. During the first session, patients were informed about the rules of the group therapies, the schedule, the need for confidentiality and the objectives of the treatment. For children, D.W. Winnicott techniques [1,2] were adapted and used; for infants and young children under three, we employed mother-baby dyads. In order to assess difficulties and the functioning of the mother-child interaction [3], we used Lebovici technique based on a psychodynamic brief psychotherapy model [4,5]. In addition to psychotherapy, patients with depression or anxiety that met the following criteria received psychotropic medication: disorders that did not allow the patient to carry out basic daily activities, experience of suicidal ideas, significant disturbances of consciousness, no response or aggravated clinical criteria after psychological treatment. Psychotropic medication was either fluoxetine and/or amitriptyline.

The patient's condition at last visit was classified as unchanged, improved based on the number of DSM IV criteria met and the overall condition reported by the patient and the psychologist. The outcome was defined as improved if a decrease of at least 80% in the total number of DSM IV criteria met initially was observed, or if an improvement regarding daily activities, personal abilities, or capacity for problem-solving compared with the initial evaluation was seen. It was defined as unchanged if the patient did not show changes in the number of DSM IV criteria met or improvement in daily activities, personal abilities, problem solving or coping.
mechanisms. The clinical outcome was defined as aggra-
vated if there was an increase in the number of criteria
met, or there was a new DSM IV diagnoses or if the
patients themselves reported aggravated symptoms.

All data were entered into EpiData version 2.0 (EpiData
Association, Odense, Denmark). Analysis was conducted
using Stata 9.2 (Stata Corporation, College Station,
Texas). Medians are given with inter-quartiles range (IQR)
[25%-75%] and were compared using the Kruskal-Wallis
test. Percentages were compared using the Fisher exact
test. Results are presented separately for patients treated in
Ibague and in the rural villages.

Between February 2005 and February 2008, the program
treated 2,411 people: 855 (35.5%) in Ibague and 1,556
(64.5%) in the villages. The majority of patients were
adults (older than 14 years) (75.1%; 1,811/2,411), and
women (67.6%; 1,624/2,404). The median (IQR) age for
children under 15 was 10 years (8-12), both in Ibague
and in the villages. For adults, the median (IQR) age in Ibague
and in the rural area was 39 years (28-48) and 40 year (28-
52), respectively (Table 1).

Among the different traumatic events reported, the most
frequent in children in Ibague was being forced to flee,
followed by the presence of family violence. In the vil-
lages, the most frequent traumatic events reported among
children were witnessing murders or physical abuse, hav-
ing suffered the break up of the nuclear family and suffer-
ing family violence. For adults treated in Ibague, having
been forced to flee was the main traumatic event reported,
followed by having received threats and having lost or
destroyed property. In the rural areas, among adults, the
most frequent traumatic events were having witnessed
murder or physical abuse and having a close family mem-
ber killed (Table 2).

Table 1: Socio-demographic characteristics of the population
treated.

|                      | Ibague (n = 855) | Rural area (n = 1,556) |
|----------------------|-----------------|------------------------|
| **Sex**              |                 |                        |
| Male                 | 293             | 487                    |
| Female               | 559             | 1,065                  |
| **Age group**        |                 |                        |
| Under 15             | 143             | 454                    |
| 15 or more           | 713             | 1,101                  |
| **Place of residence**|               |                        |
| Ibague               | 841             | 98.4                   |
| Rural village        | 14              | 1.6                    |

Table 2: Traumatic events reported by the patients.

|                      | Ibague N | Rural Areas N | p-value |
|----------------------|----------|---------------|---------|
| Children*            |          |               |         |
| Sexual violence      | 11 / 113 | 21 / 454      | 0.042   |
| Physical injury      | 4 / 110  | 4 / 453       | 0.051   |
| Close family member killed | 30 / 115 | 56 / 454   | 0.001   |
| Close family member died from illness | 7 / 112 | 25 / 454 | 0.819   |
| Witness of murder or physical abuse | 19 / 123 | 85 / 454 | 0.431   |
| Received threats     | 47 / 119 | 17 / 454      | <0.001  |
| Incarceration        | 1 / 111  | 8 / 453       | 1.000   |
| Property lost or destroyed | 45 / 121 | 4 / 453    | <0.001  |
| Being forced to flee | 137 / 142 | 22 / 453   | <0.001  |
| Break-up of nuclear family | 51 / 121 | 80 / 452 | <0.001  |
| Family violence      | 110 / 143 | 78 / 454     | <0.001  |
| Adults               |          |               |         |
| Sexual violence      | 47 / 379 | 44 / 1,101    | <0.001  |
| Physical injury      | 32 / 362 | 22 / 1,101    | <0.001  |
| Close family member killed | 141 / 433 | 166 / 1,100 | 0.001   |
| Close family member died from illness | 27 / 367 | 108 / 1,101 | 0.176   |
| Witness of murder or physical abuse | 135 / 466 | 170 / 1,101 | <0.001  |
| Received threats     | 590 / 698 | 137 / 1,101  | <0.001  |
| Incarceration        | 4 / 347  | 22 / 1,101    | 0.362   |
| Property lost or destroyed | 432 / 692 | 38 / 1,101 | <0.001  |
| Being forced to flee | 702 / 710 | 80 / 1,101    | <0.001  |
| Break-up of nuclear family | 212 / 459 | 151 / 1,100  | <0.001  |
| Family violence      | 135 / 712 | 133 / 1,099   | <0.001  |

Department of Tolima, Colombia, 2005-2008.
* Younger than 15 years old.
The main clinical expression presented was distress or anxiety (39.9%; 943/2,366) and sadness or crying (39.3%; 930/2,366). The most frequent diagnosis was "other anxiety disorder" (32.3%; 750/2,323), which included all anxiety disorders not classified as PTSD or acute stress disorder, followed by depression (18.2%; 423/2,323), acute stress disorder (9.9%; 230/2,323) and PTSD (8.4%; 196/2,323) (Table 3). Most disorders were classified as "moderate", both in children (64.0%; 375/586) and adults (64.3%; 1,144/1,779). The percentage of psychopathologies classified as severe was higher in the villages (14.6%; 220/1,509) than in the city (6.4%; 55/856) (p < 0.001), and in adults (13.0%; 232/1,779) than in children (7.3%; 43/586) (p < 0.001).

Regarding treatment, both children and adults more frequently received individual psychotherapy (table 4). The median (IQR) number of psychotherapy sessions for children in Ibague was 3 (2-4) and in the villages 2 (1-3). In adults, the median (IQR) number of sessions was 2 (2-4) in Ibague and 2 (1-3) in the villages. In addition to the psychotherapy, 37.0% (407/1,100) and 27.9% (198/711) of adult patients from Ibague and rural areas, respectively, were prescribed psychotropic drugs. This proportion was

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11.2% (16/143) and 30.0% (136/454) for children, respectively. Regarding treatment outcome, the most frequent clinical condition in the last consultation was "improved" (table 5).

There are few studies of mental health in the violent Colombian context [6-8]. Although patients treated in both settings were affected by the same conflict, we observed differences between the urban and rural setting in the traumatic events reported, the clinical expression of the disorders, the most frequent disorders diagnosed, and their severity. These differences may be explained by the displacement itself. Among the displaced living in Ibague, exposure to violent traumatic events was not recent. The urban population faced other challenges related with relocation and urban adaptation. These aspects could explain the higher number of adjustment disorders and acute stress disorders found in the urban area. Similarly, as the conflict was active in the rural area, this may also help explain the higher proportion of severe cases in the rural setting. Examining the correlation between the differences in the experience of traumatic events, symptom severity and diagnoses, although important, is beyond the scope of this study. Our objective was to provide a first descriptive analysis that could provide the basis for future studies.

Although the duration of the treatment was limited due to security reasons and access difficulties, the patient’s condition at last visit had improved in most of the patients: over 90% of our patients saw their clinical status improved on their last visit. The absence of a control group did not allow us to develop comparative analysis and therefore we cannot state that this improvement is due solely to the type of psychotherapy received. It would be interesting to look at the role of other factors, such as severity, medication, main diagnosis, although it is beyond the objective of this manuscript to identify predictors of clinical outcome, which might be an interesting second step in the future. A specific data collection and analysis plan would need to be put in place to address these questions.

These descriptive results suggest that further studies should be conducted to examine the role of short-term psychotherapy, adapted specifically to the context, can be a useful tool to provide psychological care to population affected by an armed conflict. Short-term psychotherapy, adapted specifically to the context, through the integration of the culturally variable representations of illness, suffering and treatment [9,10], may be the only viable possibility to offer mental health care in conflict. Other studies should be conducted to elucidate the benefits and constraints of short-term psychotherapy in conflict.

Ethical considerations
This manuscript is based on routinely-collected data from the MSFF program in Colombia. Authorization for analyzing and publishing the data was sought from the Secretaría de Salud Departamental de Tolima.

Competing interests
The authors declare that they have no competing interests.

Authors' contributions
ESP had full access to all of the data in the study and takes responsibility for the accuracy of the data analysis. GC and MRM participated in the interpretation of the results. GC, SH, RFG and MRM participated in the critical revision of the manuscript. All authors read and approved the final manuscript.

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Table 5: Clinical condition in the last visit. Department of Tolima, Colombia, 2005-2008

| Condition in last consultation | Ibague | Rural area | p-value |
|-------------------------------|--------|------------|---------|
| Children* (n = 117)           |        | (n = 324)  |         |
| Aggravated or Unchanged       | 13     | 33         | 0.860   |
| Improved                      | 104    | 291        |         |
| Adults (n = 500)              |        | (n = 744)  |         |
| Aggravated or Unchanged       | 47     | 61         | 0.473   |
| Improved                      | 453    | 683        |         |

* Younger than 15 years old.
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