

Psychiatric Help to Psychotraumatized Persons during and after War in Croatia

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Aim. To present organization of psychosocial support and treatment of traumatized persons during and after the 1991-1995 war in Croatia.

Method. Description of application and results of community-based National Program of Psychosocial Help to War Victims, and retrospective analysis of hospitalizations for psychotrauma at the National Center for Psychotrauma, Dubrava University Hospital.

Results. During the 1991-1995 war in Croatia, the population faced severe traumatic events, and the need for organized psychosocial help to traumatized persons was great. Government has established the network of psychosocial help in 1994. This was the beginning of the National Program of Psychosocial Help to War Victims. As a strategy in building a social support, the pyramidal model consisting of five levels of psychosocial help was used. The levels were the following: 1) preventive programs in mental health, 2) nonspecific psychological help in community, 3) basic psychological help, 4) psychiatric institutionalized help and specific psychological help, and 5) national coordination and operative planning. During the war, the work primarily centered around community-based approach, satisfying the current needs of the traumatized people, such as food, medication, and clothes, and providing crisis psychological interventions and urgent psychiatric help. In 1999, this organizational scheme was replaced by the establishment of the National Center for Psychotrauma and four Regional Centers for Psychotrauma in Zagreb, Rijeka, Osijek, and Split. In the post-war period, the emphasis was on psychological and social help in the community and on institutionalized approach to treatment of psychotrauma. According to the data of the Croatian Institute of Public Health, in the 1998 and 1999 there were 1,744 and 2,415 hospitalizations due to PTSD and related disorders, respectively.

Conclusion. The community-based approach remained central in dealing with psychotraumatized persons during and after the war. In the post-war period, the emphasis was put on non-specific and specific psychological and social help in the community, with institutionalized approach to the treatment of PTSD and related disorders, whereas satisfying the current needs (food, medication, clothing), intervention in the crisis situations and urgent psychiatric interventions were of prime importance during the war.

Key words: *anxiety disorders; Croatia; delivery of health care, integrated; psychopharmacology; psychotherapy; stress disorders, post-traumatic; stress, psychological; refugees; veterans; war*

The 1991-1995 war in Croatia had massive impact on health, education, and social services in Croatia. Health facilities, from hospitals to rehabilitation centers and primary health care units, were all involved in the provision of health care and the personnel was exhausted. Some hospitals and health care units were completely destroyed, and some were seriously damaged or under military siege (1,2). The health care budget was drained and priority was given to the physically wounded (3), although the psychological stress of the population was immense. After the war ended, the number of psychotraumatized people actually increased due to other forms of psychological trauma related to war, such as return from exile, demobilization, traumatized children, secondarily traumatized people, etc. The Government organized psychosocial program for psychotraumatized persons.

We present our experience in organizing a national program to provide psychosocial help to war-traumatized persons.

War and Post-War Situation in Croatia

During the 1991-1995 war in Croatia more than 250,000 people from Croatia were forced to flee their homes and live either with host families (approximately three quarters) or in collective centers and camps (approximately one quarter). The war in Bosnia and Herzegovina aggravated the population displacement even more (4). By the end of the 1992 and 1993, many of the people of non-Serbian nationality were displaced from Bosnia and Herzegovina, finding temporary refuge in Croatia; most of them were in the Zagreb area. They were mostly children and women, some of them with the psychological

trauma of rape and other torture (5,6). According to the data of the Government of the Republic of Croatia, over one million people in Bosnia and Herzegovina had to leave their homes, either as refugees or displaced persons, and found temporary or long-lasting shelter in Croatia. The displaced or refugee population thus represented more than 20% of the total population of Croatia, which was 4.8 million according to the 1991 census (7).

According to the data from the Croatian Office for Imprisoned and Missing Persons, the total number of prisoners of war in Serbian camps was 6,721 (8). In addition to these registered camps, there were many unregistered transit camps, so that it was estimated that 10,000 people were captured in Serbian prisoners-of-war camps.

After the end of war, the Ministry of Defense of the Republic Croatia demobilized 300,000 people, of whom 35,000 were still unemployed in 1999 (8).

With the above figures in mind, it can be estimated that at least 1,000,000 people were exposed to direct war stress (8), and even more were secondarily traumatized. The need of those people for psychological and psychiatric help and social support was immense.

Mental Health Department of the Medical Corps Headquarters

The Croatian health care service adapted very well to the circumstances created by war (9). The Medical Corps Headquarters of the Republic of Croatia was established in 1991. Professionals from various medical branches within the Ministry of Health were assigned the task of organizing different departments (10).

The Mental Health Department of the Medical Corps Headquarters was established on August 29, 1991 (10). The Department's Head Office was located in Zagreb, and four field offices were organized in Zagreb, Osijek, Rijeka, and Split. The fifth regional center was established in Pula, as a center of the Istria region, where a large number of displaced persons and refugees were accommodated.

In the beginning of the war, professionals at the Department, although experts in their fields, had no significant experience in working with persons psychotraumated in war, because this type of education was taught only at the Medical Military Academy of the former Yugoslav Army in Belgrade, Serbia, and was not a part of the civilian medical curriculum. However, the members of the Department quickly adapted to the situation and learned about post-traumatic stress disorder and other psychological disturbances related to war trauma, working at the same time with the traumatized persons. The tasks undertaken by the professionals of the Department were the following (10): protecting psychiatric patients in war, providing psychological and psychiatric help to the members of the armed forces (psychiatric care for soldiers with acute psychological problems, psychological and psychiatric help to the wounded on the surgical wards and rehabilitation centers, and prevention

of inadequate psychological reactions and disorders), providing psychological and psychiatric care for displaced persons, children's mental health care, education, publishing, scientific research, and other activities, such as psychological and psychiatric care for ex-prisoners of war, and collaboration with other institutions and their health services (Ministry of Defense and Ministry of Internal Affairs).

Programs of Psychosocial Support to War Victims

From the very beginning in 1991, many different psychosocial programs were organized by Government organizations (GOs) and non-government organizations (NGOs). Working mostly independently, mental health professionals and non-professionals established different psychosocial programs to provide various forms of psychosocial help to psychotraumated persons (11).

Croatia called upon the world, mostly the European community, for the immediate help through humanitarian work. Delegation of the European Community, called Warburton Commission, visited Croatia in December 1992 and January 1993. The same commission visited Bosnia and Herzegovina in January 1993. After the consultation with the Government of the Republic of Croatia, the Warburton Commission recommended provision of immediate short- and long-term psychosocial help for specific risk groups of psychotraumated people, including consultation for the local population by the interdisciplinary teams (12). The Commission also recommended creating self-help groups for refugees as a form of help, as well as supervision in the field by the professional teams, and preparation and distribution of materials containing information and instructions (12).

To improve coordination, evaluation, and supervision of different forms of psychosocial help, the Government of the Republic of Croatia organized the psychosocial help network in 1994 (11). The psychosocial help network was the beginning of the National Program of Psychosocial Help to War Victims.

The establishment of the network of psychosocial help programs addressed many problems in the field, such as ineffective spending, uneven distribution of psychosocial programs in the country, overlapping between projects, paraprofessionals running many projects because mental health professionals did not have the approval by the health authorities, and lack of cultural adaptability of some organizations. Many foreign organizations wanted to apply the experience they previously gained in underdeveloped countries in Croatia without sufficient consultation or collaboration with Croatian experts. Croatian professionals were often better educated than the professionals coming to educate them. Also, GOs often received no feedback from NGOs, parallel systems were run, and offers for cooperation were even openly declined.

To avoid these problems, the Government of Croatia asked the Ministry of Health to develop the national strategy of psychosocial help. In collaboration with the World Health Organization and United Na-

tions International Children's Fund (UNICEF), the Ministry decided to implement the so-called pyramidal model (13-15) as a suitable strategy for the psychosocial support. It was in 1994, the third year of the war. Basic principle of the pyramidal model was a gradual application of psychological and social help programs for the people affected by war, according to the type of trauma, intensity of the reactions, and life circumstances (15). This included social help and support, psychological counseling, special types of education, occupational therapy, psychotherapeutic and psychiatric treatment, and hospitalization if necessary. Psychosocial help was organized, whenever possible, at places where its users lived, and included the family, place of work, school, kindergarten, and every institution important to the user (Fig. 1).

Such a model requires continuous work in the community, which has to start as early as possible, an integrated approach, and teamwork of educated professionals and coordination at local and national levels, with continual funding. The model uses a community-based rehabilitation strategy (15).

There were five levels at which the psychosocial help was provided in Croatia (Fig. 1), as follows: 1) basic life and emotional needs (preventive programs in mental health); 2) activities in the community (non-specific psychological help); 3) specific psychological help and counseling (psychosocial teams for psychological help); 4) psychiatric care (institutionalized psychiatric help); and 5) national level (coordination and operative planning).

Psychological Support during and after War

Reasons for Psychosocial Support

One of the reasons for a community-based approach during the war was overcrowding in health institutions and exhaustion of personnel (2). Also, psychosocial support outside of psychiatric institutions

was preferred to avoid the stigmatization of "psychiatric patients" (16). A frequent and important dilemma of psychiatrists in war was whether and when psychotraumatised persons needed psychiatric care and hospitalization (17). The most common reasons for psychiatric treatment of refugees and displaced persons during the war were suicides, prolonged risk behavior, psychophysical decompensation, alcohol abuse, and serious exacerbated psychiatric disturbances that had existed before the war (17).

Also, the war period was the time of the differentiation among the refugees into those who developed mental disorders and those who successfully adapted to the new environment (17,18). After the war, some of the refugees were able to return to their homes, where they were faced with difficulties of adaptation, such as return of former soldiers to their families, return to destroyed homes and mined fields, and/or facing former neighbors who sided with the enemy in the war. This differentiation was especially prolonged in former soldiers and in families of missing persons, who experienced postponed mourning (17,18). These processes brought a significant change to the activities of the psychosocial support program at different levels. Mental health professionals were criticized for psychologization and psychiatrization of Bosnian refugees in Croatia, Bosnia, and elsewhere (19). It is justified to argue that human psychological suffering should not be perceived as psychiatric issue (20) and that during resettlement the main needs of refugees all over the world are material and social. The quality of the post-traumatic environment is extremely important for adaptation (12,21). However, it was clear to everyone working with the refugees and displaced persons that, given the same experience of traumatic events and living under the same objective social conditions, people who psychologically coped better than others were able to provide social resources that were vital for themselves and for their

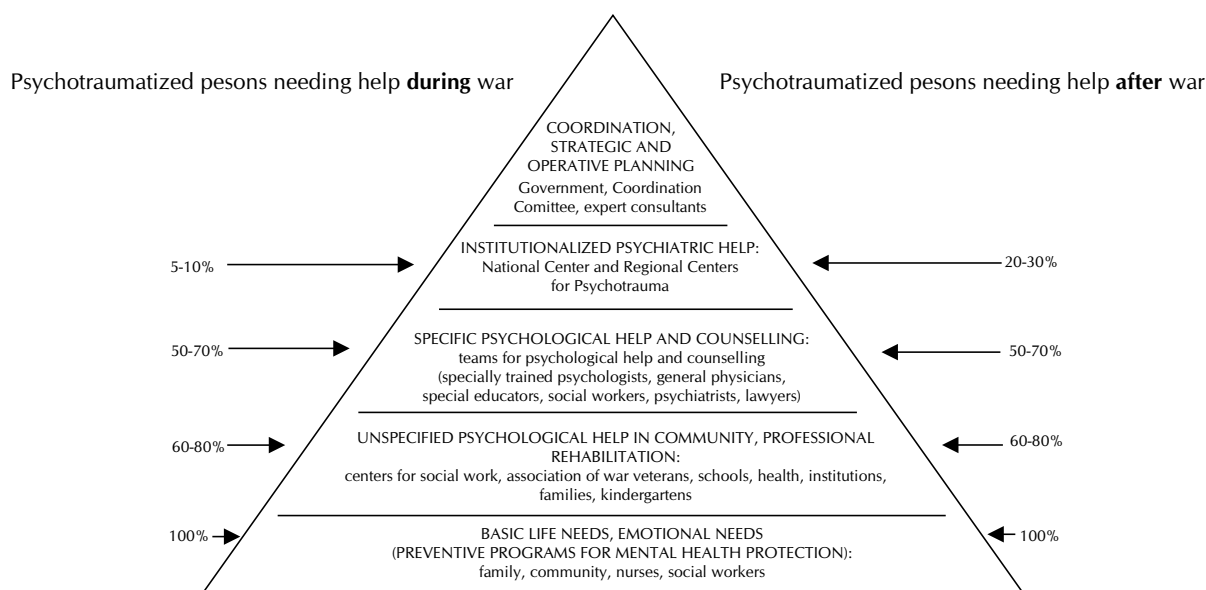


Figure 1. Pyramidal model of providing psychosocial care to war traumatized persons during and after the war in Croatia. The estimates of percentages of persons needing help at different levels of the program during the war was based on our work with displaced persons and refugees.

families (12), whereas those that could not cope psychologically with the traumatic experiences needed more intensive psychiatric help.

Activities in the Psychosocial Program

The activities in the psychosocial support program differed during and after the war. Satisfying current needs, such as food, medication, and clothes, and providing interventions in the situation of crisis and urgent interventions were of prime importance during the period of war. Treatment of acute psychotrauma was based on the fieldwork. After the end of armed operations in 1995, psychosocial programs were organized by the Government's Office for the Victims of War until 1999, and afterward by the Ministry for War Veterans. Because PTSD had a strong impact on population of Croatia, it became a health care priority. With regard to this and other issues concerning war veterans, Ministry of War Veterans was established. This Ministry provided finances for psychosocial programs for war veterans (0.03% of national budget), whereas the health treatment was provided by Ministry of Health (0.3% of national budget). Professionals included in the program implementation were psychiatrists, psychologists, pediatricians, general physicians, social workers, teachers, and educational therapists. All were mainly working in the field, using the community-based approach. After the war, the emphasis was given to nonspecific and specific psychological and social help in the community, with institutionalized psychiatric approach to the treatment of psychotrauma. The Ministry of War Veterans was in charge of the coordination of the program, whereas National and Regional Psychotrauma Centers were in charge of institutionalized help to psychotraumatized persons. Teams for psychosocial help continued to do counseling work in the field and dealt with current specific psychological, juridical, or social problems. Professionals within the psychosocial team were general physicians, psychiatrists, social workers, psychologists, and lawyers. After 1999, those teams worked 2-3 days a week. If psychological or psychiatric therapy was required, people were directed to the Regional Psychotrauma Centers or the National Psychotrauma Center. The differences between psychosocial teams on the one side, and National and Regional centers on the other, were in the complexity of the diagnostic and treatment procedures.

Estimated Number of Psychotraumatized Persons Needing Help

The number of psychotraumatized persons who needed specific psychological help and counseling increased after the war (70–80% vs 50–70% during the war) (Fig. 1). The number of psychotraumatized persons in need of specific psychiatric help in post-war period also increased (20-30% after the war vs 5-10% during the war) (Fig. 1). These estimates were based on our work in a community-based project of psychosocial support with displaced persons and refugees during the war (15). Survey was conducted in Slavonski Brod and Zagreb. Sample was selected by randomization (town-refugee camps-host families). Slavonski Brod is the town at the border

with Bosnia and Herzegovina, with the total population of 57,229 inhabitants. The sample was formed during 1995, and consisted of 17,000 displaced persons and refugees (15). The sample in Zagreb, formed in 1995, consisted of 7,000 displaced persons and refugees (12). The data for the post-war period were based on the records of the National Center for Psychotrauma, Dubrava University Hospital, Zagreb (22), and the data from the Croatian Institute of Public Health. According to the data given by the Croatian Institute of Public Health, the number of hospitalizations of persons diagnosed with PTSD and related disorders in Croatia was constantly increasing. In 1998, there were 1,744 hospitalizations because of PTSD and related disorders, and the number of hospitalizations for the same reason was 2,415 in 1999 (source: Croatian Institute of Public Health, by courtesy of Dr B. Tomić) (Table 1). According to the International Classification of Diseases, ICD-10 (23), PTSD and related disorders include all disorders related to stress (acute stress reaction, PTSD, adjustment disorders, and chronic personality disorder after catastrophic experiences). The patients were mostly men (around 90% of all hospitalizations), hospitalized in different psychiatric institutions all over Croatia. One of the important causes of the increase from 1998 to 1999 was the fact that the diagnosis of PTSD and related disorders legitimized a person's "victimhood", gave them moral exculpation, and guaranteed a disability pension because the diagnosis could be attested by a physician (24).

Table 1. Hospitalization of patients (No., %) diagnosed with posttraumatic stress disorder (PTSD) and related disorders in Croatia^a

Number of hospitalizations	1998	1999	2000
Men	1,555 (89.2)	2,172 (89.9)	3,071 (88.6)
Women	189 (10.8)	243 (10.1)	395 (11.4)
Total	1,744 (100.0)	2,415 (100.0)	3,466 (100.0)

^aPTSD and related disorders, according to ICD-10 classification, include all disorders related to stress (23).

Specific Risk Groups of Psychotraumatized Persons

Institutions involved in providing help to psychotraumatized persons have focused their work on specific groups under high risk of developing war- and post-war-related stress disturbances. Those groups are 1) persons mostly dependent upon their environment (children, adolescents, physically disabled, old persons, etc); 2) polytraumatized persons or persons exposed to very intense stresses (prisoners from detention camps, families of missing or killed persons); 3) former soldiers exposed to prolonged combat stress; 4) persons with intensive response to psychotrauma due to their premonitory psychiatric disturbance, psychiatric patients, and persons with chronic somatic illness; 5) displaced persons and refugees still in temporary accommodation as well as those returning home; and 6) persons with secondary traumatization, ie, transferred trauma (families of traumatized soldiers of prisoners of war).

Establishment of National and Regional Centers for Psychotrauma

Chronological Development of National and Regional Centers for Psychotrauma

In January 1999, the Government of the Republic of Croatia redefined the National Program for Psychosocial Help for the people who were affected by the war and instituted the National Center for Psychotrauma, as well as four Regional Centers in Rijeka, Osijek, Zagreb, and Split (8). The aim of the new psychosocial program was to organize continuous psychosocial help as a part of integrative care for participants and victims of the Homeland War, as well as for the members of their families and other inhabitants of Croatia. This program is still in function and has the same pyramidal organization as the previous one, but the number of people in need of different levels of psychosocial help changed (Fig. 1). In the period 1994-1999, future National Center for Psychotrauma was the Division for Psychotrauma, a part of

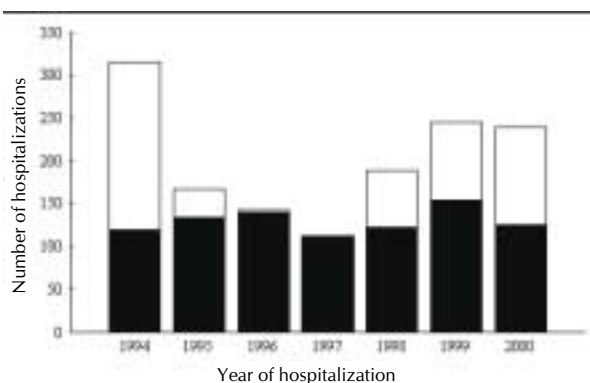


Figure 2. Hospitalizations of patients diagnosed with posttraumatic stress disorder or related disorders (closed columns) compared with hospitalizations of all other diagnostic categories (open columns) at the Division for Psychotrauma of the Dubrava University Hospital (later the National Center for Psychotrauma), from 1994 to 2000.

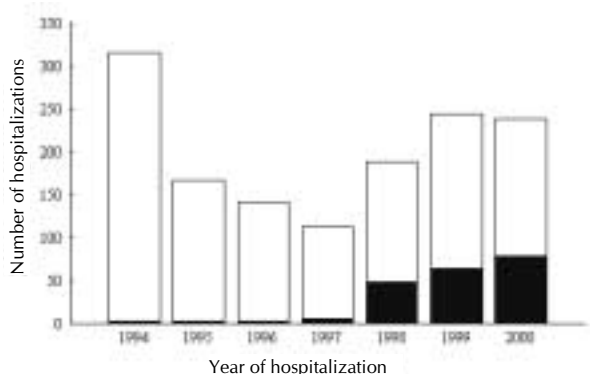


Figure 3. All hospitalizations (open columns) compared with the hospitalizations of civilian war victims (closed columns). The category of civilian war victims includes all individuals who are not war veterans but have psychological disturbances related to war. Those disturbances can be related to the refugee status, displacement, imprisonment, killed or missing family member, or direct involvement of a family member in war activities (e.g., a war veteran).

the Psychiatry Department of the Dubrava University Hospital. Since 1999, there has been the National Center for Psychotrauma as a part of the Psychiatry Department. Fifty beds at the Division in 1994 were reduced to 25 in 1995. This decrease can account for the decrease in number of hospitalizations from 316 to 176 in those years (Fig. 2). Further decrease in the number of hospitalizations in 1996 can be explained by increase in the number of days of hospitalizations. Average length of hospitalization of patients at the Division for Psychotrauma at Dubrava University Hospital in 1994-2000 period was 21.5 \pm 6.7. This number varied depending on the intensity of symptoms of PTSD and related disorders as well as on the type of program in which the patients were included, e.g., inpatient or outpatient (daily hospital) programs. In 1996 and 1997, hospitalizations for PTSD and related disorders predominated: in 1996, 140 out of total of 142 hospitalizations, and in 1997, all 113 hospitalizations were due to the diagnosis of PTSD and related disorders. Since the war in Croatia had just ended, psychotraumatised persons had priority. Increase in the number of hospitalizations from 245 in 1999 to 239 patients in 2000 is related to the establishment of the National Center for Psychotrauma, which employed more professionals, developed different programs aimed at the treatment of psychotraumatised population, and decreased hospitalization duration.

Since 1998, there was an increase in the number of hospitalizations of civil victims of war, compared with hospitalizations for other diagnosis (Fig. 3). This can be attributed to a number of different factors. Professionals in the field, working in the teams for psychosocial help, were better informed on the help provided at our Department, as well as potential users of this form of help. Also, different programs of the treatment, aimed specifically at this population, have been implemented at the Center. After the war, people were more aware of their psychological disturbances.

The Regional Center for Psychotrauma in Rijeka started its work in 1997 as a Center for Psychotrauma, and became Regional center according to the National strategy of psychosocial care in 1999. It was established in 1991 as Department for Psychotrauma within the University Psychiatric Department in Rijeka University Hospital. The Regional Center in Zagreb started its work in 1999, Regional Center in Osijek in 2000, whereas the Regional Center Split is still in the process of establishment.

Activities in National and Regional Centers for Psychotrauma

Tasks of the National Center for Psychotrauma are the following: 1) diagnostic assessment of the psychotraumatised persons in the hospital by use of a various diagnostic techniques (psychiatric, psychological, somatic, and laboratory tests when necessary), and assessment of work ability; 2) treatment of psychotraumatised persons; 3) development of highly differentiated diagnostic methods and objectivization of PTSD and related disorders; 4) development of high quality therapeutic treatment programs

and their evaluation; 5) establishment of the net of round-the-clock counseling services for marriage, family, children, and demobilized veterans; 6) establishment of referral center for PTSD and related disorders, of diagnostic and treatment algorithm for PTSD, and PTSD database; and 7) education (graduate and postgraduate level), seminars, lectures for the students of medicine, psychology, social work, education and rehabilitation, and Police Academy, as well as for the members of the Regional psychosocial teams and other psychiatric institutions working with psychotrauma.

The activities of the Regional psychotrauma centers are similar and are performed in coordination with the National Center.

Integral Approach in the Treatment of Disorders Caused by Psychotrauma at the National Center for Psychotrauma

There is no unique model in the prevention and treatment of psychotraumated person and the method chosen for the treatment often depends on the education of the therapist (25). Experts recommend primary psychotherapeutic techniques in the treatment of PTSD and its consequences, whereas psychopharmacology-oriented experts more often recommend the combination of the psychotherapeutic and psychopharmacological treatment (25).

Duration of the treatment depends upon pretraumatic, traumatic, and posttraumatic factors, intensity of clinical features, and other factors. Polytraumatized persons need more time for integration of their traumatic experience.

Integral approach (22), as the one applied in the National Center for Psychotrauma, includes different treatment techniques of psychotraumated persons and their families (group and individual psychotherapy, pharmacotherapy, and sociotherapy) (Fig. 4). The selection of these techniques depends upon the intensity and the nature of the symptoms, comorbidity, personality structure, psychological impact of the trauma, and other factors. Because the whole family can be affected by psychotrauma, it is often necessary to include the family members in the therapy.

National Center for Psychotrauma provides different types of programs for the users, such as inpatient program, daily hospital, and different types of outpatient programs. Some of the outpatient programs are specifically focused on specific traumatic experiences, such as combat trauma, imprisonment, and loss of a family member. Program of daily hospital is oriented mostly at group and individual psychotherapy, whereas inpatient program includes complementary pharmacotherapeutic, sociotherapeutic, and psychotherapeutic treatment.

The professional team of the National Center for Psychotrauma decides upon the suitable treatment for each person individually. Team of professionals working in National Center consists of psychiatrists, general physicians, psychologists, educational therapists, social workers, and nurses. When a treatment is indicated, different factors need to be assessed, such as

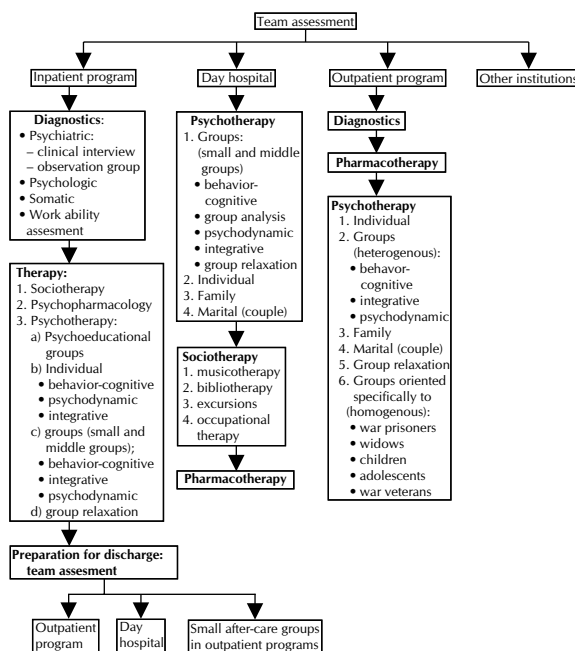


Figure 4. Integral approach in treating psychotraumated persons, Croatia, 2001.

psychological and physical symptoms, intensity of those symptoms, reasons that compelled person to seek treatment, motivation for the treatment, level of social functioning or functioning in the family, secondary gain, origin of trauma, etc.

The main forms of therapy applied in the integral approach are psycho educational groups, psychotherapy, sociotherapy, and psychopharmacologic treatment.

Psychoeducational groups. Psychoeducational groups were developed as a thematic multilevel program for the combat-experienced veterans (26). The aim is to educate the patient about his or her disorder and its treatment (psychopharmacological, social, and psychotherapeutic). Educational theme changes every week, and includes the topics such as meaning of survival, understanding the emotions, such as rage, anger, fear, guilt, and mourning, looking for significant and emotionally important relationships.

Group psychotherapy. Group psychotherapy, or group psychotherapy combined with individual psychotherapy, is the most common method of treatment of the psychotraumated person. Different forms of group psychotherapy are used, such as psychoanalytical psychotherapy (27), cognitive behavioral psychotherapy (28), and integrative psychotherapy (29). Group psychotherapy includes veteran groups, groups of family members, people with concentration camp experience, and other (30). Groups can be closed or open, with focus on the psychoeducation or trauma experiences ("there and then" orientated or highly structured, specifically orientated, or emphasizing "here and now" interpersonal reactions) (30). Sometimes, different aims and procedures are combined. Group psychotherapy can be used in fulfilling various therapeutic goals and can be focused on the feelings

of isolation, feelings of shame, guilt, and self-blame, which are often present in many of patients with PTSD.

In the first phase of treatment, each patient is included in the individual and group psychotherapy. Therapeutic techniques that are administered in the National Center for Psychotrauma can be applied simultaneously. For example, while therapist refers patient to the symptoms of hiperarousal, insomnia, control of anger, depression, addictive behavior, he or she can help the patient reconstruct the "traumatic story" and establish relationships at the same time (27).

Group and individual psychotherapies stem from constructive narrative perspective and treatment consists of 5 phases; each of those can have its own treatment goals, as follows: 1) introductory phase, 2) introduction of the PTSP and comorbidity symptoms to the patient, 3) helping the patient to reconstruct his or her trauma story, integrate traumatic experience, and change the role of "victim" into that of "survivor", 4) helping the patient to establish relationships with other people and allow family, social, and work functioning, and 5) final phase.

Sociotherapy. This type of therapy (environment-oriented therapy) is focused at increasing the patient's ability to function in the environment and have meaningful relationships with people around him or her (family, work environment). Sociotherapy is a part of inpatient and daily hospital programs, and includes musicotherapy, bibliotherapy, occupational therapy, therapeutic community, excursions, and recreational therapy (30).

Psychopharmacological treatment. PTSD may be combined with complex abnormalities within different biological systems. Systematic research in this area is still in the early stage but many trials suggest that patients with PTSD have various psychological, neurobiological, and neuroendocrine alterations (25,31). Literature on pharmacological interventions for the persons with PTSD is extensive and complex, and there are many different medications specific and effective for the different clusters of symptoms in PTSD (32).

In the process of deciding on type of drugs, dosage, and duration of treatment, the therapist has to consider factors such as patient's most prominent symptoms or reasons not to prescribe certain medication (applying psychotherapy without pharmacotherapy, contraindication for medication, side effects, or patient's refusal), or some other.

Different medications are used in the treatment of PTSD, e.g., tricyclic antidepressants, selective serotonin reuptake inhibitors, inhibitors of monoamine oxidase, anxiolytics, mood stabilizers, hypnotics for disturbed sleeping, and antipsychotics (31,32). Follow-up of the patient is necessary during psychopharmacotherapy. Authors agree upon often-contradictory results on the improvement of the pharmacological therapy for PTSD (31-33). Pharmacotherapy is usually palliative and rarely sufficient to insure complete remission of PTSD. If a disease becomes

chronic, pharmacotherapy is needed for at least one year (34,35).

Conclusion

We have been working with psychotraumatized persons and their problems since the beginning of the war in Croatia. Psychosocial care during the period of the war differed from that of the post-war period. During the war, most of the work was done in the field, through community-based approach and not within psychiatric institutions. Most often it was done outside the institutions. Small number of psychotraumatized persons was hospitalized. Reasons for the hospitalization were almost exclusively acute stress reactions and acute symptoms of PTSD or some other psychic reactions related to psychotrauma.

The number of psychotraumatized persons asking for help has increased after the war. Organizational model in the approach to the psychotraumatized persons changed with establishing the National Center for Psychotrauma and Regional Centers. Efforts towards reaching national consensus on top diagnostic, therapeutic, and expert criteria in regard to problems mentioned before are in progress. Although we presently work mostly with war-related trauma, the number of psychotraumatized persons seeking help as a result of various types of civil psychotrauma, such as violent behavior, molestation, rape, traffic-accidents, and mobbing, is increasing.

From our experience during the last 10 years, we have learned that working with acutely traumatized persons and reducing the chronicity is most important. Successful rehabilitation and resocialization of psychotraumatized person can only be achieved by intensive and well-timed treatment.

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