

# HEALING the HURT



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*We dedicate this guide to our clients.*

— THE STAFF OF THE NATIONAL CAPACITY BUILDING PROJECT  
AT THE CENTER FOR VICTIMS OF TORTURE



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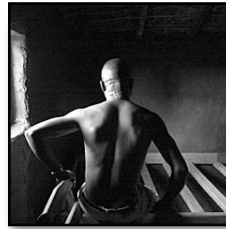
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# HEALING & HURT

## CHAPTER



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# FOREWORD

My name is Richard Oketch. I am a teacher by profession and was born in Uganda. I am a survivor of torture.

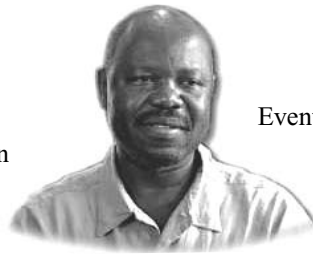
I was a young man in Uganda when the brutal regime of Idi Amin cut short my youth and disabled my entire family structure. Tribal and political affiliation landed us on the wrong side of the government. My two brothers, my younger sister and her boyfriend, the husbands of my two sisters, and other relatives disappeared. My uncle was shot and thrown in a river. My father was badly beaten and left for dead. He survived but died from those injuries several years later.

From the coup of 1971 through 1979, military harassment of the population in Uganda was constant and brutal. By the end of the regime in 1979, half a million people were dead or missing.

Between 1973 and 1977, I was arrested three times and mostly held at military detention centers. At this time, military detentions were known as death traps because no one really came back. Soldiers tortured us prisoners with whips, canes, sticks, gun butts, fists, bayonets and large knives. We were forced to ingest large amounts of vodka. I had to wash away others' blood and load wasted bodies on trucks. I endured broken ribs, a dislocated shoulder, serious lacerations, wounds on my back and thigh and, most lasting, mental numbness.

When I escaped from the prison in Uganda, I received treatment and healed well physically. Psychologically, I felt that there was a scar somewhere in my head and the memory could not and would not leave me alone.

When I came to the United States in the early 1980s, my nightmares got worse. Regular health care was not meeting my needs. The hospital setting brought back bad memories, and it was difficult to tell people what had really gone wrong with me. The doctors never asked questions about the source of my nightmares but gave me medication anyway. My symptoms were not clear cut and the medical staff suspected me of having a drug-related mental illness.



Eventually, I did not take the medications prescribed.

When I finally ended up at the Center for Victims of Torture (CVT), there was a sense of calmness about the environment. The psychiatrist, physician, clinical psychologist, and the rest of the staff all have reverence in approaching the clients. I felt completely safe going there.

After a series of multi-disciplinary treatments, including physiotherapy and psychotherapy, a heavy load was lifted from my psyche. My nightmares were significantly reduced within six weeks and my ability to sleep returned within the first few weeks of medication. My healing process proceeded at first weekly, then bi-weekly, followed by monthly and then occasional visits.

I am a father of six children, four boys and two girls. Two of them were born in the United States. I met my present wife during the course of my treatments and while on my first adventure out to a social gathering in many years.

Currently, I am on special assignment from Special Education teaching working for the Multicultural Excellence Program, an inner city curriculum to prepare and encourage minority students to attend college in Minnesota. I also serve on the board of the Center for Victims of Torture. My children and I have started a development association to care for the many widows and orphans in my former village in Uganda. I was in Uganda this past summer to attend the launching of this project. These events would never have been part of my life without the treatment and services I received at CVT.

I feel like I came back to life to embrace my family and friends and to provide a new world for my older children with whom I was reconnected in 1999. The bonds of suffering have been broken, and trust and love have been restored.

RICHARD J OKETCH

# PREFACE

*"I didn't know what to do. My pain was almost unbearable. I was afraid to ask for help because I thought no one knew what I had suffered. Then I heard about The Center and found hope."*

— CLIENT AT THE CENTER FOR VICTIMS OF TORTURE, MINNESOTA



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**REFUGEES** in the Korem camp in Ethiopia, 1984.

A growing number of treatment centers provide rehabilitative and supportive services for many of the more than 500,000 survivors of political torture in the United States. By offering specialized assessment and care, these programs help survivors to heal and to rebuild lives of self-reliance and hope for themselves and their families.

The existing torture rehabilitation programs and adjunct services cannot meet the needs of all torture survivors living in the United States. Services may not be geographically accessible to all survivors.

Not all torture survivors require a full-service torture treatment program. Sometimes survivors are looking for specific services, e.g., counseling, medical services, legal assistance, help with family reunification, or in finding housing and/or employment.

Sometimes they may simply want help and are unsure what they need or the services possible to enable their recovery process to begin. In either case, torture survivors can benefit from referrals to the appropriate agency or individuals that can help.

## THE PURPOSE OF THE GUIDE

This multidisciplinary guide was designed to encourage individuals and organizations who want to help torture survivors. It was produced by staff at the Center for Victims of Torture who provide training and consultation to programs for torture victims in the United States under a special grant from the Office of Refugee Resettlement — the National Capacity Building Project.

It does not specifically reflect the clinical program at the Center for Victims of Torture. Instead, the expertise gained from direct work with clients at the Center has been generalized through many years of providing training to a wide variety of audiences.

The information offered is not exhaustive, nor is it a substitute for training. This is a “getting started” and “where to go for more information” type of guide. We present options for providers along a continuum of services, from implementing a helpful service component to developing a full-service torture rehabilitation program.

The guide is also useful to mainstream health and social service providers who want to serve the special needs of

this population among their current clientele.

## CONTENTS OF THE GUIDE

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To best prepare personnel to work with survivors, this guide presents both general and discipline-specific information in the following chapters:

CHAPTER 1: The torture rehabilitation movement

CHAPTER 2: The effects of torture on families and communities

CHAPTER 3: Core competencies in working with survivors

CHAPTERS 4-7: Interventions and treatments in social work, medical, psychological, and legal services

CHAPTER 8: Existing models of treatment and suggestions on how to build communities of support for torture survivors

SUPPLEMENTAL RESOURCES: Listing of Web resources and referral agencies to connect readers with a national network of experts

## HOW TO USE THIS GUIDE

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This guide was written and reviewed by professionals who work with torture treatment centers in the United States: therapists, social workers, attorneys, nurses, physicians, and administrators. The information given is relevant for practitioners in these fields and also for human services workers, leaders of communities affected by torture, volunteers, interpreters, and others. It is meant for use by anyone who works with clients who have experienced political torture. This book is a primer, a starting point for those who

would provide services to survivors.

You may read the entire guide, or you may choose to read only the chapter that relates to your discipline or the discipline that is most pertinent to the work that you do (Chapters 4-7). If you plan to read one of these chapters, begin with Chapter 3. Note that there are cross-references in each chapter to other places in the text that offer information that may also be of interest to you.

As you read, you will want to learn more about serving torture survivors. Access the in-depth literature of your profession and connect with others doing this work. A list of U.S. torture treatment programs is included in this handbook. Reach out to members of these organizations for resources and as teachers and mentors.

Building a network of services, either community-wide or within an agency or several agencies, will be the next step in your journey. Volunteer or partner with appropriate individuals or agencies; this can strengthen your response to your clients and connect you with other services. Pull together those interested with a consortium-building or an educational event.

Join activists for human rights on the local, national, and international policy level. Strong efforts are needed to sustain and to improve the provision of resources to aid in the rehabilitation of survivors. Of equal importance are the steps taken at all levels to uphold human rights and to prevent torture worldwide.

We hope this guide is helpful to you as you join the rehabilitation movement on behalf of survivors of torture. ■

*The symbol of the labyrinth has been used throughout history in many diverse cultures and has had many meanings. Most often, it consists of a path leading in a patterned way from the entrance to the center and back out again. It symbolizes the journey through the daily and seasonal*



*cycles, that of life and of death and of rebirth.*

*In this guide, the labyrinth symbol marks personal stories of clients as they struggle to rebuild their lives as survivors of torture. Their names and certain identifying characteristics have been changed for this publication.*

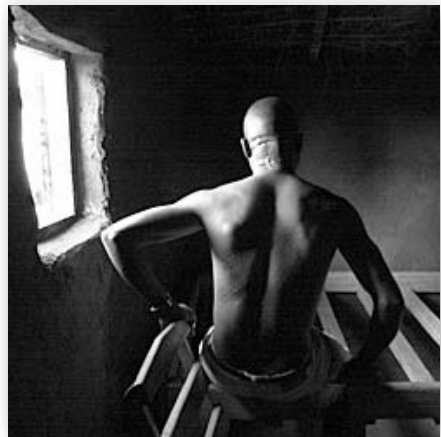


**THE LABYRINTH SYMBOL**  
at left and its inspiration above, the pavement labyrinth in the porch of Guingamp's church in Brittany, France.

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## CHAPTER 1



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# HEALING the HURT

TORTURE

REHABILITATION:

A WORLDWIDE

MOVEMENT

## CHAPTER 1

## HEALING THE HURT

TORTURE REHABILITATION:  
A WORLDWIDE MOVEMENT

## IN THIS CHAPTER

- THE NATURE of Torture
- THE TORTURE Rehabilitation Movement
- A TOOL FOR Human Rights

*They told me, 'You'll be alone with this for the rest of your life. You'll die with this alone.' But when I heard about... the Center, I knew the torturers had lied.*

— CLIENT AT CENTER FOR VICTIMS OF TORTURE, MINNESOTA

The practice of torture is so extensive that it could be called an epidemic (Gangsei, 2003). Government agents or others with official sanction practice torture in more than 104 countries (Amnesty International, 2005).

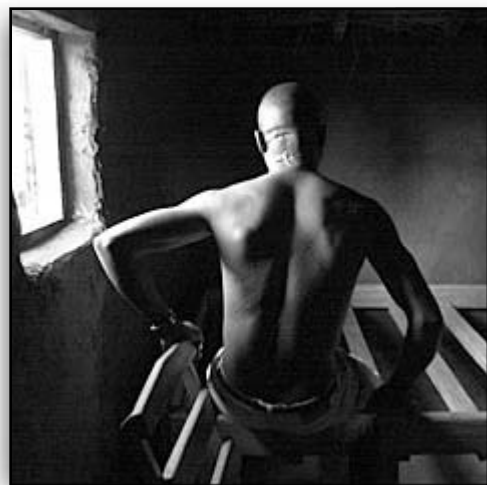
In response to the needs of torture survivors, a growing number of treatment centers offer resources and restorative services to survivors of torture. These facilities gain number and strength annually. From the first program established in Denmark in 1982, nearly 250 programs and centers serve survivors and their families in 75 countries today.

Medical, psychological, social, legal, and other services assist survivors in overcoming the long-term consequences of torture as they regain and rebuild their lives. Specialized treatment centers, with other non-center-based services, constitute a worldwide rehabilitation movement on behalf of torture survivors.

## THE NATURE OF TORTURE

## TORTURE DEFINED

The United Nations Convention Against Torture is a carefully negotiated definition approved by the United Nations system and ratified by 100 nations in 1989. According to the Convention, torture is:



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**"I WAS FORCED TO** watch as three men lifted a heavy rock and crushed my mother's head," Aiah Tomboy, 29, of Soewa, Kono district, Sierra Leone. "I could not bear to watch and burst into tears. Because I cried, a guy came and cut me in six places with a machete."

... any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

Although the Convention is widely accepted as the foremost legal and political definition of torture, interpretations vary. Psychological, medical, and sociological representations reflect professional cultures, as well as other root factors and belief systems. For example, the World Medical Association in 1975 distinguished torture more broadly:

...torture is defined as the deliberate, systematic or wanton infliction of



A TOOL FOR  
HUMAN RIGHTS

"Our role is an extremely strategic one for the human rights community, because our purpose is to regain the human leadership that was stolen, to put it back to work. But secondly, through the treatment centers, the human rights community regains hope."

— DOUGLAS JOHNSON,  
DIRECTOR, THE CENTER  
FOR VICTIMS OF TORTURE,  
MINNESOTA

physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason. This characterization may include 1) torture perpetrated by rebels and terrorists acting outside of an official capacity; 2) violence during war that is random; and 3) punishment allowed by governments that uses techniques that are similar to the techniques of torturers.

Rehabilitation specialists commonly define torture as the calculated, systematic infliction of suffering by at least one person upon another. A key component is the complete physical control of the victim by the perpetrator (Nightingale, 1990). Once seen as a product of foreign totalitarianism and repressive regimes, torture is a weapon of terror used also in war, prison, and chaotic political situations.

Physical and psychological means of torture may include:

- Beatings and mutilations
- Asphyxiation and submersion
- Mock executions and threats
- Electric shock
- Over- or under-sensory stimulation
- Rape
- Humiliation and threats
- Witnessing the torture or murder of others
- Denial of food, medical care and sanitary surroundings

Torture constitutes a major life event, a traumatic experience not expected to occur to anyone in a lifetime (Nightingale, 1990). Torture destroys individuals and sends them back to their communities as examples to others. As a tool of repression, torture is the most effective weapon against democracy.

## THE PREVALENCE OF TORTURE

It is difficult to establish a precise number of torture victims worldwide. Experts project that between 5% and 35% (Baker, 1992) of the world's refugees (11.5 million in 2004, according to U.S. Committee on Refugees and Immigrants) are torture survivors. In Minnesota, a recent community-based study of Oromo and Somali refugees found an overall prevalence rate of 44% exposed to torture. Torture exposure varied by ethnicity and gender among these East African populations, ranging from 24% of Somali men to 69% for Oromo men studied (Jaranson, et. al, 2004). The number of torture survivors in the United States is estimated at 400,000 to 500,000.

THE TORTURE  
REHABILITATION MOVEMENT

In the 1970s and 1980s, a number of individuals and facilities treated survivors of torture in repressive regimes in the southern hemisphere and in other conflict-torn regions of the world (Jaranson and Popkin, 1998). Cambodia, Laos and Vietnam in Southeast Asia; post-colonial Africa; countries with military regimes in Central and South America; and Greece, Turkey, and Northern Ireland in Europe represent some of the troubled regions of that era. Treatment services operated under difficult conditions, with arrest and harm possible for both practitioners and clients.

In the 1970s, torture treatment work received a boost from Amnesty International (AI), which formally established a network of over 4,000 physicians in 34 countries (Amnesty International, 2000). The purpose of this work was to examine and treat survivors of torture. Services eventually expanded to address the medical needs of survivors as well as the other complex needs of clients: social, psychological and legal.

In 1979, the Danish AI medical group examined torture victims at Copenhagen University Hospital in

Denmark. Three years later, they founded the Rehabilitation and Research Centre for Victims of Torture (RCT) in Copenhagen as an independent institution. The Canadian Centre for Victims of Torture opened in Toronto in 1983, followed by the Center for Victims of Torture in Minneapolis, Minnesota, in 1985.

The establishment of these centers and others represents a global movement. The number of treatment centers and resources has expanded dramatically in the past two decades, and networks have formed for the purposes of support, knowledge-sharing, research-gathering, and political impact.

In 2003, the International Rehabilitation Council for Torture Victims (IRCT), an independent network of programs and centers, published a directory of 177 rehabilitation centers and programs in 75 countries.

The National Consortium of Torture Treatment Programs (NCTTP) is the network of torture treatment providers located in the United States. The member programs gathered for the first time as a group in 1998 and the NCTTP incorporated in 2001. Of the 35 programs represented by NCTTP, 24 were 5 years old or less in 2004.

## A TOOL FOR HUMAN RIGHTS

Many survivors of torture were national and community leaders in their own countries, targeted for their leadership. Others were tortured as part of political strategies of social control.

Torture rehabilitation helps restore survivors to their full capacities and roles. At the same time, the rehabilitation movement helps communities understand and cope with the intentional legacy of fear. Healing communities is a prerequisite to developing open, democratic cultures.

The rehabilitation movement represents a

potentially powerful tool for human rights in countries with active or recent repression. In countries of refuge, rehabilitation centers develop new constituencies against torture and in support of human rights.

The U.S. Congress' 1998 passage of the Torture Victims Relief Act (TVRA) was significant progress in the torture rehabilitation movement. It authorized funding for domestic and international programs that provide medical, psychological, legal, and social services to victims of torture. In addition, the TVRA designated funds to promote research and to provide training for health care providers outside of treatment centers. In 2003, Congress reauthorized the TVRA through 2006.

## CONCLUSION

The movement to provide specialized treatment to survivors of torture is relatively new. It is growing in strength as professionals become aware of the nature of torture and respond with appropriate services.

There remain places in the world, including parts of the United States, where substantial numbers of torture survivors live, but where no rehabilitative programs exist.

The established network of providers offers a rich vein of experience and expertise for sharing with individuals and organizations wishing to offer professional services to survivors in these areas.

Education, resources, and consultations offered by the established treatment centers to mainstream medicine, mental health, social, and legal services providers will help to build new networks of support for torture survivors. ■

## FOR MORE INFORMATION

For more information on TVRA, see **CHAPTER 8**.



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## CHAPTER 2



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# TORTURE SURVIVORS

FAMILY AND  
COMMUNITY  
ISSUES

## CHAPTER 2

## TORTURE SURVIVORS

FAMILY AND  
COMMUNITY ISSUES

## IN THIS CHAPTER

- IMMIGRATION  
Statuses for Survivors
- CONTRIBUTIONS  
of Survivors
- MANY PATHS  
to Healing
- EFFECTS OF TORTURE  
on Communities  
and Families

**T**orture affects not only individuals but also the families and communities in which they live. Indeed, a primary goal of torture is to terrorize entire communities into silence and submission by making examples of individuals and their families. The message sent to communities is: "If you dare to challenge us in any way, this could happen to you, too."

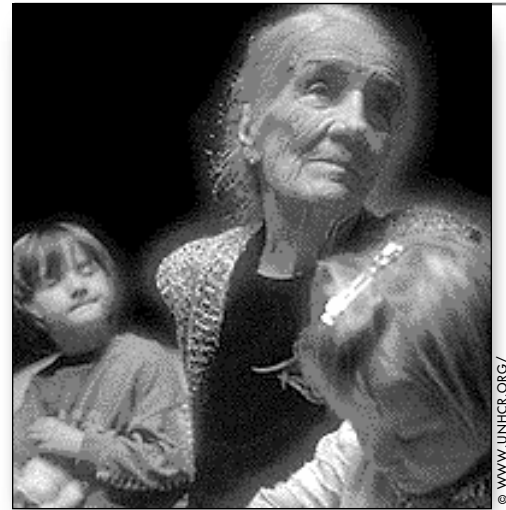
Survivors, who are valued members of communities and extensive family systems in their home countries, face many obstacles as they work to rebuild these structures and substitutes in the United States.

### IMMIGRATION STATUSES FOR SURVIVORS

Many people have little understanding of why torture survivors around the world come to the United States. Most survivors left home in order to save their lives or those of loved ones. They left their countries due to unsafe conditions and are unwilling or unable to return.

Torture survivors arrive in the United States with various immigration statuses. Some are political asylees or asylum seekers; others come to the United States as refugees, visitors, students, or employees. According to the United Nations High Commissioner for Refugees, an asylum seeker or refugee is someone who:

... owing to a well-founded fear of being persecuted for reasons of race,



religion, nationality, membership in a particular group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (1951, p.16).

The difference between refugees and asylum seekers relates to when and where their applications to resettle in the United States take place. Refugees apply for processing in other countries before reaching the United States; asylum seekers apply for processing in the United States after they have entered the country or are at the border.

If asylum seekers are granted political asylum, they become asylees.

Torture survivors might arrive under forms of immigration status that were necessary to get out of the country (e.g., visitor's visa) and then apply for political asylum once they are safely on U.S. soil.

Statistics on the actual numbers of torture survivors are difficult to obtain, while figures are readily available on refugees and immigrants. In the next two sections, the text uses statistics from studies or reports on immigrants and refugees.

## CONTRIBUTIONS OF SURVIVORS

### CONTRIBUTIONS TO THE COMMUNITY

Torture survivors strongly value the concepts of community and mutual assistance, as many come from cultures that value service to one's people over individual or material gain. That degree of commitment to community service explains why they are targets for torture and persecution by repressive governments.

Before the political upheavals that forced them into exile, many survivors' families lived in the same village or city for generations, even centuries. In these environments, people depended on each other for support, fostering strong social bonds and collective identity.

In their new country, torture survivors strive to rebuild relationships and a sense of community. Many are eager to know their neighbors and contribute to neighborhood celebrations, events, and activities.

In addition to cultural enrichment, newcomers to the United States bring fresh ideas, energy, excitement about the American dream, and motivation — often to blighted and depressed metropolitan areas. Immigrants and refugees revitalize neighborhoods, providing demands for goods and services as well as contributing to the economic base by building businesses and purchasing homes. They “largely employ neighborhood residents, serve as leaders in their communities, and offer locations where groups and associations can meet,” (Greater Twin Cities United Way, 2002).

### CONTRIBUTIONS TO THE ECONOMY AND WORKFORCE

There is a widespread perception that refugees and immigrants are a drain on the

economy and take away jobs desired by American workers. Yet evidence overwhelmingly indicates the opposite.

In the most comprehensive study ever conducted on immigration, the National Research Council of the National Academy of Sciences found that immigration has a positive economic impact at the national level, with immigrants adding \$1 billion to \$10 billion directly to the national economy each year (Commission on Behavioral and Social Sciences and Education, 1997).

The typical refugee or immigrant and his or her descendants pay an estimated \$80,000 more in taxes than they will receive in local, state and federal benefits over their lifetimes (Moore, 1998).

Most, including torture survivors, arrive in the United States in the prime of their working years, making them a fiscal bargain for our country, saving \$1.43 trillion in educational costs (National Immigration Forum, 2000).

Torture survivors are, by definition, resilient people who possess great strength of character. Many are highly educated and were professionals in their home countries. Others were small business owners, farmers, and traders. As a group, they bring strengths to the workforce in the United States, which include the following:

- Work training and experience
- Adaptability and resourcefulness
- Strong survival skills
- Strong desire to work
- Problem-solving expertise
- Community-building skills
- International perspective



### CONTRIBUTIONS TO THE COMMUNITY

Berhonu, a torture survivor from Ethiopia, was shocked to see hundreds of cars passing someone whose car had broken down on a U.S. highway. It was unthinkable to him that he could drive by without stopping to help, even though he had just arrived in the country and had fears of encountering strangers because he had heard that many Americans have guns. He stopped and drove the man to a nearby gas station.



### CONTRIBUTIONS TO THE ECONOMY, WORKPLACE

William, a journalist and student from a West African country, spent three years working two full-time jobs as a parking lot attendant and security guard. While seeking political asylum, he supported his wife and two children, who remained in hiding back home due to the risk of persecution. Once he obtained asylum, he was able to bring his family to safety. He then returned to school to finish his university education. He went on to obtain a master's degree in public administration and became the executive director of a nonprofit organization that helps African immigrants start small businesses.

Regardless of their level of education and previous job or leadership status back home, language barriers and other obstacles often restrict newcomers. As a result, they enter the workforce in the United States by taking low-paying, low-skill jobs not wanted by others. As such, they fill a critical niche in the labor market, particularly in service-industry jobs not sought by other workers. According to Andrew Sum, the director of the Center for Labor Market Studies at Northeastern University:

The American economy absolutely needs immigrants. Our economy has become more dependent on immigrant labor than at any time in the last 100 years. (Cohn, 2002)

As those in the current workforce begin to retire at a rate higher than the rate of citizens joining the workforce, this dependency is likely to increase.

Refugees and immigrants, and the torture survivors among them, are thus essential to the economy and society of the United States. The civic and economic benefits of community revitalization, increased revenue and job creation from refugee/immigrant businesses, increased demand for goods and services, and a resilient and newly energized workforce are profound.

Throughout the history of the United States, and still today, American society has profited greatly from the ideas, inventions, labor, industry, and social and cultural enrichment brought by those in search of safety and freedom.

Torture survivors are among the most highly determined, skilled, and resourceful newcomers received.

### MANY PATHS TO HEALING

For many torture survivors, obtaining official permission to work and to resettle themselves and their families safely in a new country aids them in recovery from the effects of torture. Not all torture survivors need rehabilitative services that specifically address the effects of the torture.

However, most will need some form of initial assistance in one or more service domains: legal, social, medical, nursing, and mental health. Others will need longer-term services.

Beyond the issue of demonstrable needs is the issue of human rights in the aftermath of "hell on earth," as many survivors describe their experiences. The position of the torture-rehabilitation movement is that society has a moral obligation to work toward the prevention of torture and to provide as complete rehabilitation as possible for its survivors.

To understand what this means, it is necessary to understand the effects of torture. The remainder of this chapter introduces the effects of torture on targeted communities and families.

### EFFECTS ON COMMUNITIES AND FAMILIES

#### EFFECTS ON COMMUNITIES

Torture is one of many weapons of repression in political arsenals designed to monopolize power and to reign through terror. The media often portrays the use of torture to extract information or the "truth" from individuals. Yet the primary purpose of most torture

#### FOR MORE INFORMATION

For information on the effects of trauma on individuals, see **CHAPTER 3**.



practiced systematically against a citizenry is to gain or maintain power and control by silencing any opposition.

Furthermore, information obtained under torture is notoriously unreliable. *The United States Army Field Manual on Intelligence Interrogation* states:

Use of torture and other illegal methods is a poor technique that yields unreliable results, may damage subsequent collection efforts, and can induce the source to say what he thinks the interrogator wants to hear. (1992, pp. 1-8)

Many survivors report that they made up information under torture — anything to make the pain stop.

Others report that when they did talk, they were told the authorities already knew everything they had to say but wanted them to suffer the defeat of betraying their friends and families. The terror, shame, and sense of betrayal generated by torture create a culture, climate, or community ethos of pervasive fear, distrust, and silence.

Basic trust in others is essential to hold together the social fabric of any human society. Torture is in continual use worldwide because it is so destructive in this regard. Members of targeted communities know someone or have heard of someone who was punished, tortured, or disappeared for speaking out against those in power.

Reports among torture survivors include experiences of betrayal (being turned in to authorities) by friends, colleagues, or even relatives. Feelings of distrust permeate various levels of a repressed society, which pave the way for widespread distrust of all people and

institutions. Chronic fear becomes a way of life and paralyzes the community as a whole.

Torture gives rise to discord and conflict within families, ethnic groups, and community support structures. Lifelong neighbors, friends, and sometimes relatives, lose their trust in one another as group is set against group. Former friends and confidants become bitter rivals and enemies. In a very short amount of time, entire communities become polarized and fragmented.

Fear, distrust, loss, and traumatic experiences force a constriction of families' social networks, resulting in social isolation and community-wide censorship. Ricardo, a Uruguayan citizen living in a community where government-sponsored torture was rampant, poignantly describes these effects in the following quote:

"...our own lives became increasingly constricted. The process of self-censorship was incredibly insidious: It wasn't just that you stopped talking about certain things with other people; you stopped thinking them yourself. Your internal dialogue just dried up. And meanwhile your circle of relationships narrowed.... One was simply too scared. You kept to yourself, you stayed home,



## EFFECTS ON THE COMMUNITY

"All their lives my parents, along with a nation of Dominicans, had learned the habits of repression, censorship, terror. ... And so, long after we had left, my parents were still living in the dictatorship inside their heads. Even on American soil, they were afraid of the awful consequences if they spoke out or disagreed with authorities. The First Amendment right to free speech meant nothing to them. Silence about anything "political" was the rule in our house... . To our many questions about what was going on, my mother always had the ready answer, "En boca cerrada no entran moscas." No flies fly into a closed mouth. Later, I found out that this very saying had been scratched on the lintel of the entrance of the SIM's torture center at La Cuarenta."

— JULIA ALVAREZ  
*SOMETHING TO DECLARE*,  
1998, pp. 107-109

you kept your work contacts to a minimum. The suspicion of everyone else, the sense that they were monitoring everything — or else just that reflex of self-protection, how it was better not to extend one's affections to people who might at any moment be picked up and taken away: all of that served further to famish the social fabric.” (Wechsler, 1990, pp. 88-89)

For communities under prolonged political repression and torture, feelings of community hopelessness and resignation can develop as an adaptive response to the daily reality of having little or no control over one's life. It is adaptive to “look the other way” when faced with overwhelming despair and unspeakable, incomprehensible atrocities day after day, year after year.

Elizabeth Lira is a pioneer in the torture-rehabilitation movement who worked as a psychologist under conditions of state-sponsored terror in Argentina. She has written extensively about the community effects of a chronic situation in which “people had to get accustomed to torture, exile, disappearance, rape, execution, the naked corpses of one's neighbors lying in the street, i.e., to atrocities that nobody would have imagined” (Lira, 1997).

People need to find ways to continue functioning in environments of extreme and chronic fear. They can resist community effects of torture such as collective denial, apparent apathy or indiffer-

ence, and the widespread lack of hope that things can ever change for the better.

When communities affected by torture resettle to a new country, they usually have not had an opportunity to repair or even address the effects of fractured social networks and ties. Social isolation and a collective desire to forget the past often become the norm in resettled communities.

The practical need to focus considerable effort and attention on learning a new way of life reinforces these norms. That new life includes the American cultural norm of working longer hours and spending less time in social or family relationships, in contrast to the more communal orientation of many survivors' original cultures.

The larger society in the United States is often unaware of meaningful intra-group differences among newcomers from the same country, such as education, social class, tribe, clan, religion, ethnicity, political affiliation, gender, and age, as well as rural vs. urban dwellers. Longtime residents tend to expect group unity or identity based on a single factor, such as national origin or language.

They often make mistaken assumptions about intra-group cohesion, including, for example, that within a given national group, there will be little conflict and much commonality. Issues of conflict and strife, continued discrimination, and marginalization can occur within these communities.

In fact, providers working with tor-

ture survivors must consider that in most affected communities, tensions and conflicts among groups will arise. These conflicts relate to the historical, social, and political conditions in their countries of origin.

Some people may be from the persecuted group in their home country, while others may be from the group that perpetrated the torture. Torture survivors often live with the fear of encountering their torturers or unknowingly befriending current informants in their new communities. This fear may be realistic; it is common for the “eyes and ears” of a terror-based regime to extend into communities of exile.

To summarize, some of the common effects of torture trauma on resettled communities include the following:

- Collective silence and/or denial about what really happened
- Chronic fear and distrust
- Constriction of social networks and social isolation
- Apathy and hopelessness following prolonged political oppression
- Conflict, politicization of community issues, and polarization among various elements or subgroups within communities

## EFFECTS ON FAMILIES

Torture survivors rarely flee as intact families. Many survivors are forced to leave family members behind due to the dangerous and often unplanned circum-



stances surrounding their departure.

Due to ongoing danger to family members in the country of origin, asylum seekers go through a grueling period of lengthy separation from their families in which communication and support are hampered. Survivors fear their mail is opened or phone calls are traced, leading to increased danger of family members being harassed or even tortured into revealing their loved one's whereabouts.

Sometimes authorities come to family members' homes or workplaces and threaten them with death or imprisonment if they do not produce the person who has fled.

Asylum seekers generally must wait a minimum of one year, and often much longer, before their family members are legally able to join them. Family members living in danger or hardship abroad have limited understanding of the legal system in the United States and the barriers torture survivors face in bringing family to safety.

Since the United States is seen as a world leader in democracy, human rights, and economic opportunity, many family members find it difficult to believe or understand the delays in joining their loved one, which is a source of anger, resentment, and blame within families.

Reunification takes many forms, depending on factors such as the family's ability to locate one another

and obtain means of travel. Cultural differences in definitions of family and documentation practices create additional barriers. For example, certificates of adoption are unheard of in many countries. Often reunification is a piecemeal process that causes considerable emotional distress and bureaucratic headaches for survivors.

Once a family is reunited, there is a honeymoon period. Family members are overjoyed with the sheer miracle of reunification and their survival as a family against incredible odds.

Families that shared traumatic experiences and relied on one another for survival show particularly close bonds and continue to do everything together.

As the family's resettlement proceeds, the effects of torture trauma begins to surface in a complex manner. Such effects interact with the stresses of cultural adjustment, loss of economic and/or social status, events back home (e.g., war, destruction of property, deaths and torture of friends or extended family), and other ongoing trauma the family may be experiencing in their new community (such as racism, neighborhood violence, etc.).

Cultural differences may create conflict and upheaval for families coming from different cultural contexts. For example, compared to more traditional societies, culture in the United States places relatively greater emphasis on individualism, competi-

## COMMON EFFECTS OF TORTURE ON FAMILIES

LOSS OF CULTURAL and social supports due to fear, distrust, sense of betrayal, etc.

SOCIAL WITHDRAWAL or isolation

MARITAL AND/OR intergenerational conflict

PARENTAL FUNCTIONING IS affected by parents' symptoms (e.g., parents are often less emotionally attuned and attentive to children than they otherwise would be, due to being exhausted and distracted by symptoms of depression and post-traumatic stress disorder)

LOW TOLERANCE for negative emotions (e.g., a parent can't stand to hear a baby cry because it reminds the survivor of memories of other prisoners' screams)

SILENCE WITHIN the family regarding the torture and other trauma (i.e., what happened to whom and why), sometimes leading to confusion, misunderstanding, multiple versions of what happened, and unaddressed blame, shame, anger, disappointment, and sadness

PARENT-CHILD ROLE REVERSAL (parents experience disempowerment due to both trauma-related symptoms and loss of their traditional role in the new culture; children prematurely assume adult roles due to more rapid language acquisition and acculturation)

PRESSURE ON CHILDREN to be immune to effects of the family's ordeals and to succeed (often to make up for what the family lost)

tion, mobility and fast pace, materialism, youth culture, technological innovation and change, and the nuclear family as the basic family unit. Resolving conflicts between traditional and newer values is difficult without trauma. When one or more family members is coping with effects of torture, these issues become even more daunting.

### IMPACT ON CHILDREN AND YOUTH

The issues faced by families of torture survivors, especially the youth, are often overlooked. Along with their parents, young people endure many of the stresses inherent in the pre-flight, flight, and post-flight stages (see Chapter 3 for more on the Triple Trauma Paradigm) for refugees and asylees.

Children and adolescents may be torture survivors themselves. In other cases, they are affected indirectly by the torture of another family member or members, such as parents, siblings, grandparents, and cousins.

As parents, many torture survivors fear that the intensity of their own feelings could overwhelm them. Coping with the expressed or unexpressed feelings of their children is even more frightening. Parents feel guilty about the circumstances their children endured and continue to endure.

For parents of children who were tortured or traumatized, guilt over their inability to keep their children safe and feelings of helplessness affect their parenting. Parents may under-report or overlook both past trauma and current problems suffered by their children.

As another example, children are affected when they witness how a parent or caregiver acts when confronted with memories of the past or traumatic reminders, such as violence

on television.

This response can take many forms in a parent, ranging from withdrawal to one's bedroom for prolonged periods to acute trauma reactions, such as flashbacks. These reactions can be confusing and frightening to children.

Torture survivors are afraid of family members dismissing them as "crazy." Family members are alarmed and saddened to discover that the survivor is no longer who she or he was before the torture.

Living in families and communities affected by torture conveys profound messages to youth. The lessons of torture, as identified by youth, are embedded in the following messages:

"The world is not a safe place."

"You should not trust anyone."

"Death can happen at any time."

"Nobody will believe you."

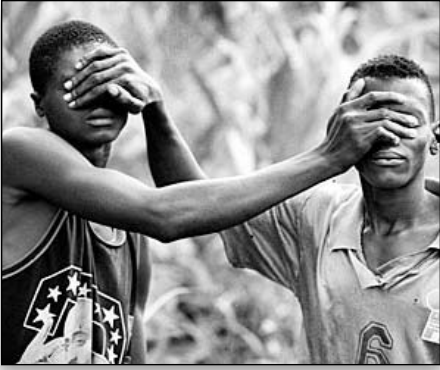
"Stay away from all politics."

"Parents and adults can't protect you."

"Your problems are not as serious  
or difficult as mine were."

These messages affect how young people behave in school and in the broader community. Without corrective experiences or appropriate intervention, they experience social isolation, adjustment difficulties, and marginalization.

For various reasons, children of torture survivors may not have access to religious, community, or school supports. This is unfortunate, given that social support and understanding from others is very helpful. Sometimes, young people in highly traumatized and isolated families view attempts to reach out to others as a betrayal of their



**SAHR, 18, LEFT:** "If I refused, they would kill me . . . I was instructed how to cock the gun and fire. It was an AK47. I cannot remember exactly how many times I fired. . . . It was the young boys who destroyed Sierra Leone."

**SAHR, 19:** "I was encouraged to join the rebels. I saw a rebel kill a man, a young man, and drink his blood."

Last names and hometowns withheld.

parents, or they have internalized the fears of their parents. They fear getting their parents into trouble with authorities by bringing attention to the family. They fear a reoccurrence of what happened back home.

Young people may also experience symptoms related to their trauma or the torture trauma of their family, as well as symptoms related to the catastrophic losses they have endured.

Children of torture survivors endure many unsafe transitional living arrangements while their families attempt to find safe neighborhoods in the United States. This disrupts their educations as well as the development of stable attachments and normative peer relationships.

Affected youth, like their parents, are highly resilient and develop strong survival skills to adapt to these abnormal environments. If a young person is behav-

ing in ways that seem strange or inappropriate, it is crucial for professionals to investigate the history and meaning of that behavior in previous environments he or she managed to survive.

Again, it is important to know that not all torture survivors, primary or secondary, will need specialized services to address the effects of their torture. As with any trauma, how a person deals with torture is contingent upon individual, family, cultural, and environmental factors.

## CONCLUSION

Attending to the needs of communities and families affected by torture is instrumental in fostering a healing environment. The thoughtful provider considers the individual torture survivor not in isolation but as a part of a larger support system of family and community.

As a group, torture survivors are hardworking, principled individuals who have sacrificed themselves to address the political and social problems in their home countries.

They are leaders with abilities, talents, intelligence, and survival skills that made them a threat to those who rule through fear. As newcomers to this country, they make invaluable contributions to our economy, neighborhoods, and social, religious, and civic institutions.

They deserve welcoming and healing communities. The rest of this manual addresses the role of health care, social services, and legal services in creating such communities. ■

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## CASE STORY

**EDITOR'S NOTE:** The following is a story of a family affected by torture. Unfortunately, this family's experiences are common among torture survivors.

**M**ohamed, the father of the family, spoke out against a repressive leader. Soon the family began to receive threatening phone calls and notes left on their door. One day, Mohamed disappeared on his way to work. No one has heard from him since and the family presumes he is dead.

The mother of the family, Sarah, and her four children were subsequently imprisoned together for 12 months. During that time, the children witnessed Sarah taken away for daily interrogation and torture sessions. Following each session, she returned to them bloody and injured. She was severely beaten and burned as part of her torture. The children and Sarah also witnessed many atrocities in the prison and lived under deplorable conditions.

After their release, they escaped on foot through the mountainous region of their country and came to the United States as refugees several years ago.

Sarah suffers from chronic pain in areas of her body that were tortured, as well as severe post traumatic stress disorder and major depression. Despite this, she attempts to make a life for herself and her children. This is difficult.

In her home country, before she



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was tortured, Sarah and her family owned several homes and enjoyed relative safety and a comfortable lifestyle. Here, the family lives in a rodent-infested apartment that Sarah will not leave or complain about because she fears the landlord and police.

Sarah works full-time in house-keeping for a hotel chain. The family is completely isolated from other families from their country. Sarah does not permit relationships with those in her cultural/ethnic community due to distrust and shame. Following her release from prison, others shunned, shamed, and betrayed her, mostly out of their own fear that they would also be targeted if they extended themselves to help her. She says she cannot forgive this. She allows the family to have relationships with people from other countries who share the family's religion, as well as health-care and social service providers.

The family continues to live with worry and anxiety that relatives back home will be persecuted because they escaped. Shortly after they arrived in the United

States, relatives phoned the family and informed them that Sarah's father was executed because of their escape.

The children worry constantly about their mother's physical and psychological condition, sometimes leading one or more of them to stay home from school to do the cooking or cleaning so that Sarah will not have to after she gets home from work. Other students ridicule them at school because of their accents and limited financial resources for clothing, field trips, etc.

For both Sarah's medical appointments and interactions with the school system, the children are in the roles of interpreter and cultural broker. They have learned to take care of the bills and the outside appointments for the household.

Both Sarah and teachers describe two of the girls, Eleni and Martha, as depressed. The son, Ahmed, struggles to assume his culture's traditional role of head of the household at age 11. He suffers from insomnia, traumatic nightmares, flashbacks of the prison experiences, and other symptoms of post traumatic stress.

The children do not know or understand what happened to their father, Mohamed, but they know that their mother cannot tolerate discussion of this topic and they have stopped raising it.

His fate hangs over the families' interactions with one another like a heavy, ever-present cloud. ■

## CHAPTER 3



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# WORKING WITH TORTURE SURVIVORS

CORE COMPETENCIES

## CHAPTER 3

WORKING WITH  
TORTURE SURVIVORS

## CORE COMPETENCIES

## IN THIS CHAPTER

- LIFE EXPERIENCES and Resettlement Issues
- COMPREHENDING Torture
- CULTURAL Competence
- WORKING WITH Interpreters

**W**hen providers are familiar with and respect the culture, language, and trauma experience of their clients, they create bridges of understanding. In order to provide appropriate and effective services, professionals need to develop a degree of expertise in the following four core fields of competency:

**KNOWLEDGE OF** the life experiences and resettlement issues of refugees, asylum seekers and asylees before, during, and after the violence

**COMPREHENSION OF** torture and its long-term effects on survivors, their families, their community, and professionals who work with them

**CULTURAL COMPETENCE** with traumatized people

**WORKING EFFECTIVELY** with interpreters

This chapter provides information on the four competency areas that apply to providers in all disciplines and service domains. The following chapters address each competency area in further detail for social services providers, medical professionals, psychological services professionals, and legal services providers.

### LIFE EXPERIENCES AND RESETTLEMENT ISSUES

Torture is rarely the only trauma a torture survivor has experienced. Exile involves the loss of an entire world and way of life, in addition



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**"THEY RAPED ME** three times a day for eight months," said Addnar Mondeh, 45, of Koidu, Kono district, Sierra Leone. "It made me afraid of men. I do not feel like having sex any longer."

tion to bringing the new and pressing challenges of starting over in a foreign land.

To appreciate what was lost or changed, service providers need an understanding of the survivor's life before the trauma and uprooting, including knowledge of the survivor's past resources, strengths, roles, status, and other core aspects of identity and meaning.

Thus, learning how to learn about survivors' life experiences and resettlement issues is crucial in understanding the impact of torture and rehabilitative priorities for a given individual, family, or community. Acquiring this type of learning skill requires hands-on training and supervision, which no manual alone can provide. However, the following section provides an introduction to common life experiences and resettlement issues that can serve as a first step in developing greater awareness.

### LIFE BEFORE TORTURE

Torture survivors coming from situations of longstanding political conflict or repression may not have known a pre-trauma period of their lives. For these survivors, family histories

or collective histories contain information and beliefs about earlier periods of stability or prosperity that carry important meaning in their current lives.

For other survivors, events such as the start of a war in a previously intact society or an overthrow of the government in a formerly stable system, clearly demarcate normal life and times of hardship or suffering. For others, pockets of normalcy may be interspersed within their countries' periods of upheaval and destruction.

At the collective level, sources for learning about the living history of a people include the following:

- Guest speakers and other resources from local refugee and asylee communities and organizations (e.g., printed materials and events)
- Written histories
- Oral history projects
- Country reports from governmental, nongovernmental or human rights organizations
- The media
- Accounts from cultural anthropology and sociology
- The arts (drama, poetry, memoirs, visual arts)
- Web sites maintained by political or social justice organizations within the country as well as outside

When assessing at the individual or family level, the following information from the home country is pertinent:

- Social, economic, educational, and political status
- Beliefs, values, practices, rituals, ceremonies, significant achievements or milestones that gave life meaning

- Family, social, and community roles (e.g., how was this family regarded within its native intact community? What were the responsibilities associated with various family roles, such as oldest son or daughter?)
- Pre-trauma functioning, or highest level of functioning in the home country (e.g., who was this person or family before the torture?)
- Homes and/or ties to the land (e.g., responsibilities for ancestral lands, farms)
- Other aspects of status or resources the person or family possessed
- A basic understanding of how daily life was lived (e.g., was life mostly lived outdoors? Were activities and physical space mostly communal or shared versus individual or private? To what extent did the genders interact in daily life? What were the normative sleeping and eating customs?)
- Beliefs and practices relevant to health, healing, wholeness, suffering, sickness, loss, grief, and mourning (with the understanding that these beliefs and practices often undergo transformation during subsequent periods of repression, flight, and exile)

### THE REFUGEE/ASYLEE EXPERIENCE

Refugees and asylum seekers typically encounter traumatic experiences and human rights abuses in the phases of their lives called the refugee experience. Knowing about traumatic events associated with the various periods of the refugee experience is necessary for providing assessments and services to torture survivors.

This requires a paradigm shift for service providers trained to think of trauma in terms of single events, such as a car accident or hurricane. In addition, as implied in the term post-

### DEFINITION OF TORTURE

"... the term *torture* means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."

— ARTICLE 1, UNITED NATIONS CONVENTION AGAINST TORTURE, 1984



**SPUTNIK** Tented Camp.

traumatic stress, providers may see trauma as having a discrete beginning and end.

For refugees, asylees, and asylum seekers in exile, there is no end to the ongoing destruction of their family, property, and community back home. Nor is there an end to events they experience as life threatening, such as the ongoing threat of deportation for someone who is seeking asylum.

To help the provider understand common phases of the refugee/asylee experience, the Triple Trauma Paradigm was developed. (See Figure 3A, next page.) This model was adapted from other stage models (e.g., Gonsalves, 1992; van der Veer, 1998) listed as references at the end of this chapter.

Phases of the refugee/asylee experience include not only traumatic events, but also other significant and meaningful life experiences. The Triple Trauma Paradigm describes three phases of traumatic stress that apply to torture survivors in exile who may or may not enter the United States with refugee status.

#### FOR MORE INFORMATION

For more information on implications for social and psychological service providers, see **CHAPTERS 4 and 6.**



**PRE-FLIGHT:** This period covers the series of events, sometimes occurring over years, that leads to the decision to flee. It includes events in the survivor's life as well as the broader sociopolitical context that created a climate of constant fear.

Often there is a pattern of escalation of traumatic events over time. Less severe forms of harassment or repression (e.g., restrictions on movement, brief arrests, monitoring) escalate to the infliction of suffering and threats on one's life (e.g., disappearance of friends or relatives, public display of atrocities, loss of job or property, detention, torture).

The decision to leave one's homeland is often one of the most difficult decisions a person or family makes. It is common for someone to undergo multiple periods of detention and torture before deciding to flee. The survivor may attempt to escape several times before succeeding.

Providers need information about the barriers to medical care faced by torture survivors in this stage. Both modern and traditional healers can be expensive and difficult to access under conditions of repression.

Beyond social and cultural influences on the type and availability of care, many torture survivors are afraid or ashamed to seek treatment for a variety of reasons. For example, some physicians are involved in torture or connected to repressive governments, and survivors fear arrest in the hospital. In addition, clinics refuse to treat members of certain groups or political parties.

**FLIGHT:** The flight period covers the escape and flight to the country of eventual refuge. It lasts from one day



to years, the latter being more common. At the psychological level, characterizations of this period include profound uncertainty and fear due to lack of security, the unpredictable future, and vulnerability to additional trauma.

Torture survivors may spend considerable time living in hiding within the home country, or cross borders of several countries under perilous conditions. They also live in refugee camps in conditions of squalor, crime, unemployment, malnutrition, and threat of attack from rebel or military forces.

Barriers to obtaining treatment for torture-related injuries and psychosocial needs are extreme in this stage. The temporary and impoverished nature of living conditions rarely permits access to health

care or social services.

People in this stage are caught in a no-man's land between the past life they knew and an unknown future in an undetermined location they hope offers them basic security. It is important for service providers to understand the psychological implications of this limbo for political asylum seekers currently in the United States.

The survivors feel they are still in flight until they gain asylum and reunite with family members who remain in danger in the home country. The process of asylum and reunification can take years.




The uncertainty and length of the asylum process makes resettlement different for asylum seekers than for refugees.

Service providers to torture survivors need to receive training about these differences and their implications for service delivery.

**POST-FLIGHT:** Post-flight is the period of resettlement and exile. The challenges of post-flight include the shock and stress of adapting to a new culture and society while ongoing events in the home country bring additional trauma and loss to the survivor.

During the post-flight period, survivors experience ongoing traumas and stresses due to their marginalized or foreign status in the new country, along with poverty, racism, or anti-immigrant prejudice. They are vulnerable to crime because of their lack of knowledge of cultural norms, less protected legal

FIGURE 3A

THE TRIPLE-TRAUMA PARADIGM		
PRE-FLIGHT 	FLIGHT 	POST-FLIGHT 
<ul style="list-style-type: none"> <li>■ Harassment/intimidation/threats</li> <li>■ Fear of unexpected arrest</li> <li>■ Loss of job/livelihood</li> <li>■ Loss of home and possessions</li> <li>■ Disruption of studies, life dreams</li> <li>■ Repeated relocation</li> <li>■ Living in hiding/underground</li> <li>■ Societal chaos/breakdown</li> <li>■ Prohibition of traditional practices</li> <li>■ Lack of medical care</li> <li>■ Separation, isolation of family</li> <li>■ Malnutrition</li> <li>■ Need for secrecy, silence, distrust</li> <li>■ Brief arrests</li> <li>■ Being followed or monitored</li> <li>■ Imprisonment</li> <li>■ Torture</li> <li>■ Other forms of violence</li> <li>■ Witnessing violence</li> <li>■ Disappearances/deaths</li> </ul>	<ul style="list-style-type: none"> <li>■ Fear of being caught or returned</li> <li>■ Living in hiding/underground</li> <li>■ Detention at checkpoints, borders</li> <li>■ Loss of home, possessions</li> <li>■ Loss of job/schooling</li> <li>■ Illness</li> <li>■ Robbery</li> <li>■ Exploitation: bribes, falsification</li> <li>■ Physical assault, rape, or injury</li> <li>■ Witnessing violence</li> <li>■ Lack of medical care</li> <li>■ Separation, isolation of family</li> <li>■ Malnutrition</li> <li>■ Crowded, unsanitary conditions</li> <li>■ Long waits in refugee camps</li> <li>■ Great uncertainty about future</li> </ul>	<ul style="list-style-type: none"> <li>■ Low social and economic status</li> <li>■ Lack of legal status</li> <li>■ Language barriers</li> <li>■ Transportation, service barriers</li> <li>■ Loss of identity, roles</li> <li>■ Bad news from home</li> <li>■ Unmet expectations</li> <li>■ Unemployment/underemployment</li> <li>■ Racial/ethnic discrimination</li> <li>■ Inadequate, dangerous housing</li> <li>■ Repeated relocation/migration</li> <li>■ Social and cultural isolation</li> <li>■ Family separation/reunification</li> <li>■ Unresolved losses/disappearances</li> <li>■ Conflict: internal, marital, generational, community</li> <li>■ Unrealistic expectations from home</li> <li>■ Shock of new climate, geography</li> <li>■ Symptoms often worsen</li> </ul>



Tamba was at home when he received a phone call soliciting contributions for an organization that helps children with cancer. The caller identified himself as a volunteer with the police union, and pleasantly explained this was their annual fund-raising drive. His voice and hands shaking with fear, Tamba offered to contribute, though he was already out of money for the month. From his perspective, he could not say no. That night he had nightmares of being back in his home country where the police would come to his house and he would pay them money to avoid abduction.

status, and limited eligibility for services as noncitizens.

At the psychological level, survivors initially feel relief at having left the daily fright and uncertainty of the flight stage. This is followed by a deepening awareness of loss and overwhelming feelings.

Psychological symptoms or distress become manifest for survivors when they are not as preoccupied with daily struggles for physical survival. Some survivors experience significant depression as they feel overwhelmed by the tasks required for adjustment and with the grief they feel at leaving their country behind.

Torture survivors encounter barriers to accessing health services in this period, including the following:

- Transportation and child-care needs
- Language and cultural barriers
- Negotiating complex U.S. health care and social service institutions
- Ineligibility for services due to lack of insurance or immigration status
- The stigma of mental health and illness (of being considered “crazy” and in need of treatment)
- Unmet basic social, legal, and physical needs
- Misdiagnosis and/or lack of facilitated referral from other service sectors
- Racism and classism

Due to these barriers and unmet basic needs, service providers need to expand their traditional professional roles. Survivors require advocacy, case management, and physical accompaniment to situations where they may require the presence of a supportive, trusted ally. Dealing with authorities and institutions is particularly difficult and potentially re-traumatizing for torture survivors who have suffered from abuse of power by these entities in their homeland.

Service providers need to address ongoing trauma and to accommodate interruptions or delays in treatment — sometimes lasting years — due to life circumstances and different developmental pathways in trauma recovery.

The post-flight stage, characterized as acculturation, bicultural integration, resettlement, or exile, is complex. Personalities, behaviors, and functioning look very different in the same survivor or family, depending on the stage of resettlement, the situation in the home country, and current level of acculturation stress. Service providers need to assess these factors in relation to current problems or symptoms and design interventions accordingly.

For those who have never imagined what it would be like to lose one’s entire world, it is helpful to supplement academic learning with training tools that connect the learner to a range of personal stories.

## COMPREHENDING TORTURE

The effects of torture exist in human responses to other extreme trauma. However, the nature and meaning of torture distinguish it from the individual traumatic events that many practitioners trained in the West treat.

### FOR MORE INFORMATION

A handout on the effects of torture can be found on **PAGE 25, FIGURE 3B.**



FIGURE 3B

A HANDOUT FOR SURVIVORS AND THEIR FAMILIES

COMMON EFFECTS OF TORTURE		
POSTTRAUMATIC STRESS DISORDER	DEPRESSION	PHYSICAL SYMPTOMS
<p>Nightmares</p> <p>Bad thoughts or memories of the torture come into your mind when you don't want them to</p> <p>Acting or feeling like the torture is happening all over again (e.g., flashbacks)</p> <p>Feeling very upset when something reminds you of the torture</p> <p>Trying to forget the torture, trying not to think about it</p> <p>Staying away from anything that reminds you of the torture</p> <p>Cannot remember important things that happened during the torture</p> <p>Feeling like you do not care about life or what happens to you</p> <p>Feeling like no one understands or cares about you, like you are alone and cut off from others</p> <p>Feeling numb, like there are no feelings inside you</p> <p>Feeling like you have no future or that you may die sooner than most people</p> <p>Difficulty falling asleep or staying asleep at night</p> <p>Feeling angry a lot, easily upset</p> <p>Difficulty concentrating</p> <p>Can't relax or feel comfortable, often afraid something bad will happen</p>	<p>Feeling sad or angry a lot</p> <p>Difficulty thinking or making decisions</p> <p>Difficulty concentrating or remembering</p> <p>Feeling worthless or hopeless</p> <p>Feeling excessive guilt</p> <p>Feeling that you do not care about life, that you are not interested in things</p> <p>Feeling too hungry or not hungry at all, gaining or losing a lot of weight without trying to</p> <p>Sleeping too much or too little</p> <p>Feeling tired a lot, not having energy</p> <p>Thinking about death a lot, thinking about killing yourself</p>	<p>Headaches</p> <p>Feeling dizzy, faint or weak</p> <p>Chest pain</p> <p>Heart beats very fast</p> <p>Stomach hurts or feeling sick in the stomach</p> <p>Shaking or trembling</p> <p>Hands or feet feel cold</p> <p>Hot or burning feelings</p> <p>Numb or tingling sensations</p> <p>Sweating</p> <p>Diffuse or generalized sense of pain, weakness, misery</p> <p>Other pains in the body</p>



Sara avoided the local grocery store. She had been in the store once when some local youths entered who were dressed in baggy fatigues with bandanas on their heads. Sara shouted something — she could not remember what — and cowered in a corner. The youth were dressed somewhat like the child rebels who had detained and raped her at a checkpoint in her country. She could not return to the store out of fear and embarrassment.

Because torture is a political weapon used to terrorize entire communities by targeting individuals, a care provider needs to understand the political and historical context in order to provide appropriate treatment. Psychologist Yael Fischman, from the Institute for the Study of Psychosocial Trauma in Palo Alto, California, offered the following admonition:

... clinicians working with survivors of human rights violations need to consider a conceptual framework that goes beyond the posttraumatic stress disorder model — one that incorporates the historical and political context in which the trauma originated.... If patients perceive that the therapist views their symptoms, reactions, and difficulties solely as products of adverse personal traits and events, they are likely to feel confused, misunderstood, or even angry. For the survivor of political repression, the elaboration and integration of a traumatic history requires an understanding of the ways in which the political/historical context of this type of trauma differs from that of traumas stemming from private encounters and events. (1998, p.28)

This broader concept of trauma goes beyond individual symptoms and disorders to address issues of meaning, power, and identity. Torture destroys these core elements of the individual and social structure.

Many torture survivors struggle with the effects of society's collective silence and denial that such atrocities happened. This may lead them to question the reality of their own experiences and reinforce the shame and powerlessness imposed on them during the torture.

While research on torture is in its infancy, according to the American Psychiatric



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Association, it has been established that post-traumatic stress disorder “may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape)” (1994, p. 424). That is, higher levels of symptoms and longer-lasting symptoms are associated with human-perpetrated traumas such as torture.

The effects of torture vary widely at the individual level, ranging from temporary distress or a few symptoms to full-blown psychiatric disorders. Nevertheless, the effects of torture are severe and disabling for many survivors.

Many factors affect how individuals react to severe stress. The intensity and duration of the trauma experience (sometimes referred to as exposure variables) are two important factors. In general, torture survivors who endured long periods of detention and multiple forms of interpersonal trauma are likely to be symptomatic and/or functionally impaired.

However, torture is torture. Distinctions among degrees of atrocity can become meaningless when dealing, by definition, with the extremes of human trauma.

### EFFECTS OF TORTURE

The following effects of torture may affect survivors, with the understanding that culture and individual differences influence the range and

manifestation of these effects. In general, these effects logically follow the reality that torture is designed to break down the spirit, mind, and will.

**DISTRUST:** Torture influences many relationships: one's relationship with oneself (body and mind), with family and friends, with groups and institutions, and with humanity in general. Survivors commonly say that torture changes them forever and that they feel like strangers to themselves.

They feel betrayed by their bodies and the degree of pain they allowed them to experience. Survivors distrust their own perceptions or intentions, as well as those of others. They feel as if they are no longer fully human, or that they are somehow different from other people.

Survivors have experienced deliberate cruelty and betrayal under highly intimate conditions. Many torturers knew their victims personally, and torture often involves intimate contact. Those in positions of authority who were supposed to protect people perpetrated torture. Understandably, many survivors resolve never to trust another human being.

One challenge for service providers is to understand the depth of the survivor's distrust and its many manifestations over time. Showing understanding and acceptance of distrust in torture survivors, even when much of the internal experience of the torture survivor may go unspoken, is a powerful intervention.

Distrust affects the length of time it takes for someone to acknowledge what happened, and it will affect the survivor's ability to build relationships with the service provider and with others. For torture survivors, rebuilding trust is a long-term recovery goal.

**SILENCE AND SELF-EXPRESSION:** Torture is used around the world because it is highly effective at silencing individuals and communities. Torture affects people's thinking and willingness to express themselves. Their fundamental views of the world, other people, and themselves are altered to accommodate what they experienced under torture, which is often bizarre, sadistic, and incomprehensible.

State censorship becomes self-censorship under repressive regimes. People are afraid to speak or even to think certain things that may be dangerous to utter.

In addition, the horrific nature of these atrocities reinforces the silence surrounding the trauma, as words often seem inadequate for explaining what one experienced. Survivors find it difficult enough to understand and believe their own experiences, so the task of explaining them to someone who was not there can seem overwhelming or pointless (Dalenberg, 2000).

#### **DISEMPOWERMENT AND HELPLESSNESS:**

Empowerment is a fundamental principle of trauma recovery. Survivors of torture experience unpredictability, helplessness, and lack of control under torture. Torturers control their victims' most intimate and basic bodily functions, such as eating and elimination. Victims under detention live for long periods with the feeling of not knowing what is going to happen next, of not knowing when death might come.

The complete control that torturers have over victims is not just physical but also mental. Mental forms of torture include sleep deprivation, mind games, direct threats, psychological abuse, brainwashing, pharmacological torture, and many other psychological methods.



During Jamal's imprisonment, the jailers placed a severely mentally disturbed man in Jamal's prison cell. The man appeared to be psychotic and was not in control of his behavior. He incessantly attacked Jamal and screamed to himself and at Jamal. At one point, he started injuring himself by banging his head against the cell wall and lurched toward Jamal to try to "eat his arm." The torturers told Jamal that this man was a ghost that had risen from the dead to haunt Jamal because he was bad. Because Jamal believes in spirits, he continues to believe that this man is a ghost that still haunts him.

Frequently, victims are told, Your mind is no longer your own. You belong to us now. The torturers force them to participate in their own torture or the torture of others.

Often torture victims receive a false sense of choice. They believe they are responsible for what happens, when in reality the torturer has complete control over the situation. (e.g., Tell us what we want to know, or we will kill your wife.) Although it is not a choice, survivors still feel responsible for the actions of the torturer, which in some cases is the killing, torture, or disappearance of other people. This kind of scenario inevitably leaves survivors with tremendous guilt that leads to self-punishing behaviors and questions of self-worth and self-blame.

This type of powerlessness undermines people's ability to act or to assert themselves. Even questions such as "Do you understand what I said to you?" or "Are you feeling all right?" are difficult for torture survivors to answer. They try to assess what is the right answer or what the authority figure wants to hear. They answer yes because they do not want anyone mad or upset with them.

This presentation places providers in a very difficult position. It is important not to confuse these responses with passivity and indifference. What the provider might be seeing is the chronic fear and helplessness created by torture and repression.

**SHAME AND HUMILIATION:** Torturers intentionally produce feelings of shame and humiliation that undermine identity and prevent survivors from talking about what happened to them. For example, forced nakedness is one technique commonly used under captivity. This act strips

away personal identity and shames victims through indecent exposure to others. Nakedness is one of many techniques that serve as a continual reminder of the differences in power between torturers and victims.

Other forms of sexual torture result in shame and humiliation. Even survivors who appear quite willing to talk about their experiences will not reveal their most shaming experiences. Providers can never assume they know the worst of what a survivor experienced.

In some cultures, it is unacceptable to disclose sexual torture. Female survivors are concerned they will lose their husbands or their communities of support. Because of the potential social and economic consequences, rape survivors may not be able to disclose this to anyone. Similarly, men who are victims of sexual torture struggle with extreme feelings of shame, humiliation, and emasculation.

Torturers call women whores or prostitutes and name men as women or wives during torture. They tell survivors they enjoyed the rape, or deserved sexual assault.

Many survivors say they will have to live with sexual torture their entire lives. The effects of this type of torture can be long-lasting and severe, including suicide when the shame becomes intolerable.

**DENIAL AND DISBELIEF:** Simply put, torture is difficult to believe. Torturers tell their victims no one will believe them even if they live to tell the story. Sometimes the torture is so sadistic and bizarre that survivors find it easy to accept that, indeed, no one else will believe what happened.

Torturers use torture to distort victims' sense of reality. The world turns upside down.

The incomprehensible and unbelievable become true, and social norms and the rules of logic or common sense in the culture no longer apply. For these psychological reasons, survivors deny, distort, or repress memories of the torture.

Torture survivors may fear laughter or disbelief if they talk about the torture. They are sensitive to the slightest gesture (often unintentional) from a provider that may imply doubt, disbelief, or denial.

### DISORIENTATION AND CONFUSION:

Under torture, the assault on the senses and the strangeness of everything that is happening confuses victims. Torturers manipulate the environment to create illusions and fears of losing one's mind.

Under captivity, even if it is only a matter of hours, people lose their sense of time. This is especially true when there is also sensory deprivation (e.g., blindfolding, imprisonment in complete darkness), multiple episodes of similar interrogation and torture, or solitary confinement. Survivors report not knowing what week or even month or season it is.

Survivors may lack memories of what happened under captivity. They do not remember start and end dates of imprisonment. Confusion and disorientation influence the ability to recall events, creating inconsistencies and gaps in their stories. Some torture survivors have experienced pharmacological torture or loss of consciousness.

Providers should use caution when interpreting memory issues, and be aware that memory gaps and inconsistencies are

FIGURE 3C

LEVELS OF ADDRESSING TRAUMA	SHORT-TERM INVOLVEMENT TASK UNRELATED TO TRAUMA (E.G., INCOME MAINTENANCE WORKER)	ONGOING INVOLVEMENT UNRELATED TO TRAUMA (E.G., ESL TEACHER)	ASSESSMENT INTERVENTION RELATED TO TRAUMA (E.G., MENTAL HEALTH PROFESSIONAL)
Ask only questions relevant to your task	X	X	
Do not identify trauma in order to help	X	X	
Know about appropriate referral resources	X	X	X
Consider culture and traumatic experiences	X	X	X
Avoid/reduce potential for reactivation of trauma	X	X	X
Respond to spontaneous disclosures of trauma	X	X	X
Respond to expressions of distress (crying)	X	X	X
Acknowledge prevalence of trauma for refugees		X	X
Normalize trauma reactions		X	X
Explore relevant refugee and trauma experience		X	X

common among torture survivors.

**RAGE:** Rage is a natural response to the violations of torture. Many survivors suppressed rage for a long time.

The force of their own rage often frightens survivors. Survivors may feel more rage or anger toward a current situation than would normally be expected, given the situation. Conversely, they may shut down when upset, in order to protect themselves from their feelings.

They may be able to discuss their fear of their anger but are often at a loss as to what to do with it. They are embarrassed or ashamed, recognizing what they are feeling is out of proportion to the present situation and feel helpless against their own fury.

Trauma-related rage interferes with the ability to remember, to think clearly, and to express oneself, especially in threatening situations where survivors either feel out of control or fear losing control. Providers may witness behaviors that the torture survivors used during their torture to survive.

**PSYCHIATRIC SEQUELAE:** Many torture survivors meet criteria for one or more psychiatric disorders. However, use of the term disorder or any concept that so labels the survivor is a very sensitive matter.

Some survivors are relieved to know that what they suffer has a name, a history of professional study, and treatment options. Other survivors feel misunder-



An interpreter for Bosnian refugees related that many Bosnians went to the American doctor complaining of headaches or stomachaches. They were alarmed when the doctor did not ask them any questions about their experiences before arriving here, but ordered a battery of diagnostic and routine tests. In their home country a doctor would only order expensive tests if the patient was thought to have a very serious illness.

stood or misrepresented by individual diagnoses. They are acutely aware that torture is fundamentally a political and social problem, which receives little attention or acknowledgment worldwide.

Survivors suffer from normal, expected human reactions to extremely abnormal and disturbed sets of events and environments. Providers need to communicate this understanding to survivors and to normalize the effects of the torture in ways that have meaning for survivors.

Diagnoses, while useful, focus on particular symptoms and on individuals. They do not cover the full range of effects on survivors, their families, and communities.

Common psychiatric disorders associated with torture and severe trauma in adults include the following:

- Posttraumatic stress disorder (PTSD) and other anxiety disorders
- Major depressive disorder
- Somatoform disorders
- Substance abuse (usually to self-medicate anxiety and depressive symptoms in the absence of other therapeutic alternatives)
- Sexual dysfunctions

For torture survivors, the most common psychiatric diagnoses are PTSD and major depression. More rarely, there may be a delusional disorder (usually persecutory in nature) or psychosis. Organic impairment (actual brain injury) has a higher base rate among refugees than other populations due to conditions and events they experience (e.g., starvation, sensory deprivation, head injuries from beatings).



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Torture survivors commonly report that during their torture, they experienced loss of consciousness following beatings to the head. Professionals overlook or underdiagnose organic impairment, as some of the symptoms of organic impairment mimic PTSD and other psychological disorders.

Trauma-related symptoms are not readily apparent to survivors. Changes in feelings and behavior often occur subtly over time. Family members may observe these changes and it is critical to include them in assessment and treatment. Trauma symptoms affect survivors' relationships, including those with family members.

### TALKING ABOUT TRAUMA

When working with survivors, it is not always necessary or even appropriate to address the trauma directly. Training in addressing torture trauma must be tailored to the setting and service provided. However, some consideration of trauma issues (e.g., minimizing the potential for re-traumatization) is relevant for all services. Figure 3C, on Page 29, gives examples of appropriate levels of engagement for the following categories of service:

- Short-term involvement
- Ongoing involvement unrelated to trauma symptoms, and



- Involvement that specifically addresses some aspect of trauma, whether expressed or not

### SECONDARY TRAUMA FOR THE PROVIDER

Service providers often experience unexpectedly strong feelings — or numbness or shock — when talking about torture or hearing survivors' stories. The effects of being exposed to trauma indirectly through others are referred to as secondary, or vicarious, trauma. Among providers working routinely with extreme trauma such as torture, secondary trauma is considered to be an occupational hazard — something that can be reduced and managed, but not avoided completely.

Secondary trauma affects the relationship between the provider and torture survivor, the treatment process, other work relationships, and the provider's life outside of work. Providers who come from communities affected by torture must contend with both secondary and primary trauma. The work can trigger reactions related to their own history of persecution and flight.

It is essential that providers who work with torture survivors receive training on secondary trauma and have access to professional consultation regularly. Training should cover the following subjects:

- Signs and symptoms of secondary trauma
- Contributing factors in the work itself
- Contributing factors in the work environment
- Contributing factors in the individual
- Methods for addressing secondary trauma

Organizations or clinics providing services to torture survivors can implement policies and procedures that prevent or ameliorate secondary trauma at the organizational level. Many contributing factors to secondary trauma are connected to the workplace and may be outside the control of the individual worker. Organizational strategies that deal openly with secondary trauma help reduce the sense of isolation, stigma, and shame that workers may experience.

### CULTURAL COMPETENCE

In the policy paper, "A Manager's Guide for Cultural Competence Education for Health Professionals," the California Endowment adapts the widely accepted definition of cultural competence from Cross, Bazron, Dennis and Issacs:

Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social or religious groups. 'Competence' implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities. (1989, p.5)

### CULTURAL COMPETENCE DOES NOT MEAN

knowing everything about every culture. It is a mindset that leads to lifelong learning with:

- Respect for differences
- Eagerness to learn
- Willingness to accept that there are many ways of viewing the world

#### FOR MORE INFORMATION

For more information on secondary trauma, see **CHAPTER 6.**





An Oromo man sits quietly, saying very little in his psychotherapy session. He is wary of his interpreter, an Ethiopian who speaks his language but is not Oromo. He does not mention his past involvement with a resistance movement and subsequent imprisonment and torture.

This general meaning can be further defined in relation to health care by asking if the individual or organization demonstrates awareness of differences in three key dimensions in various populations and integrates that knowledge into practice (Lavizzo-Mourey and Mackenzie, 1996). Those dimensions are:

- Health-related beliefs and cultural values
- Disease incidence and prevalence
- Treatment efficacy

The word competence, rather than sensitivity, is used in order to tie the learning of cultural information, skills, and attitudes to actions that benefit the client or patient.

Competence does not imply a finite level of skill that can be achieved in the same way as learning to perform open heart surgery or use a particular therapeutic approach. It is a fluid state that is defined in relation to the specific setting and a specific client. The measure of competence is ultimately in the hands of the beneficiary; the client should perceive the services as relevant to his or her problems and helpful for achieving the desired outcomes.

#### HOW CULTURAL COMPETENCE AFFECTS CARE

Lack of cultural competence can affect a relationship with a refugee or asylum seeker in many ways — from the obvious inability to communicate across a language barrier to the subtle ways trust is eroded or never built. Insufficient attention to culture can result in failure to work toward mutual goals.

On an individual level, the absence of cultural competence in rehabilitation results in unsatisfactory outcomes for the patient or client. On the community level, the result is

continuing disparities in health and socioeconomic status between the majority population and new immigrant populations, as well as disparities between the majority culture and other populations of color in the United States.

For the torture survivor, lack of cultural competence compounds a natural reluctance to bring up painful past experiences. On the individual level, this can result in continuing symptoms for the client and frustration for the professional.

On the community level, the failure to address culture impedes the ability of new immigrant groups to acculturate: learn the new language, progress in school, find and keep jobs, and rebuild family support systems.

#### STANDARDS FOR CULTURAL COMPETENCE

In March 2001, the Office of Minority Health at the U.S. Department of Health and Human Services published a set of national standards defining culturally and linguistically appropriate services (CLAS) in health care. The standards focus on the following three areas:

- Cultural competence
- Language access services and
- Organizational supports for cultural competence

Some are mandates based on existing laws (Standards 4-7), some are guidelines (Standards 1-3 and 8-13), and one is only a recommendation (Standard 14). Background information on the CLAS standards can be found on the Federal Office of Minority Health's Web site, [www.omhrc.gov](http://www.omhrc.gov).

#### TRAINING AND RESOURCES

Often, when health care providers begin to see numbers of patients or clients from ethnic



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## THE THERAPEUTIC TRIANGLE: PROVIDER, INTERPRETER, AND CLIENT

Upon intake, Sonia reported she seldom left her apartment and had no sig-



her trauma. Marta remained neutral and calm as she interpreted

significant relationships outside of her immediate family. She told the scheduler she would not work with any interpreter from Guatemala, her home country.

The staff carefully screened an interpreter, considering with whom Sonia would feel most comfortable. Prior to the first session, the therapist and Marta, an interpreter of Mexican descent, agreed to disclose to Sonia certain details about the interpreter to aid in creating safety and trust.

In the initial session, the client, interpreter, and therapist discussed the role of the interpreter, including Marta's promise of confidentiality, her credentials as a professional interpreter, and her national origin (and lack of connection to the political situation in Guatemala).

In subsequent sessions, the therapist moved slowly as she helped the client disclose the details of

Sonia's ideas as precisely as possible

Marta conveyed a tone of respect and belief in Sonia's story.

She consistently matched Sonia's tone and speech patterns to most accurately convey Sonia's messages. She provided an unspoken support for Sonia, actively contributing to the therapeutic process by aiding the communication. Sonia eventually began to open up, beginning the therapeutic process.

The therapist noted that Sonia seemed happy to see both the therapist and the interpreter each week, greeting both of them warmly at the start of each session. Marta became the communication bridge between Sonia and the therapist.

Over time, she also became a model of a person whom Sonia would choose to trust as she recovered from trauma and began building relationships.

groups unfamiliar to them, the first response is: "Teach us the first response about this group's culture." This step, based on good intentions, is not the only necessary step toward cross-cultural practice.

It can lead to stereotyping and short-circuit the important process of understanding the individual patient who has come seeking help. Each individual is a unique mix of personal, familial, situational, and cultural influences. These can only be discovered in the process of forming a relationship with the patient in order to provide care.

The training curricula need to include not only important content about the cultural backgrounds of the torture survivors in particular populations, but also process skills that serve to build trusting and effective cross-cultural relationships.

The provider who has mastered these process skills need

not be afraid of seeing a patient or client with a cultural background that is unfamiliar. Good cross-cultural relationship-building skills are not, however, a substitute for actions that increase cultural knowledge and seek to overcome any barriers to care that cultural, economic, or linguistic differences pose.

### WORKING WITH INTERPRETERS

Many providers must rely on the services of interpreters when working with survivors. Unfortunately, miscommunication occurs because the service provider, the interpreter, or both lack training. In response, the Federal Office of Civil Rights has issued guidelines for health and human services

#### FOR MORE INFORMATION

For a listing of the CLAS standards, see **PAGE 38.**



SAMPLE VOCABULARY  
FOR INTERPRETERS

(political) asylum  
 fingerprint/to get  
 fingerprinted  
 sentence  
 charges to detain/  
 detention/detained  
 to file (an application)  
 hearing  
 judge  
 attorney  
 affidavit  
 case  
 appeal/to appeal  
 passport  
 immigration  
 torture  
 affiliation/to be  
 affiliated with  
 border guards  
 dictator/dictatorship  
 to smuggle (people)  
 persecution  
 electrocution  
 disappeared  
 harassment  
 to bribe  
 rape/to be raped  
 nightmare  
 stowaway  
 demonstration

providers on what constitutes compliance with Title VI of The Civil Rights Act regarding people with limited English proficiency. These guidelines are helpful for learning how to work with interpreters and can be accessed directly at [www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep).

Using professional interpreters is often cited as a financial and time burden for nonprofit agencies and other providers. However, the price of using ad hoc interpreters (family members, friends, community members, or other employees) and untrained interpreters is high, resulting in a denied asylum application, compromised confidentiality for the client, misdiagnosis for medical and psychological treatment, or the inability to provide services.

#### THE THERAPEUTIC TRIANGLE: PROVIDER, INTERPRETER, AND CLIENT

Communication through a trained interpreter can function as part of a powerful healing process. The process of interpreting provides a unique opportunity to model and rebuild connection, relationships, and respect. The interpreter becomes part of a therapeutic triangle while linking the provider and client in communication. A relationship of confidence and trust among those involved helps the survivor to experience the safety needed to engage effectively in treatment.

#### FOR MORE INFORMATION

For a summary of basic dos and don'ts for each stage and for a general guide for providers working with interpreters, see **FIGURE 3E, PAGES 36-37.**



#### SKILLS FOR PROVIDERS

Working with interpreters involves a set of skills, as does interpreting itself. Frequent and thorough communication between provider and interpreter is required.

Most training sources stress the importance of attending three sequential stages of work for providers and interpreters: before, during, and after the use of an interpreter with a given client or patient.

#### SKILLS FOR INTERPRETERS

Interpreting for torture survivors is sophisticated work. It requires knowledge of words and concepts commonly transmitted during the course of medical, mental health, legal, or social services work and understanding of the cultures of clients as well as the experiences of clients with trauma.

Sensitivity and resilience in working with people (both clients and providers) are essential, as are strong language skills.

While each agency should provide thorough training for its interpreters, it is also the responsibility of each interpreter to seek to expand his or her knowledge base. (See sample vocabulary this page.)

Interpreting that is both cross-linguistic and cross-cultural involves many components for the effective translation of meaning.

The core competencies for interpreters described in the Massachusetts Medical Interpreters Association's (MMIA) Standards of Practice have been endorsed by the National Council on Interpretation in Health Care as the best statement of standards for



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**"HER FATHER DISAPPEARED** in the attacks on Nyaeudou camp. We don't know where he is." Cumbay Samura, 28, Falabab, Koinadougou district, Sierra Leone.

medical interpreters available.

These standards of practice for interpreters comprise three major task areas: interpretation, cultural interface, and ethical behavior. A code of ethics, derived from the MMIA standards, stresses the following:

- Confidentiality
- Accuracy and complete interpreting
- Impartiality
- Respect of client's privacy
- Maintenance of professional distance
- Professional integrity
- Obligation to deal effectively with discrimination

#### SELF-CARE FOR INTERPRETERS

Interpreting for torture survivors is a taxing endeavor on the

mind, the body, and the spirit.

Facing the degree of human cruelty experienced by clients is traumatic and can be life-changing. It should be noted that many interpreters come from communities affected by torture and may have heightened sensitivity to the material transmitted. It is important for both interpreter and provider to be aware of the changes in themselves, in their perspectives of the world and the environment, and on relationships and behaviors toward oneself and others. The changes can range from subtle to very dramatic.

Checking in before and after meetings with clients provides opportunities for interpreters and providers to assist each other in noting any feelings, reactions, and responses that may be stressful. ■

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## ADDITIONAL RESOURCES

### CULTURAL COMPETENCE

THERE ARE NOW MANY EXCELLENT resources for learning more about cultural competence that can be accessed through online. Some of them are listed here and provide an entry point for many more.

1. National Center for Cultural Competence <http://gucchd.georgetown.edu/nccc/index.html>
2. *The Providers' Guide to Quality and Culture* (Management Sciences for Health Electronic Resource Center). <http://erc.msh.org/>
3. Diversity Rx. (A joint project of The National Conference of State Legislatures and Resources for Cross Cultural Health Care at the Kaiser Family Foundation of Menlo Park, CA). [www.diversityrx.org/](http://www.diversityrx.org/)
4. EthnoMed: Ethnic medical information from Harborview Medical Center, Seattle, WA. [www.ethnomed.org/](http://www.ethnomed.org/)

### INTERPRETING

1. Massachusetts Medical Interpreters Association, c/o NEMC Box 271, 800 Washington St., Boston, MA 02111
2. Diversity Rx, [www.diversityrx.org](http://www.diversityrx.org)

FIGURE 3E

## GUIDELINES FOR PROVIDERS WORKING WITH INTERPRETERS

## Do

**BEFORE SESSION**

DEVELOP A POOL OF accessible, trained professional interpreters for the most common languages spoken in your area of service delivery.

SCREEN INTERPRETERS: Determine their level of language sophistication, knowledge of the culture, sensitivity to mental health issues (especially confidentiality), and general disposition for the tasks to be done. For mental health service delivery, it is important to ask about the interpreter's own mental health. Many interpreters have their own trauma history and need to make informed choices about re-exposure to traumatic events.

TOGETHER WITH THE INTERPRETER, determine which groups, backgrounds, languages, and dialects would be a good match for his or her skills and background.

ORIENT INTERPRETERS TO THE organization's mission, goals, structure, terminology, and roles. This should be ongoing rather than a one-time effort.

DEVELOP AND MAINTAIN good working relationships with interpreters.

## DURING SESSION

EXPECT TASKS TO TAKE longer when an interpreter is used.

EXPECT THE INTERPRETER to assist with clarification.

EXPECT THE INTERPRETER to take notes when issues become complicated.

PREPARE TO REPEAT yourself in different words.

HAVE THE PARTIES SPEAK directly to each other, not to the interpreter. Make sure the interpreter speaks to both parties in the first person.

LOOK AT THE CLIENT while you are speaking to her or him, not at the interpreter. Maintain gentle eye contact when the client or the interpreter speaks.

EXPLAIN YOUR ROLE and that of the interpreter. It is especially important to address the issue of interpreter confidentiality and how the interpreter and client will handle future interactions within the community.

USE THE INTERPRETER AS a cultural broker to avoid unnecessary misunderstanding.

## Don't

OMIT THIS STAGE. It is essential for providing culturally competent services.

USE A WORD-FOR-WORD interpreting format. Literal translation rarely makes it possible to re-express the original meaning due to the uniqueness of each language.

CHAIN QUESTIONS (e.g., "Do you smoke or drink coffee?").

SAY ANYTHING YOU DO NOT want the other party to hear.

TALK ABOUT CLIENTS IN THEIR presence. If you need to consult with the interpreter, explain what you are doing to the client.

CONFUSE THE INTERPRETER by backing up, rephrasing, or hesitating. Do not "think aloud" or use a reflective style that changes, meanders, or backs up in the middle, or erases parts.

TALK FAST.

FIGURE 3E

GUIDELINES FOR PROVIDERS (CONTINUED)		
	Do	Don't
DURING (CONT.)	<p>PAY ATTENTION TO YOUR NONVERBAL communication, which is the only means of direct communication between you and the client.</p> <p>WATCH FOR SUBTLE SIGNS of discomfort or distress clues that the interpreting is not going well.</p> <p>BE AWARE OF ETHNIC, age, gender, and class differences between the interpreter and the client.</p> <p>USE SHORT, SIMPLE STATEMENTS and stick to one topic at a time.</p> <p>PLAN WHAT YOU WANT to say ahead of time.</p> <p>REGULATE THE PACE of the interaction, pausing in natural places to permit interpretation.</p> <p>CHECK TO SEE IF MESSAGES are understood (may ask interpreter to repeat things such as instructions or directions back to you in English).</p> <p>ENCOURAGE THE INTERPRETER to tell you when he or she is having difficulty.</p> <p>ASK THE INTERPRETER to interpret completely in the event of an obvious omission.</p> <p>GIVE THE INTERPRETER TIME to interpret concepts. One word can require a lengthy explanation in either direction if the concept does not exist in the other language.</p>	<p>TUNE OUT OR THINK only of your next question while the client is speaking, even though you don't understand what's being said.</p> <p>USE IDIOMS, SLANG, obscure or ambiguous words, abstractions, metaphors, jargon.</p> <p>KEEP REPEATING QUESTIONS that aren't being answered.</p> <p>EXPECT THE INTERPRETER to know everything about the client's culture. Other cultural resources may be needed.</p>
AFTER SESSION	<p>DEBRIEF ON COMMUNICATION problems. Ask whether there was anything you did not understand or respond to appropriately (tone of voice, nonverbal communication, etc.). Ask whether there was anything that reflected your lack of understanding of the client's culture, and whether the interpreter had any difficulty interpreting (accent, dialect, client not answering the questions asked).</p> <p>DEBRIEF ON EMOTIONAL and trauma-related issues (e.g., "Did this bring up any difficult feelings for you?") This can be done with groups of interpreters.</p>	<p>SKIP THIS STAGE. The best cross-cultural learning for both service providers and interpreters often happens through immediate feedback using specific situations as learning opportunities.</p>

## THE CLAS STANDARDS

- 1** Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- 2** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- 3** Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- 4** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- 5** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- 6** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- 7** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- 8** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- 9** Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
- 10** Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
- 11** Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
- 12** Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
- 13** Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
- 14** Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.



## CHAPTER 4



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# SOCIAL SERVICES

CREATING  
SERVICES FOR  
TORTURE SURVIVORS

## CHAPTER 4

## SOCIAL SERVICES

## IN THIS CHAPTER

- **SOCIAL WORK**  
Interventions During the Resettlement Process
- **ROLES OF Social Workers**  
During the Asylum Process
- **IMPACT OF TORTURE**  
in Accessing and Providing Social Services
- **CULTURAL COMPETENCE**
- **WORKING WITH Interpreters**
- **PUBLIC POLICY WORK**

*My community is my support.  
Without my community, I am nothing.*

—SOMALI WOMAN IN MINNESOTA

**T**orture occurs within a cultural and social context. It breaks the connections between individuals and their social environment. It separates the bonds of communities.

Social work interventions, therefore, are directed at individuals, their families and immediate environments, community, social, and functional groups, and policies and systems. These are accomplished through direct service, resource development, community interventions, education and training, research, and public policy work.

The provision of social services to survivors of torture is administered by workers with a wide variety of educational foundations and life and work experiences in an assortment of settings.

While this chapter is written for professional social workers, the material is appropriate for social services providers regardless of background, training, or specific tasks.

In addition, some of the material covered in this chapter transcends the boundaries of disciplines and pertains to mem-



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**LIBERIAN REFUGEES** in Sierra Leone.

bers of other professions. All readers are invited to take what they need from the information offered.

Providing appropriate and effective services to torture survivors requires a degree of expertise in four core fields:

- Knowledge of the story of refugees and asylees — before, during, and after the violence
- Understanding of the nature of torture and its long-term effects on survivors, their families and communities, and the professionals who work with them
- Cultural work with traumatized people
- Best practices for working with interpreters

This chapter augments the information concerning the core competencies presented in Chapter 3. A discussion of social work interventions during resettlement and in the political asylum process, sample scenarios illustrating the impact of the effects of torture on accessing social services, and guidelines for cultural competency and for working with interpreters and clients are included in this section. A brief note on policy work and a summary conclude the chapter.

## FOR MORE INFORMATION

Information for clinical social workers can be found in **CHAPTER 6.**



## SOCIAL WORK INTERVENTIONS DURING RESETTLEMENT

During resettlement, social workers assist refugees and asylees by establishing trustworthy, caring, and healing relationships. Interventions should respect cultural and individual differences, address survivors' priorities, and give choice and control to the survivors.

Social work facilitates re-empowerment and capacity-building of survivors in four main categories of concern: 1) stabilization 2) social support 3) education and 4) personal and economic independence.

### STABILIZATION

Having a degree of safety and having access to food, clothing, and housing are essential to stabilization. Laws and systems in the United States can make providing for essential survival needs extremely difficult without support systems; torture survivors are often completely dependent upon others for meeting basic needs. Social workers assist survivors in identifying options, community resources, and ways to overcome barriers in their individual stabilization processes while developing the ability to meet basic needs on their own.

Efforts are focused on helping clients with the following:

- Gaining political asylum to avoid return to country or situations of danger
- Obtaining resources to meet basic needs of food, clothing, housing, transportation, etc.
- Sustaining personal safety through education and skills development.

## SOCIAL SUPPORT

Social workers help survivors expand and use social support systems to aid in recovery. By building consistent and trustworthy connections with clients, social workers help them decrease feelings of mistrust and increase the ability to form meaningful relationships with others.

Most survivors are separated from loved ones and sometimes social workers can help them locate and safely communicate with family and friends. These connections are critical to survivors' peace of mind and ongoing recovery. Some survivors say uncertainty about the fate of their families makes them feel worse than the torture.

Social workers help survivors establish networks of social support in their new communities through service referrals. For example, referrals to English classes provide clients with opportunities to build friendships with fellow students as well as with the volunteers who may offer tutoring or transportation to class.

### EDUCATION

Survivors come to the United States with varying levels of education, training, work experience, and professional rank, which may not be recognized in this country. Pursuing education in the United States can help build self-esteem and confidence, as well as a foundation for employment.

Social workers offer access to the following opportunities to survivors:

- Language classes
- Job training or recertification in a profession or trade
- Resources for higher education
- Systems to support educational



"If I give you all  
of my truth, I give  
you all of my power."

— VIETNAMESE REFUGEE

efforts (such as financial, counseling, and rehabilitative aids and referrals).

### PERSONAL AND ECONOMIC INDEPENDENCE

Independence is seen from a variety of perspectives—from being able to make choices to becoming economically independent. Social workers assist survivors as they learn about the new culture and access employment opportunities, job training, higher education, and entitlement programs for those with disabilities. As survivors gain independence in the various facets of their lives, the roles of social workers diminish.

Examples of client goals in this area include the following:

- Attaining self-sufficiency and meaningful roles in economic and community life
- Enhancing self-identity through relationships and activities that rekindle feelings of pleasure or competence
- Renewing a sense of mastery through the ability to negotiate new systems and deal with life crises in new setting.

### ROLES OF SOCIAL WORKERS DURING THE ASYLUM PROCESS

Torture survivors who do not come to the United States with refugee status may apply for political asylum. Because asylum is so important in a client's life and because it is a compli-

cated and arduous process, clients experience considerable stress and anxiety. A social worker, often as a member of a team, takes on the roles of teacher, coach, and advocate/troubleshooter within the asylum process, alleviating anxiety for the client and keeping the process running smoothly.

#### TEACHER

Although attorneys usually explain the asylum journey to clients, social workers provide further definition of the process, while taking into account limited English, memory problems related to trauma, confusion, etc. In addition, social workers help attorneys understand the long-term effects of torture for clients and how those consequences affect attorney-client relationships.

#### COACH

As social workers develop trusting relationships with clients, they encourage and support clients' efforts to tell their stories to the attorney and the asylum interviewer. Social workers offer reassurance during the entire process of application, interview, and waiting for the results. In certain circumstances, a social worker accompanies the client to the interview and — with the asylum officer's approval — sits in on the interview with the client to provide emotional support.

#### ADVOCATE/TROUBLESHOOTER

A social worker helps clients resolve conflicts within the process. The client may be unable to communicate frustration with the attorney and may not be able to resolve the conflict for one of the following reasons:

- The client sees the attorney in a position of power and does not want

#### FOR MORE INFORMATION

For more discussion of collaboration between attorneys and social workers, see **CHAPTER 7**.



to upset the attorney and jeopardize their relationship, feeling this might endanger the outcome of the case

- The client does not want to take time from the attorney, who may be providing services pro bono, and he or she feels indebted to the attorney
- the client may feel shame and embarrassment after telling the attorney the details of her or his torture and persecution history.

The social worker helps clients problem-solve or propose strategies to avoid pitfalls within the asylum process. For example, the social worker and the client strategize on how to get important documents and evidence from the country of origin that may be important for the case.

### IMPACT OF TORTURE IN ACCESSING AND PROVIDING SOCIAL SERVICES

Torture affects many relationships by damaging the well-being of its victims and destroying the expectation that people relate to each other with decency and kindness. The long-term effects of torture may severely tax the survivor's capacity to access resources and services. In the next section, several case examples illustrate the effects of torture and the corresponding implications for social work.

#### DAMAGED TRUST

*A client from a Middle Eastern country repeatedly asked the social worker a question concerning family reunification. Although she received an appropriate answer, she asked another staff member at the rehabilitation center the same question. In addition, an interpreter at the center who is from the client's community informed the social worker that the client checked the social worker's credibility by asking others*

*in the community about her.*

#### IMPLICATIONS FOR SOCIAL SERVICES:

It can take a long period of interaction in order for a client to be able to talk about needs deeper than basic survival needs. Even in a safe, care-giving environment such as a rehabilitation center, the process of building a relationship may require testing and time. Survivors judge the trustworthiness of the information given by the worker in part through the consistency of responses to themselves and to other clients.

#### LEARNED HELPLESSNESS

*A West African client asked the social worker to do many tasks for him and showed little initiative in providing for family members. When prompted to contact prospective employers on his own, he did not follow through with the phone calls or visits.*

#### IMPLICATIONS FOR SOCIAL SERVICES:

A survivor may be afraid to act because of the previous harsh consequences for any mistake such as an incorrect answer. Learned helplessness damages the ability to think for oneself, express oneself, and take action on behalf of one's needs, desires, and hopes. The social worker may respond by offering choices and opportunities for successful completion of tasks.

#### DISORIENTATION, CONFUSION, CHRONIC FEAR, AND ANXIETY

*A client from Laos appeared to lose focus and became bewildered during an asylum interview. A Kurdish client was terrified of an interpreter from his home country and did not show up for subsequent appointments at the clinic. A torture survivor refused to work at the airport because of the presence of police and others in uniform on the job site.*



"My client can't sleep  
and I can't sleep."

— SOCIAL WORKER AT TORTURE  
REHABILITATION AGENCY

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"None of us had anticipated how helpless we would be in the face of our cultural differences. Words meant one thing to Americans and something else to Afghans, translations aside."

— AFGHANI REFUGEE  
IN THE UNITED STATES

### IMPLICATIONS FOR SOCIAL SERVICES:

The social worker helps survivors cope with the environment and elements out of their control by helping them to recognize and normalize stress-producing stimuli and their responses. The worker attempts to eliminate potential stressors, such as long waits at clinics or social service agencies or encounters in classrooms with others from the survivor's country.

### RAGE

*The force of his own rage frightened a client from Eastern Europe. A miscommunication with the instructor in his English class put him "over the edge" and he left the classroom in an angry state. He hurt himself by banging his head repeatedly against the wall in the restroom in the building.*

### IMPLICATIONS FOR SOCIAL SERVICES:

Rage is contained under the surface and explodes under trying circumstances. Rage interferes with the ability to remember, to think clearly, or to communicate with others. Clients are sensitive to perceptions of differential treatment within the social service network. While acknowledging that anger is understandable given the client's experiences, the worker helps clients take actions apart systematically and build a new view of the situation.

### DEPRESSION

*A young adult from Southeast Asia was not doing well in a job-training program. He did not retain new information and appeared to be unmotivated. In addition, he overslept*

*and showed up late for class frequently although his mother said he went to bed early each night.*

### IMPLICATIONS FOR SOCIAL SERVICES:

Symptoms of depression may make language learning, academic studies, job training, or cultural adjustment tasks difficult. Stressful situations, such as court appearances or asylum interviews, exacerbate symptoms. Medical intervention or psychotherapy may improve functioning.

## CULTURAL COMPETENCE

When social workers gain awareness of their culturally derived reactions, assumptions, and values, cultural competence begins. In seeking such awareness, workers open themselves to learning from clients the meaning survivors derive from their past and present life experiences, and the meaning they place upon new relationships.

Cultural competence is an ongoing process, as the National Association of Social Workers points out in *Standards for Cultural Competence in Social Work Practice* (2001):

Cultural competence is never fully realized, achieved, or completed, but rather cultural competence is a lifelong practice for social workers who will always encounter diverse clients and new situations in their practice. Supervisors and workers must have the expectation that cultural competence is an ongoing learning process integral and central to daily supervision.

Social workers should monitor a number of contextual dimensions during the course of interactions with clients. These include non-

### FOR MORE INFORMATION

For more discussion and resources related to cultural competence, see **CHAPTER 3**.



verbal signals, communication styles, power and role differences, gender and age factors, the physical and environmental settings, and the significance of self-disclosure and the expression of feelings.

In addition, providers should note the ways in which clients perceive problems or challenges and ways in which they view giving or receiving assistance. Knowledge of the larger relational, historical, political, and religious systems in which clients are set is important.

### BEHAVIORS AND CULTURAL DIFFERENCES

Behaviors reveal differences in cultural values. It is not possible to “see” the inner workings of thought processes but one can observe behaviors. Each person may attribute a different meaning to a specific behavior, thereby creating barriers to building relationships. The scenario to the right highlights different perceptions of time that caused misunderstanding and frustration for client and worker.

Using open-ended questions may help gather useful information about the meaning of a client’s behavior. For example, “When would you come to meetings with someone like me if you were back in your country?” and “What would you do in your country before the violence if you were unhappy at work?”

### WORKING WITH INTERPRETERS

Interpreters are essential to the rehabilitation process. They are the voices of both the clients and social workers, who would not be able to communicate clearly otherwise. In addition, the method of interpreting provides a unique opportunity to model relationships, connection, and respect.

The following guidelines are helpful for social workers working with interpreters. Included are examples of likely scenarios and conversations among a social worker, a client, and an interpreter.

**1. TO ENSURE GOOD COMMUNICATION,** take time to introduce everyone and explain each person’s role. Explain what the role of social work is in relation to other professionals at the agency.

**SOCIAL WORKER:** Hello, (name of client), it’s good to meet you. I’m (your name). I’m a social worker here. I’ll be working with you on your everyday needs and concerns, as well as assisting you in reaching some of your future goals. For example, other clients have been concerned about places where they can get food, or understanding the process of getting their work permits, taking language classes and finding a job so they can help their families back home. Just as your doctor assists you with physical pains or other medical concerns, I’m here to help you with the choices facing you here in the United States.

**INTRODUCING INTERPRETER:** This is (interpreter’s name). She or he is here to help communicate your needs and concerns with me so I can better understand and provide you with support or information that can help you to make the choices that you believe are best for you.

**2. INFORM THE CLIENT THAT** the interpreter will interpret everything said in the room. Try to give an example that illustrates this for the client. If the client does not want something to be known, she or he should not say it to the interpreter.

**SOCIAL WORKER:** How are you able to meet your financial needs for such things as shelter and food?

**INTERPRETER:** How are you able to



A client did not arrive for scheduled appointments at the right time or even on the right day. The social worker viewed this as an attempt to show disrespect for the social worker’s time and a lack of interest in the rehabilitation effort. The client, however, operated from a different frame of reference. In his country, it is customary to arrive when you arrive. Many circumstances can hinder the speed of the journey, such as tropical rain, flat tires, or family obligations. The night before a scheduled appointment at the clinic, he had not slept. Falling asleep in the early morning, he awoke late and came to the clinic past the appointment time. On another occasion, he came to the clinic on a day when he felt most confident facing the outside world. The client operated on a system that valued arriving when one was able to do so.

meet your financial needs for such things as shelter and food?

**CLIENT:** Don't tell her that the person I live with got me a job with a friend, just tell her that my friends help me.

**INTERPRETER:** Don't tell her that the person I live with got me a job with a friend, just tell her that my friends help me.

**3. EXPLAIN TO THE CLIENT THAT THE** interpreter will speak as the client. At first this may sound odd to the client, especially with languages that are male/female gendered. A male interpreter may be speaking from the female perspective or vice versa.

**SOCIAL WORKER:** Are you married?

**INTERPRETER:** Are you married?

**CLIENT:** Yes, I have a wife and one child.

**INTERPRETER:** Yes, I have a wife and one child.

**4. LET THE CLIENT KNOW INTERPRETERS** are included in the agency's confidentiality agreement. Make it clear that the social worker and the interpreter will not share any information outside the agency. Clients need to know that information about their care and treatment is shared among agency staff who are providing their care and treatment. Explain clearly the purpose of the release of information form and why they are asked to sign the form each time information is to be shared outside the agency.

**5. EXPLAIN TO THE CLIENT WHY** providers speaking directly to him or her and not to the interpreter. The conversation should not focus on the interpreter. The client needs to feel that she or he is being helped.

**DO:** Do you need help paying this bill?

**DON'T:** Ask him if he needs help paying this bill.

The interpreter is not ignored, however, as the interpreter is an essential part of the healing process. Model with the interpreter a respectful relationship; this can help the client to rebuild



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trust in human interaction and relationships.

**6. INFORM THE CLIENT THAT INTERPRETERS** are instructed not to introduce their own information in a session; they interpret only what is said by the client and the provider. There may be exceptions to this. For instance, an interpreter may know that the client has suicidal or homicidal thoughts. This knowledge is critical for the client's care and well-being and needs to be communicated to the social worker immediately. They may also need to provide a critical piece of cultural information to help the provider understand the context and ensure the meaning is accurately conveyed.

**7. DEFINE ACCEPTABLE WAYS OF** communicating between interpreter and client. Explain to clients it is inappropriate to call interpreters at home. If the client needs to contact the interpreter, an English-speaking friend can phone the agency. That friend may leave a message for the interpreter to call the client, or the client may leave his or her name and phone number very clearly in her or his own language and the interpreter will return the client's call. At times it may be possible to arrange a conference call so the client, interpreter, and social worker can talk together.



**8. MODEL SPEAKING IN A NORMAL** voice to the client (not too slow or too fast and not too loud or too soft). Explain that the following will facilitate mutual understanding:

- Talk in short sentences to allow for accurate interpretation
- Ask one question at a time
- Decide on a convenient “stop signal” that everyone can understand and feel comfortable using

**9. USE WORDS, NOT JUST GESTURES,** to convey meaning. Take time to explain that interpreters need words in order to give the most accurate interpreting of what the client wishes to convey.

**10. DO NOT USE IDIOMS, TECHNICAL** words, or cultural references that are difficult to interpret or understand. (Some concepts may be easy for the interpreter to understand but very difficult to interpret.)

- Idioms: slow as molasses, pain in the neck, top dog
- Technical terms: PTSD, somatic
- Concepts: mental health, Social Security, income taxes, rental agreements

## **PUBLIC POLICY WORK**

Resolution of public policy issues locally, nationally, and internationally is an essential goal of social work with torture survivors. Social workers may choose in their own professional lives to specialize in direct services work or to focus their efforts exclusively on social change through policy work.

However, social workers in direct practice develop a vision of the larger issues that affect their clients.

John F. Longres (1990) reminds us that

direct service workers need to find ways to contribute to social change and to feel these efforts have positive impacts on the institutional policies that affect their clients. These actions may take place on a local level, such as advocating for greater community resources for low-income workers or for *pro bono* medical services for survivors.

Social workers may support agencies that work with state, national, and international governments to shape public policy that will help torture survivors build better lives. They may help clients become active with such organizations. The appendix directs the reader to some of these resources.

## **CONCLUSION**

Social work practice is influenced by a core set of professional values. These core values are the foundation of the unique perspective and mission of the profession and include:

- Service
- Social justice
- Dignity and worth of the person
- Importance of human relationships
- Integrity
- Competence

By embracing these core values and building knowledge and skills in the four core competency areas, social workers provide appropriate healing services for torture survivors. The assistance they offer empowers their clients to rediscover the self-esteem, competence, confidence, and sense of potential that the torturers tried to take away. ■

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## CHAPTER 5



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# MEDICAL SERVICES

## CHAPTER 5

## MEDICAL SERVICES

## IN THIS CHAPTER

- EFFECTS OF Torture
- ROLES OF Health Care Professionals
- PROVISION OF Medical Treatment
- IMPROVING ACCESS to Care Among Torture Survivors
- CONDUCTING Forensic Evaluations on Asylum Seekers

This chapter is a resource for physicians and nurses working with or planning services for torture survivors. Preceding chapters outline the purpose of torture and common torture methods. This chapter reviews the long-term effects of torture and describes roles and responsibilities for physicians, psychiatrists, and nurses who are helping torture survivors reduce trauma symptoms and rebuild their lives in the United States. These roles and responsibilities include education, documentation, assessment, treatment, referral, research, and advocacy.

While detailed discussion of specific treatment modalities are beyond the scope of this chapter, it will introduce areas deserving further exploration by health care providers. These topics include cultural competence, working with interpreters, use of medications, and improving access to care.

In addition to direct treatment approaches, physicians and psychiatrists are encouraged to integrate preventive components into their organization's programmatic strategies. Examples of such strategies are discussed in Chapter 8. Finally, this chapter describes resources and training opportunities for physicians and nurses interested in conducting med-

## FOR MORE INFORMATION

For more information on psychotherapeutic issues, see **CHAPTER 6**.

For more information on preventative strategies, see **CHAPTER 8**.



VIETNAMESE REFUGEE in Thailand.

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ical and psychological forensic evaluations on asylum seekers who have been tortured.

## EFFECTS OF TORTURE

The effects of torture are severe and sometimes disabling. A wide range of symptoms and levels of functioning have been associated with individuals experiencing trauma. Many factors affect symptom course and prognosis, resulting in great variability in how individuals react to severe stress.

## PSYCHOLOGICAL SYMPTOMS

Two major meta-analyses (Brewin, 2000; Ozer, 2003) of the predictors of posttraumatic stress disorder (PTSD) examined the following main categories of predictors:

- Historical or static characteristics (intelligence, childhood trauma, family psychiatric history, or other prior trauma)
- Trauma severity
- Psychological processes during or immediately after the trauma (including peritraumatic dissociation — dissociative episodes around the time of the traumatic event)
- Social support and life stress after the traumatic event

Although all four categories had significant

predictors of PTSD, the strength of prediction varied across the categories. Factors closer in time to the traumatic event showed a stronger relationship to PTSD than did characteristics of the individual or their personal history.

Intensity and duration of the trauma experience are two especially important factors. In general, refugees who have endured longer periods of torture are more likely to be symptomatic and/or functionally impaired. Those with peritraumatic dissociation or a history of childhood trauma also tend to have more difficulties. Those without prior childhood trauma who had been functioning well prior to their trauma experiences generally recover over time.

Common psychiatric disorders associated with torture include posttraumatic stress disorder, major depressive disorder, substance abuse, other anxiety disorders, and sometimes paranoia or psychosis (De Jong, 2001; Hinton, 1993; Lavik, 1996; Shrestha, 1998). Examples of common trauma-related symptoms in torture survivors include the following:

- Recurrent intrusive daytime thoughts or images of the trauma
- Recurrent traumatic nightmares
- Severe emotional distress or physiological reactions to reminders of the trauma
- Feeling watchful or on guard without reason
- Exaggerated startle response
- Marked irritability
- Concentration or short-term memory problems
- Feeling distant or cut off from others
- Numbing of emotions
- Lack of interest or pleasure
- Depressed mood

- Appetite disturbance
- Energy or motivational disturbances
- Hopelessness
- Suicidal thoughts
- Avoidance of thoughts or situations that serve as reminders of the trauma
- Chronic physical complaints (e.g. headaches, body pain, gastrointestinal problems)

Trauma-related symptoms are not always readily apparent to survivors. Changes in feelings and behavior often occur subtly over time. Family members or those in close contact with survivors may most clearly observe these changes. Trauma symptoms may affect a survivor's relationships, including with family members and in work settings. Survivors' existential views of the world, of human cruelty, and of God may be severely affected by their experiences. They may never again feel the same level of trust or connection with human beings or the divine that they had prior to their torture.

### PHYSICAL CONSEQUENCES AND SYMPTOMS

Physical consequences of torture can affect all organ systems, as was discovered with tortured prisoners of war in World War II (Klonoff, 1976). Torture survivors often complain about physical pain and headaches. Musculoskeletal system complaints are most commonly reported.

Symptoms and physical findings can vary depending upon which organ system was affected and how much time has passed since the torture. Specific types of torture may lead to particular physical findings, such as subcutaneous fibrosis or compartment syndrome in the feet from falanga (repetitive beating of the

"Social trauma affects individuals precisely in their social character; that is, as a totality, as a system."

— IGNACIO MARTIN-BARO, JESUIT PSYCHOLOGIST ASSASSINATED BY THE SALVADORAN MILITARY IN 1989

soles of the feet), sexual dysfunction from trauma to the genitals, and nerve or musculoskeletal injuries from body suspension or stretching.

Head trauma with loss of consciousness is another important injury to assess secondary to its potentially profound impact on future functioning. This can result in changes in memory and attention, as well as affective instability. Some of these effects are acute, while others can be chronic and physically disabling.

Detailed information on examining torture survivors and the medical effects of torture are available in the Physicians for Human Rights (PHR) 2001 publication, *A Health Professional's Guide to Assisting Asylum Seekers*, or from the *Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (also known as the *Istanbul Protocol*) available on the PHR web site ([www.phrusa.org](http://www.phrusa.org)).

### SOMATIC SYMPTOMS

Some torture survivors complain of unexplained pain and physical symptoms for which an organic cause cannot be found. These symptoms may be related to prior experiences of starvation, malnutrition, tropical infectious diseases, head injury, physical assault, or other untreated chronic illnesses.

Health care providers especially need to keep in mind the major infectious diseases present in the refugee's country of origin, the prevalence of rape among refugees, and practices of traditional

female cutting (female circumcision) in many cultural groups. A full examination is needed to rule out physical illness, yet many times such 'somatic symptoms' have an emotional origin or connection to trauma. Moreover, presenting with somatic symptoms can also be a more culturally appropriate way of seeking help

Depending upon circumstances, the presentation of physical symptoms can be seen as an index of disease or disorder, an indication of psychopathology, a symbolic condensation of emotional conflict, a culturally coded expression of distress, a medium for expressing social discontent, or a mechanism through which patients attempt to reposition themselves within their local worlds (Kirmayer, 1998). A thoughtful discussion of this complex subject is available in Kirmayer's article.

Despite possible trauma connections, the experience is quite real. The body becomes a metaphor, and emotional pain is frequently expressed physically. Survivors may complain of frequent headaches or stomach pain while a physical cause of the pain cannot be found with biomedical testing. Torture survivors frequently need help in understanding the links among torture, emotional effects, and effects on the body. Survivors are usually relieved to hear they are not abnormal, weak, or crazy, and their symptoms are a normal human reaction to extreme stress.

It is important to develop links in the survivor's mind between common pain or physical symptoms and their exacerbation by psychosocial stressors. With education

and guidance, survivors can learn to correlate these somatic symptoms with emotional trauma and stress, knowing that with time, as they begin to feel better emotionally, their physical pain may also lessen.

### SYMPTOM COURSE AND PROGNOSIS

Symptoms of trauma, including physical symptoms, fluctuate in severity over time. A survivor may feel very well for long periods of time before symptoms are triggered again by a stressful event or situation. It is important for trauma survivors to understand the common association between stresses and symptom exacerbation so that they do not perceive their treatment as ineffective and understand that their increased symptoms will gradually diminish over time.

Of those seeking treatment, some will require one-time treatment, some will require intermittent treatment at various periods in their life, and others will require ongoing services. When presenting information on symptom course, duration of medication treatment, and prognosis to this third group with chronic impairment, it is useful to describe their likely treatment course as analogous to that of other chronic diseases such as diabetes or hypertension. Chronic conditions necessitate ongoing care and monitoring, and also often show fluctuations in their clinical course. Like chronic medical conditions, survivors with chronic trauma-related impairment will also require ongoing treatment and can expect periodic exacerbations in symptoms and functioning.

## GRIEF AND LOSS

Finally, the loved ones of many torture survivors have been killed, or the survivors are separated from family members. During the flight to safety, there may not have been time for refugees to bury their dead in culturally appropriate ways or to mourn for them. Survivors can benefit from education on the grieving process and with encouragement to mourn the losses they have endured. Health care providers need to learn the culturally appropriate means of dealing with grief and loss in the survivor's culture. This can be discovered by asking patients and family members. Such information can be useful in determining when grieving has become inappropriate and the individual needs further assistance.

## ROLES OF HEALTH CARE PROFESSIONALS

### PHYSICIANS

Medical treatment by physicians is essential to healing torture survivors. Lingering body pains and physical symptoms often create daily reminders of past torture. Fears of disability and impaired functioning are also common after torture. Similarly, many survivors will experience unexplained physical or pain symptoms that lead to unnecessary and repetitive diagnostic workups. Medical providers play an important role clarifying the nature of physical symptoms in torture survivors and alleviating their complaints.

Physicians are involved in both planning and implementation of interventions con-

ducted by health care systems or specialized treatment centers. Individually, physicians work to prevent illness through educational endeavors, facilitating access to care via health systems change, and providing medical treatment to torture survivors.

Physicians may direct their educational efforts toward a number of areas. One important area includes enhancing community awareness of the effects of torture. A second area involves training other medical providers to assess and treat survivors. Finally, survivors themselves need education to alleviate their fears of medical illness and disability, help them understand the need for diagnostic testing or medications, and promote preventative information about tuberculosis, HIV, and other infectious diseases.

Physicians may also play a central role in advocating within health systems, HMOs and health insurance organizations for the provision of needed services for torture survivors. They may assist in public and political advocacy efforts aimed at increasing general resources directed to torture survivors locally, nationally, and internationally.

Finally, the provision of informed, skillful clinical services by physicians allows torture survivors to heal from illness and cope with their physical limitations, by:

- Assessing acute and chronic diseases in torture survivors
- Providing written and photographic documentation of torture-related physical injuries for legal purposes
- Treating acute and chronic diseases

in torture survivors

- Assisting with care coordination among center providers as well as treatment planning

### PSYCHIATRISTS

With medical and psychiatric training, psychiatrists assist in deciphering and treating physical and psychological complaints, which, for torture survivors, are often interwoven. Trained in medical settings, acute psychiatric facilities, and psychiatric outpatient clinics, psychiatrists are familiar with providing a range of services — from handling psychiatric emergencies to leading multidisciplinary treatment teams. Outpatient training provides psychiatrists with skills to treat a variety of mental disorders and use multiple treatment modalities.

Psychiatrists are helpful in disseminating preventive information to affected communities as well as individual clients regarding the medical and psychiatric effects of torture, focusing on trauma education and coping with trauma (see “Helping Refugee Trauma Survivors in the Primary Care Setting” at [www.cvt.org](http://www.cvt.org)). Helping survivors use these coping behaviors can be essential to their recovery.

Trauma education includes describing the effects of trauma, normalizing trauma symptoms, reviewing the course of symptoms and the prognosis, destigmatizing mental health services, drawing associations between stress and exacerbated symptoms, and discussing appropriate ways to grieve losses. Education on coping with trauma includes information on



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A public health nurse visited the home of a refugee woman from Iraq who had recently given birth. During the visit, the mother told the nurse that her husband suffered from anxiety and insomnia and had physical pains for which an organic cause could not be found. When the nurse asked the woman if her husband had been arrested or jailed in their home country, she began crying and stated that he had been tortured in prison and that he "has never been the same since." The nurse talked with the father about seeking help from professionals, but he was adamant about not needing assistance as he was not "crazy." After working with the family for several months, the nurse was able to make a referral to the treatment center. During a later visit to the home, the father presented the nurse with special food from his country to thank her for helping him to seek help.

the importance of regular physical activity, relaxation techniques, facilitating religious beliefs or spirituality, strengthening social connections, encouraging employment and hobbies, finding ways to find new meaning in life, and minimizing negative coping behaviors. Educating survivors about the proper use of psychotropic medications is another important task performed by psychiatrists.

Psychiatrists can also be helpful in training staff on the management of psychiatric emergencies. Moreover, they can train primary care and psychiatric providers in the community on essential aspects of recognizing, assessing, and treating torture survivors. Like other physicians, psychiatrists may also play an important role in advocating for treatment, reducing barriers to care, and increasing resources for torture survivors.

A comprehensive psychiatric assessment and timely treatment facilitates the provision of multidisciplinary treatment services. It is essential to the healing of torture survivors and includes the following:

- Standard psychiatric assessment, including: history of present illness, trauma history, past psychiatric history, review of psychiatric disorders, substance use history, family psychiatric history, past medical history, review of systems, current medications, mental status exam, pertinent lab findings, bio-psycho-social formulation, five-axis psychiatric diagnoses, and a detailed treatment plan
- Evaluation of functional impairment due to psychiatric disorders, determination of

prognosis, and completion of any disability assessments needed

- Utilization of psychiatric rating scales to assess symptom change
- Evaluation of the need for psychiatric hospitalization, including coordinating transfers of care
- Care coordination among center providers, including facilitating regular multidisciplinary treatment planning

Psychiatrists are involved in both planning and implementation of interventions conducted by health care systems or specialized treatment centers. Moreover, psychiatrists have the skills and training to provide multiple treatment modalities for torture survivors. Treatments include the following:

- Individual, group, or marital/family psychotherapy
- Psychotropic medications to alleviate trauma-related symptoms
- Dual medication management and psychotherapy visits when appropriate
- Motivational interviewing for those abusing substances
- Crisis management assessment (e.g., for acutely suicidal clients) and treatment

## NURSING

As health care providers, nurses work collaboratively within a specialized torture rehabilitation center or primary care setting. They work with physicians and other health care professionals in achieving identified medical goals, such as regularly monitoring blood pressure for those with hypertension and obtaining

laboratory testing.

Nurses may also work collaboratively in managing a survivor's health care. Nursing case management is a process of ensuring that each individual survivor receives appropriate health care services both within the torture treatment center or primary care facility and in the larger community. The case manager coordinates and monitors the clinical services that the survivor receives to assure that the individual's unique health care needs are being met. Responsibilities of the nursing case manager include the following:

- Health care service planning and resource identification
- Linking clients to needed services and coordinating individual client care in the community health care system
- Client advocacy and problem-solving with the health care system
- Monitoring service delivery
- Evaluating services

Nurses educate survivors about accessing and navigating the U.S. health care system, including patient rights. As clinic managers, nurses coordinate health care services within the torture treatment center or clinic. Responsibilities of the clinic manager include:

- Coordinating internal and external health care appointments
- Maintaining needed equipment and supplies (such as medications, physical therapy supplies, etc.)
- Assessing the quality of services delivered (e.g., through chart audits

and client-satisfaction surveys)

Caring has been identified as the central unifying focus of nursing practice; it is the essence of nursing (Watson, 1999; Leininger, 1995). Care is demonstrated and practiced through the interpersonal relationship between nurse and client that preserves human dignity, wholeness, and integrity. Nurses deliver care by respecting survivors' priorities, supporting self-esteem, and minimizing potential stressors. The nature of the nurse-client relationship concerning the survivor's physical well being allows an opportunity to rebuild trust. An important article on the role of nurses in torture treatment is "The Fear Is Still in Me: Caring for Survivors of Torture" (McCullough-Zander and Larson, 2004).

### **ALL HEALTH CARE PROFESSIONALS**

Professionals in all areas of health care are involved in documenting the effects of torture, in making outside referrals for clients, and in evaluating treatment outcomes for survivors.

Forensic documentation of the physical effects of torture is an important aspect of providing services for torture survivors and may include documenting the psychological and physical effects of torture in asylum seekers through history and physical exam, as well as photo documentation of scars or other signs of torture.

It may be appropriate to create volunteer physician treatment networks or networks for providing psychological and

medical documentation of torture for asylum seekers.

Program evaluation and research are essential to improving care for torture survivors. Research on the effects of torture, on appropriate measures of clinical change, and on how to determine treatment outcome has been limited thus far. Physicians, psychiatrists, and nurses may play a vital role by:

- Developing and implementing program evaluation and clinical outcome research strategies
- Assuring that such strategies are built into new projects or clinical programs from their inception.

## **PROVISION OF MEDICAL TREATMENT**

### **CULTURAL COMPETENCE**

Treating torture survivors requires cultural competence. While it is impossible to know the norms, behaviors, and attitudes of all cultures, it is possible to approach cross-cultural interchanges with curiosity and an open mind. Such an approach helps care providers build knowledge and skills over time.

Cultural competence incorporates nonjudgmental questioning of an individual's perceptions of culture as well as family nuances, sensitive awareness of behaviors and implicit meaning during personal interactions, and a commitment to expanding one's own personal knowledge base regarding country conditions and politics.

Furthermore, working across cultures necessitates re-examination of one's own



attitudes, beliefs, values and prejudices, usually hidden from conscious awareness. This awareness can help one work with torture survivors from a variety of cultures with increasing skill and comfort.

Prior international experience makes this process easier. Frequent use of informational web resources such as Human Rights Watch ([www.hrw.org](http://www.hrw.org)), Amnesty International ([www.aiusa.org](http://www.aiusa.org)), the U.S. State Department ([www.state.gov](http://www.state.gov)) and International Crisis Group ([www.crisisweb.org](http://www.crisisweb.org)) provide information about specific groups, their prior experiences, and current country situations.

### WORKING WITH AN INTERPRETER

When preparing to work together for the first time, it is helpful for the clinician and interpreter to discuss their experiences, skills, and expectations. The clinician should explain the need to know everything the client says and the expectation that the client will be similarly informed.

Consider matching gender whenever possible due to cultural or religious issues, potential history of sexual trauma, and sociopolitically based mistrust. Factors potentially affecting the interpreter-client relationship include mem-



bership in different or previously adversarial ethnic groups, gender differences, age differences (e.g., a much younger person interpreting for an older person), and class differences.

Spatial aspects of the client-interpreter-physician triad, as well as the manner and type of questions asked, can be important. Set up the chairs in a triangle so that each person can see the others clearly. Take time to observe the interaction and rapport between interpreter and client.

When interviewing, use relatively short sentences so the interpreter can properly convey the complete content of your questions. Do not hesitate to use clarifying questions when confused, or summarizing statements to assure proper understanding of a complex story or temporal presentation of symptoms.

When attempting to discuss difficult concepts such as suicide or hallucinations, work to structure questions so they are as unambiguous as possible. Sometimes rephrasing a similar question later in the interview to recheck certain responses can help verify important information.

A more detailed discussion of working with interpreters is provided in Chapters 3

and 4. Additional detail on working with interpreters in psychiatry can be found in Westermeyer's 1989 clinical guide.

### TRAUMA HISTORY ASSESSMENT

When working with refugees, immigrants, or asylum seekers, assess for trauma history. Features that alert clinicians to the possibility of a history of torture include the following:

- Status as a refugee, immigrant, or an asylum seeker
- History of civil war in country of origin
- Reluctance to divulge experiences in country of origin
- Client or family member politically active in country of origin
- Family member who has been tortured or killed
- History of being imprisoned
- Any physical scarring
- Physical symptoms with no known medical cause
- Psychiatric symptoms of trauma: depression, nightmares, emotional numbing, irritability, being easily startled, difficulty concentrating, avoidance, and trouble sleeping

Many torture survivors are reluctant to talk about their trauma history because of the shame of their experiences. They fear they will not be believed, and may attempt to minimize symptoms by trying not to recall the experiences.

In assessing for a torture history, ask an open-ended question about what happened in the survivor's country that forced him or her to leave. If appropriate, a health care provider can then ask more

### FOR MORE INFORMATION

For more information on working with interpreters and a more detailed discussion of working across cultures, see **CHAPTER 3.**



direct questions about a history of being imprisoned, beaten, or attacked by soldiers or rebel groups.

### MEDICAL ASSESSMENT

Torture survivors want to know what is wrong with them physically, which symptoms they can expect will improve, and what symptoms they should learn to live with. The recommended medical assessment of all refugees includes the following:

- History and complete physical exam, including genitourinary system
- Skin test for tuberculosis, and/or chest X-ray
- Vision and hearing screening
- Dental evaluation
- Stool test for ova and parasites
- Urinalysis
- Hemoglobin
- Cholesterol
- Serological test for syphilis
- Hepatitis B screening tests; possibly hepatitis A and hepatitis C screening tests
- Explanation of and offer of HIV testing
- Explanation of and offer of STD testing other than syphilis
- Immunization assessment
- Thyroid function testing

Routine events in a clinic or hospital such as electrocardiogram testing for a survivor of electrical torture, or a gynecologic exam for a rape survivor can be very stressful. Torture survivors can better tolerate tests and procedures without being severely stressed if they are given emotional support and prior education on what to expect. Emphasizing that they have control over which aspects of a physical

examination are performed or how diagnostic tests are administered is essential. Torture survivors benefit from knowing that they can stop or delay medical procedures when necessary. For some, certain procedures are best done under anesthesia.

### PSYCHOSOCIAL STRESSORS

Torture survivors benefit from understanding the role of current psychosocial stressors in increasing symptoms. Most refugees have the expectation that once they are in the United States their problems will be eliminated. There is widespread perception of the United States as a safe place and one of easy opportunity.

Many torture survivors are therefore dismayed to find that their psychological and physical symptoms often are worse during their first few years in the United States because of the additional stressors of rebuilding their lives in a new place. Examples of acculturation stressors for refugees and asylum seekers include:

- Learning a new culture and possibly a new language
- Lack of social and family networks
- Financial and work difficulties
- Concerns about their legal immigration status
- Worries about family back home
- Loss of previous social status
- Changes in family members' roles (e.g., children adopting American value of independence; wife now working outside of the home)

### SOCIAL STIGMA OF MENTAL ILLNESS

Torture survivors and refugees in general are often reluctant to seek mental health services.

### SAMPLE ASSESSMENT QUESTIONS TO BE INCORPORATED INTO STANDARD ASSESSMENTS FOR NEW PATIENTS

IN WHAT COUNTRY were you born?

CAN YOU TELL ME what made you leave your country?

HAVE YOU EVER HAD problems because of your culture or tribe? Your political belief? Your religion? Your gender?

HAVE YOU EVER BEEN arrested or put in jail?

HAVE YOU EVER BEEN beaten or attacked by soldiers, police, or rebel groups?

HAVE YOU EVER SEEN or heard others being beaten or attacked?

HAVE ANY MEMBERS of your family been arrested or attacked because of their culture, tribe, political beliefs, or religion?

IF A HISTORY OF torture or trauma is indicated, what problems are you having now from being beaten or attacked?

This is usually due to social stigma surrounding mental illness and potential implications for themselves or their families for seeking mental health treatment. Such views are common throughout the world.

To most refugees, “mental illness” refers to persistent and usually psychotic states that they might call “crazy.” In some cultures having a family member with severe mental illness brings shame on the entire family and may diminish family members’ opportunities for marriage.

Psychotherapy and psychiatric treatments are generally unknown in most countries, which typically have only one psychiatric institution for the severely mentally ill. Education is required to modify survivors’ views of mental illness. Presenting emotional problems as a continuum of severity from low-level to severe mental health problems can be useful. Recognizing that each of us moves back and forth on this continuum depending upon current stressors such as divorce, death of a child or even severe trauma facilitates understanding of mental health concepts.

### MEDICATIONS

Compliance with medications is a common barrier to treating torture survivors and refugees in general. Many refugees have either never taken Western medications or, as with antibiotics, have taken them for only short periods of time. They may lack an understanding of why medications may need to be taken for extended periods of time. Patient education on the long-term use of medications is required.

Many refugees stop taking medications

when they feel better or if they have not noticed any effects within several days. With the use of antidepressants for example, patients need to understand that it takes several weeks to notice effects. However any side effects that might occur usually happen in the first two weeks and then likely resolve. Patients need to understand that if side effects occur, dosages can be adjusted or medications changed.

Understanding how a torture survivor discusses and explains illness can help in comprehending his or her reasons for not taking medications as directed. Developing a mutual understanding of rationales for using medications is essential to ongoing compliance. Begin follow-up appointments with a nonjudgmental determination of which medications clients are presently taking and why they have chosen to discontinue other ones.

### PHYSICAL THERAPY AND MASSAGE

Specialized torture treatment centers have observed benefit among their patients from physical treatment modalities such as physical therapy or massage. Primary care or other clinics treating torture survivors may consider such interventions when addressing complaints of chronic pain and physical symptoms.

Volunteer massage and physical therapists now conduct regular sessions for CVT clients referred because of chronic pain, headaches, or other sequelae from injuries. Because torture is usually directed in part toward the physical being of the victim, attention to the body can be especially ther-

apeutic, both emotionally and physically.

### CONDUCTING FORENSIC EVALUATIONS ON ASYLUM SEEKERS

A growing number of physician volunteers are becoming involved in conducting forensic evaluations on torture survivors seeking asylum. Volunteer networks have sprung up throughout the United States, encouraged and often facilitated by Physicians for Human Rights. Physicians conducting psychiatric or medical evaluations provide objective, unbiased documentation of the physical and psychological effects of torture.

*A Health Professional’s Guide to Assisting Asylum Seekers* (Physicians for Human Rights, 2001) provides an excellent resource for physicians and mental health professionals seeking to develop the knowledge and skills needed to perform clinical evaluations on asylum seekers. It details United States asylum law, general interview considerations, physical evidence of torture, psychological evidence of torture, issues in the assessment of children that have been tortured, how to provide written documentation of medical and psychological findings, and how to provide oral testimony in court.

Much of this resource is based on recent international guidelines for medical-legal documentation of torture contained in the *Istanbul Protocol* (found on the PHR Web site). The 1999 *Istanbul Protocol* was the first document to provide international guidelines for documenting torture and was the product of three years of research,

analysis, and drafting by more than 75 forensic specialists, physicians, psychiatrists, psychologists, lawyers, and human rights monitors. This group represented 40 organizations from 15 countries.

The overall goal of medical and psychological evaluation of torture survivors is to assess the degree of consistency between an individual's account of torture and the medical and psychological findings observed during the evaluation. Both Physicians for Human Rights and Doctors of the World ([www.doctorsoftheworld.org](http://www.doctorsoftheworld.org)) offer training to organizations or networks of health professionals interested in conducting this work.

Professionals may contact PHR to find out whether existing networks for assisting asylum seekers are functioning in their area. It is possible to create a new network of health professionals if one is not available.

## CONCLUSION

Health care professionals provide a wide array of expertise and experiences essential to the care of torture survivors. Through their care and leadership, they strive to encourage resilience among torture survivors and assure that survivors

themselves play an active role in their rehabilitation. Alleviating misinformed fears of chronic impairment and offering words of encouragement are powerful tools in regaining hope and facilitating recovery. Moreover, prescription of psychotropic medications also facilitates stabilization of acute psychiatric symptoms and improvement in overall functioning for many torture survivors.

In addition to direct service provision, health care professionals need to consider a broad array of factors that limit torture survivors from availing themselves of needed treatments.

Programs and services developed to educate high-risk communities, to minimize barriers to seeking appropriate care, and to facilitate the recognition of torture survivors in settings where they are likely to present are important adjuncts to direct services that can be guided by physicians and nurses. Finally, the forensic documentation of torture among asylum seekers, advocacy for appropriate health care, and preventing torture are also essential components in the holistic provision of professional health care for survivors of torture. ■

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## IMPROVING ACCESS TO CARE AMONG TORTURE SURVIVORS

**T**orture survivors are often reluctant to seek medical and mental health services. Several key areas (including health systems and logistical barriers) have been identified as targets for improving the willingness of torture survivors to access appropriate treatments. Some examples of issues and strategies to improve access to care are described below.

### MENTAL HEALTH SERVICES IN PRIMARY CARE CLINICS

Some primary care clinics, which are a part of the health system most people are comfortable using, are beginning to incorporate mental health services into their clinics. Torture survivors may have less resistance to mental health care when these services are in the same location and not differentiated from other health care.

### SAME-DAY PATIENT VISITS

In many countries, health care visits are not scheduled in advance. Individuals travel to their provider on the day they wish to be seen, arriving as early as possible, and wait their turn. Despite sometimes waiting many hours, patients at least know they can be seen on the day when their symptoms or concerns are greatest. Some



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U.S. health care clinics are beginning to accommodate same-day patient visits.

### PATIENT EDUCATION

Education about the effects of trauma and ways of coping is essential to recovery. Primary care clinics are often a major intervention point where large numbers of torture survivors can be reached. As such, it may be helpful for primary care clinics to allot 45 to 60 minutes for the provision of individual or group trauma education by appropriate staff. As with diabetes education, using a designated staff member to conduct patient education sessions can be helpful.

### CHILD CARE

Logistical barriers often prevent torture survivors from receiving care. The availability of evening

appointments is important for many in low-paying jobs with difficulties taking time off work. Helping women to problem-solve around child care issues or providing child care at the clinic can also be helpful.

### TRANSPORTATION

Lack of transportation is another common logistical barrier. Taking the bus to appointments, especially with children, in the winter, or when in pain, is difficult. Helping survivors to explore community programs or health care plans providing alternative transportation, or even using community or church volunteers to provide transportation can help alleviate this common problem.

### MUTUAL ASSISTANCE ASSOCIATIONS

Establishing long-term relationships with staff at local refugee community organizations can sometimes improve a survivor communities' willingness to access care. Moreover, mutual assistance associations (MAAs) may provide important adjunct services to their community members and become an important referral source for health care providers. Staff at MAAs can also serve as a cultural resource to health care clinics.

## CHAPTER 6



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# PSYCHOLOGICAL SERVICES

## PSYCHOLOGICAL SERVICES

### IN THIS CHAPTER

- CHALLENGES AND rewards of working with survivors
- THEORETICAL frameworks
- ADAPTING EXISTING services for survivors
- EFFECTS OF THE WORK on the provider
- WORKING WITH interpreters

**T**orture survivors engage in psychological services to pursue a wide range of goals, from single symptom reduction to addressing the complex effects of torture on their families and communities. Psychological effects of torture vary considerably. Likewise, there is wide variation in the types of assistance sought to address such effects, depending on a host of factors ranging from service accessibility to beliefs about health and healing.

Some survivors will have very specific needs, such as getting a good night's sleep or receiving an evaluation of the psychological effects of torture for their political asylum application. Others may address mental health needs through community activities and institutions that focus on spiritual or physical health. Still others may benefit from a variety of psychological or multidisciplinary interventions as they progress through a psychosocial recovery process that involves any of the following:

- Stabilizing and reducing symptoms
- Mourning multiple losses (family, friends, country, status, culture, etc.)
- Coming to terms with the torture trauma and integrating it into one's life story
- Mourning losses
- Repairing relationships affected by torture, including the survivors' relationship to themselves, family, community, and even all humanity



Empowerment is a fundamental principle of psychological recovery, as it is with survivors of other types of trauma. Through this approach, the provider and client work collaboratively in choosing psychological services and interventions that match the survivor's self-defined recovery needs, goals, and preferences.

The range of potential interventions is considerable. It is beyond the scope of this chapter to provide a comprehensive account of psychological services that may be helpful for torture survivors.

This chapter focuses on identifying basic principles and areas of learning needed to begin providing mental health care to torture survivors living in the United States. The chapter is written for mental health providers who are relatively new to working with torture survivors. Providers may be called upon to offer any of a variety of psychological services to individuals, families, groups, or communities affected by torture, including crisis intervention, counseling, assessment, consultation, facilitation, supervision, and short- and long-term therapy.

This chapter is not intended as a "how to"

manual. Rather, it serves as a point of departure to help providers determine which types of knowledge or training they need to give qualified care. In addition, the authors offer a number of references of resources for learning.

## CHALLENGES AND REWARDS OF WORKING WITH TORTURE SURVIVORS

Mental health providers commonly feel overwhelmed when they first face the challenges of serving torture survivors. The number and severity of life-threatening traumatic events experienced by torture survivors, as well as the human design and perpetration of such events, fall outside the spectrum of trauma most providers feel prepared to confront.

Issues of secondary trauma and countertransference take on new degrees of intensity and depth. Providers grapple not only with torture as an extreme form of trauma but also sociopolitical, historical, and ethnocultural dimensions of survivors' experiences.

Added to this mix are the pressing needs of many torture survivors for medical, legal, and social services. At the same time, their eligibility for such services is limited. This is particularly true for survivors who are applying for political asylum — a complex and stressful process by itself. Transportation needs, language barriers, and cultural differences pose additional challenges.

Clearly, this unique population with many complex needs requires specialized expertise. As a result, mental health providers may need to expand their traditional roles to include more case management, advocacy, and accompaniment.

The challenges of providing appropriate, effective psychological services to torture survivors exist side by side with both the necessity and the rewards of doing so. Like other populations, torture survivors deserve access to informed, relevant psychological services in addressing their mental-health needs and concerns.

Working with survivors, who demonstrate strength and resiliency in their ability to survive torture and the flight from their countries, presents providers an opportunity to facilitate the survivors' efforts to reclaim and rebuild their lives. Many providers say serving torture survivors is a profound experience of mutual learning, one that ranks among their most valuable professional experiences. With enough resources and meaningful support, torture survivors can recover from their ordeals and go on to thrive.

Working with torture survivors is about working with extremes, such as confronting the best and worst of what humanity is capable of doing. Torture survivors, as a population, are highly resilient and resourceful and, at the same time, highly vulnerable and affected by their experiences. The challenge for psychological services involves questions of how to address both of these realities without ignoring or minimizing one at the expense of the other.

## THEORETICAL FRAMEWORKS

Due to the sociopolitical context of torture and the cross-cultural nature of most service delivery in exile, it is important for mental health care providers to draw from frameworks both within and outside of their field. For example, a study-group curriculum developed for community psychotherapists at CVT utilizes readings



from not only psychology and psychiatry, but also cultural anthropology, journalism, literature, and liberation movements.

Most trauma treatment today is based on an understanding of the recovery process that emphasizes reduction and management of posttraumatic stress disorder and other trauma-related symptoms. Judith Herman's classic 1992 work, *Trauma and Recovery*, describes common processes relevant for many torture survivors that unfold in this model for recovery.

Many providers use standard trauma treatments and approaches developed on other populations, such as cognitive-behavioral, psychodynamic, and pharmacological to treat torture survivors. For an early review, see Metin Basoglu's 1992 edited volume, *Torture and Its Consequences: Current Treatment Approaches*.

Beyond learning how providers use standard treatment with torture survivors, it is important to introduce oneself to conceptual frameworks within psychology that are broader than a DSM (Diagnostic and Statistical Manual of Mental Disorders) model of trauma. An example of a postmodern approach to psychotherapy that is relevant to working with survivors in exile is described in Bracken's (2002) *Trauma: Culture, Meaning, and Philosophy*.

The testimony method is an example

of a psychosocial treatment method developed specifically for torture survivors. This method, which originated in Latin America, draws on truth telling as a ritual of healing. It combines elements of exposure, re-telling, re-framing, and denunciation/justice-seeking. (For a description, see Cienfuegos & Monelli, 1983, or Agger & Jensen, 1990).

Current clinical trends in the mental health treatment of torture survivors in the United States include:

- Group treatment (Victorian Foundation for Survivors of Torture, 1996)
- Family-focused services (Weine et al., 2004)
- Integration of somatic psychotherapeutic techniques with more established treatments (Gray, 2001).

As with other types of therapy, the quality of the therapist-client relationship is more important than the theoretical orientation in providing a healing experience for torture survivors. The Sidran Foundation's online consumer's guide for choosing a therapist for post-traumatic stress and dissociative conditions is applicable to torture survivors:

... good trauma therapists come from every discipline, work in all settings, use a variety of approaches and techniques, and have a wide range of credentials and experience...The dual formulation of validation and empowerment seems to be fundamental to post-traumatic therapy...The four most important things a therapist has to offer a sur-

vivor are as follows:

- Respect
- Information
- Connection
- Hope

## ADAPTING EXISTING SERVICES FOR TORTURE SURVIVORS

The current dominant system for delivering health care and social services in the United States has its own culture and defining features. Health care is fast-paced, time-limited, and organized according to a Western medical model that focuses on the identification, isolation, and treatment of specific symptoms or disorders.

Providers in the health care system in the United States developed the following adaptations for mental health service delivery to torture survivors. They refer to an existing way of practice that needs to be adapted in serving this population. Among the different practice contexts represented by readers of this manual, some of these adaptations may be more or less relevant to the provider's setting and its professional culture.

### ATTEND TO CULTURAL ISSUES

Culture is said to refer to where the survivor is from as well as the general culture of fear that develops in societies where torture is widespread (see Chapter 2). Cultural issues for survivors in exile tend to be central regardless of a provider's cultural framework or expertise. No matter how much the providers know about given cultures, they must always find out what culture means to

### FOR MORE INFORMATION

For resources on trauma treatment, see **APPENDIX, PAGE 103.**



particular survivors and families.

Survivors' experiences and beliefs differ widely within cultural groups. Providers who fail to grasp this reality can develop clinical blind spots and false assumptions.

Guidelines for developing cultural understanding include the following:

- Learn to identify and articulate one's own cultural beliefs, practices, and assumptions. Without this skill, the provider may make culturally based assumptions that are automatic or unconscious.
- Investigate ways to address cultural difference/sameness among therapist, client, and interpreter. Have discussions with all members of the team on how to address these.
- Learn from multiple sources and perspectives about the countries, cultures, and subcultures of survivors the provider is serving.
- Learn about other components of the lifelong developmental learning process that are involved in cultural competence (e.g., see Sue, 1998). Culture-specific expertise is only one aspect of culturally responsive services.
- Assess and address culturally relevant variables such as spirituality and religious practices, family and social roles, stages of resettlement and/or acculturation.
- Use tools designed for cross-cultural dialogue (Kleinman's [1978]).
- Ask survivors what their culture means to them. At the same

time, help survivors understand that they are not the sole source of information on their culture.

- Find out who the survivor was before the torture. What would the survivor be doing to heal if he or she were in his or her home country?
- Depending on the culture and background of the survivor, be prepared to work with survivors who think and express themselves at the collective level (i.e., survivors talking in terms of "we," "my people" rather than "I"), or using means of dialogue common to oral traditions (e.g., proverbs, parables, riddles, storytelling).
- Incorporate discussions of the survivor's political context into treatment, particularly as it intersects with culture. For example, survivors may use passionate political discourse in therapy as a culturally acceptable method of expressing strong emotions that are unacceptable to express through other means.

### PROVIDE CLIENT-TAILORED INFORMATION, EXPLANATION, AND CHOICE

Torture survivors often are unfamiliar with health care institutions in the United States, social and professional norms, mental health services, and concepts such as confidentiality and privacy. Not knowing what to expect or how things work in a new land is frightening for many survivors and can contribute to a sense of loss of personal power.

In addition, survivors typically come from contexts where authorities, including health care providers, are associated with the unlim-

### NOTEWORTHY BOOKS

THE FOLLOWING autobiographies and field-based journalism offer valuable insight into survivors' psychological realities and dilemmas. (For instructive examples, see Cohen, 1998; Gourevitch, 1998; and Ortiz, 2002).

Anne Fadiman's 1997 book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* provides an insightful description of how well-meaning providers can miss the mark.

EXAMPLES OF integrative work about the experiences of torture survivors include:

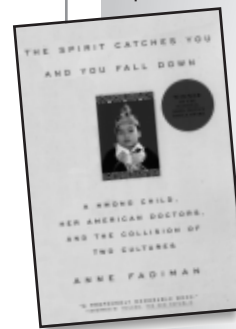
*Honoring Differences: Cultural Issues in the*

*Treatment of Trauma and Loss* by Kathleen Nader, edited by N. Dubrow and B.H. Stamm (1999) Philadelphia: Brunner/Mazel.

*Serving Survivors of Torture* by Glenn Randall and Ellen Lutz (1991) Washington, D.C.: American Association for the Advancement of Science.

*The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation* by Kenneth E. Miller and Lisa M. Rasco (2004). New York: Lawrence Erlbaum Associates Inc.

*Counseling and Therapy With Refugees and Victims of Trauma*, by Guus van der Veer (1998) 2nd ed. Chichester, England: John Wiley & Sons.



GUIDELINES FOR  
ADAPTING SERVICES

**SLOW DOWN OR BECOME** more comfortable with a slower pace. Information that a provider is accustomed to getting quickly (e.g., a person's age) takes much longer due to factors such as interpreting time, cultural differences, and psychological symptoms.

**MONITOR AND/OR REDUCE** the number of questions asked, especially in the beginning of treatment, in consultation with the client. Being asked many questions reminds some clients of the interrogation experience.

**CHECK IN WITH CLIENTS** regularly to see how they are doing and offer breaks, especially during initial interviews.

**HELP CLIENTS MODERATE** the pace of telling their trauma stories.

**ACTIVELY ADDRESS ANY** evidence of re-experiencing symptoms or other distress, allowing as much time as it takes for clients to feel comfortable enough to proceed. This often means letting go of interview protocol.

**ALLOW AT LEAST TWICE AS** much time for sessions with interpreters.

**ALLOW ADEQUATE TIME AT** the end of sessions for closure and for joint planning regarding self-care of clients after meetings and between sessions.

**ADAPT TREATMENT GOALS** to the long processes many survivors face in rebuilding their lives in a new country. For example, the establishment of safety can take years as clients move through the process of obtaining political asylum, locating and supporting family members, and bringing families to safety.

ited abuse of power. Many survivors experienced this abuse directly and intimately. Understandably, they often fear engaging in any kind of healing relationship.

Issues of power, control, and trust are paramount for torture survivors. Providing client-tailored information, explanations, and choices wherever possible and appropriate throughout treatment helps the survivor restore a sense of control and power.

Providers must be careful not to overwhelm survivors with too much information at once. However, the cursory in-person explanations and lengthy documents (e.g., data privacy notices) that are typical with mental health clinics in the United States are insufficient and potentially damaging in building trusting relationships with torture survivors. Listed below are examples of key areas in which torture survivors benefit from personalized information, explanation, discussion, and collaborative problem solving:

**ROLES AND RESPONSIBILITIES OF CLIENT, PROVIDER, INTERPRETER, AND OTHER STAFF:** For torture survivors, who may attribute enormous amounts of power to authorities, it is important to clarify the provider role, i.e., limits of power and what the provider offers. It is critical to explain who the provider is and how they can help in terms directly linked to the survivor's situation and/or needs.

**EXPECTATIONS:** What can the survivor can expect next? What does the provider expect next?

**CONFIDENTIALITY:** What is it and how does it work? What are its limits. It is important to discuss

how confidentiality applies to each role (interpreter, client, provider, bicultural worker, receptionist, etc.). Often torture survivors wonder about possible connections between the provider or clinic and governmental or immigration authorities, and it is helpful to address this openly. Asking clients what they would like the interpreter/provider to do if they see each other in the community is one of many clinical opportunities for client empowerment

**PURPOSE:** What are the goals of the work together?

**PSYCHOLOGICAL SERVICES:** What it is, how it works, how it can help the survivor achieve their goals.

**PSYCHIATRIC MEDICATIONS:** Common issues include concerns about addiction or dependency, discontinuing meds once one starts to feel better, sharing meds with others, changing one's dosage, difficulty paying for meds or knowing how to use a pharmacy, etc.

**CLIENTS' RIGHTS:** Torture survivors may or may not be familiar with the concept of "rights." What are they?

**SYSTEMS AND INSTITUTIONS:** How they (e.g., social services, health care, education, employment, legal services, etc.) relate to working together is an important issue for clients.

**SLOW THE PACE**

The fast pace of health care interactions in the United States, with 15-minute doctor appointments and single-session psychological assessments, may re-traumatize a torture survivor. A core effect of

trauma is that the body and mind are overwhelmed and accelerated; too much is happening too fast.

A corrective, healing experience for a torture survivor involves adapting oneself to a pace that is tolerable for the survivor. This pace may change throughout treatment and needs continuous monitoring.

### SITUATE PROBLEMS IN HISTORICAL AND POLITICAL CONTEXTS

Torture survivors in exile are often aware their problems are political and historical in origin. They probably would not be in this country, let alone the therapist's office, if not for the political situations back home.

If providers do not clearly demonstrate an understanding of the context of the survivor's experiences, survivors feel misunderstood, alienated, and misrepresented in whatever treatment plan follows. Providers should frame problems within larger contexts in a manner that does not minimize the very real psychological problems and distress caused by torture and exile. Rather, validating symptoms and other psychological effects as a normal, understandable result of a deliberate political strategy is a key aspect of empowerment. At a minimum, this adaptation involves the following:

- Conducting assessments and interventions in a manner that demonstrates some understanding of the common life experiences of refugees /asylees, the struggle of the survivor's people, and the effects of war.
- Discussing torture and other

human rights violations as strategic, intentional sociopolitical acts in terms that have meaning for survivors.

- Interpreting symptoms or torture-related behaviors as the results of pathological systems of oppression and injustice.
- Understanding that politics have played a formative role in the lives of many torture survivors. Survivors need to be able to discuss political issues in treatment — the political is personal. Survivors commonly recount in detail political and historical events in their country. They may begin their stories long before their individual births. Again, political and cultural factors intertwine in work with torture survivors.

### DE-STIGMATIZE

Torture survivors may feel they are going crazy or are the only ones who have problems. This is a key reason why many torture rehabilitation programs use group treatment.

Most of the time, torture is a highly solitary trauma. Many aspects of the interrogation environment are deliberately controlled and manipulated to convince detainees they are utterly alone and beyond any help.

Cultural and social factors contribute toward stigmatization of mental health problems in this country and in others. Many survivors are from countries that reserve scarce mental health services for the seriously and persistently mentally ill, such as persons with schizophrenia. Those seeking services for mental health problems are labeled "crazy" and, in their countries of origin, suffer serious social

### STAGES OF TRAUMA RECOVERY

DRAWING ON COMMON elements found across different theorists and types of trauma, Herman (1992) described the following broad stages in trauma recovery:

- 1) ESTABLISHMENT OF safety and stabilization
- 2) REMEMBRANCE AND mourning: coming to terms with trauma and its effect on one's life
- 3) RECONNECTION: Rebuilding one's life and future

PROGRESS THROUGH these stages is not linear or unidirectional and is affected by ongoing stress. Moving through the stages can take anywhere from months to years. As Herman notes, each survivor "must be the author and arbiter of her own recovery." (p.133). A torture survivor may define a successful recovery as constituting one, two, or all three of these stages.



stigma and negative economic consequences.

However, torture treatment programs do not find stigma to be an insurmountable barrier. The following examples are effective ways to de-stigmatize the effects of torture and to uphold the rights of all survivors to receive supportive assistance and care:

- Emphasize problems as normal, common, expected, solvable, impermanent, appropriate and valid.
- Use educational materials to normalize effects of torture — videos, printed materials, such as brochures, checklists, handouts.
- Consult with interpreters, bicultural workers, and other cultural liaisons to determine culturally congruent, nonshaming explanations and concepts.
- Express openness to consulting with others from whom the client seeks healing or assistance.
- Emphasize that clients deserve services and explain any differences in cultural norms regarding what it means to seek mental health services for trauma recovery (e.g., “normal” people receive psychotherapy in the United States).

#### **ADDRESS THE POTENTIAL FOR RE-TRAUMATIZATION**

There is no exhaustive list of the sights, smells, sounds, and other experiences that trigger intrusive post-trauma symptoms or lead survivors to re-experience aspects of the torture. Anything can be a reminder: ordinary objects such as an office stapler or a broom handle, and ordinary experiences such as waiting for an appointment or being questioned.

Likewise, there is no list of objects to remove from the office or things not to do that

can prevent a survivor from remembering or re-experiencing torture.

However, a provider should become familiar with common elements of service environments that can be traumatic reminders for torture survivors. These elements include the following:

- Lengthy waiting periods to meet with someone — victims often wait to be interrogated and tortured
- Room characteristics that are similar to interrogation cells — small or large, crowded, private/enclosed, windowless, dimly lit, bright overhead light
- Uniformed personnel in the building, medical staff and instruments clients sitting in the same position for long periods of time.
- Clients asked many questions

At the first interview, providers should explain their awareness of the potential for survivors to encounter traumatic reminders and should develop a mutually agreed-upon plan for how clients and providers will address the problem. If one is not sure, but suspects something is a reminder or is distressing the survivor, address the issue directly with the survivor. Ask, express understanding, validate and normalize, and negotiate a mutually agreeable solution.

For example, in one instance, a small windowless office reminded a survivor of her torture cell. The provider arranged to provide sessions in a larger family therapy room that had ample natural light.

#### **TRAUMATIC MATERIAL**

Concerns about re-traumatization are complex; probing into traumatic material is likely to raise difficult feelings and issues for providers, clients, and interpreters.

For example, mental health providers may

fear that clients will experience them as torturers. Strong counter-transference is normative in working with torture survivors. It is vital that providers have access to educational and training resources as well as professional consultation. An excellent resource for increased understanding of clinical issues involved in treating trauma is *Countertransference and the Treatment of Trauma* (Dalenberg, 2000).

Because of the nature of torture trauma, providers need to collaborate carefully with clients in the use of any exposure-based techniques, including telling one's story. In addition, providers must work closely with clients in using interventions that aim to change thoughts, beliefs, or ways of thinking, because that is also the aim of torturers.

#### POTENTIAL FOR RE-TRAUMATIZATION THROUGH ASSESSMENT

Assessment deserves special mention, because many clinics use standardized assessment tools and measures. Aside from serious validity problems for measures lacking appropriate translations and normative data on persons from survivors' countries, the responsible use of questionnaires and tests with torture survivors takes into account the potential for re-traumatization.

Survivors may be suspicious about the reasons providers are asking them to complete written measures. Questions about past trauma and current symptoms may be very evocative for survivors. Survivors may be unfamiliar with many aspects of the procedure of filling out multiple forms in a waiting room. They may lack familiar-

ity with pencil-paper measures or the kinds of questions asked on personality inventories. Clients also may be preliterate, which providers might not know at intake.

If these tools are used, providers should incorporate extra client preparation time to explain, obtain informed consent, and reassure. This is particularly true if the client does not know how to read or write and providers must administer the measure orally (if it is considered valid when orally administered). At the end of the session, providers need time to debrief with survivors about the process of completing the measures.

Privacy issues are extremely important to torture survivors. Providers should carefully explain any collection of data for the purposes of assessment or research. Providers should find ways to maximize privacy (e.g., use ID numbers instead of names). HIPAA now mandates client privacy.

#### WORK HOLISTICALLY

The many urgent needs of torture survivors in exile confront mental health providers with direct confirmation of Maslow's hierarchy. Psychological concerns must often take a backseat to more primary survival needs such as food, clothing, housing, physical safety, income, and location of missing family members.

In addition, due to culture and other

#### RESOURCES FOR PSYCHOLOGICAL ASSESSMENT

FOR PSYCHOLOGICAL evaluation of asylum seekers and/or assessment of psychological evidence of torture, the following may be useful:

PHYSICIANS FOR HUMAN RIGHTS (2001) *Examining Asylum Seekers: A Health Professional's Guide to Medical and Psychological Evaluations of Torture*. Boston: Physicians for Human Rights.

UNITED NATIONS (1999) *The Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (The Istanbul Protocol)*. New York: United Nations.

#### FOR MORE INFORMATION

For a description of HIPAA regulations, see **PAGE 70**.



HIPAA AND FEDERAL  
PRIVACY REGULATIONS

ALL HEALTH CARE PROVIDERS have both an ethical and legal duty to protect the confidentiality and security of client health care information. The Health Insurance Portability and Accountability Act (HIPAA) became a law in 1996. This law requires, among other things, that the vast majority of all health care entities nationwide, including health care providers, health insurance plans, HMOs, health care clearinghouse, and business associates of those entities, take steps to protect the privacy and confidentiality of all clients' health records.

AS OF APRIL 2003, AGENCIES are required to comply with new federal privacy regulations that were issued under the Federal Health Insurance Portability and Accountability Act (HIPAA). When state laws for privacy protections are more restrictive than HIPAA, those provisions of state law generally takes precedence over HIPAA provisions.

A CD WITH CVT's HIPAA policies and employee training manual is available to members of the National Consortium of Torture Treatment Programs.

factors, health can take on an absolute quality and meaning for torture survivors that encompasses physical, mental, and spiritual health. Providers must address survivors' health in a holistic manner.

Mental health providers must address the mental health issues of torture survivors within the broader social, political, and economic environments affecting their physical and mental health. That typically involves expansion of the provider's traditional service delivery role as well as widening the circle of those with whom one collaborates.

In psychotherapy, examples of this adaptation include the following:

- Collaborate closely with the client's social service providers. If a client does not have a social service provider, establish relationships with community agencies that provide case management services. Expand the traditional role of the therapist to include advocacy (even when there are other advocates), and accompaniment (e.g., accompanying a client to an asylum interview as a supportive presence)
- Provide some concrete assistance at the first interview and establish yourself as a resource in addressing the client's immediate needs (i.e., do not just ask questions but also offer suggestions, referrals, or other resources during an initial assessment interview)
- Address mental health within the context of primary survival needs such as food, security, housing, location of and communication with loved ones, treatment of physical injuries and serious

medical concerns

- Talk about mental health within the client's frame of reference, which may be holistic (i.e., do not separate mental from the spiritual and/or physical domains)
- In collaboration with the client, work with other services and significant persons of influence in the client's life, both stateside and abroad (e.g., social, legal, medical service providers, family members, elders, traditional healers, religious leaders, other community or cultural liaisons, embassies and immigration officials, non-governmental organizations working in the country of origin, etc.)

EFFECTS OF THE  
WORK ON THE PROVIDER

Psychological services involve intimate contact with stories of torture and associated reactions such as changes in thoughts, feelings, bodily sensations, and belief systems and worldviews. Providing psychological services to torture survivors requires providers to tolerate immense pain and to come to terms with the human capacity for evil in a manner that goes beyond psychological explanations. There are fundamental moral questions when dealing with the extremes of human cruelty and sadism as well as extremes of human resiliency and strength of spirit.

By design, torture is incomprehensible, unspeakable; its horrors take one beyond social science into the realms of faith, philosophy, and other age-old ways that human beings have tried to find meaning in suffering and evil. Simply put, working

with torture changes providers. It is foolhardy to imagine otherwise and yet impossible to anticipate how one is changed in advance — a reality that many therapists beginning with this population understandably find daunting.

The effects of working closely with trauma are covered extensively in the literature and are called by various names, such as secondary trauma, vicarious trauma, and compassion fatigue. Since secondary trauma is affected by individual factors and the work environment itself, it is important that providers receive ongoing training and consultation tailored to their particular work setting.

Secondary trauma in psychological service delivery is an issue for everyone involved: especially interpreters, bicultural workers, and others from affected communities who have their own traumatic history, collective traumatic history, and ongoing trauma back home. Interpreters are in the position of hearing the trauma twice (in both languages) and having to simultaneously absorb and interpret the trauma story. Establishing processes and procedures for screening, training, supporting, debriefing, and collaborating with interpreters in addressing secondary trauma is essential in providing interpreted psychological services to torture survivors.

Many therapists who work with torture trauma find it helpful to develop regular self-care practices that address the effects of the work on their bodies, minds, and spirits. The list of potential practices is

endless, but common examples include breath work, meditation, physical exercise, and sports, spiritual and religious practices, movement-based practices such as dance and yoga, massage, and gardening.

Relative to working with other forms of trauma, torture trauma can be particularly isolating. Psychotherapists working with torture commonly feel as though they do not have access to peers who understand them or can relate to their particular stresses, struggles, and dilemmas. Sustaining connection with sources of professional and personal support is extremely important in attending to the effects of the work on the mental health provider. Developing collegial relationships with other therapists from torture treatment programs around the country is uniquely and profoundly helpful in addressing the reality of professional isolation.

## WORKING WITH INTERPRETERS

For clinicians who do not speak the same language as the torture survivor, an interpreter will be part of the therapeutic relationship. Providers of psychological services need ongoing training on the unique impact and role of interpreters in psychological assessment and treatment.

The presence of an interpreter changes the dyadic relationship between torture survivor and clinician to a triadic relational system. Interpreters take on a powerful role in the treatment process, as they give voice to the experiences of the survivor and to the reactions and responses of the clinician. Only they understand every-

## RESOURCES THAT ADDRESS THE IMPACT OF THE WORK ON THERAPISTS

GENERAL RESOURCES FOR therapists in addressing the effects of the work include the following:

*Countertransference and the Treatment of Trauma* by Constance J. Dalenberg (2000) American Psychological Association: Washington, D.C.

*Treating Compassion Fatigue* by Charles R. Figley (2002) New York: Brunner-Routledge.

*Trauma and the Therapist* by Laurie Anne Pearlman and Karen W. Saakvitne (1995). London: Norton.

*Transforming the Pain: A Workbook on Vicarious Traumatization* by Karen W. Saakvitne and Laurie Anne Pearlman (1996) New York: W.W. Norton.

*Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers and Educators* edited by B. Hudnall Stamm (1995) Lutherville, Maryland: Sidran Press.



thing said. Various mental health concepts do not translate readily into other languages, making pre-session collaboration and post-session debriefing with interpreters essential in providing responsible, ethical service delivery to torture survivors. Many therapists beginning to work with interpreters find it challenging to have a third person present and to work with the complexities of a triadic relationship.

Issues related to the interpreter-client match can profoundly affect how the provider and client address (or fail to address) trust, dependency, shame and other common issues in therapy. The therapist may or may not be aware of how various dimensions of the match affect the relationship: gender, age, social class, political affiliation, tribe, ethnicity, religion, education, and geographic region of origin. Consult with the client — ideally, before the first appointment — on relevant dimensions of the match for a given client.

For an introduction to the dynamics of working in a triadic system, review Haenel (1997). For an introduction to building effective professional partnerships with interpreters and learning about the interpreter's role in mental health service delivery, see Lee (1997). Another general resource is *Working With Interpreters in Mental Health* (Tribe, 2003).

#### FOR MORE INFORMATION

General guidelines for working with interpreters can be found in **CHAPTER 3.**



#### FAMILIAR STRATEGIES USED BY PSYCHOLOGICAL SERVICES TO HELP TORTURE SURVIVORS

Providing torture survivors with psychological services requires new skills and knowledge. However, it is important for therapists new to this work to understand that much of their previous repertoire and training is relevant. The following strategies or interventions used by psychotherapists in their work with torture survivors may sound familiar to those who have worked with other forms of trauma:

- Provide information to survivors about posttraumatic reactions, such as PTSD and depression, and provide information about the psychological effects of trauma; normalize and validate these reactions.
- Provide a safe, therapeutic environment for the emotions that survivors feel; listen, receive, and endure the emotions with the survivor.
- Help survivors learn to calm and soothe themselves by teaching specific anxiety-management strategies and through internalization of the therapeutic relationship.
- Help survivors identify their beliefs about experiences of torture and persecution and begin to examine those beliefs imposed under torture (e.g., “I was responsible for what was done to my family.”).
- Assist survivors through the grieving and mourning of multiple losses.
- Assist survivors with their overall adjustment to a new environment and the re-establishment of occupational and educational

plans, familial roles, and responsibilities.

- Help survivors anticipate and cope with potentially re-traumatizing experiences (e.g., asylum interview or hearing) or with unexpected experiences of re-victimization (e.g., crime, racism, etc.).
- Foster the connection of thoughts, feelings, bodily sensations, and other responses to the trauma from which they originated; normalize these experiences.
- Foster the establishment or re-establishment of trust in others and in the world, to whatever extent possible.
- Promote positive connection or reconnection with others.
- Address pre- and post-torture trauma experiences which may also be of significance.
- Foster the eventual connection or reconnection with meaningful return to one's social, cultural, political, and economic roles, to whatever extent is desired by the client.

As mentioned earlier, the therapist variable is widely regarded in effective trauma therapy. For a discussion of this factor in psychotherapy for severely traumatized refugees, see Kinzie (2001).

All qualities demonstrated by a good therapist — genuineness, warmth, high positive regard, responsiveness, consistency, and respect — are as important in working with torture survivors as with any other clients.

Many survivors highlight the value of feeling heard and believed as the most healing aspect of their treatment. ■

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## ONLINE RESOURCES

The following tips on online resources and their use is adapted from the Center for Victims of Torture online resource manual created by Wendy L. Roehlke, library volunteer at the Center for Victims of Torture.

<http://www.apa.org/psycinfo/> PsycINFO®, available from the American Psychological Association (APA) is an excellent online resource because of its coverage of the field. The drawback: It requires someone to pay for the access. In some instances, the database may be used in university or public libraries at no charge.

<http://www.apa.org/psycinfo/products/psycfirst.htm> The APA also produces PsycFIRST®, containing PsycINFO's current year of data plus that from the three previous years. This database is helpful in searching for the most recent materials. It requires someone to pay for the access but may be available through university or public libraries.

## CHAPTER 7



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# LEGAL SERVICES

## LEGAL SERVICES

## IN THIS CHAPTER

- LIFE EXPERIENCES and resettlement issues
- COMPREHENDING torture
- BUILDING cultural competence
- EFFECTIVE LEGAL representation with an interpreter

This chapter provides an overview of challenges that arise when representing torture survivors and strategies to ensure these challenges do not act as a barrier to effective legal representation.

Attorneys encounter torture survivors with a variety of legal needs. Frequently, however, the survivor's initial and most pressing legal problem involves immigration matters, such as asylum, family reunification, or defense from removal (deportation). Because safety is crucial to the survivor's ability to engage fully in torture treatment services, the asylum process is integral to rehabilitation.

Other related immigration legal services, including family reunification and obtaining lawful permanent resident status, may also be vital to the survivor's steps toward rehabilitation. Survivors with a variety of immigration statuses may find themselves in need of representation in these matters.

When feasible, torture treatment centers and immigration legal services professionals work in cooperation. Lawyers, however, are rarely trained to work with survivors of torture and may be overwhelmed by many challenges presented during representation.

The goal of legal representation is deceptively straightforward: to provide sound legal advice that enables the client to make an informed choice of action, and to represent the client in achieving his or her legal objective. Realizing that goal can be far from simple, especially when the lawyer represents a client who has survived the trauma of torture.



Most survivors of torture are newcomers to the United States. They share with other newcomers the challenges of unfamiliarity with the United States legal system and lack of fluency in the English language.

Survivors often face specific trauma-related challenges—depression, post-traumatic stress disorder, anxiety, and fear of authority, including lawyers and the judicial system. The client's relationship with an attorney, prosecutor, or judge may be problematic if legal professionals participated in the client's torture or persecution.

Without a lawyer's careful attention, these issues may interfere substantially with clients' ability to participate in their representation.

In these situations, attorneys must diligently practice the basics of good lawyering: building a solid attorney-client relationship, communicating effectively with the client throughout representation, and, at all times, treating the client with dignity and respect.

### LIFE EXPERIENCES AND RESETTLEMENT ISSUES

A survivor's life experiences and issues unique to resettlement in a new country may create obstacles to the effective delivery of

legal services. The client, lawyer, and other service providers may need to address these experiences and issues before representation can move forward.

### **AVOIDING ASSUMPTIONS**

The lawyer cannot assume a torture survivor is familiar with basic U.S. legal concepts, which are often learned by those who grow up in this country through high school civics classes and television courtroom dramas. While the lawyer must clarify the attorney-client relationship with all clients, it is especially important when representing torture survivors that the attorney avoids making assumptions and takes time to start at the beginning.

Concepts like the adversarial process and the independence of the judiciary may be unfamiliar. Confidentiality of communications and attorney-client privilege — the foundation of the relationship — must be carefully explained.

Attorneys working with torture survivors, whether providing free legal services or working for a fee, must take care to draft clear retainer agreements specifying the legal fees, the costs for which the client will be responsible, and the scope of the legal work to be undertaken. The attorney must explain these agreements to the client at the outset to ensure the client understands the services.

While some clients may not know the U.S. legal system, it is a mistake to assume clients are unfamiliar with legal concepts or lack sophistication or education. Clients come from all backgrounds and may be attorneys, judges, physicians, government officials, scientists, professors, journalists, or business owners. In

short, it is critical that the attorney take time to ask questions about the client's background, explain basic concepts, and remain open to the client's questions throughout the process.

### **DEALING WITH IMMEDIATE NEEDS**

Torture survivors deal with complicated and emotionally stressful resettlement concerns. Unfortunately, many legal issues arise during one of the most stressful periods in the client's life.

Often clients will turn to their attorneys to solve the many problems they are facing, including lack of adequate housing, unemployment, isolation, medical problems, or lack of transportation. Some of these issues—such as obtaining employment or petitioning to bring family members to the United States—may not be solvable until asylum is granted, making it particularly important that the attorney act promptly to establish realistic expectations for time frames and the likelihood of success. Other issues, most obviously medical problems, should be referred to the appropriate professionals.

Still other issues may require effort, attention, and creativity on the attorney's part. For example, if the client cannot travel to the attorney's office, the attorney may need to consider meeting in a location nearer the client's home, conducting some business by telephone, and coordinating meetings with other appointments the client has in order to minimize transportation problems.

For asylum seekers, many other issues, in addition to securing legal immigration status, hinge on obtaining asylum: release from detention, employment authorization, and eligibility for government assistance, housing

## BALANCING NEEDS: LEGAL DEADLINES VS. IMMINENT NEEDS

SCHEDULE REGULAR, periodic meetings with the client. This allows the client to schedule regular transportation and coordinate the visit with the lawyer with other appointments. Most importantly, this keeps the preparation of the case on schedule even when some meetings are less productive due to the client's attention to immediate concerns.

programs, job-training services, and the ability to reunite with family members.

### REUNIFICATION WITH FAMILY

Concerns for the safety of family members left behind and efforts to be reunited with them are of critical importance to the asylum seeker. Attorneys working with asylum seekers should explain realistic time frames to avoid giving false expectations. Deadlines, such as for filing a petition for refugee or asylee family members, should be clearly explained.

Lawyers should also think about how to minimize delays. For example, in order for an asylee to petition to bring his or her spouse and children to the United States, the asylee must submit proof of the relationship (such as the birth certificate or marriage certificate) and a photograph of each family member. These documents may take months to obtain. Asylum seekers can begin gathering this documentation while waiting for their asylum decisions, so they can file petitions for the family members immediately upon obtaining asylum.

Similarly, attorneys or other legal workers helping refugees reunify with family members abroad should take care to lay out necessary steps and convey accurate information about deadlines and expected adjudication times. Torture survivors applying for lawful permanent resident status or naturalization may be relying on that status to petition to immigrate other family members, including adult sons and daughters, siblings, and parents, to the United States.

Other survivors may be unaware of the benefits of lawful permanent residence or of citizenship. Careful advice from immigration attorneys helps survivors make sound choices

that will benefit their families.

Refugees entering the United States through the refugee resettlement system face enormous stress in the refugee camps, long waits for permission to enter the United States, and a lack of access to sound legal advice while in the refugee camps. Attorneys working with refugees need to be aware of the contents of their clients' refugee files.

Attorneys must pay particular attention to refugees who enter the United States as derivative beneficiaries of a parent's refugee application before filing other applications or petitions. In some cases, the child, called the derivative refugee, may not be the biological child of the parent, or principal refugee.

Immigration authorities often discover this when the child applies for naturalization and a request is made for a change of name to the child's true name, which was concealed at the time of refugee processing. Because this relationship was misrepresented, the child's refugee status may be terminated and removal proceedings initiated. While there is little corrective action that can be taken once the misrepresentation happens, it is crucial that the attorney discuss these possibilities with the refugee before filing petitions for relatives or applications for adjustment of status or naturalization.

### BALANCING LEGAL DEADLINES AND CLIENTS' IMMEDIATE NEEDS

Dealing with legal realities in an empathetic and productive way is essential. The client needs to know the attorney cares, while understanding that the attorney may be unable to solve all problems and that there are boundaries to the attorney-client relationship.

When the client is working with profession-

als at a torture treatment center, their care team may include a social worker skilled in helping the client find solutions to immediate needs. If the client does not have access to such comprehensive services, the attorney should make, when possible, appropriate referrals to other service providers. The unfortunate fact, however, is that services may not be readily available to clients without immigration status.

Ideally, the client's immediate needs are met before they must deal with legal problems. In reality, the lawyer must balance legal deadlines and the need to prepare the case with the client's desire to focus on immediate, day-to-day concerns.

Clients may be in such distress over housing, financial, or medical concerns that they are unable to concentrate on legal issues. In such situations, preparing the case will take more time. The lawyer must keep case deadlines clearly in the client's mind while remaining aware of other important issues facing the client.

## COMPREHENDING TORTURE

Inherent in the asylum process is the telling and retelling of the client's story of torture, trauma, and persecution. While obtaining the story, the attorney must avoid re-traumatizing the client. The client must confront issues of loss—especially the loss of family, home, work, and community—during the asylum process in order to present the case to the adjudicator (asylum officer or judge). An attorney's ability to address these complex issues while assisting the client with his or her legal needs is critical to effective representation.

An attorney needs to be aware that the client's trauma is not confined to the torture

itself. The Triple Trauma Paradigm, identifies trauma the client has likely experienced at different phases: pre-flight, flight, and post-flight. In each stage, clients will experience fears and losses that influence their ability to participate in legal proceedings.

### THE TORTURE SURVIVOR'S RESPONSE TO THE LEGAL SYSTEM

In some instances, members of the home country's legal system were involved in the repression and torture survived by the asylum seeker. Understandably, this may create an immediate barrier to developing a trusting relationship between the client and the attorney. Clear explanations of the role and duties of the lawyer in the United States legal system may alleviate this concern.

Traumatized clients may be reluctant to work on the details of their asylum claims, which involve recalling and recounting extremely painful events. They may deflect these discussions by focusing on other issues.

Fear of authority figures, including the client's own attorney, immigration officials, and judges may interfere with the attorney-client relationship or with the client's ability to go forward with the legal case.

The response of the United States government to asylum seekers exacerbates the client's fears. Many asylum seekers, including torture survivors, are detained in U.S. jails, prisons, and immigration detention centers throughout their cases. Often conditions of detention mir-



A uniformed police officer passed by David and his attorney in the law office building. The attorney's response was one of mild curiosity about where the officer was going. David, who is a torture survivor, on the other hand, became silent and began sweating. His assumption, based on his experience, was that someone — perhaps he — would be taken away by the police without charge or explanation.

### FOR MORE INFORMATION

For more information on the Triple Trauma Paradigm, see **CHAPTER 3**.





Birana, a medical doctor from Nepal, developed what seemed to be a good rapport with her volunteer attorney, who was working with a torture survivor for the first time. They enjoyed lively discussions about Birana's profession and observations about the U.S. medical system. When the attorney's questions turned to the client's incarceration in her home country, however, Birana grew unresponsive. Applying traditional credibility indicators, the attorney became concerned Birana was fabricating her claim. After a meeting at the referring legal services organization, the volunteer attorney concluded Birana's trauma was probably severe and referred her to the local torture treatment center. Birana received treatment while the volunteer attorney continued working with her. After learning the extent of Birana's suffering, the attorney described her as the bravest individual she knew. Eventually asylum was granted.

ror those the asylum seeker fled.

Lawyers working with detained torture survivors need to establish that they do not work for the government and that communications with clients will remain confidential. Attorneys may be the only contact clients have with the outside world. They must be alert to the clients' medical and psychological needs, advocating for clients with detention facilities or immigration authorities to ensure clients are receiving appropriate care.

### **GATHERING FORENSIC DOCUMENTATION**

The attorney will need to coordinate the gathering of forensic documentation related to the client's asylum case, including medical and psychological assessments. Procedures governing the client's access to outside medical and psychological personnel may be difficult to navigate, and will vary depending on his or her location. Often the attorney will be called upon to obtain documentary evidence from the client's home country. Efforts must be made to ensure the detained client is able to carry the burden of proof in the asylum case.

### **DEVELOPING THE CASE: AVOIDING RE-TRAUMATIZATION WHILE GETTING THE FACTS**

A successful asylum case depends upon the client's accurate written and oral testimony about the experiences leading to flight from the country of persecution. Cases hinge on two interdependent items: first, the consistent, complete, and accurate retelling of the client's story, both in the written application and in person; and, second, the client's credibility as indicated by demeanor, specificity, detail, and consistency while retelling the story.

Asylum seekers are held to an extremely high standard. They must recount every material detail of their case, including dates, times, places, and people. They must recount their stories in a coherent manner, enabling the adjudicator to understand what took place and why. They must answer questions about why the persecution or torture took place, why they were targeted, and why they were able to escape to safety.

The client's account of events must be detailed, consistent, and complete from the outset. Once the written claim is filed, adding information later remembered or shared with the lawyer may be seen as embellishment and lead to a finding that the client is not credible.

At the same time, asylum seekers must file their claims within one year of arrival in the United States. Few exceptions apply to the one-year deadline and claims that the client was too traumatized to immediately pursue the case often will be rejected. If asylum seekers are in removal proceedings, their applications and evidence must be filed in accordance with court filing deadlines.

Developing the torture survivor's asylum case cannot be completed in one sitting. Lawyers must plan to work with the client closely throughout the available time to best develop the case. The client and attorney must build sufficient rapport and trust for the client to be able to reveal all aspects of the story, including embarrassing or humiliating details. Frequently relevant information is revealed only after the attorney and client have been working together for an extensive period.

To present the case persuasively, the attorney must become familiar with the client's



own story and the context in which the events unfolded, in addition to gathering documentary and forensic evidence.

Rushed preparation of the case risks leaving important elements undeveloped. Because so much hinges on the grant of asylum, the client may be understandably anxious for the case to proceed quickly. While the attorney needs to avoid unnecessary delays, he or she also must keep the bigger picture of case development and evidence production in mind.

Symptoms suffered by survivors, including depression, anxiety, and post-traumatic stress disorder, may interfere with clients' ability to participate in their cases. Clients may have difficulty remembering details of events. Their emotional reactions when recounting traumatic events may seem inappropriate.

They may avoid discussing the torture or other traumatic events or begin missing appointments with the attorney when they anticipate the discussion will be too painful. Clients may not recount torture events in a linear fashion; they may jump from one event to the next or omit details. This may be particularly true for individuals who have endured multiple arrests or for whom torture started at an early age.

Traditional indicators of credibility in U.S. courts—demeanor, eye contact, consistent recall of events—may not be valid indicators in the client's culture or may be affected by shame surrounding the torture itself. Both attorneys and adjudicators may jump to the conclusion that a torture sur-

vivor is lying. Counsel for the asylum seeker must understand the sequelae, or aftereffects, that result from torture. The attorney also must develop evidence to present to the adjudicator that offsets a negative credibility finding.

### **COORDINATING CARE: WORKING EFFECTIVELY WITH TORTURE TREATMENT PROFESSIONALS**

As discussed earlier, the effects of torture can interfere with the client's full participation in the legal case. There is no substitute for a care team trained in working with torture survivors to help meet the client's medical, psychological, and social needs. Where such expertise is not available, attorneys need to research providers who have sufficient training to assist their clients.

All members of the care team will better serve the needs of the client when they work together. For example, the attorney may benefit from understanding the effects of torture as they relate to the client's memory of the event. The psychologist may benefit from knowing about an upcoming asylum hearing that may be causing the client anxiety. The social worker, trying to arrange housing, may need to know the status of the client's immigration case to determine eligibility for programs. Regular communication among team members facilitates care.

In addition, medical and psychological assessments by experts may provide documentation in support of the asylum claim. Asylum seekers have the burden of producing all reasonably available evi-

dence in support of their claims. Evidence of physical injury and psychological condition, together with an expert opinion regarding the likely cause, may be persuasive. Obtaining evaluations in advance of the asylum interview or removal hearing enters this information into the record. Professionals preparing these evaluations may be called upon to serve as expert witnesses at trial.

Attorneys should never assume that the client's treating physician or therapist will provide an evaluation or serve as an expert witness. Practice will vary depending on the torture treatment center's policies and on the needs of the individual client.

At the onset of representation, the attorney and members of the client's care team should discuss whether the provider will be able to serve as an expert witness in support of the asylum case or whether an outside assessment will be required. Also, the attorney must develop a plan and timeline for developing expert assessments and witnesses.

### **BUILDING CULTURAL COMPETENCE**

Cultural competence is ever-developing and is a critical tool to building a sound, productive, and ethical attorney-client relationship. Cultural experiences affect many aspects of this interaction. These include building trusting relationships, evaluating credibility, developing client-centered case strategies and solutions, and gathering information. Cultural competence is largely a matter



When sought as a witness in a criminal investigation, Beatrice, an asylum seeker, and her attorney met with the criminal defense attorney. The defense attorney carefully laid out Beatrice's options: to talk to the police without assurances the conversation would not be used against her in later criminal charges, to seek assurances the conversation would not be used against her later, or to refuse to talk to the police. When Beatrice asked what would happen if she refused to speak to the police, the attorney replied "the government might try to make things difficult." Beatrice, a survivor of torture, went pale, believing the attorney meant she would face the same torture she had suffered in her home country. The immigration attorney, aware of the torture, explained she would absolutely not be tortured or otherwise physically harmed by the police for exercising her constitutional right against self-incrimination. The defense attorney then detailed what sort of pressure the police might bring against her in that situation. Had the miscommunication not been discovered, Beatrice would have been unnecessarily frightened and would have been unable to make an informed decision because she would have based her decision on a critical misunderstanding.

of common sense, awareness, and willingness to learn new information.

### DEVELOPING CULTURAL COMPETENCE

Communicating effectively with a person from another culture is challenging. Body language, gestures, gender roles, communication, and story-telling styles may vary dramatically.

Building cultural competence involves learning about differences that can stand in the way of clear understanding. For example, gestures such as nodding may convey a different meaning than that assumed by the listener. Paying close attention to the client's eye contact, tone of voice and manner of answering questions provides cues as to the client's comfort with the relationship and the process of obtaining legal services.

As Professor Angela McCaffrey discusses in her article, "Don't Get Lost in Translation: Teaching Students to Work With Interpreters," (2000) taking time to learn the basics of the home country's legal system and the client's social and political background helps avoid misunderstandings, saves time and frustration, and more accurately conveys the client's story.

Make sure that lawyer and client are using the same definition of a term. For example, a client maintained he had been

arrested three times, but in the course of discussion with the attorney preparing his asylum application, he mentioned many other times when he was held by the police. Eventually the client explained that when the attorney asked about "arrests," he thought only of the three times he was held in prison for extended periods of time. The dozens of other times he was stopped by the police and detained for a few hours or days he regarded as "routine" and not worthy of mention.

Basic understanding of the client's home country can greatly facilitate communication. For example, interviewing clients from Ethiopia can be challenging if the attorney does not know the Ethiopian calendar is approximately seven years and eight months behind the Julian calendar commonly used by the rest of the world.

### DEFINING FAMILY RELATIONSHIPS

Cross-cultural communication skills are never more relevant than when the attorney and client are discussing family relationships for immigration purposes. Attorneys working in the field of immigration understand the precise, technical definitions given to various family relationships under the Immigration and Nationality Act. Definitions of "spouse," "parent," and "child" all may be found at 8 U.S.C., Section 1101. These definitions are substantially different from those used in standard American English, and may be radically different from the definition commonly understood in the client's culture.

### FOR MORE INFORMATION

For more information on cultural competence, see **CHAPTER 3**.



Unfortunately, misunderstandings or inaccurate descriptions of the family relationship described by the immigrant client may have grave consequences: negative credibility findings, denial of family reunification petitions, and revocation of status and removal from the United States.

There simply is no room for error in identifying the family relationship on immigration forms. Misrepresentations, whether intentional or not, made by torture survivors on their immigration forms may come back to haunt them years later when immigration authorities demand authenticated birth certificates or paternity testing.

Because of the potentially tragic consequences of inaccuracies when listing family members on immigration forms, attorneys working with torture survivors must elicit accurate descriptions of the relationship between the client and the family members. Simply asking the client to list their children, for example, without explaining the definition of the term child and without questioning the client about the precise parentage of their children may yield an inaccurate or incomplete list.

Clients asked about their children may think broadly, applying the practical definition of child used in their country, and include the children of relatives or neighbors left in their care at the outbreak of war or the disappearance of a child's biological parents. On the other hand, clients may think very narrowly, assuming the attorney is asking only for those children living in the client's household.

Avoid assumptions about family relationships. Ask questions about the relationship rather than relying on the descriptor of uncle or sister to make assumptions. Draw family trees to understand all the relevant characters in the client's story.

It is particularly important for the attorney to apply the basic concepts of cultural communication skills in this area. The attorney must recognize that not all cultures define family relationships in the same way. Without this recognition, the attorney may fail to adequately question the client about the relationships and may not elicit sufficient information to accurately analyze the relationship under the relevant legal definition.

Equally important, the attorney must remain nonjudgmental when the client describes family relationships that are not commonly recognized in the United States. For example, a male client may indicate that he has more than one wife. While the practice of polygamy is not permitted in the United States and the client may be unable to obtain immigration status on behalf of his entire family because of this, it is critical that the attorney learns this information in order to represent the client effectively.

#### **EFFECTIVE LEGAL REPRESENTATION WITH AN INTERPRETER**

Effective legal representation depends on clear and accurate communication. For those not fluent in American English, interpreting is essential. If interpreting is necessary, a competent interpreter must

be used throughout the preparation and presentation of the case. Failure to use competent and impartial interpreters risks errors, omissions, and inaccuracy that later may be insurmountable.

Nowhere is accurate interpretation more crucial than in the asylum case. The asylum seeker's credibility will be judged on the consistency of specific, and often minute, details of the case.

Asylum seekers in the United States must provide their own interpreters at their Asylum Office interviews. Interpreters at asylum interviews are rarely certified, professional interpreters and are often friends, family, or community members.

Asylum seekers and others appearing in the U.S. Immigration Court are provided with a court interpreter, who is either an employee of the court or under contract to provide interpreting services. While many Immigration Court interpreters provide excellent interpretations, failure to detect and correct errors threatens the non-English-speaker's access to the justice system.

#### **THE CHALLENGE OF INTERPRETING**

Interpreting and translation are difficult tasks, requiring interpreters and translators to be competent in both languages. In addition, they must be familiar with the cultural backgrounds of the client and attorney, the particular dialects used, and any required technical language.

In one case cited by McCaffrey, the Spanish sentence “!Hombre, ni tengo diez



An attorney prepared an asylum application using the interpreter who initially accompanied the client to his office. The client spoke and read no English and the case was prepared entirely through the same interpreter. The asylum case was not called for interview for several years. During that time, the interpreter died. When finally scheduled, the client brought a new interpreter to prepare for the interview. It was discovered that many of the incidents included in the asylum application never happened to the client, but rather were inserted by the interpreter to bolster the case.

kilos!” was interpreted by the court interpreter as “Man, I don’t even have 10 kilos [of drugs],” rather than “Man, I don’t even have ten cents.” The mistranslation of one word *kilos*, led to a mistaken drug conviction of a Cuban man.

Interpreting is even more complex if legal or other specialized language is used. When working with torture victims seeking asylum or in any immigration matter, the interpreter needs to be familiar with specialized terminology, including technical legal language explaining the asylum and immigration laws, place names from the home country, and terms for torture techniques.

#### STEPS FOR SELECTING AN INTERPRETER

First determine whether the client needs an interpreter. If an interpreter is needed, then determine in what situations.

The client may be able to speak sufficient English to schedule appointments by telephone but be unable to understand questions or convey important information. Be alert for clients who seem to latch onto nouns in a sentence but who are unable to distinguish more complex concepts, such as time or direction. The client may be able to speak English, but not read or write important documents, so providing either translated documents or making an interpreter available to read the documents in the client’s language is required.

Partial knowledge of a new or second language is limiting when emotionally sensitive

and complicated personal experiences of a traumatic nature are discussed. Discuss with clients whether they would feel better able to convey their thoughts at a hearing in their first language.

Next, it is important to select an interpreter who will be effective in the particular situation. While there is no set rule for which interpreter will be best, certain considerations should be taken into account. For example, if the interpreter will be called upon to appear at an interview with the Asylum Office, it is important to work with an interpreter who is both unrelated to the asylum applicant and who has lawful immigration status in the United States.

It is important to find a neutral, qualified interpreter rather than a family member or friend. Immediate family members may not be permitted to interpret at official immigration interviews, such as the asylum interview. Interpreting by family or friends may inhibit open communication between the attorney and the client.

For example, a woman who was raped in prison is unlikely to discuss this with the attorney if her husband is interpreting for her and does not know of the incident. Or, the husband may leave out this information, not wanting to share his wife’s rape with the attorney. Such omissions obviously may have profound consequences on the asylum claim.

A shared cultural background between the client and the interpreter may assist in effective communication. But in some cases, the value of that shared cultural background may be outweighed by other considerations.

Some clients fear discussing their case in

#### FOR MORE INFORMATION

For more on overcoming challenges of language interpreting, see **CHAPTERS 3 and 5.**



front of a person from their own country. They fear the interpreter will not maintain confidentiality of the information and that others in the community will learn embarrassing, humiliating or simply private information. Other clients may fear that the interpreter will convey information about their political activities to the government of the home country.

When political, ethnic, and clan disputes from the home country continue to be problematic in immigrant communities in the United States, an interpreter from another faction may be perceived by the torture survivor as someone with a bias against them. The value of a shared cultural background is lost, and an interpreter from outside the client's immediate community is more appropriate. Work with the client to find an interpreter who will, in that particular situation, provide the best means of open communication.

Finally, the cost of interpreting should not be overlooked. It is customary for attorneys in private practice to bill interpreter costs to clients. Clients and attorneys should clearly understand who is to bear the cost of hiring an interpreter. Responsibility for such costs should be specified in the retainer agreement. While the use of competent interpreters is essential, the use of paid professional interpreters may not be. Attorneys should explore options for volunteers when possible.

## CONCLUSION

Legal work on behalf of torture survivors provides both enormous professional satisfaction and great challenges. The basic tenets of professional responsibility will help build a successful working relationship with clients who have survived torture. In addition, by tailoring legal representation programs for torture survivors, structural barriers can be reduced to provide survivors with the greatest access to legal services. For those attorneys providing even occasional services to torture survivors, careful consideration of the particular needs of the survivor can enhance attorney-client communication, strengthen the record, and ultimately contribute to the success of the case. ■

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## ADDITIONAL RESOURCES

[www.humanrightsfirst.org](http://www.humanrightsfirst.org)

Human Rights First (formerly Lawyer's Committee for Human Rights)

[www.lirs.org/What/programs/torturesurvivor.htm](http://www.lirs.org/What/programs/torturesurvivor.htm)

The Detained Torture Survivor Legal Support Network is a nationwide network of legal service hubs for torture survivors held in immigration detention. They have produced Pocket Knowledge, a 40-page booklet with practical information for individuals released from immigration detention. Available online in French, English, Spanish, and Arabic.

[www.aila.org](http://www.aila.org)

[www.aifl.org](http://www.aifl.org)

The American Immigration Lawyers Association and the American Immigration Law Foundation provide excellent resources to attorneys practicing in the area of immigration law, including practice advisories and litigation support.

[www.asylumlaw.org](http://www.asylumlaw.org)

Free Web site run by an international consortium of agencies that help asylum seekers in Australia, Canada, the United States, and several countries in Europe. Provides links to legal and human rights resources, experts, and other information valuable for asylum seekers.

[www.ilrc.org](http://www.ilrc.org)

The Immigrant Legal Resource Center provides technical support and publications designed for nonprofits working in the area of immigration law.

[www.uscis.gov](http://www.uscis.gov)

Web site for the U.S. Citizenship and Immigration Services. This site has location and filing information for immigration benefits, including asylum. Free immigration forms may be downloaded or filed from this site. Case status information for cases pending with USCIS may be obtained.

[www.usdoj.gov/eoir](http://www.usdoj.gov/eoir)

The U.S. Immigration Court system and the Board of Immigration Appeals. This site has court and BIA location and filing information, a Virtual Law Library, and information about free immigration legal services around the United States.

## CHAPTER 8



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# PLANNING SERVICES FOR TORTURE SURVIVORS

## PLANNING SERVICES FOR TORTURE SURVIVORS

### IN THIS CHAPTER

- STEPS IN PLANNING Services
- ASSESSING THE NEEDS of Survivors and Resources
- FINANCIAL SUPPORT for Services
- DECIDING ON THE Range and Model of Services to Provide
- INCLUDING Prevention Strategies
- TRAINING AND Supporting Staff

The existing programs for torture survivors in the United States represent a wide variety of models for structuring services for torture survivors. Each program became aware of the needs of torture survivors in its own way. Some have been providing services for two decades and others are just entering the field.

Although the field of torture treatment is in its infancy, a body of knowledge has been developing over the last twenty years through accumulated clinical experience and research. Chapter 1 outlines the history of the torture treatment movement. Chapters 3 through 7 describe in some detail the major service components of programs for torture survivors: social services, psychological services, legal services and medical services.

This chapter gives additional information for program planners on needs and resource assessment, financing, choices in structuring services, and training and supporting staff in this demanding work.

This information can be used to plan specialized programs for torture survivors. It can also be used by mainstream health, social service, or legal service providers who want to adapt their existing services to serve torture survivors.

### STEPS IN PLANNING SERVICES

The major tasks involved in planning to provide services are:

**1. ASSESS NEEDS AND** existing resources. Interview key stakeholders from communi-



**ABEER AND OMAR**, now living in Amman, Jordan, were forced to leave Baghdad after the fall of Saddam Hussein.

ties affected by torture who might be beneficiaries of increased or enhanced services for their views on needs.

Inventory the agencies and individuals in the community who are already providing services to refugees and other immigrants and assess how their missions and practice may or may not make them logical partners.

**2. DETERMINE THE POSSIBLE** sources of financial support for services for torture survivors and the challenges in financing these services.

**3. DECIDE THE RANGE AND LIKELY** model of services. If planning to provide only one type of service, make a plan for how a torture survivor can be connected to other needed services. Keep in mind that many programs have begun based on available professions or funding, and expanded those services as part of a vision for integrated services when new resources became available.

**4. DECIDE WHETHER TO INCORPORATE** approaches for preventing torture into the program plan.

**5. DECIDE HOW PROGRAM STAFF** will receive the training and support on the job they need in order to carry out their roles effectively. In particular, program leaders must develop a plan for managing vicarious

trauma and its impact on clients, staff, and the organization.

Details on pursuing each step follow.

## ASSESSING THE NEEDS OF SURVIVORS AND EXISTING RESOURCES

Before designing a program it is important to find out who are the torture survivors in the community, what kinds of needs they have, and who is already trying to address those needs and with what success. If this step is omitted, you may find that few people are knocking at the door for services, too many agencies are competing for the same few funding dollars, and/or you repeat mistakes already made by others.

### INVENTORY AGENCIES AND INDIVIDUALS IN THE COMMUNITY

Who else in the community also works with refugees or torture survivors? By collaborating with others who share a common vision, you can avoid competing for limited funds, duplicating services, and putting unnecessary limits on services. State refugee coordinators are a good starting point for the inventory process. They can be located via the Web site of the Office of Refugee Resettlement, [www.acf.dhhs.gov](http://www.acf.dhhs.gov). Look for programs that are already serving immigrants from affected communities and programs whose missions seem compatible.

Existing programs for torture survivors in the United States reflect a wide range of missions. Organizations' missions are focused on the following types of services and programs:

- Treatment services exclusively for torture survivors, i.e., stand-alone

torture treatment programs

- Treatment services for a particular group, e.g. Khmers, Bosnians
- Immigrant services, e.g. resettlement agencies
- Human rights advocacy, e.g. legal advocacy organizations
- Services based on a specific discipline, e.g., cultural psychiatry, legal aid for the poor
- Services for a designated patient population, e.g. mainstream clinics in areas with high immigrant populations

Each mission offers strengths and weaknesses in providing services for torture survivors. Most important, an organization or individual interested in developing services for torture survivors must find an honest basis in mission for doing the work and anticipate where the mission may pose limits on or contradictions with what is needed to help.

If there are not many organizational resources in your community, are there interested individuals? Many existing programs started with committed individuals, taking time from their primary jobs to assist torture survivors or asylum seekers.

### INTERVIEW KEY STAKEHOLDERS FROM THOSE COMMUNITIES AFFECTED BY TORTURE

It is imperative to collaborate with affected communities to determine their needs. Ask the following questions of members of such communities: What is the range of ethnicities torture survivors are likely to come from in your community? Does the program plan to serve everyone who is eligible for services, depending on capacity, or does the program

## A SURVIVOR PERSPECTIVE ON SERVICES

Dianna  
Ortiz, an  
American  
who was  
tortured in  
Guatemala,



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writes in *The Mental Health Consequences of Torture* from the perspective of survivors: "Talk therapy is not the only form of treatment that has proved useful.

Some survivors use traditional medicines, such as natural remedies prepared by traditional healers. Others favor techniques such as body work, massage, aroma and sound therapy, special breathing and relaxation exercises, or the ancient spiritual tradition of shamanism."



plan to serve particular ethnic communities? If the torture treatment program grows out of one serving a specific ethnic community, is it open to serving torture survivors from other countries with varying linguistic needs?

In order to obtain accurate demographic information, program planners need to go beyond state refugee admissions or the usual sources for public health information. Refugee admissions vastly underestimate the actual number of refugees because they do not include secondary migration.

They also do not include immigrants who did not officially come as refugees but who may be torture survivors. School districts' English-language-learner statistics provide good proxy information on actual immigrants with children from various language groups in the community, but may exclude highly affected populations such as Liberians, whose primary language is often listed as English.

There is little local epidemiological information on torture prevalence because immigrants are usually not questioned about this exposure by health professionals. Mutual aid associations, churches and mosques serving immigrants, and literature searches for studies of similar populations abroad may provide information and numbers on populations that have experienced higher levels of torture and war trauma.

Once you have assessed who the torture survivors are in your community, how best can you provide services to

them? If services are intended for just one or a few linguistic groups, the program may need fewer interpreters because it can use staff who speak the languages of its clients. If services are open to a wide range of ethnicities, you will need to think through the linguistic needs of prospective clients and how to meet them.

Programs that move into torture treatment from a base in serving a particular ethnic group may assume that they can continue to serve only that group. However, there are several potential problems with that approach.

First, if a program receives funding from the Torture Victims Relief Act, those funds are earmarked for torture survivors, and not particular ethnic groups. If yours is the only such program in your city, you may not exclude a client based on ethnicity alone. Second, many torture survivors have deep mistrust of people from their own country, based on the particular conditions in which the torture occurred. (See Chapter 2 for more information.) Some ethnic-specific programs may replicate the divisions that developed during conflicts in the home country.

How receptive are key stakeholders to the ways in which you plan to organize services? Do your program goals fit within culturally acceptable limits? If the proposed program serves clients from many ethnic groups with differing cultural needs, how flexible can it be when providing services? For example, group

approaches to psychological services may be very popular with some people and not well accepted by others. Torture survivors from countries with no history of mental health services may be reluctant to access those services without additional education about what they are, how privacy is assured, and how their health beliefs about certain symptoms and their causes match up with the provider's.

Existing programs that serve torture survivors differ in range of served populations. Some programs limit services to specific ethnic groups. Other programs are based in a particular geographic area with one or several new immigrant groups. The majority of programs serve a multiethnic population based on their status as torture survivors. In addition to interviewing key stakeholders from affected communities, consult with existing programs that serve the same ethnic groups the proposed program plans to serve.

## FINANCIAL SUPPORT FOR SERVICES

Torture survivors often have limited financial resources; their life's accumulations may have been stolen or lost through exile, and the symptoms of torture and the limitations of their immigration status may

### FOR MORE INFORMATION

For more information on how torture affects communities, see **CHAPTER 2.**



## CASE STORY

## BUILDING SERVICES USING A DECENTRALIZED NETWORK MODEL

**A** program serving torture survivors in the Midwest began in 1998, arising out of the refugee resettlement process. One of the early program organizers worked as a counselor at a local counseling program.

She had been involved in the Sanctuary movement of faith-based organizations providing aid and comfort to Latin American refugees fleeing torture and persecution in the political upheaval of the 1980s.

By the early 1990s, she began identifying refugees who were suffering from posttraumatic stress disorder. She organized a local coalition of agencies and individuals already providing services to refugees who could address their need for mental health services.

The partners included a psychiatrist, in-home services, emergency outreach programs, and counseling programs. Using a case management model and a decentralized network of services, the informal network then began applying for funding as a group.

Clinical members of the network provided training for



educational, medical, and mental health professionals serving survivors. Referrals came from the local International Institute, medical clinics, friends and former clients, and other mental health providers.

Clients came from many countries, and the project contracted interpreters as needed. Grants funded staff, who were paid a nominal amount. The clinical director reported the advantage of their informal network was a focus on delivering services, despite limited funding.

The disadvantage was the ability of partners to withdraw: “more freedom, more vulnerability.”

In the summer of 2001, the service network incorporated as a nonprofit public benefit corporation. That status enabled it to initiate projects on its own and to seek grant funds.

Services for torture survivors flowed from a more general mission — to help refugees function at the highest level possible, thus enabling them to adjust successfully to life in a safe environment. Key staff were the clinical director and the administrative director.

This functioning network did not receive funding from the Office of Refugee Resettlement (ORR) as authorized in the Torture Victims Relief Act (TVRA) in 2003, but received some TVRA funding through the United Nations Voluntary Fund for Survivors of Torture. With limited funding, the network was still able to provide services to about 40 torture survivors per year.

In 2004, the network joined with their county’s Mental Health Board, one other treatment program, and four legal/asylum organizations to apply for TVRA funding under ORR.

They collaborated in order to avoid competing with each other for limited funds. They were one of eight programs to receive new ORR funds in late 2004.

prevent them from working. Direct client billing will be one of the least likely sources of funding for an agency working with survivors of torture, although it maybe possible with some individuals who still have personal financial resources or insurance.

Individuals and organizations who are interested in developing services for torture survivors will need to consider multiple sources of funding: individual donors and charitable foundations, medical insurance, funding from state programs and legislatures, and federal funding that is both targeted for torture victims and available more generally. As in any nonprofit organization, a diversified base of donors insures long-term financial stability.

This section begins by describing the Torture Victims Relief Act of 1998, not only because it is a dedicated pool of funding specifically for services for torture survivors, but also because it provides a legal description of what “services for torture survivors” comprise. Unfortunately, the amounts appropriated by Congress do not meet the needs of current programs, so TVRA funds should not be seen as a likely source of funding for new programs.

#### **TORTURE VICTIMS RELIEF ACT**

The Center for Victims of Torture worked closely with key members of the United States Congress to enact the Torture Victims Relief Act (TVRA) of 1998, which provides:

Assistance for treatment of torture victims — the Secretary of Health and Human

Services may provide grants to programs in the United States to cover the costs of the following services:

- Services for the rehabilitation of victims of torture, including treatment of the physical and psychological effects of torture
- Social and legal services for victims of torture
- Research and training for health care providers outside of treatment centers, or programs for the purpose of enabling such providers to provide the services described in Paragraph 1 of the legislation

When the TVRA was reauthorized in 2003, it acknowledged differences between the United Nations and the World Medical Association in defining torture. (See chapter one for these definitions.) For purposes of determining eligibility for funding, the U.S. legislation used a definition given in Section 2340(1) in Title 18, United States Code:

...an act committed by a person acting under the color of law specifically intended to inflict severe physical pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control.

This definition encompasses the use of rape or other forms of sexual violence. The term “under color of law” is defined as *when a person acts or purports to act in the performance of official duties under any law, ordinance, or regulation*. As in the case of many recent conflicts in Africa (e.g. in Liberia, Sierra Leone, Congo, Rwanda) where there are competing rebel groups and semiautonomous militias that engage in torture as a weapon of war — human rights

#### **FOR MORE INFORMATION**

Current torture treatment programs are listed in the Appendix on **PAGE 103**.



organizations have generally understood those groups to have pretensions of governance or be *sub rosa* proxies for official government action, and thus covered by the law.

The TVRA funding guidelines allow the following activities to be deemed eligible for funding, either as a whole or in varying combinations: medical, psychological, social, and legal services. If the applicant does not propose to provide all allowable services, then it is expected to show how the missing services can be accessed by a client. Partnerships with other providers are allowed as a means to insure all components are available. TVRA legislation also allows funds to be used for training service providers outside of treatment centers. As a result, those services (in theory) enable the building of networks of individuals and organizations as well as full-service treatment centers. The domestic portion of the funding is routed through the Office of Refugee Resettlement, housed in the U.S. Department of Health and Human Services.

Without a substantial increase in current appropriation levels, TVRA funds are not large enough to maintain existing treatment centers, much less establish new treatment centers in high-need areas and also support dissemination activities for networks and mainstream providers.

Individuals and organizations who are interested in developing services for torture survivors will need to consider many other, often creative, sources of funding. Some programs have succeeded in garnering funds from medical billing, state funding, private foundations, and individual donors. Not all current treatment programs receive federal funding under the

TVRA. Some had been providing services for more than 10 years before the Act was passed.

#### **UNITED NATIONS VOLUNTARY FUND FOR VICTIMS OF TORTURE**

About 20 percent of TVRA funds are routed through the United Nations Voluntary Fund for Victims of Torture, which was established by the General Assembly in 1982. These funds are distributed internationally, with a small amount going to existing United States torture treatment programs.

The UN Voluntary Fund collects voluntary contributions from UN member nations, then distributes those contributions to nongovernmental organizations and treatment centers for the purpose of assisting victims of torture and their relatives whose human rights have been severely violated as a result of torture. The Fund also may provide limited support to projects for training health care professionals specializing in the treatment of victims of torture.

#### **FUNDING LEGAL SERVICES FOR TORTURE SURVIVORS**

Some legal services for torture survivors who are eligible by income guidelines are funded through general funds for legal aid under the Legal Services Corporation. However, the Illegal Immigration and Reform Responsibility Act of 1996 made undocumented immigrants, including asylum seekers, often *not* eligible for services through Legal Aid, unless they meet one of several technical categories specified in a policy document that was released in 2003 (Federal Register, 2003). An example of this model of legal services for torture survivors is the Legal Aid Foundation of Los Angeles.

In some states, legal services for indigent immigrants seeking protection in the United

States are provided by private attorneys working on a *pro bono* (donated services) basis. *Pro bono* work is encouraged by many state bar associations. Examples of this model are Human Rights First and Minnesota Advocates for Human Rights. Chapter seven was written by attorneys working for Minnesota Advocates for Human Rights, which has worked in partnership with CVT since its formation.

A third funding source for legal services is law schools. A number have established *pro bono* clinics in immigrant law for student-training purposes and may be staffed by very experienced immigration attorneys on the faculty. Examples of programs embedded in law schools are at Georgetown, Villanova, Harvard, and St. Mary's in Houston.

### **VOLUNTEERS AND IN-KIND SERVICES**

Many existing torture services programs make extensive use of volunteers. The Center for Victims of Torture uses over 300 volunteers a year and has a dedicated staff person to manage this program. Examples of non-clinical roles include “community guides” for clients, ESL tutors, drivers, speakers bureau members, office assistants, and research assistants.

Examples of clinical roles include forensic evaluators, surgeons and other specialists, dentists, therapists, and physical and massage therapists. A clinical volunteer program requires a higher level of screening, training, and ongoing supervision.



**THE CENTER FOR VICTIMS** of Torture headquarters in Minneapolis, Minn.

© THE CENTER FOR VICTIMS OF TORTURE

Volunteers and donated services serve several aims. First, they keep the cost of providing comprehensive services down. Second, if you are careful to track the number of hours provided by volunteers and the value of donated services, these may sometimes be used as matching funds for other grants. Third, volunteers are a visible means of demonstrating the support you and your mission enjoy in the community, which can serve to attract local funding. Finally, volunteers are likely to become program donors or advocates themselves. They help to create a local constituency for torture victims and the program.

Volunteers should be treated as staff, subject to the same standards, accountability, and assistance as paid staff. Before starting to use volunteers a program must develop policies and procedures for recruitment, screening, and

orienting any volunteers. This includes writing job descriptions and determining how liability issues will be handled. Confidentiality and boundary issues need to be addressed. Consult with a local program that has a well-developed volunteer program. Many state governments also maintain an office to encourage and support volunteerism.

There are also issues specific to programs for torture survivors in using volunteers, such as managing volunteers who may have their own trauma histories and avoiding any religious proselytizing with vulnerable clients from diverse religious backgrounds. For this reason, it is important to consult with other torture treatment programs that use volunteers by contacting them directly or by contacting the CVT National Capacity Building Project staff for a recommendation.

## BUILDING A SUSTAINABLE ORGANIZATION THROUGH THE GOVERNANCE STRUCTURE

In creating a robust and durable organization, special attention should be paid to creating a strong governance structure or board of directors. Some organizations treat board development as a *pro forma* legal requirement, perhaps filling it with staff members or inexperienced volunteers. This misses an important mechanism for building new ties to the community and deprives the organization of a stabilizing influence that can help mitigate the internal dynamics of vicarious trauma.

Organizational consultants often emphasize recruiting board members who, in their mix, supply the three W's: wealth, wisdom, and work. Wealth includes personal philanthropy by the board members, but also those who have connections to resources the organization will need to carry out its mission. Wisdom may include those who know the field of trauma, but in most communities the staff will become the experts in this field and outgrow such oversight from the board. Rather than using the board to create a superstaff, it is important to include those with expertise in fields of importance to the organization but which may not exist on staff, especially not on a full-time basis. CVT has found it very useful to include health administrators, especially CEOs and other high-level administrators, who understand the dynamics of the health care delivery business and the public

policy issues that will affect its working environment; media and communications specialists; lawyers; business and political leaders; and top-level government administrators. Effort is made to create a nonpartisan board by assuring voices from varying political persuasions within the board.

Every community faces an extraordinary array of needs competing for attention and resources. An independent board of directors makes its own judgments about how the rehabilitation of torture survivors fits into the mix of necessary services that must exist to create successful communities. The payoff for the organization is that, having made that judgment, the board is the bridge back to the rest of the community to testify to the importance of this problem and the role the organization plays to solve it on behalf of the whole community. Rather than giving up power to a strong board, a staff is thus greatly strengthened in its capacity to achieve its mission.

## DECIDING ON THE RANGE AND MODEL OF SERVICES TO PROVIDE

Over the several decades that torture treatment programs have existed in the United States, many different models of intervention have been created to respond to the diverse needs of torture survivors. Differences in models can result from a number of factors: needs and desires of specific ethnic groups served, theories of practice in treatment, available resources, special expertise, and clinical experience.

## CVT'S PROGRAM MODEL

THE CENTER FOR VICTIMS OF Torture (CVT) in Minnesota is a stand-alone, multi-disciplinary treatment center serving primarily asylum seekers from a large number of countries.

CVT's integrated approach to treatment includes the following services: medical treatment, nursing care, psychotherapy, physical therapy, social work, and massage therapy.

Clients are guided through three stages of healing either individually or through a group model. These stages are:

### SAFETY AND STABILIZATION:

Re-establishing health and trust

### GRIEF AND MOURNING:

Working through what happened

### RECONNECTION:

Getting back to community, love and work.

All services are provided on an outpatient basis in facilities in Minneapolis and St. Paul. CVT's clinics are located in renovated older homes, in environments that are as home-like and welcoming as possible.

An estimated 50% to 60% of client visits require the services of skilled interpreters trained at CVT. If a client needs additional medical or specialty services, they are referred to community providers.

Resource access issues are facilitated by a large number of volunteers, such as drivers, befrienders, ELL instructors, and job counselors, etc. CVT works closely with *pro bono* attorneys who are recruited and trained by a local legal human rights organization.

CVT provides direct services to about 225 people a year, roughly two-thirds of whom are continuing clients. About the same number of people are referred to other services in the community.

## SAMPLE CASE MANAGEMENT MODEL FOR MULTIDISCIPLINARY SERVICES

INITIAL AND ONGOING CONTACT between a client and a case manager can be very helpful. The case manager documents trauma history, builds and maintains rapport throughout the client's treatment, is aware of ongoing needs and barriers, and serves as a general resource for the survivor.

INFORMED BY ONGOING case-planning discussions with the treatment team, the case manager can assist with scheduling or referrals to the appropriate multidisciplinary health care providers.

FOR EXAMPLE, torture survivors are often unable to benefit initially from in-depth psychotherapy due to their multiple psychosocial needs. Case managers may assist survivors with such psychosocial needs, teach relaxation strategies either individually or in groups, and refer them to a psychotherapist at the time they are most able to take advantage of this modality.

SIMILARLY, SURVIVORS WITH SEVERE depression or intrusive and hyperarousal symptoms of PTSD can be referred directly to a psychiatrist for treatment. Those with physical symptoms or sequelae from their torture can be referred first to primary care physicians.

CASE-MANAGEMENT DUTIES may be shared among the multidisciplinary treatment team, which often includes social workers, nurses, psychologists, and psychiatrists, depending on availability.

THE CASE MANAGER HAS PRIMARY responsibility for coordinating the survivor's care needs and informing others of changes in these needs. Similarly, it is helpful to share group educational and therapeutic services among team members who are able to provide them.

STRUCTURING TRAUMA TREATMENT teams in this manner also allows for more time-intensive resources requiring highly trained staff, such as individual psychotherapy, to be used in a more efficient manner, as clients will begin this intervention once their immediate psychosocial needs have stabilized.

## MODELS OF TREATMENT AND SERVICE PROVISION IN THE UNITED STATES

Below are the primary types of models categorized by organizational structure and range of services, drawn from current program examples. The Web site for the National Capacity Building Project contains organizational profiles and updated contact information on participating programs. Go to [www.cvt.org](http://www.cvt.org) and click on Building Healing Communities.

**1. MODELS BY ORGANIZATIONAL STRUCTURE:** The choice of organizational structure often follows from the mission. Stand-alone programs bear all the burdens and benefits of independence: building a board of directors, finding and maintaining resources, strategic planning and leadership. But these centers provide most services needed by torture survivors in a "one-stop shopping" framework. Hospital or university-based programs may draw upon academic expertise and institutional strength. Programs embedded in larger agencies may encompass a greater range of services for the client or reflect a particular ethnic expertise, but may suffer from a lack of attention or compete internally for funding.

Decentralized collaborations are a way to share scarce resources and still provide all or most components of healing. They may also be a means to increase community support in welcoming new refugee groups. They may, however, lack enough of a strong center to grow or mature and may, in particular, have more diffi-

culty accumulating knowledge and improving clinical skills.

**2. MODELS BY RANGE OF SERVICES:** Multidisciplinary centers have developed successful trauma treatment models that integrate medical, psychological, social, somatic, and legal components. A variety of treatment models may be applied in treating survivors of torture. The essential components involve creating a supportive environment, establishing a trusting relationship, and providing appropriate multidisciplinary services at a time when the individual may best avail him or herself of that treatment.

Decentralized referral networks offer a choice, especially when a full-service specialized torture treatment program may not be financially feasible for your community. A program that links together different agencies and individuals can leverage existing resources and start providing intentional services for torture survivors with less funding. Many programs have started with the vision and energy of committed individuals and later expanded as more resources became available.

Single-service programs have developed a special expertise that is of vital importance to torture survivors and may serve as a source of learning for others in the torture treatment movement. Currently, programs that provide legal services for asylum seekers are the most common examples of single-service programs receiving TVRA funding. These programs have close relationships with agencies providing torture treatment services so that their clients have access both to evaluation services and treatment.

## PREVENTION STRATEGIES

In addition to direct services for torture survivors, torture treatment programs and human rights organizations may include preventing torture in their mission statements. For example, the mission of the Center for Victims of Torture is “to heal the wounds of torture on individuals, their families, and their communities and to stop torture worldwide.”

In the field of public health, prevention is generally categorized as primary prevention, directed at averting a potential health problem; secondary prevention, directed at early detection and intervention to delay onset or mitigate a health problem; or tertiary prevention, directed at minimizing disability and avoiding relapse. Tertiary prevention can take place within the context of individual treatment or within a community setting targeting an affected population.

Prevention, as it applies to torture, may operate outside the usual boundaries of health and include a wide range of tactics and targets. The New Tactics in Human Rights Project, coordinated by the Center for Victims of Torture, encourages creative use of tactics, drawing from many sectors, to protect and extend human rights around the world and is an example of prevention of torture. A workbook and series of tactical notebooks are available online at [www.newtactics.org](http://www.newtactics.org).

The following are examples of primary and secondary prevention strategies:



**"THEY ASKED ME** to give them a sewing machine," said Morie Momah, 50, of Gbalahun, Kailahun district in Sierra Leone. "I said, 'I don't have one ...' He was a tall man. I could not know his name ... He cut my arm off and they ran into the bush."

### 1. LEGAL ADVOCACY FOR JUSTICE AND ACCOUNTABILITY OF PERSECUTORS:

The Center for Justice & Accountability (CJA, [www.cja.org](http://www.cja.org)) in San Francisco works to deter torture and other severe human rights abuses around the world by helping survivors hold their persecutors accountable. CJA represents survivors in civil suits against persecutors who live in or visit the United States. CJA is pioneering an integrated approach to the quest for justice that combines legal representation with referrals for needed medical and psychosocial services, and outreach to schools, community organizations, and the general public.

### 2. COMMUNITY EDUCATION ON TRAUMA EFFECTS AND COPING:

Education in communities affected by torture is a key secondary prevention strategy. When survivors recognize the common aftereffects of torture and understand that their symptoms and coping responses are a normal response to

traumatic events, they are more likely to seek help. Also, community education builds awareness of available treatments for survivors and their families.

Trauma coping strategies are behaviors that have helped other trauma survivors to feel better. Trauma survivors may consider exploring one or more of these strategies in order to facilitate their own recovery.

### 3. SCREENING, ASSESSMENT, AND EARLY TREATMENT OR REFERRAL IN THE PRIMARY CARE SETTING:

Despite ongoing needs and the potential for great benefit from mental health services, many refugees do not perceive they are in need of treatment, nor do they conceptualize their trauma symptoms in terms of Western mental health concepts. Many are reluctant to access mental health services even when referred.

For these reasons, primary care providers are often the only health care professionals available to detect and treat the problems resulting from trauma. The roles of physicians and nurses are well known and accepted across cultures. Thus, primary care providers provide a critical entry point for identifying trauma survivors needing help, providing treatment in the primary care setting, if appropriate, and using their ongoing relationship to facilitate successful mental health referrals. Early intervention in treating trauma symptoms is important in preventing future disability and prolonged suffering.

Torture treatment specialists, such as psychologists and psychiatrists, may work with primary care providers in clinics that see high numbers of refugees likely to have experienced torture. These specialists help providers to recognize the effects of torture and provide treatment when possible. They also work to minimize stigma regarding seeking mental



# TRAUMA EDUCATION INCLUDES INFORMATION THAT:

NORMALIZES TRAUMA  
experiences and  
symptoms

REVIEWS SYMPTOM  
course and prognosis

DESTIGMATIZES  
mental health care

REVIEWS THE EFFECTS  
of additional stress in  
exacerbating symptoms

RELATES TRAUMA,  
stress, and somatic  
symptoms

FACILITATES  
appropriate grieving

PROVIDES AWARENESS  
of successful trauma  
treatment methods

EMPHASIZES  
medication compliance

REVIEWS IMPORTANT  
self-healing or coping  
strategies

health treatment and may facilitate successful referrals of torture survivors to mental health professionals.

**4. PREVENTION STRATEGIES USED BY TREATMENT CENTERS OUTSIDE THE UNITED STATES:** Some torture rehabilitation centers outside of the United States conduct a variety of preventative efforts.

While many are specific to their settings and not directly applicable to the United States, they may stimulate ideas of approaches in your community.

One such effort in East Asia involves outreach to isolated, rural areas using mobile clinics. A physician and legal staff member travel to the rural site and conduct general sensitization trainings regarding the effects of torture and treatments available. They also document abuse reported by local populations for use in their advocacy efforts against those who perpetrate, sponsor, and condone torture. Moreover, these mobile clinics inform the public as well as torture survivors of their rights and redress available to those who have been harmed.

In many countries, torture occurs in prisons and police detention centers. Many torture rehabilitation centers target such places by providing medical services to prisoners. Through these visits they are able to treat torture survivors, document additional torture, educate guards about the effects of their actions, and use their documentation to advocate changing institutional policies with appropriate decision-makers.

Some treatment centers in East Africa

have trained police or military officials as a strategy to prevent torture. Through sensitization about human rights, the effects of physical and psychological abuse, and legal statutes, centers have been helpful in changing norms of behavior among police and military officials. Trainings have also been conducted among the judiciary on the practice of torture in a specific country, its effects on victims, and how this may affect their testimony or willingness to press charges. These approaches and many others can be found through the New Tactics in Human Rights Project ([www.newtactics.org](http://www.newtactics.org)).

## TRAINING AND SUPPORTING STAFF

Working with torture survivors is specialized and challenging work. Staff who work in torture treatment programs are mission-driven individuals. However, many in the field have written about the effects that working intimately with clients who have been severely traumatized can have on the caregivers. The effects have been summarized as vicarious traumatization or secondary trauma. Vicarious traumatization has been defined as “a transformation in one’s inner experience resulting from empathic engagement with clients’ traumatic material” (Pearlman and Saakvitne, 1995). The effects on the provider have been discussed in earlier chapters of this book, along with suggestions for self-care. (See Chapters 3 and 6.)

Besides self-care, an organization needs to manage the effects of secondary trauma on staff, clients, and the organization as a whole. Secondary trauma can affect staff morale, staff retention, and the quality of services to clients.

For the program planner, two aspects of

## FOR MORE INFORMATION

For more information on public education strategies, see **CHAPTER 5**. Another source is CVT’s publication, *Helping Refugee Trauma Survivors in the Primary Care Setting*, online at [www.cvt.org](http://www.cvt.org).



minimizing and managing vicarious or secondary trauma are especially relevant. One is adequate training; the other is institutional policies and mechanisms to support staff in their work.

### RESOURCES FOR TRAINING STAFF IN TORTURE TREATMENT PROGRAMS

Training staff in the skills and knowledge needed to provide effective interventions with torture survivors happens at various points in a program's development. In a new organization, staff who will be working primarily with torture survivors will need in-depth training and orientation to the history and issues of the torture treatment and human rights movements across the globe, as well as focus on the research base and clinical skills needed to provide effective care.

Volunteers, *pro bono* professionals, and specialty providers within a referral network will need sensitization and skills training.

Once a program has developed a level of expertise through experience working with survivors of torture, it may seek to disseminate its expertise to others whose work includes but does not focus exclusively on torture survivors — students, other professionals interested in taking up the work, and refugee leaders. Training curricula and approaches must be tailored to the audience and trainers must be clear about what they expect from participants as an outcome of the training offered.

As outlined in Chapter 3, providers need to develop the following four core competencies when working with torture survivors:

- Knowledge of the life experiences and resettlement

issues of refugees and asylees

- Understanding the dynamics of torture and the long-term effects of torture
- Cultural competence in working with traumatized people
- Working with effectively with skilled interpreters

These core areas form the general foundation for training content.

The field of torture treatment is in its early stages, pulling in expertise from earlier work on posttraumatic stress disorder and trauma in veterans, battered women, and abused children. Only a few higher education programs and traumatic stress institutes exist that prepare clinicians to provide treatment to victims of extreme political violence. Torture treatment programs have needed to provide internal training and capacity-building to supplement the training available in traditional higher education.

The Torture Victims Relief Act also funds training activities. Since 2000, the Center for Victims of Torture has received TVRA funds to organize training and capacity-building activities for programs providing services to torture survivors that are funded by TVRA, or are members of the National Consortium of Torture Treatment Programs. CVT maintains a parallel project working with specialized treatment centers in countries where torture is prevalent.

Training and capacity-building strategies include two-day institutes, conference calls, small subgrants, self-assessment tools, web resources, and phone consultation with various content experts. For more information visit the Center's National Capacity

### TRAUMA-COPING STRATEGIES

REDISCOVERING  
innate resiliency

INCORPORATING  
regular physical  
exercise

DEVELOPING HELPFUL  
relaxation techniques

FACILITATING  
spirituality and  
religious beliefs

RECREATING  
meaning in life

ENCOURAGING  
employment and  
hobbies

STRENGTHENING  
social connections

MINIMIZING  
maladaptive coping

LIMITING EXPOSURE  
to trauma reminders

Building Project Web Resource Center at [www.cvt.org](http://www.cvt.org).

A number of programs have developed training materials, videos, and web content as part of this process. All are available to others either for a cost or for no charge via their organizations' Web sites. Current programs and their sites are listed in the Appendix of this guide.

### **POLICIES TO MINIMIZE EFFECTS OF SECONDARY TRAUMA ON STAFF**

It is important that organizations internally practice the democratic and human rights principles that they support and provide fair treatment to their employees. The components of an institutional approach to reducing staff stress and secondary trauma include adequate health insurance, paid time off, continuing education, and resources with which to do the work with clients.

Opportunities for staff members to control aspects of their work and opportunities for job variation and breaks from direct trauma client work also help minimize the results of secondary trauma. An excellent article to read on this subject is "Helpers' Responses to Trauma Work: Understanding and Intervening in an Organization" (1995) by Rosenbloom, Pratt, and Pearlman.

Supportive connections among staff members are established with structured, planned means of talking about stress and secondary trauma built into the workplace. These means including procedures for debriefing after crises, critical incidents, or difficult work situations. On-going support groups provide

opportunities to notice symptoms within oneself or in other group members.

Support groups can form among members of a profession, such as the organizations' social workers, or develop from multidisciplinary work teams. Debriefings can take place in large groups, such as staff meetings, or in meetings as small as one-to-one discussions with a co-worker, supervisor, or senior clinician.

Building these components into a program for torture survivors has budgetary and structural implications that must be taken into account.

Funding is often unpredictable in the world of nonprofit organizations, and this can add to the stress within an organization working with trauma survivors. Clinicians must build long-term relationships of trust to help survivors recover. Therefore, economic instability, staff reductions, and other fluctuations in staffing have professional and moral implications, as well as personal ones.

The organization should invest in sound financial systems and personnel to improve planning and minimize disruptions. That should include building a cash reserve that would allow the organization to fulfill its commitment to its clients despite sudden downturns.

Torture survivors carry a great deal of fear and transmit it to the organization. Earlier chapters have discussed how to handle this clinically. Managerial leadership can help the process by creating an organization that is well connected to the community and to powerful stakehold-

ers who will support its mission and encourage its success.

The clinical process is enhanced when torture survivors perceive that the organization works to protect them and their families. Strong ties to members of Congress, for example, can often be built through their local staff who provide constituency services, such as refugee resettlement and asylum cases. Visits to the center with staff and clients by public officials (mayors, governors, members of Congress, etc.) can develop strong bonds to the organization, but also give clients the opportunity to be listened to and respected by people with power.

### TRAINING TO BUILD NETWORKS OF SUPPORT FOR TORTURE SURVIVORS IN LOCAL COMMUNITIES

Most mature torture treatment programs have begun to offer training and outreach to health and social services professionals and policy-makers. Such mainstream training can increase the number of torture survivors able to receive services and educate the next generation of professionals about the special needs of immigrant populations. Also, influential members of the community can be sensitized to the problem of torture and can play active roles in defending and expanding human rights.

More established torture treatment programs also train volunteers as a strategy for expanding support for torture survivors.

Volunteers, in addition to expanding the quantity and breadth of services available to survivors, may also become pro-

gram donors, program advocates, and advocates for human rights in general.

Another approach to training is to create in-depth, ongoing interactions with refugee-led mutual assistance associations, or refugee-focused nonprofit organizations that offer special services beneficial to torture survivors.

Refugee-led organizations typically assist torture survivors with a variety of needs. Some conduct health education or trauma education efforts, while others provide supportive or educational groups for survivors.

Such services are greatly enhanced by ongoing consultation with torture rehabilitation center staff. Collaborations between refugee-focused organizations and torture treatment programs are mutually beneficial, allowing the exchange of specialized knowledge about certain issues and referrals for specialized services (e.g., with a legal organization serving refugees and/or asylum seekers).

Training an ever wider audience has the obvious appeal of stretching limited funds to cover a greater number of torture survivors. Specialized torture treatment programs, through years of engagement with torture survivors from many different countries, create a knowledge base of best practices.

Knowledge dissemination can only work if the specialized torture treatment programs continue to grow and learn. These programs serve as “centers of excellence” and visible beacons of hope for survivors of torture around the world. ■

## REFERENCES

Pearlman, L.A. & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton & Co.

Rosenbloom, D., Pratt, A., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 65-79). Lutherville, MD: Sidran

## ADDITIONAL RESOURCES

<http://www.compasspoint.org>  
CompassPoint Nonprofit Services  
Many publications and CompassPoint Board Café e-newsletter are “short enough to be read over a cup of coffee.”

<http://www.mncn.org>  
Minnesota Council of Nonprofits  
This organization sells a variety of publications at low prices that are useful for nonprofits across the country, such as *No Surprises: Harmonizing Risk and Reward in Volunteer Management, Handbook for Starting a Successful Nonprofit*

<http://www.nonprofitrisk.org>  
Nonprofit Risk Management Center

The mission of this organization is to help nonprofits cope with uncertainty. It offers a wide range of services (from technical assistance to software to training and consulting help) on a vast array of risk management topics (from employment practices, to insurance purchasing to internal controls and preventing child abuse). The Nonprofit Risk Management Center does not sell insurance or endorse organizations that do.



# APPENDIX

## APPENDIX

## IN THIS SECTION

- COUNTRY information
- LANGUAGES
- TORTURE TREATMENT Programs in the United States
- HUMAN RIGHTS
- COMMUNITY RESOURCES
- ORGANIZATIONS WITH Developed Training Curricula
- ONLINE TRAINING Courses
- OTHER LINKS

Information on providing services to torture survivors is available from a variety of sources. There are many books and journals accessible from libraries as well as numerous online resources. The following is not a comprehensive list of resources but provides a good starting point for those seeking more information.

Reference help from many libraries is available online through email and real-time interactive chat. Library catalogs and databases of journals are also available online. Librarians, trained in resources of all types, will help with research.

### COUNTRY INFORMATION

Many sources of information on countries are online. Some present only facts and figures, while others provide images or information with a definite viewpoint. Four of the following sources are portals containing links to many other worthwhile sites and two are map sites. They are reliable and generally well maintained. The information they contain is up to date. Several individual sites are also included.

[www.cia.gov/cia/publications/factbook](http://www.cia.gov/cia/publications/factbook)

The CIA World FactBook contains geographic, political, and demographic information as well as reference maps and other information.

[www.state.gov/r/pa/ei/bgn](http://www.state.gov/r/pa/ei/bgn)

The United States State Department's Country Background Notes. Includes information about people, history, government, political conditions, economy, and foreign relations of various countries.



CAMP FOR PALESTINIAN refugees in Lebanon in 1999.

©www.un.org/unrwa/

[www.amnesty.org](http://www.amnesty.org)

Amnesty International's (AI) Web site embraces information on current human rights issues, AI publications, and reports in a range of languages, as well as links to other human rights-related Web sites.

[www.un.org](http://www.un.org)

Web site of the United Nations

[www.incore.ulst.ac.uk](http://www.incore.ulst.ac.uk)

The Web site of INCORE (International Conflict Research) constitutes a set of country portals focusing on conflict and ethnicity, with emphasis on online news sources of various types. Judgment of content is left to the reader.

[www.lib.umich.edu/govdocs/foreign.html](http://www.lib.umich.edu/govdocs/foreign.html)

University of Michigan Documents Center: Foreign Government Resources on the Web. An authoritative site of government document links, many of which are not on other lists. It serves as a central reference and referral point for government information, whether local, state, federal, foreign or international, with emphasis on the areas of government, political science, statistical data, and news.

[www.un.org/Depts/Cartographic/english/htmain.htm](http://www.un.org/Depts/Cartographic/english/htmain.htm)

UN Cartographic Section:

A team of experienced mapping and GIS specialists at the cartographic authority

for the United Nations creates the very detailed maps. Many maps produced by the Section are an integral part of UN documents and others are prepared for use by the Security Council and not for general distribution. The content is updated regularly.

[www.lib.utexas.edu/maps](http://www.lib.utexas.edu/maps)

The University of Texas map collection currently has 5,715 of its map images online. The U.S. Central Intelligence Agency produced the maps, unless otherwise indicated. They are in the public domain and can be freely downloaded and printed. The country maps have less detail than those from the UN. The maps available for a particular country or region vary from few to many and include historical and nautical maps.

## LANGUAGES

[www.ethnologue.com](http://www.ethnologue.com)

Ethnologue is potentially the most comprehensive Web site about languages of the world, the result of over 50 years of research into lesser-known languages. A special feature is the language maps. Print and CD-ROM versions of the 14th edition are available for purchase.

## TORTURE TREATMENT PROGRAMS IN THE UNITED STATES

A list of service providers in the United States who work with torture survivors is on Pages 108-111. This list is not comprehensive. It includes members of the National Consortium of Torture Treatment Programs (NCTTP), as well as organizations that have received funding from the Office of Refugee Resettlement. The NCTTP advances the knowledge, technical capacities and resources devoted to the care of torture survivors and acts collectively to prevent torture worldwide. There are 35 member organizations in 21

states. More information on many of these programs can be found at the NCTTP Web site <http://ncttp.westside.com>.

## HUMAN RIGHTS

[www1.umn.edu/humanrts](http://www1.umn.edu/humanrts)

The University of Minnesota Human Rights Library produces human rights topic guides offering introductions to various human rights issues. The guides present definitions, key rights at stake, human rights instruments, and protection and assistance agencies.

[www.un.org/Overview/rights.html](http://www.un.org/Overview/rights.html)

United Nations Universal Declaration of Human Rights

[www.unhchr.ch/udhr](http://www.unhchr.ch/udhr)

The United National Declaration of Human Rights translated into more than 300 languages.

[www.ohchr.org](http://www.ohchr.org)

The United Nations Office of the High Commissioner for Human Rights

[www.newtactics.org](http://www.newtactics.org)

The New Tactics Project is an international initiative led by a diverse group of organizations and practitioners from around the world. The project is coordinated by the Center for Victims of Torture and grew out of its experience as a creator of new tactics and as a treatment center that also advocates for the protection of human rights from a unique position — one of healing and reclaiming civic leadership.

Accessible to read or download on this site are *New Tactics in Human Rights: A Resource for Practitioners*, a 200-page book that describes several innovative approaches to protecting human rights, and Tactical Notebooks that describe the implementation of various tactics, factors influencing their use, and the challenges that surfaced along the way. This Web site has a searchable database of tactics to help end human rights

abuses. The site hosts a discussion forum conducted in French, Russian, Spanish, and Turkish as well as English.

## COMMUNITY RESOURCES

[www.searac.org](http://www.searac.org)

The Southeast Asia Resource Action Center began operation in 1979. It is a national organization working to advance the interests of Cambodian, Laotian, and Vietnamese Americans through leadership development, capacity building and community empowerment. The organization recently compiled the Southeast Asian American Statistical Profile, found at [www.searac.org/seastat/profilemay04.pdf](http://www.searac.org/seastat/profilemay04.pdf)

[www.acf.hhs.gov/programs/orr](http://www.acf.hhs.gov/programs/orr)

The Office of Refugee Resettlement plans, develops and directs implementation of a comprehensive program for domestic refugee and entrant resettlement assistance. It develops, recommends, and issues program policies, procedures and interpretations to provide program direction. Search this site for funding opportunities and links to organizations and programs that provide services to refugees and immigrants.

[www.acf.dhhs.gov/programs/orr/partners/coordina.htm](http://www.acf.dhhs.gov/programs/orr/partners/coordina.htm)

Contact information for state refugee coordinators. These offices help locate resettlement agencies in each state or region. This page has links to national mutual assistance organizations.

[www.211.org](http://www.211.org) (or, by telephone, dial 2-1-1)

211 is a service active in 31 states that can help with information and referrals on a wide variety of topics. While services offered through 211 vary from community to community, it provides access to services such as basic human needs (food banks, shelters, and rent assistance), physical and mental health resources, and employment supports.

[www.refugees.org](http://www.refugees.org)

United States Committee for Refugees



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(USCR) site introduces information on global refugee issues. The USCR publishes *Refugee Reports*, a monthly information service providing in-depth coverage of: refugee resettlement in the United States, federal legislation affecting refugees and asylum seekers, analysis of court decisions that affect refugees, conditions in first asylum camps around the world, annual statistics on refugees, internally displaced persons, and asylum seekers. They publish the *Annual Refugee Survey*, an authoritative report that reviews refugee conditions and government policies affecting refugees, asylum seekers, and displaced persons.

## ORGANIZATIONS WITH DEVELOPED TRAINING CURRICULA

Many of the established torture treatment centers in the United States have developed training curricula on various topics related to providing services to torture survivors such as identifying and treating torture survivors, secondary traumatization, the social effects of torture and more culturally-specific informa-



tion on certain groups.

The Center for Victims of Torture in Minneapolis offers a self-study course for primary care physicians based on the videos *From Terror to Healing*. This two-part video and study guide can be purchased through the Center for Victims of torture at [www.cvt.org](http://www.cvt.org).

For in-depth training, the International Trauma Studies Program in New York offers a Postgraduate Certificate Training Program in International Trauma Studies. This is a nine-month training program for professionals working with survivors of domestic and communal violence, war and refugee trauma, natural and human-made disasters. More information is available at [www.nyu.edu/trauma.studies/programs\\_description.htm](http://www.nyu.edu/trauma.studies/programs_description.htm)

## ONLINE TRAINING COURSES

The Boston Center for Refugee Health and Human Rights at [www.bcrhhr.org](http://www.bcrhhr.org) offers the online course “Caring for Refugees and Survivors of Torture.”

An introductory Internet-based human rights course for health professionals (physicians, nurses, social and public health workers, psychologists), lawyers, trainees, and human rights advocates who want to learn about survivors of torture and refugee trauma.

The Manager’s Resource Center offers the online course “The Providers Guide to Quality and Culture” at <http://erc.msh.org>. This course is designed to assist health care organizations in providing high-quality, culturally competent services to multi-ethnic populations.

## OTHER LINKS

[www.irct.org](http://www.irct.org)

International Rehabilitation Council for Torture Victims. This site links to human rights and torture treatment programs around the world. The IRCT maintains a documentation center with a searchable database and hosts an online forum on torture-related topics.

<http://kspope.com/torvic/torture.php>

Resources for Torture Survivors, Refugees, Asylum-Seekers, and People Affected by War. This site accommodates links to treatment centers, online training, information about asylum and refuge and other information.

[www.phrusa.org](http://www.phrusa.org)

Physicians for Human Rights Includes access to two publications on torture evaluation that can be ordered or downloaded as PDF (portable document format) files:

*Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment United Nations Document, August 1999*

*Examining Asylum Seekers: A Health Professional’s Guide to Medical and Psychological Evaluation of Torture*

[www.crisisgroup.org](http://www.crisisgroup.org)

The International Crisis Group Web site updates information on conflict situations around the world. The site offers reports and briefings, as well as searchable databases of conflict histories, maps and other information.

[www.afpnet.org](http://www.afpnet.org)

The Association of Fundraising Professionals Web site gives information about fundraising, online handbooks, and a searchable directory of consultants and resource partners. ■



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001-718-52248

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ORGANIZATION	PHONE	FAX	ADDRESS	CITY	STATE	ZIP	WEBSITE
Center for the Prevention and Resolution of Violence	520-628-7525	520-295-0116	317 W. 23rd St.	Tucson	AZ	85713	www.hopifoundation.org
Center for Survivors of Torture (AACI)	408-975-2750 Ext. 250	408-975-2745	2400 Moorpark Ave., Suite #308	San Jose	CA	95128	www.aaci.org
Institute for the Study of Psychosocial Trauma	650-424-1314	650-424-0304	380 Edlee Ave.	Palo Alto	CA	94306	
Legal Aid Foundation of Los Angeles	213-640-3921	213-640-3911	5228 E. Whittier Blvd.	Los Angeles	CA	90022	www.lafla.org
Program for Torture Victims	213-747-4944	213-747-4662	3655 S. Grand Ave., #290	Los Angeles	CA	90007	www.phvla.org
St. Anselm's Cross-Cultural Community Center	714-437-0608 Ext. 302		13091 Galway St.	Garden Grove	CA	92844	www.saintanselm.org/ccs.htm
Survivors International	415-546-2080	415-546-2084	703 Market St., #301	San Francisco	CA	94103	www.survivorsintl.org
Survivors of Torture, International	619-278-2407	619-294-9429	P.O. Box 151240	San Diego	CA	92175	www.nortorture.org
The Center for Justice and Accountability	415-544-0444	415-544-0456	870 Market St., Suite #684	San Francisco	CA	94102	www.cja.org
Rocky Mountain Survivors Center	303-321-3221, Ext. 206	303-321-3314	1547 Gaylord St.	Denver	CO	80206	www.rmcsdenver.org
Khmer Health Advocates	860-561-3345	860-561-3538	29 Shadow Lane	West Hartford	CT	06110	www.cambodianhealth.org
Torture Abolition and Survivors Support Coalition (TASSC)	202-529-2991	202-526-4611	4121 N.E. Harewood Road, Suite B	Washington	DC	20017	www.tassc.org

ORGANIZATION	PHONE	FAX	ADDRESS	CITY	STATE	ZIP	WEBSITE
Florida Center for Survivors of Torture — A Program of Gulf Coast Jewish Family Services Inc.	727-450-7273	727-450-7285	407 S. Arcturus Ave.	Clearwater	FL	33765	www.gcjfs.org
DeKalb County Board of Health	404-294-3813	404-508-7844	455 Winn Way Suite #150	Decatur	GA	30030	www.dekalbhealth.net
The Marjorie Kovler Center for the Treatment of Survivors of Torture	773-381-4070	773-381-4073	1331 W. Albion	Chicago	IL	60626	www.heartland-alliance.org
Boston Center for Refugee Health and Human Rights	617-414-5082	617-414-4796	1 Boston Medical Center Place Dowling 7	Boston	MA	02118-2393	www.bcrhr.org
Harvard Program in Refugee Trauma	617-876-7879	617-876-2360	22 Putnam Ave.	Cambridge	MA	02139	www.hprr-cambridge.org/
International Survivors Center c/o International Institute of Boston	617-695-9990	617-695-9191	1 Milk St.	Boston	MA	02109	www.iiboston.org
Lowell Community Health Center	978-746-7851	978-275-9890	585-597 Merrimack St.	Lowell	MA	01854	www.lchealth.org
Advocates for Survivors of Trauma and Torture	410-464-9006	410-464-9010	431 E. Belvedere	Baltimore	MD	21212	www.astt.org
Lutheran Immigration and Refugee Service, Detained Torture Survivor Legal Support Network	410-230-2718	410-230-2893	700 Light St.	Baltimore	MD	21230	www.lirs.org

ORGANIZATION	PHONE	FAX	ADDRESS	CITY	STATE	ZIP	WEBSITE
ACCESS Center for Torture Survivors	313-945-8137	313-624-9418	6450 Maple	Dearborn	MI	48126	www.accesscommunity.org
Center for Victims of Torture	612-436-4800	612-436-2606	717 East River Road	Minneapolis	MN	55455	www.cvt.org
Minnesota Advocates for Human Rights	612-341-3302	612-341-2971	650 Third Ave. S., #550	Minneapolis	MN	55402	www.mnadvocates.org
Center for Survivors of Torture and War Trauma	314-533-4114	314-968-4434	1077 S. Newsstead	St. Louis	MO	63110	www.silcenterforsurvivors.org
War Trauma Recovery Project	314-771-7061		P.O. Box 63100	St. Louis	MO	63163	www.stlouis.missouri.org/wtr/index.html
F.I.R.S.T. Project, Inc. (For Immigrants and Refugees Surviving Torture)	402-488-6760	402-488-6742	1550 S 70th St., Suite #200	Lincoln	NE	68510	www.firstproject.org
Cross-Cultural Counseling Center, International Institute of New Jersey	201-653-3888 Ext. 112	201-963-0252	1 Journal Square, Fourth Floor	Jersey City	NJ	07306	www.iinj.org
Bellevue/NYU Program for Survivors of Torture	212-994-7169	212-994-7717	462 First Ave. S., 7th Floor, Room 710	New York	NY	10016	www.survivorsoftorture.org
Doctors of the World-USA Inc. Human Rights Clinic	212-226-9890	212-226-7026	375 W. Broadway Fourth Floor	New York	NY	10012	www.doctorsoftheworld.org
International Trauma Studies Program-REFUGE	212-691-6499	212-807-1809	155 Avenue of the Americas Fourth Floor	New York	NY	10003	www.nyu.edu/trauma.studies

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Safe Horizon / Solace	646-825-2227	718-457-6071	74-09 37th Ave., Room #412	Jackson Heights	NY	11372	www.safehorizon.org
Center for Victims of Torture at Jewish Family Services	614-559-0169	614-231-4978	1151 College Ave.	Columbus	OH	43209	www.jfscolumbus.org
Amigos Multicultural Services Center	541-484-2450	541-485-7293	P.O. Box 50473	Eugene	OR	97405	www.amigosmsc.org
Torture Treatment Center of Oregon	503-494-6148	503-494-6143	OHSU 3181 S.W. Sam Jackson Park Road UHN 88	Portland	OR	97201- 3098	
Liberty Center for Survivors of Torture	215-747-7500 Ext. 249	215-276-5533	231 N. 63rd St.	Philadelphia	PA	19139- 1111	
Center for Survivors of Torture	218-887-4101	214-827-9246	4123 Junius	Dallas	TX	75206	www.cstdallas.org
Boat People SOS	281-530-6888	281-530-6838	11205 Bellaire Blvd., Suite B22	Houston	TX	77072	www.bpsos.org
Asian Association of Utah	801-467-6060	801-486-3007	1588 S. Major St.	Salt Lake City	UT	84115	www.aau-slc.org
Utah Health and Human Rights Project	801-363-4596	801-363-6068	309 E. 100 South, Suite #11	Salt Lake City	UT	84112	www.uhhp.org
Program for Survivors of Torture and Severe Trauma (PSTT) at CMHS	703-533-3302	703-237-2083	701 W. Broad St. Suite #305	Falls Church	VA	22046	www.cmhsweb.org