

“...LIKE A REFUGEE CAMP ON
FIRST AVENUE”

Insights and Experiences from the Bellevue/NYU
Program for Survivors of Torture

Editors:

Hawthorne E. Smith, Ph.D.

Allen S. Keller, M.D.

Dechen W. Lhewa, M.A.

Copyright © May 2007 by The Bellevue/NYU Program for Survivors of
Torture.
New York City.
All rights reserved.

Printed in the United States of America.

ISBN: 978-0-9797197-0-7

COVER DESIGN: Original art work by Haja Kalle.

This manual was made possible thanks to the generous support of the Jacob
and Valeria Langeloth Foundation.

The Bellevue/NYU Program for Survivors of Torture

The Bellevue/NYU Program for Survivors of Torture provides comprehensive, multidisciplinary care addressing the medical, mental health, and social service needs of torture survivors and their families residing in the New York metropolitan area. The Bellevue/NYU Program brings together clinical and academic resources from Bellevue Hospital, the oldest public hospital in the United States, and New York University School of Medicine. Since its inception in 1995, the program has cared for more than 2,000 men, women and children from over 80 countries.

In addition to providing direct patient services, the Bellevue/NYU Program also serves as a training and resource center for organizations, locally, nationally, and internationally, assisting refugee and immigrant populations. It is one of the largest torture treatment centers in the United States and has established an international reputation for excellence in patient care, clinician training and other educational programs, research and advocacy. The program has received numerous awards including the Jim Wright Vulnerable Populations Award from the National Association of Public Hospitals, the Roger E. Joseph Prize from Hebrew Union College, and the 2006 Hero Award from the Robin Hood Foundation.

Bellevue/NYU Program for Survivors of Torture
Bellevue Hospital
462 First Avenue, C&D Building, Suite #732
New York, NY 10016
Phone: 212-994-7170
Fax: 212-994-7177
Website: www.survivorsoftorture.org

The Bellevue/NYU Program for Survivors of Torture is a member of the National Consortium of Torture Treatment Programs (NCTTP) and the International Rehabilitation Council for Torture Victims (IRCT). Information on NCTTP, IRCT and their members can be found at: <http://ncttp.westside.com/wsContent/> and www.irct.org respectively.

Table of Contents

About the Editors	p. vi
Contributing Authors	p. vii
Acknowledgements	p. viii
Introduction	p. xii

Contextual Issues

- 1. The Context in Which Treatment Takes Place:
The Multi-Faceted Stressors Facing
Survivors of Torture and Refugee Trauma** **p. 1**
Hawthorne E. Smith, Ph.D. & Allen S. Keller, M.D.
- 2. Multicultural Issues in the Treatment of Survivors
of Torture and Refugee Trauma: Toward an
Interactive Model** **p. 38**
Hawthorne E. Smith, Ph.D.
- 3. Immigration Dynamics: Processes, Challenges,
and Benefits** **p. 65**
John Wilkinson, M.A.
- 4. The Use of Interpreters with Survivors of Torture,
War, and Refugee Trauma** **p. 82**
Adéyinka M. Akinsulure-Smith, Ph.D.

Treatment and Service Provision Issues

5. **The Clinical Interview and Programmatic Intake Process** **p. 106**
Allen S. Keller, M.D. & Hawthorne E. Smith, Ph.D.

6. **Treatment Techniques and Priorities: A Psychological Approach to the Patient** **p. 126**
Hawthorne E. Smith, Ph.D.

7. **Medical Evaluation and Care for Survivors of Torture and Refugee Trauma** **p. 167**
Allen S. Keller, MD, Jonathan Leviss, MD, Nancy Levy, BA, Deborah Dyson, PA, MS.

8. **The Psychiatric Care of Survivors of Torture, Refugee Trauma, and Other Human Rights Abuses** **p. 217**
Asher Aladjem, M.D., F.A.P.M.

9. **Social Service Provision** **p. 271**
Hawthorne E. Smith, Ph.D. & John Wilkinson, M.A.

10. **Therapeutic Work with Children and Families** **p. 299**
Katherine Porterfield, Ph.D. & Adéyinka M. Akinsulure-Smith, Ph.D.

- 11. Supportive Group Treatment with Survivors of
Torture and Refugee Trauma** **p. 336**
Hawthorne E. Smith, Ph.D. & Edna Impalli, Ph.D.
- 12. Approach to the Client in a Psychological
Evaluation** **p. 375**
Hawthorne E. Smith, Ph.D.
- 13. Secondary Trauma, Compassion Fatigue, and
Burnout: Risk Factors, Resilience, and
Coping in Caregivers** **p. 393**
Hawthorne E. Smith, Ph.D.
- 14. Volunteer Programs** **p. 411**
Ninia Baehr, R.N.

About The Editors

Hawthorne E. Smith, Ph.D., is Co-Director of Clinical Services for the Bellevue/NYU Program for Survivors of Torture. He is a licensed psychologist who received his doctorate in Counseling Psychology (with distinction) from Teachers College, Columbia University. Dr. Smith also has degrees in International Affairs and Foreign Service, as well as an advanced certificate in African Studies from Cheikh Anta Diop University in Dakar, Senegal. He is one of the founding members of Nah We Yone, Inc., a non-profit organization working primarily with refugees from Sierra Leone and other African countries.

Dr. Smith has won several honors and awards for his clinical work, such as: The “2006 Hero Award” from the Robin Hood Foundation; The “Distinguished Alumni – Early Career Award” from Teachers College, Columbia University; The “Union Square Award” for Community Activism; the “Frantz Fanon, M.D. Award” from the Post-Graduate Center for Mental Health, and a “2007 Man of Distinction Award” from the National Association of Health Service Executives.

Allen S. Keller, M.D., is Program /Medical Director of the Bellevue/NYU Program for Survivors of Torture. He is Associate Professor of Medicine at NYU School of Medicine, Attending Physician in the Bellevue Hospital Primary Care Medical Clinic, and Director of the NYU School of Medicine Center for Health and Human Rights. Dr. Keller is recognized internationally as an expert in the evaluation and treatment of torture victims. He has written numerous articles/chapters relating to torture and caring for asylum seekers and refugees.

Dr. Keller is a member of the International Advisory Board of Physicians for Human Rights. He has served on the American College of Physicians’ Ethics and Human Rights Committee. Dr. Keller has received numerous awards including the Humanism in Medicine Award from NYU School of Medicine and the Barbara Chester Award from the Hopi Foundation, an international award given to a clinician for recognition of outstanding care provided to torture victims.

Dechen Lhewa, M.A., is a doctoral candidate in clinical psychology at Boston University. She received her B.A from Macalester College and M.A. from Boston University. Dechen was awarded the Upper Midwest Human Rights Fellowship from the University of Minnesota Human Rights Center in 2001 and completed her fellowship term at the Bellevue/NYU Program for Survivors of Torture. She subsequently worked at the Program as the research coordinator, facilitating and implementing research projects. Currently, Dechen is gathering data for her dissertation as well as doing clinical work at the Program. Dechen’s research interests include trauma and coping among refugee populations. She has authored several research publications on the topic of refugee mental health.

Contributing Authors

Adéyinka M. Akinsulure-Smith, Ph.D., Program Psychologist, Bellevue/NYU Program for Survivors of Torture and Assistant Professor, Department of Psychology, City College, City University of New York.

Asher Aladjem M.D., FAPM., Chief Psychiatrist, Bellevue/NYU Program for Survivors of Torture and Director of the Consultation-Liaison Psychiatry /Psychosomatic Medicine at NYU/Bellevue Hospital.

Ninia Baehr, R.N., Former Director of Operations, Bellevue/NYU Program for Survivors of Torture. Currently Program Manager, Montana Nutrition and Physical Activity Program, Bozeman, MT.

Deborah Dyson, P.A., M.S., Physician's Assistant, Bellevue/NYU Program for Survivors of Torture and Bellevue Hospital.

Edna Impalli, Ph.D., Former Clinical Director, Bellevue/NYU Program for Survivors of Torture.

Jonathan Leviss, M.D., Former Attending Physician, Bellevue/NYU Program for Survivors of Torture. Currently Vice President and Chief Medical Officer, Sentillion Inc., Andover, Massachusetts. Staff Physician, Thundermist Heath Center, Rhode Island.

Nancy Levy, B.A., NYU School of Medicine, Class of 2008.

Katherine Porterfield, Ph.D., Co-Director of Clinical Services, Bellevue/NYU Program for Survivors of Torture.

John Wilkinson, M.A., Social Services Coordinator/Legal Liaison Bellevue/NYU Program for Survivors of Torture.

Acknowledgements

An elder once told a tale and stated that “two watchdogs are ten times better than one.” The elder alluded to an added sense of confidence, an ability to be proactive, and a general sense of connectedness that comes with affiliation. All of these factors would inevitably increase the watchdogs’ effectiveness.

We have been extraordinarily fortunate throughout the history of the Bellevue/NYU Program for Survivors of Torture (PSOT) to have come into contact and worked with such kindred spirits, who have provided the very support, collegiality, complementary effort, and inspiration through example, referred to in the elder’s parable. We are not a solitary voice howling in the night. We recognize and appreciate the people and organizations that have made our efforts possible.

First, we recognize the two remarkable institutions of healing and learning that we call home: Bellevue Hospital Center and the New York University School of Medicine. We extend our gratitude to the Jacob and Valeria Langeloth Foundation, whose generous support makes this book possible. We are grateful for the efforts, guidance, and support of our colleagues at Bellevue and NYU and the members of our Advisory Board. Special recognition must be expressed for Drs. Ilene Cohen, Asher Aladjem, and Lucia Kellar, who are among the founders of PSOT, in collaboration with our Executive Director, Dr. Allen Keller. They have been active in supervising, consulting, and the day-to-day operation of the program since its inception. We also salute the care providers in our fellow hospitals within the New York City Health and Hospital Corporation, who share the struggle to provide needed services to underserved and marginalized populations.

The Bellevue/NYU Program is proud to be a founding member of the National Consortium of Torture Treatment Programs, which now includes more than 30 programs throughout the United States caring for survivors of torture. We are also proud to be a member of the International Rehabilitation Council for Torture Victims (IRCT) which includes more than 125 centers worldwide. Special thanks to our colleagues, Drs. Francesca Gany, James Jaranson, J. David Kinzie, and Andrea Northwood for reviewing this manuscript.

We recognize and applaud organizations such as Physicians for Human Rights and Doctors of the World, who have created networks of health and mental health professionals who provide pro bono medical, psychiatric, and psychological affidavits for clients' asylum claims. These groups also make referrals to clinicians in the community (such as our program) if it is determined that a client needs significant follow-up care. Internationally, we commend the efforts of organizations such as Médecins sans Frontières, the International Rescue Committee, and the International Committee of the Red Cross, who are among the first responders during crisis situations. We salute local organizations that provide pro-bono legal services to asylum seekers, such as Human Rights First, the New York Association for New Americans, the Catholic Legal Immigration Network, the Hebrew Immigrant Aid Society, and the New York City Bar Association. We also express heartfelt appreciation to community-based organizations in the New York Metropolitan area that provide critical social, educational, advocacy, and youth services, like Nah We Yone, the African Services Committee, the American Friends Service Committee, CAMBA (the Church Avenue Merchant Bureau Association), Catholic Charities, and Tibet House. Venues that provide ESL classes which are open to all immigrants, including

the International Center, serve a very positive and therapeutic purpose for asylum seekers. There are many other programs that merit listing, but space does not permit. Suffice it to say we are proud of the company we keep.

We salute our clinical trainees through the years (who are too numerous to list in this space), whether they have been psychology interns or externs, psychiatric residents, medical students or residents, nursing students, or social work interns. They are at the heart and soul of this program, and many of our “alumni” have gone on to promising careers in their respective fields – often retaining significant elements of the work they have done with us.

There are also many colleagues and members of the PSOT staff, both past and present, who have not explicitly written chapters in this volume. Their voices are reflected herein, however. Their talents, ideas, and efforts to make this program a reality, are infused throughout the chapters. We salute these colleagues, who have served as administrators, office staff, psychology supervisors, medical and psychiatric preceptors, social work supervisors, operations officers, fundraisers, interpreters, data and IT personnel, clinical researchers, and volunteer coordinators:

Sophia Banu, Bornali Basu, Darren Bedrosian, Sharone Bergner, Martin Blaser, Pat Blau, Beate Bolen, Minal Bopiah, Andrew K. Boszhardt, Jr., Michael Brabeck, the late Harry Breuer, Kim Busi, Kenneth Cain, Mary Caram, Alison Carper, Jackie Chindani, Winston Chiong, Tom Comerci, Shara Corn, Mehul Dalal, Irene David, Ndiaye Diaw, Alice DiBenedetto, Ann Dibble, Suzanne Dieter, Lhamo Dongtotsang, Olympia Dukakis, David Eisenman, Alan Elliot, Miguel Figuerora, Alyssa Finlay, Ken Fish, Tatiana Friedman, Ami Gantt,

Jessica Ghiglione, Joel Gold, Marc Gourevitch, Ross Gourvitz, David Greenan, Jon Gutman, Damara Gutnick, Brian Halber, Amanda Hamlin, Glen Heiss, Gina Jae, Yael Kapeliuk, Anita Karne, Lissa Kern, Irma Kingsley, Steven J. Kolleeny, Alla Landa, Donald Lee, George Lui, Candace Martin, Michelle McMacken, Michael C. McCracken, Kathy McNamara, Chris Meserve, Terry Miles, Alan J. Morrison, Meghan Nickerson, Ona Nierenberg, Leanh Nguyen, Sybil Nurse-Reeves, Taiye Odedosu, Danielle Ofri, Pasang, Jessica Pearson, Carol Pepper, Lillian Perdomo, Angela Perreira, Carol Prendergast, Joseph Rabatin, Sumi Raghavan, David Rakoff, Sitara Ramcharan, Andrew Rasmussen, Shari Ratner, Kim Reeves, Mariano Rey, Victor Rodack, Sonja Rolovic, Barry Rosenfeld, William Rush, Eileen Russell, Emily Sachs, Troi Santos, Jack Saul, Madeleine Schachter, Eric Schaefer, Sarah Schoen, Mark Schor, Jeff Schulden, Chris Sekaer, Michael B. Sheffery, Kristina Sikes, Elizabeth Singer, Lauren Silverman, Philip “P.J.” Spencer, “Bobby” Stern, Samantha Stewart, Jennifer Stoltz, Javier Timerman, Etrell Torne, Chau Trinh, Manuel Trujillo, Andrea Truncali, Katherine Warshaw-Reid, Elizabeth Weiner, and Jordana Zanger.

This list is certain to have omissions. For those people or organizations not mentioned by name, please know that you are truly appreciated. Rather than being exhaustive, we hope the list serves as a reflection of the broadly based, coordinated effort among a plethora of caring professionals that is necessary to provide appropriate care for survivors of torture and refugee trauma. We salute all of our fellow watchdogs.

Introduction

Hawthorne E. Smith, Ph.D.

The broad goal of this book is to provide practical, literature based information and guidance in a “user-friendly” manner for medical professionals, mental health service providers, community advocates, students, policy makers, and individuals who may work (or come into significant contact) with traumatized refugees and survivors of torture. This includes existing programs, and programs now being developed to serve this diverse population. We at the Bellevue/NYU Program for Survivors of Torture hope to assist service providers and human rights advocates understand the challenges that survivors of torture and refugee trauma have faced, and continue to face, as they adapt to life in the United States.

We recognize that not every new program will have the plethora of resources available to us at the Bellevue/NYU Program that are necessary to create a truly interdisciplinary treatment center, but we hope to underscore the importance of interdisciplinary collaboration to ensure a holistic approach to the client. We will discuss methods of community and professional collaboration to facilitate cooperation between service providers, and we hope to help clinicians and service providers identify and utilize appropriate resources for survivors of torture and refugee trauma.

The Bellevue/NYU Program for Survivors of Torture (PSOT) has a unique viewpoint on this important and expanding field. Founded in 1995, our program has provided comprehensive treatment for more than 2,000 patients from over 80 countries. We reflect a unique collaboration between Bellevue Hospital, the nation’s oldest public hospital, and the New York University School of Medicine, a highly respected teaching institution at the

center of New York’s vibrant academic community. Situated in this dynamic clinical and learning environment, our clinicians are consistently exposed to cutting edge research and emerging therapeutic models.

The PSOT is situated just above the Lower East Side of Manhattan, which has historically been one of America’s (and the world’s) most vibrant immigrant communities. Unfortunately, the diversity of our community is augmented by an influx of individuals fleeing the increasing incidence of torture and other human rights abuses practiced in nations from every region of the world. Immigrants who have escaped harrowing circumstances in their native lands come to the United States with hopes of partaking in the freedom and liberty for which the U.S. is widely known. These survivors often arrive in New York City, a major entry point for immigrants of all backgrounds. Consequently, a significant number of torture survivors and traumatized refugees are discovered among Bellevue’s general patient population, in addition to those who have been specifically referred to our program.

The diversity of our clientele is complemented by a professional team with a wide variety of life experiences, cultural backgrounds, and professional expertise. At the PSOT we find that these variations in worldview and training add to the richness of theoretical debate, and facilitate more nuanced and effective treatment for our patients. Our diversity in philosophical orientation and communication style is reflected by the different voices and clinical approaches presented in this volume. We are confident that the writings in this book demonstrate that our distinct voices generally resonate in harmony, even when we are not “singing” in unison.

The PSOT is unique in its comprehensive, interdisciplinary approach. Our therapeutic team comprises physicians, psychologists, psychiatrists, social workers, nurses, administrative staff, community liaisons, and volunteers such as English teachers and client chaperones. Additionally, health professionals in training, including: medical students and residents, psychiatry residents, psychology interns and externs, and social work interns participate in our program's clinical and research activities. We emphasize comprehensive care, by which we consider patients within the context of their total experience and circumstances, to provide well-informed treatment planning and useful therapeutic services.

This diverse team approach to the treatment of torture survivors and traumatized refugees can remain effective as long as the team members hold certain principles in common. Service providers at PSOT respect the sanctity of each human being's mind, body, and spirit. We share a sincere commitment to helping people recover from human rights abuses in a way that is empowering and sustainable. We work in a context of mutual respect and emphasize open communication among disciplines. We advocate the promotion of human rights issues, and share our insights and experiences through professional trainings, endeavors such as this book, and other public exchanges.

Other Programmatic Approaches to Treatment

Though we have found our interdisciplinary approach to be effective for our population of survivors of torture and refugee trauma, we recognize that other approaches are also proving to have positive clinical effects. We strive to engage in a continuing "multilogue" with colleagues engaged in similar work. We continue to learn from the insights and creative

perspectives of community leaders, resettlement workers, lawyers, English teachers, asylum officers and judges, and advocacy groups with whom we have had the privilege of interacting in the course of our work and travels. Clearly, we will focus mostly on our own clinical experiences and insights for this volume, but we would be remiss if we did not mention our colleagues in other treatment centers, resettlement agencies, and legal and social service agencies, whose interventions and contributions are greatly appreciated. A number of these close collaborators have been mentioned by name in the Acknowledgements section.

It is clear that our efforts are part of a larger movement of concerned individuals and groups struggling to provide services for survivors of human rights abuses. On the national level, our program is one of more than 30 member organizations included in the National Consortium of Torture Treatment Programs (NCTTP), also known as “the Consortium.” Within the Consortium, there are a variety of innovative approaches to service provision.

Following this line of thought, we are pleased to recognize the contribution from our outside editors from other treatment programs who helped guide us in creating a book that would be relevant, balanced, and well-informed. Two of our outside readers are from other treatment programs within the NCTTP, while the other two reviewers are from treatment and academic programs not directly affiliated with the consortium.

Dr. Andrea Northwood is a highly respected clinical psychologist with the Center for Victims of Torture (CVT) in Minneapolis, Minnesota, which is the first and oldest torture treatment program in the US. Dr. Northwood described the treatment model CVT utilizes, where referrals are made within different disciplines and clinics within their geographic community. CVT

provides individual, group and family therapy at their main offices, as well as providing resources for advocacy and social services. A doctor provides initial assessments and health screenings at their clinic on a weekly basis. Clients are then referred into the community for primary health care. CVT is also involved in providing training and psychological interventions for refugees and internally displaced people overseas, as well as taking a lead position on increasing capacity among the torture treatment centers.

Dr. J. David Kinzie, a pioneer in the mental health treatment of traumatized refugees, is the senior psychiatrist with the Intercultural Psychiatry Program at the Oregon Health and Science University, which is also a NCTTP member. He explained how his program utilizes a model in which the psychiatrist plays the lead role in providing treatment and supervising case management activities. This is done in conjunction with trained staff from within the clients' expatriate communities, who serve multiple roles as interpreter, mental health counselors, cultural brokers, and day-to-day case managers. He helped us to focus on psychiatric issues and multicultural treatment provision. Further information on treatment centers affiliated with the Consortium is available on the following web site:

<http://ncttp.westside.com/wsContent/> and we encourage our readers to get more information on programs in their geographic region.

Dr. Francesca Gany is a noted physician and public health expert. She also serves as director of the NYU School of Medicine's Center for Immigrant Health. She provided additional expertise on public health concerns and logistical challenges involved in treating the extremely diverse immigrant community here in New York City. Her insights into the use of interpreters in treatment and multicultural service provision were particularly helpful.

Dr. James Jaranson is one of the leading clinical and research minds in the psychiatric treatment of survivors of torture and refugee trauma. He is currently Co-Chair of the World Psychiatric Association's Section on the Psychological Consequences of Torture and Persecution. His insights and knowledge of current directions in treatment and research were invaluable.

Discussions and correspondence with these colleagues underscored the fact that many of the variations in our clinical approaches were primarily contextual in nature. The circumstances under which programs were founded, the ways they are funded, the size of the program, the populations a program serves, the availability of other local resources for traumatized refugees, the local political realities, and the attitudes of the local communities toward immigrants, are among factors that will affect the priorities and structures of treatment programs. As such, this volume does not aspire to be exhaustive, nor does it claim to have the only salient clinical approaches or interventions for working with survivors of torture and refugee trauma. Rather, we endeavor to share our experiences and insights, to raise difficult questions, and to provide points of intellectual engagement for those readers who actively grapple with these issues.

The discussions with our colleagues were also very collegial and supportive. They underscored that despite structural differences and varying points of emphasis in our treatment programs, we shared much of the same underlying beliefs regarding the treatment of these remarkable clients. It was very reassuring, and humbling, to hear people who have accomplished so much in this burgeoning field of inquiry, be so supportive of the ideas and conceptualizations we are putting forth in this volume.

Our greatest teachers, however, and our greatest inspiration, continue to be the survivors with whom we work. They not only share their pain and suffering, but also give us insight into the incredible resilience and healing power of the human spirit. Part of our mission is to continue learning from the survivors who define our program, and to help make sure that their voices are heard in the larger professional and social discourse. We hope that this volume will be a positive step in facilitating this collaborative ongoing communication, that will hopefully lead to even more nuanced and effective treatment interventions in the future.

Organization of this Volume

This book is ambitious in its scope, which is appropriate given the multifaceted stressors being faced by survivors of torture and refugee trauma and the multiple domains in which therapeutic interventions may take place. Again, this volume is not meant to be exhaustive in terms of content areas covered or the level of detail to which these areas are explored.

We do hope that service providers engaged in this work will find the information provided as practical and pertinent to the challenges they face in their endeavors. We hope that students and community advocates will be oriented to the complex social, historical, and theoretical underpinnings associated with each aspect of service provision with survivors of torture and refugee trauma. We also hope that the case examples and anecdotal vignettes will provide insights that will be useful for practitioners engaging in this work. We continue to learn a great deal from our colleagues around the world who are engaged in similar work, and we encourage our readers to examine the reference lists found at the end of each chapter, to explore other

views and experiences drawn from different authors, situations, and contexts.

To help ease navigation of this volume, and to help guide our readers to the specific topics they may be seeking, each chapter will be preceded by a brief chapter summary. This summary will give a “bullet-point” outline describing the structure and content of the chapter. Most chapters will also have a brief descriptive paragraph along with the outline.

Also, it should be noted that all case examples in this book are disguised in some slight ways. Care has been taken to ensure client confidentiality, but also to ensure that the pertinent content of the vignette is not corrupted in a way to invalidate the clinical point being made.

The first section of this book addresses the multifaceted context that survivors of torture and refugee trauma are facing. We ask the questions “Who are these people?” “What have they experienced?” “What issues and challenges are they currently confronted with?” “What are common reactions to these stressors?”

Chapter 1 is entitled “The Context in Which Treatment Takes Place: The Multi-Faceted Stressors Facing Survivors of Torture and Refugee Trauma.” As the title suggests, it will examine many of the significant challenges refugees and displaced asylum seekers face on a daily basis. It will focus on the nature of torture, and the detrimental effects of torture on a survivor’s physical, cognitive, emotional, and behavioral functioning. This chapter will also explore issues as to whether the emotional symptoms experienced by survivors of torture and refugee trauma are normal reactions to abnormal circumstances. The forms of torture most frequently reported by clients in our program are listed in an appendix.

Chapter 2 is entitled “Multicultural Issues in the Treatment of Survivors of Torture and Refugee Trauma: Toward an Interactive Model.” This chapter explores the mediating factors that help to determine how someone makes sense of their multiple cultural identities, and provides an interactive model of communication that facilitates the exploration of these issues. Assumptions of cultural similarity, and the need for service providers to engage in their own cultural exploration, are discussed. Finally, the importance of the client’s cultural self-definition is addressed, not just in the context of culture, but across domains of psychological functioning. This chapter is written from a psychological perspective, but has relevance for service providers, regardless of their discipline. It pertains to the overall context that the survivor is navigating, and how this impacts on all social interactions, not just exchanges in the clinical context.

For similar reasons, Chapter 3, which is entitled “Immigration Dynamics: Processes, Challenges, and Benefits” is included in the section describing contextual issues. A survivor’s immigration status impacts upon essentially every realm of his or her functioning. The relative security or insecurity wrapped up in one’s immigration status is coupled with other stressors such as whether or not a survivor is domiciled, legally able to work, able to apply for medical insurance, or permitted to reunite with his or her family, etc. These are all factors that affect a client’s emotional and social functioning, as well as their physical health and health related behaviors.

Chapter 4 is entitled “The Use of Interpreters with Survivors of Torture, War, and Refugee Trauma.” The chapter focuses primarily on the special challenges associated with using interpreter services in clinical settings, but the information also pertains to other domains (i.e. legal, educational, case management). It describes the roles of interpreters at

PSOT, and discusses finding and choosing volunteer interpreters, as well as training and supervising these interpreters. Guidelines for interpretation, including: a code of ethics for interpreters, rules regarding confidentiality, and discussions of vicarious trauma and specialized vocabulary are detailed. Finally, guidelines for training clinicians working with interpreters, including clinical “do’s” and “don’ts” are included.

The second section of this volume concerns treatment and service provision issues, and addresses them from a multidisciplinary perspective. Chapter 5, “The Clinical Interview and Programmatic Intake Process,” describes some of the cardinal principles in conducting an empathic and thorough clinical interview with a survivor of torture and refugee trauma. General interview considerations are addressed, including tips for preparing for, and conducting, the interview. Specific information about the Bellevue/NYU Program for Survivors of Torture’s intake process is also provided.

Chapter 6 is entitled “Treatment Techniques and Priorities: A Psychological Approach to the Patient.” This chapter describes the salience of safety and empowerment as clinical issues with our clientele. Specific ways of facilitating feelings of safety and empowerment will be described. Brief descriptions of psychodynamic, cognitive-behavioral, narrative-exposure, and non-verbal treatments are provided. The chapter explores how the complex stressors our clients are facing frequently necessitate a more integrated treatment approach that may call on a therapist to utilize techniques and interventions from diverse clinical orientations. A description of the multiple challenges and benefits of supervising psychology trainees engaged in this work is also provided.

Chapter 7 is entitled “Medical Evaluation and Care for Survivors of Torture and Refugee Trauma.” This chapter covers a broad domain in considerable detail. The prevalence of torture and refugee trauma in the primary care setting is explored. Interviewing techniques are revisited with regards to the medical interview. A review of diagnostic activities, including the physical examination and ancillary tests, precedes a discussion of common health problems among survivors of torture and refugee trauma. A review of systems and guidelines for performing a thorough health screening is complemented by information on how to provide appropriate medical documentation of torture for forensic purposes, such as asylum proceedings in immigration court. At the end of the chapter, the authors share a description of our weekly “Multidisciplinary Medical Clinic,” and finish with case examples that illustrate many of the concepts detailed earlier in the chapter. An example of a medical affidavit is included as an appendix.

Chapter 8 is entitled “The Psychiatric Care of Survivors of Torture, Refugee Trauma, and Other Human Rights Abuses.” This chapter begins by addressing general psychiatric issues, including variability in symptomatology among survivors of torture. The author discusses pre-morbid, co-morbid, and posttraumatic conditions. He also revisits the notion of whether posttraumatic symptoms are normative or pathological responses to the stressors our clients are facing. The chapter continues with a description of psychiatric evaluation and diagnosis, including a discussion of biological models and psychopharmacology. An exploration of the cultural and subjective “meaning” clients attach to medications is followed by a discussion of issues associated with psychiatric hospitalization.

Chapter 9 is entitled “Social Service Provision.” Similar to multicultural and immigration issues, challenges in a client’s daily life

conditions are inextricably linked to their emotional functioning, health status, and health related behaviors. We discuss the “social service essentials”: information, resources, and advocacy. Social service issues related to day-to-day necessities, medical services, housing issues, legal issues, educational and professional assistance, as well as family reunification issues are addressed.

Chapter 10 is entitled “Therapeutic Work with Children and Families.” It details children’s psychological reactions to war trauma, including: PTSD, depression, anxiety, and learning difficulties. It also explores treatment options for children traumatized by war, including: individual therapy, family therapy, group therapy, and medication. Two appendix are included that detail children’s reactions to trauma and provide guidelines for referring a child refugee or war victim to mental health services.

Chapter 11 is entitled “Supportive Group Treatment with Survivors of Torture and Refugee Trauma.” This chapter focuses on the general approach to supportive group treatment, and provides a rationale for supportive group treatment with survivors of torture and refugee trauma. The authors describe the initial development of our group treatment models through the examples of our French-speaking African support group and our support group for Tibetan survivors. The chapter considers issues regarding group membership, whether group should serve as an adjunct or main modality of treatment, and other special clinical considerations.

Chapter 12 is entitled “Approach to the Client in a Psychological Evaluation.” It describes the purpose of a psychological evaluation, and revisits the importance of safety and empowerment in this clinical endeavor. Methods for encouraging, prompting, re-directing and focusing clients in a

non-punitive fashion are detailed, and there is a discussion of how to utilize a client's clinical "process" information in addition to the "content" of his or her narrative to get a more complete diagnostic picture. Commentary on writing affidavits and testifying in immigration court are also provided. A sample affidavit, in the psychological summary format, is included as an appendix.

Chapter 13 is entitled "Secondary Trauma, Compassion Fatigue, and Burnout: Risk Factors, Resilience, and Coping in Caregivers." It describes secondary traumatic stress, and looks at the contributing factors, the parallels between a survivor's reactions and a care provider's reactions, and looks at prevention and treatment.

Chapter 14 is entitled "Volunteer Programs." This chapter is designed to assist agencies in the process of preparing to start a volunteer program. It discusses why people volunteer, and explores the processes of outreach, screening, and orientation. The chapter details potential volunteer duties and job descriptions, and describes the support and supervision of volunteers.

Advocacy and the Current Political Context

When we began working on this book, we may have imagined that we'd be in a position to advocate against coercive and abusive techniques, utilized on detainees, prisoners of war, and civilians that defy the Geneva Convention and other international protocols. We did not anticipate, however, that we'd be publishing this work in an environment in which the United States government is supporting the notion of "enhanced interrogation techniques," and other assaults on human rights in the context of the "war on terror." It would be a dereliction of responsibility for our program to refrain from commenting on the current situation.

Our programmatic position is in accord with the other members of the National Consortium of Torture Treatment Programs (NCTTP). We Consortium members express this sentiment:

Torture and other cruel, inhuman, or degrading treatment or punishments are illegal, immoral and un-American. As demonstrated by our historical commitment to human rights and our ratification of The Convention Against Torture. If the U.S. is to spread freedom and democracy abroad, we must show the world we can do so while holding firm to our belief in the rule of law and the basic human right not to be tortured.

In addition to this general language, the Consortium advocates particular actions, including:

Establishing the Army Field Manual as the minimum standard for the treatment of all detainees during interrogations conducted by all US personnel (including the CIA and any contractors) anywhere in the world.

Ending extraordinary rendition, the secret prisons and forced disappearances; ensure transparency in the capture, transfer, and detention of all persons.

We'd like to comment further on a couple of aspects of this debate. Much of the media attention and political punditry focuses on the "ticking time-bomb scenario," in which torture is used to extract information in a

time-sensitive, crisis situation, where many lives depend on extracting information from the prisoner. An individual's stand on torture (particularly for elected officials and other public figures) is often defined by whether or not they would allow torture to be used in such a scenario. There are two points that need to be made here.

First, there is no evidence that torture provides any pertinent and accurate information related to the goals of the interrogation. In fact, there is mounting evidence reported from the field that demonstrates that torture often provides erroneous information (as torture victims will often "say anything" in order to stop the abuse). This has been reported widely in the news media (such as Applebaum, 2005; Smith, 2005; Winslow, 2005), and has been cited on Capitol Hill by Sen. John McCain and others.

Professionals trained in interrogation techniques (both military and civilian) have weighed-in on the subject in editorials, articles, and interviews for TV and radio. For example, Jack Cloonan, a 25 year veteran of the F.B.I. who investigated Al-Qaeda in the U.S., spoke on the News Hour with Jim Lehrer about a growing consensus among intelligence and law enforcement officials that information gathering techniques that emphasize rapport-building generally provide more valuable insights and information than coercive interrogations (Winslow, 2005). The more benign techniques also reduce the risk of increased animosity, political "blow-back," and potential acts of revenge.

There are also questions as to whether an interrogator who used all of the new techniques and latitude provided by the "enhanced interrogation techniques," and felt that he or she was "close to breaking" the person being questioned, would go further; especially if they believed that going a bit further would elicit the desired information. The current political climate

seems to dictate that the interrogator should take the extra measures. The “grey area” keeps getting pushed back with increasing momentum, to the point that distinctions between what is acceptable and what is “over the line” are blurred.

We are not navigating a slippery slope. We are approaching a precipice. We either live in a society that respects and protects human rights, or we live in a society that abuses human rights whenever it suits its stated purposes.

Secondly, and perhaps most importantly, the “ticking-time bomb” scenario is an extremely rare circumstance (despite what we may see on popular TV shows). Torture is focused more on breaking the will and spirit of individuals and communities. The “ticking time-bomb” scenario is utilized much more frequently as procedural or political cover for the sadistic abuse of captured “enemies” and civilians who live in occupied areas.

A captive may just be a member of an ethnic group that is affiliated with a particular political movement (like a Dioula in Cote d’Ivoire, a Tamil in Sri Lanka, or a Bamileke in Cameroun) to be seen as a “grave threat to security” and savagely beaten or killed. Women from a particular region (like Darfur), or of a particular religion (like Bosnian Muslims in the former Yugoslavia) may be raped and mutilated as a “warning” or a “show of dominance” to their communities.

These abuses are frequently couched in terms of military or political strategy by the perpetrators. They may say they were seeking information. They may say they felt there was a plot brewing. They may have felt

compelled to attack the civilians in a village because members of a resistance movement may have grown up there, or perhaps received hospitable treatment there. These are all slightly less apocalyptic versions of the “ticking time-bomb” scenario, and are the context in which the vast majority of clients we treat have been victimized.

We must also consider the human emotions of combatants. Even in “developed” nations, most combatants tend to be young. In the “developing world,” the use of child soldiers (who are frequently drugged and brutalized themselves) is endemic (Briggs, 2005). These young combatants may have witnessed their friends and comrades dying in gruesome ways. They may be traumatized themselves, and their rage may find a convenient outlet when they are in control of prisoners from the hated enemy population. As such, the active search for information may serve as cover for sadistic revenge acts that are unsupervised, undocumented, and ultimately, un-punishable.

The more vicious and memorable the torture and abuse, the more effective at breaking a community’s will to resist, or even exist. It becomes a real-life version of Conrad’s “Heart of Darkness,” or the “Apocalypse Now” scenario, where the individuals in positions of authority fall under the spell of the utilitarian power of “the horror, the horror.” We must be vigilant and determined to not feed into this horrific cycle of terror, brutality, and attacks on our shared humanity.

When a torturer begins to dehumanize a victim, he or she begins to lose their own humanity. The same can be said of societies. We stand at a cross-road, and we encourage those reading this volume to advocate for moving in the direction of respecting and protecting our shared humanity and respect for human rights.

As such, we invite you to join us in this composite exploration of a complex field of inquiry. We hope that this volume will be useful to those providing services to traumatized refugees, and will be informative to those who are just beginning to develop their interest in this area. We hope that the material contained herein will play a part in the continuation of an international conversation across disciplines that will help move the science of caring for survivors of torture and refugee trauma forward into the new millennium.

References

- Applebaum, A. (2005, January 12). The torture myth. *Washington Post*. Retrieved May 10, 2007, from <http://www.washingtonpost.com/wp-dyn/articles/A2302-2005Jan11.html>
- Briggs, J. (2005). *Innocents lost: When child soldiers go to war*. New York: Basic Books.
- Smith, T. (2005, August 8). Torture: The slippery slope to surrender to terror. *Australian Review of Public Affairs*. Retrieved on May 10, 2007, from <http://www.australianreview.net/digest/2005/08/smith.html>
- Winslow, L. (Executive Producer). (2005, December 5). *News Hour with Jim Lehrer* [Television Broadcast]. New York and Washington, DC: Public Broadcasting Service.

Chapter 1

The Context in Which Treatment Takes Place **The Multi-Faceted Stressors Facing Survivors of Torture and Refugee** **Trauma - Summary**

In this chapter we offer a brief overview of the kinds of traumatic experiences that have led clients to seek treatment at our center. We detail some of the recurrent and reinforcing stressors that can complicate their healing process and adaptation to life in a new country. Understanding this context is of crucial importance to clinicians, advocates, and other professionals hoping to engage with members of this population. Some of the key issues we will discuss in this chapter are:

- * Refugee trauma and the challenges facing forced émigrés
- * The nature of torture
- * Detrimental effects of torture
 - Physical
 - Cognitive
 - Emotional
 - Behavioral
- * Normal reactions to abnormal circumstances?

**The Context in Which Treatment Takes Place:
The Multi-Faceted Stressors Facing Survivors of Torture and Refugee
Trauma**

Hawthorne E. Smith, Ph.D. & Allen S. Keller, M.D.

KH is a 30 year old Tibetan woman who goes to a local clinic for general medical care. She complains of having back pain, stomach aches, and difficulty concentrating and sleeping.

On further history, the physician learns that in her native country, where she was a nun, she was arrested for participating in pro-democracy demonstrations. Following her arrest, she was interrogated about her activities. She was repeatedly punched, kicked and shocked with electric cattle prods, including on her genital region. She was subsequently imprisoned for 2 years and forced to do hard labor. During her imprisonment she witnessed the beatings of several other prisoners. Following her release, she continued to be harassed by local authorities and subsequently fled to India and then arrived in the United States.

LR is a 52 year old physician from Kosovo who is seeing a case worker at a local refugee resettlement organization. He is concerned about finding a job, yet is frustrated at the prospect of not being able to work as a physician. Additionally, he reports that he is having some difficulties with one of his children, who is refusing to go to school.

Upon taking further history, the case worker learns that in 1997, LR and his family were forced to leave their home when Serbian forces attacked their village. They were only able to bring with them what few personal belongings they could carry. As LR and his family were leaving their village, he saw that his home and several of his neighbors' homes were in flames. LR subsequently lived with his family in a tent in a refugee camp in Albania for 4 months, before being resettled to the United States.

While these individuals come from different cultures and different parts of the world, they have much in common. Both were forced to leave their native countries because of persecution and human rights abuses. They have experienced loss of identity, loss of culture, loss of social status. Both are struggling to adapt to a new culture, while reconciling the trauma they experienced. Also, they may still be suffering from physical and psychological consequences as a result of their abuse.

Interviewing immigrants and refugees who have experienced torture and refugee trauma, and engaging them in treatment, poses significant challenges for service providers. This is true whether one is a primary care physician, a psychologist, a social service provider, or an immigration attorney. In Chapter 5, we will review some of the basic considerations in interviewing survivors of torture and refugee trauma.

Refugee Trauma and the Challenges Facing Forced Émigrés

When presenting information regarding clinical work with survivors of torture and refugee trauma to service providers, we have found it useful to

initially engage them in a couple of brief experiential exercises. The facilitator asks each member of the group to write the “five most important things in the world” to them. These should be five precious things that “make life worth living” in an emotional sense, and do not have to be “things” in the strictest sense of the word. The facilitator waits a few minutes for the responses.

While waiting, the facilitator asks a few questions that can be answered by raising one’s hand or nodding one’s head. He or she asks questions like: Has anyone ever belonged to a political party? Has anyone written a letter to the editor? Do you belong to an identifiable religious group? Does anyone not belong to an identifiable religious group? Has anyone ever protested at a political rally? Is anyone here a woman? Has anyone ever joined a student group or a union? Do you belong to a particular racial or ethnic group? Does anyone here have a friend or relative whose sexual orientation is other than heterosexual (it is striking that even in “advanced” Western culture, this information is still too socially charged to ask about it directly)?

The facilitator collects the papers from the audience, and addresses the first question that frequently comes to mind for people when they first think about survivors of torture: “Who are these people?” The facilitator can point out that each person in the room who responded by raising his or her hand or by nodding their head to any of the previous questions can honestly say that torture survivors are people just like them. Many of our clients have been abused because of their political affiliation, their expressed social opinions, their religion (or lack thereof), their gender, their social group, their community involvement, their race, ethnicity and/or sexual orientation. Their pre-trauma behaviors may not go far beyond things we think of as

every day activities. As described in Chapter 6 in this volume, many people come to this field of inquiry expecting to meet the “other,” and instead, they meet “themselves” in a humanistic sense.

The facilitator then moves on to describing the multiple losses associated with torture and refugee trauma. Without divulging names, or identifying who wrote what, the facilitator reads through some of the responses from the papers he or she has collected. Often, audience members will write down the names of family members or loved ones. They may name a relationship such as marriage. Respondents may mention material things and possessions, such as an ancestral home. Other responses may describe aspirations (i.e. obtaining an advanced degree), passions (i.e. playing or enjoying music), achievements (i.e. professional success), or a general sense of well-being (i.e. good health, freedom, etc.).

After reading through a number of these responses, the facilitator rips all of the papers to shreds. He or she then asks the audience to imagine for a moment that all of these precious things have been taken from them through violent means, and that they are currently powerless to reclaim any of them. This symbolizes the painful scenario that survivors of torture and refugee trauma who are now living in exile are facing.

MS is a 37 year old man from Guinea. He only has an old, fading snap-shot of his then new-born son, and has not seen his son in person since just after birth, due to his forced exile. The client can only imagine what his now 7 year old son is like. He was not able to contact his family at first, because he was not sure of their whereabouts. Subsequently, he could not facilitate direct contact with them for fear of the reprisals that may befall his loved ones if the

government, or other forces, learned that there was on-going correspondence between them.

MS speaks about how being a father is one of the most important aspects of his life. Not being able to provide sufficiently for his son, and not being there to witness his growth and development, are intensely painful for this family oriented man. These psychic wounds are superimposed on the torture experiences themselves, and serve to keep MS in a precarious emotional situation.

The stressors of being a refugee and living in exile are part and parcel of the human rights abuses from which our clients are endeavoring to recover. Exposure to war, torture, exile, and other traumatic events as illustrated in the examples of KH, LR, and MS are tragically, all too common. For example, during the past 20 years, more than 40 million refugees and displaced persons worldwide have been forced to flee their homes because of war and human rights violations (Drozdek & Wilson, 2004). The US Committee for Refugees and Immigrants (USCRI) reports that torture is documented to occur in more than 100 countries worldwide and that the current number of refugees and asylum seekers now tops 12 million. They also report that approximately 23.7 million internally displaced people (IDP's) are dispersed throughout the world, and about 12 million of these IDP's are living in Africa (USCRI, 2006).

As of December 31, 2005, the United States was host to 176,700 asylum seekers and refugees, with 119,000 people having sought refuge in the US during 2005 (USCRI, 2006). It is estimated that there are 400,000 survivors of torture from all over the world currently living in the United

States (Office of Refugee Resettlement, 2006). These numbers differ because not all survivors of torture and refugee trauma have officially applied for asylum or refugee status. The prevalence of torture in refugee communities has been estimated to be between 5-35% (Baker, 1992; Eisenman, Keller, & Kim, 2000; Montgomery & Foldspang, 1994). Eisenman et al. (2000) found a 6.6% prevalence of survivors of torture in a general outpatient medical clinic here at Bellevue Hospital. Other recent studies have reported higher prevalence rates ranging from 8% to 11% (Crosby et al., 2006; Eisenman, Gelberg, Lui, & Shapiro, 2003).

The psychological literature identifies three phases of traumatization that survivors of torture, war trauma, and exile endure. Initially, there is an increase in repression and persecution in the survivor's native country; then comes a period in which the survivor experiences or witnesses direct war trauma, torture, and/or other traumatic deprivations; and then the survivor is confronted with the difficult and long-term process of being uprooted and living in exile (van der Veer, 1998).

This general scenario fits the experiences of the majority of clients we see at the Bellevue/NYU Program for Survivors of Torture. Among the "multi-traumatic situations" members of this population have survived (Elsass, 1997, p.3), are severe violence and social upheaval in their home countries. These chaotic situations may have taken the form of ethnic or racial cleansing, religious intolerance, civil war, a rebel insurgency, tribal warfare, or some other form of social strife.

Many of our clients have been directly tortured, imprisoned, sexually assaulted, physically maimed, and may have lost family members in the conflict. Several of the clients we treat at our program have witnessed their spouses being raped and/or killed. Many families have been separated, and

clients are not aware if their spouses, significant others, siblings, parents, or children are still alive, or where they may be. The longing, insecurity, doubt, and possibly guilty feelings can be overwhelming.

In addition, there are many “indirect” forms of war-related trauma and human rights abuses that survivors endure. Witnessing random shootings, having family members or friends “disappeared,” navigating harrowing circumstances and physical deprivation as one flees the besieged areas to find refuge, coping with mortal fear, guilt, and bereavement, are also significant stressors that affect a survivor’s ability to function on a daily basis (van der Veer, 1998; Volkan, 2004).

These survivors and refugees have generally lost most, if not all, of their worldly possessions. This includes not only material things, but also applies to self-esteem, dreams, aspirations, feelings of emotional and physical security, and a sense of personal control (Fischman, 1998; Silove, Tarn, Bowles, & Reid, 1991). They have frequently lived as fugitives in their own country, and escaped from their native lands under harrowing circumstances. Many refugees who have been forced to flee their war-torn homelands initially find refuge in neighboring countries that are often impoverished and chaotic themselves (de Jong, 2002). All of these events precede the client’s resettling in their final “host” country; with the forced adaptation this entails (Randall & Lutz, 1991; van der Veer, 1998).

Survivors of torture who are living in exile as refugees are coping with multi-level stressors that serve to reinforce and complicate their ability to adapt emotionally. This often includes depressive feelings and symptoms (Kinzie, Leung, & Boehlein, 1997). Some survivors have stated that, “Exile is the most painful form of torture” (Fischman & Ross, 1990, p. 139).

Upon arrival in a new country, these forced immigrants are often subjected to harsh living conditions in refugee camps and/or detention centers. When they arrive in countries such as the US, there may be further questions about their legal status. While refugees and individuals granted asylum have legal status, many asylum seekers are detained by immigration authorities and are kept in custody in detention facilities for several days, months or years while their cases are being adjudicated (Chester & Holtan, 1992; Fischman, 1998; Keller et al., 2003; Silove, Tarn, Bowles, & Reid, 1991).

The clients seen at the Bellevue/NYU Program for Survivors of Torture are then confronted with the daunting task of living in New York City in circumstances that can be intimidating and disempowering on multiple levels. There are numerous examples of the kinds of educational, vocational, linguistic, and cultural problems they face that make exile seem like a continuation of the torture experience (Carlsson, Mortensen & Kastrup, 2006; van der Veer, 1998).

S.Y. had almost finished his course of study in law school in his native Mauritania, when he and his family were menaced due to his human rights activities. After several years in a refugee camp in neighboring Senegal, S.Y.'s family fled to a third country. Meanwhile, he came to the US and applied for asylum.

Rather than continuing his legal career, S.Y. found himself without proper academic documentation and without work authorization. Even if S.Y. had been able to continue his studies, his lack of English proficiency made him semi-literate at best. Unable to find suitable,

legal employment, he was racked with feelings of guilt at not being able to provide for his family in an adequate manner. These stressors helped to keep the pain of his oppression very much alive in the present. He often questioned whether it would be better to “go home to die” than suffer the feelings of isolation, guilt, poverty, and worthlessness he was experiencing in the US.

Studies have shown that the additional stressors of refugee trauma serve to exacerbate psychological sequelae of torture and other human rights abuses (Quiroga & Jaranson, 2005). The literature states that it may not be migration itself that causes the increased symptomatology for refugees, but the severe stress of the migration under harrowing circumstances, and the multiple levels of disempowerment and insecurity faced in the new environments (Berliner et al., 2004; Den Velde, 2000). Pre-migration stressors were found to be important predictors of mental health functioning (Bhui et al., 2003; Lie, 2002; Silove et al., 1997), and post-migration stressors were found to have significant effects on psychological functioning (Jaranson et al., 2004; Lie, 2002; Roth & Ekblad, 2002; Silove et al., 1997; Somnier, Vesti, Kastrup, & Genefke, 1992).

Most asylum seekers in this country are considered undocumented immigrants, and therefore cannot work legally and support themselves and their families. Although many may have been well-trained professionals with advanced educations in their countries of origin, they often work in positions below this level of expertise in menial, “off the books,” jobs - if they are able to work at all. Research shows that refugees and asylum seekers who have not been able to find gainful employment in their host countries, or who have fewer social contacts, manifest increased levels of

social distress; and that this continues many years after their initial victimization (Carlsson, Olsen, Mortensen, & Kastrup, 2006; Quiroga & Jaranson, 2005). In fact, recent data show that the emotional distress can be chronic for the majority of this marginalized population (Carlsson, Mortensen, & Kastrup, 2005).

Many of our clients, who were formerly of significant social stature in their home countries, are now confronted with a country, culture, and language that are entirely unfamiliar to them. They suddenly find themselves to be functionally illiterate, and must struggle for their very survival in the new host nation. They may also harbor the fear that they will be “exposed” because of their tenuous immigration status, and deported back into the hands of those who would persecute them.

Issues of safety and adaptation to life in this country are also stressful. Refugees may live in poor neighborhoods, occasionally in areas with high levels of crime and racial tension, in which they may become victims of crime. They may have to frequently change dwellings and some are homeless.

Such are some of the multi-faceted emotional stressors that feed into the disempowerment and psychological distress that torture survivors and those who are living in exile are grappling with on a daily basis. These multiple losses, the social dislocation, the feelings of fear and inadequacy, as well as the cultural/linguistic barriers are all part of the psychological reality for those living in exile as refugees (Randall & Lutz, 1991). Clinicians may conceptualize these recurrent stressors as “sequential traumatizations” (Basoglu et al., 1994; Quiroga & Jaranson, 2005). In our client population, these realities are superimposed on the detrimental physical and psychological effects of the torture experience itself.

The Nature of Torture

There are several widely used definitions of torture authored by international organizations such as the United Nations, the World Health Organization, and Amnesty International (Amnesty International, 1984; United Nations, 1984; World Health Organization, 1986). These definitions differ slightly in their wording, but are in accord with the clinical literature that describes torture as being designed to purposely inflict intense physical and emotional pain, with the ultimate goal of breaking the will and spirit of the person, and community, upon whom the torture is inflicted (Chester & Holtan, 1992; Fischman, 1998; Silove, et al., 1991).

The complexity and nuance of the various definitions of torture can complicate a clinician, advocate, or researcher's search for a concise operational understanding of what torture is that can be generalized to multiple settings and circumstances (Jaranson et al., 2004; Quiroga & Jaranson, 2005). In addition, the meaning and impact of torture are also moderated by the beliefs, cultural norms, and political engagement of the person upon whom the abuse has been inflicted (Holtz, 1998). A literature review of prevalence studies demonstrates that significant utilization of torture exists in almost all regions of the world, including: Africa, Asia, Europe (i.e. the former Yugoslavia), Latin America and the Middle East (Quiroga & Jaranson, 2005). The types of torture most frequently reported among PSOT clients are provided in the appendix at the end of this chapter.

Survivors of torture often experience physical, cognitive, emotional, and behavioral symptoms related to their torture experiences. Themes identified as unique to torture survivors in the literature are: "incomplete emotional processing; depressive reactions; somatoform reactions; and

existential dilemmas” (Elsass, 1998, p. 36). These symptoms result from the purposeful effort by the torturers to destroy the very things that make the victims human. Many survivors report that the psychological wounds are the most painful, and have the longest lasting effects (Elsass, 1997; Engdahl & Eberly, 1990). These effects, however, are not totally distinct from the physical effects, as we find that there is significant overlap between emotional reactions and somatic reactions to human rights abuses (Quiroga & Jaranson, 2005). An example of this follows:

AD is a 50 year old Muslim, Fulani woman from Guinea who had experienced many incidents of abuse, including imprisonment, beatings, and sexual assault. Clinically, she was experiencing significant emotional distress (she was frequently tearful, despondent, anxious, and manifested frequent mood swings). Despite her emotional distress, she was not very “psychologically minded” in terms of understanding her current functioning as an aspect of mental distress (AD had very little formal education in her home country). Rather than using general psychological vocabulary such as “depressed” or “anxious,” she would describe somatic manifestations, such as “when I get upset, it feels like there are ants crawling on my scalp” or “my head is too hot.”

Somatic descriptions must be attended to by all members of the therapeutic team, not just the treating physicians, as they often go beyond purely medical phenomena. We must be careful not to go to the other extreme, and see every somatic complaint as purely psychological. If so, we may miss important medical data.

A young woman from Tibet presented to our medical clinic and complained that “it feels like something growing in my head.” At first, it was presumed that it may be a somatic complaint linked to mental health stressors, such as her state of depression. As she maintained the same complaint at her follow-up appointment, she was referred for a neurological screening. The CT scan showed that there was a cerebral tumor, and that her somatic complaint was indeed linked to a medical condition.

Torture has been described as, “unpredictable, unavoidable, and uncontrollable” (Gurris, 2001, p. 29). Torturers take special care to inflict the most psychological damage possible through methods as diverse as sensory and social deprivation, response conditioning, and the use of pharmacological agents. Mock executions and forcing prisoners to witness other victims being tortured or killed are common practices among torturers. Victims are often forced to engage in incongruent actions, and are frequently placed in no-win, “double-bind” situations, where they are faced with impossible choices (Berliner et al., 2004; Shrestha & Sharma, 1995).

In one example of a “double-bind” situation, a member of a liberation movement in a West African country was imprisoned, interrogated, and physically tortured for many days. His captors were not able to elicit the information they desired, so they used a double-bind tactic. A young, female member of the captive’s family was captured and placed in the adjoining cell. The captive was given the choice of

giving his captors the information they wanted, or witnessing the physical torture and rape of his young family member. No matter what choice this person made, it would be the “wrong choice” that would cause harm to his family member and/or his comrades in the liberation movement.

Typically, this kind of situation leads to emotional conflict and uncertainty, a blurring of “right and wrong,” and may assault the survivor’s emotional integrity with a sense of self-blame and “survivor guilt”. The survivor may feel as though they are unworthy of life or any sort of positive feelings, and may also feel that they have abandoned those who are still struggling and suffering in their home country. Survivors of torture are often led to believe that they are the ones guilty for inflicting pain on themselves and others (Elsass, 1997; Gurriss, 2001; Somnier & Genefke, 1986).

An example of this pattern is from a young torture survivor from Cote d’Ivoire who was repeatedly visited in his tiny, darkened prison cell by two different guards. The prisoner described one as the “good guard” and the other was the “evil guard.” The “evil guard” would mistreat and physically abuse the prisoner, while the “good guard” would try to take a pleasant, non-threatening approach to interrogation (as in the “good cop, bad cop” scenario that is often portrayed in TV and movies). Every time one of the guards would leave, the prisoner was left literally “in the dark,” not knowing who would appear next, or if his next “visit” would be the last of his life. During therapy, the survivor explained that those times of doubt and

anxiety, as he stayed alone in his cell, were more painful and stressful than the direct physical torture he experienced.

Survivors are often left to feel inadequate, powerless, and confused. Ambiguity and a general fear of the future are powerful tools used to assault one's psychological well-being. This is consistent with psychological literature in which survivors describe the anticipatory fear and pauses between torture sessions as the worst part of their mistreatment (Chester & Holtan, 1992; Gurriss, 2001).

Detrimental Effects of Torture

The detrimental effects of torture are wide-ranging and insidious. The goal of modern torture, beyond eliciting information or punishing particular individuals is to undermine the psychic integrity of an entire community. The effects of torture and refugee trauma have been described in the literature as the "Four D's": disintegration of the psyche; dispossession through multiple, recurrent losses; dislocation from home and country; and disempowerment in terms of dealing with the internal and external world (Silove, Tarn, Bowles, & Reid, 1991).

One of the major misconceptions about survivors of torture and refugee trauma is that there is one clearly defined pattern of reactions to this broad array of stressors that makes it easy to identify survivors. In actuality, reactions often vary between individuals who have experienced similar types of trauma including the multi-traumatic situation of the consequences of wars (Elsass, 1997; Fabri, 2001). There is no "magic question" or "tell-tale

sign” that will clearly differentiate between survivors and non-survivors with 100% specificity and sensitivity. There are, however, some general areas in which we may expect to see signs of distress. These signs can be physical, cognitive, emotional, and/or behavioral.

Physical Functioning

The physical symptoms of torture and refugee trauma are varied, and may manifest themselves differently from client to client (See Chapter 7). There may be identifiable scars or disfigurements that document the trauma endured (i.e. cigarette burns, scars, missing teeth, and/or amputations). There may also be decrements in physical functioning due to the abuse suffered that leave no scars, such as impaired vision from violent blows to the head. Insomnia, nightmares, and other sleep difficulties are among the most frequently reported symptoms by torture survivors (Quiroga & Jaranson, 2005). Frequently, there will be no outward signs of the physical trauma, as many torturers want to inflict the maximum amount of physical pain without leaving visible physical scars (Berliner et al., 2004; Keller, Eisenman, & Saul, 1998; Shrestha & Sharma, 1995).

Some of the most common physical symptoms may be linked to psychological distress. Many clients come from cultures where emotional/psychological distress is stigmatized or not readily discussed, so symptoms of distress are manifested as somatic, physical ailments (Briere, 2001; Chester & Holtan, 1992; Johnson, Hardt, & Kleinman, 1994). Clients may not be ready or able to discuss psychological issues, but easily describe the physical ailments they experience. As is common in patients with somatization disorder, clients may complain of frequent headaches, generalized fatigue, gastro-intestinal difficulties, or musculoskeletal pains

(Keller, et al, 1998; Piwowarczyk, Moreno, & Grodin, 2000). As these symptoms are being addressed, some of the connections between the physical and emotional symptoms may be addressed by the health professional, with a potential goal of engaging the client for mental health services (Carrillo, Green, & Betancourt, 1999).

Cognitive Functioning

Cognitive symptoms stemming from their traumatic experiences are another major area of concern. According to many refugee resettlement workers across the country, with whom we have conducted training seminars, some of the symptoms they see most often among their traumatized clients are cognitive in nature.

Cognitive symptoms frequently reported include difficulty concentrating, memory difficulties, excessive rumination, and active attempts not to think about anything reminiscent of their traumatic experiences. Clients have reported that they are no longer able to retain what they have just read or heard.

Frequently, clients may be caught between conflicting extremes of avoidance and intrusion (Elsass, 1997; Haenel, 2001; Horowitz, 1976). They may be inundated by intrusive symptoms such as rumination and nightmares, by which they cannot stop reliving their traumatic experiences. Simultaneously, they may avoid or deny their experience, and suffer emotional numbing.

The etiology of the decrements in functioning must be assessed. Blunt-trauma to the head, traumatic brain injury, and the associated neurological impairment may be the root cause of cognitive impairment, but

other psychological causes must also be considered. The following case is an example of this.

BB is a client from West Africa, who had previously studied law (he said he had been encouraged to go into law because of his “quick mind” and “good memory”). BB complained that he was no longer able to read more than one page at a time without his mind wandering. He stated that he had trouble remembering new information, and was experiencing difficulty in retaining anything from his English lessons.

In his trauma history, BB reported no history of head trauma or being unconscious. There was other physical abuse, including sexual abuse, involved in his torture. He reported that he spent a significant amount of time ruminating about his trauma and the family he had left behind, and that every time he could not retain information, it would frustrate him, and serve to remind him of what he had experienced, as well as the tenuous situation he was still trying to comprehend and endure.

It became clear that BB’s cognitive deficits were linked more to psychological reactions than to a particular neurological injury. The client followed a regimen of individual therapy, group therapy, and psychopharmacological interventions with an SSRI. He responded well to treatment, was able to gain his asylum, and has been reunited with his family. He now works full-time and is successfully pursuing a college degree.

Emotional Functioning

Emotional functioning is another important sphere affected by trauma. Research with Bosnian war survivors has shown that emotional difficulties and psychiatric diagnoses persist even after three years have elapsed since the fighting (Mollica et al., 2001). Other research shows that the co-morbid diagnoses of Depression and Posttraumatic Stress Disorder (PTSD) tend to improve slowly among Indo-Chinese refugees, and these symptoms are prone to recur over time when exacerbated by external stressors (Kinzie et al., 1997). It has been noted that Major Depression and PTSD are the two most frequently utilized diagnoses for this population, and that while PTSD seems to garner the most attention, Major Depression may be the most prevalent psychological stressor (Mollica, 2004). Again, research data indicate that the emotional distress can become chronic for a majority of torture survivors living in exile (Carlsson et al., 2005).

As defined by the DSM-IV-TR (APA, 2000), survivors may be buffeted by a wide range of psychological disorders. They may experience Generalized Anxiety Disorder, which is characterized by excessive and uncontrollable worry about everyday things. The frequency, intensity, and duration of the worry are disproportionate to the actual source of worry, and often interfere with daily functioning. PTSD and specific phobias are other examples of anxiety disorders that are characterized by chronic worries and nervousness, which disturb a survivor's mood, thoughts, behavior and/or physiological activity.

Survivors may also be troubled by substance dependence, meaning the compulsive use of drugs, to the point where the user has no effective choice but to continue use. The substance dependence may have begun as an effort to self-medicate, or reduce tension, but grows beyond the survivor's control

(Briere & Scott, 2006). Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or self-worth, disturbed sleep or appetite, low energy, and poor concentration (APA, 2000). These disorders are among many that may affect survivors of torture and refugee trauma, given their traumatic experiences and current challenges. For the purposes of this chapter, we will focus on some general signs that a survivor may be struggling with psychological and emotional issues, and will briefly touch on the ongoing debate as to whether these psychological reactions are “normal reactions” to “abnormal circumstances.”

Clients may frequently manifest emotional symptoms typical of someone who is grieving. Clients may commonly become tearful, and may express sadness. They may express longing for family members and friends who are missing or have been left behind. These feelings of sadness and grief may be accompanied by suicidal thoughts or more passive questioning of the purpose of life in general.

Clients may also report being fearful and distrustful (Shrestha & Sharma, 1995). Clients may feel that they are being pursued by people who would harm them. This may be a function of the perceived hostile nature of their new environment, or it may be bolstered by delusional thinking. We have had a handful of clients who were convinced that the security forces from their home countries were working in tandem with the New York Police Department to spy on them and abuse them. This sense of fear and mistrust may make it difficult for them to engage in a trusting relationship.

Feelings of “survivor guilt” are common among survivors of torture and refugee trauma. Some clients may feel as if they are not deserving of life or any sort of positive experiences and/or feelings. Clients who have

survived extreme situations where others have perished may question their own actions (or inaction) during the tumult. These questions may feed into lingering self-doubt and self-blame (Elsass, 1997). Emotions associated with “survivor guilt” can make treatment and adaptive self-care more difficult for clients. These emotions may negatively impact on a client’s motivation to engage in the healing process, and may hinder them from committing fully to treatment. Some helpful interventions for countering this will be covered in Chapter 11 of this volume.

An example of how emotional responses may differ from client to client is the presentation of affect. Some clients will present in a volatile, emotionally charged manner. For many, there may be a wide range of emotions expressed as they recount their trauma history. Some may view relating their trauma history as a cathartic experience. In contrast, others may present with a flat affect. They may relate the most intimate and painful details of their trauma without changing the tone of their voice, or their rate of speech. The cognitive and emotional aspects of the personality may appear disconnected from one another (Randall & Lutz, 1991). For example, this disconnection has been an important issue in our training sessions with United States Citizenship and Immigration Service officers (USCIS), and United States Immigration and Customs Enforcement judges (ICE). These immigration officials often ask how torture survivors will present emotionally and we educate them that there is no one single way that torture survivors will present.

Behavioral Functioning

Changes in one's perceived health status, patterns of thinking, and emotional functioning will of course have significant impact on one's behavior. Behavioral functioning is another area where resettlement workers, teachers, and job counselors often report that they observe signs that comprehensive mental health services may be needed for a particular survivor.

There may be signs of behavioral withdrawal that mirror the attempts to avoid thoughts that pertain to the traumatic past (Randall & Lutz, 1991). Some clients may avoid individuals who come from their home countries or their region of the world. Some clients report avoiding any information such as news broadcasts, internet reports, etc. about the situations in their home countries. Some have said that any new information, particularly negative news, can be overwhelming. In contrast, other clients may be very active in gathering as much information as possible. Clients have described this as an attempt to "stay connected" to the struggle and people they have left behind.

These dichotomous reactions reflect the precarious emotional balance that survivors are trying to maintain, and demonstrates the different ways that survivors may react to similar stressors. Clients may have difficulty balancing their needs for assurance and connection, while maintaining vigilance against external threats and triggers that may activate painful memories (Elsass, 1997; Haenel, 2001; Silove et al., 1991). They may fluctuate from behaving as though they are anesthetized, to experiencing intense surges of affect brought about by intrusive thoughts and dreams.

Consequently, clients may manifest swift changes in mood. Many clients report becoming irritated without being cognizant of why their mood changed so quickly (Shrestha & Sharma, 1995). The difficulties with concentration and memory may display themselves as missed appointments,

tardiness, and forgetting some of the specifics about the trauma history (Briere, 2001). This poses problems for the resettlement process, and may cause difficulties in seeking political asylum.

The emotional burden with which clients are coping may also manifest itself in an exaggerated startle response to noises. Sudden noises, particularly those that are similar to sounds that may have been heard during the traumatic period (i.e. a car back-firing may seem like gun shots), can cause the clients to become jumpy or perspire profusely. Clients may become visibly frightened and avoid people they encounter who are wearing uniforms, particularly if they have been tortured by people in official capacities such as police or military personnel.

Clients may also seek coping mechanisms that are not always positive or therapeutic. This may lead to detrimental changes in behavior such as clients engaging in substance abuse. Such “self-medicating” behavior is common for people who suffer from anxiety disorders, such as PTSD, and/or major depression (Briere & Scott, 2006). The literature shows that substance abuse levels among trauma survivors who develop full-blown PTSD are elevated, relative to levels among survivors who do not develop PTSD (Chilcoat & Breslau, 1998). Although reported substance abuse levels are higher among US war veterans than among traumatized refugees (i.e. Quiroga & Jaranson, 2005), it remains an area of significant concern, especially among younger male refugees, as the prevalence seems to be higher among men than women (Kastrup & Arcel, 2004). This is a potentially major issue to explore regarding survivors of refugee trauma who are searching for ways to cope with feelings of anxiety, hopelessness, and depression.

Normal Reactions to Abnormal Circumstances?

The multiple stressors that survivors of torture and refugee trauma have experienced (and continue to experience) manifest themselves in varying and complex ways. There are some reactions that many clinicians view as “normal reactions to abnormal stressors,” while other clinicians may view similar symptoms as aspects of a mental illness. Questions as to whether these reactions/symptoms fall along a normative continuum, and whether psychiatric diagnoses stigmatize refugee populations are currently being debated in psychiatric and psychological circles. Aspects of this debate will be covered in more detail in Chapter 8 of this book, but for now it is important to note that the psychological context that survivors of torture and refugee trauma are navigating does challenge some of the practical conceptions of the diagnosis of Posttraumatic Stress Disorder (PTSD), as currently defined.

Refugees who have survived traumatic events are assaulted with a continuous series of attacks on their psychological and emotional integrity. Consequently, some theorists argue that the “post” in post-traumatic stress disorder can be misleading (Akukwe, Smith, & Wokocha, 2000; Briere, 2001; Elsass, 1997; Herman, 1992). Survivors are not just reacting to an isolated traumatic experience from the past; they are reacting to a constant barrage of emotional and cultural challenges, including changes in how they perceive the world and themselves (Berliner et al., 2004),

The challenges facing refugees are potentially traumatizing in and of themselves, and serve to exacerbate the psychological distress of previously traumatized individuals (Quiroga & Jaranson, 2005). The stressors work to maintain the survivor’s experience of trauma in the present tense. It has been argued that stimuli reminiscent of the trauma become generalized and can

evoke psychological responses long after the trauma has passed (Gurris, 2001; Mollica et al., 2001; Randall & Lutz, 1991). Such recurrent and reinforcing stressors have been referred to in the literature as a different entity from “classic” PTSD, and given names such as “complex-PTSD syndrome” (Herman, 1992) “on-going traumatic stress disorder” (Elsass, 1997; Straker, 1987), “torture syndrome” (Genefke & Vesti, 1998), “sequential traumatization” (Basoglu et al., 1994), and “DESNOS - disorder of extreme stress not otherwise specified” (Herman, 1992).

The diagnosis of PTSD can possibly carry the stigmatizing notion that there is something inherently wrong psychologically with the client, which contrasts directly with the views of some clinicians who wish to normalize the status of victims suffering from PTSD (Haenel, 2001; Lira, 1998; Yehuda & McFarlane, 1995). Other theorists argue that PTSD may be viewed as a purely Western construct that may not be appropriate for clients from various non-Western cultures (Chakroborty, 1991).

However, many studies suggest that the majority of people exposed to one-time traumatic stressors like car accidents, earthquakes etc. do not experience PTSD, and that those who develop PTSD usually see a decrease in symptoms over time (Shalev, Peri, Canneti, & Schreiber, 1992). It can also be argued that a common psychological reaction is not necessarily normative, just because it arises in a significant number of cases (Jaranson, 1998).

The question may be raised, however, if these findings can be applied to survivors of torture and refugee trauma for whom the stressors are not isolated in the past. For these people, the every day stressors may act as triggers that keep the memories of the trauma, as well as the painful life changes associated with refugee trauma, very much alive in their minds

(Briere, 2001; Haenel, 2001; Keller et al., 1998). In essence, the symptoms associated with PTSD are frequently exacerbated and confounded by the imposed developmental delays associated with torture and warfare (i.e. survivors not being able to work, study, marry, or create wealth in their home countries), as well as the realities of refugee trauma and living in exile (Quiroga & Jaranson, 2005; Van Velsen, Gorst-Unsworth, & Turner, 1996).

Thus, the diagnosis of a psychological “disorder,” may potentially further disempower a survivor of torture and may discourage potential clients to refrain from seeking out the services that they need (Berliner et al., 2004). To counter this notion of stigma, many clinicians try to conceptualize the troubling psychological symptoms to these traumatic events as “normal reactions” (Reeler, 1994).

There is, however, a potential danger in over-normalizing survivors’ reactions. If all client reactions are seen as normal, clinicians may ignore important diagnostic data and miss opportunities for effective psychiatric intervention. This may impede upon the optimal treatment for the client (see Chapter 8). In fact, it has been noted that when survivors learn that their suffering “has a name,” it can be validating for them, and lead to further engagement in treatment (Fabri, 2001, p. 452). This distinction between normalizing and pathologizing the reactions of survivors are currently being debated within our program and within the field of psychology itself (Quiroga & Jaranson, 2005; Randall & Lutz, 1991; Yehuda & McFarlane, 1995).

Suffice it to say that regardless of the way a survivor’s reactions/symptoms are categorized diagnostically, it is a reality that the recurrent traumas experienced reveal themselves in various domains of functioning. In our program, we try to strike a balance between the utility of

using a diagnosis that provides pertinent clinical information, without endorsing a “one size fits all” label that can serve to stigmatize clients, or dissuade them from accessing clinical services. There have been calls in the literature to view PTSD more as a sign of a need for assistance, rather than pathology per se (Quiroga & Jaranson, 2005). In this book, we will consider some of the ways of engaging clients in medical and mental health treatment to address these complex and reinforcing stressors.

Appendix A

Types of Torture Most Frequently Reported at the Bellevue/NYU Program for Survivors of Torture (in alphabetical order).

Physical Abuse

Blindfolded
Bound or tied up
Being burned (e.g. with cigarettes)
Blows with rifle butts, heavy sticks, sharp instruments etc.
Deprived of needed medical care for more than 48 hours
Electric shock
Falanga- Beatings on soles of feet
Food deprivation
Forced feeding
Forced performance of sexual acts
Forced sitting or kneeling
Held in detention
Held in isolation
Maiming or breaking bones
Overcrowding with minimal food and comfort for more than 48 hours
Rape by someone of the opposite sex (individual or group)
Rape by someone of the same sex (individual or group)
Sexual molestation
Slapping/kicking/punching
Suspension of body
Telefono-Clapping on ears with the mouth shut
Water deprivation

Psychological Abuse

Being under surveillance
Death threats against family
Death threats against self
Degradation (such as forced to be naked, denial of hygiene, etc.)
False accusations
Forced to witness family being tortured
Forced to witness others being tortured
General threats/Harassment
Mock executions
Threats against friends or colleagues
Verbal abuse

References

- Akukwe, C., Smith, H., & Wokocha, E. (2000). Enhancing the well-being of African refugees. In I. Berhane (Ed.), *Proceedings from the conference "African Refugees and the US response: Twenty years of resettlement"* (pp. 67-74). Arlington, VA: Ethiopian Community Development Council/African Resource Network.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text Revision). Washington DC: Author.
- Amnesty International. (1984). *Torture in the eighties. USA Edition*. Amnesty International Publications.
- Baker, R. (1992). Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. In M. Basoglu (Ed.), *Torture and Its consequences: Current treatment approaches* (pp. 83-101). Cambridge, England: Cambridge University Press.
- Basoglu, M., Paker, M., Paker, Ö., Özmen, E., & Sahin, D. (1994). Factors related to long-term traumatic stress responses in survivors of torture. *Journal of the American Medical Association*, 272, 357-63.
- Berliner, P., Mikkelson, E., Bovbjerg, A., & Wiking, M. (2004). Psychotherapy treatment of torture survivors. *International Journal of Psychosocial Rehabilitation*, 8, 85-96.
- Bhui, K., Abdi, A., Abdi, M., Pereira, S., Dualeh, M., Robertson, D., et al. (2003). Traumatic events, migration, characteristics and psychiatric symptoms among Somali refugees. *Social Psychiatry and Psychiatric Epidemiology*, 38, 35-43.
- Briere, J. (2001, July). *Evaluation, measurement, and assessment approaches with severely traumatized populations*. Presentation to the

- Clinical Leadership Conference of the National Consortium of Torture Treatment Centers, Minneapolis, MN.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, London, New Delhi: Sage Publications.
- Carlsson, J.M., Mortensen, E.L., & Kastrup, M. (2005). A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. *Journal of Nervous and Mental Disease, 193* (10), 651-657.
- Carlsson, J.M., Mortensen, E.L., & Kastrup, M. (2006). Predictors of mental health and quality of life in male tortured refugees. *Nordic Journal of Psychiatry 60* (1), 51-57.
- Carlsson, J.M., Olsen, D.R., Mortensen, E.L., & Kastrup, M. (2006). Mental health and health-related quality of life: A 10 year follow-up of tortured refugees. *Journal of Nervous and Mental Disease, 194* (10), 725-731.
- Carrillo, J., Green, A., & Betancourt, J. (1999). Cross-cultural primary care: A patient based approach. *Annals of Internal Medicine, 130*, 829-834.
- Chakraborty, A. (1991). Culture, colonialism, and psychiatry. *The Lancet, 337*, 1204- 1207.
- Chester, B., & Holtan, N. (1992). Working with refugee survivors of torture. *Western Journal of Medicine, 157* (Special Issue: Cross-Cultural Medicine: A Decade Later), 301-304.
- Chilcoat, H., & Breslau, N. (1998). Investigation of causal pathways between PTSD and drug use disorders. *Addictive Behaviors, 23*, 827-840.

- Crosby, S., Norredam, M., Paasche-Orlow, M.K., Piwowarczyk, L., Heeren, T. & Grodin, M.A. (2006). Prevalence of torture survivors among foreign-born patients presenting to an urban ambulatory care practice. *Journal of General Internal Medicine, 21*, 764-768.
- de Jong, J. (2002). Public mental health, traumatic stress and human rights violations in low- income countries. In J. de Jong (Ed.), *Trauma, war, and violence: Public mental health in socio-cultural context* (pp.1-92). New York: Kluwer Academic/Plenum Publishers.
- Drozdek, B., & Wilson, J.P. (2004). Preface: Broken spirits in an era of trauma, terrorism, and globalization. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. xxvii – xxx). New York: Brunner-Routledge.
- Eisenman, D.P., Gelberg, L., Liu, H., & Shapiro, M.F. (2003). Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence. *Journal of American Medical Association, 290*, 627-634.
- Eisenman, D.P., Keller, A.S., & Kim, G. (2000). Survivors of torture in a general medical setting: How often have patients been tortured, and how often is it missed? *Western Journal of Medicine, 172*, 301-304.
- Elsass, P. (1997). *Treating victims of torture and violence: Theoretical, cross-cultural, and clinical implications*. New York and London: New York University Press.
- Elsass, P. (1998). The existence of a torture syndrome. *Torture, 8*, 58-64.
- Engdahl, B.E., & Eberly, R.E. (1990). The effects of torture and other maltreatment: Implications for psychology. In P. Suedfeld (Ed.),

- Psychology and torture* (pp.31-47). New York: Hemisphere Publishing.
- Fabri, M.R. (2001). Reconstructing safety: Adjustments to the therapeutic frame in the treatment of survivors of political torture. *Professional Psychology: Research and Practice*, 32(5), 452-457.
- Fischman, Y. (1998). Metaclinical issues in the treatment of psychopolitical trauma. *American Journal of Orthopsychiatry*, 68(1), 27-38.
- Fischman, Y., & Ross, J. (1990). Group treatment of exiled survivors of torture. *American Journal of Orthopsychiatry*, 60 (1), 135-142.
- Genefke, I., & Vesti, P. (1998). Diagnosis of governmental torture. In J.M. Jaranson & M.K. Popkin (Eds.), *Caring for victims of torture* (pp. 43-59). Washington DC: American Psychiatric Press.
- Gurris, N. (2001). Psychic trauma through torture – Healing through psychotherapy? In S. Graesner & N. Gurris (Eds.), *Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity* (pp. 29-56). Baltimore, MD: Johns Hopkins University Press.
- Haenel, F. (2001). Foreign bodies in the soul. In S. Graesner & N. Gurris (Eds.), *Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity* (pp.1-28). Baltimore, MD: Johns Hopkins University Press.
- Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror*. New York: Basic Books.
- Holtz, T.H. (1998). Refugee trauma versus torture trauma: a retrospective controlled cohort study of Tibetan refugees. *Journal of Nervous and Mental Disorders*, 186, 24-43.
- Horowitz, M.J. (1976). *Stress response syndromes*. New York: Jason Aronsen.

- Jaranson, J.M. (1998). The science and politics of rehabilitating torture survivors: An overview. In J.M. Jaranson & M.K. Popkin (Eds.), *Caring for victims of torture* (pp.15-40). Washington DC: American Psychiatric Press.
- Jaranson, J.M., Butcher, J., Halcon, L., Johnson, D.R., Robertson, C., Savik, K., et al. (2004). Somali and Oromo refugees: Correlate of torture and trauma history. *American Journal of Public Health, 94*, 591-598.
- Jaranson, J.M., & Popkin, M. (Eds.). (1998). *Caring for Victims of Torture*. Washington, DC: American Psychiatric Press.
- Johnson, T., Hardt, E., & Kleinman, A. (1994). Cultural factors in the medical interview. In M. Lipkin, S.M. Putnam, & A. Lazare. (Eds.), *The Medical Interview* (pp.153-162). New York: Springer-Verlag New York, Inc.
- Kastrup, M.C., & Arcel, L. (2004). Gender specific treatment. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp.547-571). New York: Brunner-Routledge Press.
- Keller, A., Eisenman, D. & Saul, J. (1998). Caring for survivors of torture in an urban, municipal hospital. *Journal of Ambulatory Care Management, 21*(2), 20-29.
- Keller, A., Ford, D., Sachs, E., Rosenfeld, B., Meserve, C., Trinh, et al. (2003). *From persecution to prison: The health consequences of detention for asylum seekers*. Boston and New York: Physicians for Human Rights and The Bellevue/NYU Program for Survivors of Torture.
- Kinzie, J.D., Leung, P.K., & Boehnlein, J.K. (1997). Treatment of depressive disorders in refugees. In E. Lee (Ed.), *Working with Asian*

- Americans: A guide for clinicians* (pp. 265-274). New York: The Guilford Press.
- Lie, B. (2002). A 3-year follow up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavica*, *106*, 415-425.
- Lira, E. (1998). Commentary: Managing the care of patients with chronic illness and human rights survivors. *Journal of Ambulatory Care Management*, *21*, 51-55.
- Mollica, R.F. (2004). Surviving torture. *New England Journal of Medicine*, *351*, 5-7.
- Mollica, R., Sarajlic, N., Chernoff, M., Lavelle, J., Vukovic, I. & Massagli, M. (2001). Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. *Journal of the American Medical Association*, *286* (5), 546-554.
- Montgomery, E., & Foldspang, A. (1994). Criterion-related validity of screening for exposure to torture. *Danish Medical Bulletin*, *41*, 588-591.
- Office of Refugee Resettlement. (2006). *Office of Refugee Resettlement (ORR) Services for Survivors of Torture Program*. Retrieved November 15, 2006, from <http://www.acf.hhs.gov/programs/orr/programs/torturep.htm>
- den Velde, W.O., Hovens, J.E., Bramsen, I., McFarlane, A.C., Aarts, P.G.H., Falger, P.R.J., et al. (2000). A cross-national study of posttraumatic stress disorder in Dutch Australian immigrants. *Australia New Zealand Journal of Psychiatry*, *39*, 919-928.
- Piwowarczyk, L., Moreno, A., & Grodin, M. (2000). Health care of torture survivors. *JAMA*, *284*, 539-541.

- Quiroga, J., & Jaranson, J.M. (2005). Politically-motivated torture and its survivors: A desk study review of the literature. *Torture, 15* (Thematic Issue, 2-3), 1-111.
- Randall, G., & Lutz, E. (1991). *Serving survivors of torture*. Washington, DC: Association for the Advancement of Science.
- Reeler, A.P. (1994). Is torture a post-traumatic stress disorder? *Torture, 4*, 59-63.
- Roth, G., & Ekblad, S. (2002). Decreased levels of cortisol and testosterone among mass evacuated adults from Kosovo with trauma experience and PTSD. *European Psychiatry, 17* (Suppl. 1), 94s.
- Shalev, A.Y., Peri, T., Canneti, L., & Schreiber, S. (1992). Prospective study of posttraumatic stress disorder and depression following trauma. *American Journal of Psychiatry, 155*, 630-637.
- Shrestha, N., & Sharma, B. (1995). *Torture and torture victims: A manual for medical professionals*. Kathmandu, Nepal: Center for Victims of Torture, Nepal.
- Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum seekers: Associations with pre-migration trauma and post-migration stressors. *British Journal of Psychiatry, 170*, 352-357.
- Silove, D., Tarn, R., Bowles, R., & Reid, J. (1991). Psychosocial needs of torture survivors. *Australian and New Zealand Journal of Psychiatry, 25*, 481-490.
- Somnier, F., Vesti, P., Kastrup, M., & Genefke, I.K. (1992). Psychological consequences of torture: Current knowledge and evidence. In M. Basoglu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 56-71). Cambridge: Cambridge University Press.

- Somnier, F., & Genefke, I. (1986). Psychotherapy for victims of torture. *British Journal of Psychiatry*, 149, 323-329.
- Straker, G. (1987). The continuous traumatic stress syndrome: The single therapeutic interview. *Psychology in Society*, 8, 48-78.
- United Nations. (1984). *Convention against torture and other cruel, inhuman or degrading treatment or punishment*. U.N.Doc. A/39/51.
- United States Committee for Refugees and Immigrants. (2006). *World refugee survey 2006: Risks and rights*. Washington, DC: US Committee for Refugees.
- van der Veer, G. (1998). *Counselling and therapy with refugees and victims of trauma (2nd ed.): Psychological problems of victims of war, torture and repression*. New York: John Wiley & Sons.
- Van Velsen, C., Gorst-Unsworth, C., & Turner, S. (1996). Survivors of torture and organized violence: Demography and diagnosis. *Journal of Traumatic Stress*, 9(2), 181-193.
- Volkan, V.D. (2004). From hope for a better life to broken spirits: An introduction. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. 7-12). New York: Brunner-Routledge.
- World Health Organization. (1986, April). *The health hazards of organized violence*. Report on a WHO meeting, Veldhoven, Netherlands.
- Yehuda, R., & McFarlane, A.C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry*, 152(12), 1705-1713.

Chapter 2

Multicultural Issues in the Treatment of Survivors of Torture and Refugee Trauma: Toward an Interactive Model – Summary

This chapter explores the complexities of interacting with survivors of torture and refugee trauma across (and within) cultures. There is an emphasis on the professionals being open to engaging in the necessary work of self-exploration regarding their own cultural reference group identities. The chapter explores the mediating factors that help to determine how someone makes sense of their multiple cultural identities, and provides an interactive model of communication that facilitates the exploration of these issues. The importance of self-definition is addressed, not just in the context of culture, but across domains of psychological functioning.

* Introduction

Historical progress in multicultural understanding, but more progress needed

Not a “cookbook technique”

Not a simple study of “cultural others” – a focus on the interactive relationship

* Complex cultural beings

Multiple reference group identities

Saliency of identities

* Assumptions of similarity

* Cultural values - Table 1: Existential cultural categories: Range and variation

* Mediating factors

* Interactive model - Figure 1: Interactive cycle in cross-cultural relationships

* The power to define

* Self-knowledge as clinicians and service providers

Multicultural Issues in the Treatment of Survivors of Torture and Refugee Trauma: Toward an Interactive Model

Hawthorne E. Smith, Ph.D.

Introduction

The field of psychology has come a long way in terms of multicultural perspectives to treatment, but there is still significant progress to be made. Psychology has moved past the era when beliefs in racial superiority/inferiority were widely held, and when people of color and individuals coming from non-Western societies were seen as being too unsophisticated to benefit from treatment (i.e. Evarts, 1913; Hall, 1904; Lind, 1913, cited in Carter, 1995).

The discipline of psychology has also largely moved beyond the era of espousing “cultural deprivation,” where populations that did not conform to White/Western European standards of culture were stigmatized as being culturally deprived or deficient (Helms, 1990). Now we are in the era of “cultural difference,” where differences in culture and approaches to mental health are not seen as being pathological, and culturally informed treatment is seen as a clinical necessity. Helping clients to develop a deeper understanding of their cultural identities can help them to navigate our increasingly diverse society (Carter & Goodwin, 1994; Elsass, 1997).

The necessity for culturally informed treatment is especially important for those of us working with refugee populations. By definition, we are working with individuals who have been uprooted from their homelands and normative cultures. Frequently, issues of identity and cultural difference may

be among the reasons that people have been persecuted and/or forced to flee their homelands (Elsass, 1997).

Refugees are moving across national borders and cultural boundaries under significant duress. They may be confronted with acculturation stressors such as linguistic barriers, alienation, prejudice, xenophobia and discrimination in their new environment (Pope & Garcia-Peltoniemi, 1991; Randall & Lutz, 1991; Silove, Tarn, Bowles, & Reid, 1991; Stanton, 1985). We are challenged as caregivers to cross emotional, cultural, and social divides so that our clients may be better equipped to navigate the plethora of divides and challenges they are facing.

The notion of cultural difference is an important advance in thinking that helps caregivers to conceptualize treatment, but there are some common misconceptions that are important to avoid. The cultural difference paradigm (and multicultural psychology in general) is not meant to be seen as a “cookbook technique.” It cannot be assumed that a person’s identity will mirror the values attributed to his/her particular cultural group (Berry, 1990; Cross, 1994). A key theme in this chapter is that knowing how individuals construct their cultural identities is more important than simply knowing to which cultural reference groups they belong. Focusing on the client’s perceptions of the importance of their cultural background helps clinicians to overcome “risks in exaggerating or underemphasizing the cultural dimensions in psychological treatment” (Silove et al., 1991, p. 489).

Another misconception frequently held about multicultural psychology is that it is a simple study of “cultural others.” Many clinicians may undervalue or deny the importance that their own cultural background holds in terms of how they conceptualize and engage in treatment (Carter, 1995; Gurriss, 2001). A clinician may see a client’s behavior in terms of the

existing models of pathology within the clinician's population, leading to potential misdiagnoses and misunderstandings (Lansen & Haans, 2004). Frequently, psychology trainees and graduate students may expect that it will be sufficient to simply review cultural traits of different cultural groups they will contact in the course of their work. However, if training materials and academic curricula continue to place the onus on the "other," this actually falls back into the pattern of the cultural deprivation arguments, where the major scrutiny and the burden of change (adaptation) remain with disempowered groups.

Complex Cultural Beings

As clinicians we are not cultural blank slates dealing with some "other" who is "culturally different." We are engaged in a relationship between two people who are different from one another. Students and trainees are sometimes surprised (pleasantly or otherwise) to learn that working across (and within) cultures requires significant reflection on themselves as cultural beings (Pinderhughes, 1989).

We are all complex cultural beings with multiple reference group identities. Examples of cultural reference group identities are race, ethnicity, social class, religion (or lack thereof), gender, age, level of education, sexual orientation, urban v. rural, physical (dis)ability, linguistic group...just to name a few. All human beings possess these identities, although the salience attached to the identities (whether personal or societal) may vary widely.

Many survivors of torture and refugee trauma have been persecuted because they belong to, or are labeled as belonging to particular groups. For example, knowing the race or social class of a refugee from the genocide in

Rwanda may not be as salient as knowing about their ethnicity, since they are coming from a situation where being labeled a Hutu or Tutsi could mean the difference between life and death. Knowing the social class or race of someone who has lived through the “troubles” in Northern Ireland is probably not as salient as knowing their religious affiliation, because being Catholic or Protestant is often what defines a person’s experience of that struggle.

Frequently the identities that are salient for the clinician are different from what is salient for the client. If the clinician is not aware of his or her own biases and assumptions, gross miscommunications can ensue. The following is a personal example from a training session conducted for new Customs and Immigration Services (formerly the Immigration and Naturalization Service) asylum officers.

As I began to speak about multicultural issues to the group of 50 asylum officer-trainees, I noticed that there were two White men who were probably in their mid-to late fifties sitting toward the back of the room. These men seemed somewhat disengaged from what I had to say from almost the beginning of my talk. My personal experience as a Black American has been that race is the most salient issue in terms of cultural identity and social interactions. I defensively assumed that perhaps these White men thought that they “could not learn anything from a Black man,” and that is why they seemed to be tuning me out.

Fortunately, I had the time to talk with these men after my presentation. I asked them frankly about their apparent disinterest, and they answered me in an equally honest manner. One man stated that he had a “healthy skepticism” of psychology and psychologists, and figured I’d just be talking some “P.C. stuff” with little real world application. The other man

spoke about my age. He stated that when he saw how relatively young I was that he figured he'd "been working longer than I'd been breathing." The three of us had a lively conversation and learned a lot from each other.

I give this example because I had completely misread what was going on for these two men because of the assumptions I brought into the room. I had assumed that race was the salient issue when actually they were more concerned with my professional affiliation and age. By becoming consciously aware of my assumptions, and exploring them with the people with whom I was interacting, I was able to help foster freer communication and deeper understanding between us. This example illustrates the point made about clinicians knowing what is "going on in their chair" in order to know what is going on in the room (Pinderhughes, 1989).

Clinicians need to develop a deeper understanding of themselves as cultural beings in order to engage effectively with diverse client populations. This self-understanding helps to deepen awareness about the nature of objectivity and subjectivity in therapeutic interactions. This includes, but is not limited to, psychological assessment and the attribution of symbolism and status to specific verbalizations and behaviors. This deeper understanding is called for not only in situations where clinicians assume there will be cultural difference, but also in cases where clinicians assume that there is cultural similarity between themselves and the client.

Assumptions of Similarity

Another potential misperception regarding multicultural psychology is that it is only applicable when the client and clinician come from different cultural reference groups. A narrow focus on "difference" may lead

clinicians to a false sense of security when they are in a room with someone who appears to be culturally similar. Remember that it is more important to know what sense someone makes of their reference group identities than just knowing to what groups they belong. Assumptions of similarity can lead to collusions in silence, where clinician and client mistakenly assume they understand one another. Assumptions of similarity can be just as harmful to a therapeutic relationship as misreading cultural differences (Carter, 1995; Helms, 1990).

Clinicians should recognize that it is not always advisable to assign refugees to clinicians from their home country or culture. I have conducted trainings with resettlement agencies where they related stories about refugees from Russia and Haiti who were quite upset to be assigned clinicians from their respective homelands. The Russian refugees expressed anxiety about possibly having their personal affairs exposed, and being stigmatized, within the tight-knit Russian community. They also expressed fear of not really knowing “who was who,” and any potential repercussions that might befall them if they spoke openly about their experiences. One of the first Haitian clients assigned at this particular agency was a mixed-race “métisse” who had strong opinions regarding racial issues. This client viewed his Black Haitian clinician as a less qualified “affirmative action” clinician, and requested an assumedly more qualified, White American therapist.

I worked for several years as a therapist in a high school for students with emotional difficulties on Manhattan’s Lower East Side. I know that students from the same racial, ethnic and socio-economic backgrounds viewed me in diverse ways, even when I shared their racial and ethnic affiliations. I’ve had young Black American males express admiration and

respect for the fact that I had attained my doctorate and was “making it” in the world. Some even spoke of wanting to achieve similar goals. There were other young Black males who viewed me as a sell-out, an “Oreo,” or an “incog-negro” because I was wearing a suit and tie and playing “the White man’s game.” Just because a young Black American man is assigned to a Black American male therapist does not mean that they will understand their reference group identities, or the world, in similar manners.

In addition to obstructing an accurate understanding of the client’s worldview, assumptions of similarity may also feed into a clinician’s idealized sense of the client, and fuel a type of pre-emptive counter-transference that can impede the growth of the therapeutic relationship (Eisenman, Bergner, & Cohen, 2000).

A clinician may also be surprised to find that the client views them in ways that are antithetical to how they view themselves. For example, I was once assigned the case of an escaped slave from Niger. As I am descended from slaves on both sides of my family, I took a particular interest in this case and expected that there would be a natural affinity between us.

During our first session the client from Niger spoke of a general distrust and fear of White people based on his life’s experiences. He then shared that due to my relatively light skin tone, I would be much more likely to be a slave owner than a slave in his country. He perceived me as a White person even though I’ve been categorized and have identified myself as Black all of my life. The client and I worked through our perceptions, and I provided some information on the way race has been constructed here in the US. Our therapeutic relationship became a long and successful one, in part because we were able to address our perceptions and assumptions early in the treatment.

Cultural Values

Thus far this chapter has emphasized that it is more important to know what sense someone makes of their reference group identities than just to know what groups they belong to. Having discussed the complex nature of cultural reference groups, notions of cultural difference, the perceived salience of group membership, and assumptions of similarity, it is useful to acknowledge the existence of some broad cultural categories that are widely recognized in the psychological literature.

It is informative to consider how these cultural frameworks impact upon the development of an individual's stereotypes regarding other groups, as well as an individual's view of their own group. Judicious use of these broad cultural categories, and the ways cultural norms and expectations may impact therapy, give us a backdrop to help assess what meaning people make of their reference group identities, and what psychological stressors they may be facing as the cultural norms shift due to their flight from oppression.

These broad conceptions of cultural values are important in terms of context. What are the norms and expectations of a particular culture? Is there congruence and/or conflict between an individual's worldview and the worldview of the culture to which they once belonged? What changes in worldview are necessary to adapt to one's new cultural milieu? When people from different backgrounds engage one another how is it navigated? Whose values are dominant or valued in the therapeutic context?

There are many theorists who have addressed the notion of cultural values. Among them, Kluckhohn and Strodtbeck (1961) constructed a continuum of attitudes based on a society's views of human nature (good,

bad, or mixed); time orientation (whether they focus on the past, present, or future); relations with nature (mastery over nature, harmony with nature, or submission to nature); human relationships (linear, collateral, or individualistic); and activity orientation (focus on being and existence, focus on spiritual growth and “being in becoming,” or focus on achievement and doing). The graph in Table 1 illustrates their framework.

Table 1. Existential Cultural Categories: Range and Variations

Human Nature	Human Relationships	People and Nature	Time Orientation	Activity Orientation
Bad	Linear-Hierarchical	Subjugation and Control	Past	Being
Good and Bad	Collateral-Mutual	Harmony	Present	Being in Becoming
Good	Individualistic	Power of Nature	Future	Doing

Note. From “Cultural value differences between African Americans and White Americans,” by R.T. Carter, 1990, *Journal of College Student Development*, 31, p.71-79. Copyright 1990 by Journal of College Student Development. Adapted with permission.

White American and Western European cultural norms have been described by cultural theorists (i.e. Lind, 1995; Stewart & Bennet, 1991) as believing that human nature is evil or mixed as demonstrated by the notion

of original sin and the need for confession and/or atonement to reach paradise. Mastery over nature is sought and valued and the focus on time is geared toward the present and future. Value is placed on doing and achieving and the individual is seen as the preeminent social unit. There is a focus on personal preference and a general need to conform to social rules. The Judeo-Christian belief system is revered, and the aesthetic norms tend to be European. It should be noted that this is the cultural base from which psychology and psychotherapy have arisen (Frederickson, 1988).

Black or African cultural norms are described as focusing on collateral relations such as strong kinship bonds, extended family [blood and non-blood] and flexible family roles. The time orientation has been described as based in the present for Black Americans (i.e. Carter, 1995) and based in the past for many Africans who closely follow traditions and respect and revere their ancestors (Akinsulure-Smith, Smith, & Van-Harte, 1997; Akukwe, Smith, & Wokocha, 2000). This cultural group is seen as valuing harmony with nature and seeing human nature as mixed. There may be stigma associated with going to an “outsider” to discuss personal matters.

Native American cultures are widely described as valuing harmony with nature. The activity orientation is described as being in becoming, as there is a search for self-growth and development through one’s activities. There is generally an optimistic view of human nature, and familial and social ties are paramount. Time is viewed as being cyclical and rhythmic, and there is great social importance attached to generosity and sharing (Atteneave, 1982).

The pan-Asian population is made up of many distinct cultural groups. There are several religions and philosophies within this group, but there are some significant points of cultural overlap such as linear-

hierarchical social roles, deference to authority, and emotional restraint. The extended family and fulfilling obligations to one's parents are viewed as being important (Lee, 1997; Sue & Sue, 1990). It has been our experience in the Program for Survivors of Torture that many Southeast Asian clients may experience emotional pain as physical pain. They may experience emotional symptoms in such a way that a stomach ache may be a manifestation of some sort of emotional distress (Du & Lu, 1997). In order to get a sense of how an Asian client makes sense of his/her culture it is necessary to explore their level of acculturation. More will be said about acculturation attitudes later.

The Latino/Hispanic cultural group is geographically and racially diverse. Cultural values are influenced by socio-economic status and acculturation attitudes. Some areas of consistency among and between diverse Latin cultures are a sense of fatalism, the importance of dignity and respect, and social affiliation/collaboration. The time focus is based in the present, there is generally deference to authority, and gender roles tend to be pronounced. Clinicians may encounter Latinos who may understand psychological phenomena in terms of external spiritual forces (Dillard, 1983; Pinderhughes, 1989).

As previously mentioned, these general frameworks provide only a limited context for understanding one's cultural background. Similar frameworks are found in the literature based on other cultural groupings (e.g. religious affiliation, gender, sexual orientation, etc.). In fact, clinicians working with client populations similar to ours may begin to think of their clients, regardless of their cultural background, as part of a relatively homogeneous group of "traumatized refugees" or "torture survivors," rather than maintaining a broader perspective of them as distinct individuals who

are responding to severe life stressors. Such diagnostic classifications, like the cultural groupings just discussed, may have some illustrative power, but may also have limiting effects on the accurate assessment and treatment of an individual (Briere, 2001; Pope & Garcia-Peltoniemi, 1991).

Therefore, it cannot be assumed that a member of one of these cultural groups will adhere to the general worldview put forth by their culture. We observe frequently that refugee groups are not homogeneous, and there may be factionalism among particular refugee groups (Silove et al., 1991). These cultural frameworks should not serve as a “cookbook” by which we categorize people into predetermined groups; rather, they may be utilized as contexts by which we see how people identify and understand cultural issues, within and between groups.

A woman once came to our program from an Islamic nation where the roles of women were strictly circumscribed in terms of docility, home-making, and deference to men. Assuming that this woman respected these cultural norms would have led to a gross misunderstanding of her, and her life situation. In fact, she had been forced to flee her native land because of her life-long agitation against these gender roles that she viewed as repressive.

Clinicians must go beyond surface understandings of cultural archetypes. In this arena, clinicians may take on a “learning posture,” by which they may work with the client to explore mediating factors that may influence their self-perceptions and perceptions of their cultural groups (Gurris, 2001, p. 41).

Mediating Factors

For a refugee, forced to adapt to a foreign culture, a primary mediating factor affecting their psychological adjustment and perceptions of self may be their acculturation attitudes. Theorists have described four types of acculturation attitudes (i.e. Berry, 1990; Berry & Kim, 1988). There are: “separation” attitudes when an immigrant clings tightly to their original culture and rejects the new culture; “assimilation” attitudes when an immigrant adopts the new culture and rejects their original culture; “integration” attitudes when an immigrant synthesizes the two cultures; and “marginalization” attitudes when immigrant feel “betwixt and between,” and uncomfortable in both the original and new cultural contexts

The role and history of one’s cultural group, and whether that group is perceived by the immigrant as being valued or devalued within the new society, impact upon one’s acculturation attitudes (Ogbu, 1986; Pinderhughes, 1989). The perceived hierarchies of power and opportunity affect how one views their cultural group and self. This seems to be particularly salient for refugee populations, in which many have been victimized because of their cultural group memberships.

The conditions under which immigrants arrive influence their views of their new country. Scholars describe “push” and “pull” factors of immigration. Many immigrants are “pulled” to their new land by the lure of positive things such as educational or professional opportunities. In contrast, the refugee populations we serve at the Bellevue program are better described as having been “pushed” out of their homelands. Since they are not in their new country by choice, the way they perceive their situation

psychologically may be drastically different than other types of immigrants who have chosen to be here (Berry, 1990; Stanton, 1985).

Other mediating factors that affect how one understands cultural group membership are cultural links and the strength of the communities that sustain them. It may be harder to navigate the divide between cultures for refugees who arrive to relatively small or weak communities, particularly if their culture is vastly dissimilar to, and is devalued by, the host culture (Ogbu, 1986). Greater social distance between the original and host culture is reported to create greater acculturation stress (Randall & Lutz, 1991).

The profound psychological effects of trauma - especially man-made, purposeful trauma- can become a vital factor in how a person views themselves and the world (Elsass, 1997; Herman, 1992; Smith, 2003). In fact, the trauma can begin to seem like its own reference group identity, more salient than race, ethnicity, religion, etc. Some may see being a torture survivor, rape survivor, and/or refugee as the only group membership that really matters.

Helping clients to place their traumatic experiences in a context where these experiences are no longer all that defines them is often an important aspect of treatment. Hopefully clients will come to see themselves as survivors as opposed to victims. This is one manifestation of helping the client to reclaim the “power to define,” which is important in trauma work and in multicultural psychology in general.

Interactive Model

Individuals make assumptions about other people based on their reference group identities and appearances. People do this in everyday life when they make seemingly mundane decisions like whom to ask for directions or where to sit on a bus or subway. Although supporters of the notion of “political correctness” might argue that clinicians should not entertain such assumptions, others would argue that these assumptions are a normal part of the human thought process that needs to be acknowledged and examined (Carter, 1995).

An example of the subtle pervasiveness of such assumptions comes from my experiences teaching a graduate course, where students are asked to assess the race, ethnicity, religion, and social class of other students in their class without the benefit of speaking to them. The students generally balk at this initially, making the argument that they cannot make such assumptions without further verbal verification. As students share their classifications, and subsequently explain how they came to formulate their assumptions about their fellow students, they are surprised at the amount of “data” they have generated to make superficial judgments based on “first impressions.” Another striking realization the students often verbalize is that making assumptions and judging people are, in fact, part of their everyday behavior.

One of the key concepts of this article describes a situation in which two people who are culturally different from one another engage in an interpersonal interaction. This complex type of dynamic interaction is captured in the Interactive Cycle of Cross-Cultural Relations (see Figure 1). This diagram illustrates how knowledge of one’s self as a cultural being is a

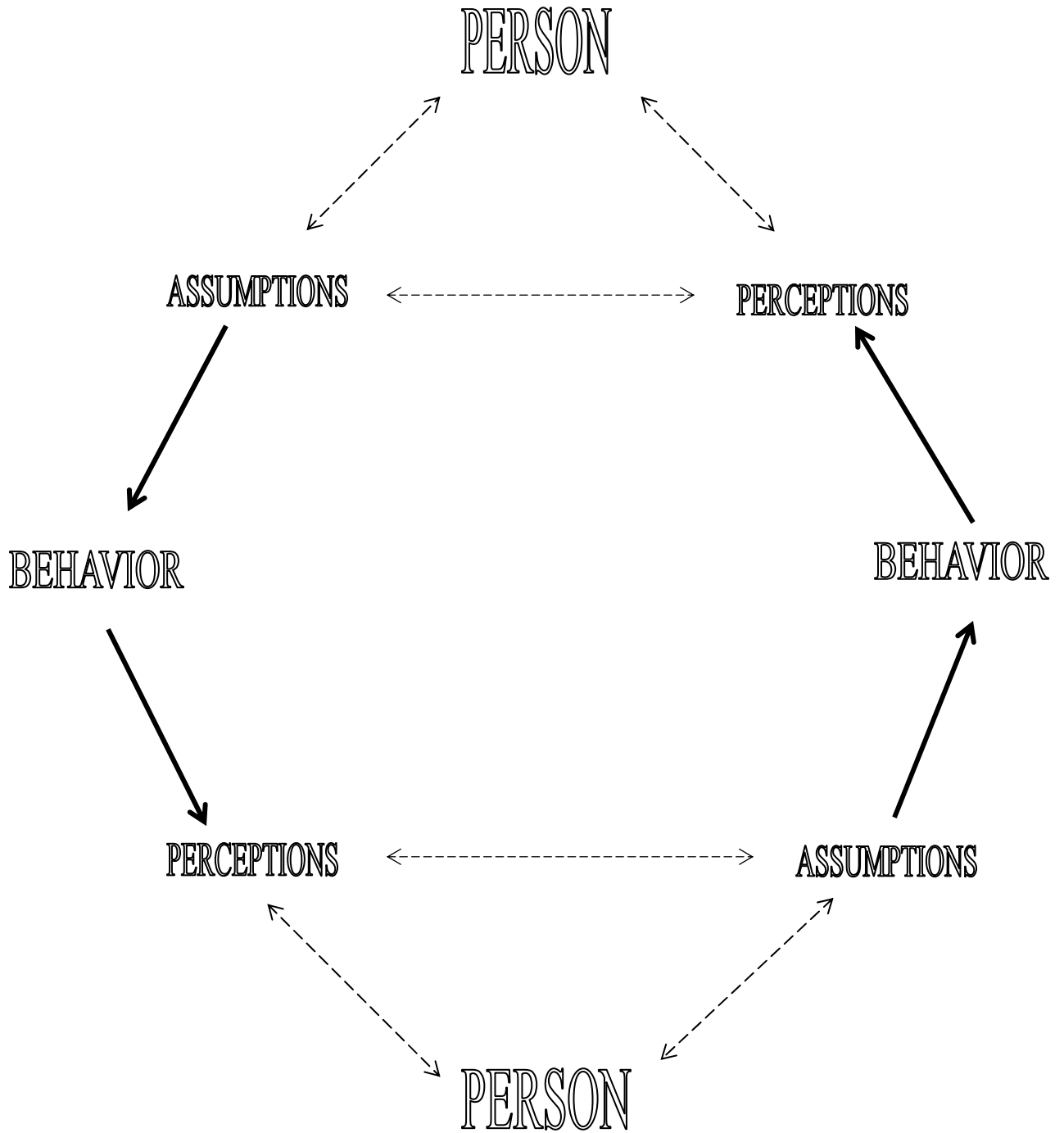
prerequisite for truly understanding what is going on within a therapeutic dyad.

Figure 1 shows that assumptions exist for the clinician and the client. The clinician's assumptions are affected by perceptions and previous experiences he/she may have had with people viewed as being similar to the client. The dashed lines in the diagram show how a person's perceptions affect their assumptions, and how their assumptions influence their subsequent perceptions. These subjective, intra-psychic notions are powerful for any person involved in an interpersonal exchange.

Figure 1 also illustrates that a clinician's assumptions will affect their observable behavior, which feeds into how the clinician is perceived by the client. The client's perceptions of the clinician are also affected by his or her assumptions. Just like the clinician, the client's assumptions and perceptions interact and influence one another. Consequently, the client's assumptions will affect their behavioral responses, which are perceived in turn by the clinician. This feeds back to the clinician's assumptions, perceptions, and behaviors, as the interactive cycle continues.

There is potentially rich clinical data available in such complex interactions, but a clinician will not be able to fully understand what is happening in the session or "in the room" unless he/she is able to understand what is going on in "his/her chair." Once again, multicultural psychology is not a simple study of the "other;" it is a dynamic interaction between complex cultural beings in a therapeutic context (Pinderhughes, 1989).

Figure 1. Interactive Cycle in Cross-Cultural Relationships



The Power to Define

The power to define one's self in terms of cultural identity is an essential aspect of multicultural treatment. It can be an important tool for clients to define themselves in other areas of psychological functioning, such as educational goals and behaviors, substance abuse, career choices, etc.

Self-definition may also pertain to perceptions of the conflict that the survivor has fled. Members of the host culture may misunderstand, or oversimplify the context in which torture took place and label these conflicts as "tribal warfare" or a manifestation of "age-old hatreds," as opposed to the complex socio-political circumstances that produce such violence (Berkeley, 2001; Weine & Laub, 1995). In contrast, it's generally the survivor who has a much more informed and nuanced understanding of the realities of the conflict situation from which they've fled. Empowering the client to express their contextual/political understanding can also help them to better comprehend the events that have impacted upon their lives, and the role that healing may play in the larger continuum as they endeavor to construct a future for themselves.

As such, aiding the client to develop understanding of their own reference group identities, within the context of the external messages that society sends, can help to empower the client to actively engage in the process of self-definition. When a client actively participates in the construction of meaning regarding their cultural identities, it can help them to navigate society more effectively (Elsass, 1997). The active construction of meaning can be a powerful tool for a traumatized refugee who is struggling to find their way in a new society, while preserving and treasuring their own cultural identity (Gurris, 2001).

An example of this pattern was an African adolescent client who was adjusting to life and school here in New York City. This young person was receiving a lot of pressure from local gang members to join the “Bloods” and engage in criminal behavior. In addition to threats, this client was frequently told that he was “selling out,” not “keeping it real,” or trying to “act like a White boy.”

In session, we spent a lot of time exploring the client’s views on what “Blackness” meant, and how life was different in his homeland. We talked about the history of the African Diaspora (the dispersal of African people through slavery and other population movements), and the wide variety of cultural and historical roles that Black people have played. After a few sessions, the client mentioned that he’d heard that there were probably a billion Black people in the world. He stated that, “If there are a billion Black people in the world, there must be a billion ways to be Black.” The client began to internalize the power to define for himself what “Blackness” meant, and was eventually able to successfully resist the external pressures that were being placed upon him.

As refugees try to make sense of their situation, and struggle to keep a positive sense of self, it may be a helpful intervention to explore what foundation a person bases their self-opinion on. Clients have spoken eloquently about making a distinction between personal character and personal circumstances. Acknowledgement that one’s current situation need not define one’s value as a human being can be empowering for refugees who are enduring educational and professional devaluation. Considerations of what refugees have endured and overcome may help to deepen their insights about their current situation, and help them to persist in pursuing

their dreams and life aspirations. This can help a refugee to defend against externally defined negative evaluations of themselves.

Our refugee clients are also helped to understand and navigate situations when their personal identity is contradicted by the identity that society places on them. Many of the cultural groupings and labels change from country to country. For example, they may find themselves defined by racial group in the US, when ethnic identities were more salient in their country. Most racial or cultural divisions are man-made and man-interpreted, as opposed to being true biological/chemical differences, so there may be significant variance from place to place.

I give a personal example of when I led an educational trip for American high school students to South Africa. When I got on the plane at J.F.K. in New York I was seen as a Black man. When I arrived in South Africa I was no longer considered Black; I was now “Coloured.” Only people belonging to one of the 11 indigenous groups in South Africa who have no other types of blood are considered to be Black. This is directly opposed to the “one drop” conceptualization in the US, where any Black ancestry means that a person will be categorized as Black (Asante, 1990; Cross, 1994). Having my race “magically” change during my flight helped me to appreciate the arbitrary nature of racial and cultural groupings. I realize, however, that these haphazard categorizations have real meaning in terms of understanding and navigating one’s society.

Self-knowledge as Clinicians and Service Providers

As a way of summarizing the issues already covered and suggesting methods for clinicians to improve their multicultural skills, I would

emphasize the following: We are all complex racial/cultural beings with multiple reference group identities. As clinicians and service providers, we bring our strengths, cultural baggage, and preconceptions into the room with us. As illustrated in the interactive model (see Figure 1), these assumptions and preconceptions will have direct impact on our therapeutic exchanges with a client.

It is not incumbent upon the treating clinician to give up his or her own cultural or professional identity in order to engage with a client from another cultural background. Quite the opposite is true. Lansen & Haans (2004) write: “There is no reason to discard our Western concepts of diagnosis and treatment, provided we are able to translate the inner world and history of the patient into our concepts, and, in return, our concepts into their universe of thinking” (p. 326).

It is imperative, however, that clinicians and trainees move beyond their own resistance and engage in the hard but necessary work of self-exploration, in order to understand better “what is going on in their own chair.” This will help to facilitate deeper understanding of the therapeutic relationship and will help to open up viable areas for exploration with the client (Gurris, 2001; Pinderhughes, 1989). Multicultural psychology is not just a study of the cultural other. We must recognize ourselves as cultural beings in order to navigate the complex therapeutic relationships we engage in with our increasingly diverse client populations.

References

- Akinsulure-Smith, A., Smith, H., & Van Harte, E. (1997). *Psychotherapy with Africans in America*. Symposium conducted at Perspectives on Black Psychology: Past, Present, and Future, Pace University, New York City.
- Akukwe, C., Smith, H., & Wokocha, E. (2000). Enhancing the Well-being of African Refugees. In S. Berhane (Ed.), *Proceedings from the conference "African Refugees and the US response: Twenty years of resettlement"* (pp. 67-74). Arlington, VA: Ethiopian Community Development Council/African Resource Network.
- Asante, M. K. (1990). *Kemet, Afrocentricity and knowledge*. Trenton: Africa World Press, Inc.
- Atteneave, C. (1982). American Indian and Alaskan native families: Emigrants in their own homelands. In M. McGoldrick, J.K. Perarce, & J. Giordano (Eds.), *Ethnicity and Family Therapy* (pp. 55-83). New York: Guilford Press.
- Berkeley, B. (2001). *The graves are not yet full: Race, tribe, and power in the heart of Africa*. New York: Basic Books.
- Berry, J.W. (1990). Psychology of acculturation: Understanding individuals moving between cultures. In R. W. Brislin (Ed.), *Applied cross-cultural psychology* (pp. 232-253). Newbury Park, CA: Sage Publications.
- Berry, J.W., & Kim, U. (1988). Acculturation and mental health. In P. Dasen, J.W. Berry, & N. Sartorius (Eds.), *Cross-cultural psychology and health: Toward applications* (pp.207-236). London, Sage Publications.

- Briere, J. (2001, July). *Evaluation, measurement, and assessment approaches with severely traumatized populations*. Presentation to the Clinical Leadership Conference of the National Consortium of Torture Treatment Centers, Minneapolis, MN.
- Carter, R.T. (1990). "Cultural value differences between African Americans and White Americans," *Journal of College Student Development*, 31, 71-79.
- Carter, R.T. (1995). *The influence of race and racial identity in psychotherapy: Toward a racially inclusive model*. New York: John Wiley & Sons, Inc.
- Carter, R. T., & Goodwin, A. L. (1994). Racial identity and education. *Review of Research in Education*, 20, 291-336.
- Cross, W.E. (1994). Nigrescence theory: Historical and explanatory notes. *Journal of Vocational Behavior*, 44, 119-123.
- Dillard, J.M. (1983). *Multicultural counseling: Toward ethnic and cultural relevance in human encounters*. Chicago, IL: Nelson-Hall.
- Du, N., & Lu, F. (1997). Assessment and treatment of posttraumatic stress disorder among Asian-Americans. In E. Lee (Ed.), *Working with Asian-Americans: A guide for clinicians* (pp. 275- 294). New York: Guilford Press.
- Eisenman, D., Bergner, S., & Cohen, I. (2000). An ideal victim: Idealizing trauma victims causes traumatic stress in human rights workers. *Human Rights Review*, 1(3), 106-114.
- Elsass, P. (1997). *Treating victims of torture and violence: Theoretical, cross-cultural, and clinical implications*. New York and London: New York University Press.

- Evarts, A. B. (1913). Dementia precox in the colored race. *Psychoanalytic Review*, 1, 388-403.
- Fredrickson, G. M. (1988). *The arrogance of race: Historical perspectives on slavery, racism, and social inequality*. Middletown: Wesleyan University Press.
- Gurris, N. (2001). Psychic trauma through torture – Healing through psychotherapy? In S. Graesner & N. Gurris (Eds.), *Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity* (pp. 29-56). Baltimore, MD: Johns Hopkins University Press.
- Hall, G.S. (1904). *Adolescence*. New York: Appleton.
- Helms, J.E. (1990). Introduction: Review of racial identity terminology. In J.E. Helms (Ed.), *Black and White racial identity: Theory, research, and practice* (pp. 3-8). New York: Greenwood Press.
- Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror*. New York: Basic Books.
- Kluckholm, F.R., & Strodtbeck, F.L. (1961). *Variations in value orientations*. New York: Harper and Row.
- Lansen, J., & Haans, T. (2004). Clinical supervision for trauma therapists. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. 317-353). New York: Brunner-Routledge.
- Lee, E. (1997). *Working with Asian-Americans: A guide for clinicians*. New York: Guilford Press.
- Lind, M. (1995). *The next American nation: The new nationalism and the fourth American revolution*. New York: The Free Press.
- Ogbu, J. (1986). The Consequences of the American caste system. In U. Neisser (Ed.), *The School Achievement of minority children: New*

- perspectives* (pp. 19-56). Hillsdale, NJ and London: Lawrence Erlbaum Associates, Publishers.
- Pinderhughes, E. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice*. New York: The Free Press.
- Pope, K., & Garcia-Peltoniemi, R. (1991). Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. *Professional Psychology: Research and Practice*, 22(4), 269-276.
- Randall, G., & Lutz, E. (1991). *Serving survivors of torture*. Washington, DC: Association for the Advancement of Science.
- Silove, D., Tarn, R., Bowles, R., & Reid, J. (1991). Psychosocial needs of torture survivors. *Australian and New Zealand Journal of Psychiatry*, 25, 481-490.
- Smith, H. (2003). Despair, resilience, and the meaning of family: Group therapy with French-speaking survivors of torture from Africa. In R. Carter & B. Wallace (Eds.), *Understanding and dealing with violence: Multicultural Perspectives* (pp. 291-319). Thousand Oaks, CA: Sage Press, Inc.
- Stanton, J.L. (1985). Adolescents, families, and cultural transition: A treatment model. In M.P. Mirkin & S. Koman (Eds.), *Handbook of Adolescent and Family Therapy* (pp. 363-381). New York: Gardner Press.
- Stewart, E.C., & Bennet, M.J. (1991). *American cultural patterns: A cross-cultural perspective*. Yarmouth, ME: Intercultural Press.
- Sue, D.W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York: Wiley.

Weine, S., & Laub, D. (1995). Narrative constructions of historical realities in testimony with Bosnian survivors of “ethnic cleansing.” *Psychiatry*, 58(8), 246-260.

Chapter 3

Immigration Dynamics: Processes, Challenges, and Benefits - Summary

This chapter is in the section of the book focusing on contextual issues because a traumatized immigrant's lawful status is of paramount importance in terms of his or her ability to truly begin a new life in the host country in a context of safety and security. As such, these immigration issues have great impact on one's psychological functioning, one's basic ability to provide for oneself, and significant aspects of one's physical health (i.e. nutritional intake, access to health insurance, etc.).

Much of the information covered in this chapter pertains to federal law, and will therefore be applicable to all states and regions within the US. However, there are several subjects that may vary based on state or regional norms (i.e. Medicaid eligibility, parole availability for detainees, duration of asylum process, etc.). As such, practitioners in states other than New York may wish to consult with the various government websites and local sources of legal information to have access to the most up to date information regarding laws salient for immigrants in their part of the country.

- * Refugees
- * Asylees
- * Asylum seekers
 - Affirmative applications to USCIS
 - Removal proceedings in Immigration Court
 - Detained asylum seekers
- * Other categories of relief
 - Withholding of removal
 - Temporary Protected Status (TPS)
- * Undocumented/No lawful status
- * Selective Service

Immigration Dynamics: Processes, Challenges, and Benefits

John Wilkinson, M.A.

Although those who are granted asylum are commonly referred to as “refugees,” there are legal differences between someone who enters the country as a “refugee” and one who becomes an “asylee” after pursuing his or her application with the U.S. Citizenship and Immigration Services (USCIS)¹ or before an immigration judge. When we hear the word “asylum,” we often think only of “political” asylum. In fact, at least one of five grounds of persecution needs to be established in order to qualify for asylum: political opinion, nationality, race, religion, and/or membership in a social group (Immigration Equality, 2005a).

An individual does not qualify for asylum simply if, for example, his or her country is in a state of civil war or anarchy; even if current news reports show atrocities being committed and seriously unstable conditions. (Such an individual may be eligible for Temporary Protected Status [TPS; U.S. Committee for Refugees and Immigrants, 2002], which will be discussed later.) The individual still must qualify based on one or more of the above grounds. An unrepresented asylum seeker may not be aware of this, and may not know how to explain his or her story within the framework of the five grounds.

¹On March 1, 2003 the Immigration and Naturalization Service (INS) transitioned into the Department of Homeland Security (DHS) under U.S. Citizenship & Immigration Services (USCIS), after briefly being known as Bureau of Citizenship and Immigration Services (BCIS). Investigative and enforcement responsibilities for enforcement of federal immigration laws, customs laws, and air security laws were transferred to the Bureau of Immigration and Customs Enforcement (ICE; U.S. Immigration and Citizen and Immigration Services, 2004b).

By understanding the different categories of immigration status, health providers can address some pressing concerns of the survivors of torture and refugee trauma they are treating. The following provides a general introduction.

Refugees

Refugees have lawful status upon entering the United States, as their applications have already been approved outside of this country. The number of people who can attain refugee status each year is set by the president of the United States (Canter & Siegel, 2001). In most cases, overseas applicants are referred by the office of the United Nations High Commissioner for Refugees (UNHCR) for interviews with an immigration officer. Once the officer approves an application, the refugee is matched with an American resettlement organization (U.S. Committee for Refugees and Immigrants, n.d.).

Starting at their first month of arrival, they are eligible for services including: Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA); food stamps; housing assistance, furnishings, food and clothing; school registration for children; referrals for medical appointments; employment services; and English Language classes. A case worker at a resettlement agency is assigned to each refugee, to provide him or her with orientation and assistance in applying for these services. Each refugee receives an unrestricted social security card and an I-94 card that authorizes employment.

Such refugees are never “detained” in the United States. Unlike asylum seekers, they are not required to testify before any officials here,

appear in court, or seek legal assistance. Their refugee status indicates that they have already met all required standards and, therefore, qualify for benefits.

Asylees

An “asylee” has received a grant of asylum after his or her arrival in the United States, rendered either by an asylum officer or an immigration judge (or, in some cases, a higher court such as the Board of Immigration Appeals).

Under a policy which started in June 2000, asylees are immediately eligible to receive benefits through the first eight months following the grant of asylum (Department of Health and Human Services, 2005). Prior to this law it was nearly impossible to collect such benefits. It is important for a health provider to confirm that a patient who is an asylee is aware of his or her eligibility for these benefits. If not, he or she can be referred to a resettlement agency or a community worker in his or her region. Contrary to the fears of many new asylees, receiving these benefits has no negative impact on their eventual Green Card applications (Jesuit Refugee Services, 2001).

An alternative to the above is the Match Grant program, offered in most states, in which refugee resettlement organizations help asylees find jobs within the first 120 days after winning asylum. In order to qualify, asylees must sign up within one month of the asylum grant. (For more information, along with contact information for organizations, go to: <http://www.acf.hhs.gov/programs/orr/programs/mgpss2.htm>.)

Prior to 2001, an asylee had to apply for and receive an Employment Authorization Document (EAD) before legally working. Processing time for this photo-ID card often lasted several weeks or months. Now, asylees (like refugees) become immediately eligible for employment as soon as they receive a final grant from an immigration judge or asylum office (Bureau of Citizenship and Immigration Services, 2003). Even though the new law was passed, unaware employers might still incorrectly insist on seeing an EAD, although a state-resident card or driver license should suffice. (Note that the I-9 form used by employers still asks for at least one photo-ID document along with the social security card.)

An asylee should always apply for an initial EAD, since it is issued free of charge. It is a legal photo-ID that is helpful when applying for state-resident cards and driver licenses, opening bank accounts, getting papers notarized, seeking employment, and other such matters. Subsequent cards (including replacement cards for those lost or stolen) cost \$180 (as of early 2007), although it is possible to file a fee waiver claiming “inability to pay” (USCIS, 2004a).

An asylee can immediately apply for a social security card in person at the local office as long as he or she can present proof that asylum has been granted (for example, the written decision of the Judge or asylum officer or an I-94 “departure record” card showing “asylum granted”). Previously, such a card was always “restricted,” stamped with the phrase “valid only with INS authorization.” If an asylee still has that phrase on the card, he or she should file for a replacement “unrestricted” card, which would remove such a limitation (Office of Refugee Resettlement, 2001). The new I-94 cards now issued to asylees may state that the individual is “employment

authorized” - a phrase that had earlier been used only for refugees (U.S. Social Security Administration, 2006).

An asylee can apply for an Alien Registration Card (more commonly referred to as “green card”) a minimum of one year after the grant of asylum (The Hebrew Immigrant Aid Society [HIAS], 2001a). In some cases, asylum can be revoked if an individual is convicted of a felony or crime of “moral turpitude” (Lewis & Madlansacay, 2001), but that is beyond the scope of this summary.

An asylee may also petition for his or her spouse and/or children to come to the United States as “derivative asylees.” Such a petition must be filed within two years of the asylum grant. Although the application is free, the sponsoring asylee must pay transportation costs. Some embassies also require the sponsor and applicants to undergo DNA tests before final approval can be given.

Both refugees and asylees are eligible (for a fee of \$170, in early 2007) for a Travel Document to travel outside the United States to any country - other than the country from which they are fleeing - for a limited period (HIAS, 2001b). This is sometimes incorrectly referred to by immigrants as a “passport.”

Asylum Seekers

The majority of clients referred to the Bellevue/NYU Program for Survivors of Torture are asylum seekers. The process of applying for asylum brings its own special set of challenges and stressors.

Prior to the Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA) of 1996, an asylum seeker often waited for months or even

years before submitting an application, already placing the individual beyond the deadline for receiving benefits. Reasons for this delay included lack of fluency in English, fear of immigration officials, unfamiliarity with the asylum process, discouraging advice from friends, etc. One who applied before April 1, 1997 could have eventually been placed under “deportation proceedings” (if inspected by an INS agent upon arrival and permitted to enter) or “exclusion” proceedings (if the individual made it onto U.S. soil without being inspected). In such a case, if one was not granted asylum by an immigration judge, he or she was usually ordered “deported” or “excluded,” pending appeal (USCIS, 2006a).

Those who have applied for asylum since IIRAIRA came into effect may be placed in “Removal Proceedings” (USCIS, 2006a), as described in Section B, below. In other words, rather than be “deported” or “excluded” from the United States, they are “removed” from the country if found ineligible. This new act included a stipulation aimed at cutting down on the number of asylum requests filed: with few exceptions, an individual must apply for asylum within one year after his or her arrival. The asylum seeker should also, therefore, be able to prove how long he or she has been in the United States – a potential problem for one who entered the country without being inspected (The Florence Immigrant and Refugee Rights Project, 1999).

If an individual files an asylum application past the one-year deadline, he or she must provide an “extraordinary” reason for being late. For example, if a negative change of conditions has occurred in his or her country, the one-year rule can be waived. One should try to document any physical or mental difficulties that caused the application to be filed late. More important for health workers to note, if an individual is believed to be

a victim of torture, the one-year rule may be waived under “Convention Against Torture” (Immigration Equality, 2005b).

Affirmative Applications to USCIS

Within the first year of their arrival in the United States, most of the asylum seekers in our program file an affirmative (non-adversarial) application for asylum to the USCIS. In response, each applicant is initially sent a receipt notice, which includes the all-important alien registration number (or file number), followed by an appointment letter to appear before an asylum officer either in Rosedale, New York or Lyndhurst, New Jersey. Although in the state of New York, such an individual may be eligible for Medicaid coverage, an asylum seeker does not receive any “refugee benefits” until he or she is granted asylum (Office of Refugee Resettlement, 2000).

Unlike at the Immigration Courts, a Berlitz-certified interpreter is not provided at this asylum interview. The asylum seeker is told to bring along an interpreter (not a lawyer or witness in the case) to the appointment.

Usually the asylum interview takes about an hour (although some can last for several hours), and asylum seekers are told to return in two weeks for the decision. If the decision is favorable, they are usually given a “Final Approval” or “Recommended Approval.” In the latter instance, the case remains pending during the period of a fingerprint/background check. Once a clearance is issued for the asylum seeker, he or she should be issued the final approval letter along with an I-94 card affirming the grant of asylum. The asylum seeker may also be given a “Notice of Intent to Deny” for which he or she has 16 days to respond to one or more points highlighted by the

officer. This is usually issued to those applicants who still have valid visas allowing them to remain in the United States.

If a case has not yet been decided within the first 150 days after receipt of the application by USCIS, the asylum seeker may be eligible to apply for a no-fee Employment Authorization Card and, if successful, a social security card (U.S. Department of Justice [USDOJ], 2006). In such a case, the card is renewable from year to year, unless a negative decision is rendered and all appeals have been exhausted (USDOJ, 2006).

If the case is not approved at the asylum office, the asylum seeker is told that the case is being referred to the Immigration Court for removal proceedings. He or she is given an appointment letter, along with a brief summary of why asylum was not granted.

Removal Proceedings in Immigration Court

The initial appointment letter instructs the asylum seeker to appear in immigration court to attend a Master Calendar Hearing. At this scheduled time, the courtroom is filled with asylum seekers, and the immigration judge will eventually schedule a new date with each of them to reappear for an Individual Merits Hearing. Unlike the asylum interview, the hearing before the judge is adversarial. At the Master Calendar hearing, many asylum seekers may enter the courtroom without attorneys. The judge will make sure each individual has received a list of *pro bono* attorneys, in case he or she cannot afford to hire one (USDOJ, n.d.b). Otherwise, one can hire a private attorney or represent him- or herself.

Also at the hearing, the judge should ask the individual what his or her best language is (taking into account what was spoken at the asylum interview) and the court will attempt to locate a certified interpreter, if

necessary, for the next hearing (USDOJ, n.d.b). An asylum seeker is advised not to answer any questions until the interpreter translates, even if he or she has some command of English. Of course, an individual also has the right to testify entirely in English.

The Immigration Court has a helpful 24-hour automated telephone information service which can be accessed by dialing (800) 898-7180. For all cases referred to the court, the caller will hear a computer-generated message (in either English or Spanish) instructing him or her to enter the alien registration number into the touchtone pad. By doing so, one can obtain useful information on the asylum seeker's next hearing date, the judge's name, number of days remaining on "the clock" before becoming eligible to apply for the employment authorization card, and status of one's case, including appeal if applicable (USDOJ, 2006).

If the case is denied by the immigration judge, the asylum seeker is required to submit a Notice of Appeal to the Board of Immigration Appeals within thirty days (USDOJ, n.d.b).

Detained Asylum Seekers

Individuals who attempt to enter the country without a valid visa or with a false document may be detained in an immigrant detention center if they indicate that they would like to pursue an asylum claim (U.S. Committee for Refugees and Immigrants, 2002). Those who attempt to enter New York City's JFK International Airport or Newark International Airport are usually transported to Elizabeth Detention Center in New Jersey. Otherwise, they may be ordered to return to their last country of residence by an Inspector at the airport through "summary exclusion" (Lewis & Madlansacay, 2001).

When an individual has indicated that he or she would like to apply for asylum, an asylum officer will conduct a “credible fear” interview, usually during the first week of detention. If the officer determines that there is a possibility of winning an asylum case, he or she will present a Notice to Appear before the judge. If the officer rules that there is no chance to win an asylum case, the detainee can request a hearing and contest the officer’s ruling (U.S. Committee for Refugees and Immigrants, 2002).

Although many detainees are lucky enough to be given legal assistance by *pro bono* attorneys or private attorneys paid for by their relatives, many have no choice but to represent themselves.

Two Other Categories of Relief

Withholding of Removal

Another category of relief is called “Withholding of Removal” (formerly “Withholding of Deportation”). The burden of proof for this is even higher than that for asylum (U.S. Citizenship and Immigration Services, 2006b). An individual must establish that it is “more likely than not that your life or freedom would be threatened on account of (one of the five grounds) in the proposed country of removal (U.S. Citizenship and Immigration Services, 2006b). In other words, an asylum applicant must show that it is possible he or she will face persecution whereas a withholding applicant must show that future persecution is probable (Immigration Equality, 2005b). This category may be interpreted differently by different judges.

A person granted withholding does not qualify for the same benefits as those granted asylum or arriving as refugees. Technically, a person

granted withholding can never qualify for a green card without a change in status. However, he or she can remain present in the United States indefinitely. The individual can renew the employment authorization each year without ever having to pay a fee; asylees, on the other hand, must pay this renewal fee after the first year (USCIS, 2006c). While asylees mail renewal requests for these cards to another state, those granted withholding must apply at the local immigration office (USCIS, 2006c). Some USCIS clerks may not be aware of the rights of one granted withholding. An individual should bring a copy of the decision of the judge, and a photo-ID (if possible).

Temporary Protected Status

Temporary Protected Status (TPS) is granted to individuals who live in unstable countries or regions deemed by the state department to be too dangerous to “remove” and return the individual (USDOJ, n.d.a.) It is based on three circumstances: ongoing armed conflict, environmental disaster, or “extraordinary and temporary conditions” that prevent a return home (U.S. Committee for Refugees and Immigrants, 2002).

If TPS is discontinued, the individual may still apply for asylum. Those who receive TPS are eligible for employment authorization documents and social security cards. The Attorney General will periodically review country conditions and determine whether to end or extend TPS (Lewis & Madlansacay, 2001).

Undocumented/No-Lawful Status

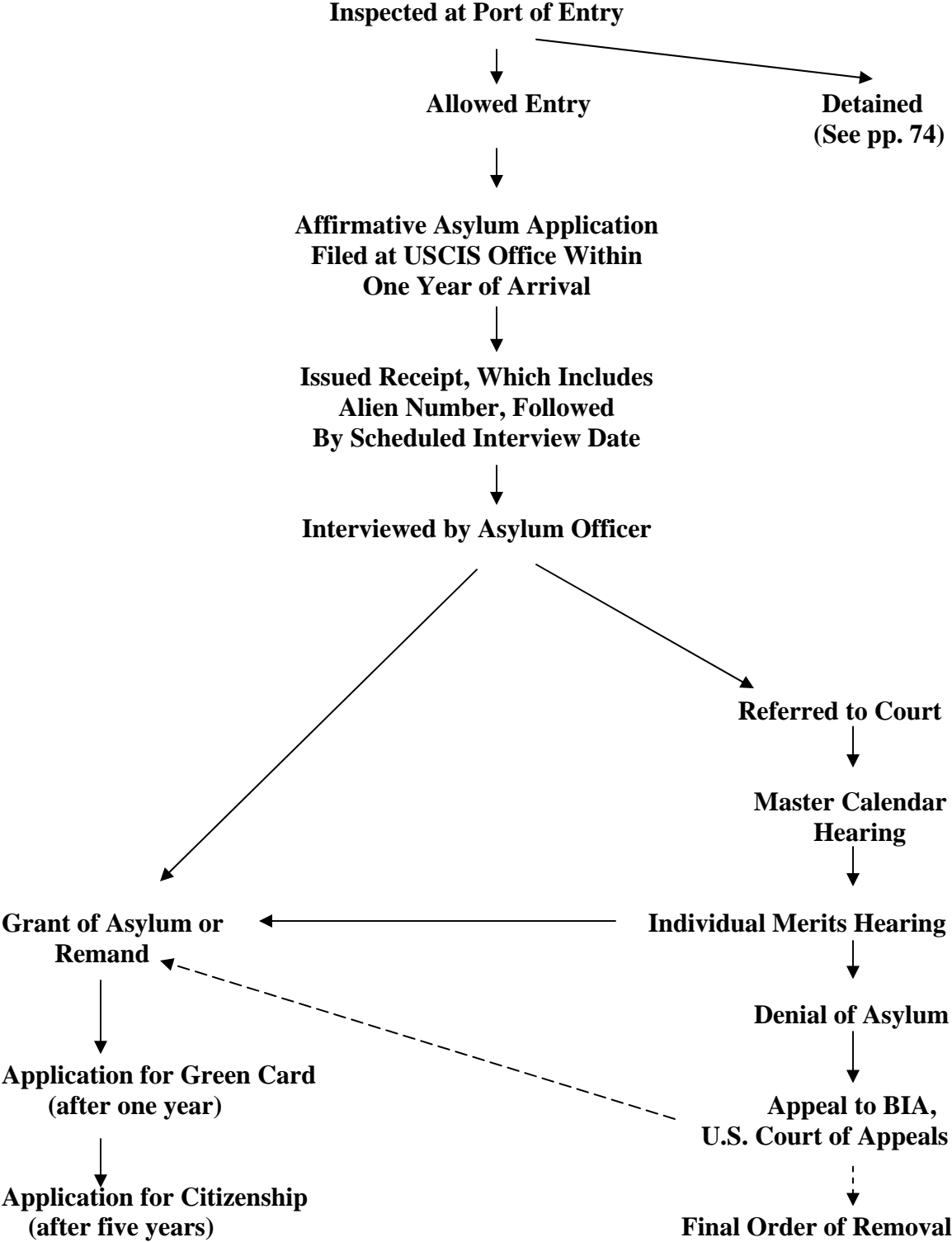
Many individuals arriving in this country have not yet applied for any lawful immigration status. Often, they become victims of non-professionals promising to help them become “legal” for a certain fee. As said earlier, immigration judges are required to ensure that all asylum applicants are provided with a list of *pro bono* legal associations. In many cases, individuals would be better advised to inquire at such agencies before submitting an application. If an individual is not working, and has little if any access to funds, he or she should request a consultation with one or more of these *pro bono* organizations before hiring a paid private attorney.

The USCIS now has a helpful web-site which provides many answers and updates on immigration law, as well as application forms. The address is: <http://www.uscis.gov>.

Selective Service

Virtually all men between the ages of 18 and 26 must register with Selective Service. Exceptions to this include only: nonimmigrant aliens on student, visitor, tourist, or diplomatic visas; men on active duty in the U.S. Armed Forces; and cadets and midshipmen in the Service Academies and certain other U.S. military colleges (Selective Service System, 2006).

Appendix A: Asylum Process for Non-Detained Asylum Seekers



References

- Bureau of Citizenship and Immigration Services. (March 10, 2003). *The meaning of 8CFR 274a.12(a) as it relates to refugee and asylee authorization for employment*. Memorandum from William Yates, Acting Associate Director of Operations, BCIS. HQADJ 70/21.1.13.
- Canter, L.A., & Siegel, M.S. (2001). *US Immigration made easy (8th ed.)*. Berkeley, CA: NOLO.
- Department of Health and Human Services. (2005). *Asylee eligibility for assistance and services through the Office of Refugee Resettlement*. Retrieved on December 4, 2006, from <http://www.acf.hhs.gov/programs/orr/AsyleeEligibility.pdf>
- Immigration Equality. (2005a). *Asylum seekers*. Retrieved on January 8, 2007, from <http://www.immigrationequality.org/template.php?pageid=159>
- Immigration Equality. (2005b). *Withholding of removal and CAT*. Retrieved on January 8, 2007, from <http://www.immigrationequality.org/template.php?pageid=168>
- Jesuit Refugee Services. (2001, November). *Just released: The what-you-need-to-know workbook 2001*. USA: Jesuit Refugee Service.
- Lewis, L.M., & Madlansacay, L.T. (2001). *How to get a green card – Legal ways to stay in the USA*. Berkeley, CA: NOLO.
- Office of Refugee Resettlement. (2000). *State Letter SL00-17*. Retrieved on December 4, 2006, from <http://www.acf.hhs.gov/programs/orr/policy/sl00-17.htm>

- Office of Refugee Resettlement. (2001). *State Letter SL01-09*. Retrieved on December 4, 2006, from <http://www.acf.hhs.gov/programs/orr/policy/sl01-09.htm>.
- Selective Service System. (2006). *Registration information: Frequently asked questions*. Retrieved on November 22, 2006, from <http://www.sss.gov/qa.htm#quest32>
- The Florence Immigrant and Refugee Rights Project, Inc. (1999). *How to apply for asylum and withholding of removal*. Retrieved on December 4, 2006, from <http://www.lirs.org/InfoRes/PDFs/FlorenceProSe/Asylum-E.pdf>
- The Hebrew Immigrant Aid Society. (2001a). *Getting your green card*. Retrieved on December 4, 2006, from http://www.hias.org/Immigration/Imm_Brochures/greencard.pdf
- The Hebrew Immigrant Aid Society. (2001b). *Traveling abroad for emigres*. Retrieved on December 4, 2006, from http://www.hias.org/Immigration/Imm_Brochures/travelabroad.pdf.
- U.S. Citizenship and Immigration Services. (2004a). *No Title*. Retrieved on December 6, 2006 from <http://www.uscis.gov/files/article/FeeWaiverGd3404.pdf>
- U.S. Citizenship and Immigration Services. (2004b). *Name change from the Bureau of Citizenship and Immigration Services to U.S. Citizenship and Immigration Services*. Retrieved on December 4, 2006, from <http://www.uscis.gov/propub/ProPubVAP.jsp?dockkey=ffd3d5c8fa93efc4c44c1d3c8896faf6>
- U.S. Citizenship and Immigration Services. (2006a). *Fact sheet on Illegal Immigration Reform and Immigrant Responsibility Act of 1996*.

- Retrieved on December 4, 2006, from
<http://149.101.23.2/graphics/publicaffairs/factsheets/948.htm>
- U.S. Citizenship and Immigration Services. (2006b). *Form I-589 instructions: Revised July 3, 2003*. Retrieved on December 4, 2006, from <http://www.uscis.gov/files/form/i-589.pdf>
- U.S. Citizenship and Immigration Services. (2006c). *Form I-765 instructions: Revised on July 26, 2006*. Retrieved on December 4, 2006, from <http://www.uscis.gov/files/form/i-765.pdf>
- U.S. Committee for Refugees and Immigrants. (n.d.). *How refugees come to America*. Retrieved on December 6, 2006, from <http://www.refugees.org/article.aspx?id=1082&subm=40&ssm=47&a rea=Investigate>
- U.S. Committee for Refugees and Immigrants. (2002). *World refugee survey 2002*. Washington D.C: U.S. Committee for Refugees.
- U.S. Department of Justice. (n.d.a). *Extension of work authorization for TPS residents from Burundi, Sudan, Honduras, Nicaragua, El Salvador, Liberia, and Somalia*. Retrieved on December 7, 2006, from <http://www.usdoj.gov/crt/osc/>
- U.S. Department of Justice. (n.d.b). *New York Immigration Court, Frequently asked questions*. Retrieved on November 22, 2006, from <http://www.usdoj.gov/eoir/sibpages/nyc/faq.htm>
- U.S. Department of Justice. (2006). *Customer service initiatives*. Retrieved on December 2, 2006, from <http://www.usdoj.gov/eoir/npr.htm>
- U.S. Social Security Administration. (2006). *Documents you need to work in the US*. Retrieved on December 4, 2006, from www.ssa.gov/immigration/documents.htm

Chapter 4

The Use of Interpreters with Survivors of Torture, War, and Refugee Trauma – Summary

This chapter describes the broad need for verbal communication in clinical and social service provision. It focuses primarily on the special challenges associated with using interpreter services in clinical settings, but the information also pertains to other domains (i.e. legal, educational, case management). Recommendations and insights are drawn from the current literature on interpretation, as well as pertinent experiences from our program.

*** Introduction**

The Roles of the Interpreter at PSOT

Finding and Choosing Interpreters

Training and Supervision of the Volunteer Interpreters

Word for Word v. Summary Interpretation

*** Guidelines for Interpretation**

Code of Ethics for Interpreters

Confidentiality

Vicarious Trauma and Specialized Vocabulary

*** Training of Clinicians Working with Interpreters**

Clinical Do's and Don'ts When Working with Interpreters

Guidelines and Role-Plays

*** Special Case of Mental Health Trauma Work**

*** Conclusion**

The Use of Interpreters with Survivors of Torture, War, and Refugee Trauma

Adéyinka M. Akinsulure-Smith, Ph.D.

Introduction

Historically, the interpersonal nature of health and mental health care has depended on good, strong verbal communication in order to establish rapport, assess needs, diagnose illness and provide treatment to individuals seeking treatment. In situations where language is a barrier, due to limited proficiency, the quality of clinical care and social service provision can become compromised. Several researchers have noted that patients who were unable to communicate adequately were less satisfied with the patient-provider relationship, had a poorer understanding of their diagnosis and treatment, and experienced distorted clinical assessments leading to misdiagnosis (Baker, Hayes, & Fortier, 1998; Flores, Rabke-Verani, Pine, & Sabharwal, 2002; Hornberger, Itakura, & Wilson, 1997; Marcos, 1979; Pöchhacker, 2000; Sabin, 1975; Wood, 2002).

When providing quality care to survivors of torture and refugee trauma who have suffered terrifying physical and psychological trauma (along with other harrowing experiences), and are now faced with the additional burden of struggling to express their physical and emotional difficulties in another language, the importance of effective verbal communication becomes even more salient (Farooq & Fear, 2003; Gany & Thiel de Bocanegra, 1996; Gong, Cravens, & Patterson, 1991; Lee, 1997). In recent years, the literature has begun to document the positive ways in which the use of trained interpreters can improve communication between

patients and care providers in order to improve health and mental health care provision (Akinsulure-Smith, 2004; Edwards & Kumru, 1999; Eytan et al., 2002; Farooq & Fear, 2003; Phelan & Parkman, 1995).

In a treatment setting such as the Bellevue/NYU Program for Survivors of Torture (PSOT), where survivors of torture and refugee trauma from over 80 different countries come seeking services, an ongoing challenge faced by the program is how to provide skilled professional staff who are multilingual in all the many languages and diverse dialects spoken by our patients. In an effort to address the ongoing need for interpreters in a sensitive, competent, efficient, yet cost effective manner, PSOT has developed a model for Volunteer Interpreter services that can be utilized effectively across service provision settings. Although the use of interpreters may require more clinician time (Kravitz, Helms, Azari, Anonius, & Melnikow, 2000), this model strives to respond to the role of cultural issues, core competencies, professional ethics, as well as the host of challenges that can arise when using volunteer interpreters to provide comprehensive care and rehabilitation to this specialized population. The purpose of this chapter is to describe this unique aspect of patient care that has become an integral part of the services offered at PSOT.

The Roles of the Interpreter at PSOT

According to Phelan and Parkman (1995), there are four main types of communication services available to assist patients whose first language is not English: bilingual clinicians, friends or relatives, untrained volunteers, and trained interpreters. Although bilingual clinicians are the ideal option for most patients, as stated earlier, this is frequently not a realistic option. When a care provider and a client speak different languages, an interpreter is

needed. An interpreter is typically defined as a person versed in both languages spoken and understood by the two parties who need to communicate with one another. While using friends or relatives of the patient may initially seem like a sound idea, the patient may be inhibited from disclosing pertinent information. The friend or relative may also be at risk for experiencing vicarious traumatization, as the patient discloses details of their trauma history. The use of untrained volunteers can be problematic for a number of reasons, including issues regarding confidentiality and a lack of adequate training.

The use of a professionally trained interpreter is really the best option when a bilingual clinician is unavailable. Such professionals abide by a code of confidentiality and are skilled at interpreting. The literature shows that clinical interventions, like cognitive-behavioral treatments, have proven to be effective even when an interpreter is used in delivering the treatment (Resick & Schnicke, 1993; Schulz et al., 2006).

Within the PSOT treatment setting, as in other refugee mental health treatment centers in the United States, interpreters play multiple roles in a wide variety of contexts (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). For example, a brief contact might involve assisting a new patient with the registration procedure at the hospital, or even telephone communication to arrange an appointment. A regular clinical contact might involve ongoing psychotherapy. Examples of other clinical contacts might involve the initial intake evaluations, psychological assessments, psychiatric appointments, or medical visits. Finally a patient might require an interpreter's assistance for non-clinical interchanges, such as, when filling out forms, applying for jobs or job training, or receiving assistance with legal services.

Finding and Choosing Interpreters

Even though PSOT is located in New York City, a city known for its large and diverse immigrant population, finding competent and qualified interpreters can present a challenge for a number of reasons. First of all, given the reality of limited resources, paying for professional interpreter fees is not always feasible. Secondly, it is often difficult to find competent interpreters for the less commonly spoken languages (e.g., Diola, Fulani, or Tibetan). As a result of these challenges, we have come to rely on volunteer interpreters to assist and support service provision.

In an effort to attract volunteer interpreters, we conducted extensive outreach to local professional interpreter organizations and educational institutions (e.g., New York University's student organization called "Language Without Borders"), through written articles and presentations about our program, and to various cultural, religious, and ethnic communities. Those individuals who responded to our appeal ranged from those with vast professional experiences interpreting to those who have only had limited experiences.

To ensure the quality and caliber of our volunteer interpreters, interested parties are invited to submit resumes, names of two references and then invited for interviews with senior clinicians in our program. During these interviews, we seek individuals who have previous interpreting experiences, who demonstrate an understanding of our client population's experiences, who exhibit a good command of both English and their language of interpretation, and who are committed to working within a public hospital setting in this capacity.

When interviewing volunteer interpreter candidates, it is important to realize that a person may be multi-lingual through a variety of means. An

American born English speaker who studied French in school as a second language will probably have different skills than a Congolese native who spoke a local language at home, learned French as a national language and English as a third or fourth language. Heavily accented English or inability to read can be problematic (though not insurmountable), but are factors to be weighed in choosing an interpreter.

To assess a potential interpreter's level of proficiency in pertinent languages, one may ask how they came to learn both languages, where they have used them, whether or not they have had formal training as an interpreter, what sort of informal experiences they have using both languages, and one may also use written or verbal tests to gauge their linguistic level. It is also helpful to engage in a discussion with the potential interpreter about the nuances and linguistic influences that they are aware of. This is especially useful when using native speakers who often know a great deal about dialects and regional differences. In addition to having a good working vocabulary, an interpreter should also possess the ability to translate "shades of meaning." This is particularly useful when interpreting for health and mental health providers who need to understand degrees of feelings and nuance.

The final step in the process is a review of their references. Upon the completion of these steps, the individuals are invited to attend a two hour mandatory group training session for all volunteer interpreters. It is important to note that due to the demand for such volunteers, and the sensitive and challenging nature of the work, this is an ongoing process. As individuals contact us to offer their services, they are assessed and the trainings are held approximately once every three to four months.

Training and Supervision of the Volunteer Interpreters

Our program recognizes the need to support interpreters not only with appropriate training in specific skill areas, but also to provide emotional support for issues that may be raised in dealing with sensitive or overwhelming content (Akinsulure-Smith, 2004; Farooq & Fear, 2003; Miller et al., 2005). Thus, it is important to realize that the training and supervision of interpreters within this setting is not a “one-shot deal,” but rather an ongoing process. All volunteer interpreters in our program are expected to attend the first mandatory two hour group training, and they receive constant, on-going supervision throughout the duration of their time as volunteer interpreters.

This supervision comes in various forms, including debriefings with the clinician after a session, and during the mandatory “Interpreter Exchange Meeting” (where interpreters meet as a group, along with the interpreter coordinator, to discuss issues and get additional training). We also realize that volunteer interpreters might need ongoing supervision that allows them a safe place to air concerns, and share valuable insight and recommendations regarding the relationship with the client and other relevant cultural information. When volunteer interpreters have additional questions or need support, the volunteer interpreter coordinator is available for them to discuss the intricacies and nuances of the interpreting services they have provide.

The two hour mandatory training for all volunteer interpreters begins with an experiential exercise on what it means to be a traumatized refugee (see Chapter 1). In this exercise, the volunteers are asked to take out a piece of paper, anonymously write down five things that make their lives worthwhile. The facilitator of the training then reviews some of the items out loud, then rips them up and throws them away. The participants are then

invited to share their reaction to this, parallels are then drawn to the refugee experience where refugees are stripped of all the aspects of their identity and forced to flee. The purpose of the exercise is to get the interpreters to begin to empathize and reflect on the experiences they will be interpreting.

The conclusion of this exercise leads into a detailed overview of the PSOT program (history and mission), the definitions of torture (both the United Nations and World Health Organization definitions), the various types of torture (physical and psychological), tools of torture, refugee trauma, information about the physical, cognitive, behavioral, and psychological impact of torture. This training also includes psychoeducation about the various types of mental health services our clinic offers so that the interpreters themselves can understand the importance of addressing the challenges survivors of torture and refugee trauma face in terms of physical, emotional and social difficulties.

With this fundamental information in place, the second half of the training shifts to the basic foundations of interpreting. In this section, volunteer interpreters are informed about the many roles of an interpreter in our setting, and about the various formats for interpretation.

Word for Word v. Summary Interpretation

We discuss “word-for-word” versus “summary” interpreting in our trainings. Word-for-word translating means verbatim or line-by-line translation, which is emotionally neutral. This is best used in contexts like gathering factual information or explaining technical procedures. Some disadvantages might be that it takes a long time, it may require interruptions, it does not pick up on nuances and cultural information, and it does not allow for untranslatable words or concepts.

In contrast, summary interpretation summarizes important points; not necessarily exact words or sentences. It is best used in a context where there is emotionally charged content, where there is a high degree of trust between clinician and interpreter, or in group or multiple person settings. Some disadvantages may be that some detailed information may be lost, and that this technique is not as useful for taking testimony or a detailed narrative.

Guidelines for Interpretation

Volunteer interpreters also explore their own role in deciphering linguistic codes, and are presented with general guidelines for interpreting. Some of the guidelines are as follows:

- *Always use first person in your interpretation in both directions. The patient and the therapist should be speaking directly to one another.*
- *Do not edit, add, substitute, omit, condense or polish statements.*
- *Do not censure or inject your own values.*
- *Become familiar with linguistic regionalisms and idiomatic phrases.*
- *Control the pacing of the interview with hand signals to slow down speakers and/or to indicate to them to break the flow into shorter segments.*
- *Feel free to ask for repetition.*
- *Let the speaker know if you do not know how to interpret what is being said.*

- *Translate ALL of the therapist's statements in addition to their questions and interventions (e.g., therapists often make reflective statements that might not seem necessary to interpret, but every utterance has a purpose and must be spoken).*
- *Do not accept money or gifts.*
- *Abide by the code of ethics.*

Code of Ethics for Interpreters

Experiential exercises are conducted to help the interpreters explore and discuss their own cultural biases and beliefs and recognize the potential complications that can occur with the multiple relationships that are in the room (interpreter-patient, interpreter-clinician, and clinician-patient). A very important part of the training revolves around reviewing our Code of Ethics for Interpreters. This is an area where we take great care to emphasize our professional expectations of our interpreters. A summary of the code of ethics follows*:

*[*Source: This code is a combination of the Codes of Ethics from the Hospital Interpretation Program in Seattle, WA. Boston City Hospital in Boston, M.A. and the American Medical Interpreters and Translators Association (AMITAS) in Stanford, CA.]*

1. Confidentiality

Interpreters must treat all information learned during the interpretation as confidential, divulging nothing without the full approval of the patient and his/her health provider.

2. Accuracy: Conveying the content and spirit of what is said

Interpreters must transmit the message in a thorough and faithful manner, omitting or adding nothing, giving consideration of linguistic variations in both languages and conveying the tone and spirit of the original message. A word-for-word interpretation may not convey the intended idea. The interpreter must determine the relevant concept

and say it in language that is readily understandable and culturally appropriate to the client being helped. In addition, the interpreter will make every effort to assure that the patient has understood questions, instructions and other information transmitted by the health provider.

3. Completeness: Conveying everything that is said

Interpreters must interpret everything that is said by all people in the transaction, but they should inform the health professional when the content to be interpreted might be perceived as offensive, insensitive or otherwise harmful to the dignity and well-being of the patient.

4. Conveying cultural frameworks

Interpreters shall explain cultural differences or practices to health care providers and patients when appropriate.

5. Non-judgmental attitude

An interpreter's function is to facilitate communication. Interpreters are not responsible for what is said by anyone for whom they are interpreting. Even if the interpreter disagrees with what is said, thinks it is wrong or even immoral, the interpreter must suspend judgment, make no comments, and interpret everything accurately.

6. Client self-determination

The interpreter may be asked by the client for his or her opinion. When this happens, the interpreter may need to provide or restate information that will assist the patient in making his or her own decision. The interpreter should not influence the opinion of patients or clients by telling them what action to take.

7. Attitude towards clients

The interpreter should strive to develop a relationship of trust and respect at all times with the patient by adopting a caring and attentive, yet discreet and impartial attitude toward the patient, toward his or her questions, concerns and needs.

8. Acceptance of assignments

If level of experience or personal sentiments makes it difficult to abide by any of the above conditions, the interpreter should decline or withdraw from the assignment.

Interpreters should disclose any real or perceived conflict of interest that would affect their objectivity in delivery of their service. For example, interpreters should refrain from providing services to family members or close personal friends except in emergencies. In personal relationships, it is difficult to remain unbiased or non-judgmental.

In emergency situations, interpreters may be asked to do interpretations for which they are not qualified. The interpreter may consent only as long as all parties understand the limitation and no other interpreter is available.

9. Compensation

Our program does have some paid interpreters for languages that are particularly hard to find, but in general, our interpreters are volunteers. As such, interpreters should not accept additional money, considerations or favors for services. Interpreters should not use Bellevue/NYU Program for Survivors of Torture's time, facilities, equipment or supplies for private gain or advantage, nor should they use their position to secure privileges or exemptions.

10. Self-Evaluation

Interpreters should represent their certification(s), training and experience accurately and completely.

11. Ethical violations

Interpreters should withdraw immediately from encounters that they perceive to be in violations of the Code of Ethics.

12. Professionalism

Interpreters shall be punctual, prepared and dressed in an appropriate manner.

Confidentiality

Following these training exercises, all interpreters are expected to sign a confidentiality agreement. The version of the agreement that we use at the Bellevue/NYU Program for Survivors of Torture follows:

The Bellevue/NYU Program for Survivors of Torture (PSOT) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. In the course of my volunteer service at PSOT, I may come into the possession of confidential information.

By signing this document, I understand the following:

- 1. I agree not to disclose or discuss any patient, research, and/or administrative information with others, including friends or family, who do not have a need-to-know.*
- 2. I agree not to consult patient charts without permission from the PSOT staff.*
- 3. I agree not to access any information or utilize equipment, other than what is required to do my job.*
- 4. I agree not to discuss patient, research, or administrative information where others can overhear the conversation, e.g. in hallways, on elevators, in the cafeteria/coffee shop, on shuttle buses, on public transportation, at restaurants, and at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.*
- 5. I agree not to make inquiries for other personnel who do not have proper authority.*
- 6. I agree not to make any unauthorized transmission, inquiries, modifications, or purging of data in the system. Such unauthorized transmission include, but are not limited to, removing and/or transferring data from Bellevue Hospital Center's computer systems to unauthorized locations, e.g. home.*
- 7. I agree to log off prior to leaving any computer or terminal unattended.*

I have read the above Confidentiality Agreement and agree to respect the confidentiality of all patients at PSOT and to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of my volunteer service and/or suspension and loss of privileges. I certify that the information that I have provided to

the staff of the Program for Survivors of Torture is correct, and I agree to abide by the guidelines of the Program for Survivors of Torture, and to uphold the policies and procedures of Bellevue Hospital Center.

- *Name (Please Print):*

-
- *Signature:*

-
- *Date:*
-

Vicarious Trauma and Specialized Vocabulary

In order to prepare our interpreters for some of the effects of hearing the narratives of our patients there is a discussion of the impact of vicarious trauma and how to cope with it (see Chapter 13). There are often complex emotional reactions that the interpreters themselves can and often do have to this type of work (Miller et al., 2005).

Finally, in an effort to have the volunteer interpreter put into practice the knowledge and behaviors that they have learned, structured role plays are conducted to give these volunteers an opportunity to practice their new skills. All participants are given a training packet complete with articles on all the topics covered during the training. They are guided in becoming familiar with terms that might come up frequently while interpreting for our client population (e.g., “nightmare,” “co-wife,” “asylum,” “torture”). Although two hours may seem like a short amount of time to cover all of this information, it is important to note that during the “Interpreter Exchange Meetings” and during the supervisory meetings, many of these topics are revisited again in more detail.

Training of Clinicians Working with Interpreters

The PSOT model for interpreter services prioritizes the provision of appropriate levels of support and training for care providers and interpreters who work with traumatized individuals to maximize these services. Thus, not only do our volunteer interpreters receive training, but training is also provided for all clinicians who use interpreters; including our clinical trainees. In recent years, our experiences at PSOT have taught us that not only do our volunteer interpreters need training to work with our patient population, but that our clinicians also need training in how to effectively work with interpreters (Farooq & Fear, 2003; Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; Miller et al., 2005). In response to this knowledge and in an effort to improve the interpreter-clinician relationship, a training component has now been added specifically for our clinicians. In many respects, this training mirrors the one offered to the interpreters, but provides specific guidelines for clinicians using interpreters.

Clinical Do's and Don'ts When Working with Interpreters

During this training, clinicians are taught specific skills in working with interpreters such as pace (slowing down their speech pattern to allow the interpreter to convey information), avoiding “clinical jargon,” and other “do's and don'ts” of using an interpreter.

Some “Do's” include:

- * *Do speak directly to the client in the first person.*

- * *Do allow the interpreter to stand or sit close to you so that the client can see you and the interpreter at the same time. This enables the client to watch your expressions to facilitate an important part of the overall communication.*
- * *Do look at the client; not the interpreter. This helps to reinforce the client-doctor relationship and models that you are listening to them, even when they are speaking in their own language.*
- * *Do speak at a normal rate of speed and make your statements clear.*

Some “Don’ts” include:

- * *Don’t say things to the interpreter that you don’t want repeated to the client. The interpreter is obligated to interpret everything that is spoken or signed.*
- * *Don’t depend on children or other relatives and friends to interpret.*
- * *Don’t ask the interpreter for his or her opinions about the client (i.e., “Do you think he understands me?”). The interpreter is simply there to communicate the information between you and the individual.*
- * *Don’t hold personal conversations with the interpreter. Once the interpreter has taken on his or her role, they can no longer be a part of the conversation.*
- * *Don’t stop to watch or wait for the interpreter to begin speaking. The interpreter may require a complete sentence in English before beginning to speak.*

Guidelines and Role-Plays

Clinicians are given guidelines for working with interpreters and participate in discussions centered on attending to the nonverbal communication of both the client and the interpreter. The following are some useful guidelines:

- * *Always use qualified interpreters to interpret.*
- * *Have a pre-interview meeting with the interpreter to clarify roles, goals, and expectations.*
- * *Establish a good working relationship with the interpreter.*
- * *Plan to allow enough time for the interpreted session.*
- * *Introduce the interpreter to the patient.*
- * *Explain to the patient what the interpreter will be doing, i.e., “set the scene.”*
- * *Use short, precise questions, when possible.*
- * *Avoid medical or psychological jargon, when possible.*
- * *Maintain eye contact and communication with the patient, not with the interpreter.*
- * *Address yourself to the patient, not to the interpreter.*
- * *If a segment continues too long, indicate to the speaker to slow down or to stop.*
- * *Feel free to ask for repetition.*
- * *Feel free to ask for clarification.*
- * *Use words not gestures to convey your meaning.*

- * *Use the simplest vocabulary that will express your meaning.*
- * *Ask only one question at a time.*
- * *Speak in short and simple sentences.*
- * *Be prepared to repeat yourself in different words if your message is not understood.*
- * *At the end of the interview, review the material with the patient to ensure that nothing has been missed or misunderstood.*
- * *Have a brief post-interview meeting with the interpreter.*

An exercise conducted in our trainings that we have found useful is a role play in which workers take turns playing the role of the interpreter. Even when this is done in English, workers can gain an appreciation of how difficult it is to keep the flow of communication accurate and effective.

This is especially pertinent in the group setting, which is a primary area of interpreter participation in our program. In groups, many clients may wish to speak at once when a particular topic is discussed passionately. The clinician must work hard to attend to body language, facial expressions, levels of engagement/disengagement, and other affective issues in the room, even as the interpreter “stacks” client interventions and translates them one-by-one. Linking affective processes with expressed content, even when there may be an extended time gap, is an important skill for group facilitators working with interpreters. Clinicians must also help the interpreter to prioritize the order in which simultaneous or overlapping verbalizations are translated or responded to, based on clinical judgment; while making sure that all voices are heard.

Clinicians are also asked to provide formal assessments of interpreters with whom they have worked. These assessments are used to provide ongoing feedback to the interpreters and information is drawn from them when PSOT is asked to serve as a reference for the individual in question.

Special Case of Mental Health Trauma Work

The use of interpreters in any health care setting is fraught with problems and complexities that require a great deal of thought and preparation in order to be truly effective. In addition to these difficulties, the additional issues of treating survivors of torture and refugee trauma, as with other traumatized individuals, makes for a difficult set of tasks (e.g., trust building, handling sensitive traumatic material). Dealing with such emotionally laden material makes the process even more delicate. A non-English speaking client who presents for mental health treatment is navigating the cumulative stresses of cultural dislocation, economic difficulties, and a perception that the social service system is alien and intimidating. These perceptions and challenges are exacerbated by the client's inability to speak English, and the inability of service providers with whom he or she engages, to understand the client's language or culture.

While competence as an interpreter is especially critical when giving "voice" to a person's traumatic experiences, there are certain areas of self-exploration that we have found are important for an interpreter (see Chapter 13). This exploration is important before and during work with this population, as the volunteer interpreter may have their own reactions to material that they are interpreting. For example, it is important for the interpreter, to reflect on their own traumatic, refugee, or torture history (if

there is one), or reflect on their own reactions to the material that they are interpreting. How might their emotional and physical reactions influence their ability to give “voice” to the person’s needs?

For interpreters who share a cultural, ethnic and religious history with the person for whom they are interpreting, this can create complications. Such personal overlaps can elicit strong reactions, ranging from over identification (which can be manifested by going above and beyond the interpreting role and providing additional services for the individual), to feelings of overwhelming sadness, guilt, or discomfort (van der Veer & van Waning, 2004). For volunteer interpreters interpreting for mental health sessions, it becomes useful to challenge them to think about their own notions of mental health (particularly concerning psychotherapy and psychopharmacology), as there can be considerable stigma around receiving mental health services in many cultures.

For clinicians who use interpreters during psychotherapy sessions, special focus during their training is placed on the ways in which an interpreter can impact the therapy session. Here emphasis is placed on the collaborative nature of the work. Clinicians are encouraged to meet with the interpreter prior to the session to explain its purpose and goal, and to meet with the interpreter after the session to discuss not only the shared experiences of the session, but to also check in on the interpreter’s emotional reactions. Additionally, in-depth information is provided about the “triad” itself (i.e., working with three sets of transference/countertransference in the room), especially the powerful impact of the transference that the patients can have towards the interpreter. Another significant area discussed involves the impact of changing an interpreter, and how this can impact the course of the therapy.

Conclusion

The use of volunteer interpreters requires extensive preparation and care. This is particularly true as ongoing training and supervision involves not just the interpreter, but also the clinicians working with them. Despite these logistical concerns, in this time when we are faced with limited resources and cutbacks, volunteer interpreters can, and do, provide a very valuable service for the treatment of traumatized refugees and survivors of torture.

References

- Akinsulure-Smith, A.M. (May/June 2004). Giving Voice to the Voiceless: Providing Interpretation for Survivors of Torture, War, and Refugee Trauma. *The Gotham Translator*, 6-7.
- Baker, D.W., Hayes, R., & Fortier, J.P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care*, 36 (10), 1461-1470.
- Edwards, C.P., & Kumru, A. (1999). Culturally sensitive assessment. *Child and Adolescent Psychiatric Clinics of North America*. 8 (2), 409-424.
- Eytan, A., Bischoff, A., Rrustemi, I., Durieux, S., Loutan, L., Gilbert, M., et al. (2002). Screening of mental disorders in asylum-seekers from Kosovo. *Australian and New Zealand Journal of Psychiatry*, 36, 499-503.
- Farooq, S., & Fear, C. (2003). Working through interpreters. *Advances in Psychiatric Treatment*, 9, 104-109.
- Flores, G., Rabke, J., Pine, W., & Sabharwal, A. (2002). The importance of cultural and linguistic issues in the emergency care of children. *Pediatric Emergency Care*, 18 (4), 271-284.
- Gany, F., & Thiel de Bocanegra, H. (1996). Overcoming barriers to improving the health of immigrant women. *Journal of American Womens Association*, 51 (4), 155-160.
- Gong-Guy, E., Cravens, R.B., & Patterson, T.E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist*, 46 (6), 642-648.

- Haenel, F. (1997). Aspects and problems associated with the use of interpreters in psychotherapy of victims of torture. *Torture*, 7 (3), 68-71.
- Hornberger, J., Itakura, H., & Wilson, S.R. (1997). Bridging language and cultural barriers between physicians and patients. *Public Health Reports*, 112 (5), 410-417.
- Kirmayer, L.J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *Canadian Journal of Psychiatry*, 48 (3), 145-153.
- Kravitz, R.L., Helms, L.J., Azari, R., Antonius, D., & Melnikow, J. (2000). Comparing the use of physician time and health care resources among patients speaking English, Spanish, and Russian. *Medical Care*, 38 (7), 728-738.
- Lee, E. (1997). Cross-cultural communication: Therapeutic use of interpreters. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians* (pp.477-489). New York: Guilford Press.
- Marcos, L.R. (1979). Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. *American Journal of Psychiatry*, 135 (2), 171-174.
- Miller, K.E., Martell, Z.L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry*, 75 (1), 27-39.
- Phelan, M., & Parkman, S. (1995). How to do it: Work with an interpreter. *British Medical Journal*, 3 (11), 555-557.

- Pöchhacker, F. (2000). Language barriers in Vienna Hospitals. *Ethnicity and Health*, 5 (2), 113-119.
- Resick, P., & Schnicke, M. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage.
- Sabin, J.E. (1975). Translating Despair. *American Journal of Psychiatry*, 132 (2), 197-199.
- Schulz, P., Resick, P., Huber, L., & Griffin, M. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioral Practice*, 13, 322-331.
- van der Veer, G., & van Waning, A. (2004). Creating a safe therapeutic sanctuary. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp.187-219). New York: Brunner-Routledge.
- Wood, B.A. (2002). Caring for a limited-English proficient patient. *AORN Journal*, 75 (2), 205-208.

Chapter 5

The Clinical Interview and Programmatic Intake Process - Summary

In this chapter we discuss the basics for conducting an initial interview with a survivor of torture and refugee trauma. We also describe the intake procedures we utilize at the Bellevue/NYU Program for Survivors of Torture.

The Clinical Interview

- * General interview considerations

 - Level of detail needed

 - Dangers of retraumatization

 - Awareness of secondary trauma

- * Preparation for the interview

 - Environmental, physical, psychological and socio-cultural barriers

- * Conducting the interview

 - Establishing rapport

 - Confidentiality issues

 - Open-ended questions

 - Verbal and non-verbal communications

Intake Procedures at the Program for Survivors of Torture

- * Purpose of the intake

- * Structure of the intake

- * Criteria for acceptance

The Clinical Interview and Programmatic Intake Process

Allen S. Keller, M.D. & Hawthorne E. Smith, Ph.D.

The Clinical Interview

General Interview Considerations²

When an immigrant or refugee presents for services, the service provider may or may not know whether the individual has experienced significant traumatic events and what impact such experiences have had on the physical, psychological and social well-being of the individual (Keller, Eisenman, & Saul, 1998). As evident from Chapter 1 of this book, however, such events are tragically all too common. For individuals from troubled areas of the world, such as Darfur, the Democratic Republic of Congo (the former Zaire), Tibet, Sierra Leone, the former Yugoslavia, or Afghanistan, where violence and trauma have been endemic, it is likely that almost everyone has been exposed (directly or indirectly) to horrific experiences.

Interviews in which a trauma victim recounts the events of his/her abuse can be extremely stressful and re-traumatizing for the individual (Iacopino, Allden, & Keller, 2001). Discussing such events may result in exacerbation of physical and psychological symptoms for the individual. Thus, it is essential that interviewers use judgment about how much information is needed about the traumatic events.

For example, an asylum attorney assisting a client in preparing an affidavit for his/her asylum application may require great detail about

² The first several sections draw extensively on materials from the following reference: Iacopino, V., Allden, K., & Keller, A.S. (2001). *Examining asylum seekers: A health professional's guide to medical and psychological evaluations*. Boston, MA: Physicians for Human Rights.

traumatic events experienced. Even here, however, there can be limits on how much detail is required, for example in the case of someone who was repeatedly tortured or raped, it is not necessary, nor perhaps appropriate to try and elicit all of the details about every single episode. Conversely, a primary care physician conducting an initial evaluation with a refugee or individual already granted asylum may not require the same level of detail. Some information, however, about why an individual had to leave their country and what traumatic events were experienced is still useful. In the examination of KH, the Tibetan woman described at the beginning of Chapter 1, her history of torture and abuse was certainly relevant to addressing her back pain.

When interviewing immigrants and refugees who may have suffered traumatic events, it is important to give them a sense of control over what they do or do not wish to share. Even if it is important to learn more about traumatic events, it may take several visits to establish a rapport and elicit a history of the traumatic events.

Every effort should be made to accommodate any preference the client may have regarding the gender of the clinician and the interpreter. In certain cultures, or situations, such as when an individual has experienced sexual assault, gender issues may be of even greater importance (Briere & Scott, 2006).

Listening to accounts of torture/trauma can be very stressful for interviewers as well (see Chapter 13). Awareness of secondary trauma and taking steps to prevent this is important in continuing to be able to work effectively with refugees and torture survivors.

In eliciting a trauma history, it is important to appreciate that there is great variability in the manner in which survivors of torture/trauma conduct

themselves in interviews and in recounting the events of their abuse. For example, some survivors will react with great emotion and frequently become tearful. Others will appear extremely calm or detached, describing the events as if this had happened to someone else. There is also variability with regards to the degree of physical and psychological symptoms or consequences which a survivor of torture or refugee trauma will manifest (Iacopino et al., 2001).

Additionally, there is often variability in the amount and detail of information which an individual will recall with regards to the events of the trauma (Weinstein, Fucetola, & Mollica, 2001). This is often the case when an individual was subjected to repeated episodes of torture/abuse. The events of a particular episode may begin to blur. Individuals may have been detained under conditions in which they lose a sense of time and/or place. For example, individuals may have been kept blindfolded or held in solitary confinement in a dark cell, or reduced to a very weakened and confused state as a result of being deprived of food, water, or sleep.

Preparation for the Interview

In preparation for the interview, it is useful to review available background documents/information, such as notes from service providers in the client's native country or the client's asylum application, if these are available. Adequate time should be set aside for conducting interviews, particularly if an interpreter is required. One should also try to anticipate, and when possible, address possible barriers to effective communication. Barriers to communication can drastically influence the value and process of an interview (Iacopino et al., 2001). Possible barriers to communication include:

1. Environmental barriers, such as a lack of privacy, excessive noise, an uncomfortable interview setting, interruptions in the interview, inadequate time for interview.
2. Physical barriers, such as pain or other discomfort the individual may be experiencing as a result of his/her abuse or unrelated medical problems. For example, musculoskeletal pain, physical symptoms such as sweating or palpitations the client might experience as a result of emotional reactions, difficulty sitting for prolonged periods, fatigue, sensory deficits such as blindness or deafness.
3. Psychological barriers, such as fear/anxiety, mental health disorders such as depression, post-traumatic stress disorder or cognitive deficits, and
4. Socio-cultural barriers, such as the gender of the interviewer (particularly important with victims of sexual assault), cultural/racial differences between the interviewer and the client, and language issues, including appropriateness and accuracy of interpreter.

Conducting the Interview

While there are a variety of specific reasons for conducting interviews with torture survivors and refugees, three broad tasks of the interview to consider are information gathering, emotion handling and providing information. Regardless of the purpose of the interview it is important to pay attention that all three of these tasks are addressed during the course of the interview.

Establishing rapport with a patient/client is essential for obtaining accurate and needed information and being able to move forward with a plan of action. Adequate time should be allowed for the interview. The interview should take place with appropriate privacy. The immediate needs of the patient and any possible barriers to communication should be addressed (see above).

It is important to clarify and perhaps negotiate the purpose of the interview. The service provider may have a specific agenda for what needs to be learned. The client may have different expectations of what they hope to achieve from the interaction. Clarification and appropriate negotiation of the goals should happen up front. Issues regarding time limitations should be clarified as well.

Care providers have a duty to maintain confidentiality of information and to disclose information only with the client's consent. If the individual is cared for by a multidisciplinary team with sharing of information, the client should be informed of this. Any concerns about confidentiality/privacy should be addressed.

Demonstrating genuine interest in the client's culture and engaging him/her as a valuable resource in teaching you about their culture can be an effective means of establishing rapport. Opening the interview in a respectful and courteous manner can set the tone for future interactions. As noted above, addressing issues of safety, confidentiality and trust are essential in effectively gathering information. Detecting and addressing barriers to communication is also important. Explanation of what information is needed and why can be very important. Acknowledgement of the potential difficulties of sharing this information should also be addressed.

If there is a need to obtain a history of traumatic events, there should be an acknowledgement of the potential difficulties and stresses. It is important to appreciate that the interview process of obtaining a trauma history, particularly for a torture survivor, may remind him/her of being interrogated, and thus evoke strong negative feelings toward the clinician, such as fear, helplessness, and anger. Feelings of shame about prior events, or fear of persecution, or guilt about friends/loved ones left behind can generate strong emotions from the individual.

In order to elicit an accurate account of abuse, clinicians must work to create a climate of trust where disclosure of information, perhaps for the first time, is able to occur. Earning trust of individuals who have suffered significant trauma requires effective communication, empathy and honesty. Active listening is essential. This entails a concerted effort to hear the patient and make the patient feel heard.

Whenever possible, one should utilize open-ended questions (example: “Can you tell me about why you needed to leave your country?” “Tell me more about that”). The individual should be allowed to tell his/her story in their own words with as few interruptions as possible. This may result in a more accurate and detailed disclosure of information than moving too quickly to a rapid-fire form of questioning, which, in fact, mimic interrogation. Further details can be elicited with appropriate follow up questions.

Providing the individual with a sense of control over the process (by such methods as informing the individual that they don’t have to answer any questions they don’t want to, or giving them control over the flow of the interview by allowing them to take periodic breaks), is important (Fabri, 2001). The torture or refugee experience often focuses on loss of control.

Thus efforts at showing respect and providing the individual with a sense of control are important.

Disclosing events of trauma may generate strong emotions for both the patient/client and the interviewer. Effective verbal and non-verbal communication, are important factors in an interview. Acknowledging to the individual how difficult it is to discuss traumatic events can serve to validate the feelings of the individual. Non-verbal communication including body posture, eye contact, and perhaps a gentle touch on the hand, if appropriate, are important in rapport building. Active listening requires appropriate pauses, and allowing for some periods of silence. This can serve as an acknowledgment of the intimacy of the information shared.

Prior to completing the interview, it is important to ask the individual if there is any additional information that he/she would like to tell you. For example, “You have told me a great deal about yourself, is there anything else that would be useful for me to know?” Adequate time should be allowed for the individual to ask questions and questions should be encouraged. For example, rather than asking “Do you have any questions,” ask “What questions do you have for me?” Follow up plans including referrals, follow up visits and additional actions to be taken should be negotiated and clarified.

In summary, while there are many potential difficulties in interviewing survivors of torture and refugee trauma, when conducted appropriately, such interviews can provide critical information necessary for effectively caring and advocating for the individual. Along these lines, we will present information regarding the structure of our intake interview protocol for all applicants to the Program for Survivors of Torture.

Intake Procedures at the Program for Survivors of Torture

Purpose of the Intake

We receive approximately 5 – 8 referrals for treatment in a given week. These referrals come from attorneys, human rights organizations, immigration officials (officers and judges), and most importantly, “word of mouth” referrals from within expatriate communities.

With such a high volume of demand for services, we must screen prospective clients to assess their appropriateness for our program, and to evaluate their clinical needs. Our intake process helps to facilitate our triage process, so that clients are linked with the specific services that will be most beneficial for them. For those clients not accepted into our program, we also want to ensure an appropriate referral for treatment elsewhere. The clinical information we gather will help us to make informed and effective referrals.

Structure of the Intake

The intake interview at the Program for Survivors of Torture (PSOT) is preceded by an initial phone-screening by our intake coordinator. During the initial phone conversation, basic demographic data are gathered and potential clients are asked about the services they are seeking. Those applicants for whom it is clear that a referral to our program is not warranted (i.e. those who live out of state or those seeking solely legal and/or forensic services) will be referred to other mental health, health care, social, and legal service providers, as appropriate. Our intake coordinator will also refer applicants who fit another trauma profile, such as victims of violent crime and those suffering from domestic abuse here in New York. These callers

will be referred to specialty services that deal directly with their populations. Frequently these services are found elsewhere within Bellevue Hospital.

An intake interview will be scheduled for those applicants for whom further screening is appropriate. When the interviewer receives the referral, he or she would be well advised to familiarize themselves with country conditions in the applicant's homeland. Sites such as www.BBCnews.com and www.state.com have proven to be useful for this task. Interviewers should consider institutional transference issues, and should be familiar with common psychological reactions to trauma, such as posttraumatic and depressive symptoms.

The interview is multi-faceted and serves several purposes. The initial part of the intake interview is designed to establish rapport, provide psychoeducation regarding confidentiality and PSOT programmatic structures, and to gather demographic information. We gather information on the applicant's current contact information and living situation. Information is also collected regarding an applicant's country of origin, family history and demographics, religion, linguistic fluency, educational and occupational backgrounds, immigration status, current earnings, insurance eligibility, and the applicant's chief complaint (i.e. the reason they have come to us seeking services). These questions not only provide needed demographic information, but it also allows the applicant and interviewer to start with relatively un-threatening material, so that there will be time for rapport-building and providing information about our program's services and structures.

The next section is where applicants are asked more directly to describe their trauma history and what brought them to the US. As detailed earlier in this chapter, using open-ended questions and allowing the

applicant to exercise significant control over the pace and direction of the trauma narrative is crucial for establishing an environment in which the applicant can share his or her painful experiences. The more open-ended approach to the trauma narrative is also helpful in observing an applicant's thought processes. There are many facets that an interviewer may observe by taking this approach (i.e. Is the narrative linear? Is the applicant tangential or circumstantial in thought? Is the narrative detailed or sparse? Are there gaps or avoidance in the narrative? Does the applicant fixate on a particular event/person? Is the applicant emotionally labile or flat?).

The more open-ended interview format of the trauma narrative is complemented by some specific follow-up questions regarding traumatic events that are designed to provide information that may not have been covered in the survivor's narrative. Interviewers use their judgment as to whether they will ask specific follow-up questions, based on what has already been covered in the applicant's trauma narrative.

Following the trauma narrative, we discuss etiological and socio-cultural details regarding the abuse. We begin to identify the reasons why an applicant may have been targeted; we look at where and when the abuse took place, and who was responsible for perpetrating the abuse. We look at the effects of being detained (whether in the country of origin, a third country, and/or here in the US), as well as the traumatic experiences on members of the applicant's family. We also detail aspects of harassment and socio-economic hardship that accompany torture and refugee trauma. We also discuss aspects of witnessing the abuse of others, surviving direct physical assault, and other potentially traumatic experiences, such as domestic violence, female genital mutilation, etc.

We then move the interview to focus on issues of current emotional functioning and mental health. We administer two psychometric surveys: the 16 item symptoms portion of the Harvard Trauma Questionnaire (HTQ), which measures posttraumatic stress (Mollica et al., 1992), and the Brief Symptom Inventory (BSI), which measures a broad array of psychological stressors, and has been normed on outpatient and inpatient psychiatric patients (Broday & Mason, 1991; Piersma, Reaume, & Boes, 1994). The HTQ and BSI are widely used by human rights organizations and treatment centers who deal with survivors of torture and refugee trauma, including organizations within the National Consortium of Torture Treatment Centers (Keller et al., 2003). These scales have been shown to have diagnostic validity and reliability (Hollifield et al., 2002; Mollica, Wyshak, de Marneffe, Khoun, & Lavelle, 1987; Mollica et al., 1992; Morlan & Tan, 1998; Smith-Fawzi et al., 1997), and have been used with diverse populations (Allden et al., 1996; Aroian, Patsdaughter, Levin & Gianan, 1995; Cardozo et al., 2000; Mollica et al., 1992; Mollica et al., 1999).

After filling out these questionnaires, applicants then answer guided interview questions regarding their subjective cultural perspectives of self (i.e. helping to ascertain what reference group identities are the most salient for the applicant) and then engage in a full mental status examination.

Applicants to our program are then given pain rating scales, and given the opportunity to describe their most pressing physical concerns. Toward the end of the interview, potential clients talk about their most pressing social service needs, and the interviewer may give a more detailed description of the services offered by PSOT. It is also important to assess the applicant's reactions to this intense interview process, and to provide

immediate therapeutic support if the client expresses significant emotional distress associated with the interview.

The entire intake interview usually lasts about 90 minutes, but this may be extended up towards three hours, especially when interpreters are involved, or when there is a particularly detailed and extensive trauma history to contend with. Aspects of a client's current functioning (i.e. processing speed, thought processes, memory deficits, etc.) will also affect the length of time that an intake interview will last. Generally, an interview is completed in one sitting, but there are times when two appointments will be needed to complete the intake. This may be based on logistical concerns, or it may be that a client will need to have the intake broken into two sessions, just to help with the intensity of the endeavor, and to help the clinician handle the emotions that accompany such an undertaking. As such, we endeavor to wed the prerogatives of sensitive and informed interviewing skills with the need for detailed and nuanced information from the applicant. Our intake protocol is designed to maximize our effectiveness in these domains.

Criteria for Acceptance into the Bellevue/NYU Program for Survivors of Torture

The criteria for acceptance into our program are linked to two broad questions. What were the applicant's traumatic experiences? What are the applicant's clinical needs? The relationship between these two questions is not linear, and the reality is that our program does not have the capacity to treat all of the people in need who seek our services. This combination of factors leads to a complex decision making process. In our intake disposition conferences we try to strike this delicate balance and accept and treat those

applicants most in need, and those who we feel would most benefit from our services.

In terms of traumatic experiences, we often conceptualize things in an informal hierarchy comprised of several levels. The first level would be those applicants who have been directly tortured in the “traditional” sense of the word; those for whom the UN definition of torture would apply. The second-tier would be those applicants who were not directly tortured, but were affected by the human rights abuses and trauma related to war trauma. Fitting within this category would be people who witnessed extra-judicial killings, those who saw family members killed, those who had their homes burned, those who were menaced and threatened, those who were kidnapped, and those who were forced to flee and live in hiding before escaping their countries. Clients from diverse countries such as Cote d’Ivoire, Colombia, Sierra Leone, the former Yugoslavia, Afghanistan, and the Democratic Republic of Congo may share these harsh realities.

The third-tier might be seen as “oppressed populations” who have been uprooted from their homeland and may have experienced further abuse in their previous country of resettlement. Many Tibetans applicants report first-tier abuses by Chinese authorities in what was once their homeland. But other Tibetan applicants, who were not directly tortured, were still forced out and then faced tenuous exiles in Nepal, India, and Bhutan. They frequently report patterns of repeated abuse, economic and cultural discrimination, and social dislocation. These members of an oppressed population who have suffered human rights abuses are also eligible for services in our program.

This hierarchy of experiences intertwines with an applicant’s clinical needs. As mentioned earlier, there may be applicants that are primarily interested in evaluation and forensic services. Generally, these applicants are

interested in receiving a medical or psychological affidavit for their asylum hearing.

Our programmatic stance is that we focus primarily on treatment, and see any provision of documentation to the immigration services as an adjunctive service to our clinical work. We will provide documentation to those clients who have sincerely and consistently engaged in treatment in our program, so that we can report on a symptom profile and a course of treatment that will be meaningful to the forensic process. Consequently, an applicant may have survived first-tier torture experiences, but if he or she is not seeking treatment, and is more concerned with obtaining medical documentation, we will refer them to organizations such as Doctors of the World and Physicians for Human Rights, who focus primarily on such forensic evaluations.

There may be occasions when an applicant who has suffered from the third-tier trauma, as described above, but is very symptomatic. As an individual's reactions to torture and/or refugee trauma will vary from person to person, so an applicant who has a "lesser" trauma history may be accepted or prioritized above an applicant with a more severe trauma history. Such a decision is based on an assessment of the perceived clinical needs.

Another population that may be accepted into our program without experiencing torture directly is the immediate family of a program client who has gained asylum and successfully reunified his or her family. There may be other torture survivors in the family, but often the children of survivors have been victim to more of the indirect effects of their parents' abuse, such as ongoing and long-standing separation from the parental figure, living in hiding or in a refugee camp, educational disruption, disease, poverty, and a general lack of security and stability. We assist the reunited

family members with the health, mental health, and social services (as detailed in Chapter 9).

Another major consideration is whether or not the applicant has been involved in any human rights abuses themselves. As will be discussed in Chapter 6, a premium is placed on creating a safe environment for our clients. We would never want to have the proverbial “victim and victimizer reunion” in the waiting room. As such, applicants that have a history of curtailing others’ human rights are referred elsewhere for treatment. Again, these referrals may be made to other clinics within Bellevue or elsewhere in the city, depending on the specific clinical needs of the referred patient.

The only times that we have considered making exceptions to this rule is when we have discussed the special cases of children forced to commit human rights abuses. Is it different when someone is first abused, drugged, and trained to abuse others at an age when they are most vulnerable to such tactics (i.e. Briggs, 2005)? We have yet to treat any clients who admit to perpetrating human rights abuses on others, but we have treated some young boys who were abducted and forced to be porters and servants for rebel and/or government forces. We have also treated young girls who were abducted and forced to serve as “rebel wives.” Is it possible that a client among this group may have participated in some abuses and not reported it? Yes. Did we feel that the clinical need of the child in question necessitated that we tolerate that ambiguity? Yes.

As this section implies, making decisions as to who will be accepted to receive services in our program is a complex undertaking. Stating that we look at the criteria on a “case by case basis” might sound like we are resisting a formalized structure. The truth is, however, that in order to balance the “sometimes complementary-sometimes competing” imperatives

for selecting clients that are most in need versus those who will most benefit from treatment, necessitates such a flexible and nuanced evaluation structure.

References

- Alden, K., Poole, C., Chantavanich, S., Ohmar, K., Aung, N.N., & Mollica, R.F. (1996). Burmese political dissidents in Thailand: Trauma and survival among young adults in exile. *American Journal of Public Health, 86*, 1561-1569.
- Aroian, K.J., Patsdaughter, C.A., Levin, A., & Gianan, M.E. (1995). Use of the Brief Symptom Inventory to assess psychological distress in three immigrant groups. *International Journal of Social Psychiatry, 41*(1), 31-46.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, London, New Delhi: Sage Publications.
- Briggs, J. (2005). *Innocents lost: When child soldiers go to war*. New York: Basic Books.
- Broday, S.F., & Mason, J.L. (1991). Internal consistency of the Brief Symptom Inventory for counseling-center clients. *Psychological Reports, 68* (1), 94.
- Cardozo, B.L., Vergara, A., Agnai, F., & Gotway, C.A. (2000). Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. *Journal of the American Medical Association, 284*, 569-577.
- Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., et al. (2002). Measuring trauma and health status in refugees: A critical review. *Journal of the American Medical Association, 299*(5), 611-621.

- Iacopino, V., Aalden, K., & Keller, A.S. (2001). *Examining asylum seekers: A health professional's guide to medical and psychological evaluations*. Boston, MA: Physicians for Human Rights.
- Keller, A., Eisenman, D., & Saul, J. (1998). Caring for survivors of torture in an urban, municipal hospital. *Journal of Ambulatory Care Management, 21*(2), 20-29.
- Keller, A.S., Ford, D., Sachs, E., Rosenfeld, B., Trinh-Shevrin, C., Meserve, C., et al. (2003). The impact of detention on the health of asylum seekers. *Journal of Ambulatory Care Management, 26*, 383-385.
- Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and post traumatic stress disorder in refugees. *Journal of Nervous and Mental Disorders, 180*, 111-116.
- Mollica, R.F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., et al. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand- Cambodia border camps. *Journal of the American Medical Association, 270*, 581-586.
- Mollica, R.F., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic I., & Massagli, M.P. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *Journal of the American Medical Association, 282*, 433-439.
- Mollica, R.F., Wyshak, G., de Marneffe, D., Khoun, F., & Lavelle, J. (1987). Indochinese versions of the Hopkins Symptom Checklist-25: A screening instrument for the psychiatric care of refugees. *American Journal of Psychiatry, 144*, 497-500.

- Morlan, K.K., & Tan, S.Y. (1998). Comparison of the Brief Psychiatric Rating Scale and the Brief Symptom Inventory. *Journal of Clinical Psychology, 54* (7), 885-94.
- Piersma, H.L., Reaume, V.M., & Boes, J.L. (1994). The Brief Symptom Inventory (BSI) as an outcome measure for adult psychiatric inpatients. *Journal of Clinical Psychology, 50* (4), 555-63.
- Smith-Faawzi, M.C., Murphy, E., Pham, T., Lin, L., Poole, C., & Mollica, R.F. (1997). The validity of screening for posttraumatic stress disorder and major depression among Vietnamese former political prisoners. *Acta Psychiatrica Scandinavica, 95*, 87-93.
- Weinstein, C.S., Fucetola, R., & Mollica, R. (2001). Neuropsychological issues in the assessment of refugees and victims of mass violence. *Neuropsychology Review, 11* (3), 131-141.

Chapter 6

Treatment Techniques and Priorities: A Psychological Approach to the Patient

– Summary

This chapter focuses on the treatment techniques that inform our programmatic approach to psychological treatment with survivors of torture and refugee trauma. Special attention will be paid to issues of safety and empowerment. Brief descriptions of various clinical orientations to trauma-focused work will be provided, as much to identify commonalities among approaches as to expose differences. The chapter also discusses the multi-faceted challenge of providing appropriate supervision to clinicians engaged in working with such traumatized and challenged populations.

* Emotional safety

* Empowering the client

* Multiple approaches to individual psychotherapy

Psychodynamic treatment with survivors of torture and refugee trauma

Cognitive –Behavioral treatment with survivors of torture and refugee trauma

Narrative Exposure Therapy with survivors of torture and refugee trauma

Non-verbal approaches to therapy

Synthesis of approaches/intra-discipline flexibility

* Supervision of clinicians treating survivors of torture and refugee trauma

Treatment Techniques and Priorities: A Psychological Approach to the Patient

Hawthorne E. Smith, Ph.D.

Given the multiple and recurrent stressors a survivor is facing, as well as the complex psychological reactions related to their experiences, some insights in terms of engaging this population in treatment are warranted. The following themes have proven to be important in our work at the Bellevue/NYU Program for Survivors of Torture.

Emotional Safety

One of the factors that has become evident in our work with torture survivors is that fostering a sense of emotional safety is of paramount importance. This finding is echoed throughout the psychological literature, where developing a relationship of confidence and trust with torture survivors has been described as being the first priority in treatment (Briere & Scott, 2006; Fabri, 2001; Fischman & Ross, 1990; Haenel, 2001; Herman, 1992; Keller et al., 1998; Pope & Garcia-Peltoniemi, 1991; Silove, Tarn, Bowles & Reid, 1991; Somnier & Genefke, 1986; van der Veer & van Waning, 2004; Vesti & Kastrup, 1991).

This is particularly important for torture survivors. Some of the clients we treat at Bellevue have been tortured by individuals in uniform in institutional settings. Many arrive at our hospital for their first visit, see crowds of people (including armed policemen and hospital security agents), become overwhelmed, and turn right around and go home. It is important to try to diminish the “negative institutional transference” that may exist for the

client, so that they will be able to engage in treatment (Fischman & Ross, 1990; Smith, 2003).

XY, a 35 year old woman from Guinea, had a long history of abuse at the hands of Guinean police and para-military personnel due to her husband's involvement in an opposition political movement. The majority of her physical and sexual abuse was carried out by men in official uniforms, in civic settings, such as a police station or military barracks.

When XY first arrived at Bellevue for treatment, she was very frightened by the New York City police, hospital police, and other law enforcement personnel in uniform at the hospital. She returned home without keeping her appointment in our clinic. When she called to notify us why she was absent, we arranged to have the clinician meet her in the courtyard outside of the hospital. The clinician then accompanied her inside, and showed her the way to our clinic. Even when walking in the hall with the clinician, XY would shudder every time she saw a uniformed officer, and would position herself so that the clinician was always between her and the passing officer(s).

When greeting new clients and showing them the way to our clinic, program staff try to normalize the potentially confusing and intimidating hospital environment. This is consistent with psychological literature that describes normalizing a client's initial fears and anxieties as an important facet of creating a less threatening environment in which to begin treatment (Haenel, 2001). It may even be useful for a clinician to reframe a client's "anxiety" as a protective mechanism that has helped them to withstand the

emotional turbulence they have experienced, and continue to experience (Gurris, 2001).

At the Bellevue/NYU Program for Survivors of Torture, clients are often accompanied as they register and navigate the hospital bureaucracy, with program staff serving as interpreters and facilitators. Through this process the client may sense that they have an ally, and a trusting relationship may begin to germinate as the staff helps to make the initial contacts more humane and manageable. Seemingly small actions can have more impact than words, especially at the outset of treatment (Fabri, 2001; Silove et al., 1991).

It is also important to remember that many survivors have been tortured in conjunction with being interrogated for information by people in powerful positions. This is of crucial therapeutic importance, particularly during the initial interview, as there is a significant danger of re-traumatizing the client if the therapist strictly adheres to their usual information gathering techniques. It is counterproductive to insist on “uncovering the whole story” if the client is emotionally unprepared to do so (Gangsei, 2001; Silove et al., 1991). The psychological literature states that it is preferable to strike a balance between uncovering the story and validating the client’s experiences (Elsass, 1997; Haenel, 2001). The role of the therapist at this stage has been described as both, “witness and supportive human being” (Gurris, 2001 p. 51).

Clients may be reticent about sharing their stories for several reasons. Clients may fear that they won’t be believed, or may be so ashamed of their experiences that they are reluctant to reveal them. They may vacillate between the intrusive and avoidant responses that accompany posttraumatic stress disorder, or perhaps they have not yet reclaimed the ability to fully

trust another human being (Chester & Holtan, 1992; Elsass, 1997; Gurriss, 2001). In fact, a client's "resistance" may be an adaptive coping mechanism learned while navigating hostile environments (Elsass, 1997). For all of these reasons, it is imperative that the clinician not engage in an "interrogation" of the client. The need for the client to feel safe outweighs the therapist's need to complete the necessary forms and paper work during the initial intake. Developing feelings of trust and safety comes first, and precedes any potential healing or resolution of traumatic symptoms through guided emotional expression (Haenel, 2001; Pope & Garcia-Peltoniemi, 1991).

During the first meeting, it may be helpful to engage the client in "anticipatory guidance," by which the clinician explains some common and expected symptoms that someone in the client's situation may experience. The therapist may also describe pertinent aspects of the recovery process, and the resources that their particular program can offer the client (Fischman, 1998; Smith, 2003). This helps to diminish some of the ambiguity that is frequently associated with incidents of psychological torture. During this phase, the client should also be enlisted as an active participant in prioritizing their needs and desires.

In our program, clients are encouraged to help decide how therapeutic resources will be prioritized and utilized. Efforts are made to understand a client's expectations of treatment, from a cultural perspective and in light of their traumatic experiences. We try to elicit the client's insights and desires regarding his or her treatment regimen. By this, we do not mean to say that a clinician should withhold his or her clinical point of view, or relinquish all control in terms of setting the direction of therapy. Rather, we find that collaborating with the client in terms of clinical decision making helps them

to engage in treatment initially, and it fulfills a larger goal of treatment, which is to empower the client in the therapeutic relationship.

Empowering the Client

As discussed earlier in this volume, survivors of torture and refugee trauma who are living in exile have been violently and purposefully disempowered on multiple levels. Survivors may see themselves as being helpless, unworthy, or less than human, as consequences of the torture experience itself. They have also been forcibly removed from their familial and social support systems, as well as the cultural and linguistic contexts in which they feel comfortable operating. These factors, in addition to possible professional devaluation and survivor guilt, work to disempower the client in complex ways (Keller et al., 1998; Silove et al., 1991).

Empowerment in this context should not be confused with the notion of autonomy. While autonomy speaks to elevated functioning and independence, and is a goal generally reserved for later stages of trauma treatment (i.e. Herman, 1992), empowerment is focused more on communicating respect, and helping the client to internalize a positive sense of self-worth. Empowerment serves to facilitate “the innate tendency for humans to process trauma-related memories and to move toward more adaptive psychological functioning” (Briere & Scott, 2006, p. 67).

For example, elevating the client in the therapeutic relationship, and offering an exchange between two individuals with unique resources and histories - not just an authoritative helper and helpless victim - helps the client to find their voice in the relationship. Clinicians can encourage the

client's voice by taking a "collaborative" rather than an "expert" stance (Fabri, 2001; Smith, 2003).

Therapists need to be flexible in their own conceptualization of the therapeutic relationship. We have already discussed how engaging the torture survivor in determining their own therapeutic priorities serves to empower them. This is particularly salient as "traditional" psychotherapy is an alien, and sometimes stigmatized, notion to many of our clients from non-Western societies (Akinsulure-Smith & Smith, 1997; Elsass, 1997).

To insist that clients learn and internalize the cultural norms of "traditional" (otherwise known as "Western") psychotherapy places an additional cultural obstacle in front of them. Clients are already struggling to traverse cultural and linguistic barriers; giving them an additional hurdle, one more context in which they are unsure of the "proper" behaviors, serves to further disempower them. Being flexible and engaging clients in a more collaborative stance helps to give them an increased sense of personal control (Fabri, 2001; Gurriss, 2001; Smith, 2003).

Another technique a clinician can use to balance the relationship is to allow clients to teach him/her about their homeland, their culture, and other salient historical and/or social issues. Of course, it helps when the clinician has some knowledge about the country and situation from which the survivor has fled. This is a way of letting the client know that their past experiences exist on the therapist's cognitive "radar screen." However, a balance can be struck, where clients can broaden the therapist's contextual understanding of their history and culture. This is another therapeutic interaction that allows clients to feel that their knowledge, experiences, and insights are valued.

This type of exchange also suggests to clients that they are respected as human beings who have something valuable to offer. This works to counter the belief among some survivors that they are powerless shells of their former selves, with nothing positive to share with anyone. As the client gains more confidence that they are being listened to and respected in the relationship, the resistance to engaging in the therapeutic process decreases (Akinsulure-Smith et al., 1997; Fabri, 2001).

Creating an environment in which the client feels emotionally safe and empowered, is a crucial element of forming a therapeutic alliance. However, there are other aspects of forming an alliance that may be unique to working with torture survivors who are living in exile. Below are some techniques, or therapeutic stances, that have proven to be effective across disciplines at the Bellevue/NYU Program for Survivors of Torture.

Our psychological work takes place within the context of a multidisciplinary treatment team. Psychologists work collaboratively with primary care physicians, psychiatrists, social workers, and activity therapists. Whenever possible, mental health and medical staff both meet with the client; especially when the client attends our specialized “Multidisciplinary Treatment Clinic,” where they receive comprehensive evaluations and care from our clinicians. This is to give the client the sense that we work as a coordinated team, and to decrease the number of times a client may feel compelled to describe the details of the torture. This also models that our program provides diverse resources in terms of health and mental health care.

Describing psychological therapy as part of a “resource” model may help to alleviate some of the fear, misconceptions, or stigma regarding therapy that clients may harbor (Keller et al., 1998). Portraying ourselves as

resources for the client also helps to empower the client in the relationship. Generally, this clinician tries to avoid asking a client the question, “How may I help you?” This simple question may be understood in the dichotomous context of the “all- powerful helper” and “helpless victim,” which would be disempowering. Rather, it is recommended to try to express queries so that the client feels that they have choices and control. “What are your most pressing goals right now?” or “What services would be useful to you right now?” seem to be a more effective ways of framing the initial question.

For psychotherapists, another unique aspect of forming an alliance with survivors of torture living in exile is that the usual therapeutic boundaries are often expanded. At Bellevue, one way we have come to conceptualize our expanded role is as an “accompanier” (Fabri, 2001; Keller et al., 1998). This is one treatment approach utilized in our program that seems to help engage the client in a meaningful therapeutic relationship. Therapy does not simply consist of a 45-50 minute clinical hour, after which the client is not seen until the following week. As previously mentioned, therapists are sometimes enlisted to help the client navigate the hospital bureaucracy, and may function as translators and advocates for the clients within the hospital system.

Members of our staff have written numerous psychological and medical affidavits, attesting to the physical and psychological evidence regarding our clients’ claims for political asylum in the United States (see Chapter 12). Therapists are often called upon to testify at US Immigration and Customs Enforcement (ICE) court proceedings on behalf of clients. At times, clients have asked us to verify their identity and program participation, since they often lack their “official” papers from their home

country. This has helped clients to receive work authorization papers, register in schools, take GED exams, or sit for the SATs, with the hope of going on to college.

These treatment priorities and techniques have been supported by the positive reactions of the clients in our treatment programs. The therapeutic relationships that develop are usually complex and profound. By empowering our clients, and listening to their insights, we have been able to develop therapeutic interventions that are increasingly culturally syntonic and effective for our client population. We feel that these overarching priorities are applicable to the variety of approaches to individual psychotherapy with survivors of torture and refugee trauma.

Multiple Approaches to Individual Psychotherapy

Not only is there a combination of variability and consensus between disciplines in our program, there is also healthy debate and variability in the approaches of particular clinicians within disciplines. One clear example of that is the variety of approaches to individual psychotherapy within the domain of psychology. Our psychologists come from academic institutions that have different clinical orientations and training philosophies. As such, particular clinicians may be more dynamically oriented, whereas other clinicians may be more inclined to use cognitive-behavioral techniques. The types of individual treatment that we utilize at the Bellevue/NYU Program for Survivors may be conceptualized as falling within the umbrella of trauma-focused techniques, which the literature describes as including cognitive-behavioral interventions, narrative exposure therapy, and

supportive dynamic psychotherapy, as well as group interventions (Drozdek & Wilson, 2004).

In a best case scenario, case assignments are made with a clinician's theoretical orientation and a particular client's clinical needs in mind. The reality is, however, that assignments are often made on an availability basis. When there is a client in pressing need of services, and a treatment slot opens up among our senior psychology staff, the referral is made soon thereafter. Clinicians are frequently called upon to stretch beyond their initial theoretical comfort zone.

This means that our more CBT oriented clinicians may enter into therapy with a client whose initial focus remains targeted more toward issues of emotional containment and tolerance of frightening emotions, questions about the benefits of engaging in therapy itself, and concerns about pressing challenges present in their everyday living situation – whether social, economic, or political (Lansen & Haans, 2004). These issues may go beyond the usual content dealt with in therapy by a clinician who primarily provides CBT treatment, but may be highly salient to the client. This period of relationship building, psychoeducation, and addressing a client's current needs may also provide insights for the clinician regarding a client's thought processes, fixations, and behavioral patterns, that may be very useful later in the treatment when more direct cognitive-behavioral interventions may become more salient.

Conversely, more dynamic oriented clinicians may utilize cognitive and behavioral techniques, such as narrative exposure therapy, to help clients process and come to a deeper understanding of their subjective feelings, and help to defragment the memories of their traumatic experiences so that they are not repeated and do not give rise to destructive motivational

forces (Ehlers & Clark, 2000). Coping techniques such as diaphragmatic breathing, relaxation techniques, and visualization may also be used in conjunction with dynamic therapy to help give the client tools to reduce anxiety and be better able to tolerate the emotions generated by their abuse and exile (Hinton et al., 2005). The usual focus on clinical pathology is also called into question with members of this multiply-traumatized client population. This idea of whether the symptoms being experienced are, indeed, pathological; or whether the suffering falls within a normative continuum, is an issue currently being debated in the field (see Chapters 1 and 8).

Questions of uncovering the trauma narrative v. shoring up a survivor's defenses are pertinent regardless of the treatment regimen utilized (Du & Lu, 1997; Goodman & Weiss, 1998). It would be pre-mature, and potentially harmful, to engage in any deep exploration or uncovering work with a client who is not emotionally prepared to do so. Trauma-focused individual therapy is not for everyone. Supportive group treatment may be more appropriate for a survivor who is not yet psychologically stable enough to tolerate strong affect and re-experience their trauma; especially as personal disclosure is predominantly a Western cultural concept (Drozdek & Wilson, 2004). Most treatment regimens, such as those used at the Bellevue/NYU Program for Survivors of Torture, use aspects of both uncovering and shoring up techniques, and are developed in combination with more supportive and psychoeducational interventions.

As such, all of our psychologists are influenced by multiple approaches to individual therapy. These multiple influences are communicated within the treatment itself, as well as supervisory sessions, intake disposition conferences, interdisciplinary case conferences, and peer-

supervision sessions. Despite the diversity of clinical orientations and experiences, or perhaps because of it, we have found that the treatment priorities of safety and empowerment are still pertinent to the individual psychological treatment of survivors of torture and refugee trauma - no matter which clinical orientation our therapists espouse.

A brief description of some of the goals and techniques linked with psychodynamic, cognitive-behavioral, narrative exposure, and non-verbal therapy approaches follows. These brief descriptions are not meant to be comprehensive or exhaustive. Rather, some of the main therapeutic underpinnings will be mentioned, as much to highlight commonalities as expose differences.

Psychodynamic Treatment with Survivors of Torture and Refugee Trauma

Drozdek & Wilson (2004) describe the goals of psychodynamic treatment with survivors of torture and refugee trauma this way: “Psychodynamic approaches aim to provide trauma survivors understanding and insight about their experiences, and place emphasis on psychosocial defenses against vulnerability” (p.246-247). The psychodynamic approach also involves exploration of conscious and unconscious ego processes affected by the trauma.

Two fundamental principles in psychotherapy come into play. One is the survivor’s capacity to reframe his or her difficult personal experiences, and the other is having a strong sense of connection to a trusted therapist in a safe therapeutic environment (Wilson, 2004b). Here, aspects linked with cognitive-behavioral therapy, such as cognitive flexibility and cognitive restructuring parallel the dynamic focus on making meaningful reframes and

developing a more adaptive understanding of one's past experiences (Neuner et al., 2004).

Wilson (2004a) also talks about the critical therapeutic concept of empathic attunement, which he defines as “the capacity to resonate efficiently and accurately to another's state of being” (p. 284). He cites Freud's early writings to emphasize the importance of a therapist being able to decode unconscious trauma-specific transference feelings with the receptive function of his or her own unconscious. He states that there are several channels by which traumatic transference gets expressed, such as words, affect, memories, thoughts, body posture, voice modulations, expressions of their personality, and “here and now” ego-state presentations (Wilson, 2004a).

The emphasis on supportive techniques at the beginning of psychodynamic treatment can lay the groundwork for an enhanced transference – countertransference matrix, and the ability to explore universal themes of asylum seekers: damage to core belief systems, fear of loss of control over feelings of rage and anxiety, shame over helplessness evoked by torture and war trauma, rage and grief at the sudden loss of control of plan, survivor guilt, and grief over loss of loved ones through death and exile (Wilson, 2004a).

Psychoeducation is an important tool at the beginning of treatment, regardless of modality. Explanations and information regarding common symptoms, changes in brain function, and secondary effects of torture and forced migration can help clients to recognize their symptoms, understand and better tolerate them by placing them in a new context. This helps to set a framework for much deeper exploration as therapy progresses.

Cognitive–Behavioral Treatment with Survivors of Torture and Refugee Trauma

Cognitive-behavioral approaches aim at reducing PTSD symptoms by enhancing control of symptoms of anxiety and depression. CBT emphasizes application of systematic, prolonged exposure, cognitive processing and restructuring of individual trauma experiences, relaxation techniques, imagery rehearsal, and relapse-prevention training (Drozdek & Wilson, 2004; Neuner et al., 2004; Schulz, Resick, Huber, & Griffin, 2006).

Hinton et al., (2005) describe several facets of cognitive-behavioral therapy with survivors of torture and refugee trauma as: providing psychoeducation about PTSD, teaching muscle relaxation and diaphragmatic breathing techniques, performing culturally appropriate visualization exercises, framing relaxation techniques with mindfulness, providing cognitive restructuring of somatic sensations and fear networks, exposing clients to anxiety related sensations, and teaching cognitive flexibility (to diminish rumination and anxiety). There is a focus on developing the ability to shift between different ways of viewing events.

The literature shows that CBT and exposure treatments have proven to be powerful tools in treating PTSD and anxiety symptoms among traumatized refugees (Foa et al., 1999; Paunovic & Ost, 2001). These treatments have been effective in symptom reduction in diverse refugee populations such as Sudanese, Southeast Asians, Kosovars, and Bosnians; and have proven to be effective even when an interpreter is used in delivering treatment (Resick & Schnicke, 1993; Schulz et al., 2006). Studies also show that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) interventions have been effective with children with PTSD (Cohen & Mannarino, 1998; Deblinger, Steer, & Lipman, 1999).

Cognitive-behavioral techniques were also shown to be effective in reducing nightmares and symptoms associated with insomnia in crime victims with PTSD. It is believed that “nightmares that are trauma-induced may be habit-sustained” (Krakow et al., 2001, p. 2044), meaning that a cognitive-behavioral intervention may be warranted. Clinicians in this study used desensitization and imagery rehearsal (i.e. rehearsing images of a changed nightmare; changing the nightmare the way the client wishes it to end; rehearsing the “new dream” while awake). They recommend starting with less-intense dreams not related to the trauma, to gradually build up a client’s habituation. (Krakow et al., 1995; Krakow et al., 2001).

Additionally, cognitive-behavior therapy has proven effective for reducing insomnia. A focus on sleep hygiene, including stimulus control (removing items or triggers that impede on one’s sleep), sleep restriction (spending less time in bed to improve the quality of sleep), accompanied by cognitive restructuring, have proven effective (Krakow et al., 2001; Kupfer, 1999).

An important element to consider when engaging in cognitive treatment with a survivor of torture and refugee trauma is that the “irrational thoughts” are not a sign of mental deficits on the part of the client. Rather, they are born out of the trauma experience itself. In addition, taking a confrontational stance to a client’s cognitions is less effective than allowing them to “experience the original trauma-related thoughts and self-perceptions (i.e. survivor guilt), while at the same time considering a more contemporary and logical perspective” (Briere & Scott, 2006, p. 111).

Narrative Exposure Therapy with Survivors of Torture and Refugee Trauma

Clinical studies show that Narrative Exposure Therapy, which is adapted from exposure therapy and testimony therapy, is more effective than purely supportive therapy or psychoeducation in reducing PTSD symptoms among traumatized refugees (Neuner et al., 2004).

Narrative Exposure Therapy goes beyond the original cognitive-behavioral framework, in the sense that it is not helping a client to habituate to a single traumatic event; rather, they focus on a client's entire life narrative. Habituation focuses on the client's entire life narrative, and the therapist helps the client to work against distortion of the memories. These distortions can lead to a fragmented narrative that helps to maintain and exacerbate the PTSD symptoms (Ehlers & Clark, 2000).

A detailed chronological autobiography is constructed, with the help of the therapist. They focus on transforming a fragmented account into a coherent narrative. The clinician – client dyad does not move past a traumatic event until the client has habituated his or her emotional reactions.

Non-Verbal Approaches to Therapy

There are many other approaches to individual therapy that do not focus on verbalized communication. Although there is less peer-reviewed research regarding art therapy, music therapy, movement therapy, massage therapy, and other approaches to treatment, these approaches seem to be backed up by the research describing biological models of trauma.

Essentially, many theorists are finding support for the notion that traumatic events change the way in which the brain processes emotion-laden information and experiences. Du & Lu (1997) provide a useful review of the literature that describes different schools of thought in terms of biological

explanations of PTSD symptoms. Some theorists posit a model that is based on the hyper-arousal of the sympathetic nervous system (i.e. Brender, 1982; Malloy, Fairbank, & Keane, 1983), while others focus more on abnormalities of the hypothalamic-pituitary-adrenocortical axis (i.e. Mason, Giller, Kosten, Ostroff, & Podd, 1986), or endogenous opioid system dysregulation (Pittman, van der Kolk, Orr, & Greenberg, 1990; van der Kolk, 1995).

In laymen's terms, it means that particular portions of the brain that are responsible for regulating, organizing, and making sense of emotional stimuli are knocked out of balance by the traumatic experiences. Aspects of memory and emotional meaning are fragmented, and because of these neurological factors, survivors are unable to construct a verbal narrative of what happened in a coherent and emotionally relevant fashion. When survivors are unable to access these painful emotions verbally, psychopharmacological and non-verbal techniques may hold the most therapeutic promise (see Chapter 8).

The realities regarding resources available within a highly utilized public hospital system make it less likely that we will have extensive access to such non-verbal therapies within the system itself. Efforts are being made to coordinate more frequently with providers within the community to facilitate such adjunctive services for our clients. Colleagues from treatment centers that have a more de-centralized structure are gaining more experience working with these types of non-verbal therapies. Their clinical reports are encouraging, and care providers should definitely keep their minds open regarding these innovative and promising techniques.

Synthesis of Approaches/Intra-Discipline Flexibility

As mentioned at the beginning of this section, our treatment is tailored to the needs of particular clients. As such, the treatment of one individual may touch upon aspects of psychodynamic, cognitive-behavioral, narrative exposure, or even non-verbal treatments. Frequently, the flow and focus of therapy with a torture survivor can be affected (at least partially) by external events. One important event that has major importance for many of our clients is the process of applying for asylum, and managing the associated emotional turbulence.

A client, whose treatment has focused primarily on psychoeducation, relationship building, social stabilization, and support, may proactively request more trauma-focused and exposure-like interventions. They will generally not couch the request in such psychological terms, they may just ask for help in “getting ready for their asylum hearing,” so that they can withstand the pain and retraumatization of sharing their trauma history in an intimidating, forensic setting.

This is generally an opportune moment for clinicians to adapt their focus toward directly addressing a client’s trauma. Adaptations may be made from the structure of the standard manualized protocols, as appropriate, if logistical factors such as the time frame for court date, or cultural factors, warrant such adaptations. A mix of exposure-focused sessions, along with a review of coping tools such as deep breathing and imagery, and the use of psychoeducation as a stress inoculation for potential resurgence of symptoms as the asylum date approaches, is utilized. This combination of techniques has been beneficial for clients who have gone on with their hearings and had positive outcomes.

For clients whose cases are continued (often being postponed for several months at a time), there is generally an immediate switch of focus to more supportive interventions. Clients may need to vent frustration about bureaucratic barriers that delayed their case, perceptions of unsatisfactory legal representation, and other immediate concerns. Therapy often turns to deeper issues of disappointment, frustration, guilt, or even the client's feelings of embarrassment and shame within their family or community for still being "without papers." Revisiting the progress the client has already made, and looking at the challenges that he or she has already overcome are ways of encouraging the client to not abandon their struggle, given this new, and significant, disappointment. For clients who have been denied asylum, a close eye is kept on their emotional functioning, including assessing for potential suicidal, or in very rare cases, homicidal ideation. We also provide psychoeducation regarding legal options and information about potential appeals processes.

It is clear from our experiences that an open-minded and flexible approach to the psychological treatment of survivors of torture and refugee trauma is needed. It seems that we are not alone in this point of view. There are several examples of this focused eclecticism in the trauma literature (i.e. Briere & Scott, 2006; Herman, 1992), and more examples of its use in treatment centers around the world. Du & Lu (1997) describe the utility of a multimodal, combination of approaches for treating Asians with PTSD. The Den Bosch Multi-phased treatment model is used at treatment centers in Holland (Drozdek, 2001), and the Danish Red Cross utilizes a brief therapy protocol that combines elements of narrative and body oriented therapeutic approaches.

Another conceptualization is Howard's phase model described in the CBT literature (Howard, Lueger, Martinovich, & Lutz, 1999; Schulz et al., 2006). This model includes an initial re-moralization phase in which relationship building and pertinent psychoeducation are used to reduce helplessness and isolation and increase optimism in the client. Patients may leave treatment after this stage, if they have felt enough symptom relief and feel that their functioning has improved sufficiently (Howard et al., 1999). It is after this phase that many clients will enter into the phases of remediation and rehabilitation, because they have a greater clinical need to learn coping behaviors and to improve their daily functioning (Howard et al., 1999; Schulz et al., 2006).

The brief therapy protocol utilized by the Danish Red Cross is an eight-week intervention that begins with an introduction to both the psychologist and relaxation therapist. The client develops a "safe place" to be utilized as a coping mechanism in daily life, and during the more exposure-oriented phases of therapy. The focus then turns to symptoms, whether they are expressed psychologically or somatically. Relaxation techniques are taught and practiced as the treatment turns to the narrative phase. The goal is to place the traumatic event in a larger, more meaningful narrative of the client's life. The last sessions focus on the future, and often include significant others (Berliner, Mikkelson, Bovbjerg, & Wiking, 2004; Levine, 1997).

The Den Bosch Model focuses on five stages: 1. establishing the therapeutic alliance; 2. taking life histories (both good and bad aspects of a client's life narrative); 3. using CBT interventions to reduce PTSD symptoms; 4. focusing on current identity issues and adaptation to the host culture; and 5. termination of treatment and graduation rituals. This approach

combines aspects of psychodynamic, cognitive-behavioral and supportive treatment approaches; and it works to reconstruct the client's history and integrate dissociated fragments of their memories. The over-arching goal is to achieve a "corrective emotional experience" (Drozdek & Wilson, 2004, p.251).

We share the focus on providing a corrective emotional experience for the survivors we serve. We feel that many effective clinical tools and interventions exist; just like those we have discussed. We feel that engaging the client in prioritizing and agreeing on a treatment rationale is the first step in helping to guide them toward symptom reduction. Given all of these treatment needs and options, it is now incumbent upon the senior clinician to help fellow clinicians (whether peers or trainees providing services in our program) to engage with the clients appropriately and effectively. This creates challenges in providing clinical supervision.

Supervision of Clinicians Treating Survivors of Torture and Refugee Trauma

A significant portion of the direct psychological contact with our client population is provided by psychology interns and externs, supervised by our senior clinical staff. The interns at Bellevue Hospital are just short of completing their doctoral programs, and have been accepted at one of the most selective clinical internship sites in the country. Our externs are generally in their third or fourth year of their doctoral programs and have considerable clinical experience before being accepted to train in our program. (It should be noted that this high level of preparation is consistent

with our trainees, across disciplines. Our psychiatric residents are generally PGY-III or above, meaning that they are in at least their third year of residency training. Our medical students are doing their elective clinical placements and our social work students are doing their advanced field work placements.)

We maintain that engaging young clinicians in this work is an important undertaking for several reasons. First, the didactic and clinical experience acquired by the trainee will be valuable as they progress in their careers. Secondly, we add to a growing professional cadre of clinicians, researchers, and advocates who can move the field forward. Third, using advanced psychological trainees, such as interns and externs, helps us to try to meet the ever-growing demand of our clinical services. It should also be noted that the principles associated with supervision are also applicable with more senior clinicians, who may continue to seek outside clinical perspectives and emotional support as they engage in this work.

Lansen & Haans (2004), describe the supervisor as being responsible for monitoring and evaluating a therapist's clinical work. A supervisor also advises and instructs trainees, while modeling the professional behavior and clinical techniques of a psychologist. Supervisors consult, and help supervisees to solve clinical and professional situations. The supervisor also works to support trainees emotionally, especially as they deal with our multiply-traumatized client population. The authors continue that supervision within the field of treating survivors of torture and refugee trauma is less about learning a specific technique, and more about developing competence for treating this specialized client population.

The supervisor's role is a complex one, with multiple responsibilities. The supervisor is responsible to the trainee, to educate, and to oversee the

training therapist's work. The supervisor is also responsible to the clinic, agency, or hospital to support the mission/vision of the institution and follow institutional procedures. At the same time the supervisor is responsible to the patient, assuring that appropriate and efficacious care is provided.

The parallels that emerge between the “therapist–client” dyad and the “therapist –supervisor” dyad are profound and diverse. One of the most obvious parallels is the potential for vicarious traumatization (See Chapter 13). Another striking parallel, however, is the utility of emphasizing issues of safety and empowerment; especially in the early stages of the relationship. These notions are powerful in the supervisory relationship, just as they are in the clinical relationship.

A safe holding environment must be provided so that the therapist feels comfortable taking appropriate risks in the work, but has the assurance that a more experienced clinician is connected to the process and aware of what is going on. A therapist who feels “safe” in his or her clinical endeavors can “radiate safety because he or she has enough awareness of his or her own mental processes, because he or she has a capacity for containment, and because he or she is able to keep optimal distance” (van der Veer & van Waning, 2004, p.212). This brief description covers a lot of ground, and merits further comment.

Helping a young therapist to be aware of his or her own mental processes is a multi-faceted task. First, there are issues of competence, and the formative function of supervision (Lansen & Haans, 2004). Despite the fine training and experiences our trainees bring, there may be some trepidation before engaging in therapy or an intake interview with a survivor of torture. So we begin the training experience with a series of didactic trainings covering many of the same treatment issues covered in this book.

We also have our trainees attend case conferences so that they can get an early feel for the interdisciplinary perspectives on client care.

Much of the early supervision is also linked to exploring a trainee's potential emotional reactions to this work. We explore "what brought them to this line of work" and what has generated an interest in serving this population. We may explore pertinent aspects of life history or cultural background that may have an impact on a trainee's approach or reaction to this work. Helping to normalize potential emotional, cognitive, behavioral, and even physical reactions that a trainee may experience is just as essential to their initial training as the didactic information.

This support and exploration must continue throughout the trainee's time with the program. Knowing that one is receiving adequate supervision and emotional support is crucial for a young clinician to have the emotional confidence to communicate a feeling of safety to a client. Beyond formal supervision, our program staff members employ a liberal "open-door" policy for any trainees or colleagues facing a particular issue, whether clinical or personal. We try to provide multiple opportunities for our trainees to engage with senior psychologists as well as clinicians from other disciplines to round out their understanding of a particular client and his or her treatment.

Interactions with peers are valued and emphasized as vehicles of support. Involvement in group interactions can help our clients to internalize a sense of connectivity and support from people who can understand and empathize with their experiences. So too, do group supervision experiences help our young clinicians to accomplish similar goals. Trainees participate in group supervision activities when they present at intake disposition conferences, when facilitating multi-leader groups, and when they attend case conferences. Trainees are also involved in supportive process groups

(one for interns and one for externs), that are facilitated by a senior clinician who is not part of our program staff. The affective components of the work are discussed openly in all of these contexts.

Trainees will also need particular support in terms of bolstering their capacity to contain and tolerate the intensity of emotion communicated within their treatment sessions. A therapist hearing about sadistic abuses that defy understanding or qualitative description, may have their cognitive schemas challenged in terms of how they feel the world functions (McCann & Pearlman, 1990). Therapists may become distrustful or cynical. They may also feel vulnerable and unsafe themselves, and feel utterly powerless to address the situation (van der Veer & van Waning, 2004). Helping young clinicians to recognize, process, and tolerate these complex feelings will help them to be more genuine and “present” with a client whose immediate clinical need is to be heard.

Supervision may also have to contend with issues of survivor guilt and over-identification with the client. The therapist, often living a relatively secure and comfortable life, may experience guilt in the face of their patients’ reports of torture and intense suffering. This can lead to an idealization of the patient and unwillingness to see him/her in a bad light and a denial of possible pre-existing psychopathology (Eisenman, Bergner, & Cohen, 2000). The therapist may also experience an increased impulse to “be helpful,” scheduling appointments at inconvenient times, checking up on patients or overzealous attempts to engage reluctant patients in therapy. The degree to which the usual therapy frame is adhered to (or relaxed) is a topic of lively discussion in supervision.

Issues of intimacy and distance are also important to consider in this work. The graphic nature of abuse and the intensity of the multiple

challenges facing our clients can pull clinicians in closer, or push them away, in terms of engaging emotionally with a client. Supervision must be geared to help the young clinician to try to strike the dynamic balance between becoming jaded and inured to emotion, or becoming overwhelmed by emotion and the intensity of the traumatic material being presented.

A therapist may distance him or herself from a client by using defenses like denying the veracity of a story, minimizing or distorting the story, avoiding direct discussion of traumatic material, or becoming numb to the material (van der Veer & van Waning, 2004). Therapists may become cynical, withdrawn, and lose confidence in their clinical abilities (Lansen & Haans, 2004).

Conversely, therapists may become overly involved, overactive, have savior fantasies, and lose clinical perspective (Eisenman, Bergner, & Cohen, 2000; Wilson & Lindy, 1994). A significant identification of the therapist with the patient sometimes occurs. Given the obvious cultural, national and ethnic differences, therapists often expect to find “others,” and in fact, find people very similar to themselves. Many of the program patients are young educated professionals or students. Many were natural leaders in their communities. These individuals may also be the most outspoken in their protests, and most committed to issues concerning equity, justice, and human rights. The personality profile of these clients may mimic the personality profile of our trainees.

The subsequent identification with the patient can be de-centering, leading to difficulties maintaining a neutral stance, contributing to possible idealization of the patient and an excessively positive counter-transference. The patients, of course, are often admirable, but they are also human. Idealization of patients can be a problem because it does not allow room in

the treatment for negative feelings or behaviors. Supervision helps supervisees more fully explore their counter-transference to the patient, in particular their resistance to identifying “negative” content in their patients and/or in themselves (Eisenman, Bergner, & Cohen, 2000). Trainees are assisted in striking a dynamic balance in the counter-transference continuum, where they avoid the extremes of avoidance and over-identification (Wilson, 2004a).

Issues of empowerment are also important for young clinicians engaged in this work. The feelings of inadequacy, or feeling impotent in the face of such horrific abuses, may serve to paralyze a clinician, who feels ill-equipped to help the client. Part of the supportive supervisory intervention will be in helping the young clinician to set reasonable expectations for clinical outcomes, including a discussion of the chronic nature of certain sequelae to human rights abuses (Lansen & Haans, 2004).

As such, the supervisor needs to be non-critical, but responsive to the trainee. This is true even when the supervisor has a very different emotional experience of the patient than what the trainee is reporting. It is the task of supervision, in fact, to work through and manage these conflicting perspectives in a way that emphasizes the multiple challenges, stimuli, emotional stressors that the client (and therefore the therapist) is trying to navigate. Helping young clinicians to tease apart how much of their confusion and potential lack of confidence is based on their circumstances, as opposed to their character or capabilities, parallels some of the attributional work they may need to engage in with their clients.

Supervision must also help empower the young clinician to expand their therapeutic role into helping with practical issues, when appropriate,

and in appropriate ways. Patients' most pressing problems may well be basic survival needs, especially when they first come to our program. The therapist is aware of the fact that safety and stability must be achieved before delving into traumatic material, and often feels some pressure to speed up this process with practical help (i.e. finding a job, connecting with legal services, etc.). The supervisor's role in this situation may be to be gently confrontational and help the therapist contain the impulse to "rescue" the patient. Even though supervision may focus on a young therapist's boundaries and limit setting, the therapist may be willing to think more creatively, knowing that their seasoned collaborator will identify any potentially inappropriate or ineffective interventions. The supervisor must also explore whether dealing with the trauma may be what the patient needs to attain the emotional stability needed to improve daily functioning. The supervisor can help the therapist to juggle the desire to respond with increased practical assistance (which may in fact help build an alliance) vs. encouraging the patient to use the sessions to directly address traumatic material.

Another important area of inquiry for clinicians beginning this work is the notion of the "judicious use of self" in the therapy. Again, this is in contrast to the usual psychotherapeutic framework in which therapists' histories, cultural backgrounds, and life experiences are generally peripheral to the therapeutic process. Many of our clients, who are foreign to the "culture of psychotherapy," may not know that it is "inappropriate" to ask personal questions of a therapist. The young therapist may need assistance in navigating these tricky situations.

For example, how does a therapist convey to a client that he or she is not willing to divulge personal information, without seeming withholding or

punitive? What if the therapist's experience really is pertinent to the client's experience, and could be helpful to the therapeutic process if shared?

Helping a trainee to make these decisions can be anxiety provoking because of therapeutic, ethical, and cultural concerns that may be in conflict. An example of a case where the "judicious use of self" was warranted and successful follows:

SH is 40 year old man from Mauritania who came to this program after an intrepid escape from life-long servitude as a slave. He received medical treatment for his many wounds, and participated in individual and group therapy.

One day, SH spoke to his therapist about the ramifications that his escape had placed on his family and friends. The "master" who owned SH and his family intended to sell SH's wife to another man as punishment for SH's escape. SH's wife found out about the plan, and escaped to "the bush" with their children. They lived in hiding in a remote Sahelian village, barely surviving at a subsistence level. The man who helped SH escape was also punished horrifically when the "master" learned that he was involved. SH spoke at length about notions of survivor guilt, and how maybe it was better that he never fled because of the suffering his escape caused. SH expressed some passive suicidal ideation, without a plan or intent.

At this point, the clinician (a Black American psychologist) shared some of his family history, speaking about how he was descended from slaves on both sides of his family. The clinician spoke of the

progress that his family had made across generations subsequent to the slavery, to the point that the clinician had attained a doctorate, and was now able to help clients such as SH.

The clinician made it clear that this would not have been possible, if it were not for his ancestors (whose names he does not even know), who withstood and struggled against slavery; ultimately earning freedom for themselves and their descendants. The therapist expressed profound and undying gratitude toward those ancestors, and placed SH's struggle in a context that spanned generations (i.e. from SH's ancestors who had lived their entire lives as slaves, to SH's parents who encouraged him to seek his freedom, to SH's children [and their children] who may yet taste freedom, and be free to go to school and lead their lives as they see fit).

A delicate balance needed to be struck, so that SH's feelings of guilt and despair were not contradicted or dismissed. The clinician simply attempted to offer an alternative narrative that may parallel, complement, or overlap with the client's own interpretations. SH began to be able to place the suffering and sacrifice that he and his loved ones were enduring in a larger context.

As treatment progressed SH began to express some relief. He was better able to tolerate the painful feelings of culpability associated with the suffering of others. Despite the emotional, health-related, and practical challenges he faced, he spoke of a new-found commitment to keep on struggling. He stated that, "Even if my life remains hard, at

least my children's children may have a better chance, In Shah' Allah."

Another key aspect of supervision has to do with notions of gratitude. Our clients tend to be very appreciative of the therapeutic bonds they have formed and the clinical assistance they have received. Frequently, clients come from cultures in which gift-giving as a sign of friendship and appreciation is the norm. It may be the one way they can express appreciation for services, especially if they are not currently paying for their treatment. This directly contradicts the general stance in psychology of not accepting gifts from clients, for fear of entering into a dual-relationship or exploiting the client.

Cultural prerogatives, a dynamic therapeutic interaction, practical concerns regarding the client's resources, issues of empowerment, ethical concerns, and genuine human connectedness all come into play in the deliberations as to what to do under these circumstances. Supervisors must help clinicians weigh and balance considerations of the meaning of accepting or rejecting the gift (in cultural terms and in terms of the therapy), and make decisions that are clinically sound, and based primarily on doing no harm to the client. In some cases it may be more harmful to the client's emotional functioning to reject the gift; in some cases, the opposite will be true. It is incumbent on the supervisor and clinician to discuss these parameters in an open-minded yet clinically focused manner.

The last aspect of supervision that we'll discuss here is, appropriately, termination. Our trainees are generally with our program for one year (July 1st - June 30th), so termination is a reality they will all face. Saying good-bye to a client with whom one has developed a deep bond is always a

complicated and nuanced affair, but the emotional pull of working with our client population is often described by trainees as being more intense than usual. As such, supervisors need to help the trainee identify, describe, and manage their feelings about terminating treatment. Again, the parallels are profound, and much of the assistance supervisors can provide to trainees in managing emotions around termination, is by helping the young clinician to help the client with the same issues.

Clients may have deep emotions about saying good-bye, as they have had so many leave-takings in their life, including their current exile from their homeland. In many circumstances, there was no opportunity to say good-bye to loved ones who were disappeared, killed, or who were left behind when the client fled. Sharing a positive “au revoir” with their therapist, in a time-frame that is controlled and predictable, may help the survivor to process some of his or her unprocessed feelings of mourning and loss (see Chapter 11). A direct approach to the emotions surrounding termination will also allow the client (and the clinician) to express the deep-seeded feelings they have about the therapeutic work and relationship they have shared. The therapeutic progress is generally mirrored by substantial clinical growth of the trainee, who now knows that he or she can handle more than they’d previously given themselves credit for. Working through issues regarding termination is never easy, but it is particularly important with our clients and young clinicians. (Editor’s note: A client who remains in individual treatment with our program after terminating with an intern or extern will generally be re-assigned to a senior staff member and/or an ongoing support group. This way they will not be exposed to repeated terminations and transfers.)

Other major issues in supervision have to do with working and communicating across and within cultures, as well as contending with vicarious trauma and its potential effects. Both of these issues are covered in greater detail in this book in Chapters 2 and 13.

References

- Akinsulure-Smith, A., & Smith, H. (1997, February). *Africans in America: Cultural and Environmental Considerations for Psychotherapy*. Symposium conducted at the 14th Annual Teachers College Winter Roundtable on Cross-Cultural Psychology and Education. Teachers College, Columbia University, New York City.
- Berliner, P., Mikkelsen, E., Bovbjerg, A., & Wiking, M. (2004). Psychotherapy treatment of torture survivors. *International Journal of Psychosocial Rehabilitation*, 8, 85-96.
- Brender, J. (1982). Electrodermal responses in PTSD. *Journal of Nervous and Mental Diseases*, 170, 352-361.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, and treatment*. Thousand Oaks, London, New Delhi: Sage Publications.
- Chester, B., & Holtan, N. (1992). Working with refugee survivors of torture. *Western Journal of Medicine*, 157 (Special Issue: Cross-Cultural Medicine: A Decade Later), 301-304.
- Cohen, J., & Mannarino, A. (1998). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment*, 3, 17-26.
- Deblinger, E., Steer, R., & Lippman, J. (1999). Two year follow-up study of cognitive behavioral therapy for sexually abused children suffering posttraumatic stress symptoms. *Child Abuse & Neglect*, 23, 1371-1378.
- Drozdek, B. (2001). Can traumatized asylum seekers be treated? In M. Verwey (Ed.), *Trauma and empowerment* (pp. 219-231). Berlin: VWB.

- Drozdek, B., & Wilson, J. (2004). Uncovering: Trauma-focused treatment techniques with asylum seekers. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp.187-219). New York: Brunner-Routledge.
- Du, N., & Lu, F. (1997). Assessment and treatment of posttraumatic stress disorder among Asian-Americans. In E. Lee (Ed.), *Working with Asian-Americans: A guide for clinicians* (pp. 275- 294). New York: Guilford Press.
- Ehlers, A., & Clark, D. (2000). A cognitive model of posttraumatic stress disorder. *Behavioral Research and Therapy*, 38, 319-345.
- Eisenman, D., Bergner, S., & Cohen, I. (2000). An ideal victim: Idealizing trauma victims causes traumatic stress in human rights workers. *Human Rights Review*, 1(3), 106-114.
- Elsass, P. (1997). *Treating victims of torture and violence: Theoretical, cross-cultural, and clinical implications*. New York and London: New York University Press.
- Fabri, M.R. (2001). Reconstructing safety: Adjustments to the therapeutic frame in the treatment of survivors of political torture. *Professional Psychology: Research and Practice*, 32(5), 452-457.
- Fischman, Y. (1998). Metaclinical issues in the treatment of psychopolitical trauma. *American Journal of Orthopsychiatry*, 68(1), 27-38.
- Fischman, Y., & Ross, J. (1990). Group treatment of exiled survivors of torture. *American Journal of Orthopsychiatry*, 60(1), 135-142.
- Foa, E., Dancu, C., Hembree, E., Jaycox, L., Meadows, E., & Street, G. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in

- female assault victims. *Journal of Consulting and Clinical Psychology*, 59, 715-723.
- Gangsei, D. (October 13, 2001). *Developing a Narrative in the Psychological Assessment of Torture and Refugee Trauma*. Paper presented at the Clinical Symposium of the Torture Treatment Center Consortium. Chicago, IL.
- Goodman, M., & Weiss, D. (1998). Double trauma: A group therapy approach for Vietnam veterans suffering from war and childhood trauma. *International Journal of Group Psychotherapy*, 49(1), 39-54.
- Gurris, N. (2001). Psychic trauma through torture – Healing through psychotherapy? In S. Graesner & N. Gurris (Eds.), *Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity* (pp. 29-56). Baltimore, MD: Johns Hopkins University Press.
- Haenel, F. (2001). Foreign bodies in the soul. In S. Graesner & N. Gurris (Eds.), *Standing at the side of torture survivors: Treating a terrible assault on human dignity*. (pp. 1-28). Baltimore, MD: Johns Hopkins University Press.
- Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence – From domestic abuse to political terror*. New York: Basic Books.
- Hinton, D., Chhean, D., Pich, V., Safren, S., Hoffman, S., & Pollack, M. (2005). A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of Traumatic Stress*, 18(6), 617-629.
- Howard, K.I., Lueger, R.J., Martinovich, Z., & Lutz, W. (1999). The cost-effectiveness of psychotherapy: Dose-response and phase models. In N. E. Miller & K. M. Magruder (Eds.), *Cost-effectiveness of*

- psychotherapy: A guide for practitioners, researchers, and policy makers* (pp. 143-152). New York: Oxford University Press.
- Keller, A., Eisenman, D., & Saul, J. (1998). Caring for survivors of torture in an urban, municipal hospital. *Journal of Ambulatory Care Management, 21*(2), 20-29.
- Krakov, B., Johnston, L., Melendrez, D., Hollifield, M., Warner, T., Chavez-Kennedy, Debie., et al. (2001). An open-label trial of evidence-based cognitive behavior therapy for nightmares and insomnia in crime victims with PTSD. *American Journal of Psychiatry, 158*, 2043-2047.
- Krakov, B., Kellner, R., Pathak, D., & Lambert, L. (1995). Imagery rehearsal treatment for chronic nightmares. *Behavior Research and Therapy, 33*, 837-843.
- Kupfer, D. (1999). Pathophysiology and management of insomnia during depression. *Annals of Clinical Psychiatry, 11*, 267-276.
- Lansen, J., & Haans, T. (2004). Clinical supervision for trauma therapists. In J.P. Wilson, & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp.317-353). New York: Brunner-Routledge.
- Levine, P. (1997). *Walking the tiger: Healing Trauma: The innate capacity to transform overwhelming experiences*. Berkeley, CA: North Atlantic Books.
- Malloy, P., Fairbank, J., & Keane, T. (1983). Validation of multi-method assessments of PTSD in Vietnam veterans. *Journal of Clinical Psychology, 51*, 488-494.

- Mason, J., Giller, E., Kosten, T., Ostroff, R., & Podd, L. (1986). Urinary free cortisol in PTSD. *Journal of Nervous and Mental Disease, 174*, 145-149.
- McCann, L., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.
- Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Counseling and Clinical Psychology, 72*, 579-587.
- Paunovic, N., & Ost, L. (2001). Cognitive-behavior therapy vs. exposure therapy in the treatment of PTSD in refugees. *Behavioral Research and Therapy, 39*, 1183-1197.
- Pittman, R., van der Kolk, B., Orr, S., & Greenberg, M. (1990). Naloxone-reversible analgesic response to combat-related stimuli in PTSD. *Archives of General Psychiatry, 174*, 145-149.
- Pope, K., & Garcia-Peltoniemi, R. (1991). Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. *Professional Psychology: Research and Practice, 22*(4), 269-276.
- Resick, P., & Schnicke, M. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage.
- Schulz, P., Resick, P., Huber, L., & Griffin, M. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioral Practice, 13*, 322-331.

- Silove, D., Tarn, R., Bowles, R., & Reid, J. (1991). Psychosocial needs of torture survivors. *Australian and New Zealand Journal of Psychiatry*, 25, 481-490.
- Smith, H. (2003). Despair, resilience, and the meaning of family: Group therapy with French-speaking survivors of torture from Africa. In R. Carter & B. Wallace (Eds.), *Understanding and Dealing with Violence. Multicultural Perspectives* (pp. 291-319). Thousand Oaks, CA: Sage Press, Inc.
- Somnier, F., & Genefke, I. (1986). Psychotherapy for victims of torture. *British Journal of Psychiatry*, 149, 323-329.
- van der Kolk, B. (1994). The body keeps score: Memory and the evolving psychobiology of posttraumatic stress. *The Harvard Review of Psychiatry*, 1(5), 253-265.
- van der Veer, G., & van Waning, A. (2004). Creating a safe therapeutic sanctuary. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp.187-219). New York: Brunner-Routledge.
- Vesti, P., & Kastrup, M. (1991). Psychotherapy for torture survivors. In M. Basoglu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 349-362). Cambridge, UK: Cambridge University Press.
- Wilson, J. (2004a). Empathy, trauma transmission, and countertransference in posttraumatic psychotherapy. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp.277-316). New York: Brunner-Routledge.
- Wilson, J. (2004b). Posttraumatic treatments: Guidelines for practitioners. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of*

traumatized asylum seekers, refugees, war and torture victims
(pp.181-185). New York: Brunner-Routledge.

Wilson, J., & Lindy, J. (Eds.). (1994). *Countertransference in the treatment of PTSD*. New York: Guilford Publications.

Chapter 7

Medical Evaluation and Care for Survivors of Torture/Refugee Trauma – Summary

Introduction

Prevalence of Torture and Refugee Trauma in the Primary Care Setting

The Medical interview

- * General Interview Considerations

- * The Need for Interpreters

- * Eliciting the Trauma History

- * Elements of the Medical Interview

 - Identifying Current Health Problems (History of Present Illness)

 - Past Medical History

 - Medications

 - Social History

 - Review of Systems

Physical Examination

Ancillary Tests

Common Health Problems Among Torture Survivors/Refugee Trauma Survivors

- * Musculoskeletal

- * Neurological

- * Dermatological

- * Infectious Disease

- * Genitourinary/Gynecologic

- * Ears Nose and Throat

- * Dental

- * Gastrointestinal

- * Psychiatric Symptoms

Health screening

Medical Documentation of Torture

Multidisciplinary Medical Clinic

Case Examples

Appendix A: Sample Affidavit

Medical Evaluation and Care for Survivors of Torture/Refugee Trauma

Allen Keller, MD, Jonathan Leviss, MD, Nancy Levy, B.A.

Deborah Dyson, PA, MS

Introduction

Medical care providers, including primary care physicians, are often unaware that there are survivors of torture and refugee trauma in their immigrant patient population. Although such patients are often silent about their past, they can be in profound need of medical care and other health services to address the suffering they have endured. Survivors of torture and refugee trauma have had to flee their homes and countries because of persecution and or war. They have been subjected to and witnessed horrific events, such as a Tibetan monk imprisoned and tortured, including being beaten and shocked with electric cattle prods, because of advocating for greater freedom, or the Kosovar refugee who witnessed her home set on fire as she was forced to flee her village by Serbian soldiers, or the young adult male from Sierra Leone, who had been kidnapped by rebel forces after seeing his family murdered. After leaving their countries, traumatic events may continue. In refugee camps, individuals may have experienced overcrowded unsanitary conditions, and continuing fears of attacks. Torture victims seeking political asylum in host countries, such as the United States, who arrive without visas, may face long periods of imprisonment while awaiting decisions on their asylum claims.

By recognizing and treating patients with a history of torture/refugee trauma, health professionals in medical settings, including primary care clinics or emergency rooms, can provide much-needed care and appropriate

referrals to a marginalized group. The general medical/primary care clinic may be the first or only health care setting to which a survivor of torture/refugee trauma presents. Such individuals may present with a known history of abuse, and be referred for general medical care or may never have been identified.

Health professionals have a unique opportunity to identify and begin to address the medical, psychological and social health consequences from which survivors of torture and refugee trauma may suffer. Thus, it is essential for health professionals working in these settings to be aware of the health consequences of such traumatic experiences, as well as effective interviewing skills for effectively caring for such vulnerable populations. Additionally, medical professionals can fill a unique role in the patient's life, one that expands to include doctor, confidante, and advocate.

Prevalence of Torture and Refugee Trauma in the Primary Care Setting

The most recent United Nations statistics on refugees indicate that there are an estimated 8.4 million refugees worldwide (UNHCR, 2006). It is estimated that 5-35% of refugees and asylum seekers were victims of torture (Baker, 1992; Eisenman, Keller, & Kim, 2000; Montgomery & Foldspang, 1994). In certain communities, particularly individuals from post-conflict countries or those known to have widespread human rights abuses, the prevalence is even higher (Jaranson et al., 2004).

Common forms of torture and mistreatment include beatings, sexual assault, forced nakedness or other humiliations, burns with hot objects, being restrained or suspended in painful positions, mock executions, sleep deprivation, witnessing others tortured. Individuals fleeing war-torn

countries may have witnessed horrific acts of violence or their after effects. The physical, psychological and social health consequences of such trauma can be profound.

More than 400,000 torture survivors are estimated to live in the United States (Office of Refugee Resettlement [ORR], 2006). Many more have been victims of political violence/traumatic events that would not necessarily meet international definitions of torture, but can nonetheless have devastating health consequences. Such individuals are by no means a rarity.

The prevalence of survivors of torture in primary care settings in the United States found in 3 studies ranged from 7-11% (Crosby et al., 2006; Eisenman, Gelberg, Liu, & Shapiro, 2003; Eisenman, Keller, & Kim, 2000). In one of these studies conducted in clinics serving the Latino population, 54% of individuals surveyed reported suffering some form of political violence in addition to torture (Eisenman, Gelberg, Liu, & Shapiro, 2003). The studies also found that few if any of the individuals had reported their history of torture/trauma to their physician despite having visited the clinic several times. For individuals coming from war torn countries such as Iraq, the former Yugoslavia or the Sudan, it is unlikely they have not witnessed or experienced traumatic events potentially impacting on their health.

Why do physicians fail to identify their immigrant patients' torture/trauma histories? There are confounding factors on the part of both the physician and the patient. Physicians may not be aware of the prevalence of torture and other traumatic events refugees may have endured. They may also feel uncertain or powerless in determining how to help such individuals. Traumatized patients, on the other hand, may not volunteer the information to a physician who doesn't explicitly ask. They may be silenced by shame,

guilt, or a mistrust of others. They also may feel that their past trauma history has nothing to do with their current medical complaints.

Whenever seeing a patient who is a refugee, asylum seeker, or comes from a war-torn country or one known to have political violence, the possibility that the patient has experienced torture and other traumatic events should be considered. Initial inquiries may focus on why the individual left his or her country before more directly asking about trauma including torture they may have experienced.

The Medical Interview

General Interview Considerations

The medical interview can be challenging with any patient, even more so with a recently immigrated patient with language and cultural barriers, and still more difficult with a survivor of torture/refugee trauma. Such individuals may have had little or no previous contact with health professionals, and if they did any previous medical records may well not be available.

In the context of the medical interview, it is crucial for the medical provider to establish rapport and trust with the torture/refugee trauma survivor. This process begins with the physician understanding the many fears and apprehensions that the survivor brings into the examination room. For example, in some cases, health professionals were involved in the patient's torture experience (Annas, 2005; Miles, 2006). Individuals may also have had substantial difficulties accessing adequate health services both in their countries of origin as well as in refugee camps or detention facilities in their countries of exile (Human Rights Watch, 2002; Keller et al., 2003).

By asking about this, the physician can make sure to take extra steps to gain the trust of the patient.

Additionally, the interview process itself may remind the survivor of being interrogated. In order to avoid re-traumatizing the patient, questions should be asked as much as possible in an open ended manner, rather than in a rapid-fire fashion. Let the patient tell his/her story with as few interruptions as possible, rather than initially trying to get a chronological, detailed history of each event. At the outset of the interview, the care provider should explain the purpose and process of the medical evaluation.

The medical care provider should demonstrate active listening at all times, keeping in mind that the patient may be revealing details that he/she has never told anyone before. Genuine empathy can be expressed by letting the patient talk about what is most important to them—for example, a person who is separated from their family may talk about that more than their actual torture or refugee experience. The physician should allow time for such matters to be discussed so that he/she can get a picture of the “whole” patient.

There are many other ways for the physician to establish trust, such as reassuring the patient of the confidentiality of the medical interview. Physicians must also take care to refrain from forcing the patient to discuss any form of torture or trauma that they do not wish to talk about. Several visits may be required for the patient to feel comfortable enough to fully disclose their experience.

The Need for Interpreters

For many patients, even those with some command of English, interpreters may be necessary for a detailed, nuanced medical history (See

Chapter 4 in this volume). Again, the confidentiality of the interview must be stressed to the patient. Clinicians must work to ensure that the match between the interpreter and the client is appropriate. Both the physician and the interpreter should be aware that the interpreter's ethnic, cultural, tribal, or religious identity may potentially be viewed as threatening by the patient; especially if the patient's torture was administered by a member of that particular group. Additionally, health professionals may have been complicit in the individual's torture and mistreatment; potentially causing more anxiety and fear.

Issues of the interpreter and care provider's gender must also be considered. Gender issues may impact, for example, on a patient's willingness to discuss a history of sexual assault. When possible, patients should be asked in advance if they have a gender preference for the clinician and interpreter, and such requests accommodated. Using family members or friends is discouraged for reasons of privacy/confidentiality, and the impact it may have on a family system.

The physician can reinforce the doctor-patient relationship by showing that he/she is listening even when the interpreter or patient is speaking in their own language. Again, remember that the patient may be revealing very traumatic experiences for the first time, and that the physician should do everything possible to show genuine empathy and interest.

Eliciting the Trauma History

As noted above, health professionals may be reluctant to inquire about traumatic events patients have experienced for a variety of reasons. The trauma history is an important component of the medical interview and may well help the physician better understand the patient and their health

problems. For example, head trauma may result in neurological damage or memory deficits. Musculoskeletal pains from beatings, or being suspended/restrained in particular positions, can help guide the clinical evaluation.

Eliciting a history of sexual assault may signal the need for specialized gynecologic/urologic evaluation including testing for sexually transmitted diseases. Unless a history of sexual assault is specifically inquired about, both for men and women, this vital information may not be offered.

Witnessing individuals killed or seeing dead bodies while fleeing from war can leave haunting memories. These psychological issues are but one aspect of the health concerns brought about by refugee trauma. Individuals who have not had access to medical care as they have lived in exile, or in the unsanitary conditions in refugee camps, may bear the consequences of this through untreated maladies and exposure to pathogens. Adjusting to the new climate, frequently with insufficient resources (i.e. lack of heating or proper winter clothing) also poses health risks. It is our clinical experience that illness, is one major factor that serves to keep clients' traumatic experiences alive in their psyches, as the medical and mental health issues feed off of one another.

Explaining the purpose for inquiring about the trauma history to the patient, acknowledging the difficulty of sharing this information as well as acknowledging that the individual may not want to discuss certain things are useful in rapport building and eliciting important information. However, the physician must keep in mind that there may be strong issues of shame, humiliation, or stigma, especially in the case of sexual assault. The clinician should use his/her judgment as to when to inquire about the trauma history.

It may naturally follow from when the individual has reported complaints such as muscle aches or neurological symptoms that may be directly related to the trauma, or the clinician may choose to wait until later in the interview; for example, while eliciting the social history.

The physician should determine what level of detail is necessary. If, for example, the physician intends to write an affidavit for an asylum-seeker, he or she will need much greater detail, ideally collected over several visits. For someone solely seeking medical care, the physician should not feel the need to “extract” information, but rather to let the patient reveal the level of detail that makes him or her comfortable.

Elements of the Medical Interview

Identifying Current Health Problems (History of Present Illness)

The physician should address the immediate concerns of the survivor of torture/refugee trauma. For the first-time visitor, the medical history should be comprehensive both pre- and post-torture/trauma. The history should include inquiries about possible exposure to tuberculosis, such as time spent in an overcrowded space (i.e. a prison or refugee camp).

After explaining the purpose and process of the medical evaluation, the health professional may begin by asking about the individual’s general health and current health concerns (i.e. “How may I be of service?” Or “Can you tell me about your health and any problems currently bothering you?”). Such a patient centered approach is important in establishing rapport and giving the individual a sense of control. The chronology of any current health complaints should be noted. It is important to appreciate that individuals imprisoned for extended periods, or who came from refugee

settings with limited access to health care, may have problems for which they received little or no care.

The health professionals should inquire about any injuries/health problems that may have resulted from reported abuse. The frequency, intensity and duration of persistent symptoms, such as musculoskeletal pain or headaches, as well as factors that improve or exacerbate the symptoms should be noted. Residual physical limitations, such as difficulty ambulating should be noted. The development of any subsequent skin lesions, including scars should be noted.

Past Medical History

Health problems, both before and after traumatic events, should be noted. Survivors of torture and refugee trauma, as with all patients, need primary care providers to identify and address their general health needs. They have common health problems seen in a general medical clinic population, including diabetes, hypertension and asthma. In fact, geographic factors and stress may make the occurrence of such illnesses even more common among refugee populations. Medical health professionals should take a full history as they would for any first-time visitor to a medicine clinic. This includes a detailed family history.

Medications

Any medications the patient is currently taking should be noted. One should also inquire about medications the patient was using before leaving his or her country, including for chronic medical conditions. It is not uncommon that such individuals may present having gone weeks or months without taking their medications. For example, in our clinic, individuals

regularly present with poorly controlled hypertension or diabetes for which they were previously taking medications, but ran out of and had no way to obtain since fleeing their country.

Social History

The physician should elicit a complete social history from the patient, both about their life in their home country, as well as in the United States. Understanding what the patient's life was like before the traumatic events of torture may help engender a greater sense of empathy. For example, many survivors of torture were singled out by their tormentors for their intellectual or political activities. For these professors, poets, or journalists, coming to the United States as a refugee and having to work as an unskilled, manual laborer may be a significant stressor. Other torture survivors may enjoy the chance to talk at length about their children, who may still be in their home country.

Physicians should also inquire about the client's current employment and living situation. Living in isolation, for example, may be a significant cause of distress, and is compounded for patients who don't speak English. Overcrowded living conditions, common among asylum seekers, may contribute to the risk of exposure to tuberculosis. Additional social service needs, including need for English classes, legal assistance (such as applying for political asylum or work authorization), should be identified and appropriate referrals made. Identifying and addressing such needs can be central to promoting the health and well being of survivors of torture and refugee trauma. Evaluation in the primary care setting is an invaluable and in fact may be the first opportunity for identifying such needs.

As with all patients, physicians should inquire about smoking, alcohol use, and drug use (including herbal remedies). Patients may be at risk for self-medicating their depression or anxiety (D'Avanzo, Frye, & Froman, 1994).

Review of Systems

For the first-time visitor, a comprehensive review of systems/symptoms is essential. This includes specific inquiries about urologic and gynecologic symptoms. As noted previously, sexual assault is common and often unreported (Hynes & Cardozo, 2000).

A review of psychological symptoms should also be elicited. This includes screening for depression, anxiety and symptoms of posttraumatic stress disorder (PTSD). The primary care provider may well be the first and only opportunity to screen for such symptoms. Furthermore, while specialized mental health services may be available, individuals may be reluctant initially to agree to such referrals.

A number of psychological screening tools are available. Two screening tools, the Harvard Trauma Questionnaire (Mollica et al., 1992) and the Brief Symptom Inventory (Derogatis, 1983), are frequently used in assessing refugees and torture survivors. The Harvard Trauma Questionnaire (HTQ) is a brief self-report inventory. It elicits a history of the patient's traumatic experiences and assesses their PTSD. The HTQ has been extensively translated and is highly associated with the clinical diagnosis of PTSD (Kleijn, Hovens, & Rodenburg, 2001). The Brief Symptom Inventory (BSI) is a self-report inventory of 53 questions that provides an overview of psychological status on nine primary symptom dimensions and three global indices of distress. Each of these screening tools takes about 10 minutes to

complete, and they can reveal important information about the mental health of the torture survivor.

An important component of the review of psychological symptoms is a detailed sleep history, given that sleep disruptions are common. For example, Blight, Ekblad, Persson, and Ekberg (2006) found that approximately 49% of their sample of refugees from Bosnia-Herzegovina reported sleep difficulties. Keller et al. (2006) found that 66% of their sample of survivors of torture/refugee trauma reported problems sleeping. As part of the sleep history, it is important to inquire about how many hours the individual sleeps on average, as well as note any difficulties falling asleep, staying asleep, or experiencing nightmares.

Physical Examination

A thorough physical examination is important in addressing health needs of victims of torture/refugee trauma as well as providing documentation (see below). While there may be lasting physical signs of torture/mistreatment, including scars, perforated ear drums or neurological findings, it is important to note that there is often a substantial gap in time between when the individual experienced mistreatment/traumatic events, and when they present for evaluation. Thus physical findings characteristic of injuries previously suffered, including dermatologic and musculoskeletal findings, may have already resolved at the time of evaluation. While physical findings may still be present, a “normal physical examination” does not necessarily negate allegations of torture, and in fact, might well be expected given the passage of time.

As with all patients, the physician should start with the less intrusive parts of the medical exam, such as checking vital signs. This is especially important for survivors of traumatic events who may feel particularly vulnerable in a doctor's office. Explaining each step to the patient will help to put him/her at ease.

The physician should also take care to avoid having the patient naked for an extended period of time. Uncovering each body part as needed, and then re-covering it promptly, will help the patient avoid feelings of humiliation. A chaperone may be helpful in some cases, such as for a female patient who is uncomfortable being examined alone by a male physician.

Ancillary Tests

When ordering ancillary tests, such as blood tests or radiographic studies, the clinician should be mindful of cultural issues as well as the potential for retraumatization. For example, in our Program, several patients from Tibet have reported being forced to have their blood drawn as a punishment and being told by their captors that essential components of their "spiritual essence" were being taken from them. Electrocardiograms may be particularly stressful for individuals subjected to electric shock torture. CT scans and MRI's may result in significant anxiety as a result of a sensation of being in an enclosed space. Appropriate explanations about why the tests are being ordered, and what the patient can expect, can alleviate stress. Pre-medication with anxiolytics for studies such as MRI's should be considered.

Common Health Problems among Torture Survivors/Refugee Trauma Survivors

Survivors of torture and refugee trauma may present with multiple medical, psychological, and social health concerns; all of which are interdependent and impact on one another. For example, a torture victim repeatedly beaten and subsequently held in an overcrowded cell may have medical/physical problems including musculoskeletal pains and exposure to tuberculosis. They may also have depression or PTSD as a result of this abuse which may worsen as a result of physical symptoms or vice versa. Similarly, such traumatic experiences may result in social isolation or substance abuse including self-medication.

The health problems that survivors of torture and refugee trauma encounter, and the evaluation and treatment of these health problems, are not necessarily unique to this population. However, the frequency of certain health concerns, such as musculoskeletal pain, infectious diseases, such as tuberculosis, and psychological symptoms of anxiety and depression, is likely higher than the general primary care population, and higher than even other immigrant groups. Furthermore, the context in which many of these health problems arose is unique. Traumatic events such as torture, forced migration because of war and violence have potentially devastating effects for survivors. The context in which these problems are experienced by individuals from diverse cultures, for whom concerns of trust and safety may be paramount, must also be considered. Empathy, effective communication and sensitivity to cultural norms are essential in rapport building and providing effective care.

Musculoskeletal

Musculoskeletal pain is one of the most common complaints among survivors of torture/refugee trauma. One study of Bhutanese refugees found that 59% of refugees who had been tortured complained of musculoskeletal pain (Shrestha et al., 1998). A recent study of 116 Iraqi refugees resettled in the U.S. and seeking mental health services found that nearly 70% complained of lower back pain (Jamil et al., 2005). The pain may be the result of beatings, various forms of positional torture, conditions of detention, or difficult travel conditions when fleeing their countries. They may also be somatic in nature. The physician should document the complaints even if he/she suspects the pain is somatic (Iacopino, Alden, & Keller, 2001).

Falanga, which consists of beatings on the soles of the feet, is a common form of torture throughout the Middle East, India, and certain African countries. Falanga can result in chronic pain on walking, as a result of damage to the underlying soft tissue. More serious complications include closed compartment syndrome, fractures and permanent deformities of the feet (Iacopino et al., 2001).

Musculoskeletal physical examination should include evaluating joint, spine and extremity mobility. Pain with motion, muscle strength, signs of fractures with or without deformity should be noted.

If fractures, dislocations or osteomyelitis are suspected, radiographs should be performed. Bone scintigraphy is particularly sensitive in demonstrating bone tissue lesions, even years after the trauma (Mirzaei et al., 1998; Peel & Iacopino, 2002). CT Scans are also useful in evaluating injuries to bone and soft tissues, with MRI's being even more sensitive, particularly for soft tissue injuries (Iacopino et al., 2001).

Pain medications, including acetaminophen or non-steroidals may be beneficial, although as with all patients, individuals should be counseled about potential side effects. Physical and Occupational therapy may provide relief of symptoms as well. In individuals suffering from depression or posttraumatic stress disorder, body oriented therapeutic approaches, coupled with treatment of the underlying psychological problem may also help to improve pain symptoms (Berliner, Mikkelsen, Bovbjerg, & Wiking, 2004).

In our program, several individuals presenting with chronic leg ulcers as a result of beatings they had suffered were ultimately diagnosed with chronic osteomyelitis, and required chronic antibiotics and in some instances amputation of the lower extremity. Two other individuals who had required amputations in their countries of origin after suffering beatings and chronic infections, presented to our Program in need of prosthetic devices, which when provided, profoundly enhanced their general functioning.

Several individuals cared for in our Program have also suffered deep vein thromboses, as a result of beatings and being forced to stand for prolonged periods. A number of these individuals have required long-term anticoagulation.

Neurological

Neurological symptoms and injury, both central and peripheral, can result from many types of torture and ill-treatment, including beatings, positional torture such as suspension, and vitamin deficiencies or un-treated disease. For example, damage to the brachial plexus is common in patients who have suffered suspension, even if the suspension lasted only a short while. Cranial nerve deficits and changes in mental status and cognitive ability can result from beatings.

Torture victims may experience vertigo and dizziness. A history of head trauma and loss of consciousness should be specifically inquired about. Additionally, patients may present with paresthesias and paralysis of a limb. In rare cases, patients may present with seizures. Asphyxiation may leave the patient with permanent memory loss or cognitive deficits, which may in turn compound the problem of eliciting an accurate trauma history (Moreno & Grodin, 2002).

The most common chronic neurological complaint reported by torture survivors is headache. Rasmussen et al. (1990) found a prevalence rate of 64%. Mollica et al. (1993) found that 74% of Cambodians living in a refugee camp, whom they interviewed, reported having frequent headaches. Torture survivors who suffered blows to the head often complain of headaches. These may be somatic, or they may be referred pain from the neck (Iacopino, Allden, & Keller, 2001). Visual changes may also result from head trauma.

Violent shaking may result in symptoms similar to “Shaken Baby Syndrome.” (The condition is sometimes called “*Shaken Adult Syndrome.*”) The chronic manifestations of this include recurrent headaches, disorientation, and mental status changes. Retinal hemorrhages, cerebral edema, and subdural hematoma are more severe sequelae (Iacopino et al., 2001).

Other manifestations of head trauma include dental problems (tooth loosening or loss), ruptured eardrums, retinal detachment or traumatic cataract, and skull fractures. Frontal lobe dysfunction is detectable with neuropsychological testing.

Neurological examination should include evaluation of the cranial nerves, peripheral nervous system, motor and sensory neuropathies. For

individuals who are suspended, for example, torn ligaments of the shoulder joints may result. It is sometimes possible to identify a “winged scapula,” which results from nerve damage and dislocation of the scapula (Iacopino et al., 2001).

Cognitive ability and mental status should also be evaluated. Referral for neurology or ophthalmology consultation or neuropsychological evaluation should be considered as appropriate. CT scans and MRI’s can help to delineate neurological lesions. Patients undergoing these and other studies should be educated in advance about them so as to avoid retraumatization such as from being in an enclosed space.

Chronic pain is common among torture survivors (Quiroga & Jaranson, 2005). It is under diagnosed and under treated. Chronic pain may be a result of musculoskeletal injury, as described above, or neurological disorders including peripheral neuropathies, such as from falanga. Psychological factors can also play a role, but organic etiologies need to be ruled out. A thorough description of each site of pain should be elicited including location, severity, frequency, timing, radiation, and factors that precipitate or improve the pain. It is important to inquire as to whether the pain began before or after the torture/trauma. Effective management of pain may require a multidisciplinary approach including primary care physicians, neurologists, pain specialists, and mental health care providers.

Dermatological

Many forms of torture can result in dermatologic manifestations, both acute and chronic (Iacopino et al., 2001; Peel & Iacopino, 2002). For example, burns can leave characteristic scars/imprints from hot objects, such as a cigarette or metal rod. Beatings with fists, sticks, or other objects may

also result in dermatologic lesions and scarring. Prolonged, tight shackling of extremities can result in characteristic linear scarring encircling the arm or legs.

Objects with mixed components leave mixed scars: belts have buckles that cut jagged areas and straps that leave linear scars. Scars may contain fragments of the object used to beat a survivor, such as glass or wire shards which have been surgically removed from survivors treated at our program.

Traditional medicine treatments, vaccinations, and surgical scars are usually distinguishable due to symmetry, repetitious patterns or location. Infection can exacerbate any scarring, even in a superficial injury.

It is equally important to note, however, that many forms of torture, such as a mock execution where a gun is held to someone's head and the trigger pulled may leave no physical marks, but the ensuing psychological symptoms can be profound. Other forms of torture, including electric shocks, depending on their severity, may or may not leave any physical marks. Some have hypothesized that torturers are becoming increasingly sophisticated so as to leave no physical marks (Moreno & Grodin, 2000).

For primary care providers working in developing countries, it is often months or even years since the reported torture occurred. Thus it is entirely consistent that many forms of abuse, including beatings, which may have resulted in soft tissue injuries/bruises or abrasions, will have entirely resolved by the time that an individual presents for evaluation. Furthermore, there is variability with regards to how individuals scar and heal. For example, vitamin deficiency and older age are risk factors for easy bruisability, while younger, fitter individuals tend to bruise less easily. Darker skinned individuals are more likely to develop keloid scars, which

are raised lesions that can be firm or rubbery. Keloids are the result of an overgrowth of tissue at the site of a healed skin. For documentation purposes health care providers can record a description from the individual of how the injury appeared immediately after the alleged torture and in the subsequent weeks and months.

In our program, we work closely with dermatologists who provide documentation, including photographs of lesions, when feasible and appropriate, as well as for treatment. Dermatological lesions, such as keloid scar formation may benefit from intradermal steroid injections. Severe burns with thickened scars may best be addressed through plastic surgery, which provides both cosmetic and functional benefits. For example, one patient cared for in our program, who was a prominent painter in his country, suffered severe burns to his hands when they were thrust by his interrogators into a coal burning oven. When he was seen in our Program, it was several years since his torture had occurred. He had severe deformities of his hands, including multiple fibrous bands, resulting in marked range of motion limitation of his hands. Furthermore, when he would hold a pencil, his hand would tremble and he would experience flashbacks of his torture. As part of his treatment, he was referred to plastic surgery. Fortunately, the underlying musculature and bones were intact. Following plastic surgery he regained substantial increased range of motion and ability to draw, as well as a marked improvement in his psychological symptoms.

Infectious Disease

Survivors of torture and refugee trauma are at risk for a number of infectious diseases including tuberculosis or parasitic infections, which may result from overcrowded dirty detention conditions, osteomyelitis as a result

of trauma/beatings (see musculoskeletal section above), or sexually transmitted diseases from sexual assault, including syphilis, gonorrhea, chlamydia, Hepatitis B and HIV. Additionally, individuals may be arriving from countries where diseases such as tuberculosis, HIV and Hepatitis B are endemic (independent of their trauma history). Appropriate screening (see below) and treatment of these conditions are essential. Health professionals should also have a low threshold for screening for Hepatitis C, and screen for this malady in the presence of other blood born infections or abnormal liver function tests. Again, this may result from individuals coming from countries with poor access to clean needles.

Genitourinary/Gynecologic

Sexual abuse and humiliations including rape, forced nakedness, beatings/electric shocks to the genitals, and instrumentation are common among men and women survivors of torture and refugee trauma. A study conducted by the Bellevue/NYU Program for Survivors of Torture found roughly 30% of all clients reported rape or other sexual assault (Keller et al., 2006.) A study conducted by the Boston Center for Refugee Health and Human Rights at Boston Medical Center found that 28% of male clients seen over a one year period reported sexual trauma (Norredam, Crosby, Munarriz, Piwowarczyk, & Grodin, 2005). Reports of rape against women as an act of war are well documented in several conflicts/civil wars including in the former Yugoslavia and Sierra Leone (Amowitz et al., 2002; Swiss & Giller, 1994). For example in a community household survey conducted in Sierra Leone in 2001, 9% of women reported having been a victim of war-related sexual violence (Amowitz et al., 2002).

Given profound shame and humiliation, which may be even more common in certain cultures, it is likely that there is substantial underreporting of the incidence of sexual abuse by both men and women (Quiroga & Jaranson, 2005; Swiss & Giller, 1993). Care providers must be respectful, empathic, and should consider asking specifically about sexual assault.

Sexual assault in women can result in sexually transmitted diseases, including syphilis, gonorrhea, chlamydia, hepatitis and HIV, chronic pelvic pain, pelvic inflammatory disease, papilloma virus, which in turn can lead to cervical cancer. Unwanted pregnancies, as well as subsequent infertility, are also considerable concerns. Irregular menses, sexual dysfunctions such as loss of libido, fear of intercourse for fear of triggering memories of the abuse and dysparania or pain upon intercourse are often expressed by female survivors of rape (Lifson, 2004; Yehuda & McFarlane, 1995). A thorough history and appropriate and gynecologic evaluation and treatment should be provided. Clinicians should be sensitive to the potential for retraumatization by conducting a pelvic examination.

Female Genital Cutting (or Female Genital Mutilation-FGM) is frequently practiced in several countries, particularly in Africa, and refers to procedures involving partial or total removal of the external female genitalia for cultural or other non-therapeutic reasons. Worldwide, more than 100 million women and girls are estimated to have had FGM. The World Health Organization (2000) has developed a classification system for the type of procedure from least to most severe. Type I refers to excision of the prepuce with or without excision of part, or all, of the clitoris. Type II refers to the excision of the clitoris with partial or total removal of the labia minora; Type

III refers to the excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation).

FGM, particularly with the more extensive procedures, can result in increased risk of health concerns including infections, obstetric complications, sexual dysfunction and psychological symptoms. Given the prevalence of this procedure, it is important for health professionals, particularly those providing gynecologic care, to be familiar with the various forms of this procedure and the potential health consequences (Toubia, 1994).

Sexual assault in men can result in similar problems, including sexually transmitted diseases, chronic dysuria, chronic genital and erectile pain, and sexual dysfunction. Diagnostic workup includes history, physical examination, appropriate laboratory studies and ultrasonography, if indicated. Oral erectogenic agents should be considered for sexual dysfunction (Norredam et al., 2005).

Victims of sexual assault are at high risk, for profound psychological sequelae including depression and PTSD (Arcel, 2002). Within our program, we have found higher rates of depression and PTSD among victims of torture/refugee trauma who were sexually assaulted compared to those who were not (Keller et al., 2006).

Ears Nose and Throat

Beatings over the ears, including a hard slap over one or both of the ears with the palm of the hands (known in Latin American countries as ‘telefono’) is a common form of torture, and can result in rupture of the tympanic membranes (Iacopino et al., 2001; Peel & Iacopino, 2002) Examination with an otoscope can document rupture or signs of scarring.

Hearing loss can be assessed by simple screening. Audiometric testing can demonstrate with more precision the extent of hearing loss and guide further treatment.

Dental

Poor dentition is a common problem among survivors of torture and refugee trauma, and may result from beatings, malnutrition, and inadequate prior access to appropriate dental evaluation and treatment. Signs of poor dentition, including missing/fractured teeth should be documented and appropriate referral for dental care provided.

Gastrointestinal

Abdominal symptoms, which are common in the primary care setting, may be even more prevalent in refugee populations. Etiologies are multifold and can include infections (i.e. parasitic infections, hepatitis), and peptic ulcer disease/gastro-esophageal reflux. Individuals imprisoned or in refugee camps are likely to have been exposed to overcrowding and extremely unsanitary conditions, making the risk of parasitic disease even greater. Hepatitis B, which is endemic in many countries, may be even higher among torture survivors given the frequency of sexual assault.

Gastrointestinal symptoms as a somatic complaint are also a consideration. As evident from literature in domestic violence populations, traumatized populations often manifest abdominal discomfort as a somatic manifestation. This, however, is a diagnosis of exclusion.

A thorough history of the course of abdominal symptoms, describing symptoms of reflux, dyspepsia (loose stool/diarrhea, including noting presence or absence of blood) should be elicited. Given a high prevalence of

parasitic infections among immigrant refugee populations, routine screening of stool for ova and parasites is often encouraged.

For dyspeptic symptoms a trial of H2 blockers or proton pump inhibitors should be considered, as well as screening for *Helicobacter Pylori*. Persistent symptoms should evoke further evaluation including upper/lower endoscopy. It is important to keep in mind the higher prevalence of gastric cancer in certain immigrant populations (Marcus et al., 1999).

Constipation may also be a frequent complaint, often resulting from individuals who previously ate a higher fiber/less processed diet than now being eaten in the United States. This may also be a manifestation of stress. Structural abnormalities, requiring a colonoscopy should be considered as well if symptoms persist.

Psychiatric Symptoms

For many torture survivors, the only scars they are left with are emotional, and these can be the most devastating and debilitating. (See Chapters 1, 6, 8, and 10). Psychological symptoms commonly occurring in survivors of torture include memory and concentration impairment, nightmares, intrusive memories, increased startle response, amnesia, flashbacks, sleep disturbance, irritability, and avoidance (Keller & Gold, 2005). General feelings of shame and humiliation, especially in light of sexual assault, often plague the torture survivor.

Many survivors will manifest somatic physical symptoms in lieu of addressing their underlying depression or anxiety. Several studies have shown that those suffering from PTSD tend to be more likely to report nonspecific somatic complaints than do those without PTSD. One study found that the number of PTSD symptoms predicts the number of organ

systems involved in the patient's complaints (Van Ommerren et al., 2002). However, physicians must avoid the temptation to write off physical complaints as psychosomatic, taking care to remember that survivors of torture suffer from the same gamut of health problems that affects the general population.

The most common psychological diagnoses among survivors of torture/refugee trauma are posttraumatic stress disorder and depression. Comorbidity of these two illnesses is common (Momartin, Silove, Manicavasagar, & Steel, 2004; Quiroga & Jaranson, 2005). Anxiety and suicidal ideation are also significant concerns.

Post-Traumatic Stress Disorder (PTSD)

This disorder is defined by the following symptoms persisting for more than four weeks in a manner that impairs normal functioning: 1) re-experiencing the trauma in nightmares, intrusive thoughts, or flashbacks; 2) general "numbing" and avoidance of situations that symbolize the trauma; 3) excessive arousal (Breslau, 2002).

The prevalence of PTSD is markedly higher among survivors of torture/refugee trauma than in the general population. In the U.S. the estimated lifetime prevalence of PTSD in the general population is approximately 8% (Kessler et al., 1995). In countries exposed to mass conflict, the prevalence rate is higher-between 16% and 37%.

Among survivors of torture/refugee trauma presenting to our program for care, the prevalence of PTSD was 46% (Keller et al., 2006). Several studies have documented higher prevalence rates of PTSD among refugees who have experienced torture compared to those who have not (Iacopino et al., 2001).

As mentioned above, many patients' PTSD manifests itself as general somatic pain complaints. While it is recommended that all survivors of torture/refugee trauma be screened for PTSD, particular attention should be paid to screening those who present with medically unexplainable pain.

Depression

This disorder is also significantly elevated among refugees and torture survivors (Gerritsen et al., 2006; Keller et al., 2006). A study of Cambodian refugee women in the United States showed levels of depression three times as high as the national average for women (D'Avanzo & Barab, 1998).

Among Latino patients in primary care settings identified as having experienced political violence, 36% had depressive symptoms and 18% posttraumatic stress symptoms (Eisenman, Gelberg, Liu, & Shapiro, 2003). Among clients referred to our Program, 85% had clinically significant depressive symptoms (Keller et al., 2006).

Anxiety symptoms, in addition to full diagnostic criteria, are common among refugees and torture survivors. Additionally, physicians should be aware of the warning signs of possible suicidality. Depression, loss, feelings of meaninglessness, rage, and guilt are all risk factors. The physician should inquire about previous attempts or current thoughts of suicide. Acute inpatient psychiatric hospitalization may be necessary and life-saving.

As noted above, screening for psychological symptoms should be a part of the initial health screening. Many refugees and asylum seekers may not be familiar with the concept of clinical depression or post-traumatic stress disorder (PTSD), or they may be from a culture that stigmatizes mental health problems. Primary care providers have a crucial role to play in recognizing such problems, providing basic psycho education about

symptoms and treatment, including encouraging appropriate referral for counseling and psychopharmacologic treatment.

At the Bellevue/NYU Program for Survivors of Torture, multidisciplinary care is enhanced through effective communication and working relationships between primary care physicians and mental health care providers including psychiatrists, psychologists, and clinical social workers. Services offered by mental health care providers working with our program include psychopharmacological consultation and treatment, as well as individual and group psychotherapy. Communication is facilitated by having multidisciplinary case conferences on a regular basis.

Early targeting of the most troublesome symptoms, such as insomnia, eases suffering, and can enhance the therapeutic alliance. We have found great utility in psychoeducation provided at initial intake into our program, and by primary care providers, about the importance and value of referral to psychiatrists and other mental health care providers for medications and psychotherapy. Such information helps to educate clients about the need and benefit of services, as well as de-stigmatize and in fact normalize referral to mental health professionals.

Primary care providers in our program often will start medications in symptomatic patients, for anxiety, depression and PTSD, particularly if individuals are not willing to be referred for evaluation by a mental health professional. Patients who are experiencing myriad depressive and PTSD symptoms are treated initially with an SSRI and a brief trial of a benzodiazepine or other sleep aid such as trazodone (Desyrel). When prescribing psychotropic medication to survivors of torture from varied ethnic backgrounds, it is important to consider a variety of factors, including that individuals from some cultures may not be used to taking any

medications. Thus starting with lower doses, so as to minimize side effects may be appropriate. A variety of psychopharmacologic interventions are used in our Program (See Chapter 8).

Health Screening

While the above clinical entities require directed treatment, survivors of torture also require primary medical care similar to other immigrants from underdeveloped regions of the world. Immigrant health care is too broad a topic to address in this text, but primary care for survivors of torture often includes the following: serology testing for evidence of immunity to diseases for which vaccines are available, tuberculosis screening, testing for ova and parasite infections, and general primary care screenings according to accepted guidelines.

Torture survivors should be screened for infectious disease and parasitic infections according to the guidelines for all refugees. Physicians should not only ask about present, apparent health problems, but also about diseases that are prevalent in their country of origin (or countries they have passed through en route to the U.S.). Thus, physicians should have access to country-specific health information.

Epidemiological studies of immigrants and refugees show consistently high prevalence of tuberculosis and other infections when compared to the general population. A 2004 study in the *New England Journal of Medicine* presents the startling statistic that the rate of tuberculosis among newly arrived refugees was 80 times higher than the U.S. national rate (Thorpe et al., 2004).

A prevalence study among refugees in Minnesota showed that 49% of refugees had a reactive tuberculin test. Prevalence was even higher among male patients and those over 18 years of age (Lifson, Thai, O’Fallon, Mills, & Hang, 2002). Seven percent of these refugees tested positive for Hepatitis B surface antigen (HbsAg), with prevalence being the highest among refugees from Sub-Saharan Africa (at 22%) They also found that 30% of African refugees younger than 18 years old—had at least one intestinal parasite (Lifson, Dzung, O’Fallon, Mills, & Kaying, 2002). Another study of African refugees in Massachusetts reported that 56% had ova or parasites. This study of 1,254 refugees found 17 different parasites among them (Geltman, Cochran & Hedgecok, 2003). The prevalence rates among children and adolescents were even higher (Geltman et al., 2003).

With such high prevalence rates among refugees, it is imperative for the primary care physician to thoroughly screen his/her immigrant patients. Physicians should routinely run the following battery of tests:

- CBC with differential
- General chemistry profile including electrolyte and liver function
- Stool for ova and parasites
- Urinalysis
- Serology for Hepatitis
- HIV and syphilis
- Tuberculin skin test (PPD)
- Chest radiograph for any patient with TB symptoms, or a positive PPD

Antibody titers for measles, mumps, rubella and varicella are commonly checked as well, to confirm immunity. Documentation of immunity to these diseases is often needed for employment and other purposes, and individuals commonly do not have records of prior vaccinations. Vaccinations are provided as needed.

Medical Documentation of Torture

Documentation of torture/refugee trauma is important for any patient seen by the physician, but especially so for those applying for political asylum. By providing such documentation, including preparation of a medical report or affidavit, a health professional can provide invaluable assistance to asylum seekers. Objectivity is paramount when evaluating an asylum seeker. Clinicians should not include any opinions that cannot be defended under oath, or during cross-examination in a courtroom. Embellishing the evidence of torture/trauma in order to help the client gain asylum will not only hurt that client's chances in court, but it will also undermine the credibility of the physician for future asylum applications.

International guidelines for documenting torture, particularly the Istanbul Protocol (Istanbul Protocol, 1999) have been established. The Istanbul Protocol is available on the Physicians for Human Rights (PHR) website (www.phrusa.org). Also available on this website is the manual "Examining Asylum Seekers," adapted from the Istanbul Protocol, specifically for application in the U.S. for evaluating individuals applying for political asylum. Sample affidavits are included in "Examining Asylum Seekers."

Multidisciplinary Medical Clinic

An important source of medical care for patients in our program is a multidisciplinary medical clinic, which meets one evening a week. This clinic is particularly helpful for individuals who work during the daytime. Health professionals including primary care physicians, nurses, psychiatrists, and social service providers are present. Trained interpreters in a variety of languages spoken by our clients (particularly French and Tibetan) are also present. The clinic allows for immediate communication and “real time” collaboration between the different disciplines. Additionally, the clinic serves as an invaluable teaching environment for medical students and residents from a variety of disciplines, who have the opportunity to participate in longitudinal care electives with our program.

Primary Care is available at other times of the week as well, by general internists and pediatricians affiliated with our program. Patients are instructed to go to the Emergency Room for urgent medical needs after regular hours or on weekends and instructed to inform our Care Coordinator. Our program has conducted trainings with the Emergency Department and other service providers throughout the hospital in order to educate them about the health needs and complexities of our patients. Additionally, service providers from a variety of subspecialties have been identified and serve as point persons within their departments for patients in our program. This includes neurologists, dermatologists, pulmonologists, and rehabilitative medicine specialists.

Case Examples

Case #1: KD

KD is a 45 year old male from the former Yugoslavia where he worked as an engineer. During the civil war, KD's neighborhood was turned to rubble by frequent shelling and gunfire, and several family friends, including children, were killed in cross-fire. KD and his family subsequently fled and eventually came to New York City where they had relatives. He was referred to our Program by a local refugee resettlement organization.

KD has a history of hypertension, but ran out of his blood pressure medication several weeks before his initial evaluation. He had an empty packet of his medication, which was a kind of beta blocker not available in the United States.

On initial medical evaluation, KD described frequent frontal headaches. He denied blurry vision or a history of head trauma. On further history, he described the headaches as worsening when he was nervous. He also described difficulty sleeping, irritability, and being easily startled when he'd hear a sudden noise like a car backfiring.

Physical examination was significant for a blood pressure of 160/110. The remainder of his physical examination was unremarkable. Routine laboratory testing was normal, including negative hepatitis serologies, and a negative skin test for tuberculosis.

KD was prescribed an alternative Beta blocker (atenolol) that was available. Subsequently, hydrochlorothiazide was added for improved blood pressure control. KD initially refused referral to a mental health provider saying he wasn't crazy. He did, however, acknowledge his psychological symptoms were causing him significant distress and agreed to medication for this. KD was started on a serotonin reuptake inhibitor, as well as on trazodone at bedtime for sleep. Subsequently, the dosage of the sertraline was gradually increased, and KD no longer required the trazodone to sleep. KD, along with his wife and children, subsequently agreed to speak with psychologists associated with our Program. KD was seen by our Program's social service provider who, in coordination with staff at the refugee resettlement agency, arranged for KD to attend English and computer classes, and subsequently assistance with finding a job as a maintenance worker.

Case #2: MB

MB is a 32 year old French speaking female from a West African country. She was referred to our program by a pro bono attorney representing her in her application for political asylum. She reportedly had been imprisoned several times in overcrowded cells for organizing peaceful political demonstrations. She was subjected to a number of forms of torture and mistreatment including beatings with a whip on her back and being burned with a lit cigarette while being interrogated.

MB was asked if she was comfortable seeing a male physician and she said that she was. A French speaking interpreter, who was female, assisted in the interview. At the time of her initial medical evaluation, MB complained of chronic lower back pain, stomach aches, and a chronic cough. She denied fevers or night sweats. She described the pain in her stomach as a “burning sensation going up into her throat.” She reported being seen in different emergency rooms on several occasions and given “stomach pills,” which she said helped a little. She stated that she had not informed doctors there of her prior trauma history because “they didn’t ask” and she was “ashamed.”

On further history, MB acknowledged that during her imprisonment she was raped on 2 occasions. While talking about this she became tearful. She said that she had not told anyone else about this.

On physical examination, she had multiple circular scars on her arms consistent with cigarette burns. She had linear scars on her back consistent with her report of having been whipped. The remainder of her physical examination was normal. Gynecological examination performed by a female clinician associated with our Program was normal. A pregnancy test was negative.

MB described difficulty sleeping and feelings of extreme sadness since her imprisonment and rape more than 3 years before. She described frequent suicidal thoughts but denied ever having tried to kill herself or planning to do so. In consultation and subsequent follow up with a psychiatrist associated with our program she was started on

antidepressant medication. She also subsequently participated in a support group for French speaking African torture survivors.

Routine Blood tests were negative, including tests for hepatitis and syphilis. HIV testing was negative as were tests for gonorrhea and chlamydia. Stool examinations for ova and parasites were negative. Skin testing (PPD) for tuberculosis was positive. Her chest x ray was normal.

MB was treated with acetaminophen for her back aches and ranitidine for her gastrointestinal symptoms with subsequent improvement. She was started on isoniazid for 9 months for exposure to Tuberculosis. Her psychological symptoms also significantly improved. Health providers prepared affidavits documenting her trauma history and findings on physical and psychological evaluation. Subsequently, she was granted political asylum.

These cases demonstrate the myriad of health concerns individuals such as KD and MB may present with. Eliciting a trauma history is crucial in identifying and addressing important health concerns. As illustrated by the case of MR, health professionals frequently fail to inquire about a trauma history. Thorough medical evaluation and treatment, in collaboration with mental health and social service providers, is invaluable in promoting the health and well-being of survivors of torture and refugee trauma.

APPENDIX A

Sample Medical Affidavit

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE OF IMMIGRATION REVIEW

-----X

In the Matter of the Application of

XXXXXXXX

A# xxxxxx

-----X

AFFIDAVIT OF ALLEN S. KELLER, M.D.

1. I am an American physician licensed to practice medicine in the State of New York. I am a graduate of New York University School of Medicine and completed my residency in Primary Care Internal Medicine at NYU/Bellevue Medical Center. The residency program provided me intensive training on the psychosocial aspects of care including effective doctor-patient communications and the evaluation and treatment of common psychiatric problems including depression, anxiety, and somatization. I am board certified in Internal Medicine and am an Assistant Professor of Clinical Medicine at NYU School of Medicine, and an Attending Physician at Bellevue Hospital in New York City.

2. I have received specialized post-graduate training from Physicians for Human Rights in the use of medical skills for the documentation and treatment of torture victims. I have been conducting medical evaluations of survivors of torture since 1990. In 1993, I worked in Cambodia where I helped develop a program to train Cambodian health professionals in the evaluation and treatment of survivors of torture. In November and December of 1996, I led a fact-finding mission to Dharamsala, India on behalf of Physicians for Human Rights to examine Tibetan refugee survivors of torture and to evaluate and document the continued use of torture of Tibetans by Chinese officials. I am the author or coauthor of multiple publications on the evaluation and treatment of survivors of torture.

3. I have also trained several health professionals in this country in the evaluation of torture survivors. I have participated in training staff of the Immigration and Naturalization Services concerning the physical, psychological, and social consequences of torture. In June of 2001, at the invitation of the Office of Chief Immigration Judge, I was invited to make a presentation concerning the evaluation of torture survivors at the annual conference of immigration judges. I am on the International Advisory Board of Physicians for Human Rights. Most recently, I have developed a program at Bellevue Hospital and NYU Medical Center in New York City to provide medical, psychological, and rehabilitative services to survivors of torture and refugee trauma. Currently, I am director of this program- The Bellevue/NYU Program for Survivors of Torture. I have been previously qualified in Federal Immigration Court as an expert witness in evaluating and treating survivors of torture.

4. Ms. X is a xx year old female from Tibet. Since xxx she has been a patient in the Bellevue/NYU Program for Survivors of Torture. She has been seen many times since then (approximately 20 clinical visits to our program), most recently on March xxx. I have conducted a detailed clinical interview and physical examination of Ms. X in order to evaluate the effects of torture and maltreatment that she reports occurred in Tibet and India prior to her entry into the United States.

5. Ms. X reports that in xxx her father and grandfather, who were volunteer soldiers, were killed by the Chinese military when they invaded Tibet. Until xxx, she reports that she lived in Tibet with family members. She reports being repeatedly harassed and mistreated by Chinese authorities. She reports that she was not allowed to attend school nor practice Tibetan Buddhism. She reports being publicly humiliated by Chinese authorities on a number of occasions because her grandfather and father had fought against the Chinese. On several occasions, she reports being forced to stand in a public square with other Tibetans whose family members had fought against the Chinese. Chinese authorities would say these are examples of troublemakers and then would force the other villagers to throw stones at them. She reports suffering some minor injuries but denies being seriously physically injured during any of these episodes. She reports however, having found the experiences to be very humiliating.

6. On one occasion in 1972, Ms. X reports again being forced to go to the town square with approximately 15 other Tibetans, including her sister in

front of the rest of the village. She reports being forced to sing communist songs. When she did not sing the song completely, she reports that the local Chinese leader hit her on the mouth and then ordered the people to beat her and the others. She reports being punched and kicked all over her body, and subsequently lost consciousness. When she woke up, she reports that she was back in bed in her house. She reports that she felt very weak and sore for many weeks after that.

7. In xxxx, Ms. X reports that she left Tibet for India and lived in xxxx, India. She reports that she became active in a number of Tibetan organizations there. She reports being arrested and tortured on three occasions by the Indian authorities.

8. In March, xxx, she reports being arrested after attending a peaceful demonstration supporting Tibetan independence. She reports being detained for 2 days at a police station in Darjeeling. She reports being kept in a cell with approximately 6 other women. On the first night, she reports that approximately 3 Indian police officers, whom she believes were drunk, came to the cell and started beating her and the other women with sticks, while being verbally abusive. She reports the police threatened to punish them even worse or return them to Tibet if they continued to protest. Before being arrested, while trying to run away from the police, in the midst of the crowd she reports that she fell on a metal fence on the side of the road and injured her left buttocks. She reports the wound subsequently became infected with a purulent discharge. She did not seek medical care for this because she felt ashamed. She used traditional, topical ointments and the wound gradually healed.

9. In April of xxx, Ms. X reports that she was again arrested after having helped organize and then attend another demonstration in New Delhi in front of the Chinese embassy. She reports being held at a police station in New Delhi for three days. On the first day, she was brought into an interrogation room with 2 Indian police who began to question her about her activities. She reports that she was beaten, knocked to the ground and kicked. One of the policemen started undressing her. Subsequently, the other police officer came with a cigarette and repeatedly burned her with a lit cigarette on her left knee. She reports that she was subsequently vaginally raped. She reports the police shouted “You deserve this, and if you keep protesting then you will be sent back to Tibet.”

10. After three days, she reports that she was released. She reports feeling very sore all over her body and experiencing some vaginal bleeding. She reports that she did not seek medical care because she felt ashamed. She reports the wounds from the cigarette burns developed blisters, which subsequently burst. She reports that subsequently her husband divorced her, she believes, because of shame associated with the rape.

11. In March of xxxx, she reports that she was again arrested after attending a demonstration in Darjeeling. She reports that she was detained for 5 days. On the morning after her arrest, she reports being interrogated by Indian police. When she refused to sign a piece of paper that she would no longer protest, she reports being beaten by police officers, including being smacked in the mouth, and subsequently bleeding from her mouth. In order to stop the beating, she subsequently signed the paper.

12. In June xxxx, Ms. X reports that she left India for the United States.

13. Ms. X reports suffering from a number of psychological symptoms, particularly since her rape in India. These symptoms include significant feelings of sadness, hopelessness, decreased energy, and difficulty sleeping. She also reports frequently experiencing recurrent memories and nightmares of her abuse, though she tries not to think about what happened. She reports that when she has the nightmares, she wakes up with palpitations and then has difficulty falling back to sleep. She also reports being easily startled, and experiencing physical reactions, such as palpitations, when reminded of the events. Since being referred to the Bellevue/NYU Program she has received psychiatric care including antidepressant/anti anxiety medication with marked improvement in symptoms.

14. On physical examination, Ms. X is a well developed, well nourished female. She has multiple scars on her body consistent with her accounts of physical abuse. She has a linear scar approximately 2 cm in length on her right pinky and another linear scar on the back of her hand, approximately 3 and ½ cm in length, which she reports resulted from injuries when she raised her arm to block being beaten. There are several scars which she does not recall how she got including a 3 cm linear scar on her right upper arm, two linear scars at the base of the right thumb, and another ½ centimeter scar on the back of her left wrist. She has a scar on her left buttock approximately 2-3 centimeters in diameter, with a central indentation, c/w her report of the injury she suffered in 1984. On her left knee are approximately 5 smooth

hypo-pigmented scars, (ie. lighter than the surrounding tissue) approximately 1 centimeter in diameter consistent with her report of having been burned there.

15. It is my clinical assessment that Ms. X has been a victim of torture. Torture, according to the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 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, or 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.”

16. Ms. X demonstrates clear historical, physical, and psychological evidence of torture. Ms. X provides great detail and consistency with the events of her abuse. Although torture may not always leave physical evidence of abuse, Ms. X clearly has multiple scars that support her allegations of abuse and are consistent with the events she describes.

17. The psychological evidence of Ms. X’s abuse is also compelling. The psychological symptoms described above are consistent with diagnosis of depression and post traumatic stress disorder (PTSD), which is a form of anxiety.

18. The detail and consistency with which Ms. X describes her mistreatment, including imprisonment and torture, as well as the findings on physical and psychological examination persuade me that she is very credible and telling the truth. It is my impression that she continues to suffer from the physical and psychological effects of her abuse.

19. Ms. X will continue to receive care through the Bellevue/NYU Program for Survivors of Torture. It is my assessment that she has benefited from this care and will continue to do so.

20. It is my assessment that to force Ms. X to leave the United States and return to India or Tibet would pose a serious threat to her physical and mental health.

I declare under penalty of perjury that to the best of my knowledge, the foregoing is true and correct.

Allen S. Keller, M.D.

March 28, 2003

References

- Amowitz, L.L., Reis, C., Lyons, K.H., Vann, B., Mansaray, B., Akinsulure-Smith, A.M., et al. (2002). Prevalence of war-related sexual violence and other human rights abuses among internally displaced persons in Sierra Leone. *JAMA*, 287, 513-521.
- Annas, G.J. (2005). Unspeakably cruel—Torture, Medical Ethics, and the Law. *New England Journal of Medicine*, 352, 2127-2132.
- Arcel, L.T. (2002). Torture, cruel, inhuman, and degrading treatment of women: Psychological consequences. *Torture*, 2, 2-16.
- Baker, R. (1992). Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. In M. Basoglu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 83-101). Cambridge, England: Cambridge University Press.
- Berliner, P., Mikkelsen, E., Bovbjerg, A., & Wiking, M. (2004). Psychotherapy treatment of torture survivors. *International Journal of Psychosocial Rehabilitation*, 8, 85-96.
- Blight, K.J., Ekblad, S., Persson, J., & Ekberg, J. (2006). Mental health, employment and gender. Cross-sectional evidence in a sample of refugees from Bosnia-Herzegovina living in two Swedish regions. *Social Science & Medicine*, 62, 1697-1709.
- Breslau, N. (2002). Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. *Canadian Journal of Psychiatry*, 47, 923-929.
- Crosby, S., Norredam, M., Paasche-Orlow, M.K., Piwowarczyk, L., Heeren, T., & Grodin, M.A. (2006). Prevalence of torture survivors among

- foreign-born patients presenting to an urban ambulatory care practice. *Journal of General Internal Medicine*, 21, 764-768.
- D'Avanzo, C.E., & Barab, S.A. (1998). Depression and anxiety among Cambodian refugee women in France and the United States. *Issues in Mental Health Nursing*, 19, 541-556.
- D'Avanzo, C.E., Frye, B., & Froman, R. (1994). Culture, stress, and substance use in Cambodian refugee women. *Journal of Studies on Alcohol*, 55, 420-426.
- Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. *Psychological Medicine*, 13, 595-605.
- Eisenman, D.P., Gelberg, L., Liu, H., & Shapiro, M.F. (2003). Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence. *Journal of American Medical Association*, 290, 627-634.
- Eisenman, D.P., Keller, A.S., & Kim, G. (2000). Survivors of torture in a general medical setting: How often have patients been tortured, and how often is it missed? *Western Journal of Medicine*, 172, 301-304.
- Geltman, P. L. (2003). Intestinal parasites among African refugees resettled in Massachusetts and the impact of an overseas pre-departure treatment program. *American Journal of Tropical Medicine and Hygiene*, 69, 657-662.
- Gerristen, A.A., Bramsen, I., Deville, W., van Willigen, L.H.M., Hovens, J.E., van der Ploeg, H.M., et al. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 41, 18-26.

- Human Rights Watch. (2002). *Hidden in plain view: Refugees living without protection in Nairobi and Kampala*. Retrieved November 21, 2006, from <http://www.hrw.org/reports/2002/kenyugan/index.htm#TopOfPage>
- Hynes, M., & Cardozo, B.L. (2000). Observations from the CDC: Sexual violence against refugee women. *Journal of Women's Health & Gender-Based Medicine*, 9, 819-823.
- Iacopino, V., Alden, K., & Keller, A.S. (2001). *Examining asylum seekers: A health professional's guide to medical and psychological evaluations*. Boston, MA: Physicians for Human Rights.
- Istanbul Protocol*. (1999). Retrieved on November 21, 2006, from <http://www.unhchr.ch/pdf/8istprot.pdf>
- Jamil, H., Hakim-Larson, J., Farraq, M., Kafaji, T., Laith, J., & Hammad, A. (2005). Medical complaints among Iraqi American refugees with mental disorders. *Journal of Immigrant Health*, 7, 145-152.
- Jaranson, J.M., Butcher, J., Halcon, L., Johnson, D.R., Robertson, C., Savik, K., et al. (2004). *American Journal of Public Health*, 94, 591-598.
- Keller, A.S., Ford, D., Sachs, E., Rosenfeld, B., Trinh-Shevrin, C., Meserve, C., et al. (2003). The impact of detention on the health of asylum seekers. *Journal of Ambulatory Care Management*, 26, 383-385.
- Keller, A.S., & Gold, J. (2005). Survivors of torture. In B. Sadock & V. Sadock (Eds.), *Kaplan and Sadock's Comprehensive Textbook of Psychiatry* (pp. 2398-2406). Philadelphia: Lippincot Williams & Wilkins.
- Keller, A.S., Lhewa, D., Rosenfeld, B., Sachs, E., Aladjem, A., Cohen, I., et al. (2006). Traumatic experiences and psychological distress in urban

- refugee population seeking treatment services. *Journal of Nervous and Mental Disease*, 194, 188-194.
- Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Posttraumatic stress disorder in the national co-morbidity survey. *Archives of General Psychiatry*, 52, 1048-1060.
- Kleijn, W.C., Hovens, J.E., & Rodenburg, J.J. (2001). Posttraumatic stress symptoms in refugees: Assessments with the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist-25 in different languages. *Psychological Reports*, 88, 527-532.
- Lifson, A.R., Dzung, T., O'Fallon, A., Mills, W.A., & Hang, K. (2002). Prevalence of tuberculosis, hepatitis B virus, and intestinal parasitic infections among refugees to Minnesota. *Public Health Reports*, 117, 69-77.
- Lifson, A.R., Thai, D., O'Fallon, A., Mills, W.A., & Hang, K. (2002). Prevalence of tuberculosis, hepatitis B virus, and intestinal parasitic infections among refugees to Minnesota. *Public Health Rep*, 117, 69-77.
- Marcus, S.G., Villanueva, G., Shamamian, P., Newman, E., Ortega, J., Lam, Y., et al. (1999). Increased risk of gastric adenocarcinoma in East Asian immigrants. *Journal of Surgical Research*, 86, 290.
- Miles, S. (2006). *Oath betrayed: Torture, medical complicity, and the war on terror*. New York: Random House.
- Mirzaei, S., Knoll, P., Lipp, R., Wenzel, T., Koriska, K., & Kohn, H. (1998). Bone scintigraphy in screening of torture survivors. *The Lancet*, 352, 949-951.
- Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma Questionnaire: Validating a cross-

- cultural instrument for measuring torture, trauma, and post-traumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease*, 180, 110-115.
- Mollica, R.F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., et al. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *JAMA*, 270, 581-586.
- Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2004). Comorbidity of PTSD and depression: Associations with trauma exposure, symptom severity and functional impairment in Bosnian refugees resettled in Australia. *Journal of Affective Disorders*, 80, 231-238.
- Montgomery, E., & Foldspang, A. (1994). Criterion-related validity of screening for exposure to torture. *Danish Medical Bulletin*, 41, 588-591.
- Moreno, A., & Grodin, M.A. (2000). Photo/essay: The not-so-silent marks of torture. *JAMA*, 284, 538.
- Moreno, A., & Grodin, M.A. (2002). Torture and its neurological sequelae. *Spinal Cord*, 40, 213-223.
- Norredam, M., Crosby, S., Munarriz, R., Piwowarczyk, L., & Grodin, M. (2005). Urologic complications of sexual trauma among male survivors of torture. *Urology*, 65, 28-32.
- Office of Refugee Resettlement. (2006). *Office of Refugee Resettlement (ORR) services for survivors of torture program*. Retrieved November 15, 2006, from <http://www.acf.hhs.gov/programs/orr/programs/torturep.htm>

- Peel, M., & Iacopino, V. (2002). *The medical documentation of torture*. London: Greenwich Medical Media Limited.
- Quiroga, J., & Jaranson, J. (2005). Politically motivated torture and its survivors: A desk study review of the literature. *Torture, 15*, 1-112.
- Rasmussen, O. (1990). Medical aspects of torture. *Danish Medical Bulletin, 37* (Supplement 1), 1-88.
- Shrestha, N.M., Sharma, B., Van Ommeren, M., Regmi, S., Makaju, R., Komproe, I., et al. (1998). Impact of torture on refugees displaced within the developing world. Symptomatology among Bhutanese refugees. *JAMA, 280*, 443-448.
- Swiss, S., & Giller, J.E. (1994). Rape as a crime of war: A medical perspective. *JAMA, 271*, 745.
- Thorpe, L.E., Laserson, K., Cookson, S., Mills, W., Field, K., Koppaka, V.R., et al. (2004). Infectious tuberculosis among newly arrived refugees in the United States. *New England Journal of Medicine, 350*, 2105-2106.
- Toubia, N. (1994). Female circumcision as a public health issue. *The New England Journal of Medicine, 331*, 712-716.
- United Nations High Commissioner of Refugees. (2006). *2005 Global Refugee Trends*. Retrieved November 15, 2006, from <http://www.unhcr.org/statistics/STATISTICS/4486ceb12.pdf>
- Van Ommeren, M., Sharma, B., Sharma, G.K., Komproe, I., Cardena, E., & de Jong, J.T. (2002). The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety and depression. *Journal of Traumatic Stress, 15*, 415-421.

World Health Organization. (2000). *Female Genital Mutilation*. Retrieved on Monday, May 7th, 2007, from <http://www.who.int/mediacentre/factsheets/fs241/en/>

Yehuda, R., & McFarlane, A.C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry*, 152 (12), 1705-1713.

Chapter 8

The Psychiatric Care of Survivors of Torture, Refugee Trauma, and Other Human Rights Abuses - Summary

Introduction – General Psychiatric Issues

- * Variability in Symptomatology among Survivors
- * Pre-Morbid Conditions
- * Co-Morbid Conditions
- * Posttraumatic Conditions
- * PTSD: Normative or Pathological Response?

Psychiatric Evaluation and Diagnosis

Psychiatric Treatment - Psychopharmacology

- * Biological Models
- * Medication:
 - Anxiolytics/hypnotics
 - Antidepressants
 - Antipsychotics
 - Mood stabilizers
 - Pain medications
 - Psycho stimulants
 - Cognition improving medication
 - Adrenergic blocking agents
- * Medication and Co-Morbid Conditions
- * Psychopharmacology and the Meaning of Medication
- * Hospitalization

Summary

The Psychiatric Care of Survivors of Torture, Refugee Trauma, and Other Human Rights Abuses

Asher Aladjem MD. FAPM.

Introduction – General Psychiatric Issues

Psychiatry has an important role in the identification, evaluation and treatment of the consequences of torture and refugee trauma. Torture has been practiced around the world, throughout history. The penetration of torture into the modern and current human experience has gained more focused attention in recent time owing to: increased number of people re-located as a result of government repression and wars, amplified media coverage of conflict and events of torture, resurgence of terrorist group violence, and the ever-present debate regarding whether torture is ever justified.

Survivors of torture and refugee trauma are a diverse group of men, women and children who have undergone and or witnessed human rights abuses for a long list of reasons, including: their gender, race, religion, political affiliation, social connection and/or sexual orientation. Many of the survivors suffer forced re-location in hostile and unfamiliar environments. They are frequently separated from their family, community, and culture. Survivors of torture and refugee trauma may concentrate in large urban centers where anonymity may be a protective factor in their arduous situation. This anonymity may also result in profound isolation. The context in which these survivors access health care is important.

Increased awareness among health care providers of the prevalence of torture and life altering experiences among immigrants and refugee

populations is of extreme importance, given the growing number of survivors of torture and refugee trauma. Implementing identification and screening methods, and reaching out to the communities most affected by such trauma, are necessary steps to improve access to care. The psychiatric involvement with survivors of torture and refugee trauma encompasses areas of immigrant health, refugee/war trauma, cross-cultural psychiatry, consultation-liaison psychiatry and psychosomatic medicine.

Clinical studies have established that the mental health consequences of torture are usually more persistent and protracted than the physical aftereffects, even though there is frequently significant overlap between the physical and psychiatric sequelae (Engdahl & Eberly, 1990; Keller & Gold, 2005). Physical consequences of torture are visible, such as scars, burns and amputations as opposed to the emotional/psychological scars that are not as evident on exam (see Chapter 7). These psychological scars are much harder to elicit and understand objectively.

The emotional experience of torture is a very subjective life altering experience. For some types of torture, such as rape, head trauma, malnutrition (and many others), it is difficult to determine whether the origin of the presenting symptoms is physical, psychological, or a result of co-morbid medical and/or psychiatric conditions.

The occurrence of co-morbid medical and psychiatric conditions compels collaboration with primary care providers and medical specialists. Availability of resources plays an integral role in access to care, the evaluation process and the choice of treatment modalities provided. In addition, multiple biological models attempt to provide an understanding of the variety of reactions to traumatic experiences that survivors may manifest. The integration and interpretations of these biological models may suggest a

framework for the most effective interventions for particular symptomatic presentations.

The Bellevue/NYU Program for Survivors of Torture (PSOT) evolved from a strong collaboration between primary care medicine, behavioral health psychology and consultation liaison psychiatry/psychosomatic medicine. This integration has increased the range of available interventions, and enabled the program to offer a wide range of multi-disciplinary treatment options. This is a collaborative model in which mental health, medical and social services combine forces to construct a new arena in which to provide care. In our program, patients are treated on site by multidisciplinary clinicians working in the biopsychosocial model. In such a collaborative style, the treatment plan is tailored to the specific needs of each individual patient.

Variability in Symptomatology among Survivors

Survivors of torture and refugee trauma often present with symptoms of posttraumatic stress disorder (PTSD), but clinical experience shows that their presentation is more varied and complex. Although most studies focus on PTSD, neuropsychiatric symptoms are often difficult to diagnose because of the presence of co-morbid conditions and ongoing stressors (Briere & Scott, 2006). Data from studies in treated and untreated populations, in countries of resettlement, refugee camps, and countries of origin, indicate that PTSD and depression are the most common diagnoses (Kinzie, Leung, & Boehnlein, 1997). Furthermore, clinical studies have shown that depression is the most common psychiatric disorder diagnosed in survivors of torture and refugee trauma (Kinzie, Leung, & Boehnlein, 1997; Mollica, 2004).

Suicide is more closely correlated with major depression than with any other psychiatric diagnosis (McGirr et al., 2007). Suicidality also manifests itself among tension reduction behaviors some trauma survivors may use to reduce the abuse-related stress (Briere, 1996; Briere & Scott, 2006; Zlotnick, Donaldson, Spirito, & Pearlstein, 1997). As such, clinicians must be mindful of suicidal risk when treating a client with significant depressive symptoms.

Suicidal ideation and suicide attempts are significantly higher among women who have been victims of assaults (Koss & Kilpatrick, 2001). Ferrada–Noli et al. (1998) studied 65 refugees with PTSD and suicidal behavior (defined as suicidal ideation, plan, or attempt), and found that the choice of method in attempting suicide was related to the trauma they had experienced. A history of blunt force to the head and body was associated with jumping from dangerous heights; water torture was associated with attempted drowning; and sharp force was associated with self-inflicted stabbing or cutting (Ferrada-Noli et al., 1998).

There is a need to review and understand a client's current presentation of symptoms in the context of the client's individual life. The possibility of the existence of pre-morbid conditions, developmental/environmental issues, co-morbid issues, and general life exposure, are essential in the formulation of the diagnosis and treatment. Our experience has been that the majority of the patients suffered from the sequelae of their traumatic experience with no obvious pre-morbid conditions. However, the patients that were identified as having pre-morbid conditions benefited from treatment that addressed the pre-morbid conditions simultaneously. Constant re-evaluation of symptoms and response to treatment should be monitored to avoid under treatment or

continued treatment when patients are stable and no longer in need of treatment.

Epidemiological studies of “high risk” individuals (i.e. those exposed to traumatic events) have revealed varying rates of PTSD occurrence. Estimates of PTSD prevalence among those exposed to traumatizing stressors (as defined by Criterion A in DSM IV-TR [APA, 2000]) range from 3% to 58% (Yehuda & McFarlane, 1995). Careful examination of these rates reveals differing percentages depending on types and severity of traumas.

Studies have shown low prevalence rates reported for populations exposed to natural disasters, and varying but much higher rates for populations exposed to what can be described as “man-made” traumas such as war and crime. Specifically, the lifetime prevalence of PTSD among crime victims has been shown to be anywhere from 19% to 75% (Kilpatrick & Resnick, 1993). Persistent PTSD among prisoners of war and concentration camp survivors has been estimated to occur in 47%-50% (Kluznick et al. 1986; Yehuda & McFarlane, 1995).

A study conducted by the Bellevue/NYU Program for Survivors of Torture (Keller et al., 2006) which represents one of the largest systematic analyses of an ethnically diverse sample of torture survivors, found high levels of psychological distress as measured by standardized symptom rating scales. Roughly half of all patients (46%) fell above the cutoff for identifying clinically significant PTSD, while more than 80% fell above this threshold on measures of depression and anxiety. These levels of distress are particularly striking given that most participants had immigrated to the United States months or years earlier, suggesting that the traumatic

experiences described by this sample had lasting and profound effects on psychological well-being.

The prevalence of PTSD following a variety of traumatic events can thus be summarized in the following way: the rates vary, depending in part on type and severity of traumatic stressor, but cannot be explained solely in relation to the traumatic experience. For example, the prevalence of PTSD is relatively high given stressors such as war and concentration camp experiences, but there are a significant percentage of people exposed to these stressors who do not develop the clinically significant threshold of symptoms for a diagnosis of PTSD. This finding, that trauma itself does not always lead to the development of full or persistent PTSD suggests that additional variables play a role in the development of this cluster of symptoms.

It has become evident over time that a diagnosis of PTSD alone is insufficient to describe the magnitude and the complexity of the effects of torture. PTSD was never intended to encompass the entire range of sequelae following torture, which is severe and usually repetitive in nature (Friedman & Jaranson, 1994). However, the diagnosis and symptom descriptions do provide clinicians with the opportunity to share common knowledge base and terminology from which they can begin formulating treatment interventions (Briere & Scott, 2006).

Pre-Morbid Conditions

Various contributing factors have been investigated to explain what is thought to be an underlying emotional vulnerability to the development of pathological reactions to traumatic events. These have included: genetic factors, family history, previous exposure to trauma (see the discussion of

'kindling' below), personality structure, developmental history, and other life events at the time of the trauma.

Case 1:

A flamboyant male dancer from the former Soviet Union was arrested and beaten by the police in his former country multiple times, following what was perceived by the local authorities to be socially unacceptable, provocative behavior in public places.

At the time he presented for treatment at our program, he suffered from several symptoms of PTSD such as flashbacks, difficulty sleeping, and hyper-vigilance. After careful evaluation, a more prominent psychiatric diagnosis of Bipolar Disorder was formulated.

The symptoms of Bipolar Disorder were thought to be most likely pre-morbid and persisted with the co-morbid symptoms of PTSD reported at the time of the evaluation. This better understanding of the patient's psychopathology allowed more focused remedy with Mood Stabilizer medication (Depakote) resulting in better outcome of treatment of the target symptoms and improved longitudinal adherence to therapy. The psycho-pharmacological treatment enabled the patient to participate in a meaningful form of psychotherapy ultimately achieving better control of symptoms, better adjustment to the new life circumstances and successful relief from his long-standing suffering.

The concept of ‘kindling’ has been described in the literature, and is a useful model for understanding some of the points discussed above (McFarlane, 1996). On the basis of clinical experience with affective disorders, it has been learned that life events play a significant role in first episodes of affective disease, but their importance decreases as the neurobiology of the disorder takes on a life of its own and becomes relatively autonomous of instigating events. This understanding is the basis for the kindling model.

According to this model, there is a “biological memory” of initial episodes of an illness, and later episodes or phases of affective disorder are a consequence of the progressive, now neuro-biologically based vulnerability. Thus, further affective disorder results from heightened sensitivity to affective destabilization, which now requires only mild instigating events or stimuli to develop (Breslau, Chilcoat, Kessler, & Davis, 1999; McFarlane, 1996). As applied to PTSD, this model is used to explain the observation of a modification in the stress responsiveness of individuals previously exposed to trauma. Such a modification is viewed as an important factor in the individual’s vulnerability to symptomatic exacerbation in the face of even relatively mild stressors that, in and of themselves, are not traumatic.

The kindling model suggests that anti-kindling agents (i.e., anti-epileptics), in addition to having some therapeutic value, may also have preventative value. The stress and cortisol-induced neurotoxicity model of PTSD (Hypothalamic-pituitary-Adrenal Axis) suggests that medications that have been found to block stress-induced hippocampal damage, including anti-epileptic and SSRIs and possibly anti-cortisol drugs, may also be useful in preventing PTSD.

Co-morbid conditions

Psychiatric co-morbidity has been reported in 50% to 90% of individuals with chronic PTSD (Yehuda & McFarlane, 1995). In terms of co-morbid conditions, PTSD and depression commonly occur among survivors of torture and refugee trauma. For example, rates of co-morbid depression and PTSD in refugees have ranged from 21% to 40% (Mollica et al., 1999; Momartin, Silove, Manicavasagar, & Steel, 2004).

In addition to depression, a common co-morbid diagnosis in individuals suffering from PTSD is alcohol and substance abuse. Research has shown that people with PTSD are four times more likely to abuse alcohol and drugs than those without PTSD, regardless of their trauma histories (Chilcoat & Breslau, 1998). This suggests that there is a secondary psychopathological process that unfolds following the onset of PTSD, perhaps as a result of individuals' efforts to self-medicate (Briere & Scott, 2006). It is also possible that substance abuse disorders may have existed prior to the development of PTSD. In such cases, substance abuse may be related to predisposing factors, such as previous trauma, or other personality factors related to poor coping skills.

Case 2:

A 35 year old Tibetan patient was tortured for his activism and forced to flee leaving his wife and two small children behind. In New York City he managed to find some employment in construction and lived with a number of roommates in a very small and overcrowded environment. He had such severe symptoms of depression and anxiety that he was self-medicating by abusing alcohol, "drinking myself to sleep." The recurrent and intrusive recollection of his torture, his

sleep disturbance, and his separation from his family were overwhelming for him, affecting his ability to function, support himself, and foresee and plan for a better future. Hopelessness and helplessness were dominant symptoms that influenced his ability to work with his attorney representing his case in immigration court for his application for political asylum.

This patient was started on a Benzodiazepine, Clonazepam 0.5 mg PO at bed time and Mirtazapine 15 mg PO at bed time. He was seen and given prescriptions as frequently as possible but at least every two weeks and he continued to participate in psychotherapy. The medication had to be regulated, increasing Mirtazapine to 30 mg at bed time, and slowly tapering the Benzodiazepine's frequency until it was discontinued. After about 8-10 weeks of treatment this patient was able to sleep better and was able to stop drinking. His functioning had improved, he was granted political asylum, and he was working on bringing his family to join him in America.

The challenges in the treatment of this patient were many:

- The intensity of the symptoms was paralyzing for him and required acute intervention with the expectation of quick relief.
- The co-morbid concurrent alcohol abuse needed to be addressed. The prescribing of psychotropic medication to patients who are also actively abusing alcohol is, at least, controversial.
- The patient was so trapped in feeling guilty and thinking that he deserved to suffer, that the notion of feeling well was contrary to his experience.

- The alternative to out-patient treatment may have led to an involuntary psychiatric hospitalization for a patient currently re-experiencing the trauma of forced imprisonment and torture.
- The safety and management of psychotropic medications including monitoring compliance for an out-patient who works in a potentially dangerous construction job.

A number of studies have noted the effectiveness of psychopharmacological treatment with people suffering from PTSD and other co-morbid conditions. More detailed discussion of these treatments will be covered later in this chapter, in the section on Psychiatric Treatment and Psychopharmacology.

Post-traumatic Conditions

Posttraumatic conditions, such as the presence or absence of social supports, and exposure to subsequent reactivating events or reminders of the trauma, have also been considered to affect the experience of survivors of torture (Yehuda & McFarlane, 1995).

A study of populations exposed to traumas in Turkey revealed that those who remained in their familiar environment fared better than those who immigrated following the events (Basoglu, 1993). This suggests the importance of considering other contributing factors related to the relocation experience itself. Separation from the family is an important contributing factor, particularly in cultures that place a great deal of importance on the family and emphasize each member's interdependence on the family for material and emotional support.

PTSD: Normative or Pathological Response?

It is important to regularly revert to the debate as to whether the presence of PTSD is a “normal reaction to abnormal circumstances” (see Chapter 1). There are practical as well as conceptual pitfalls of using the PTSD diagnosis too globally or loosely to capture the often variegated clinical presentations.

The PTSD diagnosis falls under the rubric of anxiety disorders, and therefore a diagnosis of PTSD indicates, or dictates, a treatment targeting symptoms of anxiety. However a significant number of patients present with a broader array of symptoms than such a specific diagnosis of an anxiety disorder can fully explain. When symptoms of depression, psychosis, dementia, or mood instability secondary to trauma are more salient, or when patients suffer from profound feelings of loss, sadness and demoralization, not currently captured in the DSM IV-TR formulation of PTSD, there is a need to formulate a more comprehensive understanding and tailor treatment to address all the pertinent clinical issues.

Review of the literature provides a reasonable framework that the “emergence of PTSD following exposure to a trauma may represent the manifestation of an underlying diathesis rather than a normative adaptation to environmental challenge” (Yehuda & McFarlane, 1995, p. 1709). Such a statement is important to consider, but must be placed within a context that is extremely complex, and differentiates among types and severity of traumatic events.

Recall that populations that suffer “man-made” traumas have higher prevalence rates of PTSD, in general, than those exposed to natural disasters (Yehuda & McFarlane, 1995). On the basis of clinical experience, it is worth considering that people who are exposed to malevolent, intentionally

harmful perpetrators must contend with a psychological embodiment that is different from the one found in the aftermath of acts of nature (or “acts of God” as some people view them) that do not undermine the capacity to trust and rely upon other people (Laub & Auerhahn, 1993).

In the event of terrorism, for example, people often struggle to comprehend the meaning of the act. Questions are raised regarding the relationship between the perpetrators and the victims. For example, survivors may ask “Why do they hate us?” – reflecting a need to make sense of the disparity in values between the two groups, which are assumed to belong to the same world community with its usually shared core values regarding human life. As such, perceptions of the nature, the severity, and the intent of the violence will affect how individuals experience and react to the traumatic circumstances.

Additionally, underlying diatheses and tolerance levels vary from individual to individual. It is critically important to recognize the contribution of development and personality, not only to the emergence of PTSD, but also to the way PTSD symptoms are experienced and how survivors may react to them. There is also mounting evidence that variations in symptomatology are associated with neuro-biological factors. This topic will be explored further later in this chapter.

Clearly, there are significant areas of inquiry (including: the nature, extent and purpose of the violence; an individual’s pre-existing neuro-anatomical, executive, emotional, and hormonal functioning; and an individual’s previous trauma history) that will affect one’s reactions to traumatic events in very individualized and subjective ways. How ought such an understanding shape the approach to the evaluation, diagnosis and treatment of our patients? How ought this wide-ranging understanding shape

our approach to training? How ought we to "label" those patients whose suffering, while profound, does not precisely fit the PTSD diagnosis as it is currently defined? Are we too limited by current criteria? Are we affected -- by our counter-transference and the accepted diagnostic categories as they currently exist -- to utilize PTSD as the insufficient but only sanctioned and thus effective tool for mobilizing resources?

These questions bring up to date the foundation of the efforts to provide comprehensive, uniquely-tailored care to our diverse patient population. In our program, the focus has been on treatment of symptoms - not diagnoses. This practice is put forth as an undertaking to avoid the extremes of over-generalizing treatment with a "catch-all diagnosis," and /or not providing adequate services when an individual does not meet full criteria for a particular diagnosis.

Perhaps the introduction of a more detailed presentation of aspects of the approach to evaluation and treatment can be illustrated with some clinical case examples.

Case 3:

A 34 year old woman from Mauritania survivor of FGM (Female Genital Mutilation) came to New York from Ohio where she had been living with a husband that she married after her arrival in the US about 3 years earlier. She came to the program asking for help and assistance with her pending political asylum case, family reunification (her 5 year old daughter had been left back in Mauritania), and her inability to keep up with her computer course (she had registered for the course to learn a marketable skill to support herself). At the time she was earning some money by braiding

hair, wandering from home to home of her clients, staying for few days and moving constantly. She reported that she had left her home and her husband in Ohio due to being mistreated. She did not want to re-instate any contact with him.

During the psychiatric evaluation it became apparent that her thinking was highly disorganized. Her reporting of past events was vague, inconsistent, and at times, incoherent. Her mood was labile, laughing and crying with minimal stimuli, and being unable to describe her thoughts articulately. She engaged in treatment with a plan to participate in individual and group psychotherapy. Her attendance of group sessions was minimal due to her feeling of shame and discomfort in sharing her experience with other people. Her ability to engage in psychotherapy was also impaired due to her inability to adhere to a schedule and to a methodical exploration of her emotional experience. At that point her treatment was enhanced with the addition of a Sertraline 50 mg daily and low dose neuroleptic, Risperidone 0.5 mg at bed time. The target symptoms of this medication regimen were the disorganized thinking, mood lability, anxiety and insomnia. It was a challenge to get an accurate sense of her adherence/ compliance with the medication but she kept coming back for appointments requesting renewal of prescriptions.

The treatment with medication continued over few months and her ability to participate in treatment increased. At the same time she was able to advance her immigration case and brought her daughter to the US to avoid her exposure to FGM. Currently, the patient is on

Sertraline 200 mg daily and her overall functioning has much improved.

.Case 4:

A young Bosnian woman who had been raped by a Serbian official presented for treatment. She was one of an estimated 50,000 women raped as part of the ethnic violence in the former Yugoslavia.

The patient was kept in detention camp throughout the pregnancy to prevent any plan of termination/abortion. As a result she carried the baby to term and then gave it up for adoption. The patient was being treated with psychotherapy and psychopharmacology for symptoms of Depression and PTSD. She was on Sertraline 100 mg daily and Clonazepam 0.5 mg at bed time.

During the course of psychotherapy, the patient's therapist became pregnant. Issues regarding pregnancy were discussed within the therapeutic dyad, and the patient eventually became pregnant, as she and her husband had initially planned. Once pregnant, the medications had to be stopped with the understanding that the patient needed to remain medication-free for the duration of the pregnancy.

During the pregnancy the patient suffered re-occurrence of symptoms that had already responded to treatment with medications. These symptoms included: irritability, nightmares, flashbacks, and reliving the experience of the traumatic rape and the symptoms of the pregnancy that resulted from it.

She was treated with intensive psychotherapy throughout the pregnancy and was restarted on anxiolytic and anti-depressant medications soon after giving birth. She made the decision not to breastfeed so she could be started on medication immediately post partum. Psychotropic medications are not recommended during breast feeding.

Psychiatric Evaluation and Diagnosis

Psychiatric services at the Bellevue/NYU Program for Survivors of Torture generally follow the framework and model of a Consultation-Liaison Psychiatry service. Psychiatrists and psychiatry residents are often referred patients for evaluation from other clinicians for more specific diagnostic evaluation and for targeted psycho-pharmacological interventions. The clinicians in other disciplines, most frequently staff psychologists and psychology trainees such as psychology interns and psychology externs, are assigned to evaluate and treat patients within the program. They work closely with the psychiatrists in a team approach with bi-directional referrals. In this way clinicians progressively familiarize themselves with other treatment modalities, increase their level of comfort in integrating these modalities in treatment, and enhance the effectiveness of the comprehensive care they provide.

Patients are seen for an initial intake appointment and go through a screening interview, which includes a mental status examination and two psychological measures (see Chapter 5). Those patients who score high on anxiety and trauma symptoms scales and/or report symptoms suggestive of

significant distress and difficulty coping are referred for more focused evaluation. Most of the initial referrals for mental health treatment are referred to psychologists for individual and/or group therapy. Alarming symptoms such as suicidal ideation, with or without a specific plan, extreme despair or high anxiety, will trigger an immediate, high priority referral for further psychological and psychiatric evaluation.

After the initial evaluation and a decision that the patient would be able to benefit from the comprehensive services provided by the program, the patient is generally referred to an orientation group. The purposes of the orientation group are to provide psychoeducation regarding common symptoms and reactions among survivors of torture and refugee trauma, to provide some training on relaxation and deep breathing techniques, to inform patients of the resources and services available to them (in the hospital and the community), and to empower them to proactively access these resources.

The initial clinical presentation may be affected by such factors as: problems in communication, language, and clients under-reporting or over-reporting of symptoms on the questionnaires. Clients may not be familiar with the existence of symptoms as such, and may have difficulties conceptualizing or verbalizing them with transparency.

Many emotional symptoms are described and manifested differently from culture to culture. Consequently, subtle somatic complaints linked to emotional distress require active solicitation with cross cultural sensitivity and competence. Primary care physicians and/or psychologists participate in ongoing dialogues with their psychiatric colleagues to further explore such clinical presentations (see Chapter 2).

Given this interdisciplinary functioning within our program, the psychiatric evaluation functions in a narrower context than it might with a different population; or even within a different program treating a similar population in a different programmatic system. In our program, the psychiatric evaluation captures a “snap-shot” in time of a client’s functioning. The evaluation is symptom focused, and it is structured to provide a guide on how to best provide treatment geared toward symptom reduction.

With a general outpatient population, the psychiatric evaluation would also explore and pay meticulous attention to a client’s life history, and the emotional meaning they attach to the salient life events. But since the evaluating psychiatrist is receiving the referral through the “filters” of other clinicians that are already working on some of the somatic symptoms and psychodynamic formulations, we tend to focus more strictly on identification and alleviation of current psychiatric symptoms. Fears, sadness, insomnia and other somatic complaints have been common complaints. When there is a history of traumatic brain injury, special attention is paid to issues of memory impairment, difficulties with concentration, and other symptoms of impaired cognition. As such, symptoms are elicited and referrals are made for neuro-psychiatric and neurological examinations. As a member of an evaluating team of clinicians, the evaluating psychiatrist is compelled to offer the patient a more targeted intervention.

The multi-tiered, programmatic evaluation assesses dimensions of the patient’s experience and presentation, in order to collect an inclusive synopsis. Such an outline is captured by the DSM-IV TR multi-axial system (APA, 2000), which covers the following: Clinical Disorders, Personality

Disorders and Mental Retardation, General Medical Conditions, Psychosocial and Environmental Problems, and Global Assessment of Functioning (GAF). Once such a summary is produced, a working diagnosis is formulated and a treatment plan is tailored to the patient's specific needs and presentation.

Some patients clearly meet diagnostic criteria for Posttraumatic Stress Disorder (PTSD), without significant clusters of symptoms that would be sufficient to warrant an additional diagnosis. To warrant such a diagnosis, a client must be exposed to traumatic circumstances in which his or her physical or emotional integrity is threatened, and have significant positive symptoms along three axes: symptoms of intrusion, symptoms of avoidance and withdrawal, and symptoms of hypervigilance. However, survivors of torture and refugee trauma frequently present with a history of multiple traumatic experiences and describe painful feelings of loss or alienation that while difficult, do not fit any psychiatric category suggesting psychopathology captured by a diagnosis of PTSD (Briere & Scott, 2006). We re-emphasize the point that our program clinicians identify and treat symptoms, not diagnoses. Patients suffering intense reactions do merit treatment, even in the absence of a specific and definitive psychiatric diagnosis.

Other survivors present with an intricate clinical representation suggestive of multiple diagnoses. A patient may suffer symptoms of PTSD, but relate a life narrative that indicates the presence of poor coping skills and/or other personality dimensions that pre-date the trauma. For instance, a person may have a life-long history of difficulty establishing meaningful or stable relationships, problematic dealings with authority figures, or a tendency for impulsive or self-destructive actions and behavior.

Additionally, patients may have developmental deficits such as learning disabilities. These deficits may have affected their ability to function and adjust to novel situations even before the traumatic event, and continue to do so subsequent to the event. Other survivors present with substance abuse histories, which also predate the trauma and certainly complicate coping once the trauma has occurred. In such cases, the treatment plan includes psychotherapeutic and psychopharmacological interventions reflecting a psychodynamic formulation that places the person's current symptoms within the context of his or her life and pre-trauma, base-line personality.

Case 5:

A 52 year-old woman from China fled following her arrest, prolonged detention in isolation, and risk of repeated interrogations. During the detention she was frequently beaten all over her body. These actions were inflicted reportedly because of suspected contacts with the Western world.

Once in New York, she found herself in the streets, collecting soda cans in an attempt to support herself. At that time she was robbed of her few belongings which included her passport that was her only identifying document. Subsequently, she was hospitalized in a psychiatric unit, and referred to the Bellevue/NYU Program for Survivors of Torture upon discharge.

Due to her level of disorganization, she missed the deadline for filing her asylum application. Her overall presentation was one of great

disorganization, with labile, silly, regressed affect. Ms. L was diagnosed with a psychotic disorder in the range of schizophrenia, disorganized type vs. schizoaffective disorder and treated with both antipsychotic (Risperdal 2mg po BID) and antidepressant (Zoloft 100 mg po Daily) medications. Her symptoms improved dramatically.

Ms. L was able to mobilize resources through her church, obtain legal representation, and was able to go through the asylum process successfully. She was able to apply for her husband to join her in the US.

Case 6:

An Afghani couple that escaped the Taliban presented to our clinic, seeking help for the husband who had reportedly been injured in the war. The referring agency believed that he had sequelae from this war injury, and viewed him as “shell-shocked.” The wife, an articulate, pleasant woman in traditional clothing, described their marriage as an arranged marriage and hinted that her husband was developmentally impaired. They had three young children and the husband was unable to work and support the family.

The husband would have angry, violent outbursts, would walk out of the home in the middle of the night, could not be trusted with the children, and generally required constant care and supervision.

Careful assessment of this man revealed that he suffered from a severe developmental disorder. He was recruited to fight the war in

Afghanistan during the conflict with the old Soviet Union despite his deficit, and was injured at that time. He did suffer PTSD symptoms from the war trauma, such as flashbacks, that were super-imposed on his baseline of limited functioning, mood lability, and violent outbursts. His symptoms were targeted with anti-depressant and antipsychotic medications, which were selected in order to enhance his cognition and achieve behavioral control. His functioning stabilized and improved, leading to a more successful adjustment for his whole family.

Psychiatric Treatment-Psychopharmacology

As discussed above, survivors of torture and refugee trauma present with very diverse psychological and physical symptoms. Psychopharmacology is an important tool in the treatment of these symptoms. Keeping in mind that there are many biological models conceptualized in the understanding of PTSD, anxiety, and depression, it is obvious that the armamentarium of medications available is vast.

Biological Models

Conceptualizing psychopharmacological treatment for survivors of torture and refugee trauma follows the biological models most associated with posttraumatic reactions. These biological models provide explanations for the emergence of symptoms associated with such life experiences, and attempt to illustrate the physical changes that follow.

Torture and other traumatic events cause changes in an individual's life experience, and there is mounting evidence that these changes are

associated with neuro-biological functioning. A comprehensive model remains elusive, as no one model will suffice to describe the entire pathophysiology involved in the manifestation of posttraumatic stress (Scott & Briere, 2006). Most neuro-biological studies associating sequelae of traumatic events on the CNS have primarily focused on two systems.

First, there are differences between individuals in terms of their neuro-anatomical make up. These differences cause variations in terms of individual vulnerability and pre-disposition to severe emotional reactions subsequent to traumatic events (Du & Lu, 1997). One must also consider the extent of the neuro-anatomical changes caused by the trauma itself (Scott & Briere, 2006). The extent of the changes will greatly impact an individual's ability to cope with the trauma, emotionally and physically.

Secondly, neuro-transmitters are highly involved in the way the brain processes and reacts to acute traumatic events. The brain responds to acute stress by releasing various neurotransmitters that allow the body to respond adaptively. Such sympathetic release is implicated in the hyper-arousal cluster of symptoms.

The brain's utilization of neuro-transmitters in response to a traumatic event will impact upon two systems directly linked to an individual's hormonal and emotional processing: the sympathetic nervous system (i.e. Brender, 1982; Malloy, Fairbank, & Keane, 1983), and the hypothalamic-pituitary-adrenal axis (i.e. Mason, Giller, Kosten, Ostroff, & Podd, 1986). These processes impact on a survivor's emotional functioning in the following ways:

- * Symptoms of intrusive memories and symptoms of hyper-arousal are thought to be in part due to adrenergic hyperactivity.

- * Chronic hyperactivity of the catecholamine, subsequent to continued and repeated stress, can result in down-regulation of receptors in the locus coeruleus. This contributes to the avoidant, depressive, numbing, and social withdrawal symptoms frequently reported by survivors of torture and traumatized refugees.
- * Serotonergic depletion seems to be responsible for impulsivity, irritability, and affective dysregulation.
- * The endogenous opioid system, with the increased release of endogenous opiates, seems to be responsible for numbing and depressive symptoms.

These reactions will also vary from person to person, and therefore create a wide-range of emotional and physical reactions to trauma between different individuals. As such, a firm grasp of these biological systems can be a good starting point for gaining insight on how the brain is reacting to repetitive traumas, and providing some bio-physiological basis for understanding the symptom profile of a particular survivor of torture.

Medication

During the psychiatric evaluation the psychiatrist must elicit the psychiatric symptoms in order to formulate a psychiatric diagnosis, when and if present. After evaluating a client's presenting symptoms, a psychiatrist will develop a treatment plan, which may, when indicated

include a psychopharmacological intervention. The premise is that there is no one treatment that is effective for all.

The evaluation and the treatment plan are symptom based, and include different categories: Target symptoms, breakthrough symptoms, residual symptoms, associated symptoms, and adverse events. Remission of symptoms is the desired outcome criteria.

The asymptomatic state may remain elusive for a long period of time, and possibly never be reached. Reduction in the intensity of symptoms may be an initial amelioration that should be considered as an improvement and an indication to continue treatment, and not as the ultimate desired outcome. The crucial distinction to be considered is between patients getting better and reaching a durable asymptomatic state of well being.

It is common to under-medicate and not maximize treatment based on self reporting of some improvement in the presenting symptoms. The outcome measure has an objective observable component but it is mostly based on self reporting. Patients may be very eager to report improvement and could become resistant to change or increase in medication. It may require great conviction on the part of the treating psychiatrist in following recommended treatment algorithms, keeping constantly in mind the goal of treatment - a symptom free state.

The treatment decision between classes of medications is based on the patient's presentation of symptoms, and a review of the most current body of knowledge and literature, and understanding of which class of medication is proven to be the most effective class for the particular symptom profile. The choice of a particular medication within each class is most frequently based

on the side-effect profile, pharmacy formulary, and the familiarity and experience of the psychiatrist with the specific medications.

Different medications within a class engender different secondary effects, some which may help target symptoms and others that may not be tolerated as well and cause some discomfort. The choice of medication is therefore predicated on finding the medication and the right balance that will maximize the positive effects and minimize the disconcerting ones.

We begin a discussion of psychopharmacological treatment by identifying the classes of medications most often used to treat the presenting symptoms we see in our client population:

- * Anxiolytics/hypnotics
- * Antidepressants
- * Antipsychotics
- * Mood stabilizers
- * Pain medications
- * Psycho stimulants
- * Cognition improving medication
- * Adrenergic blocking agents

Anxiolytics/Hypnotics

Anxiolytics are indicated when the symptoms of anxiety are prevalent, acute, and require fast relief. This group of medication has high addiction potential and their use should be controlled and for short term use only. The fast action of this class makes it useful while waiting for other classes of

medication to take effect. Tolerance and dependence make long-term management with these medications complex and potentially unsafe.

Anxiolytics are classified by their long or short-term action properties. Half-lives of anxiolytics range from 1-6 hours to 24-36 hours. Different rates of absorption vary according to lipophylic properties. Equivalent doses of different anxiolytics refer to a base dose of Diazepam 5mg.

These medications are used for their hypnotic effect as well. The medications with short and intermediate half life are more effective in inducing sleep and the longer half-life in maintaining sleep.

Benzodiazepine	Dose Equivalent	Half Lives
Diazepam (Valium)	5mg	Long
Lorazepam (Ativan)	1mg	Intermediate
Clonazepam (Klonopin)	0.5 mg	Long
Alprazolam (Xanax)	0.25mg	Intermediate
Chlordiazepoxide (Librium)	10 mg	Intermediate
Zolpidem (Ambien) (non benzodiazepine)	2.5 mg	Short
Buspiron (Busapr)	5-60 mg	Intermediate
Zaleplon (Sonata) (non benzodiazepine)	10-20 mg	Short

Antidepressants

Antidepressant medications are indicated when symptoms of depression are prevalent and/or when symptoms of anxiety and depression co-exist and should be targeted at the same time. Different classes of antidepressants have different mechanisms of action and side effect profiles. These different properties are beneficial to target clusters of symptoms and can provide guidance in the selection of a particular medication. The metabolism of these medications by liver cytochromes is an important indicator for side effects profile. Drug-drug interactions and adverse effects must always be considered carefully. The most frequently used groups are: SSRI, NSRI, and TCA.

SSRI- Serotonin Selective Reuptake Inhibitors:

Research and clinical experience have overwhelmingly established the effectiveness of SSRIs as a class of medication in the treatment of symptoms of depression and associated anxiety. As such, SSRIs are considered as the first line of treatment, and some of the specific medications have gained FDA approval for the use in the treatment of PTSD. It is this writer's experience that symptom focused treatment is better managed than diagnosis based treatment.

Frequent and careful adjustment of these medications is indicated to monitor response to treatment and maximize outcome. Addressing side effects is crucial to assure compliance and adherence over time. A familiar reaction of patients to treatment is that when they start feeling better, they stop taking the medication, preventing them from reaching a completely symptom free state.

Antidepressant	Dosage
Fluoxetine (Prozac)	20-80mg QD
Sertraline (Zoloft)	25-200mg QD/QHS
Paroxetine (Paxil)	20-60mg QD
Fluvoxamine (Luvox)	25-100mg QD
Citalopram (Celexa)	20-40mg QD/QHS
Escitalopram (Lexapro)	10-20mg QD/QHS

NSRI- Non-Selective Reuptake Inhibitor

Non-selective reuptake inhibitors have a different mechanism of action by regulating 3 biogenic amines (serotonin, epinephrine, and dopamine) and can be used as first line of treatment based on the desired side effects profile, such as being more or less activating or sedating. Mirtazapine, being relatively more sedating, is frequently used as a bed time dose to help with regulating sleep and avoiding the use of a second sleeping aid medication.

Medication	Dosage
Venlafaxine (Effexor XR)	25-225mg QD/QHS
Bupropion – (Wellbutrin XL)	150-300mg QD
Mirtazapine (Remeron)	15-45mg QHS
Trazadone (Desyrel)	50-400mg QHS

TCA- Tricyclics Antidepressants

Tricyclics are the oldest class of antidepressant medication. Currently they are less commonly prescribed but are very important for their historical value and as part of the useful armamentarium of anti-depressant treatment. TCA are also used in different combination for augmentation of treatment. These medications have been used worldwide and may have been a part of the treatment that some of the patients received in their country of origin. Familiarity with these medications is useful in the reporting of treatment experience. Amitriptyline has been used extensively in many countries as a treatment for depression, anxiety, induction of sleep and to increase pain threshold. Other TCA's include:

- *Clomipramine (Anafranil)
- *Imipramine (Tofranil)
- *Amitriptyline (Elavil, Endep, Tryptizol; Loroxyll)
- *Nortriptyline (Pamelor, Noratren)
- *Protriptyline (Vivactil)
- *Maprotiline (Ludomil)
- *Amoxapine (Asendin)
- *Doxepin (Sinequan, Adapin)
- *Desipramine (Norpramin, Pertofran)
- *Trimipramine (Surmontil)

Antipsychotic Medications

Antipsychotic medications are effective in the treatment of acute and chronic psychotic symptoms. The use of this class of medication is not common for treatment of patients who do not suffer clear psychotic and/or

severe anxiety symptoms. At times it may be a challenge to elicit, distinguish, and clearly define impairment in reality testing. In these instances careful prescribing from this class of medications can be safe and extremely effective.

Psychotic symptoms should be treated with antipsychotic medications independent of co-morbid conditions that may exist simultaneously. Depression with psychotic features, or a patient suffering from PTSD who is very fearful and paranoid of people, could be indications for anti-psychotic medications.

The typical anti-psychotics are generally dopamine receptor antagonists, based on the theory that excess dopamine could be contributing to the etiology of disorganized thinking leading to poor reality testing and psychotic states. Typical anti-psychotics are also mostly known for their historical value, and have been used (as well as abused) in several countries as a treatment for survivors of torture.

Antipsychotic Medication	Potency	Dose Equivalent
Chlorpromazine (Thorazine)	Low	100mg
Thioridazine (Mellaril)	Low	100mg
Haloperidol (Haldol)	High	2-10mg
Perphenazine (Trilafon)	Medium	10 mg

The atypical anti-psychotics are newer medications. These have been established as a first line of treatment for their effectiveness, side effects

profile, and safety. They are both serotonin and dopamine receptors antagonists. They are very effective for both positive symptoms such as delusions and hallucinations, and also for negative symptoms such as social withdrawal and isolation.

Atypical Antipsychotic Medications	Dosage
Risperidone (Risperdal) Janssen	1-3mg BID
Olanzapine (Zyprexa) Lilly	5-10mg QD
Quetiapine (Seroquel) Astra Zeneca	100-400mg BID
Ziprasidone (Geodon) Pfizer	20-80mg BID
Clozapine (Clozaril) Novartis	12.5-50mg TID
Aripiprazole (Abilify) BMS	10-15mg QD

Mood Stabilizing Medications

The class of Mood Stabilizing medication is indicated primarily in the treatment of Seizure Disorders and Epilepsy. They have also been established as the treatment of choice for Bipolar Disorder and severe symptoms of mood instability, impulsivity and agitation. Some of these medications have been used for a long time worldwide, and some patients may report having been prescribed such treatment.

These medications are also not commonly indicated in our patient population, but familiarity with them is essential. Survivors of torture may suffer pre-morbid conditions such as Bipolar Disorder, or they may have a history of Traumatic Brain Injury (TBI) and co- morbid Seizure Disorder. Except lithium, most of the medications in this class are primarily anti-seizure medications, and require careful monitoring of compliance and blood levels.

Mood Stabilizing Medication	Dosage
Lithium carbonate(Eskalith)	300-450mg TID
Valproate (Depakote)	250-500mg TID
Carbamazepine (Tegretol)	200-400mg BID
Gabapentin (Neurontin)	300-600mg TID
Topiramate (Topamax)	50-400mg QD
Oxcarbamazepine (Trileptal)	300-600mg BID
Lamotrigine (Lamictal)	100-200mg QD

Pain Medications

Pain is a very common symptom, especially among our traumatized client population. It becomes more challenging when there is no direct organic, easily recognizable, etiology. Pain is considered as the 5th vital sign, and needs to be addressed. Pain medication is divided into different classes.

The first line of treatment is Acetaminophen (Tylenol) and non-steroidal anti-inflammatory preparations such as: Aspirin and Ibuprophen. These medications are available “over the counter” and are easily managed. More potent non-steroidals are available by prescription. It is important to note the significant potential for gastrointestinal symptoms from these medications.

The second line of treatment is comprised of the Opiates, such as: Codeine, Morphine, and Fentanyl. These medications have high addiction

potential and are controlled substances. They should be prescribed with caution and for short periods of time.

When it is perceived that the pain may have psychological and emotional influences, anxiolytics, antidepressants, and mood stabilizing medications can be used. As a psychological component is involved, these psychopharmacological medications have proven to be helpful in addressing physical sensations. Trials of antidepressant medications have been described as alleviating pain symptoms by increasing the pain threshold (i.e. Peghini, Katz, & Castell, 1998). Anti seizure and mood stabilizing medications have also been effective in addressing pain symptoms. These may be indicated in situations when pain symptoms have been resistant to other forms of treatment.

Psycho-Stimulant Medications

Psycho-stimulant medications are an effective class of medications that are indicated predominantly for conditions such as ADHD (Attention Deficit Hyper Activity Disorder) and Narcolepsy. They are very fast acting and as a result have high addiction potential.

In treatment of depressive symptoms, psycho-stimulants are used for augmentation of treatment. This augmentation is indicated in situations in which waiting for a few days for the antidepressant medication may be of serious concern. In such situations, an antidepressant regimen is initiated simultaneously with a psycho-stimulant for more immediate effect. Subsequently, the psycho-stimulant is discontinued when there is some clinical response to the anti-depressant regimen. Psycho-stimulants are rarely prescribed for extended periods of time.

Cognition Improving Medications

Dementia is a marked deterioration in cognitive functions and is a very serious condition. Dementia has a long list of possible etiologies including traumatic brain injury and substance abuse. In situations in which no other co-morbid medical condition could provide a possible etiology, there are medications that can be used to slow the progression of these symptoms and possibly reverse them.

Survivors of torture may suffer cognitive decline, even though it has only been recognized sporadically with clients in our program. Regardless of its prevalence, and because of the devastating implication of such symptoms, the evaluation of cognitive functions should always be included in a comprehensive medical and/or psychiatric evaluation.

Medications that are available to address such cognitive decline include:

- Donepezil Hcl (Aricept),
- Rivastigmine tartare (Exel),
- Galantamine hydrobromide (Reminyl)
- Cognex

The above listed medications perform by delaying the breakdown of acetylcholine. This is achieved by inhibiting cholinesterase, the enzyme that is responsible for its embolism. Since acetylcholine is an important neurotransmitter for cognitive functions, having more acetylcholine available in the neuronal synapse can improve symptoms for those suffering from diminished cognition. Mematine (Namenda) is a new agent that can extend memory and cognitive functioning by blocking excess amounts of glutamate.

Adrenergic Blocking Agents

Symptoms of intrusive memories and symptoms of hyper-arousal are thought to be in part due to adrenergic hyperactivity. In our experience with adrenergic blocking agents, we have observed that beta adrenergic blocking agents (like Propanolol), and alfa adrenergic agonists (like Clonidine), have resulted in improvement of such symptoms, both in acute and chronic presentations.

Medication and Co-Morbid Conditions

As mentioned earlier in this chapter, psychopharmacological interventions have proven to be effective in treating many co-morbid psychiatric conditions. Brady, Sonne, and Roberts (1995), studied the treatment of co-morbid PTSD and alcohol abuse with SSRI anti-depressants. The medications were well tolerated, and were related to decreased alcohol consumption.

Dow and Kline (1997) found that when treating patients with co-morbid depression and PTSD, that SSRIs (Sertraline and Fluoxetine) were more effective than TCAs (Nortriptyline and Desiparmine), when patients were treated with the anti-depressant at therapeutic levels for at least one month. Brady and Clary (2003) also concluded that treating patients suffering from PTSD, as well as current co-morbid depressive and anxiety disorders, with Sertraline 50-200 mg/d was effective and well tolerated.

Smajkic et al. (2001) used three antidepressants to treat Bosnian refugees in the Chicago area. They also found that Sertraline and Paroxetine produced statistically significant improvement at 6 weeks in PTSD symptoms, severity in depression, and Global Assessment of Functioning.

They reported that Velafaxine produced improvement in PTSD symptom severity and Global Assessment of Functioning, but did not yield improvement in symptoms of Major Depressive Disorder. Velafaxine also had high rates of side effects. Notwithstanding improvement of symptoms, all patients remained PTSD positive at the diagnostic level at the 6-week follow-up.

Hamner et al. (2003) worked with survivors of torture who presented with positive and negative symptoms of psychosis co-morbid with PTSD. They reported that the use of Risperidone was linked with a significant decrease in the global psychotic symptoms associated with PTSD, and was linked with improvement in core re-experiencing symptoms as well.

Psychopharmacology and the Meaning of Medications

Referral for psychiatric evaluation and the decision to recommend medication are complex issues, reflective of the conceptualization of trauma, symptoms, coping, and the therapeutic context. Furthermore, other influencing variables are: the background preparation and level of comfort with medications among the different clinicians, and the range of attitudes toward receiving psychiatric medications conveyed by culturally diverse patient populations.

Some patients express familiarity with medications and a strong desire for those medications which may have been readily available in their home countries. They may have the conviction that these medications helped them survive previous hardships. Such attitude leads to the belief that these medications could be useful in “pulling them through” present and possibly future difficulties. Some of these patients may meet criteria for a diagnosis of Benzodiazepine dependence. Other patients may be distrustful of

authorities subsequent to their abuse (Scott & Briere, 2006), or may come from countries where medications are culturally incongruent. Or they may reject the notion of medication, viewing it as an assault on their integrity.

These positions represent two extremes. In the middle lie those patients who have had mixed experiences and some knowledge of psychiatric medications. Other patients may have different levels of ambivalence about medications and those who accept the doctor's prescription out of submission to authority and a strong wish to please the physician.

Frequently, patients who are open to the idea of psychiatric medications are comfortable accepting medications for specific symptom relief such as sleep or pain, as these are viewed as physical symptoms and therefore less stigmatized, guilt-free, and more socially acceptable. Corresponding diversity is present among clinicians. Internists, specialists, psychologists and social workers will have different rates of referrals for psycho-pharmacological evaluation based on their prior experience, recognition of symptoms and confidence in the outcome and effectiveness of treatment.

It is important to recognize, however, that patients who have suffered the multiple traumas of persecution, torture, and immigration, often experience sadness and deep feelings of loss and displacement, which cannot be "cured" with medication alone. Medication can offer symptom relief and enable patients to engage in psychotherapy, which then facilitates the painful process of addressing profound changes in one's self and worldview.

In fact, it is important to recognize that the practice of psychopharmacology includes a consideration of psychodynamics, and a comprehensive understanding of the patient's experience. Psychotherapy

and psychopharmacology should not be viewed as disjunctive, but rather as points along a continuum of care. Medications can help patients in their efforts to build a new life while navigating multiple stressors. However, outcome measures of treatment with psychotropic medications should be realistic and monitored carefully.

The following case is an example of a patient who discontinued her treatment with psychotropic medications because she experienced it as interfering with her suffering:

Case 7:

Ms. Q is a professional woman in her early thirties from a nation in Northwestern Africa. Her traumatic experiences dated back almost twenty years prior to her arrival at the Bellevue/NYU Program for Survivors of Torture. Her family had been targeted because her father was involved in human rights advocacy. She and another sibling were arrested along with the father, and they were subsequently separated from him. The father was executed and the children were imprisoned. Ms. Q was sexually abused, beaten, and verbally humiliated. Her other imprisoned sibling was killed.

Ms. Q was referred to our program by an international human rights group. She presented with symptoms of Major Depression and was referred for individual psychotherapy and psychopharmacological treatment. She was prescribed treatment with antidepressant medication. After only a few days on the medications, Ms. Q confided to her therapist that she wished to stop taking the antidepressant.

Ms. Q reported feeling flat, uncomfortable and “not like myself” while medicated (even though her SSRI medication would not reach its therapeutic level for at least another couple of weeks). She stated that “When I feel sad at least I know that the pain is mine.” The idea of being relieved from some of her symptoms triggered such sentiments of guilt, loss, and emptiness that it was intolerable for her.

Ms. Q discontinued her medication regimen, but continued with psychotherapy. Her symptoms of depression gradually remitted, but were occasionally reactivated by external stressors, particularly as she re-engaged in human rights advocacy. Supportive therapy helped her to try to strike an emotionally viable balance between her needs to heal and to advocate for change.

In light of this discussion, the process of referrals for evaluation for psychiatric medications deserves additional attention. As mentioned earlier in this chapter, sometimes clients are not directly referred for psychiatric treatment after their intake interview. Frequently, it is the primary care physician that will first identify the need for psychopharmacological treatment. The primary care physicians in our program are trained in psychopharmacological interventions, and will generally prescribe the medicine that they feel is appropriate. A subsequent referral to a psychiatrist is generally facilitated in one of several ways.

The first scenario is one in which the primary care provider prescribes the medication and monitors the patient’s progress. If the PCP is not satisfied with the response to treatment and finds that there is insufficient clinical progress, he or she will then refer to a psychiatrist for a consultation.

The second scenario for referring is when the PCP provides the patient with the initial prescription, but will immediately refer the patient for psychiatric follow-up. Thirdly, the PCP may refer the patient for psychiatric evaluation without having prescribed any medication. All of these processes have been used in our program, largely depending on the primary care physician's level of training in psychopharmacology, and their comfort in prescribing psychotropic medications.

There are other factors that affect how psychiatric referrals are facilitated. Health professionals refer patients for psychopharmacological evaluations based on their own attitudes towards medication and counter-transference reactions. Physicians following a more medical model may refer patients for medication evaluations more often than for psychotherapy. Psychotherapist may delay referring their psychotherapy patients for medication evaluations because of a wish to avoid "split" care. Furthermore, counter-transference, and a lack of familiarity with the range of available medications and biological theories, also limits the rate of referrals. The Bellevue/NYU Program for Survivors of Torture provides ongoing constructive exchange of information and ideas between clinicians from different disciplines that contributes to appropriate referrals, evaluations and truly collaborative treatments.

What messages does the clinician give the patient by prescribing medications? Generally, when the clinician prescribes medications, he or she may communicate the hope of alleviating some symptoms by providing medication, or they may be perceived by the patient as conveying the sense that "I am powerful, I can cure you of your distress." If the patient continues to suffer despite taking the medications, such as when the patient continues

to express sadness, feelings of loss, or a lack of complete relief from symptoms, a common response by clinicians is to rush to change medications, sometimes before maximizing and waiting for them to take effect. This rush to change often arises out of the clinician's need to be effective and not disappoint the patient's expectations.

It is important to clarify the message perceived by the patient. Commonly, a prescription of medication suggests a disease to be treated, and patients may be reluctant to accept a disease model of their distress. Therefore a discussion regarding the meaning of the medication is essential.

Medications have important meaning for patients, their significant others, and all involved in their care. This meaning should be explored and addressed. The clinician should continue the exploration and understanding of the meaning of medication for the duration of treatment, since such meaning may continue to evolve with treatment. Interpretation of the power, limits, and significance of the medications could become an important component of the overall treatment and care provided. If hidden meanings are not addressed, treatment with medications is more likely to fail, and patients are more prone to conclude, erroneously, that medications cannot be helpful, or alternatively that they themselves cannot be helped.

Hospitalization

The large majority of the patients at the Bellevue/NYU Program for Survivors of Torture are seen on an outpatient basis for medical care, psychotherapy, or psychiatric follow-up. At times, inpatient treatment and hospitalization may be indicated for medical, surgical or psychiatric treatment.

Psychiatric hospitalizations are described as informal, voluntary, and involuntary. When hospitalization is indicated the clinician must weigh the patient's past trauma experience carefully, so as to decide upon the proper treatment as well as introduce it to the patient in a sensitive manner that is culturally congruent and responsive to particular circumstances in the patient's life.

Patients may fear isolation and the temporary separation from their families or other supports systems. Others with limited supports may fear the loss of independence, freedom, and or the loss of a job or shelter. The meaning of hospitalization may expand to other implications and meanings and trigger symptoms related to trauma. Patients may worry that a hospitalization may negatively impact on their asylum-seeking process.

These issues must be confronted directly and openly. If not addressed sufficiently there is a risk that the patient may be re- traumatized and continue fearfully to resist hospitalization and adherence to treatment with negative outcome. The following cases also describe situations for which hospitalization was indicated:

Case 8:

A man from a West African country received news of his brother's recent murder. Overwhelmed, he came to the hospital seeking protection from his own reaction. He was concerned about his suicidal impulses. He was hospitalized on a psychiatric unit for several days, received intensive psychiatric treatment, and was discharged when he felt safe and in control of his behavior and actions. For this man, hospitalization was a sought-after place of safety.

Upon discharge, this patient continued with individual and group therapy, as well as psychopharmacological follow-up. The patient was visited frequently at his home by “brothers and sisters” from his support group for French-speaking African survivors, who “checked in” and made sure the patient was eating well, and not feeling isolated in his grief (see Chapter 11).

Case 9:

A young Tibetan monk in NYC required medical hospitalization for acute Tuberculosis. He was placed in an in-patient, negative-pressure isolation room for TB, and did not seem to be suffering from any psychiatric symptoms or distress. During the hospitalization, the patient noticed a Chinese American hospital policeman in uniform standing outside his hospital room. This triggered a flashback and acute episode of agitation, reliving the past experience of arrest and torture by Chinese authorities.

In an acute psychotic reaction, the patient barricaded himself in his room and planned his escape to freedom by jumping out of the hospital window. This window overlooking the building of the United Nations had magnified symbolic meaning in this patient’s mind. This patient required treatment with anti-psychotic medication (Risperdal) for a short period of time.

The patient responded well to treatment with complete resolution of his symptoms and discontinuation of the anti psychotic medications.

He was able to be discharged safely to his community with continued out-patient group psychotherapy.

Case 10:

A Middle Eastern professional, and mother of two, arrived to her regularly scheduled psychiatric appointment with her two sons. During the session, she expressed suicidal wishes, including a clearly spelled-out plan to jump off a bridge with her two young children. The patient's husband was contacted so that he could take the children home. Once he arrived, the patient was escorted to the psychiatric emergency room for an evaluation for admission. That evaluation confirmed the need for hospitalization. The patient refused hospitalization and was admitted on an emergency status involuntarily.

The patient's suicide/infanticide plan was understood as stemming partly from her rage at her husband, whom she blamed for not having been there to protect her from a brutal rape. The patient's husband had been out of the country at the time of her attack. The understanding of the complex dynamics underlying the patient's plan made the patient's intent to carry out her plan seem credible. She was viewed as being dangerous to both self and others, clearly meeting criteria for an involuntary psychiatric admission.

The patient's initial reaction to the hospitalization was an expression of re-traumatization and one of severe disappointment and feelings of betrayal; she stated "How could you do what they did to me?"

After in-patient treatment, including insight-oriented psychotherapy and mood-stabilizing medication, she began cooperating with her treatment. Upon discharge from the hospital, she continued with both psychotherapy and psychopharmacology as an outpatient. She expressed appreciation for the intervention.

Case 11:

A young West African man developed paranoid psychosis, fearing all law enforcement personnel and imagining personally targeted persecution. These symptoms developed following a highly publicized case of police brutality against another West African young man in New York City. He was admitted to an in-patient psychiatric unit for treatment. During a relatively long hospitalization, the patient continued to be reluctant to leave the hospital, which he came to experience as a safe haven. Upon release, he continued to receive individual and group therapy, as well as psychotropic medication on an outpatient basis.

Summary

Psychiatric work with survivors of torture and refugee trauma is a challenging and complex field of psychiatric practice. Many professionals may engage in this area of work only to eventually feel helpless, impotent, and ineffective in the face of patients' horrific experiences and deep suffering. These clinicians may themselves disengage, experience burnout, and retreat from working with such patients (see Chapter 13).

Conversely, clinicians may see that the overabundance of challenges leaves substantial room for varied and innovative responses. These responses may help to promote the individual clinician's growth and development, and may also help to deepen understanding of how to best treat and advocate for survivors of torture and refugee trauma across the board. As the needs are vast, so are the ways that psychiatrists can get involved and be able intervene providing care to this underserved population.

Beyond clinical evaluation and treatment, psychiatrists as physicians have an important social role in denouncing torture and other human rights abuses. This includes raising awareness of physicians' participation in torture and other abuses. As such, advocacy is another realm in which psychiatrists can play an active role in advancing the cause of respecting human rights.

Contemporary research and writings on PTSD (Shalev, 1996; Yehuda & McFarlane, 1995), as well as our clinical experience, suggest that at present we lack tools for accurately diagnosing clusters of symptoms with which traumatized patients present. There are, however, many ways in which psychiatrists doing rigorous quantitative and qualitative research can broaden and deepen the understanding of individuals' complex reactions to trauma. Direct psychiatric treatment of traumatized survivors of torture by itself is a very rewarding area of practice. Psychiatrists can assume a more significant role in the struggle for human rights and human dignity by assisting people who have been directly wounded by oppression and violence.

References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text Revision). Washington DC: Author.
- Basoglu, M. (1993). Prevention of torture and care of survivors: An integrated approach. *JAMA*, *270* (5), 606-611.
- Brady, K. T., & Clary, C. M. (2003). Affective and anxiety comorbidity in post-traumatic stress disorder treatment trials of sertraline. *Comprehensive Psychiatry*, *44*(5), 360-369.
- Brady, K.T., Sonne, S.C., & Roberts, J.M. (1995). Sertraline treatment of comorbid posttraumatic stress disorder and alcohol dependence. *Journal of Clinical Psychiatry*, *56*, 502–505.
- Brender, J. (1982). Electrodermal responses in PTSD. *Journal of Nervous and Mental Diseases*, *170*, 352-361.
- Breslau, N., Chilcoat, H., Kessler, R., & Davis, G. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: Results from the Detroit Area Survey of Trauma. *American Journal of Psychiatry*, *156*, 902-907.
- Briere, J. (1996). *Therapy for adults molested as children* (2nd ed.). New York: Springer.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, and treatment*. Thousand Oaks, London, New Delhi: Sage Publications.
- Chilcoat, H., & Breslau, N. (1998). Investigation of causal pathways between PTSD and drug use disorders. *Addictive Behaviors*, *23*, 827-840.

- Dow, B., & Kline, N. (1997). Antidepressant treatment of post-traumatic stress disorder and major depression in veterans. *Annals of Clinical Psychiatry, 9*, 1–5.
- Du, N., & Lu, F. (1997). Assessment and treatment of posttraumatic stress disorder among Asian-Americans. In E. Lee (Ed.), *Working with Asian-Americans: A guide for clinicians* (pp. 275- 294). New York: Guilford Press.
- Engdahl, B.E., & Eberly, R.E. (1990). The effects of torture and other maltreatment: Implications for psychology. In P. Suedfeld (Ed.), *Psychology and torture* (pp. 31-47). Washington , D.C.: Hemisphere Publishing Corp.
- Ferrada-Noli, M., Asberg M., Ormstad, K., Lundin, T., & Sundbom, E. (1998). Suicidal behaviour after severe trauma. Part 1: PTSD diagnoses, psychiatric comorbidity and assessments of suicidal behaviour. *Journal of Traumatic Stress, 11*, 103-112.
- Friedman, M., & Jaranson, J. (1994). The applicability of the post-traumatic concept to refugees. In A. J. Marsella, T. Bornemann, S. Ekblad, & J. Orley (Eds.), *Amidst peril and pain. The mental health and well-being of the world's refugees* (pp. 207–227). Washington, DC: American Psychological Association.
- Hamner, M.B., Faldowski, R.Q., Ulmer, H.G., Frueh, B.C., Huber, M.G., et al. (2003). Adjunctive risperidone treatment in post-traumatic stress disorder a preliminary controlled trial of effects on comorbid psychotic symptoms. *International Clinical Psychopharmacology, 18*, 1-8.
- Keller, A.S., & Gold, J. (2005).Survivors of torture. In B. Sadock & V. Sadock (Eds.), *Kaplan and Sadock’s Comprehensive Textbook of*

- Psychiatry* (pp.2398-2406). Philadelphia: Lippincot Williams & Wilkins.
- Keller, A.S., Lhewa, D., Rosenfeld, B., Sachs, E., Aladjem, A., Cohen, I., et al. (2006). Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. *Journal of Nervous and Mental Disease*, 194 (3), 188-294.
- Kilpatrick, D. G., & Resnick, H. S. (1993). PTSD associated with exposure to criminal victimization in clinical and community populations. In J. R. T. Davidson & E. B. Foa (Eds.), *Posttraumatic Stress Disorder: DSM-IV and Beyond* (pp. 113-143). Washington, DC: American Psychiatric Press.
- Kinzie, J.D., Leung, P.K., & Boehnlein, J.K. (1997). Treatment of depressive disorders in refugees. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians* (pp.265-294). New York: The Guildford Press.
- Kluznik, J.C., Speed, N., van Valkenburg, C., & Magraw, R. (1986). Forty-year follow-up of United States prisoners of war. *American Journal of Psychiatry*, 143 (11), 1443-1446.
- Koss, M.P., & Kilpatrick, D. (2001). Rape and sexual assault. In E. Gerrity, T. Keane & R. Tuma (Eds.), *The mental health consequences of torture* (pp. 177-194). New York: Kluwer Academic/Plenum Publishers.
- Laub, D., & Auerhahn, N. (1993). Failed empathy: a central theme in survivors' Holocaust experience. *Psychoanalytic Psychology* 6 (4), 377-400.

- Malloy, P., Fairbank, J., & Keane, T. (1983). Validation of multi-method assessments of PTSD in Vietnam veterans. *Journal of Clinical Psychology, 51*, 488-494.
- Mason, J., Giller, E., Kosten, T., Ostroff, R., & Podd, L. (1986). Urinary free cortisol in PTSD. *Journal of Nervous and Mental Disease, 174*, 145-149.
- McFarlane, A.C. (1996). Resilience, vulnerability and the course of posttraumatic reactions. In B. A. van der Kolk, L. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp.155- 181). NY: Guilford.
- McGirr, A., Renaud, J., Seguin, M., Alda, M., Benkelfat, C., Lesage, A., et al. (2007). An examination of DSM-IV depressive symptoms and risk for suicide completion in major depressive disorder: A psychological autopsy study. *Journal of Affective Disorders, 97*, 203-209.
- Mollica, R.F. (2004). Surviving torture. *New England Journal of Medicine, 351* (1), 5-7.
- Mollica, R.F., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic, I., & Massagli, M. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *Journal of the American Medical Association, 282*, 433-439.
- Momartin, S., Silove, D., Manicavasagar, V., & Steel, D. (2004). Comorbidity of PTSD and depression: Associations with trauma exposure, symptom severity and functional impairment in Bosnian refugees resettled in Australia. *Journal of Affective Disorders, 80*, 231-238.

- Peghini, P.L., Katz, P.O., & Castell, D.O. (1998). Imipramine decreases oesophageal pain perception in human male volunteers. *GUT*, *42*, 807-813.
- Scott, C., & Briere, J. (2006). Biology and psychopharmacology of trauma. In J. Briere & C. Scott (Eds.), *Principles of trauma therapy: A guide to symptoms, evaluations, and treatment* (pp.185-229). Thousand Oaks, London, New Delhi: Sage Publications.
- Shalev, A. (1996). Stress versus traumatic stress: From acute homeostatic reactions to chronic psychopathology. In B.A. van der Kolk, L. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp.72-101). NY: Guilford.
- Smajkic, A., Weine, S., Djuric-Bijedic, Z., Boskailo, E., Lewis, J., & Pavkovic, I. (2001). Sertraline, paroxetine, and venlafaxine in refugee posttraumatic stress disorder with depression symptoms. *Journal of Traumatic Stress*, *14*, 445–452.
- Yehuda, R., & McFarlane, A.C. (1995). Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. *American Journal of Psychiatry*, *152* (12), 1705-1713.
- Zlotnick, C., Donaldson, D., Spirito, A., & Pearlstein, T. (1997). Affect regulation and suicide attempts in adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 793-798.

Chapter 9

Social Service Provision – Summary

- * Social Service Essentials
Information, Resources, Advocacy
- * Day to Day Necessities – Facilitates client’s use of program’s services
Food; Clothing; Transportation; Emergency loans
- * Social Service Aspects of Medical Care –
Scary when clients receive big bills; Can be an impediment to treatment
Fee reductions; Insurance – Medicaid (PRUCOL); Specialized services;
Supplemental Security Income (SSI)
Hospice care; Discharge planning
- * Housing – Very difficult domain; Lack of resources; Potentially re-traumatizing
Shelters; Community resources; Section 8
Psychiatric reports which help prioritize clients for affordable housing
- * Legal – First tier issue of immigration status
Finding pro-bono legal services v. “volume lawyers”
Acting as liaison for lawyers and doctors for supporting documentation
Asylum, work authorization, family petitions, citizenship applications
Permanent Residency applications
Psychoeducation about one’s rights
Immigrant’s rights at home, work, or if arrested
311/911 and hotline information
- * Educational Assistance – Empowerment; Advocacy at school; English literacy
Diploma equivalencies/Transfers
Training referrals
- * Professional Assistance - Direct referrals; Professional development
- * Family issues
Reunification information/applications
Folds back into other services
- * Appendix A: Some Social/Legal Service Resources in the New York City Area

Social Service Provision

Hawthorne E. Smith, Ph.D. & John Wilkinson, M.A.

Social Service Necessities

Social services are not seen as an adjunctive branch of services added to a client's clinical involvement with the Bellevue/NYU Program for Survivors of Torture; rather, they are seen as a critical component of the clinical care that serve to facilitate a client's use of the other clinical services. Aspects of social service needs are given significant weight during case formulations and treatment planning. The stressors facing traumatized refugees are varied and profound. Before addressing particular content areas, some mention should be made of three key concepts that are pertinent in social service provision across domains. They are information, resources, and advocacy.

Information

There are several factors that impede traumatized refugees from accessing pertinent and accurate information regarding social and legal services. Traumatized refugees' cognitive and psychological functioning may be impaired in areas that affect their ability to seek and retain information. Fear, mistrust, and a general sense of disempowerment may dissuade refugees from actively asking questions and seeking information within their communities, or from social service providers. For example, a significant number of our clients who did not file for political asylum within the required 12 month filing deadline simply failed to do so because they

were not aware that any such deadline existed. Acquisition and retention of information may also be compromised by survivors' emotional states.

In addition to a lack of information, our clients also find themselves in contexts where misinformation abounds. Rumors about changes in immigration law, shortcuts to asylum, and nightmare scenarios where anyone seeking information may be immediately deported, are among the myths and untruths that abound within expatriate communities. We have encountered situations where refugees are "steered" to substandard, or fraudulent, lawyers or social service agencies who exploit these disempowered people for the few material resources they possess.

As previously written, our clients have many intellectual, spiritual, and emotional resources. Generally, these are people who are not only able to fend for themselves, but are eager to do so. Sometimes the provision of pertinent information can be the key that allows clients to take control of their own situation and to act proactively to improve their lot. As such, social service providers must make it their goal to have access to as much pertinent information regarding the situations and challenges that traumatized refugees may be facing, as well as viable information regarding programs, processes, and resources that can help our clients.

Resources

External resources are needed to bolster the internal resources our clients already possess. Providing tangible items, or at least concrete referrals for services, can also help a survivor to realize that they are not alone in their daily struggles. Receiving essential resources, whether food, winter clothing, medicine, legal services, emergency cash, can help to provide hope to clients facing daunting situations. Clients have said that

“The difference between having no hope and a little bit of hope is infinite.” So, it is incumbent upon the social services provider to identify and establish connections with community, philanthropic, or governmental agencies that can provide needed resources to our client population. This information should be updated frequently.

Advocacy

Traumatized refugees, who may be fearful of asking questions, may be even more afraid to argue or advocate for themselves with the individuals and bureaucracies that have so much power over them. As such, it often falls to the clinical team, including the social service provider, to advocate for clients when their rights are being compromised.

Program staff members have intervened with landlords, attorneys, and employers who treated clients in an unfair or exploitative manner. Having a partner who knows the “lay of the land” and who is willing to defend a client from potential exploitative situations can also serve to increase a client’s confidence, and therefore his or her ability to advocate for themselves. As stated in the Acknowledgements section of this book, “Two watch dogs are ten times better than one.” A survivor, who no longer feels isolated or exposed, is more willing to take reasonable risks and follow through on plans of action that can change their situation for the better. We will now discuss some of the particular areas in which social service provision is crucial.

Day-to-Day Necessities

One such area that helps to strengthen clients' ties to clinical services is helping them with day-to-day necessities. These necessities include food, clothing, access to transportation, and financial support during times of crisis. Access to such resources can be extremely limited for individuals marginalized due to their immigration status, their lack of employment authorization, or other linguistic and cultural barriers that may prevent them from fending for themselves successfully in the realm of subsistence.

First, our social service department helps identify existing services, such as food pantries and soup kitchens, in the New York metropolitan area. Clients are then accompanied to these sites to help make sure that they and their families receive adequate nutrition and sustenance. After initially accompanying clients to these centers, clients are empowered to take responsibility for accessing these resources in the future. PSOT staff and volunteers are made available if there are continued logistical difficulties. If there seem to be medical or emotional reasons that clients are unable/unwilling to access services, these concerns will be communicated within the PSOT treatment team, and the appropriate clinicians will be kept abreast of clients' behavioral functioning.

On one occasion, Ms. Z, a West African woman with 5 children, attended her asylum hearing. Her "clock" which measures the amount of time elapsed before an asylum seeker is eligible for work authorization, had been stopped at 145 days out of the necessary 150 to become "work eligible." Her case was continued by the immigration judge to conduct forensic research and have birth

certificates translated. The case was rescheduled for 6 months later. The judge was asked to allow the “clock” to continue moving, but since the client’s lawyers had failed to translate the birth certificates, the delay was deemed to be the client’s responsibility. As such, her “clock” was stopped until her next hearing.

In essence, the client was not able to work and independently provide for her children during the next six months. PSOT volunteers mobilized and identified food pantries and soup kitchens in the client’s neighborhood in the Bronx. Occasional transportation was arranged for large food acquisitions. The family received their sustenance by these means for the six months until the following court date. The client was then granted asylum, and she subsequently entered the work force successfully, and became far more self-sufficient.

. To further explore the importance of providing basic necessities (such as food), and the importance of networking with other social service agencies in the city, consider the following example:

AZ, a 30 year old male from one of the former Soviet republics, was unable to find employment, and needed food assistance. We were able to address that immediately by referring him to a program that not only gave him some supply of food, but also gave him referral to food pantries and soup kitchens to utilize on an ongoing basis, while awaiting a change in his immigration status that would permit him to

work. These referrals helped to sustain him physically over a period of several months.

Another key element that plays a role in a client's ongoing health maintenance is locating and providing appropriate clothing. This is especially important for clients arriving from tropical climates, who usually do not own clothing that will keep them sufficiently warm during the winter months. Winter coat drives have been an essential part in this effort. Education regarding the importance of dressing in layers, and removing one's outer clothing when inside for a significant period of time are important tips for people who have never dealt with winter weather before. We also help to provide clients with clothes suitable for academic or professional interviews. We see that facilitating these efforts is a crucial part in empowering clients and helping them to achieve tangible successes.

Clients need to keep a plethora of appointments during the course of the week. Transportation costs can be a substantial impediment to clients accessing the services they need. Social service providers should orient clients to available public transportation. New York City is fortunate to have an expansive public transportation system. We raise funds to provide "metro cards" for our clients in need. While we cannot cover expenses for all of their travel, we try, at the very least, to provide round-trip fare to and from each hospital visit.

In crisis situations, we have been able to pay for cabs and arrange ambulette services for clients who were not able to use subways or buses. We have also been able to create a small "petty cash" account and identify emergency funds through local philanthropic groups to help when clients are on the verge of being evicted, or have collection agencies pursuing them

(due to circumstances the clients are not legally able to control or resolve). These funds are limited, however, and we are always seeking more “general operating expense” funds that can be put directly to clients’ use.

The following case is illustrative of many of the domains in which social services are called to the fore:

Ms. K, a 54 year old woman from Central Africa with two teenage children had been in treatment with us for three years. She had already earned her political asylum, and had moved to another state that was “quieter than New York City.” Unfortunately, Ms. K was diagnosed with advanced stages of liver cancer. She decided to return to New York with her children, and began receiving medical care at our hospital, including chemotherapy.

During this time, her social benefits (including public assistance and housing benefits) were caught between the bureaucracies of two different states. The PSOT social service staff intervened to help her family find temporary housing while her case was being transferred. Our Program also helped to pay for ambulette service and taxis, as the client was too weak to utilize public transportation. During a particularly intense summer heat wave, PSOT paid for her to stay for several nights in a local hotel with air conditioning, because the client’s non air-conditioned 11th floor apartment was a risk to her health during this time.

We will revisit this particular case as we discuss other aspects of social service provision. We believe that this case serves as an appropriate

transition to issues concerning liaising between medical services and other service providers.

Social Service Aspects of Medical Care

The social service aspects concerning medical care should not be underemphasized. When our clients receive large medical bills, or are confronted with undecipherable medical or insurance bureaucracies, it can be a significant impediment to treatment. Patients may decide that receiving medical care “is not worth it” after receiving threatening letters about financial liabilities, or even requests for follow-up medical testing, or procedures that they do not understand. These realities are not unique to our hospital or to our population, but the feeling of vulnerability may be particularly stressful for traumatized refugees who have tenuous immigration, and therefore legal status.

One of the first steps in intervening in this domain is to make sure that there are staff members or volunteers who are able to translate letters and other medical communication to clients in a language in which they are proficient. Many misunderstandings are just that – misunderstandings. Beyond that, awareness of bureaucratic and medical realities, and sharing this information with patients, also helps to break down barriers and facilitates access to necessary medical services.

PSOT staff work closely with the medical staffs at both Bellevue Hospital and NYU Medical School to arrange fee reductions for our indigent clients. Bellevue even created a special billing category for survivors of torture that would allow them to receive their medical care free of charge while their asylum cases were being adjudicated. In most cases, asylum

seekers were not able to access Medicaid, and therefore could not pay for their care. We were able to work out arrangements so that these most vulnerable of patients would receive the needed services. Fortunately, things have changed for the better in New York State.

Court decisions led to the creation of the PRUCOL mandate (Persons Residing Under the Color of Law) in the state of New York. This states that people who have a pending asylum case are not living in the US “unlawfully.” As such, they have the right to be covered medically, and we have been able to successfully sign-up our asylum-applicant clients for Medicaid benefits. This has been of great importance to our clients (who receive the necessary care), to the participating hospitals (which are now reimbursed for a significant portion of the costs for treatment of our clients), and our program (which is in a stronger position regarding clinical and financial productivity within the hospital systems).

There are also times that special advocacy is necessary. We have had two occasions when clients were in need of liver transplants. Ironically, both clients were from the same West African country. The first client is the one that prompted us to begin making the calls, writing letters, and beseeching medical services to expedite her eligibility for such services, and then to locate and secure a donor, and facilitate the transplant.

We encountered many engaged and energetic individuals who helped to expedite the process. Unfortunately, we also encountered many pitfalls and missteps that hindered the process. In the end, we were able to obtain Medicaid status – but for this patient it was too late. The patient expired before her name could be added to the priority list for transplant recipients.

We would like to think that the first client’s efforts and struggles were not in vain. The second time we were confronted with a similar situation, we

were better informed and better equipped to move ahead with alacrity. The transplant was completed successfully, and the second patient is now a healthy member of the community – working hard to take care of his burgeoning family (he and his wife have had a healthy baby son since then).

End of life issues are another area where the social services and medical realms overlap. We have been called upon to work with various departments within the hospital (i.e. HIV services, cardiac care, palliative care, oncology) to help facilitate hospice care, or other discharge dispositions. Often, we play an educative role in terms of what resources are available for our clients with the immigration statuses that they possess, and often we can provide focused advocacy for those that might otherwise “fall through the cracks” of large city and state bureaucracies. We help to facilitate addressing cultural issues, which are important in all phases of interaction with clients, but become especially salient during end of life situations – with their myriad of stressors and potential triggers for retraumatization.

We find that many of the departments we work with are grateful to have collaborators who are able to put more time into a particular case than they may be able to do, or to be available to consult on cultural issues. We must always be mindful of sensibilities of “turf” and authority issues to make sure that we do not alienate fellow service providers we are trying to assist. To date, our collaborations with other departments have been fruitful, and guided toward the best interest of the patients.

In the case of Ms. K, we were in the midst of beginning to plan for her children’s future when she received a prognosis of having less than

six months to live. Case workers from both the inpatient unit, and the temporary shelter where her family lived, were involved. Physicians from PSOT and the oncology unit were involved in trying to treat her illness and ease her physical suffering. Her PSOT psychologist and case worker were involved in providing support for Ms. K, her children, her extended family members, and the other program clients who mourned her loss.

It looked like things were moving toward resolution in terms of finding stable housing and enrolling her children in school, when her health took an extreme turn for the worse. The months we counted on turned to days, and Ms. K died soon thereafter.

There was no living will and there was no money. There were questions about whether Ms. K would be buried in a common grave, with no viewing, no headstone, and no opportunity for her family and children to mourn in a culturally appropriate way. There were many questions in terms of where the children would live. Would the eldest child (who had just turned 18) be able to be “head of household” and keep the family together (the youngest child was fifteen years old)? Was there any potential that the children would be repatriated? Who would be able to register the youngest child for school as “next of kin?” Would the children be able to keep the mother’s housing benefits? How do we provide information to the children without overwhelming them during their period of grief, but also get enough information and positive direction to move things in an appropriate direction?

The answer to this plethora of questions is that through our social service providers, and their careful coordination with other care givers and agencies (such as the Department of Homeless Services; Administration for Children's Services; The New York Legal Assistance Group; the Board of Education, etc.), the majority of these questions were resolved positively.

Through funds raised by PSOT, and by the extended support network in the expatriate African community (largely mobilized by other African clients in our program), there was a viewing, a church funeral, and a burial in a cemetery where her children can visit Ms. K's grave. The siblings lived together with the eldest sibling serving as legal guardian, while social workers and members of their religious and national community provided supervision and support. They enrolled in school, and received the financial assistance necessary to support them. Both siblings continued to receive medical treatment and supportive psychological services through our program for some time. Perhaps most importantly, they had the opportunity to bury and mourn their mother in a way that was appropriate given their religious beliefs, cultural background, and emotional needs.

This case helps to illustrate the complex and overlapping roles that social service staff members take on when working with this multiply-challenged population.

Housing Issues

One area that remains very difficult for our clients and our social service staff is the domain of adequate housing. This is especially true for our clients who are asylum seekers, who have not yet been accorded any sort of permanent status such as asylum, refugee status, or a green card. These clients are generally in a disadvantaged position relative to other populations in need of scarce housing resources, because our clients do not have legal access to publicly subsidized housing. Many of our clients find themselves at the mercy of other members of their expatriate community; many of whom are in marginal living situations themselves. Our clients find themselves in the position of being “an extra burden” to already struggling members of their extended families or ethnic communities. Often when clients are sleeping in other people’s living rooms, hallways, or sleeping in shifts in overcrowded apartments; they can be made to feel unwelcome. The circumstances, including a general lack of privacy and a sense of being in someone else’s space, can potentially be re-traumatizing. These issues tend to keep feelings of insecurity, self-reproach, and loss of status very much alive for traumatized refugees.

The ways in which the social service provider can intervene in these circumstances are, unfortunately, limited. Clients may be guided into the shelter system, but this is often less than optimal. The New York City shelter system is one of the most largely populated systems in the country. Its shelters are often crowded, with people from all walks of life and frequently suffering from substance abuse and/or other psychological and behavioral issues. As such, the shelter environment can often be noisy, chaotic and serve to reactivate a trauma survivor’s sense of insecurity and perceived

threat. There have been times when a homeless shelter may be the appropriate referral given someone's housing status, but it may be an inappropriate referral given their emotional state.

A social service provider may also be able to assist in registering the client in specialized housing programs. In New York State, specialized "Section 8" housing exists for New York residents with demonstrable mental illnesses. Our social service coordinator is instrumental in arranging supporting documentation from program psychiatrists, to put forth formal Section 8 applications. Axis I Diagnoses, such as PTSD and Major Depression have been deemed appropriate diagnoses for clients to participate in this special housing program.

Housing bureaucracies can necessitate social service interventions that go beyond the norm. In one instance, a family from the Caribbean (a mother and two young children) had been given temporary shelter by another family in their expatriate community. After a period of time, the host family rescinded their offer, and told the family that they needed to vacate the premises immediately.

The family tried to access services at a shelter for homeless families, but were refused by the housing authority because they had it on record that the family was "currently domiciled" by the family who had just evicted them. Homeless services were being denied to this family because the system did not consider them to be truly homeless – despite the fact that they had nowhere to go besides the streets.

Our social services team intervened in this housing crisis during the weekend (the family was evicted from their previous residence on a Friday evening). We tapped into our limited “emergency funds” to place the family at a hotel, so that the young children would not be on the street. Our social services coordinator then accompanied the family to their previous residence to “witness” them being denied entry to the home. Afterwards, they went to a police station to have an “official record” that the family had been refused entry.

With the subsequent affidavit from our program regarding the family’s situation, shelter officials re-evaluated their request, and allowed them to re-enter the shelter system the following Monday morning. The emergency funds from the program, coupled with the advocacy effort, were enough to keep this family of traumatized survivors off of the street in the short-term. We recognize that the challenges with housing are longer-term and very broad in scope.

Legal Issues

A crucial issue with which our social service providers must grapple is our clients’ immigration status. Much of the general context regarding immigration law has already been covered in Chapter 3. However, it is worth exploring some of the associated activities and issues that our social service and legal liaison team encounters.

Accessing pro-bono legal services for asylum seekers is a very important task. Most asylum seekers do not have proper work authorization, and therefore find it difficult to pay for legal services. There are many

asylum attorneys who offer “discount” services for asylum seekers. Even these “discounted” services may cost between \$1,500 and \$3,000 in New York City for people with limited or no income.

While the grand majority of immigration attorneys (whether private or pro-bono) are ethical and diligent, the demand for services and the vulnerability of the population can lead to a potentially exploitative situation. Some immigration judges have made reference to “volume lawyers,” who make their money by maintaining extremely high-volume case loads. In this scenario, many clients may not have adequate access to their lawyers for case preparation, document procurement or verification, or even adequate information regarding the structure, processes, or expectations of an asylum hearing.

Finding pro-bono (derived from Latin, meaning “for the public good”) attorneys has helped many of our clients to navigate the asylum process. Not only do the pro bono services reduce costs for our clients, but we have found that legal teams doing such work tend to have more time to devote to the particular cases. In the New York Metropolitan area, we find pro bono attorneys through programs such as: Human Rights First (formerly the Lawyers’ Committee for Human Rights), HIAS (The Hebrew Immigrant Aid Society), Catholic Charities, NYANA (the New York Association for New Americans), and through law school legal clinics (i.e. NYU Law School, Fordham University Legal Clinic, CUNY Law School, Brooklyn Law School, Hofstra University Law School, etc.). Generally, these schools provide teams of law students who provide the bulk of the direct services, under the supervision of experienced law professors. These teams have proven to be so motivated and enthusiastic, that at times it has been our duty to provide them with psycho-education about the potential of re-traumatizing

a client who is expected to recount his or her story repeatedly, as part of the preparation process. We sometimes need to reassure a client that just because the services are free does not mean that they are somehow sub-standard.

Part of helping our clients to prepare for their asylum cases also means serving as a liaison between the lawyers and the doctors to provide supporting documentation, when appropriate. Not all clients who apply to our program are accepted, and no one is promised an affidavit (whether medical, psychiatric or psychological) upon acceptance to our program. But for those clients who engage consistently and conscientiously in their treatment, and for whom we have clinical data and observations that can shed light on their functioning, we provide supporting documentation for their asylum hearings (see Chapters 7 and 12). A large part of the legal liaison work has to do with facilitating reports coming from the appropriate doctors, in a timely fashion. Scheduling clinicians for potential testimony (usually telephonically) is another logistical detail we try to arrange.

Legal assistance also stretches into other domains, such as helping clients to obtain legal work authorization, reunifying the families of asylees by helping to file family petitions, facilitating green card lottery applications, and aiding with permanent residency and citizenship applications. We also provide legal and civic education about one's rights. Workplace law, domestic law, tax law, and child protection laws are discussed with individuals, and also covered during sessions of the psycho-educational "orientation" groups we conduct for newly arrived clients. In addition, issues regarding the rights of those who have been arrested and about the use of "911" and other emergency services are discussed. We also

give information about the use of “311” and other government information sites found in the New York Metropolitan area.

In essence, two of our major goals in the provision of legal liaison services have to do with access to information and access to services. We endeavor to place our clients in a position where they can best adjudicate their cases and advocate for themselves.

Educational Assistance

Another major issue for social service providers is educational assistance. Beyond the concrete benefits that continued education can bring, it provides clients with concrete skills, such as English and computer literacy, and empowers clients to look toward a future they can construct, as opposed to being emotionally dominated by their traumatic past.

This kind of support takes place on multiple levels. For example, one challenge that service providers working with refugees face is educational integration for children and adolescents from traumatized populations attending American schools. In our program, we have been called upon to help facilitate communication between school administrators, teachers, and the families of young survivors around cultural and disciplinary issues.

Some traumatized children and young adults may manifest behaviors in school that are disruptive and disconcerting to school personnel. Our staff has intervened on occasion to help provide psycho-education to school staff regarding some of the sequelae and secondary effects of torture and refugee trauma, particularly as they pertain to young survivors. PSOT service providers have spoken with teachers who have “just assumed that the kid was ADHD” because of disruptive behaviors, without a full understanding

of the context of what the child has experienced, and is experiencing. Our clinicians have often been able to provide therapeutic support for children that the school has identified, and we have responded when parents have called us in to advocate for their children, where they have felt that they did not have the ability to advocate for themselves.

For adults, our efforts include facilitating inscription into English as Second Language (ESL) courses for those coming from the non-Anglophone world. This can have extraordinary therapeutic value, especially when the client may be awaiting the decision of their asylum case, and are not yet authorized to work legally. These ESL courses help them to have concrete tools to survive in our society, but they also serve the purpose of allowing them to feel as though they are making some progress, even while they feel stuck in the immigration and employment domains.

Helping clients to access vocational training or specialized schooling are other concrete steps that can help clients to move toward economic self-sufficiency. This can help recently arrived immigrants, who may have marginal English skills, to branch out beyond the menial labor or service jobs they are often forced to occupy.

Seeking educational equivalencies for those clients who arrive in the US with advanced degrees is another important aspect of helping the clients to progress logistically, which also helps them feel valued by the larger society. These concrete steps counteract the multiple levels of disempowerment that clients are facing. As one francophone support group member put it: “You never know who is driving your taxi in this country. You never know who is sweeping your floor.” Information and access to educational resources is a key element in helping clients to ameliorate their circumstances, such that they will be more in line with their capabilities and

talents. Assisting clients to identify, access, and pay for university studies is another way of assisting them educationally, professionally and emotionally. Helping clients to apply for financial aid is another way to make their educational aspirations become their reality.

Professional Assistance

Educational issues are intrinsically linked to issues surrounding work and career development. For many of our clients, who not only are struggling to survive, but are responsible for the economic survival of their families, issues surrounding work are of the utmost importance.

Job referrals are made to job development social service agencies. PSOT staff members also refer to our own volunteer program and other social service resources to help prepare clients with regards to their English proficiency. These volunteers have also been active in helping clients to prepare for job interviews. They discuss matters particular to the field for which the client is applying, and they speak of general concerns, including aspects of the “culture of work” in the US, such as the importance of being punctual for appointments, self-motivated, and dressing in a professional manner.

One pertinent example of the overlap between educational, professional, and clinical issues is the case of Dr. KN. It helps to illustrate the complexities facing refugees who wish to advance educationally and/or professionally.

Dr. KZ, a 33 year old physician from central Africa, was forced to leave his country without any diplomas or documentation of his status

as a physician. KZ had broad medical experience in sub-optimal circumstances; working with limited medical resource in a theater of war. He had delivered more than 2,000 babies, done open heart surgeries, and had provided emergency medical care on battle fields.

Even with proper documentation, he would not have been able to practice medicine in the US without going through residency training. The process for gaining a residency position is extremely competitive. With a lack of accredited diplomas here in the US, the outlook for Dr. KZ was bleak. This was emotionally troubling for KZ, who had already surpassed that level of training in his home country.

After studying English and gaining his political asylum, KZ was able to take a GED Course and took placement exams at a local university. He was eventually able to provide some documentation of his former academic and professional status. As such, he began working for a phlebotomy lab. He at least felt like he was back in “his field.”

After two years working as a phlebotomist, KZ applied for a graduate program in Public Health. Our program wrote recommendation letters, and helped nominate him for a “Disadvantaged Student” scholarship. KZ once again felt that he would be able to help the large underserved population that he left behind. His focus is different than when he was a physician working directly with patients. But now he might still be able to affect change from a distance, while bringing new resources to bear. This struggle has helped KZ reclaim “the

person he was” by making him feel useful, and feeling that he had not “abandoned his people” in the end.

Family Issues

One of the dreams that many recently arrived survivors of torture and refugee trauma often share, is the hope of one-day reuniting their families in their new homeland. After being granted asylum, it is possible for clients to engage in this process, but the bureaucracy can be daunting. There are applications to fill out by specific deadlines. There may be medical exams, including DNA analysis to determine parenthood. There is a lot of coordination between offices to be facilitated, in addition to the financial burden of paying for all of the exams, visas, and the plane tickets needed to come to the US.

Social service providers can play an important role in assisting with these logistical challenges with the client and his/her legal team (which may or may not still be involved after the grant of asylum). But the social service challenges of reuniting the family pale in comparison to the social service challenges posed by the reunited families themselves. These tasks overlap with the general themes outlined already in this chapter, meaning that the newly arrived family members will need support in the three general domains of information, resources, and advocacy.

Specific tasks and challenges include: day-to-day necessities, such as food, clothing, and shelter. Frequently, the family member who is receiving newly arrived family members was already in a financially precarious situation. Often, people are forced to leave the studio apartment, or the room they inhabited in someone else’s home, because the family has become too

large to stay in such lodgings. Perhaps the costs of feeding the newly enlarged family goes beyond what the person with political asylum can afford. Helping these families to access financial and day-to-day resources is an extremely important step in facilitating family reunification.

Specific issues regarding health insurance and access to care will vary depending on one's location within the US. Keeping current with local and state laws regarding access to medical care is essential for social service providers. At PSOT, we are able to enroll newly arrived family members in our program for initial health screenings, check-ups, and interventions. We also seek to enroll them in Medicaid as soon as possible, so that they can access care elsewhere if they so desire. Many of our clients move to the outer-boroughs (i.e. Queens, Bronx, Brooklyn or Staten Island), so it may be more pragmatic for arriving family members to have access to medical services in their own neighborhoods.

Generally, newly arrived family members come with a valid I-94 document which proves their asylum status, if they have been petitioned by a family member who already has asylum. Therefore, the needs for legal assistance with immigration are not as great with this population. However, there can be pressing needs for legal advocacy in terms of educational, professional, housing, and social service resources.

Many times, the social service coordinator will be the primary contact for the newly arrived family members. Not all of these family members have been tortured, but there are issues surrounding long separations, feelings of resentment or abandonment toward the family member who came to the US first. The social service provider must have his or her eyes and ears open to potential emotional discord within the family, and be prepared to make appropriate referrals to mental health clinicians in the program to help

family members navigate this potentially difficult transition period. The family issues can fall into the domain of culture and acculturation. As extended families regroup here in the US, there may be varying attitudes regarding one's view of their "original culture" v. their "host culture."

CS, a torture survivor from West Africa is also the father of six children. His years in exile in a neighboring country in Africa, and then his time in the US fighting for asylum status, necessitated an absence from his family that stretched to eight years. During that time, his 8 year old son became a 16 year old adolescent, who grew up largely without paternal supervision.

When the son arrived with his younger siblings, there was initial euphoria for the family. Over time, however, schisms began to come to the surface. The boy (or young man) was used to being the "man of the house." He did not take kindly to his father's redirection, stating that his father "had not been around," and striving to emphasize his independence.

The father, by contrast, had more traditional beliefs from his culture, stating that young people were to respect and obey their elders without question. As the son began sporting some of the popular hip-hop styles (i.e. saggy pants, baseball caps), and began staying out late with his friends, sparks flew within the household.

Referrals were made for individual counseling for the son. He now had a safe place to express his frustrations and pain. He also received

information on some of the pitfalls (legal, social, and cultural) he may encounter if he continued to “hang out” with some of the rough kids from his neighborhood. The father was supported in his frustrations, and supportive interventions were made at the level of the school.

The situation remained tense and somewhat volatile, for a number of months. The son did eventually pick up a minor charge. The Administration for Children’s Services (ACS) did open a case within the home regarding child custody. Happily, the son was found not guilty of the charges against him and the father and mother retained all parental rights and privileges after an investigation by the ACS. The supportive therapeutic environment provided for this family helped them to navigate this situation in a way that respected their current needs and traditional norms. We endeavored to help this family cope with the emotional realities of this tenuous transitional situation that they never asked for.

As can be seen by these examples, the role of social service providers is vast, complex, and nuanced. We work with clients from their first entry into the program, and follow them through beyond when their family members are able to join them. It can seem daunting at first, when one considers the vast needs of our client population. But one can also take heart in the fact that there are so many ways to intervene, and that small concrete steps that help to improve someone’s day-to-day lives can have a large impact on their social, educational, medical, and psychological functioning.

Appendix A: Some Social/Legal Service Resources in the New York City Area

Community/Immigration Service Agencies

African Services Committee, 429W 127 th St, 2 nd Fl, NY, NY	212-222-3882
American Friends Society Committee, 89 Market St, 6 th Fl, Newark, NJ	973-643-1924
Catholic Charities of New York, 1011 First Avenue, NY, NY	212-371-1000
CAMBA, 1720 Church Avenue, 2 nd Fl, Brooklyn, NY	718-287-2600
Int'l Inst. of NJ (IINJ), 1 Journal Square Plaza, 4 th Fl, Jersey City, NJ	201-653-3888
International Rescue Committee, 122 East 42 St, 12 th Fl, NY, NY	212-551-3000
Nah We Yone, Inc., 2417 Third Avenue/138 th St, Suite #607, Bronx, NY	718-292-0509
New York Association for New Americans, 2 Washington St, NY, NY	212-425-2900

Legal

City Bar Justice Center, 42 W 44 St, NY, NY	212-382-6629
Comite Nuestra Senora De Loreto Sobre Asuntos de Inmigracion, 856 Pacific St, Brooklyn, NY	718-783-4500
Hebrew Immigrant Aid Society, 333 Seventh Avenue, NY, NY	212-967-4100
Human Rights First, 333 Seventh Ave, 13 th Fl, NY, NY	212-845-5200
Immigration Equality, Inc., 40 Exchange Place, 17 th Fl, NY, NY	212-714-2904
Legal Aid Society Immigration Unit, 199 Water St., NY, NY	212-577-3300
Lutheran Family and Community Services, 308 West 46 th St, 3 rd Fl, NYC	212-265-1826
Sanctuary For Families, PO Box 1406 Wall St Station, NY, NY	212-349-6009
United States Citizenship and Immigration Services (USCIS) website: www.uscis.gov	

Education Resources

Riverside Language Program, 91 Claremont Avenue, NY, NY	212-662-3200
The International Center in NY, 50 West 23 rd St, 7 th Fl, NY	212-255-9555
International Rescue Committee, 122 East 42 nd St, NY, NY	212-551-3000
Literacy Assistance Center, 32 Broadway, 10th Fl, NY, NY	212-803-3300

Health

NY City Dept of Health and Mental Hygiene Call Center	212-447-8200
Immunization Clinic General Information	212-349-2664
Child and Maternal Programs Hotline	800-522-5006

Public Housing Application Offices

Minors (up to age 21 yrs) Covenant House, 460 West 41st St, NY, NY	212-613-0300
Bronx: 1 Fordham Plaza, 5th FL, Bronx, NY	718-329-7859
Brooklyn: 350 Livingston Street, 2nd Floor, Brooklyn, NY	718-250-5900
Manhattan: 55 West 125th Street, 7th Fl, New York, NY	212-828-7100
Queens: 59-17 Junction Boulevard, 2nd Fl, Corona, NY	212-828-7100
Staten Island: 120 Stuyvesant Place, 2nd Fl, Staten Island, NY	718-448-7326

Food Pantries/Soup Kitchens

Yorkville Common Pantry, 8 East 109 th St, NY, NY	917-720-9700
Bronx: Abraham House Inc., 340 Willis Avenue, Bronx, NY	718-292-9321
Brooklyn: First Baptist Church, 360 Schermerhorn St., Brooklyn, NY	718-875-1858
Manhattan: African Services Committee, 28 E 35 th St, NY, NY	212-222-3882x.116
Queens: United Methodist Center, 1521 Central Ave, Far Rockaway, NY	718-327-8460
Staten Island: Salvation Army, 15 Broad St. Stapleton, Staten Island, NY	718 448-8480

Chapter 10

Therapeutic Work with Children and Families – Summary

In the following chapter, we will outline issues pertaining to the impact of war violence on children and on families. Specifically, we will review the consequences of war and refugee trauma on children and outline treatment methods for working with traumatized refugee children and their families.

- * Children's psychological reactions to war trauma
 - PTSD in children
 - Depression
 - Anxiety
 - Learning difficulties
 - Moderating factors
 - Family factors
- * Treatment options for children traumatized by war
 - Referral to therapy
 - Family therapy
 - Individual therapy
 - Group therapy
 - Medication
- * Summary
- * Appendix A – Children's reactions to trauma
- * Appendix B: Guidelines for Referring a Child refugee or War Victim to Mental Health Services

Therapeutic Work with Children and Families

Kate Porterfield, Ph.D. & Adéyinka M. Akinsulure-Smith, Ph.D.

A sixteen year-old boy watches as his father is dragged from their home in Kosovo, beaten in the front yard, and taken away, never to be seen again.

An eight year-old girl returns from school in Sierra Leone to find that her mother is locked away in the bedroom, inconsolable and unable to explain that she has been raped by rebel forces.

A four year-old in the Congo witnesses his father and older brother being attacked with a machete and is, himself, wounded while trying to protect them.

War violence and the disruption associated with it reverberate throughout families. While individuals within a family may be targeted or singled out for torture or detention, rarely do other family members remain untouched by these victims' maltreatment.

The Bellevue/NYU Program for Survivors of Torture has primarily cared for adults who are survivors of torture and war trauma. However, when survivors are able to flee with their families, and when families are reunited after winning grants of asylum, the program often receives referrals of traumatized children who are also victims of war and refugee trauma. Many of these children are helpless witnesses to killings, shootings, beatings, mutilations, and arrests of family members, neighbors and strangers. Often they have been deprived of basic safety, nutrition and

education. In addition to experiencing the destruction to their communities and having spent time in refugee camps, many have endured losses and challenges that defy the imagination. For many of these children, the stressors continue as they struggle to adjust to their new "safe" country.

Caregivers of these children- i.e. professionals who encounter refugee youth in an array of settings, including schools, medical settings, refugee agencies and mental health clinics- must take into account the range of experiences that these youngsters have been through, and consider these issues as they develop services for the children and their families. In the following chapter, we will review some of these issues, including the impact of war and refugee trauma on children and the types of interventions that may be necessary for their healthy adjustment.

Children's Psychological Reactions to War Trauma

The impact of trauma on children has been documented in a variety of contexts including human rights abuses, child abuse, kidnapping, disasters, parental death, and war (Garbarino & Kostelny, 1996; Kaffman & Elizur, 1984; Lustig et al., 2004; Randall & Lutz, 1991; Terr, 1990). The impact of war trauma on children's functioning has been well-documented over the past 20 years. Several excellent reviews on the impact of war and refugee trauma on children exist (Dyregrov & Raundalen, 1987; Jensen & Shaw, 1993; Lustig et al., 2004; Macksoud, Dyregrov, & Raundalen, 1993). While not all children who have experienced war demonstrate psychological disorders, many experience some difficulties in their functioning. If caregivers do not recognize some of these signs of distress, they may overlook the child survivor's need for appropriate treatment or intervention.

Below, we review major psychological consequences of war on children and adolescents. (See appendix A for an additional list of behavioral difficulties based on age.)

Posttraumatic Stress Disorder in Children

Posttraumatic Stress Disorder (PTSD) has received wide attention over the last 20 years in clinical and research literature focusing on traumatized individuals. The Diagnostic and Statistical Manual of Mental Disorders-IV-TR (*DSM-IV-TR*; American Psychiatric Association, 2000) defines it as a diagnosis for identifying individuals who:

1. “experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” and
2. had a response that involved “intense fear, helplessness, or horror,” or in children, disorganized or agitated behavior (p. 467),

and who demonstrate a particular cluster of experiences in the aftermath of the event[s]. Because the criteria for PTSD diagnosis in the DSM-III of 1980 were originally based on adult combat veterans, it did not take into account the many ways in which children's manifestations of PTSD differ from those of adults. Thus the distinct and special symptoms that are seen in children were not taken into consideration (Shelby, 1997).

Reports on the prevalence of PTSD in children who have survived war trauma show tremendous range. For example, rates of 20% are reported in a study of a group of Kurdish children in Iraq (Ahmad, 1992), 30% in a group of Tibetan refugee children (Servan-Schreiber, Lin, & Birmaher, 1998), and 43% in a group of Lebanese children (Macksoud & Aber, 1996).

These rates are commensurate with an overall rate of PTSD of 36% found across other types of traumatic events (Barrios & O'Dell, 1998). However, studies of more severe and pervasive war violence such as that experienced by abducted child soldiers in Uganda and Kurdish children in Iraq show much higher rates of PTSD (97% and 87% respectively; Ahmad, Sofi, Sundelin-Wahlsten, & von Knorring, 2000; Derluyn, Broekaert, Schuyten, & Temmerman, 2004).

Thus, there are problems with comparing rates of PTSD after war without providing a context of what the war experience was like in certain regions and what kind of exposure occurred in the children living there. Rates of PTSD in war-traumatized youth have been shown to be remarkably persistent over time in some populations and situations. For example, in a longitudinal study of Khmer youth exposed to the violence under Pol Pot, rates of PTSD stayed at high levels at 6 years post-exposure (38%) and even 12 years post-exposure (35%; Sack, Him, & Dickason, 1999). These authors provide an excellent argument for the need for thorough assessment and appropriate intervention for war traumatized youth, given the persistence of PTSD symptomatology in some cases.

In terms of the course of symptoms, PTSD may not develop to full-blown criteria in the initial post-trauma phase (During the first month after exposure, a diagnosis of Acute Stress Disorder is appropriate). Several authors have pointed out that symptoms of PTSD in children may wax and wane and not reach full diagnostic criteria (despite the child's intense distress) until later (Pfefferbaum, 1997; Shelby, 1997).

Overall, the symptoms of PTSD cluster into three categories: re-experiencing symptoms, avoidant/numbing symptoms, hyperarousal symptoms. While the diagnostic criteria for PTSD are the same for adults

and children, children's symptoms tend to manifest themselves slightly differently than adults' due to children's ongoing cognitive and emotional development and their smaller repertoire of defense mechanisms.

In terms of re-experiencing the trauma, children tend to exhibit traumatic play and behavioral reenactment of the trauma (Pynoos & Nader, 1993). This could include war play or repetitive portrayal of a particular violent incident. The quality of this kind of play is unique, in that it is usually pressured, intense and without resolution. In addition, posttraumatic play rarely involves mutuality with another person and the child rarely seems to be enjoying himself. Adults who try to engage in this kind of play with a child will often find themselves thrust into the role of passive victim--repeatedly shot, bludgeoned, or stabbed. Another common re-experiencing symptom for children is intrusive remembering or imagining of the trauma. Children will describe being overwhelmed by a frightening image of the war, often in moments when they are trying to do something else (bedtime, school, homework time). In addition, children frequently report bad dreams that are related to the trauma they experienced during war and that sometimes generalize to other kinds of nightmares.

In terms of the cluster of symptoms that are characterized by hyperarousal, children who have been through war are most likely to demonstrate sleep disturbance, physiological reactivity, such as hypervigilance and poor concentration (Frederick, 1985; Pynoos, Kinzie, & Gordon, 2001). While these symptoms are also quite common in adults who have been through a trauma, children often do not report these experiences to caregivers unless directly queried. While a parent is likely to become aware of her child's sleep difficulties, she is less likely to know that her child frequently is overcome by sweaty palms and a racing heart. Similarly, children from war

zones who find themselves unable to focus on schoolwork may not link this to the fact that they are preoccupied with safety or distracted by disturbing images and memories. Adults may not recognize this poor concentration as a byproduct of trauma, and may instead feel that children are misbehaving or acting out.

The final cluster of symptoms in PTSD is that of avoidant behavior and emotional numbing. These symptoms most frequently take the form of children's purposeful avoidance of events or conversations that remind them of the trauma. In many cases, this avoidance reaches the level of a phobia. For example, a child may purposely avoid looking at or encountering police, due to reminders of soldiers or paramilitary groups. Children may even avoid innocuous cues that have somehow become associated with the war. A child who watched his mother being beaten by a soldier with a beard may not be able to talk to or be near bearded men. Other signs of avoidance or numbing in children are an inability or refusal to talk about the events of the war. Also, some children may develop a flat or inappropriately blank affect after war trauma or may seem to show less range of emotion or affect than they did before the war.

While much of the diagnostic criteria of PTSD are the same for children and adults, there are symptoms that are unique to children and, therefore, important that caregivers recognize as signs of distress. These symptoms can include, as discussed above, repetitive play in which themes or aspects of trauma are expressed. In some cases, there will be a loss of recently acquired developmental skills such as toilet training or language skills. In addition, some younger children demonstrate increased clinginess and dependency, along with more generalized nightmares. Finally, somatic

symptoms, such as stomachaches and headaches may be prevalent after a trauma.

Depression

While the symptoms of PTSD are important to recognize in children from war situations, it is important to not overlook other symptoms of emotional distress that children may be demonstrating. Research on children who experienced war traumas has found high rates of depression and anxiety in these children, both immediately after the trauma and several years later (Heptinstall, Sethna, & Taylor, 2004; Hubbard, Reallmuto, Northwood, & Masten, 1995; Mghir & Raskin, 1999; Sack et al., 1999). Signs of depression include a sad mood, decreased appetite, sleep disturbance, inability to experience pleasure and, in some cases, feelings of suicidality. In young children, depressive symptoms also may manifest themselves in somatic complaints, such as stomachaches or headaches. Older children and adolescents who are experiencing depression after war may report feelings of guilt and shame. This is particularly true when the youngster witnessed harm being done to a loved one. In these instances, feelings of helplessness and powerlessness may harden into shame at not having prevented the violence (Pynoos et al., 1993.)

Anxiety

Other psychological reactions to war trauma that can occur include anxiety difficulties, such as Separation Anxiety Disorder, phobias, and Generalized Anxiety Disorder. In Separation Anxiety Disorder, children express great fear at being away from their parent or caregiver, often out of fear that something will harm them or the parent. These fears result in the

child being unable to engage in age-appropriate activities, such as school, camp, or play with peers.

Phobias involve an overwhelming fear of a specific stimulus. The fear is so intense that the child avoids contact with the object or location. For children traumatized by war, phobias often become crystallized around stimuli that remind the child of war events, such as police, weapons, and crowds.

In Generalized Anxiety Disorder, children express anxiety and worry about a range of experiences and events in their lives, regardless of their relationship to war. These children report chronic feelings of worry, including psycho-physiological symptoms of tension, such as difficulty breathing, chest pain, muscle tension, and aches and pains. While this reaction is less frequent in children from war zones, GAD can develop if a child's initial anxieties are not addressed.

Learning Difficulties

It has been argued that school performance is an important indicator of how a refugee child is faring after his or her migration experience. Several authors have noted that refugee children are more vulnerable to learning problems than other children (Rousseau, Drapeau, & Corin, 1996; Sack, Kinzie, & Roth-Ber, 1986). Emotional difficulties that the child may be experiencing as a result of his war experience may lead to difficulties with learning and school performance. In some cases, the child may not express his emotional stress, but may demonstrate it in his poor functioning at school. This means that school personnel are an important source of information about the functioning of a refugee child. Teachers and guidance counselors can provide information about a child's academic performance,

her concentration and attention, her absenteeism, and her general mood and social engagement in the classroom. These are vital pieces of information about that child's adaptation.

Moderating Factors

Several factors have been shown to influence the degree and manner in which children are affected by war. Below, we review some of these variables and discuss their implications for caregivers of refugee children.

Exposure

The risk of psychological problems after war has been shown to be strongly linked to the amount and degree of exposure to traumatic events—often called the “dose” effect (Pynoos, Kinzie, & Gordon, 2001; Thabet & Vostanis, 2000). Pfefferbaum (1997) notes the dimension of “proximity”—both physical and emotional—as central to the child’s dose of trauma. Thus, the variables of emotional and physical proximity capture different ways that a child may be affected by a traumatic event. The physically proximal experience of having a bomb explode nearby would be expected to be intensely frightening for most children. An emotionally proximal trauma—such as the child’s father being killed in a nearby bomb explosion that the youngster did not actually see—is also considered to be a severe “dose” of trauma.

Children’s likelihood of difficulties after war violence is increased even more when the child suffers direct physical harm (Randall & Lutz, 1991). Increasingly, children are suffering from the complex physical effects of war. According to the United Nations Children’s Fund (2000), many

children are being physically injured as a direct result of exposure to combat, such as being forced to fight as child soldiers, being used as sex slaves or porters, or being exposed to disease or malnutrition in the frontline conditions. Sick and/or malnourished children are compromised and more likely to be injured and more severely limited in their ability to get well than a well-nourished, healthy child. Additionally, malnutrition in children can create severe mental and physical developmental consequences for the child (Randall & Lutz, 1991).

Pre-migration Community Disruption

For many children, living through war not only exposes them to horrifying situations of violence and danger, it also disrupts the most basic of their daily needs and routines. In most war zones, basic public services, such as schools, hospitals and utilities are drastically impaired, if not completely shut down. Thus, children's needs for education, medical care and safe and hygienic living space are inadequately served, often for extended periods of time. This loss of the basic societal structures that support children's development cannot be underestimated in its impact. Due to ongoing wars around the world, entire communities of children are experiencing, at the very least, educational deprivation and, in some cases, massive societal disorder (National Child Traumatic Stress Network [NCTSN], 2003; Smith & Akinsulure-Smith, 2004).

Because of parents' need to focus on their families' most basic safety and survival needs during war, children often receive little in the way of emotional or psychological support during these profoundly frightening events. Parents may be preoccupied with getting food and water for their family (sometimes enlisting the children to accompany them, despite the

danger of venturing outside), with protecting their home and belongings, or with simply making an escape plan. With bewildering events going on around them and parents who are preoccupied with the family's survival, children are often left to watch the unfolding events in confused silence. The lack of information and clarification being provided to children may leave them with distortions about the actual events going on around them. For example, some children in Kosovo during the NATO air strikes of 1999 have since reported that they were confused about who was bombing their communities, and were afraid they were under further attack from the Serbian military. While parents may not be able to reassure children that they are safe in the midst of active combat, the provision of basic information about what is happening and a willingness to answer some of the children's questions may help children feel somewhat more secure.

Post-migration disruption

Heptinstall et al. (2004) noted the impact of post-migration factors on the functioning of displaced children. For many families who survive a war situation, there are huge changes in the social and economic status that they held before the war. The search by the child's family or caretakers for a safe haven means that the child may have had to change schools, move from one community to another, flee their home countries, or endure economic hardship (NCTSN, 2003). The resettlement process itself can further create stressors for the family and thus for the child. Having to adjust to a new country, culture, and climate can create stressors that will reverberate throughout the refugee family. In addition, language barriers may place the refugee child in a disadvantage as he tries to simultaneously acclimate to the demands of American culture and education, while often serving as a

linguistic and cultural “bridge” for his parents. Finally, it is rare that the refugee family finds themselves in a position of economic security in their new home. Most of these families find themselves living in poor, disadvantaged communities, sometimes fearing for their safety in the very country they thought would provide them "safe haven".

Parental functioning after war

Parents' own psychological functioning in the aftermath of war has been well-documented to have a profound effect on children's reactions to war (NCTSN, 2003; Pfefferbaum, 1997; Thabet & Vostanis, 1991). Children whose parents are experiencing serious psychological distress after war are more likely to have difficulties themselves. The effect of parents' psychological problems on children has a ripple effect--not only must the child witness their parent's compromised functioning, but they must also endure the inevitable disruption of routine and structure that accompanies serious parental impairment. This is not to suggest that refugee parents undergoing stress due to migration and adaptation issues after a war are destined to also struggle with problems in their children. However, parents who are so symptomatic as to be unable to function in the aftermath of war are more likely to have children who are similarly compromised.

Child-based Variables

Numerous variables intrinsic to the child—such as gender, developmental level and temperament—have been linked to how the child functions after experiencing war. For example, girls, like women, have been noted to be at higher risk of sexual violence and exploitation during situations of war and flight from war, thereby increasing the likelihood that

they will experience psychological and emotional difficulties after the war (Women's Commission for Refugee Women and Children, 2006). A child's age and developmental level may influence that child's reactions to the trauma in both protective and risk-enhancing ways. For example, a younger child may be protected from certain experiences by virtue of not understanding the ramifications of what is happening and by being more shielded by parents who are concerned about exposure. School-age children and adolescents, on the other hand, may be fully cognizant of what is occurring in their community—witnessing the destruction of their homes, realizing the extent of what they are leaving behind as they flee—and, therefore, more distressed about the experience. Conversely, infants and toddlers who are pre-verbal may have few coping strategies at their disposal in the face of traumatic circumstances and little ability to comprehend the situation, such as being able to understand that the family is finally out of danger (Pfefferbaum, 1997). Therefore, it is important to recognize the interplay between the child's developmental level and his exposure to the war and flight situation.

As with adults, children with significant psychological problems that existed before the war may have more difficulty in the aftermath of the trauma they experienced (Randall & Lutz, 1991). Posttraumatic stress may exacerbate existing psychological problems or a difficult temperament. Thus, it is important to assess children's pre-trauma functioning in order to determine the presence of risk factors that may impinge upon their recovery.

While children suffer many of the same traumatic events during wartime as adults, there are important variables that should be assessed to determine the impact of these events on the children. It is important to determine not only what children were exposed to, but what effect the

trauma has had on the child's caregiver, what socioeconomic and cultural changes the family has endured, what the child's physical health and nutrition has been, and, if possible, how the child was functioning before the events of war.

Treatment Options for Children Traumatized By War

We have reviewed the various psychological and behavioral difficulties that can manifest themselves in a traumatized refugee child, including moderating factors that can influence these responses. In the majority of cases, children who have migrated from war zones will not require professional mental health evaluation and treatment. Many will adapt well to their new communities, especially with appropriate parenting and supportive structures in place (school, medical care, etc.). However, in the case of a youngster who is having difficulties that are serious and pervasive enough to warrant treatment, it is important to recognize these needs quickly and respond to them with an appropriate intervention. Below, we review referral issues pertaining to the refugee child and treatment options available for these children and their families.

Referral to Therapy

When caregivers outside of the family become concerned about a youngster, they often consider making a referral to a mental health provider. The manner in which this is done, in terms of how the concern is communicated and how the referral is explained, can make a tremendous difference in how the parent hears it. For example, in making a referral for mental health services for the refugee child, psychoeducation should be

provided to the parent about the process, such as what mental services are, what services are available (individual, group or family therapy), and how they might help the child.

In many cultures, therapy is a fairly unusual service, especially for children. Thus, caregivers must fully explore with parents their reactions to and questions about the treatment being recommended. In addition, it is important to communicate to the parent or guardian the central and primary role that they play in the life of the child and to elicit from them *their* concerns about the youngster's functioning. Furthermore, the child's parent or guardian should be prepared to provide as much information as possible regarding the child's psychosocial, emotional, educational and developmental history, as well as information about the child's current functioning.

Family Therapy

If a family is fortunate enough to find themselves out of immediate danger, either due to flight from a war zone or the ending of conflict, adults in the family often feel a sense of relief and a desire not to revisit or discuss the events of the war at all (Frederick, 1985). Unfortunately, this reaction may stand in stark contrast to the children's need to process the trauma--even in the most basic way. For example, one of the most common symptoms that children report after a trauma or disaster is fear that the trauma will reoccur (Frederick, 1985). Thus, parents who arrive in a refugee camp or in a new country with their children may assume that children understand that they are now safe from the war, when in fact; the children may harbor no such appraisal of this new and strange setting. In this situation, children's symptoms may actually increase as the immediate danger and chaos

subsides, their parents become somewhat more available to them, and their defenses become somewhat less rigid. Parents may be bewildered and frustrated that the child is misbehaving or acting out now that the family is out of imminent danger. One refugee parent, speaking about her child's separation anxiety, noted "I couldn't believe after all that we had survived, that we were finally safe in America and now he was acting scared."

Thus, it is not uncommon for a refugee child to be behaving symptomatically, seemingly the only member of the family still having difficulty after the war. In this situation, the temptation may be to focus on the child as the person in need of services, when, in fact, a family intervention would provide greater relief to all of the family members. A family-based intervention is designed to take the focus off of the symptomatic family member--in this case, the child--and place the emphasis on the entire family's adaptation and ongoing development after the traumatic events of the war.

There are several goals in most situations in which family therapy is recommended for the war-traumatized family. Below, we discuss these goals, which may be addressed simultaneously over the course of a treatment.

1. Return of equilibrium. One common goal in family therapy with a war-traumatized family is the return of equilibrium to the family system (Shapiro, 1994). Before the family can process or revisit difficult memories, it is essential that the family have some level of security and safety. The basic needs of food, housing, and freedom from further persecution or violence must be met in order for a family to be able to begin a therapeutic process. Beginning treatment in which memories and feelings about the war

are explored before a family feels relatively safe and secure is strongly contraindicated, as family members may feel more vulnerable, and more likely to terminate the treatment prematurely.

If the family is in a situation of some safety and predictability, the treatment can serve as a way to create further balance and order with the family, in terms of boundaries and roles. As mentioned earlier, some parents, themselves traumatized by the events of the war, are highly compromised once they resettle and may be unable to manage the “executive” roles of keeping the family functioning appropriately. This can happen when parents have severe depression or PTSD and are unable to provide basic structure and support to their children. In addition, this can be exacerbated by cultural and linguistic hurdles that prevent the parents from feeling able to enter the community, find jobs and advocate on behalf of their children as they would in their home countries.

In these situations, an imbalance sometimes develops in which parents lose their ability not only to manage their family’s needs, but also to discipline and keep abreast of their children’s behaviors. Conversely, parents who are feeling overwhelmed by the new environment and the challenges of parenting in a new country may respond by being overly strict and protective, leading to conflict in the family or to the children feeling squelched and unable to develop appropriate interests or activities. In one Kosovar family treated at the Bellevue/NYU Program, a highly anxious and depressed mother insisted that her teenage children rush home from school to be with her, thereby preventing them from engaging in appropriate school activities that interested them and would have helped them socially.

Restoring the family to a healthy equilibrium with appropriate boundaries can take place with some parent guidance sessions, in which

parents' opinions about the family's functioning are elicited and concrete recommendations are made about rebuilding parental authority and supervision. Specific recommendations must be adapted to the family's situation, but they can include instituting homework and academic expectations and following up on these expectations with contact with the school. Also, behavioral rewards and consequences may be recommended to help foster appropriate behavior in youngsters who are having behavioral difficulties.

Finally, for parents struggling with depression and PTSD, it is essential that the therapist be utilized for discussions of their distress so that children are not overly exposed to parental difficulties, thereby undermining their authority. Sometimes, this requires that the parent be referred for individual therapy or psychiatric care if symptoms are severe. In the Kosovar family mentioned above, the mother entered individual treatment to address her severe PTSD and family sessions were held with her and her children to strengthen the family's overall functioning. Family sessions were used to help this mother see that her teenage children needed some age-appropriate independence. In addition, sessions were used to help the children feel more able to separate by recognizing that they were not solely responsible for their mother's emotional well-being, as those issues were being addressed in her individual therapy.

2. Enhancement of understanding/empathy. Another goal of family therapy with the traumatized family is to enhance communication and, in the process, intra-family understanding and empathy. In many families who have survived war, the parents can find it difficult to recognize and accept how hard the children's experience has been. This can be a protective

instinct, borne of the parents' wish both that their child did not have to experience the fear and sadness that the trauma engendered, as well as their wish that they had been able to protect them better. In another Kosovar Albanian family that fled their home on foot for a refugee camp, passing many dead bodies on the way, the mother explained to the therapist that the children had not seen the bodies because it was dark when they traveled. This description stood in stark contrast to the story told by the children, who provided vivid and grotesque details of the corpses they saw, some hanging from trees in broad daylight. A parent's inaccurate perception that their child was not affected by traumatic events must be understood as a protective defense and must be sensitively addressed.

This process of enhancing the parents' understanding of their children's experiences requires a balance of helping the parent see that their children suffered unique and painful disruptions due to the war, while also emphasizing how much the parents have tried and wanted to protect the children. The therapist should not criticize or shock the parent with the "truth" about the children's experiences, but must carefully address how much the parents have done in the best interests of their family's safety and well-being. Emphasizing the out-of-control nature of war and the fact of having to make some decisions with little information or under extreme duress can help parents feel less guilty about what their children experienced. In addition, providing a time for the children to speak about their memories and questions about what happened during the war can lead to a better understanding by the parents of their children's experiences. The mother mentioned above, who denied that her children had seen any bodies during their flight was ultimately able to listen in family sessions as they showed her drawings they had created of their memories of the war. With

some preparation and coaching from the therapist, she was able to respond empathically to their stories and let them know that she heard them.

3. Meaning-making. Another goal of family therapy with war survivors is to create a cohesive story or narrative about what the family went through, so as to allow family members to make meaning of their experience and move on from it. As with families who experienced an unexpected death of a family member, families from war zones will likely need to revisit the circumstances of the trauma experience in order to be able to move past these painful memories and go on with the process of living and developing as individuals and as a family.

Families often find that topics they cannot discuss outside of the therapist's office, such as specific, painful memories, are easier to discuss in the presence of the therapist and with some structure. Therapists may use a number of structuring techniques to elicit these memories. Some of these methods include:

- Family story-telling: A process in which the family shares memories of their experience together during the war, with the therapist serving as “secretary” to create a record of their story. This is best used with older school-aged children and adolescents. With smaller children, it is recommended that the youngster be able to write his or her story and draw pictures if possible, including an emphasis on what he would teach other kids about his experience or a way that he mastered the situation.

- Letter writing: This can be particularly salient for a family who lost a member during the war. In this exercise, each family member and the therapist writes a letter to the person who died, sharing memories of him and feelings about losing him. Each family member then reads his/her letter, thereby creating an experience of shared memories and meaning-making about the loved one's life. The therapist can share a letter in which she expresses what she has learned about the deceased family member and about the family's love for him/her.
- Memorializing: This process can also create a structure for allowing a family to memorialize or grieve the people and things they left behind and lost due to the war. The therapist leads a discussion with family members about what they lost in the war, providing equal emphasis to all family members' concerns. For example, a child may have as much expressed distress about leaving behind a cherished toy as a parent has about losing their home. The therapist helps family members see how losses are reflective of where the individual is in his/her life and what his/her developmental concerns are. After reviewing the family's list of things they have left behind, they are offered a chance to memorialize or remember these things. This can provide an opportunity for a culturally appropriate ritual or gesture to be used together by the family to mark the loss, such as a prayer, a song, or a ceremony. This process is designed to provide an expression of the family's shared losses and to help them find meaning in their experience. Empathy is

also enhanced as members learn from one another what their loved ones are grieving or missing.

These exercises must be approached carefully and can lead to intense family sessions in which a range of emotions and memories are shared. The therapist must provide time for closure and discussion of the exercises. Contraindications in using these kinds of techniques include the presence of a severely traumatized member of the family whose experience was markedly worse than those of other family members. This individual is more likely to need individual therapy to address what occurred. Other contraindications include severe psychopathology in one or more members of the family, including suicidality, and domestic violence occurring in the family.

Individual Therapy

Individual therapy is sometimes indicated--alone or in concert with other types of treatment-- for children who have suffered war trauma. Particular situations that often indicate the need for individual treatment include severely impairing symptoms of anxiety or depression in a child or adolescent, prominent feelings of guilt or shame, or absence of family members or other supportive caregivers to engage in family therapy.

Individual treatment with a child or adolescent may take several forms. Cognitive behavioral therapy methods have been found to be effective with anxiety disorders in children (Barrios & O'Dell, 1998). In addressing the avoidant behaviors and specific phobias that often manifest themselves in war survivors, techniques of desensitization and exposure can be used. For example, with desensitization, a child who experiences a phobia

based on his war experience would practice imagining the feared object or situation, while using relaxation techniques such as controlled breathing and deep muscle relaxation. In exposure treatment, the child is faced with the feared stimulus in imagination and, if possible, in real situations. Both of these methods either alone or in combination with other cognitive-behavioral strategies have been shown to be highly effective in decreasing children's anxiety symptoms (Barrios & O'Dell, 1998).

In some cases, it is not enough to simply decrease isolated fears and worries in children--particularly children with full blown PTSD-- who have been traumatized by situations of war. In these cases, there is a need to address the traumatic circumstances that the children were exposed to during the war. Most effective PTSD treatments involve some kind of gradual exposure to remembering and re-telling these memories (van der Kolk, McFarlane, & van der Hart, 1996). Depending on the age of the child and the degree of exposure to trauma, this revisiting of traumatic memories may take place through story-telling, drawing, play, writing or other structured age-appropriate formats.

Generally, younger children work better in displacement—i.e. telling their story through a character's eyes—as this prevents overwhelming their defenses. For young children struggling with memories of war, play therapy and story-telling are effective in meeting this requirement of displacement. The youngster can master the frightening situation by escaping, defeating the "bad guys," or repairing the damage that was done, sometimes with the aid of a beloved superhero. Helping the child to create a book about his experience—"Something Scary Happened to Jean"—can provide him with the exposure to the frightening memory, while enhancing integration and cohesion of the memories.

Two young Haitian brothers, in therapy at the Program, wrote and illustrated a book that described the details of their kidnapping by antigovernment rebels, with vivid drawings accompanying it, and descriptions of what they felt. At the end of the book, the therapist worked with them to create an advice section for other children who have scary things happen to them, thereby providing a sense of mastery and expertise in these youngsters. Thus, while they were able to tell their story in the first person, they could use displacement to imagine that they were helping other children who had bad things happen to them.

For older children and adolescents, a more direct re-telling of the events of the war may be appropriate. Included in most of these techniques of retelling of the trauma is psychoeducation for the adolescent about the symptoms that accompany traumatic memories as well as training in relaxation techniques. This process helps the youngster habituate to the bad memories, thus “detoxifying” them and making them more tolerable and less fragmented (Onyut et al., 2005). As the youngster is asked to face the difficult memories, he is armed with coping strategies to help manage the accompanying discomfort.

In situations of individual therapy for children who have survived war, it is essential that there be parent guidance sessions for the parents or guardians of the youngster. These sessions can be used to educate the caregivers about the normal reactions to trauma that they may be witnessing in the children. This process is designed to enhance parental empathy towards the child and it may take place in sessions with the child and parent. In addition, strategies for managing the child's symptoms can be presented to the parent or guardian. For instance, the parent of a child who is frightened to go to bed at night can be coached on supporting the child, while assisting

him in mastering this fear. Also, parents can receive guidance on how to address children's questions about the war or their re-telling of troubling memories.

Group Therapy

Group therapy can be an effective treatment modality for young war survivors. For children who have lost important sources of security, group treatment can provide structure, stability, consistency, and a safe learning environment. Group treatment after war trauma can serve two goals: First, groups offer children the opportunity to see that they are not alone in their feelings and experiences, thus providing a feeling of affiliation and connection. Second, groups provide the opportunity for children to see how other youngsters react to their war experiences and allow them a chance to learn new ways of coping and problem solving. Thus, group members can develop solutions together to their difficulties, rather than have problems "solved" for them by adults in authority.

Several types of groups can be offered for survivors of war and refugee trauma. In *recreation groups*, children meet for simple games, sports and structured play activities. These groups have as their emphasis the creation of social affiliation and support among the participants. They are less focused on direct discussion of the war experience or memories, though some conversations can be expected to arise organically as members feel closer to one another and more comfortable. *Activity groups* are focused on forms of expression for children and adolescents, such as visual art, music, and story-telling. In this kind of group, there is more opportunity for processing of war memories and feelings associated with the trauma. Thus, the tasks of normalizing and, in some cases, problem-solving are often

achieved for group members. In some cases, particularly with pre-adolescents and adolescents, a *therapy group* in which the emphasis is on direct discussion of experiences and feelings is appropriate. Group leaders still may choose to structure these sessions somewhat, perhaps by providing an opportunity for self-reflection at the beginning of the group, or providing some questions for discussion. In addition, coping strategies such as breathing retraining, progressive relaxation, guided visualization and thought stopping may be taught to group members.

For groups in which there will be discussion of war experiences and other potentially distressing material, it is especially vital that the group leaders not only create an atmosphere of openness and safety so that the children can express their needs, but also one of structure, stability and consistency. Therefore, group goals and rules should be clearly articulated and reviewed in each session, such as the expectation of confidentiality, promptness, and respect for others' opinions. Also, the group should meet in the same place and at the same time, and the leader should leave time to wrap up the group after each meeting.

Medication

For some children traumatized by war experiences, an evaluation for medication may be necessary. This is the case when children's symptoms are severe enough to cause impairment across several domains of the child's life. For example, a child who is depressed and unable to engage in normal activities of play, school, and family life may need antidepressant medication. Expressions of suicidal feelings or psychosis are both indicators of the need for an evaluation for medication and possibly hospitalization. Similarly, for some children with severe anxiety reactions, medication may

be indicated until symptoms have been reduced through other therapeutic means.

It must be noted that many refugee populations come from cultures in which the use of medication for emotional difficulties is highly unusual and, in some cases, stigmatized. Thus, it is important to work with clients around their opinions and beliefs, rather than to facilitate a referral that will be ineffectual or unsuccessful.

Summary

Every year, millions of children are exposed to the violence and disruption associated with modern warfare. While many children come through these experiences and are able to function well, there are some children who have experienced war and refugee trauma who are at risk for psychological, behavioral and emotional difficulties. A number of factors can influence how a child functions after fleeing a war zone, including the amount of traumatic exposure, the amount of pre- and post- flight psychosocial disruption, the psychological functioning of the parents, and the youngster's developmental level and temperament.

For children and adolescents from war zones who demonstrate severe or impairing symptoms of distress, a referral for a mental health evaluation is recommended. Caregivers who work with these children, such as teachers, doctors, nurses and clergy can be important witnesses to a child's functioning and therefore, an important resource to parents and, ultimately, to mental health practitioners who work with these children. Mental health treatment, such as family, individual and group therapy, can be a powerful

intervention to assist these youngsters and their families in recovering from their experiences and moving on with their lives.

Above all, the work of caring for children who have endured and survived war requires a unified effort on the part of caregivers and loved ones to help these children feel safe again and able to return to the task of being children.

Appendix A

This information has been compiled by the National Organization for Victim Assistance.

CHILDREN'S REACTIONS TO TRAUMA

Common reactions to war and/or refugee trauma in children under 2 years of age:

- Crying excessively or getting hysterical
- Showing little interest in what is happening or being frightened of people
- Eating and sleep disturbance
- Banging his or her head or rocking backwards and forwards
- Decrease in “babbling” or “baby talk”
- Unresponsive behavior
- Regressive behavior
- Difficulty meeting developmental milestones

Common reactions to war and/or refugee trauma in preschoolers (2–4 yrs):

- Regression: Going back to an earlier stage of development, e.g. the child sucks his/her thumb or fingers, the child demonstrates separation anxiety
- Losing control over his/her bowels - wets the bed at night or wets himself in the daytime even though he has already been toilet-trained
- Having nightmares and sleep problems
- Feeling frightened of real or imagined objects
- Engaging in hyperactive behaviors or uncontrollable behavior
- Acting aggressive towards others
- Demonstrating obvious fear and mistrust of others
- Difficulty concentrating
- Demonstrating unresponsive and inactive behavior
- Having learning difficulties
- Demonstrating post-traumatic play

Common Reactions to war and/or refugee trauma in school age children (6-11 yrs):

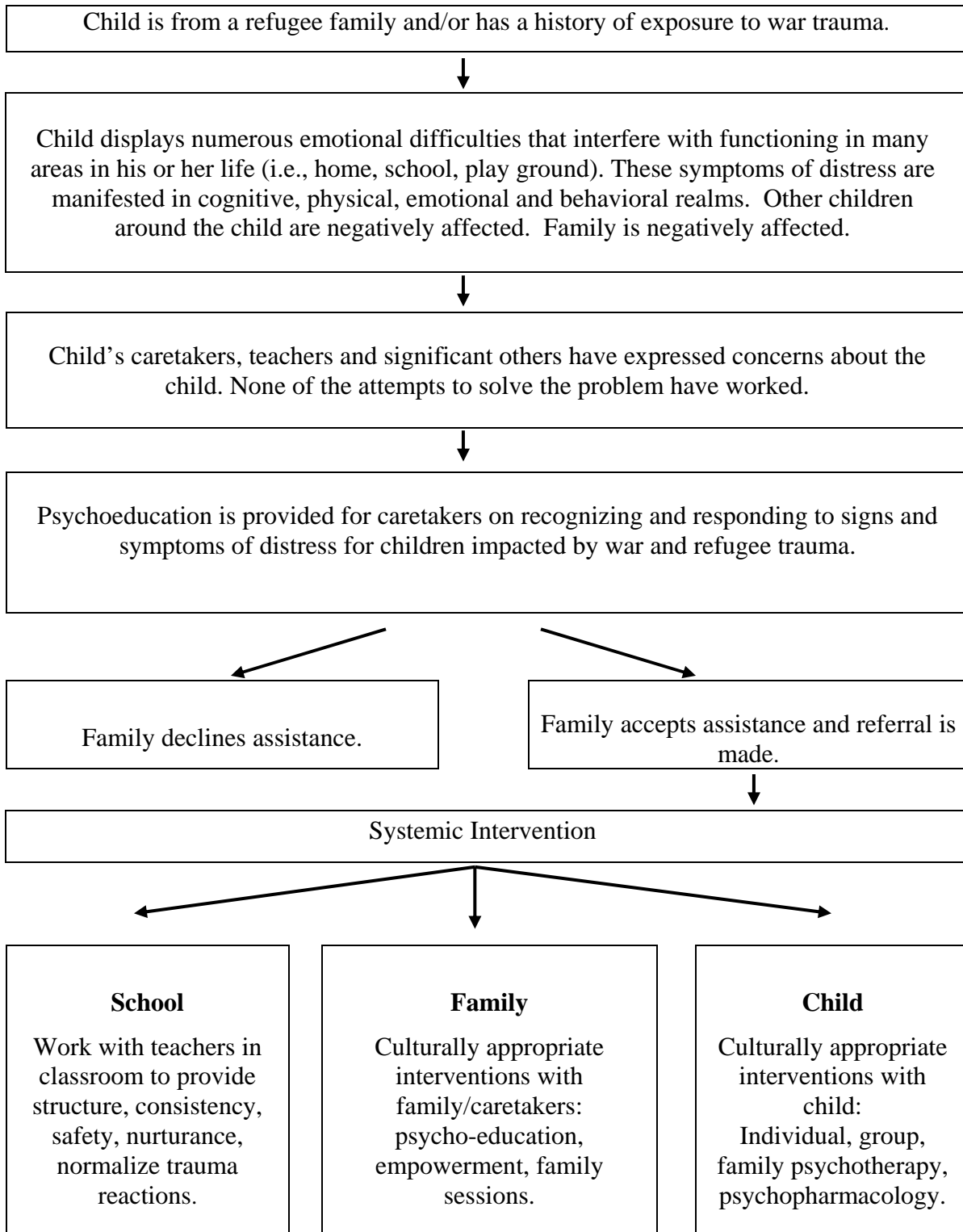
- Crying a lot or appearing very sad
- Demonstrating post-traumatic play
- Trembling or appearing frightened
- Indulging in self-stimulation i.e., rocking back and forth or banging head
- Sleep disorders, nightmares or sleeplessness, or excessive sleeping
- Bedwetting
- Eating disorders
- Numerous physical complaints, such as headaches, dizziness, back aches, or stomach upsets with no apparent cause
- Physically aggressive play including being loud and rough during play.
- The child may be extremely withdrawn, quiet, and well-behaved, never expressing feelings or desires, or depressed and unresponsive
- Regression: The child may start acting like a much younger child
- There may be restlessness and inability to complete a task
- Difficulty concentrating or remembering things in school
- Irritable towards others or unable to work with others
- Feeling frightened of others and unable to trust them
- Always thinking that bad things will happen in the future
- Demonstrating separation anxiety
- Feeling apathy, withdrawal, avoidance
- Feeling sadness, depression

Common Reactions to war and/or refugee trauma in adolescents (12-18 yrs):

- Withdrawal from others, failure to form relationships
- Being overly dependent on others for direction/assurance
- Aggressive behavior, attitude or actions
- Agitation, restlessness or inability to remain still or concentrate
- Depression
- Moodiness or changes of mood and behavior from one extreme to another in a short time
- Numerous physical complaints
- Sleep problems, nightmares
- Paranoia or inability to trust others; feeling that others are threatening to do harm
- Suicidal feelings
- Fears, worries about self, safety, and family
- Attention, memory difficulties
- Sense of foreshortened future
- Feelings of guilt and shame
- Risky, dangerous behaviors
- Hallucinations

Appendix B

Guidelines for Referring a Child refugee or War Victim to Mental Health Services



References

- Ahmad, A. (1992). Symptoms of PTSD among displaced Kurdish children in Iraq: Victims of a man-made disaster after the Gulf war. *Nordic Journal of Psychiatry*, *46*, 315-319.
- Ahmad, A., Sofi, M.A., Sundelin-Wahlsten, V., & von, Knorring, A.L. (2000). Posttraumatic stress disorder in children after the military operation "Anfal" in Iraqi Kurdistan. *European Child & Adolescent Psychiatry*, *9*(4), 235-243.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text Revision). Washington DC: Author.
- Barrios, B., & O'Dell, S. (1998). Fears and anxieties. In E. Mash & R. Barkley (Eds.), *Treatment of Childhood Disorders* (pp. 249-337). New York: Guilford.
- Derluyn, I., Broekaert, E., Schuyten, G., & Temmerman, E.D. (2004). Post-traumatic stress in former Ugandan child soldiers. *Lancet*, *363*, 861-863.
- Dyregrov, A., & Raundalen, M. (1987). Children and the stresses of war: A review of the literature. In C.P. Dodge & M. Raundalen (Eds.), *War, violence and children in Uganda* (pp. 109-132). Oslo: Norwegian University Press.
- Frederick, C. (1985) Children traumatized by catastrophic situations. In S. Eth & R. Pynoos (Eds.), *Posttraumatic Stress Disorder in Children* (pp. 71-99). Washington D.C.: American Psychiatric Press.
- Garbarino, J., & Kostelny, K. (1996). What do we need to know to understand children in war and community violence? In B. Simon (Ed.), *Minefields in their hearts: The mental health of children in war*

- and communal violence* (pp.33-51). New Haven, CT: Yale University Press.
- Heptinstall, E., Sethna, V., & Taylor, E. (2004). PTSD and depression in refugee children. Associations with pre-migration trauma and post-migration stress. *European Child and Adolescent Psychiatry, 13*, 373-380.
- Hubbard, J., Reallmuto, G., Northwood, A., & Masten, A. (1995). Comorbidity of psychiatric diagnoses with Posttraumatic Stress Disorder in survivors of childhood trauma. *Journal of American Academy of Child & Adolescent Psychiatry, 34*(9), 1167-1173.
- Jensen, P.S., & Shaw, J. (1993). Children as victims of war: Current knowledge and future research needs. *Journal of American Academy of Child & Adolescent Psychiatry, 32*, 697-708.
- Kaffman, M., & Elizur, E. (1984) Children's bereavement reactions following death of the father. Family psychiatry in the kibbutz [Special issue]. *International Journal of Family Therapy, 6* (4), 259-283.
- Lustig, S.L., Kia-Keating, M., Grant-Knight, W., Geltman, P., Ellis, H., Kinzie, J.D., et al. (2004). Review of child and adolescent refugee mental health. *Journal of American Academy of Child & Adolescent Psychiatry, 43*, 24-33.
- Macksoud, M., & Aber, J. (1996). The war experience and psychosocial development of children in Lebanon. *Child Development, 67*, 70-88.
- Macksoud, M., Dyregrov, A., & Raundalen, M. (1993). Traumatic war experiences and their effects on children. In J. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 625-633). New York: Plenum Press.

- Mghir, R., & Raskin, A. (1999). The psychological effects of the war in Afghanistan on young Afghan refugees from different ethnic backgrounds. *International Journal of Social Psychiatry*, 45(1), 29-36.
- National Child Traumatic Stress Network, Refugee Trauma Task Force. (2003). *Review of child and adolescent refugee mental health*. Retrieved on December 7, 2006 from http://www.nctsnet.org/nctsn_assets/pdfs/reports/refugeereview.pdf
- Onyut, L.P., Neuner, F., Schauer, E., Ertl, V., Odenwald, M., Schauer, M., et al. (2005). Narrative exposure therapy as a treatment for child war survivors with posttraumatic stress disorder: Two case reports and a pilot study in an African refugee settlement. *BMC Psychiatry*, 5, 1-9.
- Pfefferbaum, B. (1997). Posttraumatic stress disorder in children: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36, 1503-1511.
- Pynoos, R., Goenjian, A.K., Tashjian, M., Karakashian, M., Manjikian, R., Manoukian, G., et al. (1993). Posttraumatic stress reactions in children after the 1988 Armenian earthquake. *British Journal of Psychiatry*, 163, 239-247.
- Pynoos, R., Kinzie, J.D., & Gordon, M. (2001). Children, adolescents, and families exposed to torture and related trauma. In E. Gerrity, T.M. Keane, & F.Tuma (Eds.), *The mental health consequences of torture* (pp. 221-225). New York: Kluwer Academic/Plenum Publishers.
- Pynoos, R., & Nader, K. (1993). Issues in the treatment of posttraumatic stress in children and adolescents. In J. Wilson & B. Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes* (pp. 535-549). New York: Plenum Press.

- Randall, G., & Lutz, E. (1991). *Serving Survivors of Torture*. Washington DC: The American Association for the Advancement of Science.
- Rousseau, C., Drapeau, A., & Corin, E. (1996). School performance and emotional problems in refugee children. *American Journal of Orthopsychiatry*, 66 (2), 239-251.
- Sack, W., Him, C., & Dickason, D. (1999). Twelve-year follow-up study of Khmer youths who suffered massive war trauma as children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38 (9), 1173-1179.
- Sack, W., Richard, J.A., Kinzie, H., & Roth-Ber, D. (1986). The psychiatric effects of massive trauma on Cambodian children: The family, the home, and school. *Journal of the American Academy of Child & Adolescent Psychiatry*, 25, 377-383.
- Servan-Schreiber, D., Le Lin, B., & Birmaher, B. (1998). Prevalence of Posttraumatic Stress Disorder and Major Depressive Disorder in Tibetan refugee children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37, 874-879.
- Shapiro, E. (1994). *Grief as a family process: A developmental approach to clinical practice*. New York: Guilford.
- Shelby, J.S. (1997). Rubble, disruption, and tears: Helping young survivors of natural disaster. In H.G. Kaduson, D. Cangalosi, & C.E. Shaefer (Eds.), *The playing cure* (pp.143-170). Northvale, New Jersey: Jason Aronson.
- Smith, H., & Akinsulure-Smith, A. (2004). A global perspective on youth outreach. In C. Clauss-Ehlers & M. Weist (Eds.), *Community Planning to Foster Resilience in Children* (pp. 127-140). New York: Kluwer Academic Publishers/Plenum Publishers.

- Terr, L. (1990). *Too Scared to Cry*. New York: Harper & Row.
- Thabet, A., & Vostanis, P. (2000). Posttraumatic Stress Disorder reactions in children of war: A longitudinal study. *Child Abuse and Neglect*, 24, 291-298.
- The United Nations Children's Fund. (2000). *The state of the world's children 2000. Undeclared War. Conflict and violence: No haven for a child*. Retrieved on December 6, 2006, from www.unicef.org/sowc00/uwar4.htm
- van der Kolk, B.A., McFarlane, A.C., & van der Hart, O. (1996). A general approach to treatment of Posttraumatic Stress Disorder. In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 417-440). New York: Guildford Press.
- Women's Commission for Refugee Women and Children. (2006). *Displaced women and girls at risk: Risk factors, protection solutions and resource tools*. Retrieved on December 7, 2006, from <http://www.womenscommission.org/pdf/WomRisk.pdf>

Chapter 11

Supportive Group Treatment with Survivors of Torture and Refugee Trauma

– Summary

- * General Approach to Group Treatment
 - Historical Antecedents
 - Specialized Client Population Needs
- * Rationale for Group Treatment with Survivors of Torture and Refugee Trauma
 - Support
 - Reduction of Isolation
 - Empowerment
- * Initial Development of Group Treatment Models
 - French-Speaking African and Tibetan Groups
- * Considerations Regarding Group Membership
- * Group as an Adjunct or Main Modality of Treatment?
- * Linguistic Issues
- * Special Clinical Considerations
 - Contact Outside of Group
 - Confidentiality
 - Group Structure and Dynamics
 - Content of Sessions
 - Saying a Positive “Au Revoir”
 - Supervision and Self-Care for Group Facilitators
- * Conclusion

Supportive Group Treatment with Survivors of Torture and Refugee Trauma

Hawthorne E. Smith, Ph.D & Edna Impalli, Ph.D.

General Approach to Group Treatment

In general, human beings are group oriented. The human tendency toward groups begins within the family unit, and extends to school, career, and other peer and community related activities throughout childhood, adolescence, and adulthood (Burlingame & Layne, 2001). The formation of an individual's personality is largely predicated upon the experiences with the different groups in which the individual interacts. In addition, opportunities to observe and modify one's behavior are very much affected by the groups in which they are involved.

Many psychological theorists have explored and written about the ways that group therapy can be curative for clients in psychological distress (Lonergan, 1994). Early points of view have varied from Joseph Pratt's use of a psychoeducational model to help treat tuberculosis patients in 1905, to LeBon (1920) and Freud's (1921) efforts to understand primal horde dynamics. Although a unitary theory of group treatment has yet to be developed and widely accepted, therapists have come to use a combination of supportive, psychodynamic, interpersonal, psychoeducational, and cognitive-behavioral models as the foundation of group psychotherapy practice (Foy, Eriksson, & Trice, 2001). As previously mentioned (see Chapter 10), activity groups and play groups have also been used as effective interventions for children who have survived war trauma.

There is a growing body of literature concerning group treatment for survivors of traumatic events (i.e. Bernard & MacKenzie, 1994; Stubenbort, Donnelly, & Cohen, 2001; Foy et al., 2000; Saxe et al., 1993). However, at the time the program was preparing to launch our initial treatment groups we searched the literature for insights specifically relating to conducting groups with survivors of torture living in exile, and to our dismay, did not find a great deal written on the subject.

There was one particularly helpful article that described a time-limited group for survivors from Central and South American countries (Fischman & Ross, 1990). Even though there were significant differences between the group described in the article and the groups we were proposing at Bellevue, we were encouraged to see that treatment results supported the contention that an increased sense of community and belonging does foster individual healing in survivors. We were nevertheless concerned that we were venturing into relatively uncharted therapeutic waters.

Rationale for Group Treatment with Survivors of Torture and Refugee Trauma

Two of the primary goals that we identified for our treatment groups were that clients would feel supported, and that their sense of social isolation would decrease. In individual therapy, many African clients, for example, reported feeling “lonely,” “all by themselves,” or that “nobody could understand” their problems. Group treatment would strive to support these clients in multi-faceted ways consistent with the “curative factors” described by Yalom (1985) such as: hope, universality (the reduction of isolation), information sharing, altruism, and interpersonal learning. It was hoped that

clients would come to find out that they were not alone, in terms of their torture experiences, or in terms of the challenges facing them as they attempted to adapt to life in the United States (Drozdek & Wilson, 2004).

Another major goal of the treatment groups, which is consistent with the treatment priorities discussed earlier in this volume, was to empower the client. The literature suggests that survivors, who are able to regain a sense of purpose in their lives, perhaps by building relationships and feeling useful in helping other people, have shown overall improvement in their psychological functioning (Berliner et al., 2004; Fischman, 1998; Fischman & Ross, 1990; Saxe et al., 1993; Yalom, 1985).

Our program's initial group endeavors were based more on the general framework of supportive therapy groups rather than specifically psychodynamic or cognitive-behavioral models. This intervention was chosen because of the focus that support groups place on normalization, coping, attending to current life issues, and group cohesion (Foy, Eriksson & Trice, 2001; Yalom, 1995). Supportive group therapy focuses more on adaptation to one's new circumstances and validation of the traumatic experiences, as opposed to delving into uncovering the details of the trauma itself. Supportive groups are amenable to an open format, and have been shown to reduce depressive and anxious symptoms (Foy et al., 2001). Some theorists suggest that supportive interventions should precede confrontation in the group context, and that indirect supportive methods may be more useful for survivors from certain cultures than pushing them to talk about their traumatic past (Dies, 1994; Mollica, 1988).

We felt that the attributes of supportive group therapy would mesh well with the treatment priorities of safety and empowerment that we had found useful in the individual treatment of survivors of torture in our

program. Additionally, treatment outcomes in the literature did not seem to favor one sort of group intervention over the others, whether they were supportive, psychodynamic, or cognitive-behavioral (Drozdek & Wilson, 2004).

Our treatment groups were conceptualized with the hope that clients would begin to see that they are more than people who are needy. In an emotional sense, they would come to realize that they are people who are needed, as well. As clinicians, we also hoped to get a clearer understanding of the question, “What sort of resilience and coping mechanisms must a people utilize to survive such harsh life conditions?” In our long-term, on-going groups, it was hoped that group members would be able to model for one another that progress was possible, and that progress has indeed been occurring. The social reinforcements would work in multiple directions, serving to create an environment where clients could begin to feel hopeful again.

Initial Development of Group Treatment Models

The first groups developed at the Bellevue/NYU Program for Survivors of Torture were supportive groups, one for French speaking African torture survivors and the second for Tibetan torture survivors. These communities were targeted because of the significant numbers of clients from these populations already being treated in the program, and because these therapeutic interventions were thought to mesh well with the cultural sensibilities of survivors from these regions of the world (see Chapter 2).

In creating the support group for French-speaking African torture survivors, it was hoped that the group modality would be a more culturally

syntonic way of addressing mental health concerns than individual psychotherapy. This idea was partially based on the Pan-African cultural norms of hospitality and openness, in which strangers, foreigners, and those who are not capable of supporting themselves are usually taken in and cared for by members of the community (Akinsulure-Smith, Smith, & Van Harte, 1997). Consequently, one of the major cultural difficulties that African immigrants report facing in America is the perceived lack of hospitality, and the lack of communal support. Many African clients complain about “Western” society in terms of clichés such as, “It’s every man for himself,” “It’s a dog-eat-dog world,” and, of course, “Time is money” (Smith, 2003).

We believed that for clients suffering from social isolation, and who are deprived of culturally appropriate coping mechanisms, that a supportive group in which collateral ties would be fostered would be a positive psychological intervention (Saxe et al., 1993). We considered the importance that is placed on the extended family in the Pan-African context. We strove to create an environment that might not seem as foreign as individual psychotherapy to our African clients, where a sense of family could be reformulated in a psychological sense. Our hypothesis was that African clients might be more likely to engage effectively in supportive therapeutic work in a context that seemed more aligned with the ways they might have dealt with significant stressors in their cultures of origin.

The development of the Tibetan group is also a prime example of how the program was able to respond with careful attunement to the needs of patients. In the first three years of the program, an increasing number of Tibetans were seen for medical care. Although many of these individuals were clearly experiencing psychological symptoms, there was a notable

trend of failed referrals for individual psychotherapy. This is not an unusual phenomenon among Asian populations for whom mental health services often carry a social stigma and are traditionally underused (Sue & Sue, 1990). Understanding these and other obstacles was a key to figuring out a way to address the psychological needs of these clients without alienating them in the process.

Similarly to African cultures, many Asian cultures generally view the family as encompassing more than the nuclear family, and there is a strong sense of obligation to reciprocate when one has received help or other services (e.g. Lee, 1997). Group was thought to be a good way to allow for this process to occur. Also, with respect to Tibetan Buddhism, the central tenet of karma places an emphasis on the need to do for others. These cultural and religious influences seemed to indicate that group therapy might be a comfortable and effective intervention with this population.

In addition to what has been established in the literature on Asians and mental health, focus groups and informal interviews with several of the Tibetan clients who did not follow through with psychotherapy referrals revealed some interesting information. First, the notion of individual therapy was often felt to be unnecessary or was not seen as a priority. These clients viewed the plight of the Tibetan people and the pressing need for political activism abroad and in the US as being more important than individual therapy. Additionally, though the Tibetans appeared to be supportive and cohesive as an ethnic group, many of the clients felt that there was a lack of organization and efficacy within the community as a whole.

In light of these observations and sentiments, the program decided to offer a sub-group of Tibetan clients a group treatment situation to address

some of their psychosocial needs. It was believed that group dynamics would supersede the issues regarding the superficial or stated content/purpose of the groups. Therefore, the group was not explicitly defined as a strict psychotherapy group. In fact, some of the psychological literature puts forth that more activity focused groups would be more appropriate than insight oriented, psychodynamic, “talking” groups, which may not be as culturally syntonic for Asian populations (Du & Lu, 1997; Kinzie et al., 1988). Some license was taken regarding the concept of a support group and what was felt would be supportive in the eyes of the clients. It was felt that gaining the interest and commitment to regular meetings of clients who were clearly in need of social support and mental health monitoring or intervention was the most important task in starting the group.

In that vein, staff began to notify clinicians and clients of the intention to form a group for Tibetans who were interested in gathering to discuss common concerns of Tibetan clients receiving services at the Program for Survivors of Torture. References to mental health aspects and individual’s problems were de-emphasized. This was not meant to be simply a deception, but rather, was a genuine reformulation on the part of the group facilitators. An attempt was made to suspend notions of traditional groups and how they were formed (i.e. pre-selection of members, addressing a clearly defined purpose or content area such as: interpersonal issues, smoking cessation, or parenting skills). It was felt that if a group of self-motivated clients with common experiences were brought together, they would naturally begin to address problems and solutions and develop a process (with the help of a skilled and open-minded facilitator) that would be mutually beneficial.

Since there was already a general feeling that there was a lack of organization and effective communication among Tibetans in the community, it was proposed that these meetings could serve as a forum to discuss some of the problems being experienced by many members of the community. Group facilitators intentionally did not emphasize the discussion of “common problems” as a major goal of the group in order to avoid potential feelings of shame or embarrassment. “Loss of face” is an issue commonly discussed in relation to mental health treatment of Asian Americans (Sue & Sue, 1990).

Early participants also indicated a strong need to discuss the political situation in Tibet and to develop outlets for Tibetans in the US to continue to be active in fighting for the Tibetan freedom cause. On the surface, this would seem to be an overtly political agenda which would be avoided or discouraged from a traditional group psychotherapy standpoint. In this case, however, the group facilitators recognized that part of the disempowerment the clients were experiencing was manifested in this particular material, and more importantly, could potentially be addressed by it as well.

The group facilitators learned that an effective way to elicit participation of usually reserved and private individuals was to ask questions about culture and the historical and current situation in their country. While traditional views of psychotherapy might view this as a collusion to avoid discussing more personal and potentially challenging material, this “technique” was actually useful in educating the facilitators about relevant cultural and historical facts and items they knew virtually nothing about. Also, this appeared to provide a more comfortable way for clients to begin talking about more personal experiences as it related to giving more general information.

The format of the group was a 90 minute session held every other week. Membership was open to all current Tibetan clients of the PSOT and participation was open-ended (i.e. clients could be present at only one session, several sessions, or all sessions with no demands for consistent or prolonged attendance). The group was facilitated by a psychologist and a psychiatric resident both of whom did not speak Tibetan. Therefore, an English-Tibetan interpreter was present at all sessions to facilitate the bilingual communication among facilitators and participants. The program was fortunate at that time to have the volunteer services of a bilingual Tibetan medical doctor to serve as the group interpreter which was extraordinarily helpful.

One of the problems incurred with this format was that the group quickly became so well attended within the first few months as to be somewhat unwieldy, with at times upwards of 30 attendees at a single meeting. Although membership was supposed to be restricted to current clients of the program, word of mouth quickly spread about the program, and clients began to bring friends and acquaintances in need of services to the group in order to introduce them to the program. At this point, the group facilitators were faced with a critical decision. In order to continue the feeling of trust among the group members, it was felt that the group should continue to welcome potential new members who were being triaged and given intake appointments after the regular meeting. The choice was made to take a more inclusive stance rather than maintaining a strict policy for visitors. This was consistent with the more informal nature of the group and also felt more in line with the tone set forth by the clients themselves.

Eventually, however, it became apparent that the success of the drop-in group was also its downfall as a therapeutic milieu. The large numbers of

participants made it very difficult, almost impossible to conduct a discussion in which all members could partake on a regular basis. In addition, the open membership format served to hamper the members who were consistently attending with regard to their comfort level in sharing increasingly personal information. The “drop-in” format also made it impossible to carry on discussions from week to week without great redundancy or the need to fill people in who were not present the previous week.

After much deliberation and some input from several of the more consistent members, a decision was made to form a closed, formal support group with most of the referrals coming from the drop-in group members who indicated interest and who seemed appropriate for such a modality. Due to personnel constraints, the drop-in group was discontinued, and after brief prescreening interviews, the new group began meeting within several weeks of the last drop-in group meeting. Two drop-in group members were also referred for individual therapy and had complied with these referrals. We felt that the drop-in group had therefore, served its original purpose of gaining the trust of members of a population that had previously been reluctant if not impossible to engage in psychological treatment. It served an educational purpose as well as a rapport building one. In addition, PSOT staff learned a great deal from this group. We deepened our understanding of the Tibetan culture, their diverse experiences and attitudes regarding mental health and health issues.

Considerations Regarding Group Membership

Who should be included in the group and what is the rationale for inclusion or exclusion of members? How should clinicians evaluate the

appropriateness of a particular patient for group treatment? As Yalom (1995) states, “The fate of a therapy group and its members is to a large extent determined before the first group session” (p. 19).

As mentioned earlier in this volume, safety is of paramount importance for group members. When the client meets with the group facilitator before joining the group, it helps foster a sense of security in several ways (MacKenzie, 1994). It allows the client to develop a rapport with the group facilitator, and provides safety in terms of potential political schisms. Clients are carefully screened before being referred to the group to make sure that they were not involved in repressive activities, and to make sure that “mortal enemies” are not included in the same treatment group.

Thus, the Bellevue/NYU Program for Survivors of Torture’s screening process is multi-layered. As described in Chapter 5, there is an initial screening for acceptance into the program. At that time, current needs, including medical, psychiatric, and psychological treatment, are assessed and recommended. If a client is referred for supportive group treatment at that point, or any later juncture, by one of our program’s clinicians, the group facilitator meets with the client for a separate screening to determine appropriateness for group membership.

Theorists (i.e. Piper & McCallum, 1994; Yalom, 1995) have suggested that the minimal skills necessary for participation in a verbally oriented therapy group may also serve as screening criteria. They identify those minimal skills as: having a minimum level of interpersonal skill; being motivated for treatment; experiencing current psychological discomfort; having a current interpersonal problem; having positive expectations of gaining assistance from group treatment; being committed to changing their interpersonal behavior; being somewhat approval-dependent, such that

group members will have some influence on their behavior; and a willingness to be of help to others.

For survivors of torture and refugee trauma who are struggling with issues of social withdrawal, but who desire social contacts, supportive group treatment may be indicated. In addition, for clients who are seeking concrete advice or suggestions in terms of dealing with specific issues concerning cultural adjustment and navigating the new culture and social systems, a supportive group environment may prove to be useful.

Clinical questions have arisen about the heterogeneous or homogeneous nature of the group membership. Some clients at PSOT have expressed initial concern about safety and security, as they fear that they may be meeting other people from their own country, who might be government spies, enemies, or some other dangerous element.

In the African group there has only been one occasion (post-screening) where it appeared that a political schism might arise, but group members worked hard to make sure that politics did not adversely affect the group functioning.

On that one occasion, there were two group members who viewed the president of a particular West African nation from diametrically opposite positions. To a male member of the group from that country, this president was directly responsible for his torture, exile, and the death of two of his family members. To a woman in the group, who had been tortured and raped in a neighboring country, it was this president who intervened and made it possible for her to escape alive. To one person, he was the devil; to another, a savior.

After some tense, but respectful, exchanges, these two survivors were able to express within the group, that it wasn't important which side of a conflict you were on. They concurred that the important thing was that group members were all human beings. As sons and daughters of Africa who had all suffered horribly, the political details were inconsequential. The group members stated that they were all family, and it was now time to move forward. This anecdote has become the basis of an important group norm that is shared with new arrivals into the group by more long-standing group members.

Clinicians also need to be conscious of other issues regarding the safety, comfort, and trust for clients engaging in groups with members from various regions, ethnicities, class backgrounds, and religious groups. The Tibetan group is somewhat homogeneous in that all its members are ethnically Tibetan. However, Tibet covers a large region, and group members have come from many different parts of the territory. In the case of this group, the concerns about inclusion seemed to have less to do with potential spies or other personal danger, but rather were about differences between those who had principally been raised and lived their lives in Tibet versus those who had primarily been raised in Nepal or India.

Although all group members were ethnically Tibetan, many of the clients who were more recently in Tibet felt understandably that there were differences in their experience that made it not only uncomfortable to share with those who had come from other countries, but also had caused some resentment and even mistrust with respect to asylum applications. Because of this, the initial group members for the therapy group were carefully screened with regard to this factor.

All members of the PSOT Tibetan group do speak Tibetan. At various times, however, group members from different regions have spoken distinct dialects, which require additional translation. Thus far, group members have also shared Tibetan Buddhism as a religion, with some being former monks or nuns. During the first year of this group's existence, all of the members were male. This was not an intentional but rather an incidental characteristic of the group. In its second and then into its third year, the Tibetan group became a mixed gender group.

In terms of the African group, there were additional concerns about the heterogeneous nature of the group. The proposed group would be of mixed gender, with people from many African nations, who may be Islamic, Christian, members of other faiths, or non-religious. The group's original co-therapists were, respectively, from the United States and Israel, male and female, Black and White, Catholic and Jewish. We were concerned that politics, prejudices, and other social schisms may stand in the way of forming a cohesive group. As we moved ahead with our work, we learned that many of the issues that concerned us as we began the group actually proved to be sources of strength. As Piper and McCallum (1994) point out, a homogeneous group will often find variance and domains of difference among members, while a heterogeneous group will often find common areas of concern.

The mixed gender composition of the African group led to profound discussions of traditional gender roles in Pan-African culture, and how these roles affected coping strategies. Group members have grappled with the question of whether it is culturally appropriate for an African man to cry, particularly in public. Men seemed to be more comfortable focusing primarily on logistical, problem-solving techniques, while minimizing or

trying to ignore the associated feelings and emotions. Women were more likely socialized to focus on their emotional reactions, sometimes to the detriment of their decision-making abilities. The group process served as a model of a more holistic coping strategy that incorporated both cognitive and emotional strengths. Male and female group members spoke of valuing this new experience, and moving beyond the strict socialization of gender roles. It should be noted that in the aftermath of such discussions, men have cried during group on several different occasions, and the group proved to be a safe place for them to do so. Female group members have also expressed that they have become more comfortable and confident with actively grappling to improve their current living situations.

It has become apparent that spirituality and religion are generally important coping mechanisms for African survivors of torture. The multi-religious composition of our group has not led to friction. In areas of Africa where religion has not become overtly politicized or linked with the ruling hierarchy, there has also been a long history of religious tolerance. Muslims and Christians have often lived side by side in the same villages for centuries (Smith, 1988). Group members seem to be comfortable in carrying forth this tradition of tolerance. They generally speak of “spiritual” matters, and find consensus in the need for faith, in whichever form it may take.

The members of the French-speaking African group have managed to conceptualize their cultural, ethnic, gender, and religious differences in terms of being unique members of a “family.” The notion of family is an important one for the African group, and has been described in other treatment groups working with traumatized populations (Saxe et al., 1993).

Even as the group facilitators conceived of the African group as becoming an extended family in a psychological sense, we never labeled it

as such for group members. It is an important group process, particularly at the outset, that group members are permitted to create their own group identity. In order for there to be group cohesion, it is crucial that group members come to realize that “This is not just *any* group, this is *our* group” (Mackenzie, 1994, p. 36). Over time the members of the French-speaking African group began referring to the group as “la famille.” It seemed that we had been on-target in terms of creating a culturally syntonetic intervention for our African clients.

Group as an Adjunct or Main Modality of Treatment?

In our program, there has been a great deal of flexibility in the way that group treatment has been utilized within the multidisciplinary treatment paradigm. There have been occasions where clients have not been referred for group, because it has not been deemed therapeutically appropriate given their needs, level of functioning, or willingness to engage in meaningful relationships with other survivors. There have also been cases where group has been used as an adjunct modality for those in individual treatment who are working on issues regarding avoidance and social withdrawal. This is supported by the psychological literature that states that supportive therapy groups can serve as a primary or adjunctive modality of treatment (Foy et al., 2001).

One common pattern in the program's use of group treatment has been the following: an initial screening leads to referrals for medical treatment, individual therapy and/or psychopharmacological treatment. Individual treatment is combined with an assessment of whether group treatment is appropriate for this client. If deemed appropriate, an interview is set up with

the group facilitator. The client then begins attending group as well as individual therapy. Over time, as the client becomes less symptomatic, group may become the main modality of treatment, as the client reduces the frequency of individual sessions. Individual treatment may transition to a PRN, or "as needed" framework, with the client still attending the ongoing group and working with the rest of the multidisciplinary team for psychopharmacological, medical, and social services. This PRN modality has been more difficult to accommodate with the Tibetan clients because of logistical issues, especially the need to schedule interpreters ahead of time.

As the program's experience with more and more groups broadens and deepens, we have become more comfortable with recommending group therapy as a primary modality of treatment. Survivors come to us in various stages of their traumatization and recovery, and some individuals are already at a point where reconnection with social groups is appropriate from the outset of treatment.

In fact, the majority of clients accepted into the Program are now initially referred to "orientation groups," which are short-term, eight week psycho-educational groups that introduce clients to the services the program offers, as well as other legal, educational, and social resources. Clients are also exposed to information regarding one's potential emotional reactions to trauma and forced immigration. These "orientation groups" also provide program staff with the opportunity to further observe clients in a clinical setting, which helps us to triage priority cases, and make more comprehensive referrals for ongoing treatment.

Linguistic Issues

One of the advantages of working in a multi-cultural, multi-lingual setting such as our program is that we have had many opportunities to offer and experience many combinations of therapist-client pairings with respect to language and cultural factors. We have found that it is not necessarily the case that there must be a direct match between therapists and the clients with whom they work.

The Tibetan group was initially run by a Chinese-American female psychologist and a Jewish Canadian male psychiatrist. Subsequent facilitators were White American and White Danish female clinicians. More recently, facilitators have been psychiatric residents who have been White and male. None of these clinicians spoke Tibetan.

The African group is run by a Black American male clinician whose co-leaders have included: White American female clinicians (Jewish, Muslim, and Christian), an Israeli female clinician, a Ghanaian/Swiss female clinician, a female clinician with ethnic/racial roots in France and Singapore, two Black American female clinicians, a female clinician of mixed European and Japanese ancestry, and most recently, our first male co-leader – who is of Swiss ancestry. Group co-facilitators have been psychologists, psychology interns and externs, social work interns, and a psychiatric resident. We have found that the salience attached to a co-leader's professional discipline is often just as pertinent to the group process as the salience attached to other reference group identities (i.e. race, gender, religion, etc.). All of our group facilitators have had French-English bilingual skills, and one common thread among these diverse clinicians has

been a willingness to discuss issues of race, culture, nationality, gender etc., as they pertained to society-at-large, or to dynamics within the group.

As discussed in Chapter 2 of this volume, it is our considered opinion that it is more important what meaning one attaches to their cultural reference group identities, than to just know which cultural groups they belong to. We focus on exploring the cultural differences and overlaps, and working through them, as opposed to focusing solely on assigning therapists based on their cultural reference identity groups. Our experience with the groups has borne out this approach.

For example, because of the nature of the relationship between Tibetans and the Chinese government and nationalists, the fact that the first Tibetan group leader was a Chinese-American was raised from the very early sessions. The general response of group members to this fact was a simple, straightforward distinction made between Chinese-Americans and the government and peoples who were their persecutors. In later sessions, however, the issue of discrimination by Chinese-American employers and coworkers brought another opportunity to explore potential feelings regarding the relationship among group members and this particular therapist. Again, members expressed confidence in their group facilitator, and expressed clearly that they saw her as being clearly separate from their abusers. The fact that there was no collusion of silence around these issues has helped to facilitate feelings of safety, ownership, and trust within the Tibetan group.

Cultural meaning may also be attributed to one's level of proficiency in a particular language, particularly when people are coming from different countries, and have different levels of exposure to the language in question. In the group for French speaking Africans, all of the clinicians have been

proficient in French, but only two have been native speakers. The differences in language skills were found, not only between facilitators and group members, but also within the group members themselves.

Many group members have done advanced university studies in French (sometimes in France, Belgium, or first-tier universities in Africa), while others have received little to no formal education, and struggle with the “colonial language.” There are many meanings attributed to these linguistic differences, including acculturation and class issues, notions of social hierarchy, or ideas pertaining to African “authenticity.” It has been important to stress periodically during group sessions that the thoughts one wishes to express are more important than the linguistic dexterity used in expressing these thoughts. All voices are to be respected, regardless of their level of French, but the meanings and dynamics of such linguistic diversity among Africans (and group members) remains an appropriate topic for exploration within the group context.

In the case of the Tibetan groups, where none of the facilitators have had Tibetan language skills thus far, Tibetan interpreters have always been relied upon to conduct the sessions. In the case of the Tibetan drop-in group, as mentioned earlier, the program was fortunate to have the volunteer services of a native Tibetan speaking medical professional. As this individual’s commitments to other projects increased, there became the need to recruit other interpreters for the drop-in group. We were again fortunate to engage the services of a mature, dedicated Tibetan woman with interpreting and health care experience. When planning for the transition to the closed therapy group, this interpreter was hired and became an integral member of the treatment team. The use of interpreters in a group setting involves several unique issues (see Chapter 4).

As mentioned earlier in this chapter, the heterogeneity of the African group has proven to be a source of strength. The added diversity between group members and staff, has also added opportunities for exchanges that have broadened clients' understanding of the culture they are now trying to navigate. Clients have often asked questions about the history of racial relations in the US, including the era of slavery, the civil rights movement, and attitudes about immigrants from various parts of the world. Clients state that this deepened cultural understanding helps place them in a context in which they can be more confident navigating social interactions, as they better understand shared links and possible divisions among and between cultural groups in their host country.

Special Clinical Considerations

The psychological literature shows that in order to be effective, diagnostic and treatment strategies must be in sync with cultural norms (Akinsulure-Smith et al., 1997; Fischman, 1998). Therefore, to become even more effective, we have allowed our groups to evolve into something a bit different than the traditional group psychotherapy models taught in most graduate school programs. We do not disavow the more traditional models, but have felt that additional adaptation to fit the cultural norms displayed by the group membership has helped make our group treatment more effective.

Contact outside of group setting

In working with survivor of torture and refugee populations, it is important to understand that treatment groups centered on certain ethnic groups or geographical regions will often draw members from an already

formed subgroup or community. This means that individuals may already be familiar with or may come in contact with other members outside of therapy in the present or in the future. Setting group rules about confidentiality will be important given this fact. Obviously, the group leaders must have an understanding of how this will impact disclosure in the group and other dynamics. This may also impact who is initially included or not included in the group.

In many traditional therapy groups, members are discouraged or even prohibited from contacting one another outside of the group meetings (MacKenzie, 1994). Other theorists have stated that outside contacts, including phone contacts, have helped to decrease depressive symptoms in trauma survivors suffering from PTSD and panic attacks (Falsetti, Resnick, Davis, & Gallagher, 2001).

Our experience with survivors of torture groups, has been that group members often cannot avoid outside contact because of the nature of their communities (often they live in same neighborhoods, attend the same churches, mosques, etc.). In addition, a great number of survivors of torture and refugee trauma have no family or friends (social networks) due to their migration circumstances, and it is believed that the therapeutic benefits of having additional social contact often outweigh the potential negative dynamics created by having external relationships with other group members. In fact, members will often refer members of their community who are in need of services to our program. Clinicians do need, however, to consider the specific cultural and clinical issues that may make outside contact a good or bad idea for a particular group (Porter, 1994).

For example, the French-speaking African group is different from traditional group psychotherapy in several ways. While the traditional group

model states that the therapeutic work goes on during sessions, and outside contacts among group members are discouraged, if not forbidden; outside client contacts are allowed, and even encouraged, in the African group.

During our initial group sessions, members made it clear that they desired a way of being able to converse with each other between group meetings. Upon further exploration, members spoke to feelings of loneliness, particularly at night. They said that it would be nice to hear a friendly voice when you needed it, as opposed to waiting a few days until you can see your “family” in-group. Group members and clinicians decided that an exchange of phone numbers would be allowed among group members.

This intervention has paid several dividends. One client expressed it this way, “Sometimes when you feel sad, just having the numbers is enough. You don’t even have to call. But you know someone that cares about you is just a phone call away. It makes it easier to cope with life’s struggles.” Clients have cooperated and accompanied each other to social service agency appointments, and have helped each other in finding work.

Similarly with the Tibetan group, many program clients know one another from the New York area Tibetan community and through the many local Tibetan cultural and political organizations or activities with which they are involved. In addition, it is often the case that newly arrived Tibetans would be taken in to live in apartments with other already settled Tibetans. Because of the high cost of rent and the meager means of these individuals, it is common for eight to ten individuals to share a small apartment. It was therefore quite likely that clients of the program would be roommates. Accordingly, in the initial group, half of the members were roommates or close neighbors. In the pre-screening process and throughout

the existence of the group, this issue was addressed directly with potential and current members discussing their thoughts and feelings about this issue. It was important in pre-screening to help group member candidates anticipate ways in which this might interfere with their participation in group, as clients had no previous experience with any type of therapy or knowledge of the potential awkward situations that might arise.

Confidentiality

As a result of this possible outside contact, group members must be very clear about confidentiality and the need for added awareness and caution regarding session material (Porter, 1994). It has been a stated policy in our groups that members can have a safe place to explore some of their traumatic material if they so desire, but that this type of sharing is by no means obligatory. In fact, many of our clients prefer to work through their traumatic experiences in individual therapy, whereas the groups are utilized more in terms of emotional support, practical advice, philosophic discussions, and re-establishing social connections. Members are consistently reminded that “what goes on in the group stays within the group.”

Along these lines, especially in the Tibetan group which initially included roommates and friends, members were also reminded to be respectful of group boundaries. For instance, if a member had gained some personal information outside of group about another member, it was suggested that discretion be used within group unless the specific group member had himself disclosed the relevant information to the group. This often proved to be a subtle yet effective way to maintain appropriate

boundaries and have group members feel “safe” to have separate relationships outside of group.

Group Structure and Dynamics

As with many groups that are just getting started, it may be difficult to counteract the tendency of group members to speak directly to the therapists rather than to each other, particularly those with pre-existing clinical relationships with the group leader (MacKenzie, 1994). Trauma content may heighten this inclination leading individuals to be even more hesitant to interrupt or speak directly to other members. Cultural norms regarding appropriate age, gender, and general interpersonal interactions may also make facilitation of a group process more difficult.

When the Tibetan therapy group was instituted (which was a shift from a larger, drop-in group format) the members appeared unsure of how the group was “supposed to work.” They waited patiently for the group facilitators to speak and ask questions and were not accustomed to initiating a comment without an invitation to speak. When a question was addressed to the general group, members often were silent for several minutes. Often, one of the members would “nominate” the eldest member (by age) to speak first. The group leaders were concerned that this would put undue pressure on this particular member to speak first all the time and suppress a more “natural” flow of group participation based on interest in the topic and relevant input of all members. Once again, though, it was important to adopt a “wait and see” approach as the facilitators wished to be respectful of the group’s own inertia and comfort level.

The group members were invited to decide for themselves how they would like to structure the group. The group facilitators explained that

groups tended to work best when all members felt comfortable participating at their own will. They explained that the facilitators' role was to provide a safe environment for members to speak in and to make suggestions that would ensure that the group would stay focused and be helpful to each member while not allowing any type of activity that would be harmful. Other than that, there were many ways that the group could run. The group members decided that each session would be divided in half, and that one member would speak about their story during the first half, and then another member would speak in the second half. This format was followed for several weeks until each member had had a "turn" telling his story. By this time, group members felt more comfortable with one another and the group leaders were able to suggest a less structured format.

It is important to note that the group leaders had obvious concerns when the initial format was first proposed. While hearing separate monologues by each group member is obviously not an ideal method/tool for group therapy, it served several useful purposes. First, it allowed for each member to have a safe space in which to tell their trauma story to the group without interruption. The space was secure because they knew how much time they would have to speak (45 minutes) and concerns about being too self-centered were minimized as the task was defined for them. (This refers to cultural and personal concerns that members had about speaking too much about themselves and not being considerate of others.) It also helped members to feel that they were on somewhat equal footing with the other members. Now they each knew each other's "stories" and realized that each had been through similar, yet unique, experiences. Finally, the "monologue" format allowed for a safe space in which to express both factual and emotional content. Once the group membership had been stabilized and

members felt they had a basis on which to discuss current issues, the group structure shifted.

The lesson learned was that group facilitators need to be flexible and respectful of group members' comfort level, especially during the beginning phases of group treatment. At the same time, group leaders need to balance their flexibility with a willingness to educate members about the importance and potential benefits of sharing their own experiences with others in a therapeutic context. Such psychoeducational interventions can help to facilitate active connections among group members (Stubenbort, Donnelly, & Cohen, 2001).

Content of Group Sessions

In the French-speaking African group there is no predetermined content area. As previously mentioned, group members may choose to share their previous trauma experiences, but the group focuses on many diverse areas. Sometimes the group focuses on concrete logistical issues, philosophical issues, social support, adaptation issues, and occasionally, issues regarding crisis intervention (Smith, 2003).

As an on-going group, long-standing members will welcome a new member and explain group processes, and share some of their experiences and benefits of the group. Although, much of this information is covered with the group therapist during the individual screenings for group, it seems to carry much more weight when it comes from members who have lived through experiences similar to the newly arrived client's. This process helps to set a familial, collegial tone that helps a new member to feel like "they belong."

In terms of concrete issues, group members often share insights, or vent frustrations regarding employment problems, immigration concerns, health issues, and social services in general. Group members have gone so far as to help find, or even provide, emergency shelter for members who have lost their place to stay. This would probably be frowned upon in more traditional group therapy. Group members help each other navigate the hospital system, so that members can access the medical care that they need, sometimes by acting as interpreters or showing new members where to find particular clinics or offices. Members help each other by providing guidance in terms of how they have navigated particular situations in the past, and they support each other when progress is slow, and frustration levels are high.

The philosophical group discussions are especially fascinating and rewarding. Group members share insights and proverbs from their homelands to help illuminate complicated issues. Group members have discussed the relative merits of “forgiveness” versus “forgetting” in terms of recovering from their trauma. They have explored the thin line between fear and wariness, and how it affects one’s ability to navigate their new, and sometimes threatening, environment. Group members have also broached the subject of positive self-concept, and the importance of valuing one’s personal character above and beyond one’s troubling circumstances. They have also debated their perceptions of positive and negative aspects of their home cultures vis à vis the new culture they are attempting to navigate. Group members have discussed the frustrations of wanting to change the world, but feeling powerless to do so. They have discussed the need to look at change and progress gradually. Over time they have developed a list of the things required for a person to change the world (and adapt to difficult

circumstances). The necessary ingredients they have identified are wisdom, courage, and hope. They have spoken about how it is necessary to have all three of these traits, as any combination of two will still be insufficient (Smith, 2003).

Group members frequently struggle with feelings of hopelessness, shame, and/or survivor's guilt. These painful feelings are often brought up in-group, as members strive to cope with this tormenting emotional baggage. One way that group members have made sense of these feelings, and have supported each other, is to view these painful emotions as an intended part of the torture experience. It has been shown that being able to place the burden of responsibility on the torturers for the current distress is an adaptive step on the way to recovery (Fischman & Ross, 1990; Somnier & Genefke, 1986). Group members have stated that by giving into the feelings of guilt and hopelessness, they are giving power back to the torturers. They feel that fighting against these painful emotions and overcoming them, is like fighting against the torturers, and denying them their ultimate victory.

As previously mentioned, the group often focuses more on adaptation than emotional exploration. Adaptive defenses are supported, not dismantled. As always, special care is taken that group members are not re-traumatized by the therapeutic work. We have found it to be important to end sessions, particularly those that have been emotionally charged, in a way that leaves the clients feeling empowered and supported. It is helpful for the clinician to be able to sum up what has transpired in group in a way that focuses on the wisdom that was shared, the courage that was displayed, and most importantly, that engenders continued hope for the future.

Saying a Positive “Au Revoir”

As refugees who have been so brutally uprooted from their homes and families, they are painfully aware that people are not always able to say good-bye to their loved ones. Even though good-byes are always painful, each positive good-bye that they are able to express is valuable. In a psychological sense, saying “*au revoir*” to family members from the group is an opportunity for survivors to find an adaptive way to process some of the unresolved feelings they may hold regarding the good-byes they never got to say in the past to people they have loved.

This issue comes into play annually, as some of our trainees end their clinical involvement with PSOT, and move ahead with their studies and/or careers. Termination issues are addressed early and directly – both in group sessions and in supervision. Group leaders strive to place this particular “*au revoir*” in a context that is predictable, controllable, and in which group members and clinicians have an opportunity to express their feelings, and perhaps, shed cathartic tears.

These issues are addressed in other ways as well. Periodically, the French-speaking African group engages in a “Ceremony of Remembrance and Thanksgiving” for those who have lost family members, do not know the whereabouts of family members, or are separated from family members and friends. Group members offer prayers and songs from their various religious, spiritual and ethnic backgrounds. They speak about the need for continued courage and mutual support to surmount the challenges they face. They also expressed appreciation for all the blessings they have received, despite their troubled situations.

This kind of interaction has been particularly poignant as group members have coped with death and dying among their “new family.” In the

almost 12 years of the African group, we have lost three members (after protracted illnesses), and have also mourned the tragic accidental death of a member's child. In each instance, group members visited and assisted the dying members while they were hospitalized, attended the vigils, wakes, funeral services, and burials. Funds were collected from within the extended community to support the grieving families.

In one instance (see Chapter 9), group members helped make it possible for a woman to be memorialized and buried in accordance with cultural norms. If not for their efforts, she would have been buried with no viewing of the body (which is “unacceptable” according to the norms of her community), and interred in a “common grave” with no marker or headstone. Group members intervened (along with PSOT staff and community members) to make sure that at least the children would always have a place to visit and pay respects to their mother.

Care must be taken that group members do not become too overburdened or retraumatized by such distressing situations. If this seems to be the case, clinicians can intervene on the individual or group level to help normalize reactions, and set limits in terms of members' emotional capacity to be engaged in such difficult undertakings. Forbidding such demonstrations of solidarity would be counter-therapeutic, however, despite the risk of emotional reactivation. Clients have stated that being supportive of their fellow group members in times of sorrow, was empowering for them, despite the pain. One of our dying group members described it with his dying words: “L'esprit de partage.” He spoke of a “spirit of sharing” signifying our common humanity. Holding onto this notion shared humanity is at the very essence of our group interventions.

Supervision and Self-care for Group Facilitators

In the Bellevue/NYU Program for Survivors of Torture, group facilitators receive supervision in two distinct ways: Facilitators (particularly those in training such as psychology interns and externs, social work interns, and psychiatric residents) receive outside supervision from senior, licensed clinicians (see Chapter 5); and facilitators engage in co-leader/peer supervision.

In terms of co-leader/peer supervision, a couple of different models have been found to be useful. A more traditional model has been used, in which co-therapists share responsibilities for clinical documentation of group progress, and they meet on a weekly basis to discuss their observations, suggestions, and concerns with one another.

The other model has arisen due to the growth of the French-speaking African group to encompass two sessions per week. As such, the senior clinician responsible for the group is joined at each meeting by a junior co-facilitator. There are two junior co-facilitators, and they each attend one group session per week. The group sessions are arranged so that group members may attend both sessions if they wish, but may also pick one or the other, depending on their schedules and outside commitments. So, even though members may be there twice a week, the junior clinical facilitators are only there once a week. Supervision takes place with both trainees and the senior clinicians sharing their experiences from the previous week's sessions.

The trainees are able to bring each other "up to speed" in terms of group developments and processes. The group supervision sessions help to bolster a sense of continuity for the clinicians involved. In addition, the trainees are able to bring fresh questions and perspectives regarding the

session they did not attend, which can be challenging and helpful for the clinicians who were “in the room.” These detailed discussions also help the clinicians to grapple with larger meta-issues regarding overall group processes, emotional reactions, and clinical principles.

Conclusion

It has been our experience at the Bellevue/NYU Program for Survivors of Torture that the group treatment modality has been effective for the populations served. As such the number and variety of groups we provide have grown. In addition to the French-speaking African group and the Tibetan group, we have subsequently designed and begun groups for English speaking Africans, for female survivors of sexual violence, for men persecuted due to their sexual orientation, and for Albanian and Fulani speaking survivors, in addition to the short-term orientation groups for newly arrived clients described earlier. In fact, many clients have utilized group as their primary support system, and have talked about the importance of “belonging to a family again.”

A great deal of work and preparation needs to go into planning a treatment group for traumatized populations. Member selection, group processes, and content areas need to be well-considered before commencing such a treatment group (Piper & McCallum, 1994; Smith, 2003; Yalom, 1995). There are potential dangers in terms of retraumatizing clients or violating their sense of safety that need to be considered (Porter, 1994). It should be noted, however, that not everything needs to be written in stone before beginning the group. Allowing the clients to be actively involved in the creation of group norms and processes goes toward empowering them,

and makes it more likely that they will fully utilize the service being provided (MacKenzie, 1994). This is consistent with our experience at the Bellevue/NYU Program for Survivors of Torture.

Based on client feedback and needs, we are also in the midst of planning groups that would be more activity and training based than clinical in nature. We believe firmly that “it doesn’t have to be therapy to be therapeutic.” As the social service needs of our clients are so great, we hope to institute groups that will focus on literacy, job seeking and computer skills, and informal social networking. We continue to listen to the voices of our clients as we endeavor to tighten, expand, and move forward with these group interventions.

References

- Akinsulure-Smith, A., Smith, H., & Van Harte, E. (1997). *Psychotherapy with Africans in America*. Symposium conducted at Perspectives on Black Psychology: Past, Present, and Future. Pace University, New York City.
- Berliner, P., Mikkelson, E., Bovbjerg, A., & Wiking, M. (2004). Psychotherapy treatment of torture survivors. *International Journal of Psychosocial Rehabilitation*, 8, 85-96.
- Bernard, H., & MacKenzie, K. (1994). *Basics of group psychotherapy*. New York: The Guilford Press.
- Burlingame, G., & Layne, C. (2001). Group-based interventions for trauma survivors: Introduction to the special issue. *Group Dynamics: Theory, Research and Practice*, 5(4), 243-245.
- Dies, R. (1994). The therapist's role. In H. Bernard & K. MacKenzie (Eds.), *Basics of Group Psychotherapy* (pp. 60-99). New York: The Guilford Press.
- Drozdek, B., & Wilson, J. (2004). Uncovering: Trauma-focused treatment techniques with asylum seekers. In J.P. Wilson & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims* (pp.243-276). New York: Brunner-Routledge.
- Du, N., & Lu, F. (1997). Assessment and treatment of posttraumatic stress disorder among Asian-Americans. In E. Lee (Ed.), *Working with Asian-Americans: A guide for clinicians* (pp. 275- 294). New York: Guilford Press.
- Falsetti, S., Resnick, H., Davis, J., & Gallagher, N. (2001). Treatment of posttraumatic stress disorder with comorbid panic attacks: Combining

- cognitive processing therapy with panic control treatment techniques. *Group Dynamics: Theory, Research and Practice*, 5(4), 252-260.
- Fischman, Y. (1998). Metaclinical issues in the treatment of psychopolitical trauma. *American Journal of Orthopsychiatry*, 68(1), 27-38.
- Fischman, Y., & Ross, J. (1990). Group treatment of exiled survivors of torture. *American Journal of Orthopsychiatry*, 60(1), 135-142.
- Foy, D., Erikson, C., & Trice, G. (2001). Introduction to group interventions for trauma survivors. *Group Dynamics: Theory, Research and Practice*, 5(4), 246-251.
- Foy, D., Glynn, S., Schnurr, P., Jankowski, M., Wattenberg, M., Weiss, D., et al. (2000). Group therapy. In E. Foa, T. Keane, & M. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies* (pp. 155-175, 336-338). New York: The Guilford Press.
- Freud, S. (1921). Group psychology and the analysis of the ego. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 67-143). London: Hogarth Press, 1955.
- Kinzie, D., Leung, P., Bui, A., Ben, R., Keopraseuth, K., Riley, C., et al. (1988). Group therapy with Southeast Asian refugees. *Community Mental Health Journal*, 24, 157-166.
- LeBon, G. (1920). *The crowd: A study of the popular mind*. London: Fisher Unwin.
- Lee, E. (1997). *Working with Asian-Americans: A guide for clinicians*. New York: Guilford Press.

- Loneragan, E. (1994). Using theories of group therapy. In H. Bernard & K. MacKenzie (Eds.), *Basics of Group Psychotherapy* (pp. 189-216). New York: The Guilford Press.
- MacKenzie, K. (1994). The developing structure of the therapy group system. In H. Bernard & K. MacKenzie (Eds.), *Basics of Group Psychotherapy* (pp. 35-59). New York: The Guilford Press.
- Mollica, R. (1988). The trauma history: The psychiatric care of refugee survivors of violence and torture. In F.M. Ochberg, (Ed.), *Post Traumatic Therapy in Victims of Violence*. New York: Brunner/Mazel.
- Piper, W., & McCallum, M. (1994). Selection of patients for group interventions. In H. Bernard & K. MacKenzie (Eds.), *Basics of Group Psychotherapy* (pp. 1-34). New York: The Guilford Press.
- Porter, K. (1994). Principles of group therapeutic technique. In H. Bernard & K. MacKenzie (Eds.), *Basics of Group Psychotherapy* (pp. 100-122). New York: The Guilford Press.
- Saxe, B., Johnson, S., Barrett, P., Erickson-Fraser, L., Kalil, K., & Collins, N. (1993). *From victim to survivor: A group treatment model for women survivors of incest*. Ottawa, Ontario: National Clearing House on Family violence.
- Smith, H. (1988). Historical impact of Islam and its future prospects in Africa. Case Studies: Nigeria and Sudan. *Journal for the Institute of Muslim and Minority Affairs*, 9(2), 311-330.
- Smith, H. (2003). Despair, resilience, and the meaning of family: Group therapy with French-speaking survivors of torture from Africa. In R. Carter & B. Wallace (Eds.), *Understanding and Dealing with*

- Violence: Multicultural Perspectives* (pp. 291-319). Thousand Oaks, CA: Sage Press, Inc.
- Somnier, F., & Genefke, I. (1986). Psychotherapy for victims of torture. *British Journal of Psychiatry*, 149, 323-329.
- Stubenbort, K., Donnelly, G., & Cohen, J. (2001). Cognitive-behavioral group therapy for bereaved adults and children following an air disaster. *Group Dynamics: Theory, Research and Practice*, 5(4), 261-276.
- Sue, D.W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice*. New York: Wiley.
- Yalom, I.D. (1985). *The theory and practice of group psychotherapy*. (2nd ed.). New York: Basic Books.
- Yalom, I.D. (1995). *The theory and practice of group psychotherapy*. (3rd ed.). New York: Basic Books.

Chapter 12

Approach to the Client in a Psychological Evaluation – Summary

General clinical concerns in conducting a psychological evaluation

- * Purpose of a psychological evaluation
- * Revisiting the importance of safety and empowerment
- * Ways of encouraging, prompting, re-directing and focusing clients
- * Utilization of clinical “process” information in addition to the “content” of the client’s narrative

Comments about writing affidavits

- * Formats: Legal affidavits or psychological summaries
- * Limitations of competence
 - Reported events v. historical facts
 - Reported symptoms v. observed symptoms
 - Consistency v. causation
- * Broad array of psychological indicators of distress
 - Look beyond strict DSM defined syndromes (like PTSD) – all mental distress is “culture bound”
- * Also look for: Impaired social functioning, somatization, changes in educational, professional and/or familial functioning

Comments about testifying

- * How to respond when your credentials are challenged
- * Balance of being an expert witness v. client advocate when testifying

Approach to the Client in a Psychological Evaluation

Hawthorne E. Smith, Ph.D.

General clinical concerns in conducting a psychological evaluation

Some of the content in this section overlaps with the material that has been covered in the section entitled “Treatment Techniques and Priorities.” However, there are aspects that pertain specifically to clinicians who are engaged in conducting psychological evaluations. Clinicians must keep in mind that the goal of the psychological evaluation is not to win a case, convince a judge, or beat the United States Immigration and Customs Enforcement (ICE) bureaucracy, but to produce the most detailed, comprehensive, and insightful report possible about an applicant’s emotional functioning.

The treatment techniques and priorities that have already been written about (i.e. safety and empowerment) are also important in the context of a psychological evaluation. These therapeutic tools are not designed to be “touchy-feely” or “politically correct” interventions. They are utilized because they have been found to be effective in attaining the stated goals of the evaluation, even within tight time constraints. Our experiences have shown us that when asylum applicants feel that their knowledge and experiences are valued and heard in a context of respect, they are more willing to fully engage in the process, and therefore help us in writing detailed, insightful reports (Gangsei, 2001).

In terms of safety, clinicians are encouraged to remember the disparity in power between the asylum applicant and the state-licensed “expert” whose clinical impressions carry a substantial amount of weight with USCIS officers and ICE judges. For many of our clients, the asylum process can literally mean the difference between life and death. It is also important to consider that the evaluative interview structure can mimic certain aspects of

a torture situation, and can evoke traumatic memories (Pope & Garcia-Peltoniemi, 1991).

As such, clinicians need to recognize and normalize an applicant's feelings of anxiety regarding this all-important process. Acknowledging that sharing such intimate and perhaps stigmatizing detail can be painful is one way of trying to set an applicant at ease. Understanding that "not being believed" is another fear applicants may have, based on their torture experiences, is another key area that clinicians may choose to address (Haenel, 2001).

Evaluators may want to arrange the evaluation room in such a way as to be as non-threatening as possible. The psychological literature states that sitting across a table from an applicant and maintaining eye contact helps to reinforce the power hierarchy, and is less than an optimum environment for a psychological evaluation or screening interview (Gurris, 2001).

In addition, evaluators should provide "anticipatory guidance" early in the session so that the applicant will understand what is to be expected (and not to be expected) from this process (Fischman, 1998; Gangsei, 2001). Evaluators cannot give assurances about the outcome of an applicant's asylum process, nor should the evaluator make statements about whether (or how) they plan to advocate for the client. The job of the evaluator, once again, is limited to providing the most thorough and thoughtful report possible, based on their clinical observations and the self-report of the applicant. It should be made clear to the applicant, however, that there are potential benefits to engaging in this anxiety provoking exercise. A detailed psychological report based on comprehensive information can be a compelling tool in the asylum process. It can communicate the applicant's

history, functioning, and state of mind to the court in a powerful way that helps encapsulate an applicant's experiences.

Evaluators do not usually have the luxury of many individual sessions in which to elicit a trauma history and make observations as to an applicant's psychological state (Gangsei, 2001). Consequently, there may be more pressure to move quickly in terms of uncovering the applicant's history as a significant contributing factor to their overall emotional state. Even though this is part of the reality that psychological evaluators face, we need to keep in mind that many torture survivors who are applying for asylum have been tortured in the context of interrogations. So evaluators need to be sensitive to the possibilities of re-traumatizing an applicant if the pace of the interview moves too quickly.

The other treatment technique detailed in Chapter 6 of this volume was that of empowerment. It is also a key element in conducting a thorough psychological evaluation. Remembering that asylum applicants have often been purposely and sometimes violently disempowered, clinical evaluators may need to help applicants to find their voice in an intimidating situation. As stated before, subtle interventions like allowing the applicant to share information about the historical background and cultural heritage of his/her homeland, and acknowledging multilingual skills in applicants who are struggling with English, are also ways in which the applicant can be empowered within the session.

Applicants may need reinforcement in the perceived power hierarchy, and this can come into play in terms of setting the pace and direction of the interview. This is, of course, a delicate balance as evaluators often do not have the benefit of unlimited time. One way applicants may be encouraged to be more forthcoming with intimate details in a timely fashion that does

not disempower them is to couch requests in terms of mutual respect. Remind the applicant that they are not there to provide service to the evaluator; in fact, it is the evaluator who is providing a service. The applicant is simply assisting the evaluator to do the most thorough job possible on the applicant's behalf. The process can be seen as a collaborative endeavor in which a cycle of cooperation is constructed as opposed to a power hierarchy where the evaluator possesses all of the authority.

Allowing the applicant to have some control in terms of the pace and progression of the evaluation can also be facilitated by the evaluator being flexible enough to be at ease with asking specific sequences of questions or permitting the applicant to engage in a more free-flowing narrative. The choice in procedure will be based largely on whether an applicant is forthcoming with their trauma history or whether they need prompting and encouragement to tell their story.

For those applicants who need prompting, a sequence of guided questions can be helpful. Evaluators may arrange their questions in many different ways. They may work chronologically (forward or reverse), or organize their questions based on content area (i.e. family history, political involvement, pre-morbid functioning, trauma experiences, etc.). As the evaluator engages in this verbal inquiry, it is helpful to normalize an applicant's anxiety and/or resistance. It is also useful to re-emphasize the need for detail and re-state the purpose and potential benefits of the evaluation process. These interventions often help the client to answer the questions in a more complete fashion.

For those applicants who are more verbal and forthcoming with their narratives, the evaluator is well advised to follow the flow of the applicant's story and then inquire about missing details later. The evaluator should be

prepared to redirect the applicant if they digress too much from the main thrust of the narrative or get caught up in too much detail. Any such redirection should be communicated in a collaborative, as opposed to a punitive, context. Evaluators do not want to discourage sharing by making the applicant feel that they are doing something wrong. A statement of redirection to an applicant in such a situation may begin, “In order to present the most effective report to the court, I’m going to ask that we focus more on...”

Not only does such flexibility by the evaluator serve to empower the applicant, it also allows him/her to observe the thought processes that the applicant is exhibiting. The evidence gleaned from “process” can be every bit as valuable as evidence gleaned from the “content” of a survivor’s trauma narrative. Where does the applicant begin the narrative? What is the focus? How is the story told? Do they recount the story with vivid affect or in a detached manner? Are there gaps or inconsistencies in the narrative? Are there subjects upon which the applicant seems to fixate? Are there topics the applicant tries to avoid? Does the applicant focus more on personal suffering or the suffering of his/her “people” or his/her family? Do you feel that the client is bringing the story to you, or that you are extracting it? Are these observed behaviors consistent with the symptomatology that the applicant describes in terms of his/her current psychological functioning?

A clinical evaluator may also glean significant data and deepen their understanding by paying attention to their own subjective reactions to the client. If an evaluator has particularly strong reactions to an applicant (whether positive or negative), the evaluator needs to be able to examine what the reaction may be about. A clinician’s assumptions, perceptions, and behaviors are in a dynamic interaction with the applicant’s assumptions,

perceptions, and behaviors (see Chapter 2). The clinical evaluator's subjective feelings and preferences need to be considered, especially since their ostensibly objective reports are based in large part on subjective data.

Comments about Writing Affidavits

There are different forms of psychological affidavits that the Bellevue Program uses in asylum hearings. Examples of both formats are included in the appendixes of this volume. One format is the standard form of legal affidavit, with numbered paragraphs and the evaluator's professional qualifications detailed at the outset. The other format is the psychological summary, which includes: presenting problem, means of referral, brief client history, course in treatment including how symptoms fit in with the given diagnoses and clinical summation, including a detailed five axis DSM-IV-TR formulation (APA, 2000).

It has been our experience at the Bellevue program that a brief affidavit (no more than three or four pages) is optimum. A longer affidavit may only be skimmed, and may not carry the impact that a more concise report may have on the court. Also, writing a focused, concise report forces an evaluator to concentrate on the aspects of an applicant's presentation and reported history that are relevant to the psychological findings.

In this vein, we have found it to be very important to be transparent about what we can and cannot determine in our psychological evaluations. Clinical evaluators realistically need to focus on consistency, as opposed to causation. Typically, the psychological evaluator was not present in the applicant's home country at the time of the torture or war trauma, so it is disingenuous to talk about events with 100% certainty. Evaluators can write

about the trauma that the applicant reports, but cannot write about past events as though they are undeniably true. Evaluators rarely have pre-morbid contact with applicants (meaning pre-torture or pre-war), so we cannot write about marked changes in the client's behavior and functioning with a high degree of objective certainty. Again, evaluators are basing their findings largely on the applicant's self-report, and there are some applicants who may purposely malingering or exaggerate their symptoms (Resnick, 2001).

Although, evaluators cannot hope to eliminate all of the ambiguity regarding the veracity of an applicant's trauma history, there is usually ample evidence that allows evaluators to speak with confidence about the consistency of an applicant's psychological presentation with what one would expect to see from someone who has undergone the severe trauma that they report. Often, this subtle recognition of the limits of an evaluator's ability to speak about unobserved past events will do a lot to preempt possibly confrontational cross-examination by ICE attorneys.

Data that evaluators have to demonstrate an applicant's consistency generally include the psychological distress that an applicant manifests. As the effects of torture and refugee trauma are pervasive and multifaceted, evaluators must be willing to engage in complex assessments of asylum applicants. The spheres of potential psychological and behavioral difficulties go beyond the simple diagnosis of PTSD to include such complex combinations of problematic symptoms such as: depression, various anxiety disorders, issues of complicated bereavement, shame, phobias, guilt, substance abuse, suicidality, or excessive rumination about family or the situation back home (Briere, 2001; Resnick, 2001; Smith, 2001).

During a presentation to the clinical staffs of the Consortium of Torture Treatment Centers held in Minnesota, John Briere (2001) described the key areas that psychological evaluators need to explore:

The primary areas to assess are the spectrum of post-traumatic symptoms, including PTSD, anxiety, and depression. Issues surrounding suicidality, especially cognitions of hopelessness and helplessness, are to be discerned and attended to. Indications of social impairment can be important signs of post-traumatic psychological difficulty for an applicant.

Symptoms of “culture bound” disorders should also be recognized and investigated. Evaluators are encouraged to look beyond the main content areas of the DSM-IV-TR, because the diagnoses carried within the DSM-IV-TR (including PTSD), are also culture-bound syndromes (they just happen to be accepted as part of our “Western” culture). PTSD is part of the potential trauma reaction spectrum, but it is not the sum of it.

The secondary areas for assessment according to Briere (2001) are issues of somatization, dissociation, sexual dysfunction, personality problems, and symptoms linked to possible psychosis. Cultural variations need to be considered when gathering information about somatization, dissociation, and psychosis in particular. Different cultures may view certain out of body experiences, trance-like states, spirit possession, or physical manifestations of emotional pain as being more normative than other societies. As such, evaluators are challenged to discern what is culturally normative as opposed to a true symptom of psychological dysfunction.

The third area Briere (2001) identifies as being key in a psychological evaluation includes issues of personal identity and affect regulation. Changes in one’s educational, vocational, or familial situations can alter one’s view of themselves. Logistical concerns, including family functioning

and generational transmission of symptoms, are other factors that bear exploration, as we are now seeing that children of traumatized refugees may be prone to post-traumatic symptoms themselves.

At the Bellevue/NYU Program for Survivors of Torture we have the advantage of seeing applicants in ongoing treatment, so we are able to chart their progress in therapy, remark on subtle changes and reactions to additional stressors. We can also comment on client's commitment and sincerity in seeking treatment and their compliance with the treatment regimen. These are clinical luxuries that come with extensive longitudinal contact that not all clinicians doing evaluations will have.

Nevertheless, these factors cannot totally eradicate the ambiguity as to the veracity of the client's reported trauma history (Herily, Scragg, & Turner, 2002). The findings regarding consistency can, however, help to reduce the ambiguity, and give a professionally valid rationale as to why the evaluator feels that the applicant's presentation is credible (if this is indeed the case). Experienced clinicians also call for what has been called, "forensic gustiness," such that expert witnesses will be reasonable about what they put forth, but will also be authoritative in their presentation (Briere, 2001). Clinical evaluators are, after all, helping the court to come to a more nuanced decision based on increased knowledge.

Comments about Testifying

During the court proceedings it is also important that when an evaluator is providing expert testimony, that they be careful not to be drawn into an adversarial relationship with the government attorneys or the judge. An evaluator should be prepared to have his/her credentials called into

question, as well as their diagnoses. There may be questions about whether the evaluator is a “hired gun” consultant, whose objective is to win a case for a paying client. An evaluator’s conclusions may be critiqued as being too sweeping and general. An experienced evaluator will be able to defend their findings and expertise without any discernible rancor or defensiveness. These are further examples of why it is crucial for evaluators to stay within the limits of their competencies and not overreach to say things that cannot be verified with 100% certainty (i.e. issues of causality).

It is also vital that the evaluator present themselves and conduct themselves as a professional/expert witness, and not as an advocate of the applicant. By being openly partisan about how one feels the ultimate asylum decision should be go, an evaluator can reduce his/her own credibility, and make it look like they are not being professional and objective. Even for clinicians who have an on-going therapeutic relationship with the asylum applicant, staying within the bounds of objective, professional testimony fills the prescribed role of the expert witness. This type of approach lends more credibility and illustrative power to the evaluator’s testimony (Smith, 2001).

Along these lines, evaluators should also be careful not to try to “sell” the judge. It is not the job of a psychological evaluator to convince the judge or change anyone’s mind. The psychological affidavits and expert testimony are intended to simply make sure that the court understands why the evaluator is convinced, based on the clinical data and his/her professional judgment (Gangsei, 2001; Smith, 2001). Clinicians who provide psychological evaluations for clients in the Bellevue/NYU Program for Survivors of Torture have been informed by immigration judges and attorneys that this is a much more effective way of impacting on the court’s opinion than overtly trying to convince the court officials to render a

decision one way or the other. As such, it is imperative as evaluators, clinicians, and human rights advocates, that we make sure the court understands the rationale and reasons behind our professional conclusions.

To close this section, including some words from clients who have undergone the asylum process seems appropriate. Several asylees from the Center for Victims of Torture in Minneapolis, MN spoke to (then I.N.S.) asylum officers about their experiences during a training a few years ago. Their voices reflected the wide range of presenting styles and reactions of those who have undergone this stressful process.

One man from a Persian Gulf country spoke of “finally getting to express himself,” and the relief that ensued. Another woman from the Horn of Africa spoke of the difficulty and perceived futility of trying to put words to her experiences. As she stated, “My heart holds more than I can say.”

One common theme that the asylees agreed upon was that setting a humane context was the key in helping them to open up and share their stories. One male survivor talked about the power differential he felt at the outset of his interview. When asked what he held on to emotionally to complete the process, he replied that the human relationship was the only thing that allowed him to find his voice. “Humanity is the only thing we have in common.”

In the end, it was an African woman whose words seemed to catch the essence of the process. She made this simple statement while wiping away tears: “Treat me like I’m a human being who has no country, no home, and I’m asking if I can stay with you.”

Appendix A:

SAMPLE PSYCHOLOGICAL SUMMARY

Client: Mxxxxxxx Sxxxxxx Jxxxxx

Chart #: xxx-xx-xx

Clinic: Bellevue/NYU Program for Survivors of Torture

Clinician: Hawthorne Smith, Ph.D.

Date of Report: August 10, XXXX

Presenting Problem:

Mr. Jxxxxx was referred for psychological assessment and treatment by two separate organizations: the African Services Committee and Nah We Yone, Inc. Mr. Jxxxxx had numerous complaints regarding physical and emotional distress stemming from reported incidents of abuse and mistreatment in his home country of Sierra Leone. His initial psychological evaluation was conducted on 9/19/XX.

Mr. Jxxxxx is a 46 year old Black male from Sierra Leone who belongs to the Fulani ethnic group. His initial presentation was one of a person suffering from clinical depression. He complained of “feeling sad” and becoming tearful during his initial screening, particularly when talking about being separated from one of his children, and the atrocities he witnessed in Sierra Leone.

Mr. Jxxxxx’s history is covered in more detail in his legal and medical affidavits, but some significant traumatic events that he has reported have been: being displaced from his home region of Sierra Leone by Revolutionary United Front (RUF) rebels; losing his livelihood; having his house and shop burned by the rebels; witnessing widespread killings, mutilations, and amputations; having one sister, one uncle, and one aunt killed by the rebels; taking in his sister-in-law and her child after his brother had been killed, and they had been burned out of their house; having several teeth knocked out, and receiving wounds on his chest and leg due to beatings and mistreatment by rebels; being internally displaced in Sierra Leone; being forced to flee the country without one of his children; living in a refugee camp with his wife and children in Guinea in impoverished, unsafe conditions; being separated from his family; living in exile in the US.

Course of Treatment:

Mr. Jxxxxx has been working with our multidisciplinary team since September XXXX. He meets with his primary care physician for some of his physical complaints, and has received dental treatment and psychopharmacological medications. Mr. Jxxxxx has been aided by members of our social service staff, and has utilized community based resources such as *Nah We Yone, Inc.*, a

community organization that aids Sierra Leonean refugees. I have been working with Mr. Jxxxxx as an individual therapist since September XXXX.

Mr. Jxxxxx has attended 22 individual sessions to date, and attends sessions on a fairly consistent basis. He is amenable to psychological treatment, and will generally telephone ahead of time to confirm a session, or explain why he is going to miss a therapy session. He has been compliant with medication to alleviate his sleep difficulties and excessive rumination, but has needed assistance to navigate the pharmacy and hospital bureaucracy. Mr. Jxxxxx has never received any formal education beyond rudimentary Koranic schooling, but he displays insight into his situation by stating that not knowing his family's whereabouts or whether they are safe or not, makes it "hard for his mind to see clearly."

Mr. Jxxxxx appears to be a man suffering from Major Depression. He reports frequent tearfulness, and often appears dysthymic during therapy sessions. He complains of feeling fatigued, and states that he does not find as much pleasure in being sociable with people as he once did. He complains of significant changes in his sleep patterns and a decrease in his appetite. All of these symptoms are consistent with a diagnosis of Major Depression. His major complaint is of rumination, or "thinking too much" about the condition and safety of his family (particularly when he hears reports of the growing ethnic strife and intolerance of "foreigners" in Guinea). He has shared that when he was forced to leave Sierra Leone for Guinea without his son, it "made him crazy." These are aspects of the trauma that serve to exacerbate his depressive symptoms. These symptoms seem to be aggravating Mr. Jxxxxx's physical health, as he complains of frequent headaches and gastro-intestinal difficulties.

During treatment, Mr. Jxxxxx has also manifested and complained of classic symptoms of Posttraumatic Stress Disorder (PTSD). He manifests intrusive PTSD symptoms, such as recurrent intrusive thoughts, rumination, nightmares, and difficulty sleeping. Mr. Jxxxxx reports that his rumination is worse at night, and that he sometimes goes through an entire night without sleeping. Mr. Jxxxxx has been receiving psychopharmacological medication (Mirtazapine) to help treat this problem. Mr. Jxxxxx also reports having frequent, trauma-related nightmares. These nightmares had begun to decrease in frequency and intensity, but they worsened as he approached the one year anniversary of his arrival in the US. In his dreams he is usually back in Sierra Leone witnessing atrocities where the "blood runs like water;" or he is being pursued by a rebel who wants to cut him with a machete.

Mr. Jxxxxx also manifests symptoms of withdrawal associated with PTSD. Some of these symptoms overlap with the depressive symptoms that have already been discussed. Mr. Jxxxxx tries to avoid reports regarding the situation in Sierra

Leone, because it causes him a great deal of anxiety and pain. He talks about wanting to avoid thinking about it. Even in therapy, he has stated that there are certain aspects of his trauma that he is not yet ready to express because he may “lose control.”

Over time, Mr. Jxxxxx has been better able to share pertinent aspects of his trauma history, but this is still extremely difficult for him. He has needed a great deal of psychological support in order to fully relate his traumatic past to his legal representatives. During the time he was preparing his legal affidavit, there was a marked increase in his intrusive PTSD symptomatology.

As an example of his avoidant behavior, it took Mr. Jxxxxx months to share that the “neighbor” who came to his home with her child during the rebel siege was actually his sister-in-law. He states that he avoided sharing this information because it was too painful to think of his brother’s death. Mr. Jxxxxx engages in many activities (such as writing and rewriting verses from the Koran) as ways of “not thinking about what has happened.” He states that when he thinks too much about what he and his family have been through his “mind is not clear.”

Mr. Jxxxxx also manifests PTSD symptoms of hypervigilance. He reports being fearful when around strangers, including when he travels on the subway to his appointments. He describes himself as “jumpy,” and reports that he “doesn’t have the mind” to concentrate on things. He also states that he becomes irritable with his housemates without understanding why. It took some considerable effort for Mr. Jxxxxx to accept that his lawyers were people trying to help him that he need not fear.

Mr. Jxxxxx is actively utilizing his therapeutic and community supports to try to feel “like he belongs to a family again.” Mr. Jxxxxx has been willing to engage in both individual treatment and community activities in a sincere manner. He does this despite significant limitations in his English language fluency. He has been slightly more willing to speak about his traumatic history, including his hospitalizations in Guinea, and has definitely begun to explore his current psychological state in a more profound fashion.

Mr. Jxxxxx also uses his religious base as a coping mechanism and as a way of conceptualizing his traumatic experiences. He talks about fate, and how Allah has sustained him through these trials. He repeatedly states that Allah will repay all of the service providers who have helped him. He sometimes questions the meaning of life, but denies suicidal ideation, as his faith helps him to cope with his suffering.

It is my clinical judgment that Mr. Jxxxxx suffers legitimately from Major Depression and Posttraumatic Stress Disorder. These findings are consistent with what one would expect to find with someone who has suffered the severe physical and emotional trauma that he reports.

DSM-IV Diagnosis:

- Axis I: Major Depression – Recurrent and severe (296.33)
Posttraumatic Stress Disorder (309.81)
- Axis II: Deferred
- Axis III: Scars on body; missing front teeth; insomnia; frequent trauma-related nightmares; frequent headaches and gastrointestinal complaints
- Axis IV: Murder of family members; witness to atrocities; survivor of torture; living in exile; separation from wife and children; concern over children’s well-being in a refugee camp; uncertainty of immigration status
- Axis V: Initial: 52 Current: 58

Hawthorne Smith, Ph.D.
Psychologist
NY State License #: XXXXX

References

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text Revision). Washington DC: Author.
- Briere, J. (2001, July). *Evaluation, measurement, and assessment approaches with severely traumatized populations*. Paper presentation to the Clinical Leadership Conference of the National Consortium of Torture Treatment Programs. Minneapolis, MN.
- Fischman, Y. (1998). Metaclinical issues in the treatment of psychopolitical trauma. *American Journal of Orthopsychiatry*, 68(1), 27-38.
- Gangsei, D. (2001, October). *Developing a Narrative in the Psychological Assessment of Torture and Refugee Trauma*. Paper presented at the Clinical Symposium of the Torture Treatment Center Consortium, Chicago, IL.
- Gurris, N. (2001). Psychic trauma through torture – Healing through psychotherapy? In S. Graesner & N. Gurris (Eds.), *Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity* (pp. 29-56). Baltimore, MD: Johns Hopkins University Press.
- Haenel, F. (2001). Foreign bodies in the soul. In S. Graesner & N. Gurris (Eds.), *Standing at the Side of Torture Survivors: Treating a terrible assault on human dignity* (pp. 1-28). Baltimore, MD: Johns Hopkins University Press.
- Herily, J., Scragg, P., & Turner, S. (2002). Discrepancies in autobiographical memories – Implications for the assessment of asylum seekers: Repeated interview study. *British Medical Journal*, 324(7333), 324-327.

- Pope, K., & Garcia-Peltoniemi, R. (1991). Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. *Professional Psychology Research and Practice, 22*(4), 269-276.
- Resnick, P. (2001, June). *Malingered torture-induced PTSD*. Paper presented at the US Department of Justice Immigration Judges' Conference, New York City.
- Smith, H. (June 25, 2001). *Evaluating the psychological scars of torture*. Paper presented at the US Department of Justice Immigration Judges' Conference, New York City, NY.

Chapter 13

Secondary Trauma, Compassion Fatigue, and Burnout: Risk Factors, Resilience, and Coping in Caregivers – Summary

This chapter addresses issues of secondary trauma, and other ways in which care providers can be adversely affected by engaging in this challenging work. An overall description of secondary trauma is further illustrated by examples of ways in which the multiple traumas, stressors, and frustrations that our clients face can be manifested in care givers themselves. Recommendations are then made in terms of preventing and treating these potentially debilitating symptoms.

- * Description of secondary traumatic stress
- * Contributing factors
- * Paralyzing parallels
- * Prevention and treatment

Secondary Trauma, Compassion Fatigue, and Burnout: Risk Factors, Resilience, and Coping in Caregivers

Hawthorne E. Smith, Ph.D.

In the dream, the sun has been blocked out, and all of the familiar environs are shrouded in shadow. The sleeping therapist cannot make out the face of her pursuer, who seems to blend in and out of the shadows, but she feels mounting dread as the pursuer draws nearer no matter what evasive action she takes. Straight roads become cul-de-sacs, and she consistently loses her bearings in previously well-known surroundings. She awakens just before the pursuer reaches out to touch her. She is in her bed, breathing heavily and perspiring. Her heart rate is elevated and it takes her over an hour to fall back to sleep. She does not readily make the connection between her nightmare and the trauma history she had taken earlier in the week from a survivor of torture, until she shares her dream with colleagues at her clinic.

Description of Secondary Traumatic Stress

There is a broad array of terms used to describe the range of psychological and physiological effects observed in those caregivers who work closely with traumatized individuals and populations. Theorists, (i.e. Eisenman, Bergner, & Cohen, 2000; Figley, 1995a; Hesse, 2002; Holmqvist & Andersen, 2003; Joinson, 1992; Kinzie, 2001; Miller, Stiff, & Ellis, 1988; Trippany, WhiteKress, & Wilcoxon, 2004) list and describe some of the terms used in the psychological literature, such as: secondary victimization,

vicarious traumatization, compassion fatigue, empathetic strain, emotional contagion, countertransference, burnout, and secondary traumatic stress.

Figley (1995a) argues for the inclusion of secondary traumatic stress disorder (STSD) as a diagnosis to parallel PTSD in psychiatric texts. He looks at the level of exposure to a traumatic event needed to meet criterion for potential PTSD, as described in the DSM-IV (APA, 1994). He states that people can be traumatized without actually being harmed or threatened with harm, they only need to learn “about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” (APA, 1994, p. 424). Kleber (2003) posit that exposure to a traumatic event (whether primary or secondary) can be determined if the person experiences the following two elements: *powerlessness* – the inability to influence or alter the occurrence; and *disruption* – where the certainties and assumptions in one’s worldview are irrevocably altered.

Figley (1995a) continues that secondary traumatic stress reactions may occur in family members, friends, community members, and in the professionals who are providing care to the directly traumatized individuals. As such, providing support for the people who are indirectly traumatized can help to strengthen the support network and improve the quality of care for the people directly traumatized by horrific events. This is in addition to providing symptom relief for those, including clinicians, who may be suffering the ill-effects of STSD.

The effects of burnout and secondary traumatic stress described in the literature seem to be quite similar, despite the fact that they can be distinguished as overlapping yet distinct concepts. Theorists argue that burnout emerges gradually, and is a result of emotional exhaustion, while secondary traumatic stress (often called “compassion fatigue”) can emerge

suddenly (Figley, 1995a; Figley & Kleber, 1995; Hesse, 2002; Pines & Aronsen, 1988; Trippany et al., 2004).

The symptoms of secondary stress have often been considered as a form of countertransference in the psychiatric literature, but current theorists point out the subtle, yet significant differences (Hesse, 2002; Trippany et al., 2004). These theorists point out that countertransferential attitudes are linked to a therapist's past experiences and sub-conscious processes. This is in contrast to secondary trauma issues, in which the pre-existing personal characteristics of the therapist may have little to nothing to do with their reactions to the traumatic material (Hesse, 2002). Countertransferential attitudes should not be discounted or ignored, however, particularly when care providers treating trauma survivors are survivors of trauma themselves. This is frequently the case with resettlement workers who provide care for refugees, and who are often traumatized refugees themselves.

It has been the experience of clinicians from the Bellevue/NYU Program for Survivors of Torture, who have conducted numerous trainings and workshops across the nation with refugee resettlement agencies, that resettlement workers and other caregivers report varied reactions to working with uprooted, traumatized populations that are similar to the types of reactions detailed in the literature on burnout, compassion fatigue, and secondary traumatic stress. Many of these reactions can be organized according to Kahill's (1988) five categories: physical, emotional, behavioral, work-related, and interpersonal.

In terms of physical symptoms, resettlement workers and other caregivers have complained of headaches, stomach aches, general fatigue, joint pain, and becoming sick more frequently with colds, flu etc. Emotionally, these workers have reported sadness, depression, irritability,

anxiety, hyper-arousal, as well as feelings of helplessness and hopelessness. In addition, some have reported an increase in feelings of cynicism, discouragement, disbelief, personal vulnerability, and pessimism. These feelings may accompany behavior changes such as increased substance abuse, and work-related behavior changes such as tardiness, absenteeism, intolerance of other clients' problems, and "lackluster" work performance in general. Caregivers may also notice changes in their communication patterns, more dramatic mood swings, increased irritation, social withdrawal, and a lack of patience with the concerns or problems of other colleagues and/or family members (Kahill, 1988; Kinzie, 1994; Kleber & Figley, 1995). The parallels between these reactions and those found in people who have been directly traumatized will be discussed a little later in this chapter.

Contributing Factors

Potential contributing factors to secondary traumatic stress are varied and insidious. One of the primary factors that contribute to secondary traumatic stress is the ability to empathize, which is a hallmark of a caregiver's ability to engage in effective therapeutic treatment with traumatized clients. Empathy can help a caregiver to understand a client's experience, but it may also make them vulnerable to being traumatized themselves (Figley, 1995b; Wilson & Lindy, 1994). As many caregivers have experienced trauma, or may be refugees themselves, the possibility for empathic strain is even greater than one would usually find in a therapeutic milieu (Figley, 1995a; Kinzie, 1994).

Other potential issues that may exacerbate adverse psychological reactions on the part of service providers may be that some caregivers have expressed feeling that they are “doing something small” in the face of massive tragedies. Some caregivers have complained that their efforts may help particular individuals or families, but it will not affect the root causes of the problems. These types of thoughts may foster a sort of powerlessness, or a “what’s the use?” attitude, that can make it increasingly difficult for caregivers to feel a sense of positive accomplishment from their work (Kleber, 2003).

Other caregivers and theorists describe situations in which a worker may feel less than competent in their interactions with clients. This may be because of cultural or linguistic barriers, but more often it may stem from the worker’s perception that the client’s problems are beyond their capacity to effectively intervene in a way that is helpful to the client (Maslach & Johnson, 1981). Caregivers may also feel that there is too much work to do in too short a time, and that they have lost the ability to set their own pace and priorities in their work (Rench, 1996).

These thoughts can lead to a worker feeling powerless, and potentially hopeless, when engaging with a survivor of torture in their clinic. These perceived failings may impact a therapist’s self-image in terms of their overall competence as an effective therapist (Hesse, 2002; Trippany et al., 2004). These feelings may be exacerbated when the caregiver has internalized an “idealized image” of the client as deserving the best of treatment and outcomes (Eisenman, Bergner, & Cohen, 2000). A caregiver may feel that his or her efforts, no matter how sincere, are not sufficient for such a deserving client. Or, conversely, the caregiver may harbor “savior”

fantasies which can also erode reasonable expectations as to the probable outcomes of treatment (Kinzie, 1994; Smith, 2003).

Resettlement workers and other caregivers may also experience frustration with inadequate resources and funding at their particular clinic or agency. These same workers may also feel frustrated by the bureaucratic structures in many of the service provision agencies that they are called on to help navigate (Barr, 1984; Karger, 1981; Rench, 1996). When one considers the multiple social needs of a traumatized refugee, the opportunities for bureaucratic roadblocks are numerous, and the roadblocks can have extremely important implications for the traumatized refugee's well-being. As workers discuss their encounters with the immigration/asylum system, housing bureaucracies, educational systems, financial assistance services, medical and insurance bureaucracies, and other such entities, one can see how unpleasant or frustrating interactions with these important resources can lead a worker to feel less than supported or respected in their efforts.

Care and service providers may also harbor feelings of ambiguity about a particular client or group of clients that can reduce their confidence that they are indeed "doing the right thing." Doubt may arise as to the client's veracity in detailing the history of their traumatic experiences. Some clients may exaggerate details of their trauma to help ensure that they receive asylum or other social service benefits. Other clients may have antagonized service providers by being especially demanding, unappreciative, and manipulative, and it may come to light that a "victim" may have also been a perpetrator of human rights offenses themselves (Eisenman et al., 2000). These scenarios can also have significant impact on a service providers' ability to engage fully and find fulfillment in their work.

In addition, if a caregiver feels isolated within their family or social circles regarding the challenging nature of their work, it can also exacerbate emergent feelings of burnout and compassion fatigue. A caregiver may feel that “no one else will understand,” or may ask themselves “who wants to listen to this stuff anyway?” and may feel increasingly withdrawn emotionally from those who have been close to them throughout their lives. This reduction in the effective utilization of one’s support networks is yet another potentially pernicious effect of working with highly charged traumatic material (Rench, 1996; Spahn-Nelson, 1996).

Paralyzing Parallels

One may notice that the effects of secondary traumatic stress are similar to the effects of PTSD, which frequently affect survivors of torture and refugee trauma. The literature regarding secondary traumatic stress consistently makes the point that the ill-effects felt by clinicians working with traumatized populations often mirror the symptoms experienced by those who have been directly traumatized (i.e. Figley, 1995a; McCann & Pearlman, 1990). Beyond mimicking the symptoms of intrusion, avoidance, and hypervigilance associated with PTSD, secondary traumatic stress and burnout may mirror depressive symptoms, such as hopelessness and decreased energy, in addition to other psychological problems associated with refugee trauma (Figley & Kleber, 1995; Pines & Aronsen, 1988).

Certain theorists have put forth the notion of Constructivist Self-Development Theory [CSDT], and have demonstrated how working intimately with survivors of trauma can affect a therapist’s cognitive schemas (Hesse, 2002; McCann & Pearlman, 1991; Trippany et al., 2004).

These theorists posit that working with trauma survivors can affect therapists' views of their own frame of reference regarding themselves and the world: their belief systems; their sense of safety, trust, and control; their sense of independence and self-esteem; and their ability to be emotionally intimate with others.

For example, caregivers' may be affected by scenarios in which they feel that they are only doing something small in the face of great obstacles. Their worldviews and belief systems may be altered to the point that they feel that it's no use to continue with such small endeavors in a world filled with evil. These feelings may mirror the feelings of powerlessness and hopelessness that frequently confront traumatized clients.

Caregivers may lose the sense of trust in governmental and other systems (such as the immigration services) that are ostensibly set up to assist refugees and asylum seekers, but may end up putting additional strains on the situation. When caregivers feel as though they do not have sufficient time to complete their work, or when they feel less than competent in their dealing with clients, these feelings may run parallel to clients' feelings of being overwhelmed by insurmountable challenges.

There are other similarities in the way clients and caregivers may react to the reported trauma experiences and the subsequent recovery process. Caregivers who feel less than competent, or who may idealize their clients, run the risk of denigrating their own skills and placing unrealistically positive expectations on another person (Eisenman et al., 2000). This is not dissimilar to a client who has been violently disempowered, and may feel as though they are undeserving of assistance.

At times, the client may also idealize the caregiver, which can have some therapeutic benefits in terms of a transitional object, but can be

counterproductive over time if the client is not able to internalize positive feelings about themselves and take proactive action to improve their situation (van der Kolk, 1996). The caregiver may also join the client in avoiding pertinent issues linked to the trauma (Hesse, 2002). Holmqvist & Andersen (2003) call this avoidance “collusive resistance” (p. 294).

Other potential parallels that may adversely affect the therapeutic process are: that therapists may seek praise within the dyad in order to bolster their shaken self-esteem; therapists may be so full of rage that they preclude their client’s ability to say anything positive about the people who may have mistreated them, or admit that that they too participated in abusive behavior; or that therapists may over-medicate or hospitalize patients too often to compensate for their feelings of helplessness or incompetence (Hesse, 2002).

An empirical study by Holmqvist & Andersen (2003) shows that therapists who work predominately with trauma survivors feel less objective and enthusiastic over time, and that they show significant decreases in empathy. The same study showed a 10% prevalence rate of secondary traumatic stress among the therapists sampled.

The fact that some caregivers report feelings of frustration with bureaucratic procedures, isolation, personal devaluation, or some feelings of ambiguity about the nature of their work or the client they are working with may also parallel the realities faced by survivors of torture and refugee trauma. Clients are often frustrated by a lack of tangible progress in their immigration, educational, and professional struggles in the US. They often report feeling isolated or “all alone” with their traumatic memories, and may also be ambivalent about engaging in a therapeutic relationship with a stranger. They may doubt the efficacy of the treatment they are offered, and

may have reservations about engaging with the particular caregivers they are working with.

The following recollection from a senior clinician in our program from when they were a trainee is an illustration of the insidious parallels that may exist:

I remember going to my supervisor and explaining that I felt like a complete fraud, and that I had no idea what I was doing during my first session with the survivor. My supervisor asked about the general progression of the session. I shared that it was a severely depressed man from an Eastern African country who literally bore scars from his torture experiences on his face. He was tearful, frightened, and so sad that he could barely keep his head off of the desk in my office.

When my supervisor asked how I recalled feeling during the session (apart from feeling like a fraud), I responded that I felt lost. I remembered not knowing what to say, and not being sure what we could accomplish together in treatment. I remembered being scared and tense. I worried that the survivor would not find me credible. I felt sad and was overwhelmed with the immensity of the problem. I literally felt like fleeing the room.

My supervisor and I began to explore how the survivor may have been feeling during the session. As I shared my impressions, I realized that the survivor was also giving signals that he was feeling lost, unsure, scared, vulnerable, and overwhelmed. He may have also harbored a desire to flee the room.

My supervisor helped point out that not only was I not “a fraud,” but I was actually in tune with many of the survivor’s fears and anxieties. My tangible discomfort during the session, and in its aftermath, was only a diluted, momentary snapshot of the pervasive pain the client experiences constantly. He pointed out that as clinicians; we serve as our own healing instruments. The ability to truly listen, attend, and empathize with someone who is suffering is a powerful therapeutic tool; but it comes at a price. It can often mean pain and discomfort for the caregiver. It can mean that we feel lost. In those instances, we have to give ourselves “permission not to know.”

Prevention and Treatment

Having remarked that many of the symptoms of secondary traumatic stress mirror those of PTSD, we at the Bellevue/NYU Program for Survivors of Torture have found that the core therapeutic principles of safety and empowerment are also effective in helping caregivers to tolerate the challenging nature of their work.

In terms of safety, we strive to create an environment where colleagues feel free to share concerns, insights, and most importantly, feelings about the work we are doing. Writers on this subject are basically unanimous in espousing the importance of open communication among work colleagues (i.e. Figley, 1995a; Hesse, 2002; Kinzie, 1994; Smith, 2003; Spahn-Nelson, 1996; Trippany et al., 2004).

Multidisciplinary case conferences and/or staff meetings occur weekly, and serve as vehicles for the exchange of information and ideas across professions. Although traumatic case material is often exchanged

during these meetings, the supportive cross-discipline relationships they facilitate help to decrease feelings of professional isolation. Weekly supervision sessions include individual, group, and peer supervision formats. Informal case consultations and planning meetings are encouraged. In essence, we try to avoid any collusion of silence, in which we assume everyone is maintaining a healthy equilibrium in the work.

When caregivers express feelings of anger, discomfort, fatigue, or frustration, that may indicate secondary stress, they are listened to in a supportive, non-judgmental or stigmatized way. Attempts are made to facilitate understanding of the feelings in the context of the difficult nature of the work we are engaged in. Many authors in the field focus on the need to acknowledge and normalize countertransference and secondary stress reactions (Figley, 1995a; Figley & Kleber, 1995; Hesse, 2002; Kinzie, 1995; Spahn-Nelson, 1996; Trippany et al., 2004; Wilson & Lindy, 1994).

Another important element in combating secondary traumatic stress and burnout is to find positive outlets for one's energy and feelings. Smith (2003) has written that it is crucial to "be a conduit, not a container" in doing this work (p. 314). It is important to make time and space for the things you love to do in life. Sublimating the traumatic case material can be facilitated by engaging in creative pursuits, such as writing poetry or playing music, exercising and doing fun physical activities, or engaging in relaxation techniques, such as meditating and deep breathing exercises. Listening to music, hanging out with friends, and finding occasions to laugh, are other potentially therapeutic activities that can protect from the long-term effects of burnout.

Of course, basic ideas like eating well-balanced meals, getting enough rest, avoiding use of alcohol or drugs, and avoiding excessive use of

stimulants like sugar and caffeine are recommended. Work related issues, like rotating through different types of work activity, or having intermittent work-free periods, if possible, can reduce the negative impact of working with traumatic material (Trippany et al., 2004). Some clinicians have encouraged the sharing of painful clinical material with significant life partners (while respecting ethical guidelines), so that the clinician will not be so isolated in terms of family or social functioning (Figley, 1995a).

One of the important factors for preventing compassion fatigue is that caregivers set realistic expectations of themselves in doing this work (Hesse, 2002). Clinicians should resist the desire to "fix" everything for the survivor, and realize that we are not able to fully erase the trauma from someone's mind. These are key factors in staving off compassion fatigue and secondary trauma. Victories need to be measured in small steps, and the gradual process of recovery needs to be respected and tolerated. A program clinician remembered his first day of work as a junior counselor as such:

A more experienced counselor pulled me aside and said that he could tell it was my first day by my wide-eyed expression. He told me that I needed to get the "Robin Hood Complex" out of my head. I immediately asked him what that was. He responded that I had to realize that I couldn't save everybody. When I acknowledged his statement and started to walk away, he stopped me.

He said, "Not only can you not save everybody; you can't save anybody. All you can do is help to put people in a context where they can save themselves." Once again, I started to walk away, but he added, "You seem to be reasonably intelligent, so you may learn this

pretty quickly up here," he said as he pointed to his head. "But it will probably take you a lifetime, or at least your career to learn it here," as he pointed to his heart.

These words turned out to be prophetic for the young therapist in question. The emotional learning that the senior counselor was alluding to continues to be a major component of the continued growth - both as a clinician and a person - for that therapist, who has become one of the senior clinicians in our program. Engaging in work with this population of survivors of torture and refugee trauma helps to take this emotional learning to a whole new level.

References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington DC: Author.
- Barr, D. (1984). Burnout as a political issue. *Catalyst*, 4(4), 68-75.
- Eisenman, D., Bergner, S., & Cohen, I. (2000). An ideal victim: Idealizing trauma victims causes traumatic stress in human rights workers. *Human Rights Review*, 1(3), 106-114.
- Figley, C. (1995a). Compassion fatigue as secondary traumatic stress disorder. In C. Figley (Ed.), *Compassion fatigue: Coping with traumatic stress disorder in those who treat the traumatized* (pp. 1-18). New York: Bruner/Mazel, Inc.
- Figley, C. (1995b). Epilogue: The transmission of trauma. In C. Figley (Ed.), *Compassion fatigue: Coping with traumatic stress disorder in those who treat the traumatized* (pp.248-252). New York: Bruner/Mazel, Inc.
- Figley, C., & Kleber, R. (1995). Beyond the “victim”: Secondary traumatic stress. In R. J. Kleber & C. R. Figley (Eds.), *Beyond Trauma: Cultural and Societal Dynamics* (pp.75-98). New York: Plenum Press.
- Hesse, A.R. (2002). Secondary trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal*, 30(3), 293-309.
- Holmqvist, R., & Andersen, K. (2003). Therapists’ reactions to treatment of survivors of political torture. *Professional Psychology: Research & Practice*, 34(3), 294-300.
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22(4), 116-122.

- Kahill, S. (1988). Interventions for burnout in the helping professions: A review of empirical evidence. *Canadian Journal of Counseling Review*, 22(3), 310-342.
- Karger, H. (1981). Burnout as alienation. *Social Service Review*, 55(2), 268-283.
- Kinzie, J. (1994). Countertransference in the treatment of Southeast Asian refugees. In J. P. Wilson & J. D. Lindy (Eds.), *Countertransference in the Treatment of Posttraumatic Stress Disorder* (pp. 249-262). New York: Guilford Press.
- Kinzie, J. (2001). *Psychotherapy for massively traumatized refugees: The therapist variable*. Portland: Oregon Health and Sciences University.
- Kleber, R.J. (2003). *Coping with trauma: Theory, prevention, and treatment*. London and New York: Taylor & Francis.
- Maslach, C., & Jackson, S.E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, 2(2), 99-113.
- McCann, L., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-149.
- McCann, L., & Pearlman, L.A. (1991). *Through a glass darkly: Understanding and treating the adult trauma survivor through constructivist self-development theory*. New York: Bruner/Mazel.
- Miller, K.I., Stiff, J.B., & Ellis, B.H. (1988). Communication and empathy as precursors to burnout among human service workers. *Communication Monographs*, 55(9), 336-341.
- Pines, A., & Aronsen, E. (1988). *Career burnout: Causes and cures*. New York: Free Press.

- Rench, J. (1996, April). *Positive outcomes in the face of burnout*. Proceedings from the 20th Annual Convening of Crisis Intervention, Chicago, IL.
- Smith, H. (2003). Despair, Resilience, and the Meaning of Family: Group Therapy with French-Speaking Survivors of Torture from Africa. In R. Carter & B. Wallace (Eds.), *Understanding and Dealing with Violence. Multicultural Perspectives* (pp. 291-319). Thousand Oaks, CA: Sage Press, Inc.
- Spahn-Nelson, T. (1996, April). *Vicarious trauma: Bearing witness to another's trauma*. Proceedings from the 20th Annual Convening of Crisis Intervention, Chicago, IL.
- Trippany, R., White, V., & Wilcoxon, S. (2004). *Journal of Counseling and Development*, 82(1), 31-37.
- van der Kolk, B. (1996). Foreword. In J. P. Wilson & J. D. Lindy (Eds.), *Countertransference in the Treatment of Posttraumatic Stress Disorder* (pp.vii-xii). New York: Guilford Press.
- Wilson, J. & Lindy, J. (1994). Empathic strain and countertransference. In John P. Wilson & Jacob D. Lindy (Eds.), *Countertransference in the Treatment of Posttraumatic Stress Disorder* (pp.5-30). New York: Guilford Press.

Chapter 14

Volunteer Programs – Summary

This chapter describes basic principles in beginning and maintaining a successful volunteer program. The process of selecting and training volunteers is described, and the multiple roles that volunteers can play are explored. It is written with the intent of providing practical information, particularly for agencies that are considering starting their own volunteer programs.

- * Introduction
- * Preparing to Start a Volunteer Program.
 - Why people volunteer
 - Outreach
 - Screening
 - Orientation
- * Volunteer Job Descriptions and Support/Supervision for Volunteers.
 - English Tutors
 - Interpreters/Accompaniers/“Befrienders”
 - Administrative Volunteers
 - Special Projects
 - Evaluation

Volunteer Programs

Ninia Baehr, R.N.

Introduction

Whether a torture treatment program is large or small, well established or brand new, it can probably benefit from the help of volunteers. Indeed, until recently, many torture treatment centers in the United States operated almost entirely on volunteer labor provided by physicians, psychologists, psychiatrists, attorneys and other professionals offering pro bono services to clients. Many treatment programs still use networks of professionals, both paid and unpaid, to care for survivors. Although these unpaid professionals—along with the program’s Board of Directors, etc.—are technically volunteers, the term “volunteer” as used in this chapter refers to people who do not have any special training in caring for survivors of torture, but who are willing to contribute their time and energy to help a torture treatment center and the individuals it serves.

A volunteer program can help an organization both directly and indirectly. Directly, a volunteer program allows volunteers to donate labor that the organization would otherwise have to pay for or do without. Indirectly, this type of program helps by educating a pool of people about the problem of torture, possibly prompting them to promote the organization by soliciting contributions to the agency, advocating on behalf of torture survivors, or taking some other action that benefits the organization.

Implementing a volunteer program can also help individual survivors of torture in direct and indirect ways. Directly, a good program provides

clients with valuable services like English lessons or transportation assistance, which would be otherwise unavailable. Indirectly, a volunteer program can provide torture survivors with a sense of hope and healing. One of the goals of torture outlined in the literature is to destroy the personality, shattering an individual's self-confidence and causing a survivor to believe that his or her welfare is unimportant to others (Randall & Lutz, 1991). Without a central notion that he or she is a valuable member of the human race, a survivor loses their social stability. Volunteers can contribute to rebuilding a survivor's trust in others. The very fact that strangers are willing to give freely of their time proves that the survivor is not alone. Each volunteer demonstrates—through his or her continued presence—that he or she supports the survivor's struggles, and that they care about the individual enough to donate their most precious gifts: their time, energy, and their very selves.

Preparing to start a volunteer program

Torture treatment programs that are considering starting a volunteer program should consider several issues before launching the program. It is helpful to have a clear idea of what they want the new volunteers to do for their agency and clients. They should also determine whether or not the organization has liability insurance, and whether it covers volunteers on-site and off-site. Many non-profit organizations require that their volunteers show proof of health insurance. Others require that volunteers present certain types of health records (such as TB test results) prior to beginning work. Torture treatment facilities that exist under the auspices of a larger agency should comply with agency policy regarding volunteers.

Why people volunteer

There are many reasons why people choose to volunteer. Some reasons make them a good fit with a particular organization, while others do not. Since volunteers, by definition, provide services without receiving financial remuneration, it is important that they find the experience to be worthwhile in other ways. In many cases a volunteer can get what he or she wants out of the experience while simultaneously helping the organization and its clients. This, however, is not always the case.

When it becomes evident that a potential volunteer is not well suited to a particular task, then it may be best to refer the volunteer to a different organization. In this way, a volunteer coordinator can concentrate on developing volunteers who can provide the organization and its clients with something that is truly needed, and in turn, the organization can give the volunteer what he or she is seeking without becoming too distracted from the mission of serving clients.

In a multi-disciplinary torture treatment setting that includes medical, mental health, social, legal, and/or educational services, some of the most common reasons people may want to volunteer are:

They are members of a religious congregation that emphasizes serving needy community members and they are looking for a site at which to perform their mission work.

They want to contribute something positive to society.

They want to broaden their friendship networks.

They want to apply to medical school and need to volunteer in a medical setting prior to submitting their school application.

They are studying psychology and want to gain experience with a program that provides mental health services.

They want to get school credit for undertaking a project in a community-based setting.

Outreach

An organization should consider what they want from a volunteer, as well as what they can offer a volunteer. This can help a volunteer coordinator to decide where to do his or her outreach. Universities and congregations often offer a good forum for recruitment, but a wide variety of groups (including ethnic associations, language clubs, and professional associations) should be considered as potential recruiting grounds. Visits and presentations to congregation and associations to tell members about the program and inform them of opportunities to volunteer have proven to be successful. If a volunteer coordinator is unable to speak to people in person, he or she can put up fliers or post short articles in newsletters. Websites specializing in matching benevolent-minded individuals with non-profit organizations are another emerging and efficient way to recruit volunteers. Such sites as Idealist (www.idealists.org) and Volunteer Match (www.volunteermatch.com) allow organizations to publicize their volunteer opportunities to an audience already actively seeking to contribute to their communities.

As working with survivors of torture can be an especially gratifying experience, volunteers may appreciate it so much that they recruit their friends and family members. Starting with a few top-notch volunteers and asking them to help in expanding the program through word of mouth can be an efficient approach to increasing a volunteer base. Volunteers who are

found to be capable, reliable, and personable are likely to bring friends who share similar qualities.

Screening

When setting the foundation for your volunteer program, it is extremely important to screen prospective volunteers thoroughly. The population served by torture treatment centers is vulnerable in many ways, and it is thus imperative that clients are able to trust all people associated with the center, including volunteers (Fabri, 2001).

When first speaking with potential volunteers, it is helpful to have a stock of basic information about each individual, provided by either a resume or a completed application. It is also a good idea to ask for two or three references from people who can attest to their reliability. A volunteer coordinator should explain the various roles that volunteers fill in the organization, and ask if any of those job descriptions sound appealing. Perhaps most important, the coordinator should ask them why they are interested in volunteering at a torture treatment center. This is the most important question because it will provide an opportunity to spot any red flags that might indicate that the person is not a good match. Below is a small sample of some actual answers to this question that prompted the interviewer to proceed with caution:

“I had a bad childhood; living in my parents’ house was like living in a concentration camp, and it really ruined my whole life, and so I’m very interested in trauma.”

“I’m taking a freshman psychology class and I want to practice making some diagnoses and trying out different therapeutic techniques.”

“I love everyone and I want to help everyone and I’ve been trying to get here for a long time but I think some evil forces have been trying to stop me, you know what I’m saying, but I got around them and now I’m here.”

“My girlfriend just broke up with me, so I feel like I can really understand suffering, and misery loves company, so I thought I’d volunteer at a torture treatment center.”

Remember, it is easier to terminate a relationship with an inappropriate volunteer before “hiring” him or her than it is to “fire” the volunteer once he or she is on the job. A volunteer coordinator who is unsure about an applicant’s stability or motivation, should not commit to taking them on. If the potential volunteer does seem appropriate, great! The next step is to schedule him or her for orientation and training.

Orientation

Depending upon the needs of the clients and the program, a volunteer coordinator may orient new volunteers individually as they are “hired,” or may schedule group orientations periodically. Either way, volunteers should be provided with a thorough orientation before they begin working in any capacity (see Chapter 4). Generally, it makes sense to educate new volunteers about the population the agency serves and what services are available. The volunteer coordinator may want to give them a tour and

introduce them to staff or other volunteers they are likely to come in contact with.

Two things that are extremely important to discuss with new volunteers are confidentiality and boundaries. The volunteer coordinator should stress that confidentiality means that volunteers do not discuss clients, their trauma history, or their current situation with anyone outside the treatment team of physicians, psychologists and other care providers. It also means that, unless asked to do so by staff in particular situations, volunteers do not mention clients by name, confirm that a client is receiving care at a torture treatment center, or reveal details of a client's story in casual conversation even when the name is omitted.

Unless a specific situation calls for it (and permission is given), volunteers do not see clients' medical charts, psychologist's notes, or any other personal information. In cases where volunteers do have access to personal information, volunteers should maintain a high level of professionalism and respect with regard to each client's privacy. Issues of boundaries and confidentiality are especially pertinent in the case of our program, as we are situated within a large public hospital, where our entire environment is considered clinical space, in which volunteers, staff, and community members interact in multiple fashions.

Training should even address "no-brainer" issues like making sure that the trauma history of a particular torture survivor is not turned into a topic of conversation at a cocktail party by an overly enthusiastic volunteer. Whereas confidentiality protects the client, boundaries protect the client and the volunteer alike. In general, volunteers should present themselves in an appropriate manner in terms of:

Appearance (i.e., do not dress in a sexually suggestive manner; be neat and clean);

Demeanor (i.e., be friendly but not overly intimate or boisterous; do not assume that it is all right to touch a torture survivors even in ways that are meant to be supportive, such as placing a hand on a client's shoulder or giving the client a hug);

Conversation (i.e., do not probe the client for personal information, and do not discuss your own personal problems with the client.)

Unless asked to do so by staff, volunteers should never exchange telephone numbers and addresses with clients, nor should they make arrangements to see clients privately or socially. These guidelines may seem unnecessarily restrictive, but following them is better than running the risk that a volunteer might stalk a client, that a client might stalk a volunteer, that a volunteer might insert him or herself into a client's life in a way that feels uncomfortable to the survivor, or that a survivor might overwhelm a volunteer with neediness.

Volunteer Job Descriptions and Support/Supervision for Volunteers

English Tutors

Many clients seeking care at torture treatment centers are not proficient in English. Although it is wonderful when newcomers can have access to trained English as a Second Language teachers, many clients, especially those who do not yet have asylum, may not be eligible for

existing ESL programs in the community. Torture treatment centers can offer their own informal ESL classes by recruiting volunteers who are fluent in English and who are patient and supportive. An easy and relaxed way to offer English tutoring is to establish certain regular times when volunteers will be available and when clients can drop in to practice conversations or to work on their reading and writing skills.

Having ESL materials or basic texts on grammar available can be helpful, although study sessions may very well take on a life of their own as students and teachers use their imagination together. Developing a welcoming atmosphere, a reliable cadre of teachers, and a core of regular students can provide the basis for informal membership in a group, which can decrease clients' isolation and increase their sense of connection to and support from the community. In this way, English classes serve a variety of purposes and can prove to be quite therapeutic.

While English classes may be therapeutic, they are not intended as a setting for therapy. Most torture treatment centers have access to trained, experienced therapists who can provide clients with appropriate care. Volunteers should not "play" therapist. As mentioned earlier, they should not ask clients leading questions. If clients reveal information about their trauma history or how they are feeling, however, it is important not to give them the message they cannot talk about it. Instead, a volunteer can say something like "This really sounds important... have you been able to talk with your doctor about your concerns?" The volunteer should always feel free to give feedback to staff, and a qualified staff person should always be on site to follow up on any issues that may arise. Volunteers should be encouraged to tell a staff person if a client seems to be especially sad, tearful, distraught, fearful, anxious, stressed or upset.

In addition to notifying staff when clients are having difficulty, volunteers should also be offered a channel for maintaining regular communication with staff. This could take the form of short after-class debriefings, regularly scheduled process groups, or informal conversations on an as-needed basis (see Chapter 4). It is extremely important for these volunteers to have direct contact with some type of supervisor, as volunteers occasionally need reminders about material covered in the orientation.

A supervisor should be alert to signs that a volunteer has perhaps inadvertently crossed boundaries with clients or strayed from his or her designated role in the program. If a general inquiry about how the volunteer is enjoying his job elicits a response like, “I love working in the ESL program, especially one-on-one with the students. I mean, I’ve cried, they’ve cried... I’ve learned so much working here,” it may be time to remind the volunteer of the guidelines addressed during volunteer orientation. Checking in with volunteers can also ensure that no one is becoming burnt out or traumatized by their work with your program.

Although working with torture survivors can be immensely rewarding and gratifying, it can also be difficult, as hearing about torture can cause what is referred to by mental health professionals as secondary traumatization, a process by which the volunteer develops reactions similar to those of the survivor of the traumatic event (see Chapter 13). This is particularly true for volunteers who listen to and repeat many clients’ stories as they translate for clients at intake screenings, psychotherapy sessions, doctor’s appointments, lawyer’s appointments, and other occasions at which the survivors must tell his or her trauma story. Volunteers in this situation, in particular, need regular support and supervision from staff (see Chapters 4 and 6).

Interpreters/Accompaniers/Befrienders

As noted above, the demands placed on volunteer interpreters can be intense. Interpreters often have a great deal of contact with clients and become extremely familiar with the clients' trauma histories and current situations. Clearly, volunteers chosen to serve as interpreters must not only be bilingual, but they must also be reliable, stable, and able to maintain confidentiality (Fabri, 2001; Haenel, 1997).

Volunteers working in this capacity also need extra training and support. Many issues regarding supervision, working with interpreters and secondary traumatization are detailed elsewhere in this volume (see Chapters 4 and 13). Incorporating aspects contained in these chapters as part of a volunteer interpreter's training has proven helpful in our experience. It is also important for the therapist to "check in" with the interpreter after each session. Interpreters may be at special risk for secondary traumatization, especially when they have a particularly heavy case load. It may be wise to offer the volunteer interpreter a regular supervision session during which he or she can process his or her own emotions regarding the work (Haenel, 1997; Lee, 1997).

Accompaniers also have a great deal of contact with clients, although they may or may not serve as interpreters. Generally, accompaniers help clients get to and from appointments. They may also advocate for the clients by helping to navigate bureaucracies so they can accomplish their immediate goals. Accompaniers can also help clients become more self-sufficient by taking actions like teaching clients how to use public transportation.

Accompaniers and/or interpreters, who work fairly intensively with one client over time, may, in some cases, evolve into "befrienders." Befrienders are volunteers who maintain some regular contact with clients

outside the torture treatment center. They may do things like teach a client how to shop in a western supermarket, cook in a western kitchen, use a computer, or open a bank account. They may also engage in recreational activities with clients, going with them to parks, museums, concerts, and other inexpensive attractions. Or, they may simply meet or talk with a client on a regular basis.

Because befrienders interact with clients relatively independently, it is clearly extremely important that volunteers selected to serve as befrienders are trustworthy and that they possess common sense. It is also imperative that program staff work with the befriender from the beginning to set and maintain appropriate boundaries. Boundaries should be clearly defined and comfortable for both volunteers and clients. Supervisors should work to ensure that these volunteers are not overwhelmed by the traumatic material, or by an inflated sense of “idealizing” the client (Eisenman, Bergner, & Cohen, 2000). Volunteers should “check in” with staff on a regular basis, and staff should also maintain contact with the client so that the client’s satisfaction with the arrangement can be monitored. If either the volunteer or the client becomes uncomfortable with any aspect of the befriender arrangement, staff should be prepared to assist both parties in making changes, and to intervene if necessary. Highly selective screening, good volunteer training, and regular communication can all help ensure that the befriender relationship is a positive one for all concerned.

Administrative Volunteers

It surely comes as no surprise that volunteers can provide a great deal of valuable assistance in the day-to-day operations of an office. Remember, though, that virtually anything can seem easy once you know how to do it.

Even a routine task to a staff person may be confusing for a volunteer who must perform it for the first time. It is important to be very clear and specific with new administrative volunteers, to check on their progress frequently, and to leave sufficient time to train and supervise them. Emphasizing the need for confidentiality from these volunteers, who work in environments where they have access to private material, is of paramount importance.

Special Projects

In addition to all the work that volunteers perform on a regular basis, some volunteers may also be able to undertake special projects. One volunteer might be qualified to work with you on building or updating a web page, while another might be able to engage in research, or to chair a special events committee. Keep in mind that no matter what volunteers do for your organization and its clients, you will need to dedicate some staff time to ensuring that the work contributed by volunteers is successfully integrated with the work of the organization as a whole (Elsass, 1997).

Recognition

Successful volunteer programs almost always employ some form of volunteer recognition. In many non-profit settings, this is necessary because the volunteers do not get much positive feedback from the people who benefit from the volunteers' work. For example, if volunteers spend time doing rehabilitation work on an abandoned house for eventual rental to low-income tenants, the volunteers may never meet the people who move into the renovated building.

Torture treatment centers, by contrast, tend to serve clients who are aware of volunteers' contributions, appreciative of their assistance, and able to express their gratitude to volunteers directly. By definition, the clients at torture treatment centers are survivors. As such, they are a somewhat self-selected group. Often, the people who are targeted for torture in their home countries were targeted precisely because they were intelligent, articulate, resourceful, effective and courageous critics of the regime in power.

These same traits may have helped them to survive their torture, to flee their countries, and to find their way to the United States. These traits can also help torture survivors rebuild their lives successfully in this country. Volunteers who work with torture survivors can have the gratifying experience of seeing clients take the resources available to them and build upon them to great effect. Volunteers are able to see that their efforts make a difference in the lives of torture survivors. They can witness changes over time as torture survivors heal. All of this is deeply rewarding.

A client's gratitude is icing on the cake. And although it is not necessary, clients may offer thanks over and over and in many different ways. In fact, we have found that the gratitude can be quite humbling, and may make staff and volunteers alike to ponder the question, "Who am I to be thanked?" (See Chapter 6.) Consequently, the staff of a torture treatment center may not need to manufacture a volunteer recognition event, because volunteers are likely to feel appreciated on a continuous basis through their ongoing interactions with clients and staff.

That being said, it is still a good idea to do something special every once in a while to let volunteers know they are appreciated. Program staff can take volunteers out to dinner, hand out awards, present them with plaques, or make a number of other appreciative gestures; but the most

meaningful thing a program can do to let your volunteers know they are appreciated is to invest sufficient time and money in volunteer development.

On a daily basis, this means ensuring that volunteers are treated courteously, that their time is not wasted, that staff has time to train and supervise them, that volunteers have mechanisms for providing feedback to staff, and that staff is responsive to volunteer feedback. On an as-possible basis, it may mean sending a volunteer interested in public policy to a public policy conference, or sending a volunteer interested in fundraising to a grant writing workshop.

These activities have two benefits. First, just as spending time and money on staff development can ultimately benefit the organization and its clients, so too can investing in volunteer development. The organization and its clients are likely to benefit because the volunteers will probably use their new skills and connections on their behalf. In addition, volunteers will see that they are valued enough for the organization to invest in them. They will know that the worth of their efforts is recognized and appreciated. Their attachment to the organization may very well strengthen over time, and these skilled, committed, experienced individuals may become board members or other key stake holders in the future. In this way, they will continue to share their talents with the program, and the initial “investment” in them repays itself over and over again.

Evaluation

Whether starting a program or refining an existing program, it is helpful to make sure that the goals and objectives are stated clearly and measurably, and that they truly express the organization’s plans and desires. In addition to determining whether or not the program is reaching its goals, a

volunteer coordinator should encourage volunteers to participate in the evaluation process. Clearly, establishing ways for volunteers to provide staff with feedback should be an ongoing aspect of any volunteer program. From time to time, it is also a good idea to host focus groups during which volunteers are asked for their suggestions about what might make the program better. A volunteer coordinator can also provide them with an opportunity to give written evaluations. Developing a method of including client feedback in the evaluation of your volunteer program is also an important consideration.

At any phase in the evolution of a volunteer program, a volunteer coordinator can almost certainly benefit from talking with others who are experienced in the field. In addition to contacting volunteer coordinators at other torture treatment centers, he or she may also be able to obtain technical assistance from local agencies specifically created to support non-profit agencies. Furthermore, many cities and states and some federal agencies have offices dedicated to promoting volunteerism. All of these can be good resources for building a program.

Constructing a volunteer program—like working as a volunteer—is a rewarding experience wrought with challenges. While the topics addressed in this chapter may provide some practical information for starting a volunteer program, it is by no means comprehensive, as it is impossible to predict all of the issues that one may confront along the way. With a small corps of superior volunteers, a set of general guidelines and a flexible mindset, however, an agency can take the first steps toward creating a volunteer program that benefits clients and volunteers alike.

References

- Eisenman, D., Bergner, S., & Cohen, I. (2000). An ideal victim: Idealizing trauma victims causes traumatic stress in human rights workers. *Human Rights Review, 1*(3), 106-114.
- Elsass, P. (1997). *Treating victims of torture and violence: Theoretical, cross-cultural, and clinical implications*. New York and London: New York University Press.
- Fabri, M.R. (2001). Reconstructing safety: Adjustments to the therapeutic frame in the treatment of survivors of political torture. *Professional Psychology: Research and Practice, 32*(5), 452-457.
- Haenel, F. (1997). Aspects and problems associated with the use of interpreters in psychotherapy of victims of torture. *Torture, 7* (3), 68-71.
- Lee, E. (1997). Cross-cultural communication: Therapeutic use of interpreters. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians* (pp. 477-489). New York: Guilford Press.
- Randall, G., & Lutz, E. (1991). *Serving survivors of torture*. Washington, DC: Association for the Advancement of Science.