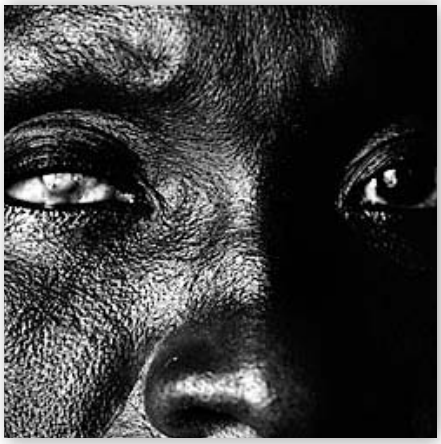
CHAPTER 3





# WORKING WITH TORTURE SURVIVORS

## CORE COMPETENCIES

CHAPTER 3

# WORKING WITH TORTURE SURVIVORS

## CORE COMPETENCIES

IN THIS CHAPTER



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

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

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

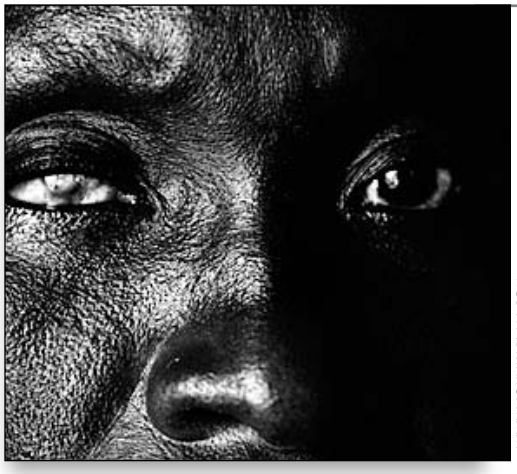
CULTURAL COMPETENCE with traumatized people

WORKING EFFECTIVELY with interpreters

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

### LIFE EXPERIENCES AND RESETTLEMENT ISSUES

Torture is rarely the only trauma a torture survivor has experienced. Exile involves the loss of an entire world and way of life, in addition to bringing the new and pressing challenges of starting over in a foreign land.



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

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

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

#### LIFE BEFORE TORTURE

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

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

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

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

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

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

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

## THE REFUGEE/ASYLEE EXPERIENCE

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

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

### DEFINITION OF TORTURE

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

— ARTICLE 1, UNITED NATIONS CONVENTION AGAINST TORTURE, 1984


**SPUTNIK** Tented Camp.

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

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

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

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

**FOR MORE INFORMATION**

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

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

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

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

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

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

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

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

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

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

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

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

The uncertainty and length of the asylum process makes resettlement different for asylum seekers than for refugees. Service providers to torture survivors need to receive training about these differences and their implications for service delivery.

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

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

FIGURE 3A

THE TRIPLE-TRAUMA PARADIGM

| PRE-FLIGHT | FLIGHT | POST-FLIGHT |
|---|---|---|
| ■ Harassment/intimidation/threats<br>■ Fear of unexpected arrest<br>■ Loss of job/livelihood<br>■ Loss of home and possessions<br>■ Disruption of studies, life dreams<br>■ Repeated relocation<br>■ Living in hiding/underground<br>■ Societal chaos/breakdown<br>■ Prohibition of traditional practices<br>■ Lack of medical care<br>■ Separation, isolation of family<br>■ Malnutrition<br>■ Need for secrecy, silence, distrust<br>■ Brief arrests<br>■ Being followed or monitored<br>■ Imprisonment<br>■ Torture<br>■ Other forms of violence<br>■ Witnessing violence<br>■ Disappearances/deaths | ■ Fear of being caught or returned<br>■ Living in hiding/underground<br>■ Detention at checkpoints, borders<br>■ Loss of home, possessions<br>■ Loss of job/schooling<br>■ Illness<br>■ Robbery<br>■ Exploitation: bribes, falsification<br>■ Physical assault, rape, or injury<br>■ Witnessing violence<br>■ Lack of medical care<br>■ Separation, isolation of family<br>■ Malnutrition<br>■ Crowded, unsanitary conditions<br>■ Long waits in refugee camps<br>■ Great uncertainty about future | ■ Low social and economic status<br>■ Lack of legal status<br>■ Language barriers<br>■ Transportation, service barriers<br>■ Loss of identity, roles<br>■ Bad news from home<br>■ Unmet expectations<br>■ Unemployment/underemployment<br>■ Racial/ethnic discrimination<br>■ Inadequate, dangerous housing<br>■ Repeated relocation/migration<br>■ Social and cultural isolation<br>■ Family separation/reunification<br>■ Unresolved losses/disappearances<br>■ Conflict: internal, marital, generational, community<br>■ Unrealistic expectations from home<br>■ Shock of new climate, geography<br>■ Symptoms often worsen |

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

status, and limited eligibility for services as noncitizens.

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

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

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

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

FOR MORE INFORMATION

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

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

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

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

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

## Comprehending Torture

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

FIGURE 3B A HANDOUT FOR SURVIVORS AND THEIR FAMILIES

## COMMON EFFECTS OF TORTURE

### POSTTRAUMATIC STRESS DISORDER

- Nightmares
- Bad thoughts or memories of the torture come into your mind when you don't want them to
- Acting or feeling like the torture is happening all over again (e.g., flashbacks)
- Feeling very upset when something reminds you of the torture
- Trying to forget the torture, trying not to think about it
- Staying away from anything that reminds you of the torture
- Cannot remember important things that happened during the torture
- Feeling like you do not care about life or what happens to you
- Feeling like no one understands or cares about you, like you are alone and cut off from others
- Feeling numb, like there are no feelings inside you
- Feeling like you have no future or that you may die sooner than most people
- Difficulty falling asleep or staying asleep at night
- Feeling angry a lot, easily upset
- Difficulty concentrating
- Can't relax or feel comfortable, often afraid something bad will happen

### DEPRESSION

- Feeling sad or angry a lot
- Difficulty thinking or making decisions
- Difficulty concentrating or remembering
- Feeling worthless or hopeless
- Feeling excessive guilt
- Feeling that you do not care about life, that you are not interested in things
- Feeling too hungry or not hungry at all, gaining or losing a lot of weight without trying to
- Sleeping too much or too little
- Feeling tired a lot, not having energy
- Thinking about death a lot, thinking about killing yourself

### PHYSICAL SYMPTOMS

- Headaches
- Feeling dizzy, faint or weak
- Chest pain
- Heart beats very fast
- Stomach hurts or feeling sick in the stomach
- Shaking or trembling
- Hands or feet feel cold
- Hot or burning feelings
- Numb or tingling sensations
- Sweating
- Diffuse or generalized sense of pain, weakness, misery
- Other pains in the body

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

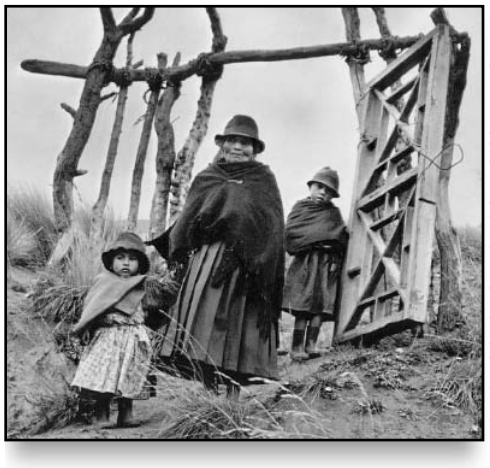
Because torture is a political weapon used to terrorize entire communities by targeting individuals, a care provider needs to understand the political and historical context in order to provide appropriate treatment. Psychologist Yael Fischman, from the Institute for the Study of Psychosocial Trauma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

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

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

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

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



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

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

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

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

### EFFECTS OF TORTURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**SHAME AND HUMILIATION:** Torturers intentionally produce feelings of shame and humiliation that undermine identity and prevent survivors from talking about what happened to them. For example, forced nakedness is one technique commonly used under captivity. This act strips away personal identity and shames victims through indecent exposure to others. Nakedness is one of many techniques that serve as a continual reminder of the differences in power between torturers and victims.

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

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

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

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

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

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

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

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

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

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

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

Providers should use caution when interpreting memory issues, and be aware that memory gaps and inconsistencies are common among torture survivors.

FIGURE 3C

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### TALKING ABOUT TRAUMA

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

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

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

### SECONDARY TRAUMA FOR THE PROVIDER

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

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

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

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

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

## CULTURAL COMPETENCE

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

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

FOR MORE INFORMATION

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

### CULTURAL COMPETENCE DOES NOT MEAN

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

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


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

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

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

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

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

### HOW CULTURAL COMPETENCE AFFECTS CARE

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

On an individual level, the absence of cultural competence in rehabilitation results in unsatisfactory outcomes for the patient or client. On the community level, the result is continuing disparities in health and socioeconomic status between the majority population and new immigrant populations, as well as disparities between the majority culture and other populations of color in the United States.

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

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

### STANDARDS FOR CULTURAL COMPETENCE

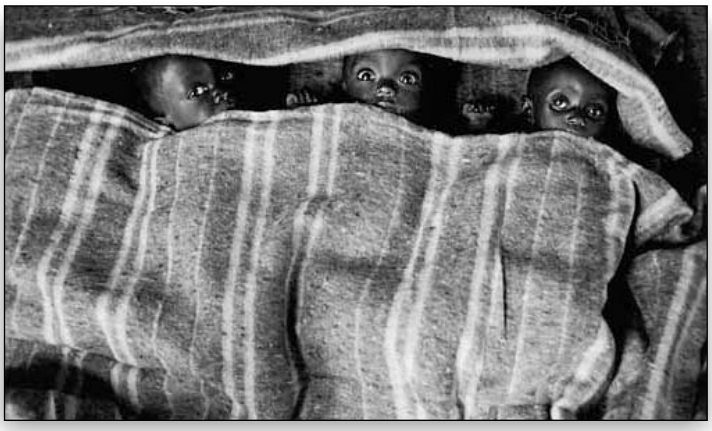
In March 2001, the Office of Minority Health at the U.S. Department of Health and Human Services published a set of national standards defining culturally and linguistically appropriate services (CLAS) in health care. The standards focus on the following three areas:

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

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

### TRAINING AND RESOURCES

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



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

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

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

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

## Working with Interpreters

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

FOR MORE INFORMATION

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

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

WWW.LABYRINTHOS.NET

Upon intake, Sonia reported she seldom left her apartment and had no significant relationships outside of her immediate family. She told the scheduler she would not work with any interpreter from Guatemala, her home country.

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

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

In subsequent sessions, the therapist moved slowly as she helped the client disclose the details of her trauma. Marta remained neutral and calm as she interpreted Sonia's ideas as precisely as possible

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

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

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

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

**SAMPLE VOCABULARY FOR INTERPRETERS**

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

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

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

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

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

**FOR MORE INFORMATION**

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

### SKILLS FOR PROVIDERS

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

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

### SKILLS FOR INTERPRETERS

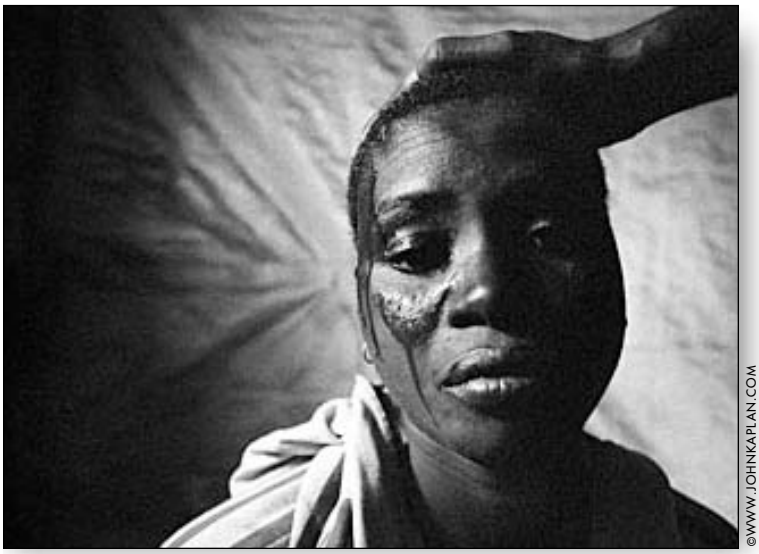
Interpreting for torture survivors is sophisticated work. It requires knowledge of words and concepts commonly transmitted during the course of medical, mental health, legal, or social services work and understanding of the cultures of clients as well as the experiences of clients with trauma.

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

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

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

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




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

medical interpreters available.

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

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

### SELF-CARE FOR INTERPRETERS

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

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

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## ADDITIONAL RESOURCES

### CULTURAL COMPETENCE

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

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

### INTERPRETING

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

**FIGURE 3E**

## GUIDELINES FOR PROVIDERS WORKING WITH INTERPRETERS

| | DO | DON'T |
|---|---|---|
| BEFORE SESSION | DEVELOP A POOL OF accessible, trained professional interpreters for the most common languages spoken in your area of service delivery.<br><br>SCREEN INTERPRETERS: Determine their level of language sophistication, knowledge of the culture, sensitivity to mental health issues (especially confidentiality), and general disposition for the tasks to be done. For mental health service delivery, it is important to ask about the interpreter's own mental health. Many interpreters have their own trauma history and need to make informed choices about re-exposure to traumatic events.<br><br>TOGETHER WITH THE INTERPRETER, determine which groups, backgrounds, languages, and dialects would be a good match for his or her skills and background.<br><br>ORIENT INTERPRETERS TO THE organization's mission, goals, structure, terminology, and roles. This should be ongoing rather than a one-time effort.<br><br>DEVELOP AND MAINTAIN good working relationships with interpreters. | OMIT THIS STAGE. It is essential for providing culturally competent services. |
| DURING SESSION | EXPECT TASKS TO TAKE longer when an interpreter is used.<br><br>EXPECT THE INTERPRETER to assist with clarification.<br><br>EXPECT THE INTERPRETER to take notes when issues become complicated.<br><br>PREPARE TO REPEAT yourself in different words.<br><br>HAVE THE PARTIES SPEAK directly to each other, not to the interpreter. Make sure the interpreter speaks to both parties in the first person.<br><br>LOOK AT THE CLIENT while you are speaking to her or him, not at the interpreter. Maintain gentle eye contact when the client or the interpreter speaks.<br><br>EXPLAIN YOUR ROLE and that of the interpreter. It is especially important to address the issue of interpreter confidentiality and how the interpreter and client will handle future interactions within the community.<br><br>USE THE INTERPRETER AS a cultural broker to avoid unnecessary misunderstanding. | USE A WORD-FOR-WORD interpreting format. Literal translation rarely makes it possible to re-express the original meaning due to the uniqueness of each language.<br><br>CHAIN QUESTIONS (e.g., "Do you smoke or drink coffee?").<br><br>SAY ANYTHING YOU DO NOT want the other party to hear.<br><br>TALK ABOUT CLIENTS IN THEIR presence. If you need to consult with the interpreter, explain what you are doing to the client.<br><br>CONFUSE THE INTERPRETER by backing up, rephrasing, or hesitating. Do not "think aloud" or use a reflective style that changes, meanders, or backs up in the middle, or erases parts.<br><br>TALK FAST. |

**FIGURE 3E**

## GUIDELINES FOR PROVIDERS (CONTINUED)

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

# The CLAS Standards

1 Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

2 Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3 Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4 Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5 Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6 Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

8 Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9 Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

10 Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

11 Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12 Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS- related activities.

13 Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14 Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.