

CHAPTER 6



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PSYCHOLOGICAL SERVICES

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

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

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



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

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

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

This chapter is not intended as a "how to"

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

CHALLENGES AND REWARDS OF WORKING WITH TORTURE SURVIVORS

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

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

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

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

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

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

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

THEORETICAL FRAMEWORKS

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

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

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

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

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

The testimony method is an example

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

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

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

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

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

vivor are as follows:

- Respect
- Information
- Connection
- Hope

ADAPTING EXISTING SERVICES FOR TORTURE SURVIVORS

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

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

ATTEND TO CULTURAL ISSUES

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

FOR MORE INFORMATION

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



particular survivors and families.

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

Guidelines for developing cultural understanding include the following:

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

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

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

PROVIDE CLIENT-TAILORED INFORMATION, EXPLANATION, AND CHOICE

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

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

NOTEWORTHY BOOKS

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

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

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

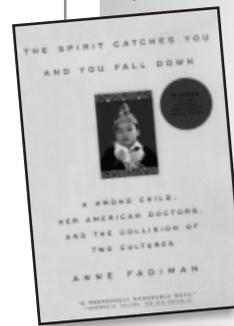
Honoring Differences: Cultural Issues in the

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

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

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

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



GUIDELINES FOR ADAPTING SERVICES

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

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

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

HELP CLIENTS MODERATE the pace of telling their trauma stories.

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

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

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

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

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

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

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

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

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

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

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

PURPOSE: What are the goals of the work together?

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

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

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

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

SLOW THE PACE

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

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

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

SITUATE PROBLEMS IN HISTORICAL AND POLITICAL CONTEXTS

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

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

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

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

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

DE-STIGMATIZE

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

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

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

STAGES OF TRAUMA RECOVERY

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

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

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

stigma and negative economic consequences.

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

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

ADDRESS THE POTENTIAL FOR RE-TRAUMATIZATION

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

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

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

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

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

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

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

TRAUMATIC MATERIAL

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

For example, mental health providers may

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

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

POTENTIAL FOR RE-TRAUMATIZATION THROUGH ASSESSMENT

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

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

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

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

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

WORK HOLISTICALLY

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

In addition, due to culture and other

RESOURCES FOR PSYCHOLOGICAL ASSESSMENT

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

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

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

FOR MORE INFORMATION

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



HIPAA AND FEDERAL PRIVACY REGULATIONS

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

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

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

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

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

In psychotherapy, examples of this adaptation include the following:

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

medical concerns

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

EFFECTS OF THE WORK ON THE PROVIDER

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

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

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

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

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

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

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

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

WORKING WITH INTERPRETERS

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

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

RESOURCES THAT ADDRESS THE IMPACT OF THE WORK ON THERAPISTS

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

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

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

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

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

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

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

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

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

FOR MORE INFORMATION

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



FAMILIAR STRATEGIES USED BY PSYCHOLOGICAL SERVICES TO HELP TORTURE SURVIVORS

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

- Provide information to survivors about posttraumatic reactions, such as PTSD and depression, and provide information about the psychological effects of trauma; normalize and validate these reactions.
- Provide a safe, therapeutic environment for the emotions that survivors feel; listen, receive, and endure the emotions with the survivor.
- Help survivors learn to calm and soothe themselves by teaching specific anxiety-management strategies and through internalization of the therapeutic relationship.
- Help survivors identify their beliefs about experiences of torture and persecution and begin to examine those beliefs imposed under torture (e.g., “I was responsible for what was done to my family.”).
- Assist survivors through the grieving and mourning of multiple losses.
- Assist survivors with their overall adjustment to a new environment and the re-establishment of occupational and educational plans, familial roles, and responsibilities.
- Help survivors anticipate and cope with potentially re-traumatizing experiences (e.g., asylum interview or hearing) or with unexpected experiences of re-victimization (e.g., crime, racism, etc.).
- Foster the connection of thoughts, feelings, bodily sensations, and other responses to the trauma from which they originated; normalize these experiences.
- Foster the establishment or re-establishment of trust in others and in the world, to whatever extent possible.
- Promote positive connection or reconnection with others.
- Address pre- and post-torture trauma experiences which may also be of significance.
- Foster the eventual connection or reconnection with meaningful return to one's social, cultural, political, and economic roles, to whatever extent is desired by the client.

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

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

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

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ONLINE RESOURCES

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

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

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