

Refugee Survivors of Torture: Trauma and Treatment

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It is increasingly likely that psychologists may be faced with clients who have been tortured, although the significance of this background can be easily unrecognized or mishandled. With the growing incidence of refugees to the United States escaping from organized violence and human rights violations in many parts of the world, the need for psychological assistance in the recovery from torture is well documented. By integrating principles from trauma theory and multicultural theory with a conceptual analysis of power and liberation theory, the author offers an understanding of both the nature of the damage inflicted by politically based torture and strategies to help overcome that damage.

In order for the oppressed to wage the struggle for their liberation, they must perceive the reality of oppression not as a closed world from which there is no exit, but as limiting situation which they can transform. (Freire, 1973, p. 34)

Politically driven torture may not seem a likely factor in the course of much conventional clinical work, but the unfortunate fact is that the consequences of barbarity inflicted elsewhere are increasingly to be encountered within resettlement populations here and throughout the world. Despite the ringing condemnation of such crimes against humanity more than a half century ago in the United Nations' *Universal Declaration of Human Rights*, Amnesty International currently reports that torture has increased by 23% in the past decade, and nearly 7 out of every 10 countries are in direct violation of the United Nations Convention Against Torture (Schulz, 2001). In this article, I advocate that for reasons of professional responsibility and social justice, psychologists in a widening arc of settings and practices respond to those realities, and I present a framework of principles and guidelines for doing so.

The Refugee Experience

Present migration rates worldwide are the largest in history, and the great majority stem from developing countries whose refugees carry severe burdens of deprivation and hardship. It has been estimated that in distinction to other immigrant groups more motivated by economic or natural conditions, almost 20 million international refugees throughout the world have been forced by extreme abuse of human rights to flee their home countries (Jablensky, Marsella, Ekblad, Jansson, Levi, & Bornemann, 1994). In addition to suffering from extensive trauma, their condition is

commonly exacerbated by exile and resettlement, asylum proceedings, and threats of deportation (Brody, 1994).

Although more than 13.5 million of all refugees are resettled in Africa, the Middle East, and South Asia, unprecedented numbers also have been coming to the United States as both legal and illegal immigrants. In recent years, the U.S. Immigration and Naturalization Service annually authorized almost 200,000 asylum cases for humanitarian reasons and diversity, and another 90,000 illegal immigrants received amnesty permitting them to stay in the country, with a backlog of more than 450,000 applications for political asylum pending. Among documented immigrants to the United States, the largest group has come from Asia (37%), with 32% more from Mexico, the Caribbean, or Central America and 18% from Europe, predominantly Eastern European countries (Stoll, 1997). Illegal migrants are by definition more difficult to survey and characteristically face even greater difficulty in their efforts to relocate.

Regardless of their status, all refugees have undertaken a crossing of "interpersonal, socioeconomic, cultural-linguistic and geographic boundaries . . . [and] a significant number must make a transition from life in traditional, rural, or village cultures to that in secular, modern, and urban settings" (Brody, 1994, p. 66). Westermeyer and Williams (1986) and McFarlane and Yehuda (1996) have found that a complex matrix of genetic, social, temperamental, and experiential issues affect vulnerability and resiliency for refugees in the passages from health to distress or to impairment and back to recovery. As with all trauma, access to therapeutic, rehabilitative, social, and legal services also significantly affects the ultimate outcome for many individuals, if the assistance is culturally appropriate.

The Impact of Torture on Refugees

The generally accepted definition of torture was formulated in 1975 by the 29th World Medical Association's assembly in its Tokyo Declaration. It described torture as "the deliberate, systematic or wanton infliction of physical or mental suffering . . . to force a person to yield information, to make a confession, or for any other reason" (Bağoğlu, 1992, p. 1). Many commentators (e.g., Bustos, 1990; Elsass, 1997; Stover & Nightingale, 1985) have found that the most insidious aim of torture is not to uncover intelligence or obtain statements from its victims. The ordeal is

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meant instead to induce, as Stover and Nightingale titled their book on torture, "the breaking of bodies and minds," in order to stifle dissent, intimidate opposition, and strengthen the forces of tyranny. "The goal is to destroy the individual's personality. Ultimately, it serves to terrorize the entire population and end any resistance to the regime" (Bustos, 1990, p. 333).

Freire (1973) explained the dynamics of systematic oppression as entailing a psychological adaptation to the political realities of domination, in which the subjugated internalize their imposed condition and feel incapable of resistance. In effect, torture as an instrument of political and social control is intended to rob its victims of their "voice" and their agency, to have them serve as abject warnings to the general populace. It is a particularly concentrated and inhumane means of subordination by which power is maintained (Fanon, 1963). When the concept of traumatic oppression is extended to people brutalized for incidental or "nonpolitical" reasons, such as innocent bystanders caught in the middle of an armed conflict or families who suffered the murder or disappearance of a loved one, the parameters of victimization become even more encompassing.

In attempting to assess the prevalence of survivors of torture, Chester (1990) cited surveys of centers serving torture victims that indicated from 35% to 50% of the total refugee population had been so traumatized. More recently, Marsella, Friedman, Gerrity, and Scurfield (1996) and de Girolamo and McFarlane (1996) reviewed numerous studies demonstrating similar or higher rates of trauma among various samples of refugees. These percentages yield estimates between 200,000 (Rosenberg, 1997) and 400,000 survivors of torture (Shelton, 1998) currently residing in the United States.

It is difficult to arrive at more exact numbers of refugees who were tortured, however, because of the frequent reluctance of victims to attest to their experience. They may fear facing legal consequences for themselves in the new country or for their families left behind if they call attention to their presence and their history. They may have acquired a sense of blame and shame for what they had undergone, for what they were forced to do during their ordeal, or simply for their having survived. In addition, they may be unfamiliar with or distrustful of services and forums through which they could make their cases known, particularly when cultural contrasts loom large between their backgrounds and their current circumstances.

As Mollica and Caspi-Yavin (1992) noted, "the cataclysmic impact of the torture event on an individual's personal life often makes the realities of this unique experience and its psychological sequelae difficult to obtain from torture survivors" (p. 253). Torture provokes defenses of (a) somaticization, (b) denial or repression, and (c) dissociation, and conditions of guilt, helplessness, depression, or posttraumatic stress disorder (PTSD), which, unless treated, can effectively prevent the injured from addressing the trauma they suffered. The resultant symptomatology can leave the individual estranged and emotionally shut down. To that extent, the torture has been "successful" in silencing and disabling its victims.

Another factor complicating the identification and rehabilitation of tortured refugees has been the lack of sufficient caregivers qualified and willing to attend to their stories of atrocities. "The tendency for individuals, including health professionals, to withdraw from survivors of violence has been well documented . . . the

medical or psychiatric interviewer is often emotionally unprepared to listen to the horrifying experiences of the survivor of torture" (Goldfeld, Mollica, Pesavento, & Faraone, 1988, p. 2725).

Although traumatized refugees present distinctive issues in terms of pre- and postmigratory and cross-cultural factors such as acculturation and petition for asylum, their general concerns correspond to those for any form of victimization, and PTSD and comorbid conditions are common. Somnier, Vesti, Kastrup, and Genefke (1992) reported large-scale studies of torture survivors showing pronounced and homogeneous patterns of extreme anxiety, impaired memory, intrusive thoughts and impaired concentration, insomnia and nightmares, emotional disturbances, sexual dysfunction, occupational and social impairment, somatic symptoms, substance abuse, learned helplessness, depersonalization and dissociation, fear of intimacy, and changes in identity. The authors concluded that a specific concept of "torture syndrome" appears to be unsubstantiated, and torture sequelae seem better understood as a list of a varying constellation of symptoms not qualitatively different from other stress response syndromes.

The symptomatology associated with torture trauma will vary with respect to learned patterns of coping and the particular ethnic, political, and spiritual perspectives through which an individual views the experience. It must be interpreted accordingly, in terms of both the culture of origin and the relocation setting, when formulating therapeutic interventions. For example, Elsass (1997) noted that "the difference between guilt and shame cultures may have a decisive influence on psychotherapeutic work with torture survivors" (p. 112).

In addition to multicultural considerations in diagnosing traumatized refugees, labeling them in terms of psychopathology can serve to "depoliticize issues such as state violence and hence may devalue the fundamental issues of causation, impunity and prevention" (Turner, McFarlane, & van der Kolk, 1996, p. 544). If the problem and its etiology are viewed as if they exist only within the victim rather than in the context of the pathological system that made the reactions a "normal" response, the effect can be one of compounding the trauma. In other words, limiting the frame of analysis to an intrapsychic formulation may do further if inadvertent injury by discounting the moral and ethical outrage of social injustice for individuals struggling to come to terms with the meaning of their traumatization (Martín-Baró, 1988, 1994).

A related and equally important warning has been voiced by Bustos (1990), among others, not to turn the ordeal of torture in itself into a diagnosis in which "the mere fact of having lived through the experience suggests . . . stigmatization [and] the subject is deprived of substantive interiority and stripped of the purposefulness, reflection, and intentionality demonstrated by his or her conflicts" (p. 152). Instead, psychological effects of torture should be seen as "meaningful conditional reactions for a sound and forceful constitution that make survival possible in a very pathological situation" (Somnier et al., 1992, p. 68). Many of the symptoms shown by torture survivors, such as emotional numbing, hypervigilance, social withdrawal, grief, and loss can be appropriate means of coping with profoundly abnormal circumstances. It is their perpetuation into the future and their aggravation by new stressors that often render them more psychologically harmful as posttraumatic and depressive reactions. Alleviation of these difficulties must begin with an acknowledgment of the unconscionable cruelty and sociopolitical deviance that gave rise to them.

Treatment Developments

Answering to the plight of victimized refugees requires understanding of the migratory experience, the trauma of torture, the psychology of liberation, and the cross-cultural paradigms of treatment. In the last several decades, an international convergence of human rights concerns with mental health practices has led to the creation of programs to this end. Chester (1990) and Van Willigen (1992) dated its inception to the overthrow of the government of Salvador Allende in Chile by General Augusto Pinochet in 1973 and the response by networks of health professionals there to care for victims of the new regime's campaign of violence and persecution.

In 1982 the first international clinic to specialize in the medical and psychosocial treatments of torture survivors was established in Denmark, and a year later a second was opened in Toronto. Other centers subsequently emerged elsewhere in Europe and many other countries. Within 15 years, there were 173 agencies and organizations worldwide concentrating on the care of victims of torture (International Rehabilitation Council for Torture Victims, 1997). Significant beginnings in the United States dealt with refugees from Southeast Asia, such as the program at the Oregon Health Sciences University, started in 1978, and the Indochinese Psychiatry Clinic in Massachusetts, started in 1983. The first U.S. program specializing in treating international victims of torture was established in 1985 in Minneapolis. Currently there are 26 programs across the United States, Mexico, and Canada.¹

It is widely agreed that the call for these services far exceeds current capacities to respond (International Rehabilitation Council for Torture Victims, 1997; van der Veer, 1998). Furthermore, Westermeyer and Williams (1986) observed that in dealing with traumatized refugees, mental health issues may be underestimated: "Physical health needs seem so overwhelming in comparison to available health resources that they assume priority, to the neglect of psychiatric problems" (p. 235). The difficulties are further complicated by the especially wide range of national, religious, educational, and personal backgrounds that refugees bring to treatment and that require individualized psychological treatment strategies. There are, however, certain essential guidelines that should underlie all therapeutic endeavors with this population. Two bodies of contemporary theory, research, and practice provide the foundation: the psychology of multicultural diversity and that of trauma recovery and rehabilitation.

Multicultural Principles

The multicultural movement has been designated by Pedersen (1989) as the "fourth force" in mental health services, bringing a crucial dimension to prevailing psychodynamic, cognitive-behavioral, and humanistic approaches. D'Andrea and Daniels (1996) and Jackson (1996), among others, have argued, however, that its effects on clinical practice with culturally different groups have only slowly come about. Standards of care necessitate that cross-cultural proficiency no longer be regarded as an area of specialized interest if psychology is to be relevant to the emerging societal realities of demographic change. When working across differences with respect, for example, to class, disability, ethnicity, race, national origin, sexual orientation, or religion, psychologists must be cognizant of and able to "bracket" their own culturally

derived reactions, assumptions and values. They need to maintain a phenomenological stance to appreciate the meaning of clients' distinctive ways of being in the world. In assisting refugees, the American therapist is likely to be dealing with even greater cultural discrepancies than may be the case with other minority groups. Knowledge must be gained in each instance from the client and from background sources about the historical, spiritual, and sociopolitical realities from which he or she comes.

Treatment interactions should be especially attuned to contextual and "metalevel" considerations, such as nonverbal signals, communication styles, significance of self-disclosures and expression of feelings, power and role differentials, gender and age factors, the physical setting, and the attributional ways of perceiving problems and the giving or receiving of help. Therapy with culturally different clients should focus with special care on the exploration of strengths and supports as well as vulnerabilities, risks, and uncertainties in their own terms. It is also important in building a credible and informed working alliance to understand these qualities in terms of the larger relational and belief systems in which they are embedded. "Treating the minority client in isolation is perhaps the most frequent cross-cultural psychotherapeutic error" (Elsass, 1997, p. 118).

Failure to appreciate the significance of diverse cultural realities of the *self in relation* can result by default in serious distortions, such as assuming standards for Eurocentric, male, middle-class, heterosexual, and able-bodied individuals as universally normative and ignoring or devaluing unfamiliar religious attitudes, communal or tribal affiliations, and ancestral lineages or aesthetic and traditional practices that hold existential meaning for the client. Ivey (1995) criticized prevailing constrictive monocultural models of therapy and highlighted instead the importance of the idea of liberation in the formulation of multicultural treatments. As people learn to recognize and analyze such dynamics as status, economic and power inequities, societal biases, and ascribed role values, they can become increasingly freed from imposed and internalized constraints and increasingly enabled to reassert the fundamental worth and potentiality of their lives (Martín-Baró, 1994).

Ivey (1995) referred to the social critiques of Fanon (1963) and Freire (1973) to demonstrate "how important it is for the oppressed to find their own voice and language to name and describe their condition" (p. 55). These writers have made clear that the dimensions of power and self-determination constitute a major theme in work with all disenfranchised and marginalized minority populations.

Applying the foregoing considerations to rehabilitation for refugee survivors of torture, therapists will attend to the cultural grounds on which they and their clients each engage in the encounter. Moreover, they will implement treatment not only in multicultural terms but also in terms of human rights, liberation, and reconstruction of identity in relation to significant others, the broader community, and the world at large (van der Veer, 2000). The alienation engendered by torture, with its "political dialectic of domination and defenselessness" (Bustos, 1990, p. 145) and the dislocation inherent in exile commonly can produce an impoverished sense of selfhood and efficacy and a damaged capacity for

¹ A list of these programs can be found at <http://www.pacinfo.com/eugene/tsnet/dspcenters.html>.

relationships. A twofold therapeutic questioning of past power structures by which refugees were debased and present ones by which they may be diminished or stigmatized promotes an integration of their backgrounds with new existential possibilities and a transformation to their status as survivor from that of victim.

To accomplish the shift from victimhood, survivors of torture must reaffirm their integrity and reclaim their ability to act in the face of contravening hierarchical inequities. They can then reject the feelings of worthlessness and weakness instilled by their torturers. Like other minority groups, they can also come to value their distinctive cultural reference groups while finding ways to relate within an expanding interpersonal field in which differences connote pride of identity, not inferiority or marginalization. Finally, they can also then rebuild the capacity for connection with other individuals with a reopening to a life of community and of future opportunity.

On the therapist's side in this endeavor, it is essential to interpret the survivor's initially presenting symptoms as an understandable response to pathogenic systems of tyranny. At the same time, it is equally necessary to respect the distinctive attributions made by the refugee to such experiences, whether that be, for example, imperialism, karma, or "God's will." The therapist must work within the clients' frame of reference and seek to encourage the recognition of their condition not as a world in which they are trapped but, as in Freire's (1973) terms, "a limiting situation which they can transform" (p. 34). To do so, the therapist must add to multicultural perspectives the strategies for rehabilitation of trauma.

Trauma Recovery Principles

The concept of loss is at the heart of working with torture victims, given their prototypic ordeals of multiple traumatization. Victimized refugees tend to define themselves in terms of the systemic oppression done to them, the world that they gave up in migrating, and lastly the new society in which they are trying to find a place. In each frame of reference, traumatization is commonly linked with issues of disempowerment and deprivation. Silove (1996) differentiated the experience of torture from other forms of trauma because it is an ideologically driven and malevolent planned assault, intended to render the victim helpless and intimidated, and frequently involving the use of sophisticated psychological techniques to undermine attitudes, beliefs, self-concept, and personality development. Furthermore, Silove noted that when victims are released, they often return to conditions of more general chaos and persecution or become displaced persons subject to ongoing social instability, facing complex legal and bureaucratic hurdles.

The dehumanization inherent in torture attacks the refugee's usual sense of personhood, of social bonds, and of values, causing him or her instead to feel acutely isolated and vulnerable. The psychological legacy of the experience was expressed powerfully by Primo Levi in writing of his time as a prisoner at Auschwitz:

Imagine now a man who is deprived of everyone he loves, and at the same time of his house, his habits, his clothes, in short, of everything he possesses: he will be a hollow man, reduced to suffering and needs, forgetful of dignity and restraint, for he who loses all often easily loses himself. . . . The ocean of pain, past and present, surrounded us and its level rose until it almost submerged us. It was useless to close one's

eyes or turn one's back to it. . . . The just among us, neither more nor less numerous than in any other human group, felt remorse, shame and pain for the misdeeds that others and not they had committed, and in which they felt involved, because they sensed that what had happened around them and in their presence, and in them, was irrevocable. Never again could it be cleansed. (Levi, as quoted in Bernstein, 1999, p. 42)

Such feelings are subsequently magnified for the refugee by the travails of escape, exile, and resettlement as "outsiders" in a strange culture. Although the primary focus of the work of Herman (1992) was on victims of domestic and sexual violence and veterans of combat, her elucidation of the effects of trauma is particularly apt for torture victims: "Trauma robs the victim of a sense of power and control; the guiding principle of recovery is to restore power and control to the survivor. . . no other therapeutic work can possibly succeed [until security has been established. . . and it may take] days to weeks with acutely traumatized people or months to years with survivors of chronic abuse" (pp. 159-160). Adaptation of Herman's general model of three stages in the trauma rehabilitation process, *safety*, *reconstruction*, and *reconnection*, provides a useful set of goals for assisting survivors of torture. In discussing these stages for the recovery from torture, Elsass (1997) noted that although they "do not have any common theoretical background, [they] are a pragmatic way of bringing order into clinical therapeutic experience" (p. 80).

Establishment of Safety

The first stage deals with the encouragement of rapport and confidence, which will be increasingly complicated in proportion to the severity, duration, and early onset of abuse. Therapists can foster a quality of safety in the treatment by first addressing control of one's body (e.g., through physical therapy or relaxation techniques) and gradually moving outward toward control of the environment. In addition, according to Herman, the initial stage always includes an element of social support. She notes that one of the most frequent therapeutic errors in treatment of trauma victims is "the premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and stability, building trust and a therapeutic alliance" (Herman, 1992, p. 172). Similarly, Bouhoutsos (1990) has stated that "a basic admonition is that the torture victim should never be coerced to deal with material for which he or she is not ready" (p. 132).

In working with refugees, promoting a sense of safety entails from the outset a high degree of cross-cultural sensitivity to the setting and pacing of treatment, linguistic differences, context and use of interpreters, informed consent and confidentiality, and case management efforts. Because of this population's frequently impoverished status and extensive needs for services, multifaceted and open-ended treatment in agencies in the public sector, when available, is preferable to the more limiting strictures of managed care or independent private practices. Starting with survivors' most proximal and physical requirements conveys respect for their rights, well-being, and autonomy as affirmed in the therapeutic dyad, before moving toward more sensitive psychological issues. Because refugees frequently present with immediate situational, social, economic, legal, or medical problems, a sequential approach is all the more indicated, and focus on the traumatizing experience may be slow in emerging.

According to Mollica (1988),

Highly traumatized refugee patients initially can only tolerate limited discussions of their lives. . . . [They] need to be told by the staff that they can be seen indefinitely until their situation improves [and] this is especially important to those refugees who are socially isolated and feel hopeless about their ability to recover from the atrocities they have experienced. (pp. 303–304)

Vesti and Kastrup (1992) found that length of treatment “depends upon factors such as resistance toward reexperiencing the trauma, motivation for treatment, the severity of symptoms, the verbal ability of the patient, the complexity of the case, and particularly the presence of concomitant somatic or adjustment problems” (p. 352).

The role of an interpreter in forming the therapeutic team when patients and therapists lack a common language is a complex and key factor in creating a safe and empathic therapeutic engagement. Although the intermediary functions of interpreters cannot be sufficiently examined in this article, they have been discussed usefully by Vesti and Kastrup (1992). Among other factors in engendering conditions of safety with torture survivors are clarifications about boundaries, client rights, and therapeutic goals and the character, interests, and role of the therapist, especially with refugees for whom psychotherapy is culturally unfamiliar. Because at times the torture activities may have included the presence of a purported doctor and other official figures of authority, it is often essential to explain the therapeutic format, including the explicit message that the treatment team works for the client. It is he or she who determines when and how to proceed, lest the therapist inadvertently trigger fears of intrusion and danger, recapitulating the earlier duress of interrogation and compromising or even terminating the treatment.

Frequently, the torture process has also included sexual assault and violations, although they may not be reported at the onset of treatment. Particularly in such instances, the gender of both the therapist and the interpreter can have major impact on the establishment of trust and the eliciting of the survivor’s story. When the refugee is also seeking asylum with its attendant demands for legal testimony in the intimidating and often adversarial hearings of the Immigration and Naturalization Service, the working through of safety concerns becomes still more protracted and complex. At times, the submission of affidavits or the accompaniment by the therapist or therapeutic team to the hearing can be of major import in helping both to support the refugee and to explain to the hearing judge such phenomena as emotional detachment, vague or inconsistent memories, confused cognitions, or cross-cultural discrepancies or misperceptions.

Process of Reconstruction

In Herman’s second stage, the individual constructs over time the narrative of the trauma within the therapeutic relationship and, in so doing, modifies the traumatic memory, allowing it to become a more meaningful part of his or her life story. “One of the fundamental fears experienced by survivors of torture, both at the time of the trauma and even long thereafter, is that their stories will not be comprehended or worse still, their testimony will not be believed” (Silove, Tarn, Bowles, & Reid, 1991, p. 484). The role of the therapist then becomes one of witness and ally, enabling the

patient “to speak of the unspeakable.” The task for both parties in this stage is overcoming the natural suppression or repression that heretofore permitted the patient a limited degree of coping, albeit at the expense of a fuller range of experience. “Denial is indeed the enemy of counseling . . . patient and therapist want to get on with everyday life and bury the past . . . as the most available defense mechanism to avoid pain” (Allodi, 1990, p. 250).

Rather than obfuscating or negating the historical and psychological reality of the injury, a narrative should be developed that includes the traumatic imagery and bodily sensations in measured ways that are culturally relevant and expressive for the person. It is concurrently necessary to assess the continued experience of safety in the therapeutic situation and the possible emergence of disruptive symptoms either within the treatment or outside it. The pace and intensity of the uncovering work must remain within the realm of what is tolerable for the survivor as experiences of self-efficacy and psychological integration are incrementally reconstituted. “It is important for the therapist to evaluate whether a client’s strategies [of avoidance or detachment] reflect pathological denial or conversely, a self-protective manoeuvre which is adaptive at that point in therapy” (Silove et al., 1991, p. 487).

Religious, artistic, ritualistic, or other systemic modalities of expression may also prove to be of great benefit, particularly when they are culturally attuned to the world view of the individual. The goal is for the survivors gradually to grow from a feeling of trust in the therapeutic team through a sharing of their story to an internalized reclamation of acceptance and confidence in themselves. One notable technique to promote reconstruction has been the use by Chilean psychologists of formalized testimony (Agger & Jensen, 1990; Cienfuegos & Monelli, 1983). They create a detailed record of the traumatic experience, slowly assembling disjointed and depersonalized recollections into a coherent and more ego-syntonic rendering of the events. Initially, the account of the trauma is typically made in a flattened, fragmented, static, and repetitive form—what Mollica (1988) termed a “prenarrative” presentation—without feeling, nuance, or interpretation. As the partial chronological and affective sequences are connected in the reporting and in the written transcript of the record, the patients “learn to identify, understand and integrate the meaning of their political commitment and suffering” (Cienfuegos & Monelli, 1983, p. 50).

Herman (1992) found that in centering on a therapeutic testimony, the therapist must gradually examine the social and affective nature of the injury as an intense reliving of the experience elicited within the context of a benign and reliable relationship. The foundational steps in the narrative process are the modulated emotional reworking of the trauma and the cognitive restructuring of resultant attitudinal and belief schemas. As a consequence, the significance of the trauma changes over time. “The new story that emerges is no longer a story about powerlessness—about losing the world and being totally dominated by someone else’s reality . . . no longer about shame and humiliation—it becomes a story about human dignity and virtue” (Mollica, 1988, p. 312). As agonized, protracted, and singular as the story may be for each person, the goal is that it gradually becomes a message of renewed existential affirmation and agency, rather than subjugation and demoralization.

In becoming able within the safety of the therapeutic context to relate to their torture experience with deepening feeling, individ-

uals can gain perspective on what they endured and begin to rediscover the emotional range previously available in their lives. Although many different strategies of intervention or models of therapy may be used in the rehabilitative process, "the trauma story emerges as the centerpiece of treatment" (Mollica, 1988, p. 305), and inherent in the story is the need to grieve.

"The descent into mourning is at once the most necessary and the most dreaded task of this stage of recovery" in which the usual rites of bereavement offer little consolation (Herman, 1992, p. 188). The forced migration to escape dangers of further torture or death typically causes grief over separation from family, friends, and community. Refugees also leave behind traditional language, familiar customs, livelihood, and significant social roles. The degradation and afflictions of torture, in addition, can take from victims their assumptions about bodily integrity, self-respect, faith in themselves or others, hope for the future, and beliefs in a fair or meaningful world and in the capacity to affect one's fate. Revisiting these deprivations in the course of the narrative process requires a highly consistent, compassionate, and empathic therapeutic presence.

As refugee survivors give voice to their multiple traumas of loss, they must deal as well with the realization that there can be no adequate response or compensation for the wrongs done to them. The protective numbing gives way to a fuller comprehension of the injustice they endured, and negative feelings naturally follow. Even for those who see forgiveness as the morally desired outcome, a process of coming to reckon with their undeserved brutalization must be undertaken. Herman (1992) has described how the narration allows the individual to become aware of and vent in safety their outrage and how "helpless fury gradually changes into a more powerful and satisfying form of anger: righteous indignation" (p. 189). Bloom (1994) has written comparably of the process in which survivors first

express anger either passively at the self, passive-aggressively toward others, or aggressively toward self or others [and] when they discover that they can release rage in a nonharmful way, without doing any damage to themselves or others, without "going crazy" [or using alcohol and drugs to deal with impotent fury] . . . then their anger can serve a useful and constructive purpose. (p. 483)

According to Herman (1992), "giving up the fantasy of revenge does not mean giving up the quest for justice; on the contrary, it begins the process of joining with others to hold the perpetrator accountable for his crimes" (p. 189). Perhaps the most dramatic and public manifestation worldwide of the use of testimony to heal the body politic and promote social justice for victims of torture has been the institution of Truth and Reconciliation Commissions in countries such as Argentina, Guatemala, and South Africa and the International Criminal Tribunals for Rwanda and for the former Yugoslavia. In these arenas, governmental change and international support are bringing to light human rights violations committed in secrecy, to be exposed to condemnation and the collective refrain *nunca mas*, "never again." Individuals who decide to offer accounts on so large a scale can find much therapeutic gain in the process, providing they have sufficient preparation and support for the psychological requirements it necessarily invokes.

Centers for the treatment of torture survivors are cooperating in assisting clients who choose to make their records known beyond the safety of the private office: in support groups, public speeches,

legal affidavits, and published declarations. It is important, however, to recognize that not all individuals have the stamina or the political will to take on the additional demands of speaking out. Furthermore, truth commissions do not yet exist for many countries in which human rights abuses have been widely reported, such as Iraq or Tibet, although as the concept of international accountability spreads, hearing panels and commissions are presently being formed in other long oppressed countries, such as East Timor, Nigeria, and Sierra Leone (Neier, 2001).

A critical factor that is beyond the scope of this article but should nonetheless be noted is the potential impact on the therapist in empathically hearing firsthand of the atrocities of torture, and the consequences for the treatment process resulting from the therapist's reactions. "The work with torture survivors is itself a challenge to the therapist's own existential beliefs, since the essential quality of torture is the meaningless and the unpredictable" (Elsass, 1997, p. 87). Secondary or vicarious traumatization, compassion fatigue, countertransference, and the risk of burnout must be sensitively monitored in the therapeutic role, and the use of consultation and peer support is often of much value. Boehnlein, Kinzie, and Leung (1998), Bustos (1990), Comas-Díaz and Padilla (1990), Danieli (1994), Fischman (1991), Turner et al. (1996), and Vesti and Kastrup (1992) have written about these issues in helpful detail.

Herman (1992) has found that as the patient's new story emerges through the treatment process, the intrusive and hyperarousal symptoms appear to subside, but "the constrictive symptoms of numbing and social withdrawal do not change, and marital, social and work problems do not necessarily improve . . . [because] by itself, reconstructing the trauma does not address the social or relational dimension of the traumatic experience" (p. 193). The abreactions and catharses of grief, guilt, fear, and anger may diminish through creation of the narrative, but the challenges of engaging again with the world and overcoming the impairments to one's capacity for attachment and relationships remain to be met.

Reconnection: Completing the Recovery

In Herman's third stage, the movement is from consolidation of the self toward formation of new options: "Having come to terms with the traumatic past, the survivor faces the task of creating a future . . . [and just as] helplessness and isolation are the core experiences of psychological trauma, empowerment and reconnection are the core experience of recovery" (Herman, 1992, pp. 195–196). No matter what the losses, the stark but profound fact of survival becomes the essential grounds for choosing again to give meaning to one's life, as trust and hope slowly become again possible. As Herman proposed, "the simple statement—I know I have myself—could stand as the emblem of the third and final stage of recovery" (p. 202).

Reconnection means that refugee survivors draw on those aspects of themselves that they most value from the time before the torture, from their endurance of the traumatizing ordeal itself, and from the subsequent period of resettlement and recovery to forge a more resilient and enabling sense of identity. Respect for one's own "traumatized victim self" is united with an earned pride in the "survivor self." The intent is that when the past is successfully reembodyed in the present and an openness toward new develop-

ment is realized, a more complete and tempered personality can result (Başoğlu, 1998).

Paralleling the reconciliation with oneself in Herman's third stage is the regaining of a capacity to relate to others, as nurtured initially in the therapeutic alliance and conceptualized in terms of self in relation. The treatment relationship often provides the first opportunity for an accounting of the torture narrative to an empathic but unflinching listener. When this is accompanied by a reinterpretation of the torturer's message as one to be overcome, the healing process can slowly advance. The multicultural paradigm proposed by Ivey (1995) helps the individual find reflected in therapy an integrated identity, drawn from his or her own cultural background, and able to interact with the larger host culture as well. In learning more realistically to accept one's own strengths and limitations and to balance the interplay between societal power and personal liberation, the refugee survivor correspondingly can move from the therapeutic bond toward deeper and more trusting engagements again with others, negotiating his or her rightful place in the new world at hand.

As with the other stages, the process here is not typically a simple progression forward but rather a complex spiral within which advances, impasses, and regressions occur (and are often complicated by flashbacks, intrusive memories, or avoidant strategies with respect to the trauma experience). "Even after substantial gain, there may be recurrence of symptomatology after a particular event triggers recall of earlier experience" (Bouhoutsos, 1990, p. 132). Until psychological integration is relatively achieved, refugee survivors who begin in a state of alienation may vacillate between a greater emphasis on "fitting in" within the dominant new culture and an isolationist attempt to preserve their sense of difference on the basis of an identification with their background and current minority status. It is critical that the therapist understand and respect the cross-cultural dynamics that underlie such transitions.

The successful progression from safety through reconstruction to reconnection frequently uses several other important therapeutic modalities in addition to individual psychotherapy and psychosocial rehabilitation. Van der Kolk (1987) and van der Veer (2000) have recommended the special function that group modalities can play in overcoming the anomie, depersonalization, and despair that characterize traumatic reactions, and Bouhoutsos (1990) has discussed the potential value of family approaches. Davidson and van der Kolk (1996) and Marmar, Foy, Kagan, and Pynoos (1994) have described the importance of medication in the course of treatment, allowing emotional intensity to become more modulated and amenable to therapeutic resolution. Besides the traditional models of psychotherapy, a number of innovative therapeutic techniques have also been recently developed and are currently being applied in the treatment of trauma. They include *eye movement desensitization and reprocessing*, *traumatic incident reduction*, *visual kinesthetic dissociation*, and *thought field therapy* (summarized by Wylie, 1996).

Finally, it must be emphasized that centers for the treatment of trauma and torture are commonly multidisciplinary in their service models because the range of needs of their clients is so broad (Marmar et al., 1994). The roles of physical, art, and occupational therapists; pastoral and peer counselors; case managers; language tutors; and medical, dental, nursing, social work, and legal specialists are indispensable in a comprehensive therapeutic approach

for many survivors. Addressing their immediate situational needs can contribute preeminently to the establishment of reassurance, the alleviation of stress, and the inculcation of a sense of efficacy and hope. Given first the uprooting of the migratory experience and second the social constriction and shame common to the trauma of torture, the encouragement of participation in a therapeutic network of support and in a broader social community is often essential for the tasks of reconnection.

Conclusion

Herman's model of stages in diverse forms of trauma recovery fits well within a multicultural framework to provide a valuable orientation to the concerns of tortured refugees. Conceptualizing a progression of themes allows the therapist to recognize and respond to the sequential and hierarchical needs of the traumatized individual. In light of the explicit intent of torture to destroy one's system of beliefs, values, and relationships, the ordering of therapy from safety to reconstruction to reconnection represents an almost exact reversal of the internalized oppression suffered by the victim. *In addition, therapy must define as goals both a psychological liberation from debilitating injustice and an opening toward a redefined and empowered sense of identity in relation to family, community, and the larger society.*

Within the convergence of multicultural treatment and trauma recovery, the metaphor of the client regaining his or her voice is central. In both therapeutic models the treatment team must forge a therapeutic alliance in which the survivor's story can be fully presented and, as importantly, can be authentically received. Therapists must be aware not only of the client's distinctive struggles and strengths in terms of his or her background and worldview but also of the divides in cultural perspective that they must bridge with the refugee survivor in the therapeutic endeavor.

As clients become better able to reject the burden of blame, shame, impotence, and nihilism wrought by the torture, they can thereby transcend the "limiting situation" by reaffirming the worth of their lives and condemning the outrages suffered. Practical concerns with asylum, language barriers, medical and dental problems, housing, employment, education, and cultural adjustment must also be addressed by the refugee and, when necessary, by the treatment team. At the same time, political, spiritual, and existential issues may need to be dealt with as well, as the survivors contend with questions of ultimate meaning and core value in integrating more fully the past, present, and future parts of their lives.

In the encounter with tortured refugees, therapists may be brought close to unfathomable cruelties and evil and at times may find themselves in the uncertain position of trial-and-error learning in adjusting the treatment to the unique qualities of each client. Nevertheless, the significance of trying to contribute even a modicum of balance and redress on the scale against the widespread inhumanity to one's fellow man and woman makes the effort one of psychology's more important mandates.

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Received April 3, 2000
 Revision received April 2, 2001
 Accepted April 18, 2001 ■



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