

Study Group Guide for Psychotherapy with Torture Survivors

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The following study guide was developed at The Center for Victims of Torture (CVT) in Minneapolis, MN, to meet the needs of local psychotherapists who were interested in learning how to work with torture survivors in psychotherapy. For two years, CVT staff facilitated study groups in which psychotherapists from the local community met once a month for nine months to discuss readings and case material. This guide was developed over the course of several study groups. It contains the curriculum used for the nine group meetings, each of which focuses on a core component of psychotherapy with survivors of politically motivated torture who are living in exile. While it is useful to have case material from which to learn, it is not necessary to be doing clinical work with torture survivors in order to use this curriculum. The sample discussion questions are based on the readings, and users are encouraged to supplement them with questions based on current case material or situations in order to make the group most relevant for their own purposes. The group readings provide a common ground for participants and keep the group rooted in the broader literature, which helps participants begin to develop a conceptual framework and place their own experiences in context. Additional sources relevant to a given topic are offered at the end of each unit; these were not used as group readings but could serve as supplemental readings if participants want to explore an area further on their own. Study groups at CVT were each facilitated by two staff psychotherapists with two or more years of experience in psychotherapy with torture survivors. Guest facilitators were also utilized on occasion, and it is especially recommended that one or more professional interpreters are invited to co-facilitate Meeting 4, Working with Interpreters, in order to learn from their perspective.

We have found the study group method to be an excellent means of providing in-depth training that can be absorbed and integrated over time. Other training forums, such as intensive workshops, are limited by the amount of material on torture that learners can be expected to assimilate in a short time period. We hope others will benefit from our study group materials. We welcome any questions, comments, or suggestions based on use of this curriculum. Contact Andrea Northwood at anorthwood@cvt.org.

Meeting 1: Overview of the Study Group
 Encountering Evil: Secondary Trauma

Rationale

As with any group, it is important to allow ample time at the first meeting to review the purpose, format, and content of the group (i.e., as covered in the selection and screening process) with everyone together. For a study group, two critical areas to cover are (1) ground rules for participation and case discussion (e.g., confidentiality and its limits) and (2) clarification as to whether the group is providing consultation or supervision, and the implications of this distinction. We have found it helpful to organize these discussions according to relevant ethical guidelines and principles. Each group will vary as to how it conducts itself and what it offers participants. For each of our study groups, we have devised an informed consent form that is signed by participants at the first group meeting, following this discussion. Additional time to discuss logistics and other organizational issues is often needed at the first meeting. Once this is completed, a discussion of the readings can take place.

The rationale for discussing secondary trauma in terms of “encountering evil” at the first meeting is that participants will be grappling with their own reactions to traumatic material, particularly in the case of torture, from the first meeting onward. Doing psychotherapy with torture survivors requires therapists to come to terms with the human capacity for evil in a manner that goes beyond psychological explanations. From a training perspective, we believe it is helpful to acknowledge the fundamental mysteries and paradoxes (e.g., “speaking the unspeakable,” Herman, 1992) one must be prepared to encounter in listening to stories of torture, particularly before attempts at analysis or understanding are made.

Group Reading:

The readings are chosen to stimulate discussion about the range of reactions witnesses have to encountering the phenomenon of evil perpetrated by human beings.

1. Dalenberg, C. (2000). Chapter 3: Speaking trauma: The inadequacy of language in trauma treatment. Countertransference and the treatment of trauma. American Psychological Association: Washington, D.C.
2. Gordimer, N. (1999). Heroes and villains. In Living in hope and history: Notes from our century. Gardonsville, VA: Farrar, Straus, & Giro.
3. Gourevitch, P. (1998). Chapter one. We wish to inform you that tomorrow we will be killed with our families: Stories from Rwanda. New York: Farrar Straus & Giroux.

Sample Discussion Questions:

1. What are your reactions/concerns about the effects of listening to stories of torture on the therapist? Was there anything in the readings that related to these concerns?
2. Taking off your hat as a therapist for a moment and looking at torture from a purely human point of view, what do you see as the most important issues/questions raised by torture? How do you understand the human capacity for evil? Where do the limits of your

understanding begin? What are the unanswerable/unknowable aspects of the human capacity for committing acts of atrocity or cruelty?

3. The Dalenberg chapter gives many excellent examples of the failure of language in fully capturing or expressing trauma. The poem by Don Pagis on p. 59 is one such example. How might you address this issue in therapy with torture survivors? In what ways might this issue affect the relationship between you and the client? How would you explain and normalize this phenomenon (the inadequacy of language) to clients who are torture survivors?
4. What are your reactions to the inset quote by Elie Weisel on p. 67 (“Well, now, what was it really like?...”)? How do you feel as a therapist reading this quote? How would you address this issue with a torture survivor who might feel this way?
5. Gordimer articulately captures the juxtaposition of extremes one can experience while sitting with torture survivors in therapy. What are the paradoxes she is describing on p. 126? What are your reactions to these paradoxes, and how might they alter or affect the experience of encountering evil for the therapist? What burdens might such paradoxes place on a torture survivor in psychotherapy? How might a therapist address these potential burdens with a client?
6. What does the search for meaning look like for Gourevitch? For the survivors he interviews? (E.g., see p. 20). How are their perspectives different (survivors vs. Gourevitch)? How do you address questions of meaning as a therapist? What does your own struggle for meaning look like in response to events such as genocide and torture? What does the search for meaning mean in response to meaningless slaughter? How do you understand your role in helping survivors of massive trauma search for meaning?
7. How is death viewed by the survivors Gourevitch interviews (e.g., p. 21, 23). What are some of the various ways in which torture survivors might understand survival? What is traumatic about surviving?
8. What did you notice about how Gourevitch tells the story? What is he struggling with when he describes encountering the massacre in this way? What parallels might exist for torture survivors attempting to tell you about atrocities or mass destruction? How do you feel as a therapist in response to hearing descriptions in this way? How do you respond when you are encountering a scope of evil or atrocity that is too much to take in, too much to believe fully or to “really see,” (p. 19)?
9. What are ways in which your agency could support you and the other staff, including support and clerical staff, in managing reactions to working with trauma survivors? What systemic barriers may need to be addressed?
10. (For group discussion or personal reflection) What are 1-2 specific actions you can take to be proactive in taking care of yourself and addressing the secondary trauma that is part of working with torture?

Additional Sources:

- Danieli, Y. (1984). Psychotherapists' participation in the conspiracy of silence about the Holocaust. Psychoanalytic Psychology, 1, 23-42.
- Kinzie, D. (2001). Psychotherapy for massively traumatized refugees: The therapist variable. American Journal of Psychotherapy, 55(4), 475-490.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3, 131-150.

Northwood, A. (2000). Secondary traumatization. In Lessons from the field: Issues and resources in refugee mental health. Washington DC: Immigration and Refugee Services of America.

Pearlman, L.A., & Saakvitne, K. W. (1995). Trauma and the therapist. London: Norton.

Stamm, B. H., (Ed.) (1995). Secondary Traumatic Stress: Self-care issues for clinicians, researchers & educators. Lutherville, Maryland: Sidran Press.

Meeting 2: Theory and Practice of Torture

Rationale

The readings and discussion for this meeting provide an introduction to the psychology of torture and repression as well as the phases of traumatization and events commonly experienced by victims, particularly those who are forced into exile. This information is important in developing a framework for understanding the context and meaning of torture, which is necessary before issues of treatment and recovery can be considered.

Group Reading:

1. Gibson, J. T., & Haritos-Fatuoros, M. (1986). The education of a torturer. Psychology Today, 20(11), 50-58.
2. Gonsalves, C. J., Torres, T. A., Fischman, Y., Ross, J., & Vargas, M. O. (1993). The theory of torture and the treatment of its survivors: An intervention model. Journal of Traumatic Stress, 6, 351-365.
3. van der Veer, G. (1998). Chapter 1: The experiences of refugees. Counseling and therapy with refugees and victims of trauma, 2nd ed. Chichester, England: John Wiley & Sons.

Sample Discussion Questions:

1. How is torture taught? What are some of the universal principles and strategies used to create torturers?
2. Based on research studies described in the Gibson and Haritos-Fatuoros article, what is the psychological profile of torturers?
3. Based on the readings, what are the main purposes of torture? How does torture achieve these purposes? What are the psychological dynamics and effects of torture that make it so effective as a political tool or strategy? How would you use this information in therapy with torture survivors?
4. What are some common psychological methods of torture?
5. What are some of the psychological dynamics of the torturer-victim relationship and the experience of torture that are important to be aware of in the therapist-client relationship and the experience of psychotherapy?
6. What are the three phases of traumatization for refugees and the typical traumatic life events that occur in each phase?
7. Amnesty International's estimates on the number of countries practicing torture varies from year to year; it is typically somewhere between 90-120 countries. Discuss the implications of this statistic for base rates of torture among refugee populations.
8. Discuss the psychological effects of torture at the level of (a) the individual, (b) the family, and (c) the society.

Additional Sources:

Gorman, W. (2001). Refugee survivors of torture: Trauma and treatment. Professional Psychology: Research and Practice, 32(5), 443-451.

- Marsella, A. J., Bornemann, T., Ekblad, S., & Orley, J. (Ed.). (1994). Amidst peril and pain: The mental health and well-being of the world's refugees. Washington D.C.: American Psychological Association.
- Pope, K. S., & Garcia-Peltoniemi, R. (1991). Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. Professional Psychology: Research and Practice, *22*(4), 269-276.
- Weschler, L. (1990). A miracle, a universe: Settling accounts with torturers. New York: Pantheon.

Meeting 3: Political Context

Rationale

The topic for this meeting is another core component of the contextual framework introduced at the last meeting. Torture is a sociopolitical act, and therapists working with torture survivors must develop and communicate to their clients an understanding of the political and historical context in which torture occurs (Fischman, 1998). Political and historical context includes not only regional and national levels of analysis but also international or global levels, as the silencing and denial that is part of the victimization in torture occurs on all these levels and this impacts the transference and countertransference within the therapy relationship. The readings and discussion for this meeting provide an introduction to the political context of torture. The Fischman article provides an overview of the sociopolitical context and its implications for treatment. The chapter by Roger Cohen provides an exemplary look at the political context of torture and genocide in the former Yugoslavia as the rest of the world watched.

Group Reading:

1. Fischman, Y. (1998). Metaclinical issues in the treatment of political trauma. American Journal of Orthopsychiatry, 68(1), 27-38.
2. Cohen, R. (1998). Chapter 14: Disappearances. Hearts grown brutal: Sagas of Sarajevo. New York: Random House.

Sample Discussion Questions:

1. Why is the political context regarded as so important or critical in treating torture survivors?
2. What are the risks or potential negative consequences in therapy with torture survivors when the political and historical contexts are not addressed adequately?
3. What sorts of things does “addressing the political context” entail in therapy? What role do political views play in the mental health work you do with clients? Are politics a significant aspect of identity for your clients?
4. What relation do you see between the political context and the questions of meaning/purpose that are raised by the torture trauma?
5. Have you had the experience of conflict or strong disagreement with a client’s ideology, political loyalties, or political actions? If so, discuss what this was like and what you learned that might be helpful to other therapists. How will you handle differences between your political views and those of your client? Are there differences in political views that would prevent you from providing services to a client?
6. Have you had the experience of feeling uncomfortable with your country’s role in a client’s suffering (either because the client raised it or you were aware of it)? If so, discuss how you handled this inside and outside of the therapy. What did you learn that might be helpful to others?
7. Fischman states, “It is critical that therapists working in the area of human rights violations be alert to the ways in which countertransference issues may relate to their own motivations to treat this particular population,” (p.33). How do we go about this?

8. In terms of the political context in the U.S., what do you think of Cohen's assertion that our age has made it easier to look without seeing? If this is accurate, what are the implications for the therapy relationship? For a client's expectations of a psychotherapist in the U.S.?
9. Cohen also maintains that, in a culture afflicted with the "numbness of comfort" (p. 172), it is not easy to feel. What do you think about this observation and what it means for our ability to understand the realities of clients coming from situations of far less comfort and privilege? Discuss other implications of the differences in power and privilege between the therapist and the client who is a torture survivor in exile. How might you address these issues in the therapy?

Additional Sources:

- Agger, I., & Jensen, S. (1996). Trauma and healing under state terrorism. London: Zed Books.
- Martín-Baró, I. (1994). Writings for a liberation psychology. Ed. A. Aron and S. Corne. Cambridge, MA: Harvard University Press.
- Weschler, L. (1990). A miracle, a universe: Settling accounts with torturers. New York: Pantheon.

Meeting 4: Working with Interpreters

Rationale

Another core skill that therapists must develop, often for the first time, is that of working with professional interpreters in psychotherapy. This is particularly the case at The Center for Victims of Torture, where we have seen clients from over 60 countries. At other clinics and with other treatment models, it may be possible to arrange for a therapist who is fluent in the client's language or a bicultural worker who functions as a co-therapist. While direct communication with a therapist who speaks the client's language is usually ideal, it is not always possible or ideal from the client's perspective and clients' preferences should always be ascertained, as they should for other critical components of the match (e.g., gender). It is also important to consider the match between the interpreter and client, as this relationship is as complex and often as powerful as that of the therapist and the client. At the Center for Victims of Torture, our approach is to work in a partnership model with interpreters who are trained to facilitate communication of both language and culture. The articles chosen for this discussion are congruent with our understanding of the dynamics and best practices in the use of interpreters. More information on working with interpreters, particularly web links, can be found in our online manual *New Neighbors, Hidden Scars* at www.cvt.org.

Group Reading:

1. Haenel, F. (1997). Aspects and problems associated with the use of interpreters in psychotherapy of victims of torture. *Torture*, 7 (3), pp. 68-71.
2. Lee, E. (1997). Cross-cultural communication: Therapeutic use of interpreters. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians*. New York: Guilford Press.

Sample Discussion Questions:

1. What is the distinction between translation and interpretation (Lee chapter), and what are the implications of this distinction for understanding the significant role of the interpreter in filtering all communications within the therapy relationship?
2. What are some important elements of the screening and selection process that might need to be considered by the therapist in determining whether a given match between an interpreter and a torture survivor will be workable?
3. What do you think needs to be covered by the therapist in a pre-session meeting with an interpreter who will be working with a torture survivor?
4. While listening to, and interpreting, trauma is difficult by itself, many interpreters from refugee communities also have their own history of trauma. What do you see as the role of the therapist in addressing this issue with interpreters?
5. What are the competencies needed by interpreters who are working with severe trauma and also interpreting in cross-cultural interactions?
6. Why is it important not to use family members or friends to interpret for torture survivors?
7. The interpreter should not have the burden of being the therapist's sole cultural informant/broker, although s/he can be an important resource in this domain. What other mechanisms or resources can the therapist put in place so that more than one perspective (ideally, multiple perspectives) on a given culture are obtained?

8. What is difficult about the interpreter's job? What biases or pressures from the community can you imagine interpreters might face? What role conflicts might interpreters from a refugee community face? How can therapists help interpreters negotiate these challenges?
9. What are common problems in interpretation, and how can the therapist know when the interpretation is not going well? Have you ever had to dismiss or change interpreters? At what point might such a decision need to be made with a torture survivor? If this needed to happen, what would be important to address in handling this with both parties (interpreter and client)?
10. How does the therapist need to modify or adapt in-session communication to facilitate accurate communication when using an interpreter?
11. When might post-session feedback or debriefing with an interpreter be important for the therapist to initiate?
12. What are the 3 basic role expectations clinicians tend to use with interpreters (Lee chapter)? Which one is preferable for therapy, and why?
13. The Haenel article gives clinical examples of the interdependency within the therapist-interpreter-client triad (i.e., changes in one relationship inevitably produce changes in the other two relationships, sometimes resulting in an asymmetry of alliances that needs to be corrected). Can you think of other clinical scenarios with torture survivors (actual or imagined) in which the psychological distance between any two parties becomes unbalanced (too much or too little distance), creating an unbalanced triad?

Additional Sources:

- Egli, E. (1991). Bilingual workers. In Westermeyer, J., Williams, C. L., & Nguyen, A. N. (Eds.) Mental health services for refugees (DHHS Publication No. [ADM] 91-1824). Washington D.C.: U.S. Government Printing Office.
- Villareal, Y. (1994). Psychological assessment via an interpreter. Chicatanews, 7 (4), pp. 5-6.
- Westermeyer, J. (1990). Working with an interpreter in psychiatric assessment and treatment. The Journal of Nervous and Mental Disease, 178, pp. 745-749.

Meeting 5: Building a Healing Relationship: Trust and Rapport

Rationale

One of the most difficult challenges torture survivors face following their ordeals is the re-establishment of trust. This challenge occurs on many levels, such as trust in oneself, in another human being, in human institutions and humanity in general, in the faith or beliefs one held dear before the torture, etc. Building rapport and, eventually, trust are ongoing processes in psychotherapy with torture survivors, and many survivors have commented that the construction of a healing relationship, over time, *was* the therapy for them. This often differs from therapy with other populations, where the issue of trust is regarded as critical but is often treated more as an initial foundation or springboard to other issues rather than as the crux of the therapy or a long-term goal. For many therapists working with torture survivors in exile, issues of rapport and trust are inextricably interwoven with the need to provide culturally competent and congruent treatment. For this reason, the readings and discussion for this meeting emphasize the integration of cross-cultural considerations into the conceptualization of what it means to build a healing relationship with a torture survivor. Emphasis is also placed on understanding the survivor's perspective by reading and discussing one of the many recent contributions survivors have made to the literature on torture.

Group Reading:

1. Ortiz, D. (2001). The survivors' perspective: Voices from the center. In E. Gerrity, T. M. Keane, & F. Tuma (Eds.), The mental health consequences of torture (pp. 13-34). New York: Plenum Press.
2. Randall, G. R., & Lutz, E. (1991). Chapter 4: Approach to the patient. Serving survivors of torture. Washington, D.C.: American Association for the Advancement of Science.
3. van der Veer, G. (1998). Chapters 3-5: Diagnostic appraisal; Working with cultural differences; Treatment goals and the therapeutic relationship. Counseling and therapy with refugees and victims of trauma, 2nd ed. Chichester, England: John Wiley & Sons.

Sample Discussion Questions:

1. What are your reactions to hearing the various perspectives of torture survivors in the Ortiz chapter? How will these voices affect your work with torture survivors?
2. Cross-cultural relationship-building is just as much about becoming more conscious of one's own culture as it is about learning about "the other." What do you see as the primary values and characteristics of current American culture? What about the cultures or subcultures with which you identify? How might these values/characteristics resonate or conflict with the cultures with which you are working (or may be working in the future)?
3. What are some examples of cultural differences in communication norms (verbal and nonverbal) from your own clinical experience? How do you approach the ongoing challenge of elucidating and examining the culturally-based assumptions therapists inevitably make in assigning meaning to behavior?
4. What are some of the varying dimensions of human identity that might be relevant in working with torture survivors in exile (e.g., nationality, religion, etc.)?

5. Culture is not static. It is dynamic, continually evolving. This is particularly true within refugee communities. How might this affect therapists' efforts to learn more about the cultures of torture survivors in exile? What are some of the intergenerational issues this can create for families of torture survivors in the U.S.?
6. Discuss how you define and understand the following terms as they relate to therapy with torture survivors in exile: cultural competency, culturally congruent interventions, culturally appropriate services
7. Being from a different culture than a torture survivor has its advantages and disadvantages, as does being from the same culture. What are some examples on both sides with respect to building trust and a therapeutic alliance?
8. Randall and Lutz mention disbelief as one of the ways we may react to the horrors described by torture survivors, in order to defend ourselves and preserve our worldview. What are other ways in which you may expect yourself and others to react to the stories of torture survivors? How do you see yourself managing these possible reactions? How might you help torture survivors deal with such reactions?
9. Van der Veer describes the diagnostic assessment as a continuous process, a "regulative cycle" that involves "making reconstructions" after each interview based on six components (see p. 66). How do you see yourself using this type of process in the diagnosis and treatment of torture survivor clients? What are ways you can make this process explicit to your torture survivor clients so that they come to understand the helping (and healing) process?
10. Many refugees are unfamiliar with non-directive treatment approaches and tend to misinterpret them as signs of inadequacy or disinterest on the part of the provider (van der Veer, p. 78). What non-directive techniques in your repertory may not be appropriate for your torture survivor clients?
11. What are ways to explain how treatment works that you may be able to use with torture survivor clients?
12. van der Veer cites Littlewood (1992) on the following "universal features of therapy" and asserts the following: "A socially recognized healer, who has superior status to the client and who is trained in a particular technique, can be an effective therapist in any cultural situation, as long as he shares an explanatory model for the problem with the client, offers him a new perspective, mobilizes the client's sense of hope, provides experiences of success during the therapy, and facilitates emotional arousal," (p. 79). How do you agree and disagree with this statement? What other features of therapy do you consider essential in your work with torture survivors and/or refugees?

Additional Sources:

- Fadiman, A. (1997). The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures. New York: Noonday Press.
- Kinzie, J. D. (2001). Psychotherapy for massively traumatized refugees: The therapist variable. American Journal of Psychotherapy, 55(4), 475-490.
- Kitayama, S., & Markus, H. R. (1994). Emotion and culture: Empirical studies of mutual influence. Washington D.C.: American Psychological Association.
- Marsella, A. J., Friedman, M. J., Gerrity, E. T., & Scurfield, R. M. (Ed.). (1996). Ethnocultural aspects of posttraumatic stress disorder. Washington, D.C.: American Psychological Association.

- Nader, K., Dubrow, N., & Stamm, B. H. (Ed.). (1999). Honoring differences: Cultural issues in the treatment of trauma and loss. Philadelphia: Brunner/Mazel.
- Randall, G. R., & Lutz, E. (1991). Chapter 7: Introduction to psychological treatment. Serving survivors of torture. Washington, D.C.: American Association for the Advancement of Science.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. American Psychologist, 53, 440-448.

Meeting 6: Stabilization/Safety

Rationale

The establishment of safety and stabilization is widely regarded as the first stage of trauma recovery, a necessary foundation for all that follows (e.g., Herman, 1992; van der Kolk, McFarlane, & van der Hart, 1996). For many torture survivors, the goals of this stage are the primary reasons and motivators for getting treatment, and it is not unusual for treatment to end once these goals have been accomplished. It is also the case, however, that progression through the identified stages of trauma recovery is not a linear process and issues of safety and stabilization must frequently be returned to as new stressors or reminders of the trauma are encountered. This is particularly the case for torture survivors in exile, who face numerous potential forms of re-traumatization as they work to obtain political asylum or other legal status, reunify their families, and rebuild their lives. Safety and stabilization needs occur on many levels (psychological, somatic, social, legal etc.) and can be achieved through a variety of means with torture survivors; the readings chosen here provide a selective introduction and are not intended to be comprehensive. The Davidson and van der Kolk (1996) chapter provides an introductory overview of the use of medication to facilitate stabilization of PTSD symptoms. The van der Veer (1998) chapter covers psychotherapeutic techniques for addressing common presenting symptoms and achieving initial stabilization with torture survivors and is well-illustrated with case material. The issue of assisting survivors in obtaining safety through political asylum is another common component of this stage but goes beyond the scope of this meeting. Each group may want to consider adding a meeting to address this topic. References pertaining to forensic documentation of psychological effects of torture for political asylum cases are included in the list of additional resources below.

Group Reading:

1. Davidson, J., & van der Kolk, B. (1996). The psychopharmacological treatment of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, and L. Weisaeth (Eds.), Traumatic stress: The effects of overwhelming experience on mind, body, and society, pp. 510-524. New York: The Guilford Press.
2. van der Veer, G. (1998). Chapter 6: Treatment of crises and symptoms. Counseling and therapy with refugees and victims of trauma, 2nd ed. Chichester, England: John Wiley & Sons.

Sample Discussion Questions:

1. What do the multifaceted concepts of “safety” and “stabilization” mean for torture survivors in exile? What do you see as the role of psychotherapy in restoring safety for this population? What issues are important for the therapist to address proactively in the first 1-2 contacts (e.g., preparing clients for an increase in symptoms after the first session).
2. What are the goals of using medications to treat PTSD? (The Davidson and van der Kolk chapter describes seven goals.) Can you incorporate these goals into a rationale that could be used with torture survivors to explain the use of medications to achieve their treatment goals

or help them make better use of therapy? What issues in the recovery from torture would be important to cover in discussing use of medications (e.g., control, dependency, etc.)? How would you approach these issues differently with a client who had been tortured with pharmacological methods?

3. As van der Veer emphasizes, fears of going crazy/losing control/losing one's former personality are common among torture survivors and refugees, and such fears are often linked with feelings of helplessness. This makes validation, psychoeducation, and normalization of the effects of torture extremely important. How would you explain the effects of torture to a survivor in a manner that addresses these fears and serves the goal of increasing the client's tolerance for his/her own emotions? What skills are important to strengthen or instill for survivors to restore a basic sense of bodily control? What cross-cultural adaptations might be needed in assessing and strengthening/teaching such skills?
4. What are risk factors for suicide among refugee clients? What might be additional times of high risk during the course of a torture survivor's treatment (e.g., asylum decision, bad news from home, etc.)? What might be special considerations in developing safety plans with torture survivors who are suicidal (e.g., willingness to call 911 or contact authorities, risk of deportation)?
5. How would you use some of the supportive techniques described by van der Veer to facilitate stabilization in a torture survivor who is presenting with many physical complaints (headaches, body pain, diffuse sense of weakness, etc.)?
6. Sleep problems are extremely common among torture survivors. Discuss how you might use van der Veer's ideas (pp. 107-115) to give torture survivors information about nightmares and to treat this symptom.
7. Safety and control issues are closely intertwined for torture survivors, as the absolute loss of control is a defining feature of torture. How would you explain to a torture survivor how psychotherapy can be helpful in gaining control over distressing symptoms? (see p. 112, van der Veer)
8. In your clinical experience with trauma survivors, when has it been important to return to working on safety and stabilization as the treatment progressed? With torture survivors, it is not uncommon to spend much, if not all, of the therapy on these two goals. What are your reactions to this possibility? If you find yourself becoming frustrated by the slow pace or seemingly limited scope of the therapy, what resources or supportive assistance would be helpful to you in managing these common reactions?

Additional Sources:

- Fabri, M. (2001). Reconstructing safety: Adjustments to the therapeutic frame in the treatment of survivors of political torture. Professional Psychology: Research and Practice, 32(5), 452-457.
- Gordon, M. (2001). Domestic violence in families exposed to torture and related violence and trauma. In E. Gerrity, T. M. Keane, & F. Tuma (Eds.), The mental health consequences of torture (pp. 227-245). New York: Plenum Press.
- Herman, J. (1992). Chapter 8: Safety. Trauma and recovery. New York: Basic Books.
- Jacobs, U. (2000). Psycho-political challenges in the forensic documentation of torture. The case of psychological evidence. Torture 10 (3), 68-71.
- Jacobs, U., Evans, B.F. & Patsalides, B. (2001): Principles of documenting psychological evidence of torture – Part I. Torture 11 (3), 85-89.

Jacobs, U., Evans, B.F. & Patsalides, B. (2001): Principles of documenting psychological evidence of torture – Part II. Torture 11 (4), 100-102.

Jacobs, U. & Iacopino, V. (2001): Torture and its consequences: a challenge to clinical neuropsychology. Professional Psychology: Research and Practice, 32 (5), 458-464.

Physicians for Human Rights. (2001). Examining asylum seekers: A health professional's guide to medical and psychological evaluations of torture. Physicians for Human Rights (www.phrusa.org).

Meeting 7: Working Through Trauma: Remembrance and Mourning

Rationale

Once a basic sense of safety is restored and the survivor is stabilized to the extent that the effects of the trauma no longer overwhelm his or her capacity to function, it is possible to work towards assimilation and integration of the trauma. As Herman (1992) notes, this stage has been called many different names by different theorists but the common denominator is a focus on coming to terms with past trauma, so that what was once overwhelming, unspeakable, and unassimilated can be transformed and incorporated into the life story of the survivor, thereby empowering the survivor to no longer be held captive by the trauma and to regain authorship of his/her own experience and life. That is, this is the stage where the survivor tells the story, in its entirety. Herman calls this stage “remembrance and mourning” in recognition of the losses that must be grieved in coming to terms with trauma. We find this title most fitting in working with torture survivors in exile, who must grieve the loss of their entire world in addition to the losses experienced under torture. There are many creative methods and modalities described in the broad literature on torture survivors for how traumatic memories can be reconstructed and transformed. The group readings for this meeting offer a sampling of some of the methods and techniques we have found useful in our work at the Center for Victims of Torture. The van der Veer chapter is particularly useful due to its extensive illustration of techniques through case material.

Group Reading:

1. Basoglu, M. (1992). Behavioral and cognitive approach in the treatment of torture-related psychological problems. In M. Basoglu (Ed.), Torture and its consequences: Current treatment approaches, pp. 402-429. Cambridge, England: Cambridge University Press.
2. Cienfuegos, A. J., & Monelli, C. (1983). The testimony of political repression as a therapeutic instrument. American Journal of Orthopsychiatry, 53, 43-51.
3. van der Veer, G. (1998). Chapter 7: Restoring emotional stability. Counseling and therapy with refugees and victims of trauma, 2nd ed. Chichester, England: John Wiley & Sons.

Sample Discussion Questions:

1. How does retelling the trauma story differ from “working through” the trauma? What do you see as the main components/processes of “working through” the trauma for torture survivors?
2. How do you approach this stage of recovery with your clients who are trauma survivors? How might cognitive-behavioral techniques either facilitate or complement other therapeutic methods used during this stage? What potential caveats do you see in using CBT methods with torture survivors, and how might they be addressed (e.g., cognitive therapy and torture share the goal of changing another person’s thoughts)?
3. How might the testimony method be adapted from the specific conditions under which it developed in Chile for use with torture survivors in the U.S.? Discuss how the process of applying for political asylum could be used by a therapist to implement this method.

4. Re-traumatization and decompensation are risks that must be continuously addressed in any therapy method that re-exposes survivors to the memories of their torture. What are some strategies for (a) assessing these risks and (b) minimizing or managing them that you have used (or can imagine using) with torture survivors?
5. What metaphors/images/stories can you think of that might help describe or explain to clients this stage of recovery? How might you explain therapy constructs like “reconstruction,” “integration,” or “transformation” of the torture trauma?
6. In the additional source by Herman (1992), she states, “The second stage of recovery has a timeless quality that is frightening. The reconstruction of the trauma requires immersion in a past experience of frozen time; the descent into mourning feels like a surrender to tears that are endless. Patients often ask how long this painful process will last. There is no fixed answer to the question, only the assurance that the process cannot be bypassed or hurried. It will almost surely take longer than the patient wishes, but it will not go on forever,” (p. 195). What fears might torture survivors have about the frozen or endless feel of traumatic memories? Keep in mind that for some torture survivors, the torture is not what they consider to be the worst trauma they endured (you can never assume what was worst for a survivor). What strategies can therapists use to help survivors modulate their affect and endure the terror/horror that accompanies plunging into the depths of the trauma story?
7. When do you think the “working through” process might be contraindicated for a torture survivor? Under what conditions can you imagine this being the case, and how might you proceed?
8. For torture survivors, the number of catastrophic losses are often staggering and can take years to mourn fully. Ordinary/mainstream models of grief and loss, typically based on a single traumatic event such as the loss of a loved one, may have limited application when the therapist is faced with a torture survivor in exile who has lost her country, climate, culture, immediate and extended family, job, social and educational status, house, belongings, friends, etc. In addition, torture survivors must often endure unresolved or “ambiguous” (Boss, 1999) losses, such as the disappearance of a family member by the regime. Compared to your work with other clients, what changes might you make in addressing the scope of grief and loss faced by a torture survivor in exile? How might grief and mourning look or proceed differently for this population?

Additional Sources:

- Agger, I., & Jensen, S. (1990). Testimony as ritual and evidence in psychotherapy for political refugees. Journal of Traumatic Stress, 3, 115-130.
- Gray, A. E. L. (2001). The body remembers: Dance/movement therapy with an adult survivor of torture. American Journal of Dance Therapy, 23(1), 29-43.
- Herman, J. (1992). Chapter 9: Remembrance and mourning. Trauma and recovery. New York: Basic Books.

Meeting 8: Reconnection

Rationale

Reconnection with the social, political, and occupational worlds is a task of extreme importance and difficulty for torture survivors living in exile. Unfortunately the clinical literature is still in its infancy with respect to psychotherapy with torture survivors in this stage of recovery.

Consistent with this dearth of literature, the groups readings for this meeting include an article by a torture survivor reflecting back on his psychotherapy that is critical of the extent to which this stage in his recovery was neglected. For many torture survivors, this stage is dominated by a focus on family reunification –often after many years of separation- and the difficult dilemma of how, if at all, to resume the political work and life projects that led him or her to be a target of torture. More broadly, however, this stage concerns the rebuilding of one’s life, a process that typically has been going on throughout treatment but attains greater saliency in the later stages. Group psychotherapy, support groups, and community-based approaches have been used successfully in helping torture survivors re-connect with others and with their communities; thus, some references are included in the additional sources that describe these approaches.

Group Reading:

1. Agger, I., & Jensen, S. (1996). Chapters 10-11: Trauma and healing on the territorial level; Issues of social reparation. Trauma and healing under state terrorism. London: Zed Books.
2. Randall, G. R., & Lutz, E. (1991). Chapter 9: Self-help therapeutic initiatives. Serving survivors of torture. Washington, D.C.: American Association for the Advancement of Science.
3. Tizon, O. (2001). Dreams and other sketches from a torture survivor’s notes. Professional Psychology: Research and Practice, 32(5), 465-468.

Sample Discussion Questions:

1. Discuss the healing strategies that evolved at the community level in the case of Chile. What are other strategies for facilitating reconnection for survivors who are living under oppressive political regimes. What do you see as critical elements of healing at this level? Specifically, what issues must be addressed at the collective level to facilitate reconciliation and reconnection for torture survivors and their families? (It may be helpful to look back at the Fishman ‘98 article from meeting 3.) How do you see these processes applying to refugee communities in exile? What is different and what is the same? What might be easier and what might be harder to achieve?
2. How might this stage of trauma recovery differ for torture survivors in exile as contrasted with other trauma survivors? What implications for psychotherapy might you expect these differences to have?
3. What is healing about survivors’ groups and how might they function to facilitate reconnection for survivors of torture? What do you see as the role of the health care provider or facilitator in survivors’ groups?
4. Reconnection on various levels is not always indicated or possible for torture survivors, as it requires certain conditions (e.g., safety) that cannot always be met. What are some of the

barriers torture survivors might encounter as they attempt to reconnect with, and rebuild, their social, occupational, and political worlds? How is the recovery of survivors affected by the success or failure of reparations at the societal level? How might the conceptualization or goals of this stage need to be modified accordingly?

5. What do you see as the achievements and failings of Tizon's therapy? What are the lessons for therapists to learn from this article?
6. Tizon describes the "posttherapy phase" as follows: "...the task is for the survivor to phase out gently from the formal therapy phase. Here it is necessary to monitor the phasing out through some structures or transitional arrangements so that the survivor swims freely in the "normal" world of relationships but is not left entirely alone, possibly leading to retraumatization," (p. 467). Tizon's description is similar to descriptions of the reconnection stage in the trauma literature. How could therapists working with torture survivors facilitate and support the transition into this "posttherapy phase," as conceptualized by Tizon? How might you encourage survivors to speak in and outside of therapy in a way that facilitates their recovery?

Additional Sources:

- Agger, I., & Jensen, S. (1990). Testimony as ritual and evidence in psychotherapy for political refugees. Journal of Traumatic Stress, 3, 115-130.
- Herman, J. (1992). Chapter 10: Reconnection and Chapter 11: Commonality. Trauma and recovery. New York: Basic Books.
- Peddle, N., Monteiro, C., Guluma, V., & Macaulay, T. (1999). Trauma, loss, and resilience in Africa: A psychosocial community based approach to culturally sensitive healing. In K. Nader, N. Dubrow, & B. H. Stamm (Eds.) Honoring differences: Cultural issues in the treatment of trauma and loss, pp. 121-149. Philadelphia, PA: Brunner/Mazel.
- Saul, J. (1999). Working with survivors of torture and political violence in New York City. Zeitschrift für Politische Psychologie, 221-232.
- Von Wallenberg Pachaly, A. (2000). Group psychotherapy for victims of political torture and other forms of severe ethnic persecution. In R. H. Klein & V. L. Schermer (Eds.) Group psychotherapy for psychological trauma, pp. 265-297. New York: Guilford Press.
- Weschler, L. (1990). A miracle, a universe: Settling accounts with torturers. New York: Pantheon Books.
- Wessells, M. G. (1999). Culture, power, and community: Intercultural approaches to psychosocial assistance and healing. In K. Nader, N. Dubrow, & B. H. Stamm (Eds.) Honoring differences: Cultural issues in the treatment of trauma and loss, pp. 267-282. Philadelphia, PA: Brunner/Mazel.

Meeting 9: Countertransference

Rationale

To come full circle, we return to the critical topic of the therapist's reactions to the stories of horror and stories of triumph told by torture survivors. At this point in the study group, it is possible to explore countertransference in much greater depth, due to the wealth of clinical issues, contextual factors, and case material that has been laid forth. While the discussion at the first meeting is preparatory and focuses on participants' anticipated concerns in working with torture trauma, this last meeting deals with actual countertransferential reactions or experiences that have emerged in the clinical work and/or the study group.

As with any group, it is important to allow time at the final meeting to discuss and evaluate the group as a whole, to plan for any continued consultation or contact among participating therapists, and to discuss the ending of the study group and any closure issues. The structure and content for this part of the meeting will vary according to the nature of each particular group and is the responsibility of the facilitator(s).

Group Reading:

1. Comas-Diaz, L., & Padilla, A. M. (1990). Countertransference in working with victims of political repression. American Journal of Orthopsychiatry, 60, 125-134.
2. Fischman, Y. (1991). Interacting with trauma: Clinicians' responses to treating psychological aftereffects of political repression. American Journal of Orthopsychiatry, 62, 179-185.

Sample Discussion Questions:

1. Comas-Diaz and Padilla identify feelings of helplessness, vulnerability, despair, ambivalence and fear as common countertransference reactions to working with survivors of political torture. How are you touched and affected by your work with torture survivors (either in clinical practice, this study group, or both)? Identify both positive and negative reactions.
2. Comas-Diaz and Padilla suggest that facing the pain with survivors in treatment offers a way to reintegrate the trauma and work toward a higher meaning. How might you work with your countertransference feelings productively in your therapy with survivors?
3. What are some of the differences between working with survivors in the immediate context of political oppression and working with survivors who are living in exile?
4. Survivors often express a wish that they could just forget about their history of torture. What are some reasons why it is not helpful to encourage survivors to forget about their trauma? (see Fischman, p.181)

5. Suggest some ways in which you plan to address your countertransference reactions in an ongoing way in the future.

Additional Sources:

- Boehnlein, J. K., Kinzie, J. D., & Leung, P. K. (1998). Countertransference and ethical principles for treatment of torture survivors. In J. M. Jaranson and M. K. Popkin (Eds.), Caring for victims of torture, pp. 173-183. Washington, D. C.: American Psychiatric Press.
- Dalenberg, C. (2000). Countertransference and the treatment of trauma. American Psychological Association: Washington, D.C.
- Kinzie, J. D., & Boehnlein, J. K. (1993). Psychotherapy of the victims of massive violence: Countertransference and ethical issues. American Journal of Psychotherapy, 47(1), 90-102.
- Kinzie, J. D., & Engdahl, B. (2001). Professional caregiver and observer issues. In E. Gerrity, T. M. Keane, & F. Tuma (Eds.) The mental health consequences of torture, pp. 309-315. New York: Plenum Press.
- Wilson, J. P., & Lindy, J. D. (1994). Countertransference in the treatment of PTSD. New York: Guilford Press