



REBUILDING
SHATTERED
LIVES

Produced by the Victorian Foundation for Survivors of Torture Inc.

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The Victorian Foundation for Survivors of Torture Inc. (VFST)

The Victorian Foundation for Survivors of Torture (VFST) was established in 1987. The VFST provides psychological counselling and community support services to survivors of torture and trauma now residing in Victoria. The service focuses on the provision of assistance to people entering Australia via the refugee and humanitarian migration program. Since its inception, the VFST has developed a holistic approach to service provision, thereby ensuring that the psychological, physical and social needs of people receiving assistance are fully addressed.

Services Offered by the VFST

Psychological Services:

These include individual psychotherapy, child, adolescent and family therapy and group work programs.

Medical and Complementary Therapies Services:

The VFST has developed a network of health professionals including GP's, medical and surgical specialists, masseurs, homoeopaths and other complementary therapists.

Community and Social Work Services:

Community and social support in areas such as housing, social security, language development and employment are part of VFST service provision.

Community Education and Consultancy Services:

The VFST aims to create greater awareness and sensitivity in the community about the needs of survivors of torture. The VFST provides a library and information service, and runs training seminars for professionals in education and community health.

Acknowledgements

Responding to people who have survived torture and trauma often represents a significant challenge for those in a position to help. The horror and pain contained in a survivor's story can weaken our resolve and undermine our belief that anything can really be done to assist. Over the past decade the Victorian Foundation for Survivors of Torture has dedicated itself to promoting human rights and assisting people recover from experiences of torture. Much of that effort has centred on building and sharing its expertise with other people. To progress this effort further the VFST has produced *Rebuilding Shattered Lives* to provide people in the field with a comprehensive training resource.

In particular, special mention must be made of Dr Ida Kaplan whom is the principal author. Her dedication to assisting survivors of torture is reflected in the depth of her contribution to this resource. An exceptional body of knowledge, including the expertise of staff at the VFST, is drawn on to produce a highly accessible manual and an invaluable tool for people in the field.

The project development and editorial support offered by Jenny Mitchell added to the quality of the final product as did the excellent layout and graphic design work of Mary Read and Steve Saville. Other significant contributors in writing and editing the manual include, Diana Orlando, and Lynne Haultain.

With devastating effect, torture and trauma continues to have a profound and unrelenting role in many parts of the world. While our ultimate goal is to bring an end to its use, those who have survived deserve the best support possible. Persecutory regimes and their torturers rely upon the brutality of their acts overwhelming their victims forever. They depend on reluctance and fear, preventing people in a position to help from doing so, thereby enabling their goal of domination to be achieved. Our responsibility is to stand against such practices and alongside those who have survived. *Rebuilding Shattered Lives* is offered as a challenge to the torturers aspirations and in respect of the survivors courage to reclaim their lives on their own terms.

Paris Aristotle
Director VFST Inc.

How to use this Guide

This guide is designed to assist those working with survivors of torture and trauma. Almost all survivors are refugees, a term which will be used in the broad sense to refer to all forcibly displaced persons. The material presented can be used by workers in community centres, accommodation services, primary health care agencies, language centres and schools. The focus is on adults and the family. A complementary guide, available from the VFST, is aimed at practitioners working with young people (12-25 years).

The Introduction provides a framework for understanding the impact of trauma and torture and the goals for recovery. For anyone using other sections as a guide to interventions, the introduction and the second chapter describing the psychosocial impact are requisite reading.

Chapter One presents an overview of the refugee experience and the countries of origin of Australia's Humanitarian entrants.

Chapter Two discusses the psychosocial impact of torture and trauma, and presents in detail the resultant manifest symptoms, signs and behaviours.

Chapter Three discusses recovery goals, key approaches to intervening with individuals and families, and specific strategies which can be used.

Chapter Four discusses skills central to effective intervention, including developing a quality relationship, cross-cultural skills and ways to effectively deal with worker's emotional reactions.

Chapter Five addresses practitioner issues, applicable to specific professions: health professionals, adult English as a second language (ESL) teachers, primary school teachers and immigration case officers.

Case examples and extracts from VFST reports are presented in italics.

The contents of this guide form the basis of a number of training programs designed for various groups of practitioners. Information about these programs can be obtained from the VFST.

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Introduction and Framework

The socio-political situations and events of this century have led to human rights violations on a massive scale. Torture, extrajudicial detention, mass killings, the destruction of homes and other forms of state sanctioned violence have been perpetrated by oppressive regimes to destroy both the mind and body of the individual; and the spirit and fabric of the community of which they are part. In this guide, relatively little information is provided about forms of torture, persecutory methods, and specific country information because there is ample resource material regarding these topics. The focus is on the impact on the individual, the family and the communities of which they are part, the goals for recovery, and how they can be achieved.

Given this focus, it is important to underline that the causes of trauma are seen to be in the systems that perpetrate them, not within the individuals who suffer the effects. But it is the psychological and social reality of survivors and their communities which are altered as a result of violations. It is the experience of terror which is internalised. Core attachments to others are disrupted and the integrity of the self, family and their relation to the community is fragmented. The most invasive of persecutory acts are used to create shame and guilt, condemning people to isolation and exile from their communities and from themselves.

The consequences of trauma are widespread and long term. Transgenerational effects now having been widely documented. The impact of trauma can be observed in expressions of fear, grief, confusion, suspiciousness, anger and in a host of other signs. Such signs will be described and they are important to notice and understand because they are indicators of what type of assistance may best be offered. However, much of the the suffering is not observable, nor the struggle for survival. As a worker, one aims to alleviate suffering, but this is

essentially the task of the survivor. Nevertheless, in understanding the impact of trauma, one can make a significant contribution to assisting in recovery and upholding the dignity of every human being.

The reaction to trauma and its causes can be conceptualised in different ways. At the VFST, the core causal components of the trauma reaction are analysed in terms of the main social and psychological experiences which impact on the individual and family to destroy the community of which they are part. The framework looks at the impact of horrific events in a context which emphasises the meaning for individuals, families and communities. Understanding the terror, helplessness, isolation and degradation caused by torture is far more important than knowledge of techniques used to inflict torture. Similarly, understanding the reaction to trauma depends on grasping the meaning of events, which is influenced by personality and the social, cultural and political context. This approach leads to an understanding of the multiple ways in which the trauma reaction is manifested and is a basis for understanding recovery.

In the conceptual framework, depicted in Figure 1 (overleaf), both causes and reactions to trauma are grouped into four categories. This division is somewhat arbitrary and the categories are highly interrelated, but the scheme does justice to the far-reaching effects of trauma. It also provides a conceptual structure which can be easily used to remember the range of causes and the meaning of trauma which underpins the very wide range of manifestations. The conceptual model adopted determines the focus of intervention and the time frame adopted to facilitate recovery.

The first column summarises the initial causes of trauma - persecutory acts and human rights violations perpetrated by oppressive regimes. The second column shows the social and psychological experiences which result. These are internalised by individuals, families and communities. These experiences can be understood to underpin the trauma reaction, the core components of which are described in the third column. The recovery goals in column 4 address each of these core components.

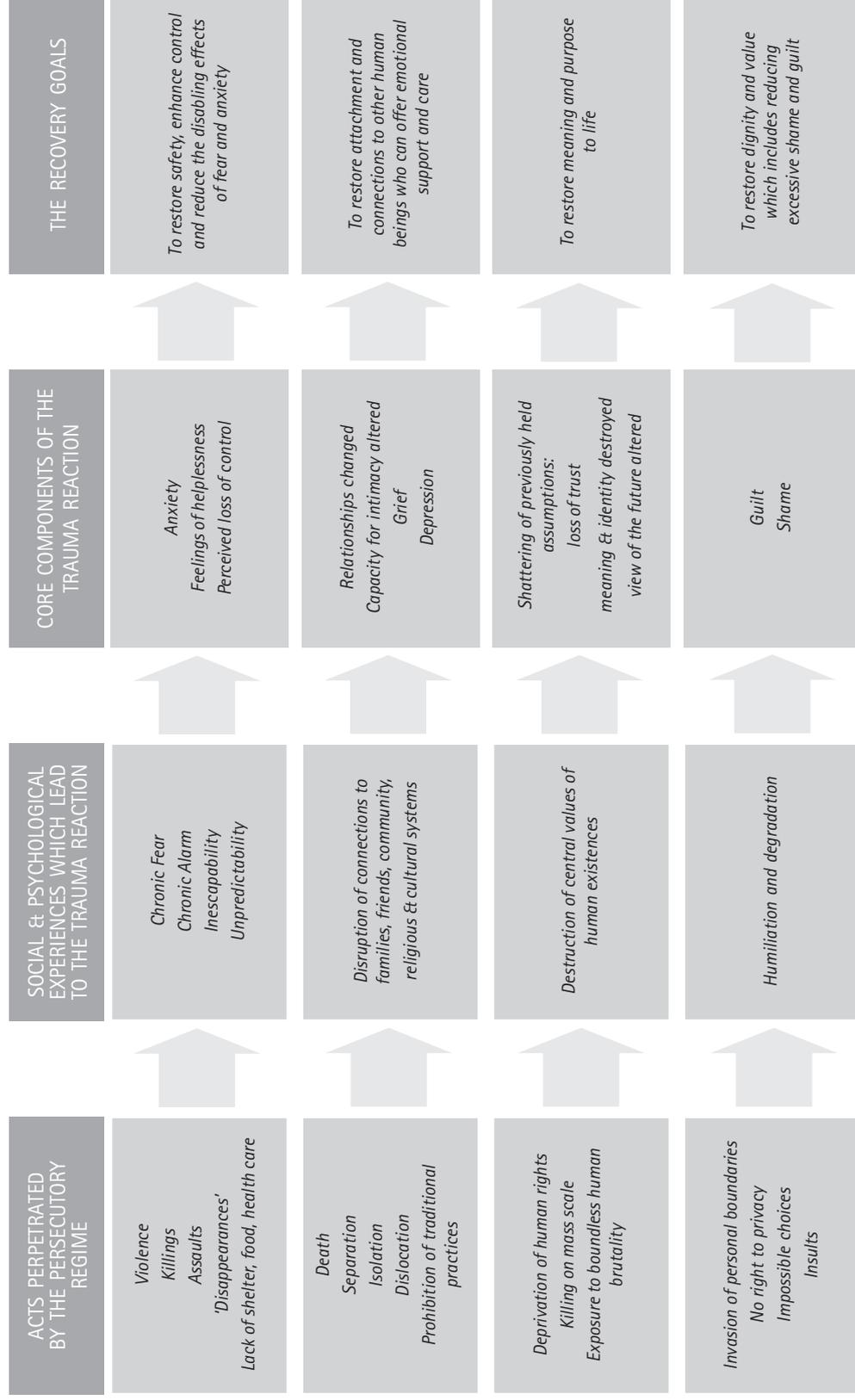


Figure 1
Causes of the Trauma Reaction, its Core Components and Recovery Goals

Detailed descriptions of the trauma reaction are given in Chapter 2 and the ways in which the recovery goals can be achieved are presented in Chapters 3, 4, and 5. Most adults do not present themselves for help. Anyone working with a refugee is in a position to identify people at risk and contribute to their recovery. Workers involved with refugees in community based agencies, primary health care services, language centres, schools, employment and housing services, are well placed to identify people at risk of developing persistent problems which will interfere with their capacity to recover. Workers can also enhance recovery directly by reducing the effects of trauma.

Individual, family and group approaches are complementary and should not be considered in isolation. They are most effective when the worker is part of a service and community which upholds the rights of the individual to comprehensive care. The ethos of the agency, the attitude of workers, the approach to acknowledging and accommodating the specific needs of refugees, contribute to the recovery process and the building of every person's self value.

The principles of service delivery which are central to maximising the benefits to service users have been described by Aristotle (1):

- Services must respect and reinforce the concept of human rights as expressed in various international charters and agreements.
- Services must strive to be culturally relevant, sensitive and understanding of the history and struggle of the service user in the international, national and local context.
- A service needs to address both the internal and external needs of the individuals and groups, while promoting access, equity, and participation.
- In working with those who have lived through the experience of torture, the agency must give due respect to the fact that as *survivors* they have already displayed remarkable resourcefulness, resilience and strength.

- The agency should have an absolute commitment to informed consent, with the provision of services guided by needs as identified and expressed by the survivors themselves. A primary role of the service is to inform those seeking assistance of their rights and to reinforce those rights.
- The agency must be committed to increasing the level of power that survivors have over their lives, in psychological, social, cultural and economic terms. They are socially and economically disadvantaged in their new society, and as such the agency must understand the importance of the redistribution of income and resources necessary for empowerment.
- Services should be provided in a context where the therapeutic benefits are derived from understanding the relationship between the social, physical and psychological worlds of the client.
- The provision of services must be guided by the expressed needs of clients and the capacity to heal or to recover is recognised as being predominantly in their hands. The VFST provides practical assistance and support through crisis intervention, therapeutic assistance and the facilitation of access to services required to meet the total needs of clients.

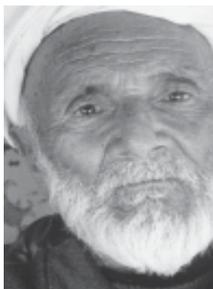
A well functioning organisation is essential to ensuring quality service provision and optimising the achievement of recovery goals for clients. It is beyond the scope of this guide to consider issues of organisational framework, structure or culture, however it is important to point out that an organisation's internal structure and the development of collaborative relationships with other services and government are as vitally important as working with people on the ground.

References

- (1) Aristotle, P., A Wholistic Approach in Hosking, P. (Ed.), *Hope after Horror: Helping Survivors of Torture and Trauma*, Uniya, Sydney, 157-176, 1990.

WHAT DOES IT MEAN TO BE A REFUGEE ?

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1

What Does it Mean to be a Refugee?

1.1 The Refugee Experience

Traumatic events are rarely isolated incidents. In a climate of political oppression and legitimised brutality, persecution is a daily event, culminating in arrest, torture and often death.

A VFST client from East Timor described the daily harassment he and his family experienced. Very frequently the military would come to his home, sit down uninvited, sometimes for hours and watch television, ask for food to be prepared and make derogatory sexual comments about his wife. At other times, they would present “authorised requests” for money. He normally kept them at bay with bribes, but eventually he was detained and tortured and his wife raped. The time came when he decided they had to flee - when he was asked to assassinate someone. Everything they owned was sold and they eventually arrived in Australia, after a very long period of uncertainty regarding obtaining their visas.

Anybody can become a victim of torture or trauma. Children have been tortured and they, along with adults, are witness to the invasion of their homes by death squads who search for and kill family members before their eyes. Children also watch their homes being destroyed. In some countries, disappearances are common - a family member fails to return home or appear at work and no official trace is left. Sometimes, years after their disappearance, information becomes available about their fate. There is no end to trauma for victims and families whilst they live under oppressive regimes. After release from detention and torture, the survivor continues to be watched as does their family. In many cases the person has to keep reporting to the very military officials who tortured him or her.

A male survivor talked of the weekly torture he endured when he had to return each week to do a day's "work" at the military offices in the camp where he had been previously detained and tortured. He was constantly taunted and threatened with castration while he was forced to perform humiliating tasks designated as work.

Large scale massacres have taken place in several regions of the world - such as Central America, Middle East, Horn of Africa, and South-East Asia, leading to forced displacement of large numbers of people. Large scale displacement can hide the very painful trauma which individuals and families face when deciding whether to flee or not. (1) Some people are too weak to flee and others cannot leave their homes. Dislocation usually means separation from other family members with no prospect of reunion.

Indira was eleven years old when she had to flee her home town with her two younger sisters while civil war raged in her country. Her parents and other siblings were believed to have been killed in a bomb blast which destroyed the family home. En route to a refugee camp in a neighbouring country, the youngest sister who was five, died from dehydration. She died while Indira left her in the care of someone else while she searched for her other sister who had become separated from them.

Having escaped persecution, most refugees face years in refugee camps, where they face prolonged squalor, malnutrition, lack of adequate shelter and no protection from violence. Infant mortality is high and the development of children is severely curtailed by the continuing violence, lack of educational opportunities and the chance to play. Adult mortality is also high due to dehydration, infectious diseases, as well as cardiac and respiratory disease. The plight of women in refugee camps is terrible due to the frequency of rape and overt discrimination. For example, women who fled Somalia to Kenya, experienced not only sexual assaults in the refugee camps but would be attacked when they left camp to forage for firewood. (2) Afghani women in refugee camps in Pakistan, are not entitled to any food vouchers, only males are.

Other refugees who do not live in camps live itinerant lives, begging for food and shelter.

Flight is often perilous, the most notorious being the escape of Vietnamese boat people who were attacked by pirates, robbed, raped and killed. A hundred thousand boat people are estimated to have been killed as a result of pirate attacks or drownings. (3)

Refugee families who fled Iraq have described months of trekking in mountains under extremely harsh conditions. Many adults and children died whilst fleeing or once they arrived in refugee camps where there was insufficient food. Having arrived in Australia, the trauma continues, some of them learning of the arrest and execution of family members as punishment for their escape.

TRAUMATIC EVENTS CHARACTERISTIC OF THE REFUGEE EXPERIENCE

- ➔ *witnessing death squads*
- ➔ *witnessing mass murder*
- ➔ *disappearances*
- ➔ *forced marches*
- ➔ *extreme deprivation – poverty, unsanitary conditions, lack of access to health care*
- ➔ *persistent and long-term political repression, deprivation of human rights and harassment*
- ➔ *removal of shelter, forced displacement from home*
- ➔ *perilous flight or escape*
- ➔ *separation from family members*
- ➔ *refugee camp experiences – prolonged squalor, malnutrition, lack of protection*
- ➔ *deprivation of education and for children, deprivation of the opportunity to play*

1.2 Torture

According to Amnesty International (4), 98 countries in the world practise “state sanctioned violence”. State sanctioned violence means that the institutions created in a society for the purposes of protecting people, such as the police force, are the structures that perpetrate the violence. Torture which is commonly practised in these countries, is one of the most brutal forms of violence. Its purpose is not only to destroy the individual but to break down the family and community and ultimately to eliminate resistance and opposition. It suits the purposes of torture to have survivors and to have people who do not survive. Through the release of the survivor, or through the discovery of dead victims, torture is able to spread its message of terror and the futility of opposition.

The word ‘torture’ is usually associated with the detention and brutal abuse of the individual. However, torture is also a strategy used by governments to destroy communities. “The phenomenon of torture often follows a predictable chain of events: a violent raid on a house or meeting-place by members of the security forces, illegal arrests, lengthy incommunicado detention without charge or trial. Even without the unique brutality of the torture that so often follows, these events in themselves are very traumatic for the individual, family and community concerned”. (5) Consequently, the trauma created as a result of torture and other forms of human rights violations, is a powerful tool for assisting oppressive regimes to maintain influence, both over the individual and community, long after the violence has taken place. The disruption to the community can appear to be random but it is part of a strategy whereby indiscriminate attacks and violation of human rights are calculated to maximise control through fear, unpredictability and isolation.

Many different methods of torture have been used and they continue to be practised and refined. Some methods are peculiar to just one country while many other forms appear commonly practised in a variety and number of countries. Some tortures include the involvement of medically trained people. Torturers may try and cover up torture by using increasingly sophisticated methods that do not leave physical scars in an effort to allay the suspicion of an international world. Commonly used forms of torture are listed overleaf.

FORMS OF TORTURE

- ➔ **Severe beatings** occur with rifle butts, batons, fists, boots, iron rods, cables, rubber truncheons, whips. In telephone torture, both ears are hit. Falange refers to soles of the feet being beaten for hours. Wounds and fractures are also subject to repeated beating
- ➔ **Deprivation** of sleep and sensory stimulation
- ➔ **Use of psychotropic drugs**
- ➔ **Electric shock** - electrodes are placed on the body's sensitive areas: tongue, gums, fingertips, genitals, nipples
- ➔ **Burning** - with cigarettes, hot irons, burning rubber, welding torches, corrosive liquids
- ➔ **Mutilation** - extraction of hair or nails, cutting with knives, amputation of body parts, insertion of objects under nails
- ➔ **Suspension** - hanging of the victim by arms and legs
- ➔ **Isolation and solitary detention**
- ➔ **Sexual violence and rape (of men, women and children)** - includes molestation, stripping, touching, rape by animals, insertion of objects into vagina and rectum
- ➔ **Starvation and exposure to heat and cold**
- ➔ **Sham executions**
- ➔ **Water or submarine torture** - the head of the victim is forced under water usually containing faeces and urine until near suffocation, a breath is then allowed and the process repeated many times.
- ➔ **Being forced to maintain abnormal body positions for long periods**
- ➔ **Forcing victims to witness the torture of others, including loved ones**
- ➔ **Abuse of family members** - degrading insults, threat of harm. (6)

1.3 Identifying Survivors of Torture and Trauma

By knowing the country of origin of a person and their age, the possibility of their having undergone torture or trauma can be considered. For example, people from East Timor who resided there after 1975 will have lived in a climate of oppression and harassment. Some will have been tortured and frequently beaten. Anyone living in Cambodia in the years 1975-1979 is a survivor of extreme trauma. People who fled Vietnam on boats were commonly subject to being raided by pirates who raped women and killed family members. There are many survivors of torture and trauma who have arrived in Australia from countries such as Turkey, Chile, El Salvador, Somalia, Eritrea, Ethiopia, Iran, Iraq, the former Yugoslavia, East Timor and Sri Lanka. For information regarding human rights violations in various regions of the world, the reader is referred to the reports published annually by Amnesty International.

People rarely identify themselves as survivors of torture and trauma. Certain questions, which do not require direct enquiry about experiences, can further establish the likelihood of someone being a survivor if one has sufficient country of origin information to appreciate the degree of conflict, oppression or persecution operating at different times in different regions of the world.

Examples of questions are:

When did you leave your country?

Did you choose to leave or were you forced to?

What was the journey to Australia like?

Have you spent time in a refugee camp?

Terrible things have happened to people who have been forced to leave their country. There is no need to tell me what happened, but have you had any terrible experiences?

1.4 *Definition of a Refugee and Australia's Humanitarian Program*

People who flee their country for fear of being persecuted for reasons of race, religion, nationality, political opinion or social group are deemed refugees by United Nations High Commission for Refugees (UNHCR). The international protection of refugees was a mandate given to UNHCR by the General Assembly of the United Nations.

The UNHCR definition of a refugee is someone who:

“Owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country”. (7)

Notably, this definition does not apply to people who have fled their country for economic reasons or for reasons of violence which are not specified in the above definition.

There are many people who do not meet the UNHCR definition of refugee but have suffered gross violation of human rights. A small number of countries, including Australia, have responded to their plight and have provided resident visas on ‘humanitarian’ grounds.

Under Australia’s migration program, approximately 12,000 visas a year are issued to people who meet the above definition of a refugee or who meet humanitarian criteria of having suffered gross violation of human rights but fall outside the definition. Specific definitions of various entrant categories are shown in the box below. (Current at the time of preparation of this guide). Although they may change in future, the general humanitarian basis for them will continue.

The AUSTRALIAN HUMANITARIAN PROGRAM comprises the traditional Refugee and Special Humanitarian Programs as well as the Special Assistance Category

- ➔ **The Refugee Program** provides protection for people outside their country fleeing persecution, ie people who meet the definition of a refugee (this includes emergency rescue and women at risk).
- ➔ **Special Humanitarian Programs (SHP)** comprise the In-country Special Humanitarian Program for people suffering persecution within their own country, and the Global Special Humanitarian Program for people who have left their country because of significant discrimination amounting to a gross violation of human rights.
- ➔ **The Special Assistance Category (SAC)** embraces groups determined by the Minister for Immigration & Multicultural Affairs to be of special concern to Australia and in real need, but who do not fit within traditional humanitarian categories. This program also assists those internally and externally displaced people who have close family links in Australia.

There are 40 million refugees (including internally displaced persons) in the world, a third of whom are in Africa. The war in former Yugoslavia has alone produced 3 to 4 million refugees and displaced persons. (2) Over the past 50 years, half a million refugees and displaced persons have resettled in Australia. Table 2 shows the countries from which these refugees and displaced people have come in the past year.

Table 1 Arrivals to Australia under the Humanitarian Program 1995-97

COUNTRY	1995-96	1996-97
Ukraine	193	178
Former USSR & Baltic States	270	28
Bosnia-Herzegovina	3,318	1,993
Croatia	551	495
Other Former Yugoslavia	2,352	-
Afghanistan	-	242
Iran	644	315
Iraq	2,170	1,599
Sudan	426	328
Burma	360	264
Indonesia	163	77
Cambodia	549	275
Vietnam	271	1,042
Sri Lanka	379	251
El Salvador	167	94
Eritrea	153	90
Ethiopia	239	134
Somalia	383	261
Total No. of Arrivals under Humanitarian Program ¹	13,824	9,886
No. of Arrivals (Intended Residence - Victoria)	4,359	3,057
No. of Settler Arrivals (Non-Humanitarian & Humanitarian)	99,139	85,752

¹Countries not listed are those where less than 100 visas were issued in both years

A recent study of entrants to Australia under the Humanitarian Program indicated that 25% had experienced extreme trauma or torture. (8) Another 38%, in the same study, reported traumatic experiences such as dangerous flight, incarceration and loss of family members. (3) This represents 75,000 entrants over a ten year period. The percentage of people who have been tortured or severely traumatised varies from year to year and can be very high depending on the country of origin. As a result of health assessments undertaken by the VFST with new arrivals under the Federal Government's Humanitarian Program, it is estimated that for some countries such as **Iraq**, 70% of entrants under the Humanitarian Program, have been tortured or severely traumatised.

There have been obvious changes in the intake over the years, largely reflecting changing zones of conflict. In the 1989-90 period for example, refugees came mainly from Vietnam and El Salvador. The former Yugoslavia and Iraq did not appear on the list of countries. In the 1970s, the focus was on Indochina, with 137,600 people from Vietnam, Laos and Cambodia having settled in Australia under the Humanitarian Program. (8) In the future, the proportion of people arriving from any one country will change. Again, this will depend on zones of conflict. The Victorian Foundation for Survivors of Torture (VFST) commenced service delivery in 1989. Since then clients have come from over 40 different countries. In 1995/96 alone, 33 different countries were represented in the VFST's client base. They are listed in Table 3.

A percentage of these clients are asylum seekers. These are people seeking refugee status in Australia, who hold fear of renewed persecution if they returned to their country of origin. They do not have permanent residence. They are required to apply to the government immigration authorities for refugee status. If their application is rejected they can appeal to the Refugee Review Tribunal which reviews their claim. Sixteen hundred asylum seekers were recognised as refugees in the 1994-95 financial year. At the end of April 1996, the number of refugee claims was 6,500 representing 9,250 people. (9)

People not recognised as refugees can apply for residency in Australia on humanitarian grounds. In such cases, residency can be granted on consideration of extraordinary circumstances such as extreme levels of suffering due to torture and trauma. If that application fails they are returned to their country of origin.

Table 2

Country of Origin of Clients seen at the Foundation (1996-1997)

COUNTRY	NO. OF CLIENTS
Afghanistan	6
Algeria	5
Bangladesh	1
Bosnia*	355
Burma	6
Cambodia	11
Chile	6
China	3
Croatia	32
East Timor	27
El Salvador	8
Eritrea	11
Ethiopia	25
Ghana	1
Guatemala	1
India	4
Iran	16
Iraq	125
Lebanon	2
Pakistan	1
Philippines	1
Russia	1
Somalia	65
Sri Lanka	25
Sudan	7
Tanzania	1
Thailand	1
Turkey	18
Uruguay	1
Vietnam	8
TOTAL	774

*Bosnia comprises Bosnian Croats, Bosnian Muslims and Bosnian Serbs

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THE PSYCHOSOCIAL IMPACT OF TORTURE AND TRAUMA

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2

The Psychosocial Impact of Torture and Trauma

2.1 *Acts Perpetrated by the Persecutory Regime and their Social and Psychological Effects*

There are four key ways that persecutory regimes destroy individuals, families and communities.

1. The first way in which the breakdown of communities and political opposition is achieved, is by **creating a state of terror and chronic alarm**. Individuals are assaulted in ways which lead to the permeation of an individual's torment through the family and community as a whole. Helplessness to change the situation is maximised. The elements of inescapability and unpredictability combine to instil and maintain a state of extreme fear.

Uncertainty about safety maintains fear at extreme levels and is manipulated to the extreme in torture. "Torture is fear ... it's the not knowing, the uncertainty of menace, that drives you to panic. Not just what they do to you, but what they may do to you next, what they have the power to do to you, at any moment, at every moment ... and if the world keeps silent afterward, torture is not only victorious but permanent, eternal, continuous" (1, p.300). Herman describes the inconsistent and unpredictable outbursts of violence which "convince the victim that the perpetrator is omnipotent, that resistance is futile, and that *the victim's* life depends upon winning *the perpetrator's* indulgence through absolute compliance" (2, p.77, italics are the author's). Paralleling the victim's necessary submission to his or her torturer, a community's safety is made dependent upon submission to the oppressor.

2. The second key trauma-inducing element is the systematic disruption of basic and core attachments to families, friends, religious and cultural systems.

This creates a deep sense of loss designed to shatter the sense of continuity and identity. There are various ways in which this is achieved - through killing, dislocation and prohibition of traditional practices. In the community a climate of suspicion and mistrust is fostered to break down social cohesion and foster extreme vulnerability. Deprivation of basic human rights such as the right to work, education and health further disrupt a sense of belonging. As a result of such losses, people can become passive, depressed and withdrawn.

Lasting feelings of condemnation to isolation can continue for years. Under conditions of torture, indefinite isolation from family is utilised as a major threat. The torturer's famous boast is that, "No-one will ever know, no-one will ever hear you, no-one will ever find out" (1, p.300).

Oppressive regimes also disrupt continuity in the community by banning commemoration ceremonies. Where this ban, implicit or explicit, is breached, further punishment is implemented. Oppressive regimes also go to great lengths to conceal political violence and torture, as was the case in Argentina. Such strategies effectively isolate victims further.

3. The third cause of enduring trauma is the destruction of central values of human existence.

The refugee, of whatever age, who has experienced imprisonment, torture, and witnessed death and destruction, has been exposed to the very darkest side of human nature. As Simpson (3, p.153) poignantly wrote of the torture victim, he or she "confronts the world's loneliness, mercilessness, and nothingness." Trust, dignity and the value of life itself are questioned by those who have been victims of organised violence. Shattering previous assumptions of the self and the world lead the victim to more readily accept a submissive position in relation to an oppressor. Even death can lose its meaning. The survivor is a witness to "absurd death", the ultimate act of destruction - to see people die as if they were worth nothing.

The boundless nature of torture is another critical element destroying central values of human existence. In torture, nothing is sacred. In fact torturers will manipulate the most essential elements of humanness to exact suffering. Religious beliefs are abused, the innocence of children, parenthood and intra-family relationships are all violated by the torturer in an attempt to make the oppression complete.

Where dictatorships have been overthrown, impunity enhances the sense of injustice and reactivates feelings of helplessness. Argentinian workers have described how the media reported on missing detainees being thrown alive from airplanes into the sea. Under protective impunity, perpetrators publicly described what happened and “then went home”.(4)

4. The fourth key way in which persecutory regimes oppress is through **the creation of shame and guilt.**

Physical boundaries are invaded, the right to privacy is deliberately violated, basic functions of eating, sleeping and going to the toilet are closely controlled, family members are cursed, degraded and violated. These acts taint the individual as worthless, bad and even inhuman. Rape is used as a weapon against entire communities because of the power it has to destroy families with shame.

Guilt is induced by confronting the individual with impossible choices such as choosing who should die or who should be left behind. Both guilt and shame weaken the individual’s capacity to fight back long after the act of assault. Even though it may have been impossible to have acted differently, many survivors retain the belief that they could have done something to help others and themselves. This is not necessarily a tangible action but a stand against cruelty. As Lifton points out, the sense of “failed enactment” or helplessness becomes a source of inadequacy and self-blame, and maintains passivity (5).

Each of these causes brings about fundamental changes in belief systems - about the self, others and the world. Symptoms and behaviours emerge which are disruptive to everyday functioning and the quality of life and they perpetuate the impact of traumatic events. They are detailed in the following sections.



2.2 *The Trauma Reaction*

The impact of war and human rights violations depends on the nature and extent of the trauma, the age of the person and on the quality of the care and support available. Arrival in a safe country represents the end of brutal circumstances, but restoration of security and safety which are essential to recovery, cannot be assumed.

The psychological effects of trauma have been written about since World War I, but it is only since the Vietnam war that a great deal of attention has been devoted in the western world to understanding the impact of trauma. This interest reflected the fact that many Vietnam veterans were presenting with severe psychological difficulties many years after the war. Due to the initiatives of the World Health Organisation and Amnesty International, the effects of torture also began to receive much needed attention in the late 1970's and publications began to appear documenting both the physical and psychological impact of torture. As evidence accumulated about the psychological effects of trauma, post-traumatic stress disorder became included as a diagnostic category in the psychiatric classification system (6). Basically, post-traumatic stress disorder (PTSD) is the name given to a number of symptoms which have come to be recognised as often following exposure to horrific, usually life-threatening events. The list of symptoms is presented in Appendix 1. Most of the signs and symptoms listed are caused by the intense levels of anxiety which are associated with trauma.

However the psychological effects are far more extensive than those captured by post-traumatic stress disorder. Horrific events which instil fear and overwhelming helplessness, do not occur in isolation from loss of loved ones; and loss which occurs under violent circumstances is known to lead to depression and prolonged grieving. Furthermore, the circumstances are such that fundamental aspects of human existence which are central to survival and some quality of life are shattered. **The most basic unit of human civilisation - trust - is often destroyed** (7). Identity, religious and cultural values, and political ideologies can also undergo enormous change. Guilt and shame which can persist for years, are part of the legacy of trauma. Further, PTSD, currently defined as a response to one event, (6) does not capture the response to

situations involving protracted violence and systematic persecution, sometimes perpetrated over generations.

The trauma reaction arising from various social and psychological experiences was summarised in Figure 1. The four core components of the trauma reaction and its manifestations are discussed in the following sections.

2.2.1 *Anxiety, Helplessness and Loss of Control*

Intense anxiety, fear and sheer terror can persist for a long time after a traumatic event or events. The anxiety is the result of having been exposed to life-threatening situations or intolerable danger, where the victim has been helpless to act. The experience of helplessness rather than the ostensibly horrific nature of an event is the critical factor in determining the severity of the trauma reaction. (8)

There are many ways in which anxiety manifests itself. They are important to recognise because where they are persistent, a referral for specialist counselling is indicated. Where the occurrence of anxiety is less frequent and when the intensity of the anxiety interferes less with daily functioning, specialist counselling is not so critical.

SUMMARY OF EFFECTS ASSOCIATED WITH ANXIETY

- ➔ **intrusive and recurrent distressing recollections of the traumatic event**
- recurrent memories, images, nightmares of trauma and flashbacks
- ➔ **impairment in ability to think, concentrate and remember**
- ➔ **conditioned fear response to reminders, places, things and people's behaviour, leading to**
- avoiding fearful situations
- emotional withdrawal
- ➔ **generalised fear not directly related to trauma**
- fear of strangers
- fear of being alone
- ➔ **hypervigilance or watchfulness**
- "being on guard for danger"
- ➔ **startle responses**
- reacting with startle to sudden changes in environment such as noise
- ➔ **capacity to manage tension and frustration is reduced**
- reduced control over impulsive behaviour
- ➔ **emotional numbing**
- denial, detachment, reduced interest in activities and people
- ➔ **psychosomatic complaints eg headaches**

Intrusive, Recurrent Experiences of the Trauma

For many survivors, the trauma continues in the form of memories, images and nightmares of the trauma which can be extremely vivid. The nature of “traumatic” memory is different to normal memory in that the details of events including actual sensations can be evoked. Normal memory rarely involves “reliving” an event, it is instead a story of what happened, a summary of an event in words. The vivid nature of memories which intrude into the minds of trauma survivors is extremely disturbing and distressing and revives the fear that was felt during the traumatic event. The following example applies to people of any age.

“Almir was afraid to close his eyes. Every time he did, the scene replayed itself upon the screen of his mind’s eye; his mother and sister, Amina, are raped by soldiers while he stands by, helplessly. During the day, he tried desperately not to blink, for even a flash of darkness would bear the nightmare imprint. At night while others slept, he stared out into the darkness until exhaustion pulled him into uneasy slumber.” (9, p.327)

A survivor of a concentration camp in Bosnia described being disturbed by images of events in the camp which appeared in front of his eyes, as if a roll of film was being screened.

Numbing, Constriction and Dissociation

Re-experiencing the event threatens to overwhelm a person with anxiety or other intense emotions such as anger, and as a result he or she often copes by “shutting down”. This occurs in several ways - through the unconscious mechanisms of denial and numbing and through restricting the amount of information from the outside world. Detachment from people and things also serves to reduce the intensity of emotions. “Shutting down” manifests as withdrawal from social participation, avoiding stimulation, looking blank and expressionless and limited imaginative activity. Horrific events can be related without any feeling. Some people are quite aware that they ‘lost’ their feelings and no longer react to anything. One survivor commented, “My heart is cold”, another



said, “I feel dead inside”. These mechanisms are a way for the mind to cope with intense levels of fear.

A female client who had been detained, tortured and on the run for many years would spend long periods of time by herself. She walked with her head to the ground and when we sat in the same room together, her “shell” was almost palpable.

A male client described himself as no longer having any feelings. He then touched the cup sitting on the table before him and said - “I am like it, like stone”.

In extremely traumatic situations such as being raped or having a gun put to their head, some people “dissociate”. This term refers to escaping the external reality to an internal fantasy. For example, a child in a dangerous situation like being searched for by the military, may imagine themselves as “shrunk to an imperceivable dot” (10). With this fantasy, the child can feel they cannot be found. This way of coping can re-emerge when reminders of the trauma re-evoked frightening memories. To an observer, the person will appear to be “somewhere else” or they may re-enact their behaviour at the time of the trauma by, for example, diving for cover. This process is an unconscious one. In some cases, the period of dissociation can last for hours, even days. The person does not have a memory of where “they went” for this period and therefore cannot report on what happened.

Although numbing and dissociation are protective mechanisms against overwhelming emotions, when sustained they produce a constriction in behaviour, thought and emotion. People who no longer feel the pain of their trauma also have difficulty letting go sufficiently to experience joy.

It is quite typical for periods of intense anxiety, associated with re-experiencing the trauma in the form of nightmares or intrusive memories, to alternate with periods of withdrawal and emotional numbing. This pattern together with symptoms of over-arousal forms the constellation of symptoms known as PTSD.

Conditioned Fear Response

Reminders of the traumatic event act as triggers to cause extreme anxiety and fear long after the trauma. Stimuli in the environment and everyday situations commonly act as reminders of the traumatic incident, evoking fear. Some stimuli have a fairly obvious connection with traumatic events. For example, the sight of a policeman can remind a person of the time their home was raided by military officers. Other stimuli are not so obvious.

For one client at the VFST the sight of a bus brought back the anxiety of having helplessly watched a bus load of children being transported away from their families.

Another client, being accompanied to a medical appointment, suddenly leapt out of the car when he heard the sound of a jet flying overhead. He thought it was a bombing raid and had to run and dive for cover.

A client from the Middle East became terrified at the sight of black plastic bags which had accumulated during a garbage strike. He believed that there were bodies inside the bags.

Many stimuli can only be identified as triggers for anxiety, once details of the personal history are known. People who have been tortured with cigarette burns report memories of their torture being triggered by certain smells. Job interview situations commonly raise traumatic memories of interrogations. Authoritarian and threatening behaviour of any kind can act as powerful triggers for anxiety.

A woman who had been raped reported great difficulty in carrying out daily activities. She could not attend English classes or go shopping because she would become frightened at the sight of men.

A male client, who had been tortured in Chile, could not bathe or drink water because it brought back the terror of being nearly suffocated, after repeated immersion in water contaminated by urine and faeces.



Increased Arousal

In survivors of trauma, physiological arousal is readily elevated. Symptoms of **increased arousal** accompany high levels of anxiety. That is, the threshold for reacting to stimuli is lower than usual and the person is jumpy and nervous. It is as if the person is constantly alert to danger. This is termed hypervigilance. The other signs are **inability to concentrate and an exaggerated startle response**.

Some clients at the VFST have reported jumping at the sound emitted at traffic lights. These sounds are intended to indicate safety to proceed. For people who have been in war situations, the sound evokes gunfire.

During counselling sessions, clients have been observed to often startle to the sound of the train running close by.

A client who had spent a year in solitary confinement could not bear any unexpected noise from his neighbours because he would be so disturbed by any sound.

With the pressure of anxiety and tension which the person cannot manage, he or she may become highly irritable, be unable to tolerate frustration of any kind and thereby show reduced control over impulsive and aggressive behaviour.

Some people have panic attacks, a discrete period of time of intense fear which develops abruptly. Typical symptoms include heart palpitations, trembling, shortness of breath, chest pain, nausea, feeling dizzy, tingling sensations and hot flushes. The intensity is such that people typically fear that they will die due to a heart attack or due to choking. Some people fear that they must be going mad.

Psychosomatic Complaints

Symptoms which are “psychosomatic” refer to physical symptoms that are caused by emotional factors such as stress. The body systems or organs which are affected are those innervated by the autonomic nervous system which regulates the activity of the heart, liver, digestive system, sweat glands and endocrine system.

People with psychosomatic symptoms do not necessarily experience a subjective sense of anxiety, fear or conflict. Nevertheless unconscious fear arouses the autonomic nervous system and when this arousal is chronic, persistent bodily symptoms emerge.

List of common psychosomatic symptoms:

- Headache - tension and migraine
- Nausea
- Diarrhoea
- Constipation
- Heart palpitations, hypertension
- Skin complaints
- Gastric ulcer
- Chest pain
- Allergies

There is a belief expressed in the literature that people from non-western countries “somatise” their emotional distress more than their western counterparts. However, while there is evidence that people from non-western countries present more with somatic complaints, it does not necessarily mean that they experience more somatic sensations. (11)

Conversion Symptoms

Earlier this century during World War I, soldiers suffering from so called “shell shock” developed symptoms such as blindness, paralysis, and fixed postures. They had suffered no physical injury but their minds had “converted” an emotional trauma or conflict into a bodily expression of that trauma. There was usually a detectable symbolic connection between the physical symptom and the emotional conflict. For example, blindness meant that the soldier no longer had to see horrific atrocities. These are called conversion symptoms. Over the century, they have been seen less frequently in Western countries. Their current prevalence amongst survivors of torture and trauma is not clear.

Several female clients from Bosnia have complained of numbness in their legs from the knees down. In one case, a woman could not walk. No physical basis for the numbness has been found. In some cases, it is known that they have been raped. The numbness can be understood to symbolically represent the need to push away the pain of their rape as well as the inability to go on.

The Manifestations Of Anxiety: Physiological, Cognitive and Behavioural Effects

From the above description it is apparent that there are many specific ways in which anxiety shows itself. Because anxiety involves cognitive, physiological and behavioural systems, the effects can also be conceptualised or grouped according to the system affected. The following list summarises the effects according to these categories.

Coping with anxiety

The effects of anxiety are very disturbing when they are experienced, and as mentioned earlier, they reinforce feelings of helplessness and inadequacy. Most survivors do not link their anxiety to the experience of torture and trauma and are bewildered when everyday situations can produce intense levels of fear. In striving to cope, methods to alleviate anxiety are used which are beneficial or adaptive in the short-term, but produce new problems, or are maladaptive in the long-term.

Where someone finds themselves having an anxiety attack whenever they use public transport, they will naturally avoid going into that situation. This keeps anxiety at bay but clearly interferes with the person's capacity to access much needed services. In the long-term, the sense of helplessness is worsened. Similarly, smoking and drinking are very effective palliative measures for reducing anxiety and provide much needed relief. However, heavy and persistent usage can create debilitating problems of substance abuse.

THE MANIFESTATIONS OF ANXIETY



PHYSIOLOGICAL OR SOMATIC SYMPTOMS AND SIGNS

- *panic attacks*
- *pain*
- *headaches*
- *heart palpitations*
- *hypertension*
- *nausea*
- *ulcers*
- *diarrhoea/constipation*
- *asthma/difficulty breathing*
- *dry mouth*
- *trembling*
- *heightened state of arousal*
- *tension*
- *easily startled¹*
- *hypervigilance*



COGNITIVE SYMPTOMS AND SIGNS

- *poor concentration, poor memory*
- *apprehension*
- *distressing memories of the traumatic event*
- *worries*
- *anticipating the worst, imagining terrible things that might happen*
- *confusion*
- *over reaction/phobic perception of stimuli reminiscent of the traumatic event*
- *sleeping disturbances: difficulty falling asleep, waking up every few hours, waking up early, nightmares*
- *feeling like events are happening again (flashbacks)*
- *constricted receptivity to information*
- *dissociation*



BEHAVIOURAL EFFECTS

- *avoidance behaviour of potentially fear-evoking situations*
- *passivity*
- *escape behaviour from fear-evoking situations*
- *withdrawal*
- *impulsive behaviour*
- *aggressive behaviour*
- *detachment from others*

¹ Underlined symptoms and signs are included in the diagnostic category PTSD



Aggressive behaviour can become a way to deal with excessive anxiety because it enables the survivor to feel powerful rather than continually helpless. The immediate effects do indeed provide a sense of strength but the destructive effects are felt and in many cases produce guilt and a deep feeling of weakness.

Other coping strategies which are used are extremely effective and have long term benefits. The person who gradually approaches a normally fearful situation can develop a sense of mastery rather than failure. People newly arrived in Australia who give themselves time to deal with the enormity of settlement tasks effectively protect themselves from disappointment and feelings of failure.

2.2.2 *Loss, Grief and Depression*

The connection with others and the world is usually dramatically altered as a result of trauma. Loss of others and/or prolonged isolation and separation from important figures such as parents, spouses and friends typically characterise the lives of refugees. The process of resettlement can exacerbate the sense of loss, particularly when survivors struggle to regain material security, employment and some standing in the community.

SUMMARY OF EFFECTS ASSOCIATED WITH LOSS



GRIEF

- *numbness, denial*
- *pining, yearning*
- *preoccupation with lost person*
- *anxiety*
- *emptiness, apathy, despair*
- *anger*



ATTACHMENT BEHAVIOUR IN RELATIONSHIPS ALTERED

- *increased dependency, clinging behaviour*
- *fierce self-sufficiency*
- *compulsive care-giving*
- *guardedness, suspiciousness*
- *withdrawal*



FEAR ABOUT RELATIONSHIPS

- *fear of renewed loss*
- *fear of intimacy*
- *scrutiny of motives*
- *death taint*
- *ready devaluation and idealisation of others*



DEPRESSION

- *pessimism*
- *loss of interest*
- *sleep disturbance*
- *appetite disturbance*
- *poor concentration*
- *self degradation*
- *self blame*
- *hopelessness*
- *suicidal thoughts and plans*



The Grief Reaction

Grief is the normal reaction to loss of significant others and other things of central value to the person. The length of the grieving process for loved ones depends on a number of factors identified in the general literature on bereavement:

- whether the death is anticipated or not
- the degree of violence associated with the death
- the availability of community support
- the quality of the relationship with surviving family members or caregivers
- the extent of other associated losses.

Virtually all these risk factors apply in the case of refugees. Death can be anticipated but is certainly premature and virtually always associated with violence. Losses are extensive and the family and community are also damaged, limiting their availability to support any one individual. Furthermore, in circumstances of war with the disappearance of loved ones and unplanned flight, mourning rituals can rarely be carried out.

The grieving process can continue, sometimes for years, and not necessarily with resolution. In Western psychology, grief is understood to occur in stages which are described below. It is not known to what extent the responses characterising these stages are universal. Bowlby (12), one of the best known contributors to this field, believes that whereas customs and mourning rituals vary enormously, the emotional response is not culture specific.

In the **first phase**, the length of which is highly variable, numbness and denial are usual. There can be partial disbelief that the loss has occurred, denial of feelings and an avoidance of reminders. Denial can alternate with anger and anxiety.

The **second stage** is characterised by yearning or intense longing for the lost person. Pangs of grief, pining, crying, preoccupation with the lost person, believing the person is close and hallucinations are all part of this phase. It has also been described as the protest stage. The

grieving person experiences an alarm reaction, and it includes anxiety, restlessness and physiological complaints. It is essentially a response to the threat of loss of safety.

Guilt for not having done more for the person or people who have died is also usual.

The **third stage** is one of disorganisation and despair. Emptiness, apathy and depression predominate with the increasing realisation that the loss is permanent. Anger and guilt also occur. Sometimes traits of the deceased are adopted or another person is treated as a substitute for the dead person.

In the **final phase** acceptance and resolution occur. There is an attempt to make sense of the loss, to fit it into a new life. The view of the world is changed and new roles are adopted. This stage is often not reached after extensive loss, as occurs in situations of mass violence and genocide.

Impact on Relationships

There are profound consequences for the capacity to form new relationships when grief is unresolved. The following patterns of attachment behaviour can develop at any time of life after loss.

In **anxious attachment**, the individual is constantly fearful of losing attachment figures. This can manifest as clinging behaviour and jealousy. When these behaviours are extreme, they disrupt relationships and perpetuate loss. Anger is harboured when the attachment figure is unavailable. This anger is often not expressed for fear of rejection.

Compulsive self reliance is another reaction to unresolved grief. Such individuals have lost hope of finding an adequate attachment and avoid close relationships. It can easily be misunderstood as a healthy reaction because the person appears self sufficient.



In **compulsive care giving** personal needs are denied to fulfil others. Again, this can appear as a healthy reaction because the person appears so helpful and accommodating but this is at the expense of their own needs being met. It is also a form of relating which can easily be taken advantage of by others. In its extreme form, relationships are sustained by fostering gratitude.

Many **fears about relationships** develop after torture and trauma. It is important to be aware of such fears because it affects the person's capacity to form new attachments. A new relationship may be avoided because of the possibility of renewed loss. "After severely traumatic experiences, investing in loving relationships and caring about anything make oneself again a hostage to horror, again vulnerable to traumatic loss of these relationships" (3, p.676).

Intimate relationships can evoke intense anxiety because they can remind the torture survivor of their relationship with the torturer. The torturer's aim is to have total control over their victims and this is achieved at times by intermittently granting small favours or small comforts. This fosters dependence on the torturer. Once the victim is released, the survivor will avoid dependency, it being associated with captivity and the shame of having been dependent.

People are also carefully scrutinised for their motives. The following excerpt is taken from a written account provided by a client, about his experience at the Rehabilitation and Research Centre for Torture Victims, Copenhagen.

"I met another therapist at the centre with whom I am still in contact. We started, and he talked with me about my personal problems. In the beginning I laughed to myself, thinking, "Who are you? You who have never even had a smack on the ear. You have not even tasted pain. Who are you to talk to me? How can you manage my problems? You live in another world. People in your world beat each other in a different way - for example, when a girl and a boy have an argument and offend each other - but in my country these things are very different, maybe to such an extent that it is unbelievable.

It was a new situation for me, and I found it amusing that someone from Western Europe, the world of capitalism, was to give me, a person from Asia, treatment for my pain. In the beginning I thought his questions were dumb, really dumb - excuse my expression - dumb because he asked me, "What do they do in the prison?" I said, "What do they do in prison?" "Yeah, what do they do?" "How would you know sitting here with your patients in your clinic? They beat you, of course; they beat you with cables." "What more do they do?" "They strap you down, and" I named all the different kinds of torture. It was puzzling to me. What did he want? I had studied psychology myself, and his questions were so ignorant that from time to time I had to laugh to myself. In the first sessions, he went on with these silly questions." (13)

Such scrutiny, born of lack of trust as a result of torture, maintains the feelings of isolation. Isolation is also compounded by the victim feeling as if he/she is "tainted by death". (5) He or she who has known death so closely fears infecting others with death. Contact with others is therefore avoided.

Relationships can also be characterised by extreme fluctuations. Attachment can alternate with detachment, idealisation can quickly change to devaluation. These swings reflect the sensitivity of the survivor to the behaviour of others. A minor disappointment can become the cause for dismay, an act of courtesy can lead to excessive gratitude.

A male client who had been tortured as a young man spent the next 15 years constantly on the alert for informers. It was a realistic fear in his country. In Australia he led a very isolated life. During therapy he would become very angry with his counsellor if she had to cancel an appointment and he would say that she no longer cared. At other times he would be effusive with gratitude for the concern she showed. Both reactions reflected his need to be close to someone and his concurrent fear of dependence.



Depression

Depression is part of the grief reaction and persists when grief is unresolved. Even in the absence of loss of close family members, depression will still occur in response to other profound losses. Because refugees have faced losses of many kinds - their friends, their homes and place of safety, their homeland and part of themselves, they are at risk of developing ongoing depression. Previously valued goals cannot be replaced leading to a pessimistic view of the future.

One client from Bosnia had been a professional of international repute. He had owned his own house, a holiday house and travelled extensively. He was in tears when he talked about never being able to find work again in his own field and how instead he would have to live off social security benefits. His self esteem was shattered with the loss of employment prospects and a previously held valued place in society. "I used to be someone, now I'm invisible".

Depression can develop over time with the dawning realisation of permanent loss. A torture survivor suffered greatly as he became increasingly aware of his loss of personality, "I'll never be normal". He thought that he could make a new start in Australia, that things could be better but he began to believe that he was too damaged to change.

A newly arrived chemist was optimistic about his future in the early stages of resettlement. After 18 months, his aging parents arrived. He realised that they would never be self-sufficient as they had been at home and that he would have to look after them. He had also failed to find employment in his profession. He began to see the future as hopeless, began drinking and had to face charges of assault after having started a fight while drunk.

The features of depression are:

- pessimistic mood
- loss of interest in things and activities which previously would have been pleasurable
- sleep disturbances - sleeping too much or sleeping too little, difficulty falling asleep
- appetite disturbance - eating too much or eating too little

- poor concentration
- difficulty making decisions
- feelings of worthlessness and expressions of self degradation
- feelings of hopelessness
- suicidal thoughts, plans or actions.

A mother well described the depression of her young son, when she said that the things which used to make him happy did not make him happy any more.

The person may also be withdrawn or irritable and aggressive. Feelings of hopelessness and sadness are not usually expressed directly and the depression can be masked by drug and alcohol abuse.

Depressive symptoms in themselves perpetuate other features of the trauma reaction. The lack of energy, interest and pessimism reinforce the person's perception that they are weak and inadequate. Where loss of motivation is profound, renewed feelings of passivity, helplessness and defeat are aroused.

2.2.3 *Shattering of Assumptions about Human Existence*

The effect of trauma is known to dramatically change, at an existential level, how a person sees themselves, other people and the world at large. Notions of good and bad, trust in others and the future can be irrevocably changed, affecting fundamental values about the self and life itself.

SUMMARY OF SHATTERED CORE ASSUMPTIONS ABOUT HUMAN EXISTENCE

- ➔ *Loss of trust and meaning*
- ➔ *Capacity to trust damaged, deep sense of betrayal*
- ➔ *Loss of future*
- ➔ *Sensitivity to injustice*
- ➔ *Moral concepts affected*
- ➔ *Loss of continuity of the self*
- ➔ *Identity shattered*

Loss of Trust and Meaning

One of the most fundamental changes is the destruction of trust in the world or oneself as a safe place. “The essence of psychological trauma is the loss of faith that there is order and continuity in life. Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences” (14, p.31). Closely associated with the loss of safety is the loss of meaning. The witnessing of mass killings, the seemingly capricious acts of violence taint the survivor with a sense of discardability. Having seen boundless horror and senseless death, survivors also fear contaminating non-survivors with death.

Loss of safety and meaning are rarely expressed directly unless there is a close relationship with a survivor. Such effects show themselves indirectly through isolated behaviour, non-self disclosure, suspiciousness and close observations of others' behaviour. Depression is part of the response to loss of faith and meaning.

The loss of trust can extend to a loss of faith in a world community which upholds the value of life. Survivors of the war in Former Yugoslavia have expressed their dismay at a world which allowed the atrocities to continue.

One of the most painful experiences expressed by survivors of the war in the Former Yugoslavia is the incomprehensibility of the betrayal they witnessed. Former friends and neighbours became perpetrators within days. Families and communities were divided in ways that could not be imagined.

One of my clients constantly asks how can she know who a friend is. She was sure she had friends but they allowed her to be captured without giving her prior warning. What has enabled her to keep some faith in humanity is the fact that some people did take risks to eventually secure her release.

Once the world is perceived as untrustworthy, the maintenance of fears such as sensitivity to reminders of the original trauma or traumas is far more likely, and more general fears begin to dominate the person's life.

Loss of Future

The future can become an emptiness after betrayal and the witnessing of violations on a mass scale. If the future holds no purpose, and one cannot look back because of fear and the pain of loss, the sense of continuity of life itself is shattered.

The pursuit of justice often becomes an important goal for the future and many survivors dedicate themselves to social/political activism. This is an adaptive response but where it is associated with a lack of tolerance for any incursion on fairness, everyday life can become a constant source of provocation to anger.



Other survivors find purpose in their survival as a way to bear witness to atrocities and human rights violations so that others know and learn. This is also a way to resolve grief because bearing witness becomes a way to honour the dead.

Effects on Notions of Good and Bad

The young are particularly susceptible to having their moral development truncated as a result of their exposure to violence. Adults too, change their basic notions of what is right and wrong. Research has shown that children exposed to inescapable violence over years develop the belief that revenge is the best way to obtain justice. (15) Adults, can similarly develop such a belief. (14) The potential for retributive justice combined with identification with the aggressor, which is another way to deal with chronic feelings of helplessness, can lead to the perpetration of violent acts. Aggressive acts which counteract the lack of control and loss of meaning engendered by chronic exposure to violence are more likely to manifest under a banner of an ideology or cause which will legitimise violence. In contrast, adopting an ideology to comprehend the meaning of violent trauma can also enhance constructive acts for the benefit of others.

Impact on Identity

The sense of self is often shattered after torture and trauma. Self regard and the many beliefs and values which define “who one is” are questioned. Filipino psychology makes a useful distinction between different dimensions of the self which are altered as a result of torture. One dimension is that of ‘loob’, or the ‘within’ which consists of the person’s private thoughts, feelings, values and sense of wholeness and value. As a result of torture the person asks, “Am I still moral, am I still kind, am I still true to my ideal, have I failed, have I yielded?”. The other dimension is the self as seen by others, the shared self, or Kapwa. There are four reference groups - comrade, friend, spouse or partner and family and relatives. The question the survivor puts is, not only whether they can face themselves again, but how they will still be considered as comrade, friend, partner and relative. (16)

Identity can thus be destroyed, who one is and what one stands for are no longer the same. The loss of continuity with the self can be very profound.

One survivor, who had been in a concentration camp in Bosnia for three years was unable to connect his life before the war with the present. He felt that he had to begin again but did not know which direction he should take. All his previous expectations about the course his life would take were shattered and he could not remember how and why he had decided to come to Australia.

Cultural dislocation attendant to trauma compounds the effects of torture and trauma on the sense of the self and the sense of place in the world. Systems of meanings and values are radically overturned with a new language and a new cultural system. The level of distress engendered by such uprooting can produce a variety of effects - apathy, withdrawal, anger and self destructive behaviour.

The consequences of changes to core assumptions of human existence can be transmitted across generations. Children of survivors of the Holocaust have described the way a lack of trust in others is communicated continually to them by parents. Parents can also transfer feelings of meaningless and futility. On the other hand, values of integrity, commitment and ways to find the light amongst the darkness can also be transmitted.

2.2.4 Guilt and Shame

Guilt and shame are common consequences for the survivors of torture and trauma, and guilt is known to be associated with the maintenance of post traumatic anxiety. **Even when nothing could have been done to change a situation, people imagine that they should have been able to do something. This is preferable to facing sheer helplessness.**



SUMMARY OF EFFECTS OF GUILT AND SHAME

- ➔ *Preoccupation with feelings of having failed to do something more to avert traumatic events*
- ➔ *Use of fantasy to exact revenge and repair damage done during traumatic event*
- ➔ *Self-destructive behaviour*
- ➔ *Avoidance of others due to shame*
- ➔ *Experience of pleasure inhibited*
- ➔ *Self blame expressed as self-derogatory comments*

One of the most profound effects of guilt is that it can inhibit the experience of pleasure of any kind. This is another form of self-punishment to deal with painful feelings and can serve to expiate guilt. Survivor guilt can last for decades. A Holocaust survivor continued to look for his twin brother 50 years after the war, even though he “knew” his brother was dead. When describing the way he saw his brother return from daily medical experiments, progressively more debilitated until he died, he confessed with great distress that at the time he had been glad it wasn’t him who had been experimented on.

The torturer purposefully plans to put their victim in a situation whereby they transgress their own moral principles such as loyalty. Forcing the victim to witness atrocities committed against others is deliberately contrived to maximise not only the person’s fear but to force them into a position of having failed to protect loved ones or colleagues. As Herman writes “the sense of shame and defeat comes not merely from his failure to intercede but also from the realisation that his captors have usurped his inner life”. (2, p.84)

Shame shows itself as feelings of unworthiness, anxiety about self disclosure and embarrassment. It is also a response to feelings of inner weakness.

To control a sense of shame, contact with others is often avoided.

The person does not want to be seen because they have the feeling that others can “see through them”. This is the result of having had their personal boundaries invaded. Shame can also lead to aggression, whereby aggression towards others can disguise feelings of aggression towards oneself. Defiance is also a typical defence against shame.

Rape

Rape of men and women is a common form of torture and leads to deep shame. A study by Lunde (17) found that 53% of 135 torture survivors had been subjected to sexual torture. Associated with physical sexual torture is the torturer’s promise that the victim, whether male or female will no longer be able to have children or if offspring are produced they will be deformed. Insulting comments about sexual appeal and sexual preferences are also typical.

The prevalence of rape of women is not known because it is impossible for women to disclose a trauma which, for many, means permanent ostracism from their families and communities. Familiarity with the use of rape as a frequent form of torture needs to lead people working with female survivors to greater sensitivity.

Reports from Bosnia, where rape has been used systematically to destroy individuals and communities, indicate that women who were raped suffered shame and disgust of their bodies. The degree of violation was horrendous. The majority were raped by more than one person and on several occasions. Humiliating treatment, including degrading comments about their cultural group, was the norm. Many of these women also experienced or witnessed sexual torture, involving the insertion of objects into body openings. (18)

Shame reported by women is not only for themselves but for their families and communities. When the family’s honour depends on the chastity of



their daughters, rape means permanent condemnation. At the VFST, female clients who have been raped express feelings of self-disgust, say they feel dirty and commonly feel suicidal. Suicidal intent is especially prominent when women know they will not be able to prove their virginity when they marry. In the case of married women, they report that their marriages have broken down when their husbands found out about their rape. Many women became pregnant as a result of rape and face the traumatic decision about bearing and raising the child. (19) Reactions range from suicide to determination to rear the child.

Shame can manifest as eating disorders, mainly a failure to eat. Self care can be very poor in cases of women who have been raped because they feel so degraded and undeserving.

It is only in the context of a long-term counselling relationship, that male clients disclose their rape. The shame is very difficult to shed and sexual problems are long lasting.

A male survivor stated: 'I was at a gathering where I felt one of the men present "make eyes at me" and make a sexually inviting gesture. I remembered the torture situation where the tormentors forced a large bottle into my anus and said that I was no longer a man; then they laughed. I thought perhaps I had changed or maybe that was what I was supposed to feel. I was terribly uncertain. But I feel no sexual desire or attraction either toward men or women - I am sexually dead.'" (17)

Male survivors of sexual torture who have been raped can be prone to violence. Some express rage at the perpetrator, but usually the anger is generalised to others and can be expressed in the domestic situation. Their outbursts of rage or violence are usually regretted, perpetuating the sense of shame.

Physical injury from rape can be debilitating and is a constant reminder of the trauma. Unfortunately medical assistance is not usually sought for such injuries because of shame.

2.3 *Impact of Torture and Trauma on the Family and Impact on Settlement*

Understanding the way families and communities are affected by trauma is important, because it is the degree of integrity of these systems which largely influence the recovery of its members.

SUMMARY OF IMPACT OF TORTURE AND TRAUMA ON THE FAMILY

1. *Roles within the family and responsibilities are often dramatically altered.*
2. *Traumatised parents often have their capacity for emotionally supporting and protecting their children reduced.*
3. *Extreme disturbances in parents such as violence become new traumas for family members.*
4. *Financial difficulties and generational conflict produce extra burdens on all family members.*
5. *Traumatisation for the family continues with bad news from country of origin. People from the same country of origin can be perceived as a threat.*
6. *Dislocation from culture and tradition and the language barriers add enormous pressure.*
7. *Children are often taught not to trust anyone.*
8. *Guilt associated with leaving family behind disrupts emotional recovery for all family members.*



Often several members of a family have been victims of, or witnesses to, torture and trauma. The trauma experiences of the family change the family system and quality of care giving, profoundly influencing relationships in the family.

Many families are far from intact on arrival in Australia. Many young refugees in Australia may be unaccompanied. Some have been separated from their parents involuntarily due to the death or illness of those parents, or they have become lost. Other separations are voluntary, where the parent has entrusted the child in the care of another adult, or given up their parental rights, or consented to the child living apart.

Where the family unit does exist, the impact of torture and trauma interacts with the effects of settlement to bring about many changes in the family system.

1. Roles within the family are commonly drastically altered. For example, the father may no longer be the bread-winner. Patterns of responsibility shift. Children may carry the burden of communicating with institutions and service providers in the new country. They may also carry primary responsibility for caring for younger children and their parents.

Women arriving as sole parents face adjusting to new roles and carrying the responsibility of child rearing alone. In some situations they become the bread winner even if they have arrived with a husband. The loss of face and self esteem for the husband can lead to considerable tension and conflict because of the feelings of helplessness.

2. Parents may lose their protective and nurturing roles due to current dysfunctioning and due to parents' reduced capacity for intimacy. Parents who are traumatised may become aggressive, perpetuating a lack of safety. They may also become more authoritarian and restrictive (20). Surviving children may be neglected or over-protected particularly when parents are grieving over children who have died.

3. Extreme disturbances in family members in the form of suicidal behaviour and psychotic breakdown constitute new traumatic situations for the family. Violence can be a major problem. Anger toward perpetrators cannot be expressed. As a result, family members can be subjected to outbursts of violence and aggression by a person within the family in response to conflict and frustration.
4. Loss of employment, financial and social status add enormous burdens. Not only is there a struggle to provide material needs but the self esteem of parents suffers enormously with the loss of their previous role and family position.
5. The exposure to new values can produce generational conflict. Parents and children usually adapt to the new culture at different rates and to different extents. When children relinquish the values of the old culture, this compounds the sense of loss for parents.
6. In the majority of cases, refugees arriving in Australia were forced to leave their family members behind in what were often perilous conditions. Consequently, parents face renewed traumatisation when serious threats persist such as family members exposed to danger in the country of origin.
7. The sense of distrust of others can be directly conveyed to children and they may be taught not to trust anyone. Other expectations are also transmitted which may have long-lasting, even trans-generational effects. For example, children of Holocaust survivors report the pressure to compensate for loss of family members. They feel that they serve as “memorial candles”.
8. Secrets in the family such as circumstances surrounding loss can lead to fearful fantasies in children. (21)



2.4 *The Settlement Process and its Effect on the Trauma Reaction*

In the country of settlement many circumstances and encounters can maintain and exacerbate the trauma reaction, as shown in Figure 2.

As previously described, serious threats can persist, particularly when family members remain exposed to danger in the country of origin. Countries from which refugees come often continue to be war zones. For refugees, other significant family members and friends have been left behind. Anxiety about their welfare continues and maintains a sense of helplessness and powerlessness. Other refugees from the same culture can provide support but they can also remind the person of earlier trauma as well as represent an ongoing threat if they are perceived as being linked to perpetrators. An unfamiliar environment, and the disruptive effect of symptoms create anxiety about ever gaining control and engender great uncertainty about the future. The loss of language facility can also provoke fear. On the other hand acquisition of language enables control and self respect.

An East Timorese client spoke of the atmosphere of constraint and erosion of control in East Timor. Travelling required a pass and exposure to authorities. This could lead to capricious acts of violence. Having to obtain permission was a fundamental restraint and caused fear. In the same session she spoke of a recent incident at work where she had to pretend she understood her boss's instructions, delivered in English, and then looking stupid when she failed to do what was requested. Not being able to communicate triggered the fear of loss of control and led to compliance, failure and self degradation even though there was no external condemnation in this instance.

Disrupted attachments continue after arrival. Apart from family members who may have remained behind, dislocation from culture and tradition persists. Cultural beliefs are challenged as refugees settle in a new country and they are no longer part of the dominant culture. Consequently, the sense of belonging is seriously affected. Contact with refugees from the same country does not necessarily restore connections if they are viewed with suspicion or fear.

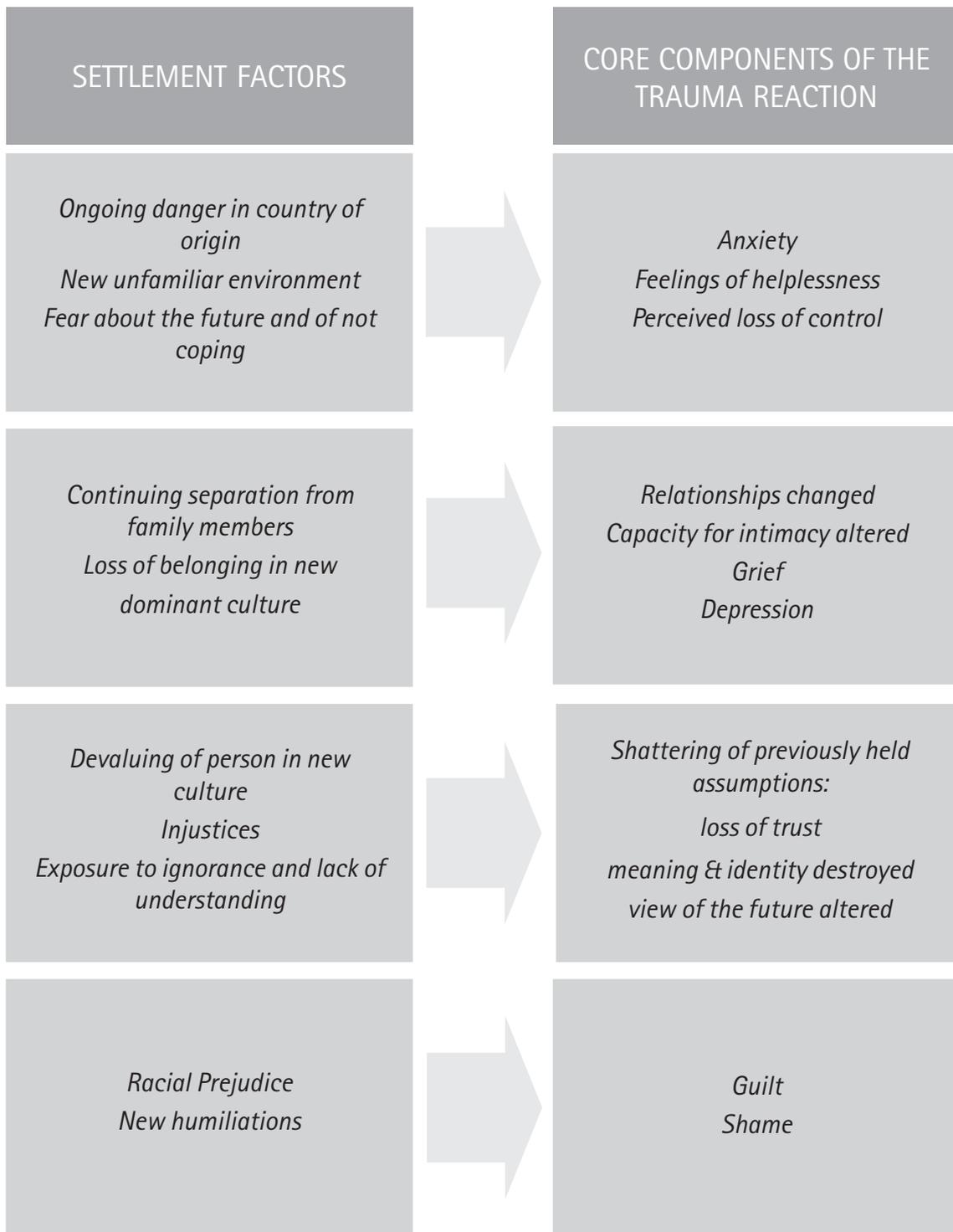


Figure 2

Factors in the Settlement Process which Exacerbate and Maintain the Trauma Reaction

The language barrier compounds social isolation. Even differences in non-verbal communication - gestures, intonation, ways of showing gratitude, approval or disapproval are part of the barrier which reduces the capacity of both the individual and the community to establish itself in a new social system. (22)

The possibility of a new life can restore a sense of purpose and meaning but exposure to encounters with people who have no or little understanding of their background maintains distrust and isolation. Injustice, or lack of awareness of human rights violations act as insults to values of human dignity. Refugees can be scapegoated for economic ills and asylum seekers in particular can be seen as unwelcome burdens on the community.

To appreciate the extent to which identity can be shattered as a result of dislocation, one has to think of all the things that are not normally even attended to, by people who have not experienced upheaval. "There are a lot of aspects of our identity which we take for granted. These form a substratum on which the more identifiable elements fit. This substratum consists of a great number of smaller elements which together form a coherent whole. These include the fact that we belong to a country; that our country exists; that we belong to a certain language group and are used to certain sounds; that we belong to a certain geographical landscape and milieu; that we are surrounded by particular types of architectural designs, etc. Ordinarily, we do not think about these elements because they are quite basic and we take them for granted. However, in their totality they form a background mosaic upon which the more tangible aspects of our identity are based." (23, p5)

Guilt and trauma are carried within but humiliations can persist with exposure to racial prejudice. The country of origin may be perceived as backward or uncivilised (21). Guilt can persist as a result of having left family members behind and can act to prevent a person from taking advantage of new opportunities. A successful step toward resettlement can be experienced as a betrayal of loyalty to family members left behind.

Many of these factors which exacerbate the trauma reaction coincide with the early stages of settlement but others occur later when the

individual and their family are exposed to new stresses such as loss of employment, ill health or a new life stage.

Refugees face the difficulty of migrants in general. There are many demands - to learn a new language and ways to communicate, to adjust to unfamiliar surroundings, to have secure accommodation, to adjust to a new educational system, to obtain employment, to bridge two cultures and to grieve for one's homeland.

Their experiences are different to that of the migrant in some important ways.

Refugees have been forced to leave their country, unlike the migrant who has chosen to leave and planned their departure.

Refugees flee their country because of war, prolonged periods of political repression and human rights violations which endanger the survival of individuals, families and often entire communities, and because of unsustainable hardships, such as lack of basic shelter and food. Their flight is born of necessity and it is often perilous.

Life in refugee camps is also characterised by lack of protection from violence, total dependence on camp authorities and extreme hardship. Trauma-inducing components can continue in the camp - threat to life, continued loss and separation from family members, devaluation as a human being and invasion of personal boundaries.

Refugees generally forego the possibility of returning to their country.

The conditions which led to forced migration can continue for years making return impossible. Some situations continue to deteriorate or are irretrievably altered with the permanent destruction of communities.

An Iranian woman maintained the hope that she would be able to return to her beloved country and be reunited with her family. When she learned of a colleague's detention she experienced profound grief with the realisation that she would never again see her homeland.



In countries where peace and political and human rights are restored, return is possible. Some refugees from Central and South America, for example, have returned to their countries of origin, years after their flight.

The tasks of resettlement which can traumatise refugees, are often minimised by the refugees themselves. Hoping to begin a new life and put the traumatic past behind them, they can be shocked by their lack of ability to cope. Some refugees blame themselves for their problems seeing themselves as failures. This further reinforces feelings of helplessness. Others throw themselves into adjusting to the new environment as quickly as possible and succeed in securing housing and employment with little assistance. This is extremely important for regaining feelings of control and basic security but it can make acceptance of problems, which emerge later on, very difficult.

2.2.4 *Asylum Seekers*

Asylum seekers apply for refugee status once they are in Australia. To be accepted they need to meet the U.N. Convention definition of a refugee (Chapter 1, page 7). Typically they have arrived on a visitor's visa or student visa. Asylum seekers face additional stresses to those of the refugee who has arrived in Australia with residency secured. While awaiting the determination of their refugee status, chronic anxiety and helplessness are maintained due to the ongoing threat of forced return.

The lack of control over their future security is marked and compounded by the growing perception conveyed in media reports that asylum seekers place an undue burden on national economies.

This perception is readily reinforced by changes in government policy in relation to asylum seekers. For example, it has recently been decided by the Australian Government that benefits for asylum seekers whose application for refugee status is rejected at the primary stage, be eliminated. Previously, benefits continued until the decision, was reviewed by the Refugee Review Tribunal. This change has meant that

the asylum seeker's capacity to survive day to day is virtually impossible without employment. The most basic form of security is threatened with such a policy change.

A decision to cut benefits can also cause trauma, because it is seen as a profoundly unjust act by a government which was previously perceived as humane. Even relatively minor acts of injustice can evoke and intensify feelings of futility and meaninglessness for the survivor of torture and trauma. The deprivation of rights to basic material assistance can certainly provoke a sense of despair and reinforce feelings of worthlessness.

Another major stress faced by asylum seekers who are survivors of torture and trauma is the sense of humiliation and shame evoked by feeling they are not believed when presenting their refugee claims. Their credibility can be questioned due to features of their persecution such as inconsistencies in their accounts, confusion, memory gaps and lack of feeling when describing horrific events. To the lay person, such characteristics suggests a lack of veracity about claims of persecution, but they are in fact typical consequences of torture and severe trauma.

The sense of loss can also intensify as the asylum seeker awaits processing of their refugee claim. Their status as a minority group in a culture radically different to their own, which questions their right to protection, heightens the impact of separation from family and friends. As critical as the loss of family and culture, is the loss of a sense of future, which is essential for sustaining interest in life.

The effects of settlement can therefore parallel those resulting from persecution. Although the degree of violation experienced in the country of origin is on a different scale to that which might be experienced in Australia, refugees are sensitised as a result of their trauma to new threats, loss, injustices and humiliation. Adults are likely to deal with renewed experiences of traumatisation by withdrawing further, due to fear and despair, or by becoming angry with systems and people in the new country. This anger can take the form of resistance to settlement and adjustment.



2.5 Conclusion

This chapter has considered the social and psychological impact of trauma which may result from the experience of torture and trauma.

The emphasis in this module has been on the difficulties caused by trauma because it is so vital not to neglect effects, some of which can be transmitted across generations. However it is equally important to appreciate the strengths of survivors.

In all but those who are destroyed by their experiences, there is a striving to live and renew a claim on the inviolable right to be valued as a human being. The next two chapters focus on the process of recovery and how it can best be facilitated by professionals working with individuals, families and communities.

Appendix 1

Criteria for Post Traumatic Stress Disorder (PTSD) (*Diagnostic Statistical Manual, APA, Edition 4*)

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others;

(2) the person's response involved intense fear, helplessness, or horror.

Note: In children, this may be expressed by disorganised behaviour.

B. The traumatic event is persistently re-experienced in at least one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed;

(2) recurrent distressing dreams of the event. **Note:** In children there may be frightening dreams without recognisable content;

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific re-enactment may occur;

(4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event;

(5) physiological re-activity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.



C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma;
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma;
- (3) inability to recall an important aspect of the trauma;
- (4) markedly diminished interest or participation in significant activities;
- (5) feeling of detachment or estrangement from others;
- (6) restricted range of affect (eg unable to have loving feelings);
- (7) sense of a foreshortened future (eg Does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep;
- (2) irritability or outbursts of anger;
- (3) difficulty concentrating;
- (4) hypervigilance;
- (5) exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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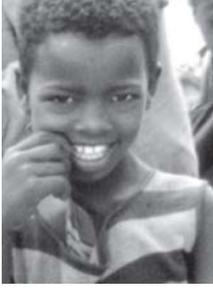
3

RECOVERY

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3

3



3

Recovery

Where trauma is prolonged and people suffer persistent disabling symptoms or are at risk of deterioration in their level of functioning, interventions are required to overcome the effects of trauma. These may vary in terms of being short, medium or long-term. Methods which are applicable for use in long-term approaches are not the focus of this guide but signs which indicate a need for referral and long-term work are presented. Interventions, both short and long-term, need to be applied at the individual, family, organisational and community level, whatever the discipline of the worker.

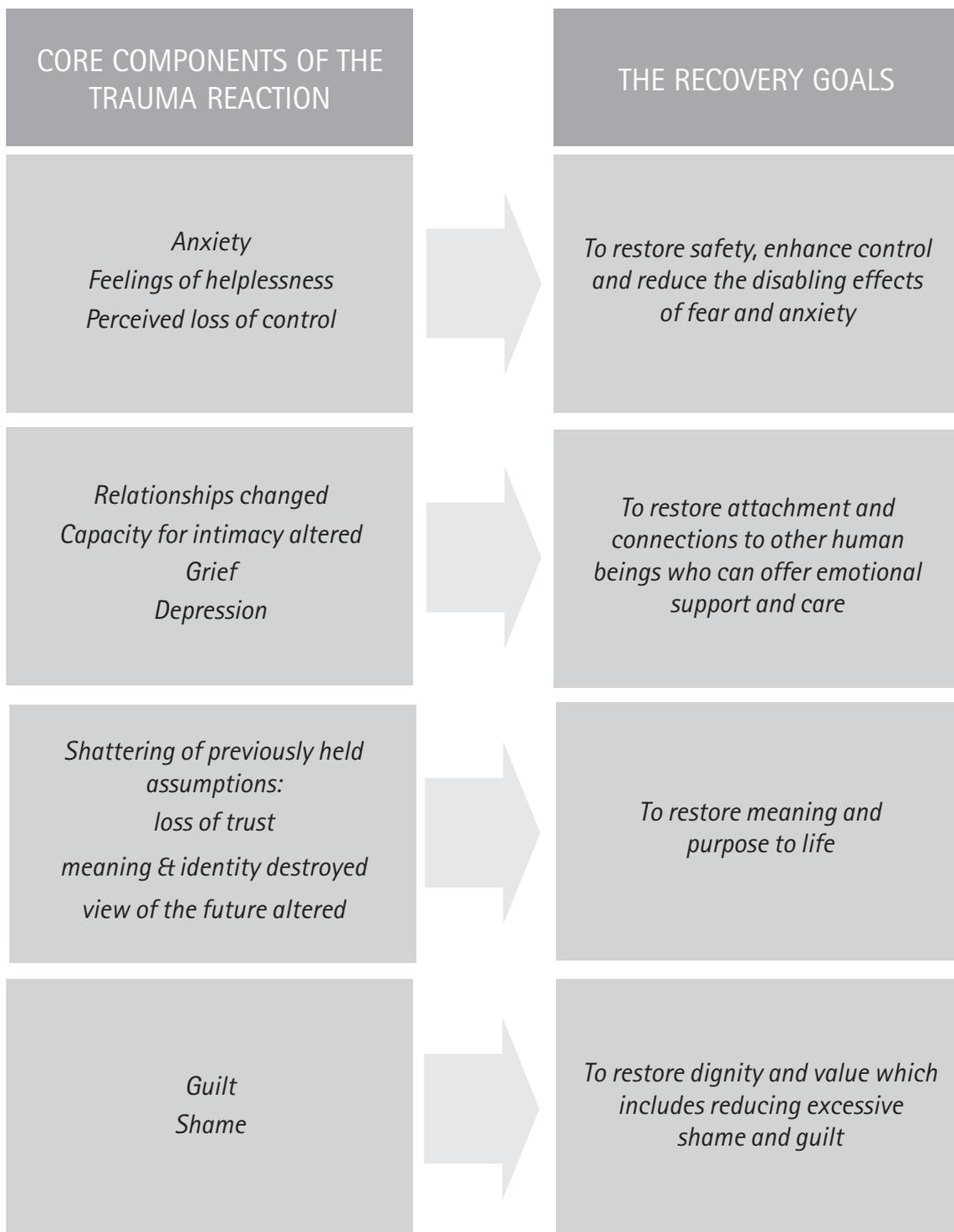


Figure 3
 The Four Recovery Goals

3.1 Recovery Goals

The goals of recovery and the aspects of the reaction to trauma they address are shown in Figure 3.

The following sections describe the way in which recovery goals can be achieved. Principles are outlined, rather than details of specific techniques. The degree of applicability to any one setting will of course vary.

3.1.1 Recovery Goal 1: Restoring Safety, Enhancing Control and Reducing Fear and Anxiety

Provision of Basic Needs – Health, Welfare, Education and Accommodation

A secure environment with adequate provision and access to health, welfare, education and accommodation are amongst the most basic rights of people. All refugees have been subject to deprivation in these areas and it is the worker's responsibility to facilitate access to these systems of care. Their availability is central to the experience of safety, predictability, protection and control and their resolution generates substantial therapeutic benefits.

Where people have been tortured, assistance with ensuring access to and availability of sensitive health care is vital. This usually requires accompanying the person to initial appointments. Invasive medical procedures can be expected to create enormous fear and often require the presence of a worker. The experience of torture will rarely be revealed, but it is important to be aware that avoidance of medical treatment situations, when accompanied by very high levels of anxiety, suggests a background of severe trauma. In such cases, a referral to a counsellor is necessary.



A young male client at the VFST was believed to be suffering from tuberculosis on the basis of a preliminary medical assessment. Making a conclusive diagnosis required an invasive medical procedure (bronchoscopy) which he refused to have. He had recently been tortured and was overcome by fear at the prospect of having the procedure conducted. With the client's permission, his counsellor informed the specialist of the situation and she accompanied him to the appointment. During the consultation she reassured him that he was safe, all steps of the procedures were carefully explained and he was given the option of terminating the investigation at any point. By maximising the young man's control over the situation and by providing comfort and reassurance, his anxiety was manageable and the investigation was successfully completed.

Identifying Causes of Anxiety and Accommodating the Effects

Anxiety is sometimes visible and is readily observed when a person is tense, restless, looks worried or fearful. More often, there are behaviours which, although observable, only suggest anxiety as a possible cause. They include poor concentration, memory difficulties, lack of participation, blank spells and incessant talking.

Anxiety can also be quite invisible. Psychosomatic symptoms such as headaches and stomach aches may not be accompanied by feelings of anxiety. In other cases, strong feelings of fear, worry and apprehension are experienced but are completely masked.

Causes of anxiety can lie in the past and in the present. Past traumatic experiences often lead to the spontaneous occurrence of memories and intrusive images of frightening events. Stimuli in the present environment can evoke fearful memories. Commonly, such stimuli include smells, sounds and sights, such as people in uniforms. Other stimuli, which act as triggers in this way, include people's behaviour such as an authoritarian manner. Feelings of failure can also remind a person of helplessness and associated terror.

Living in a new country also evokes anxiety. Continuing crises and war in the country of origin can cause enormous fear, as can stress related

to settlement and home life. Often a refugee in Australia has been separated from other family members who have been left behind in the midst of ongoing conflict. Constant images of this in the media can perpetuate the anxiety related to such issues. Messages and letters from family and friends still in perilous situations can also have this effect.

Most of the recently arrived refugees from Iraq have spent five years in the Rafha Camp. It is only once they have arrived in Australia that some of them have discovered that relatives have been executed or detained.

It is important to recognise that little can be done in most working contexts to alter causes. For example, it is very hard to do anything about causes when memories are spontaneously occurring. Also, little can be done to prevent certain triggers occurring because they are beyond one's control. But something can be done about likely and predictable triggers such as an authoritarian and harsh disciplinary manner. Sources of anxiety can be reduced when causes such as unrealistic expectations about performance are identified. Stresses related to settlement can also be effectively responded to, with the assistance of a worker.

A young woman from El Salvador was bewildered and distressed by her perceived failure to learn English. Initially, in counselling she did not see any link between her learning difficulties and the mass killing she had witnessed as a child. Once she was placed in a small class and tasks were specifically tailored to accommodate her difficulties, she began to make marked, albeit gradual progress.

The other way workers can make a difference is to accommodate the effects of anxiety by conveying realistic expectations about performance and the different ways in which anxiety is handled by the person. The worker needs to stay close to the person's method of coping and not attempt to alter it too quickly. For example, it is common for people to drink large amounts of coffee and smoke to ease tension. Developing alternative methods of coping can only be achieved gradually.



Restoring Safety

Restoring safety is crucial. It can be achieved in different ways and depends on the setting in which one works. In an adult school setting for example, strategies for providing safety include:

- providing a predictable environment
- explaining the purpose of activities
- setting realistic expectations for performance
- acknowledging and accommodating the blocks to learning
- creating opportunities to set individually appropriate goals which are attainable
- providing a quiet place as an alternative to the classroom
- providing information regarding common problems for recently arrived people.

Another important principle to apply in maximising safety is the gradual exposure to fear-inducing situations. If a person, for example, is afraid of being with other people, it is important to allow them to deal with social situations gradually. Other people are afraid of the learning situation, because failure is fear provoking. Carefully graduated tasks can reduce their fear. Taking risks and placing people in situations that are beyond the level at which they can cope, can be counter productive.

Providing Information

Information provision serves to **destigmatise psychological problems by educating people about the response to trauma**. This can be crucial in influencing the course of recovery. As Bettelheim described, one of the responses of survivors to prolonged horrific trauma, as was the case of World War II concentration camp survivors, was to make up for what was lost by struggling to be as they were before or to make a new start. (1) Survivors facing the stress of settlement discover that they are not as they were, but are depressed, unable to sleep and fearful of seemingly innocuous situations. If they are not prepared for this, the psychological symptoms are experienced as a personal weakness and failure. “Demoralisation” is a term used in the psychotherapy literature to describe how people feel when beset with a number of overwhelming

problems. It can prevent people from using their coping resources. Remoralisation can be achieved fairly quickly when people understand the causes of their difficulties. (2)

For refugees, providing information about the trauma reaction so that the symptoms themselves do not evoke excessive anxiety is invaluable. This allays fears of losing one's mind. Such fears are normally dealt with over time in a counselling context, but information can also be provided in settings where it is ideal to offer general orientation programs for the newly arrived. An example of information provided as part of an orientation program developed by the VFST for the newly arrived is appended (Appendix 2). The orientation program essentially aims to give newly arrived refugees who are survivors of torture and trauma, an understanding that their reactions, which may be disturbing to them are in fact normal reactions to abnormal events. The orientation program also aims to reduce the isolation of the newly arrived refugee who often imagines that they are the only ones experiencing difficulties.

Information also weakens the wall of denial which commonly surrounds the experience of trauma.

Parents, for example, find it difficult to face the fact that children are harmed by witnessing and experiencing violent events. The myth that they will naturally get over it is dominant. Unfortunately, without information to the contrary parents will usually ignore and try and distract children from feelings of sadness or fear when it is therapeutic to allow the expression of such reactions and provide emotional support.

Building coping strategies and promoting client's resources is also largely based on educational information.

In a counselling context, the provision of information serves goals other than promoting control. It can mobilise motivation to face difficult situations. The torturer tells the victim that "she/he will never regain normal reactions, ... never be able to read a book and remember what is in the book, never be able to have a normal sexual life again". (3, p.158) The torturer also conveys to his victim that they will never be able to explain their suffering and that no one will believe them.



By revealing that the perpetrator aims to produce the very symptoms they are suffering - fear, weakness and isolation, the person's desire to confront anxiety is enhanced.

Connecting Body and Mind

Describing the effects of anxiety on the body is useful. Simple explanations of the way the mind sends signals to the body to prepare it for danger are very helpful. This can be illustrated by using the example of a tiger suddenly coming into the room. The mind quickly sees the tiger as dangerous and as a threat to one's life. It sends signals to the body to prepare it for "fight or flight". Messages are sent to the heart so that it can beat faster, to the lungs so that breathing is faster, to the gastro-intestinal system so that it slows down and does not waste the body's energy. Muscles become more tense to prepare for fight or flight. It can be indicated to the person that the body reacts this way whenever the mind notices danger and danger can include any frightening situation or reminder of a frightening situation.

Relaxation exercises to deal with the effects on the body can easily be taught and enhance the sense of control over one's body. However, it is important to be aware that some people are too afraid to relax because traumatic memories may intrude. It is best to present relaxation techniques as something which might help the body to feel calmer rather than as something which will alleviate anxiety. Massage and other tactile therapies can also be extremely useful in this regard.

Reducing Pain

Chronic pain is one of the most common enduring effects of torture and trauma. It is the result of direct physical injury and it is also associated with the development of psychosomatic symptoms. Reducing pain is a powerful way of assisting survivors regain control over their bodies and diminish their sense of helplessness. Tactile therapies such as massage have been found to be very effective in reducing muscular pain and tension, relieving persistent headaches and more generally contributing to the well-being of clients who associate being touched with being violated.

Mr. B, a Sri Lankan client, presented at the Foundation suffering with severe physical pain. He was withdrawn and heavily burdened by his past experiences. During Mr. B's detention, he was subjected to persistent beatings, electrical shock and falanga (beating the soles of the feet). Mr. B stated that the pain from his torture was so great that he sometimes wished that they had killed him. Mr. B experienced back and neck pain, muscle tension, headaches and intermittent sharp pains in his feet. He felt emotionally withdrawn from his family and suffered with insomnia and nightmares. Mr. B described the pain in his feet as a "piercing pain that shoots up through my spine". He also described feeling "like I am not connected to my body".

A natural therapies assessment and discussion with Mr. B resulted in the establishment of a massage program. Over an eight month period, Mr. B received weekly treatment.

Due to Mr. B's severe muscular pain and his acute sensitivity, initial massage sessions were slow and gentle. This allowed for a gradual introduction to "therapeutic touch". Once trust was established, it was possible to work together for longer periods. Gradually Mr. B began to relax into the massage, allowing for the muscle tension to ease and for the pain to diminish. As a result of the relaxation he experienced, Mr. B slept better, had less nightmares and headaches.

Perhaps the most significant experience for Mr. B was the release he felt from having his feet gently massaged. The relief that this provided to a site of much pain and a constant reminder of his torture, had a dramatic affect on his ability to cope day to day. Relaxation massage was a powerful healing therapy for Mr. B on many levels, which he aptly summarised by stating "Now I feel more able to be touched and to touch my family." (4)

Disclosure of Traumatic Material

Talking about the traumatic event and/or working through it is essential in long-term counselling with severely traumatised people. **In settings outside of counselling, people may disclose traumatic material even without encouragement to do so. In dealing with such disclosures the following guidelines apply.**

1. Where disclosures occur, acknowledgment is sufficient.

Acknowledgment involves saying, for example, "That it is a terrible experience you have been through." It is tempting for a worker to 'undo' traumatic events and make up for what happened. One way to do this is by prematurely offering reassurances that things will be better. Experiences need validation first. If the worker listens and acknowledges feelings without judgement or striving to change the feeling, then the person disclosing is more likely to accept their feelings as understandable. This process contributes considerably to alleviating distress which is caused by survivors condemning themselves as abnormal or weak.

Safety has been discussed as a core condition for recovery. External conditions of safety are obviously important but internal safety is vital as well. It rests on the belief that emotions, including intense fear are normal and can be gradually overcome. If the worker acts to avoid knowing about psychic pain then the survivor will also believe that it should be avoided.

Fear can also be experienced by the survivor as proof that the self has been destroyed especially when it is experienced in seemingly innocuous situations. Fear can also restimulate a sense of shame and loss. The disclosure of fear is therefore a disclosure about the self at its most vulnerable, and a non-judgemental response is essential.

2. It is important to recognise that disclosure can alternate with numbing and denial and then it may not be possible to talk again about what happened or acknowledge painful feelings.

It is appropriate at such times to talk about current situations which may be causing difficulties such as learning a new language and making friends.

3. When intense emotion is expressed, the worker acts as a buffer against a person being overwhelmed and must act with offers of comfort and support.

This provides the opportunity for the person to learn that expression of emotions does not result in a complete loss of control. Should there be an emotional release with expressions of fear, offering comfort is important. Remind the person that they are in a safe place now, and that it is normal to feel afraid because fear can continue for a long time, even if things happened a while ago.

4. Not all aspects of a traumatic event or series of events are equally horrific when there is disclosure. The worst part of the experience can never be assumed and there needs to be sensitivity to the person's sense of what was most frightening or overwhelming for them.

For example, helplessness in the face of witnessing violence to others, is often particularly disturbing and more distressing than violence perpetrated against their physical person. Exploration of the worst experience cannot be undertaken outside of a counselling context and should not be probed for.

5. Closing a discussion when traumatic material has been expressed requires sensitivity.

It is difficult to leave a person after they have disclosed personally traumatic events. It is useful to remember at such times that the person has to carry the memory and legacy of their experiences every day and that their pain cannot be alleviated quickly. Nevertheless, it is important to explore with people if they need anything which you are in a position to assist them with.



3.1.2 *Recovery Goal 2: Restoring Attachment and Connections and Overcoming Grief and Loss*

“Traumatic stress changes multiple relationships - one’s relationship with oneself, with one’s closest relationships, with one’s community, with society at large and with God and the universe”. (5, p675)

As a worker, learning about and confronting the extensive loss experienced by refugees is a demanding process evoking many reactions - horror, despair, helplessness and anger. Consequently one of the most important things to realise when interacting with a survivor of trauma is that every encounter has the potential to promote the restoration of a meaningful connection with another human being.

Fostering Connections

Multiple sources of support can be fostered - amongst friends, the host community and in some cases, through the therapeutic relationship. Survivors have long known that one of the strongest ways of making reconnections is to assist others.

Arnold has described the way Cambodian refugees dealt with living for years in refugee camps after having experienced untold horror. “When you ask some how they survived eleven years in camps as well as having survived the Pol Pot years, they answer by saying that they help other people. Some people who have lost everything and everyone are still able to give themselves to helping others.” (6, p.97)

Writing and the expression of feelings is also a powerful way to reconnect with others. Words ultimately acknowledge the self while reaching others. M. Aidani captures the striving to touch others by the very act of speaking about feelings. “For most of my life I have wanted to stop adding to my own suffering, and to ease the suffering of others. I tell people that it doesn’t matter where one comes from as long as one strives for dignity and freedom to rid oneself of the abyss of repression one experiences in one’s life. Beneath the surface, many of us live in the darkness of pain and loneliness, simply because fear prevents us from letting our real feelings come out.” (7, p.15)

Programs which make social contact their central aim need to consider the multiple effects of trauma. It is normal for the survivor of torture and trauma to have difficulty forming relationships for a number of reasons. High levels of anxiety are often managed by reducing new input from the environment which can also include needing to avoid social stimulation. Relationships can also be avoided for fear of renewed loss. Distrust of others, suspiciousness, feelings of anger and shame all interfere with the capacity to be close to another person. To accommodate these effects, social contact should be structured so that there is room for withdrawal as well as opportunities for the gradual development of trust.

Restoring the integrity of the family is of paramount importance unless breakdown is irretrievable. Investigations and research have shown the critical benefits of family care in moderating the effects of trauma on children. Although children's development is very dependent on the continuing presence of a carer, close positive relationships of any kind, are very important in providing a sense of safety, restoring self esteem and a sense of belonging.

There are several ways in which connections can be fostered:

- **a trusting, continuing connection with an available caring adult**
- **group participation to reduce social isolation**
- **promoting belonging by assisting with problems of settlement**
- **linking with supportive groups, agencies**
- **reconstructing a valued purpose such as social/political action**
- **provision of information about role expectations, communication patterns in the dominant culture**
- **participation in training and educational programs.**



Grief

The degree of loss associated with torture and war-related trauma is immense and inextricably linked with the exposure to violence.

The consequences of loss and disconnection were previously described in Chapter 2, as leading to the grief reaction, changes in interpersonal relations and depression.

Recovery from grief is a long process, and a long grieving period of up to several years must be allowed for.

Resistance to Grieving

There are several reasons why people may resist grieving. Recognising them is important because it can be counterproductive to expect resolution of grief when they are operating.

1. Firstly, adults can resist being plunged into grief and sadness. This is in part due to a fear of being overwhelmed by intense emotions, but for some, such emotions represent a victory to the perpetrator and an admission of utter helplessness. (8)
2. Some survivors expect that grief can be resolved through revenge. Through retaliation against the perpetrator, the death of loved ones may no longer seem to have been in vain. However as Herman points out, repetitive revenge fantasies and plans can be a source of increased torment and degradation for the survivor when they conflict with values against violence. Some survivors do however resort to acts of revenge.

Herman believes that the survivor must come to terms with not being able to get even with the perpetrator, not by forsaking the quest for justice but joining with others at the societal level to make perpetrators accountable.

3. Remembrance of those who died and loyalty to their memories, inhibit the resolution of grief. In such cases, the pain of loss cannot be allowed to fade because this would be tantamount to betrayal.

4. The wish for compensation for loss, while understandable, may block mourning. The survivor cannot confront the loss and focuses instead on insisting that others make up for it. This can be expressed as impossible demands on workers to do more and more. Certainly, societal recognition is vital and survivors who work for such justice are successfully engaging in the resolution of resolving loss.

Mourning Rituals and Remembrance

Engaging in mourning rituals which are culturally appropriate is invaluable in contributing to the resolution of grief. Further, establishing a place or means to 'speak with' relatives and friends who have died is very helpful. For example, planting a tree to commemorate the dead can provide meaningful solace. Religious ceremonies performed by traditional healers and spiritual leaders to honour the death of loved ones is extremely helpful. For Cambodians it has been found that putting 'troubled spirits' to rest is of great benefit to them.

Mourning cannot occur without remembering and experiencing. It is only through the integration of previous loss that resolution can be achieved but it is this task which seems at times to be unachievable. The way in which torture and trauma survivors overcome loss is a relatively neglected area of documentation.

In reviewing the recovery of adult clients at the VFST, the persistence of depression in people who have experienced extensive losses, is striking.

A client in his mid-forties had suffered severe symptoms of PTSD after his arrival in Australia. Within a few months, with counselling these symptoms had abated. However he continued to describe feelings of hopelessness about the future. It was his sense of obligation to care for surviving members of his family which sustained him but he failed to recover an interest in living. He had been orphaned as a very young child as a result of World War II. Having rebuilt his life after that, he could not resolve the new losses experienced as a result of another war, 50 years later.



Dealing with Depression

The central belief underlying depression is that highly valued outcomes such as intimate relationships, having a meaningful place in the world or successful endeavour in any field of achievement have been lost and will never be attained. (9) Loss induces sadness, but depression is underpinned by the future projection of loss as irreversible. The continuing course of depression can only be changed with the renewed expectancy or perception that valued outcomes can be attained. There are several ways to foster such a perception.

- Creating a new goal which is valued and attainable in the host country. The conditions of exile can make this very difficult but survivors do invest in rebuilding their lives and that of their families. Many refugees highly value the absence of violent ethnic conflict in Australia and feel they have secured a safe future for their children.
- The perception of oneself as competent and strong reinforces the belief that striving will bear fruit. Enhancing self esteem is therefore vital in reducing the risk of depression. This can be accomplished by creating opportunities for achievement in work, educational, social and political domains. Access to health care is also vital. A sense of physical integrity contributes to a sense of integrity of the self.
- Perceived control over events is closely related to a sense of competence and fosters expectancies of valued outcomes. A sense of control over one's mind is necessary, and therefore reducing an individual's fear of going crazy not only moderates anxiety, as previously outlined, but reduces depression as well.
- Entitlement to valued outcomes, or in other words, the belief that one is deserving of them, is necessary for hope and a positive expectancy of the future. This is the very belief that is undermined as a result of the humiliating and degrading treatment suffered by survivors of torture and trauma. Therefore, restoring dignity and value is central to the alleviation of depression.
- A depressed mood maintains a negative view of self, the world and the future. Ways to lift mood include the experience of pleasure and

the experience of connectedness with others. Facilitating opportunities for fun and communication are therefore extremely important.

Fatima woke up feeling depressed having to escape her flat due to the noise of building going on outside. Not knowing what to do, she went to her Language Centre even though she did not normally attend on a Monday. Everyone was surprised to see her, and greeted her enthusiastically. She arrived at her counselling session with a sense of vitality not seen before. She was very pleased to have been so warmly welcomed at her English class.

A recently arrived family who had survived several years of war and detention heard that a famous singer from their country was touring. They found out the details of her performances, bought tickets and went to the dinner dance. It was very successful - they enjoyed it and met people they liked. They had not known such pleasure in Australia before, and their hopes were rekindled.



SUMMARY OF WAYS TO REDUCE DEPRESSION

- ➔ *Creating new goals which are valued and meaningful*
- ➔ *Enabling achievement by improved access to educational and employment opportunities*
- ➔ *Building self esteem*
- ➔ *Enhancing perceived control over events*
- ➔ *Restoring dignity and value in order to foster a sense of deservedness*
- ➔ *Creating opportunities for the experience of pleasure*
- ➔ *Fostering connections*

3.1.3 *Recovery Goal 3: Restoring Identity, Meaning and Purpose*

The restoration of meaning and purpose is the third core recovery goal, and is fundamental to survival beyond mere existence.

STRATEGIES TO RESTORE IDENTITY, MEANING AND PURPOSE

- ➔ *Promoting communication, reducing isolation and enhancing self esteem*
- ➔ *Creation of new opportunities to form a view of the future*
- ➔ *Exploring concepts of self, other and the community*
- ➔ *Validation of the trauma experienced*
- ➔ *Validation of profound cultural differences in values between country of origin and Australia*
- ➔ *Integrating past, present and future*
- ➔ *Knowledge of political background to violence*

Restoring a Sense of Future

Recovery requires the restoration of belief in the future, a belief which is often shattered after trauma.



One young client expressed how the war had changed his life from one of peace and safety to one of utter destruction. He said that he could not wake up in the morning and be confident that he would see the end of the day. This was despite the reasonably safe environment in which he now lived.

Traumatic events can leave a legacy of doom, an expectation that the survivor is destined to misfortune. This belief is often reinforced by the experience of settlement. Everything has to begin again - the attainment of financial security, employment, housing, social status, a meaningful place in the community, and the learning of language - the crucial tool in adjusting to a new environment.

The sense of displacement, exile and lost continuity with previous generations and traditions impairs the expectations of a positive future. When family members have been left behind in the country of origin, a future without them is usually unthinkable and a lot of effort is typically devoted by people to assist in the sponsoring of family members. This is a very difficult process because it is slow and the outcome is extremely uncertain. Where family reunion is the only source of hope, the person usually finds it very difficult to invest in anything else.

A female client who had been progressing well, arrived at her counselling session extremely distressed. She had received notice to leave her rental accommodation which had been very cheap. She knew that as a result of having to pay more rent she would not be able to send any money to her family who would starve without her support. As a result she could no longer see any future for herself.

Restoring Meaning

The restoration of meaning to life and the formation of a comprehensible picture of the world are core recovery processes.

Questions about the extent to which people recover meaning are still unanswered. At one extreme there is no recovery, "He who has been tortured remains tortured He who has suffered torment can no longer find his place in the world. Faith in humanity - cracked by the first slap across the face, then demolished by torture - can never be

recovered.” (Jean Amery, cited in (5)). Jean Amery did go on to commit suicide. Paul Celan, a poet who wrote of the “thousand darkneses” of the Holocaust, devoted himself and his writing to remembrance and truth. However, it seemed that he found no companion in his journey of survival and after he lost his closest correspondent and friend, he killed himself.

This is in contrast with Eli Wiesel who wrote “I know the paths of the soul, overgrown, often know only the night, without landscapes and yet I tell you: we’ll get out. The most glorious works of man are born of that night.” (5)

Bettelheim (1) describes three responses in the struggle to recover meaning amongst Holocaust survivors.

1. One group of survivors are indeed destroyed by their experiences because what gave life its meaning is gone - too many who have been close were murdered; what one did could not be forgiven; any new meaning would be as untrustworthy as the old.

Bettleheim points out that part of the tragedy in failing to find meaning lies in rebuilding too soon at a time of psychological and physical depletion when failure is inevitable.

2. Other survivors find meaning by aiming to rebuild - to be as one was before. Such survivors may do quite well as appearances go, but they are not building a new world view based on integrating their experiences. Instead, repression and denial are used to isolate their terrible experiences from consciousness.

Experiences are feared because they may shatter the fragile attempts to live as before. “If people deny meaning and impact to the most horrendous experiences, can they live again facing pain and joy”.

Where no new meaning is forged, survivors still attempt to cope but this does not necessarily represent an integration. Some cope by living through their children, by having others such as family



and community do things for them all the time, by having others prove that he or she was worthy to be saved, or by investing in proving that life is supremely unfair.

3. The third response is integration. This involves:
 - accepting that one has been traumatised;
 - seeing the potential for greater meaning in life by including what is the dark side of humanity;
 - serving the living as a way of honouring the dead; and
 - openness to a variety of experiences.

Restoration of meaning can occur through embracing an ideology. This can be for better or for worse. It is worse when sense also is made of the experience through dehumanisation and demonisation of enemies. (10) These processes, when cultivated, are the very basis for the training of perpetrators. Ideology can serve the survivor to cope, but at the risk of perpetuating violence. Religious fundamentalism (from which no religion is immune) and political ideology can portray revenge and death to enemies as a noble mission.

Some survivors find meaning through bearing witness to their experiences and by writing about them. This endeavour should be supported and encouraged where possible. Opportunities for other constructive activities such as socio-political action, leadership roles and community projects should also be fostered.

Opportunities should also be provided where possible to discuss racism, history, politics and moral dilemmas.

Part of the struggle for meaning entails answering questions about why one has survived whilst others have died. In a counselling context, survivors can be asked such questions and their system of meaning will emerge. For some, survival is God's will, for others, causes can lie in the deeds of ancestors and their spirits. It is in this area that awareness of different socio-cultural and religious realities amongst survivors and between worker and client is particularly important.

3.1.4 Recovery Goal 4: Restoring Dignity and Value

All the interventions described thus far contribute to restoring dignity and value. However, dealing with guilt and shame requires particular attention, without which recovery can be limited.

STRATEGIES TO REDUCE GUILT AND SHAME

- ➔ *Allow the expression of guilt and shame.*
- ➔ *Reflect to the person that it is a normal wish that they could have done more to have prevented others being harmed.*
- ➔ *Events and stories need to be told and retold to reduce guilt. Counselling is the appropriate setting for this.*
- ➔ *Assist with developing ways in which the person can actually do something to reduce guilt.*
- ➔ *Alleviating shame and guilt requires community acknowledgment of human rights violations and the need for redress.*

Acknowledging Guilt

Feeling guilty for having failed to do something in the face of brutality perpetrated by others, appears highly irrational. However, to take some responsibility for what happened, even if it results in painful self blame, is to retain some control. Therefore, it is usual for people who have experienced or witnessed violence, to blame themselves for a part of what happened, or blame themselves for having failed to do something which would have prevented harm coming to others.



Feelings of guilt are usually not disclosed directly. Should they be expressed, validation of the emotion is suggested rather than dismissal with a rational explanation of why they should not feel guilty. To illustrate, a suitable response would be “when something terrible has happened to someone, you think you could have done more to have stopped it”, or “you wish you could have done something to stop the things which happened”.

To inform the person that there is nothing they could have done is not helpful for overcoming guilt. They need to arrive at this conclusion themselves, after having thoroughly explored what did happen, the possible actions they could have taken and why they did not. This type of exploration is only possible in a long-term relationship such as that provided by counselling.

Guilt is especially difficult to resolve when members of the family have been left behind in the country of origin. This guilt can be mitigated if some form of ongoing contact is maintained where possible. Some means of restitution also needs to be found whereby the person feels that she or he is doing something to help the family left behind.

Recovery does not only involve expiation of personal guilt, but wide recognition of the trauma which has been experienced and appropriate retribution and justice. In countries like Argentina, impunity has been granted to perpetrators of torture through legal mechanisms such as laws and presidential rulings. It has been observed that such impunity reactivates anguish and symptoms. (11) Impunity which can lead to former perpetrators regaining positions of power is retraumatising because it is a profound injustice failing to redress the survivor’s experience of degradation. Further, impunity isolates the survivor as someone who cannot share their history and it also stimulates feelings about having suffered for nothing.

Conversely, the opportunity to give public testimony, as is the case with the Truth and Reconciliation Commission in South Africa, enables survivors to have their experiences acknowledged, breaking the wall of silence and allowing blame to be clearly assigned to the perpetrators.

Rape

Overcoming shame and guilt is a major focus in work with rape victims. A World War II report pointed to the importance of dealing with the guilt and shame of rape victims. "... the main problem which arises is ... the depth and usually unrecognised problem of guilt and shame in the individual. In other words, however unreasonable it sounds, the problem is to ... help the victims of such assaults to forgive themselves in relation to the very real but unreasonable sense of guilt which they possess over the incidents concerned ...". (12, p.166)

It can be difficult as a worker to accept the guilt and shame of a rape victim, but it is important to stay close to the experience of the victim and understand the meaning they have given to the event. Cultural factors deeply influence the meaning given to rape.

A young woman who as an adolescent was raped whilst in detention in Sri Lanka felt very strongly that she must have done something wrong for this to have happened. She would re-examine her life and find the causes for her rape in the mistakes she had made. It was only after many counselling sessions, that she saw her rape as a planned act by the military, to terrorise and eliminate a political party and that many women had been targeted for this purpose.

No assumptions can be made about the reaction of women and girls to rape. Thousands of women were raped in Bosnia in camps dedicated to sexual abuse. For many of them, rape has meant a life sentence of shame and disgrace and condemnation to isolation. This is particularly so for girls coming from traditional, religious and patriarchal families. Other women have felt less shame, seeing themselves as part of "thousands" who have been similarly victimised. (13) Tragically, although some women are better "protected" from the experience of shame than others, they suffer the enormous pain of having experienced and witnessed the ruthless and brutal rape of other women and girls, many of whom died as a result.

The denouncement and prosecution of rape as a war crime needs to be part of the response in assisting young women overcome their humiliation and ostracism.



An International Criminal Tribunal for the Former Yugoslavia has been established by the United Nations Security Council. Rape and sexual torture are being included in war crimes to be prosecuted.

The Tribunal can provide a platform for the telling of people's stories, so that there is a world-wide witnessing process for the victims "... However since the Tribunal is a criminal justice system, the stories of survivors may get buried in the concern for the rights of the accused. This is critical to the issues of women's (and children's) rights as human rights. Will there be a satisfactory vindication, affirmation of the suffering of the victim, and compensation provided?". (14) An affirmative answer to this question is unlikely and there is little evidence that the War Crimes Tribunal will provide more than some justice for a few survivors.

Confidentiality is a major issue for survivors of sexual assault. The sense of shame usually precludes disclosure and it will not occur unless the person is extremely sure of the worker's sensitivity and regard for protecting privacy. The person's fear of ostracism, fear of being permanently tainted, and feeling that others can see that they were raped by merely looking at them, need to be anticipated.

3.1.5 *Strategies to Deal with Anger*

Dealing with anger has not been conceptualised as a separate recovery goal, because it is a secondary reaction to the experience of anxiety, helplessness, loss, injustice and shame. Nevertheless it is a significant problem for many survivors. For some people, anger is suppressed because it is culturally unacceptable. This can create conflict and inner turmoil when feelings of anger are aroused. For other people, anger is expressed all too readily.

STRATEGIES TO DEAL WITH ANGER AND AGGRESSIVE BEHAVIOUR

- ➔ *Allow the experience of anger, recognising that it is a normal reaction to torture and trauma.*
- ➔ *Explore the causes of anger. Different causes will require different responses.*
- ➔ *Expect hostility to be attributed to you as a worker.*
- ➔ *Limits to aggressive behaviour need to be set and made explicit.*
- ➔ *Aggressive behaviour, which is perceived as legitimate, usually needs sustained long-term intervention.*

Allowing Aggressive Fantasies

Aggressive material can emerge in fantasies which represent wishes rather than fact or intent. For instance, revenge fantasies are very common. A poignant example is offered by Yuri who witnessed all the male members of his family being shot. He had revenge fantasies but quickly added after describing them, that he would not carry them out. It is therefore important to allow fantasies to be expressed as wishes. If for some reason you think somebody is at risk of being harmed, then this intent should be directly explored by asking the person about their plans. This should be done in a one-to-one setting.

If they have witnessed violence, people may be scared of their anger and poor impulse control, especially if they are entertaining revenge fantasies. To help here offer reassurance if you know it is the last thing a person would do.



Exploring the Causes of Anger

Making sense of anger as the appropriate emotional reaction to violation and injustice is important. If this is recognised, the person will be more motivated to express anger in a way which is not destructive to self and others.

Exploring the cause of anger toward others is to be encouraged. It can be achieved by asking what it was that the person did to make them angry. This can be followed by checking with the person if it really was a bad thing that was done to them. If they believe it was “really bad”, pursue an understanding of what was bad.

If they seem to recognise that they have over-reacted to a minor provocation ask if there is anything else which is making them angry. If so, then this is the issue to deal with.

For adults, their expression of anger can feel justified and appropriate, but violence or aggression is not regarded as legitimate. This often represents an attempt by adults to make others “see” what is really happening in the world. This pursuit of truth and its public acknowledgment can become a highly adaptive and meaningful purpose but can easily be misconstrued by others, when associated with an overly hostile attitude.

Aggression which is Legitimised

Some people readily interpret the behaviour of others as constituting a violation. A taunt, or a minor physical incursion is seen as an act of aggression and retaliation is regarded as legitimate. In such instances, when violent behaviour is perceived as legitimate, the task of assisting such people is a different one. Considerable time needs to be devoted to understanding the basis for the violence and challenging it as a strategy for dealing with conflict. This issue is not in any way peculiar to survivors of torture and trauma. It applies to any person who uses aggression to bolster self-esteem and overcome feelings of helplessness and lack of control.

Promoting Self Control

Poor control over aggressive impulses can occur for a number of reasons such as having seen people failing to control themselves and the desire for retaliation. The constant suppression of phenomena such as intrusive memories can produce tension and irritability and lower the threshold for the expression of anger.

Methods of self control can be taught. For example, self-statements can be developed to be used in situations where anger is aroused. Examples of self-statements to counter anger (these must be tailored to the individual) are:

“That was accidental, they didn’t mean to hurt me.”

“What might be another reason for their behaviour?”

“It doesn’t have to be an eye for an eye.”

“What else can I do when this happens?”

Beliefs Predisposing to Aggressive Behaviour

Beliefs which are deeply held and which increase the likelihood of aggressive and violent behaviour are listed below.

BELIEFS PREDISPOSING TO AGGRESSIVE BEHAVIOUR

- ➔ *Aggression and retaliation are the best way to respond to injustice, insults etc.*
- ➔ *Other people should know what it is like to be hurt*
- ➔ *Dominance over others is better than affiliation*
- ➔ *Victim suffering, victim retaliation and peer rejection do not matter*
- ➔ *Expectation that aggressive behaviour will produce tangible rewards*
- ➔ *Belief that others are hostile and deserve punishment.*



Such beliefs develop as a result of people, especially when young, having themselves been the victim of violence and brutality, but clearly only some respond in this way.

Common Defenses

When interacting with people who are angry, it is important to be prepared for the fact that sometimes everything you do is wrong in their eyes. Permitting their anger, while setting limits on unacceptable behaviour, is desirable. Workers become the object of psychological defenses such as projection, displacement and projective identification.

In projection, an inner feeling of badness or anger toward oneself is externalised and attributed to another. In this way, a person who projects hostility, experiences other people as angry or hostile, regardless of how they may actually behave.

Projective identification is a complex process whereby the person who is the recipient of the projected anger actually begins to feel bad or hostile. Therefore, the adult who feels angry when dealing with young people may be accepting an attribution of hostility coming from them. For example, a person who is unaware of their own anger may constantly provoke a parent and incite their anger. The other then feels angry, lashes out at the person who reacts with surprised indignation.

In displacement, anger is not directed to the violator but towards another person, to whom it is safer to direct the anger. As a result, family members are often the recipients of intense anger which was actually incited by someone outside the family. This can apply to workers and they may also be the recipients of displaced anger.

An understanding of these mechanisms can assist in more accurately interpreting people's behaviour and one's own reactions.

3.2 *Comparing Methods used in Counselling with those used in Non-counselling Contexts*

The principles of recovery in non-counselling and counselling settings are the same. Many of the specific strategies are similar including:

- information provision
- setting realistic goals which enhance control and the sense of achievement
- gradual exposure to feared situations
- overcoming settlement problems
- giving explanations of what you are doing and why
- reviewing progress and barriers to change
- providing a predictable and safe environment
- linking with supportive groups and agencies
- strengthening personal resources
- a respectful and accepting attitude
- facilitating coping and problem-solving skills
- encouraging opportunities for sharing and the experience of pleasure.

What is distinctive about counselling is that the counsellor has the opportunity to assess the specific causal determinants, both current and historical, of psychological problems, in order to implement specific strategies to overcome maladaptive behaviour patterns, reduce symptoms and emotional distress, and build coping and problem solving skills.

The quality of the relationship in counselling is critical to recovery as it is in all worker-client relationships. The advantage of a long-term professional relationship is that the worker can deal with fears concerning close relationships. The relationship develops into one where dependence on the counsellor can be quite pronounced. Although independence is the aim, dependence inevitably develops. Lack of trust, anger, disappointment emerge in the relationship and can be talked about.

The therapist's stance is one of "disinterest" and neutrality. Disinterest means the therapist should not use their power to gratify their own needs.



Neutral means that the therapist does not direct the client's decisions. (8) Herman points out that the therapist is not "morally neutral" but understands that recovery requires the restoration of justice.

As indicated earlier, intense fear can be evoked by the process. These fears are such that the therapeutic relationship may not be entered into or be periodically avoided. Therapists are frequently tested as a result.

Control is put in the hands of the client but this does not mean that one does not challenge the person or take responsibility when self-harm or harm to others is threatened.

Working through of traumatic material and overcoming guilt and shame can only be achieved in a counselling context. Telling of the past and family history before the trauma is encouraged. Not all difficulties are trauma related but are the result of relationships with parents, friends and community. Reclaiming and remembering the earlier history restores continuity and explaining the role of trauma in disrupting the life cycle of a person, family and community is also helpful.

Since 'working through' is a core part of counselling and is a process which is not well understood, the reader is referred to the description in the box below for more information.

Working through Traumatic Material

The essential nature of trauma as a response is that it is extremely distressing emotionally and “cognitively shocking”. By this it is meant that trauma always involves the confrontation with an experience or set of experiences which shakes existing beliefs, values and expectations, to the point where the changes confronting the person cannot be assimilated.

To reduce the distress and shock, it is generally accepted that the traumatic experience needs to be worked through, kneaded until a form or meaning emerges which can be accepted, or to continue the metaphor, digested and incorporated.

For individuals who re-experience traumatic memories and virtually relive the pain, the telling of the trauma may be crucially important in transforming vivid sensory based memory to a narrative based memory which produces less arousal. Normally our memories are a telling of what happened. What is distinctive about traumatic memory is that images and sensations (involving any of the senses) predominate and there is little linguistic elaboration. (8) Therefore one of the important therapeutic processes which relieves the pain of remembering is to elaborate on the experience with words.

So called therapeutic activities which encourage the re-experiencing without the telling seriously risk re-traumatizing the person. Nor is telling sufficient - its shocking nature needs to shift so that it is less so. This is at the core of therapeutic approaches which have been described and reported as effective in overcoming the trauma reaction.

There are various ways to think about the shift in meaning and how it occurs. Personal helplessness, and self-condemnation for such states as a sign of personal weakness and failure can change to a sense of strength and survival. The “unspeakable” and its sentence of isolation can change to the speakable and shareable. Personal guilt for having failed to resist can shift to shared obligation for fighting continued human rights violations.



Such changes rest on the person revealing enough of what he or she has been through in order to understand what overwhelmed them. The counsellor and the client both can too readily assume that they “know” what happened. Understanding requires continued openness to unexpected meanings. Interpretations, clarification, sensitivity to transference and countertransference responses and dealing with defenses all enable increased understanding and new meanings to emerge.

The opportunity to develop understanding lies in the exploration of the present as well as the past. Current situations and the reactions to them will include the legacy of past trauma.

Women survivors often report their distress about yelling at their children for misdemeanours they recognise as trivial. The nature of the provocation for such intense responses of anger seems at first puzzling, but it is very helpful and a great relief when they recognise that the source of their anger lies elsewhere - toward the perpetrator of previous violence to whom they cannot express anger.

Telling connects the past with the present and the imagined future. It is extremely important to allow people to speak of their past in all its vicissitudes and their relationship to the present, because in this way, the survivor can experience continuity in the most fundamental way - as having survived. Memories too, when recaptured, add to the experience of continuity.

The importance of client control is universally emphasised in the therapy of trauma survivors. Understanding, and clarification of patterns of behaviour and psychological defenses which would otherwise “fix” the trauma, lead to choice and control.

3.3 *Advocacy*

The fundamental goal of advocacy is to promote well-being and empower people so that their choices and capacities to produce change are maximised. The recovery goals for survivors of torture and trauma, presented earlier, also rest fundamentally on the importance of restoring control and choice. To respond adequately to the needs of torture and trauma survivors, improving client services and encouraging broader systemic responses are required. Advocacy must be client focused and driven by client needs as opposed to being driven primarily by the political ideology of the professional.

Advocacy is intrinsic to all of the strategies and processes described in this chapter. For example, providing physical health care to enable recovery from injuries and restore the integrity of the body is seen as essential to enabling a person to develop a sense of inner security and reduce anxiety. Access to ensure receipt of adequate health care usually involves considerable advocacy - at an individual level to alert a general practitioner to the special needs of a torture survivor and at a systemic level to ensure the provision of interpreting services and suitable assessment and diagnostic procedures for refugees. As a minority group within the community, advocacy can work to ensure that their needs are not marginalised.

In this module, the nature of advocacy at individual, organisational and structural levels is presented.

3.3.1 *Individual Advocacy*

Generally, the torture experience and sequelae will often inhibit the survivor from approaching and utilising many essential services. The role of the advocate is to ensure that individuals and families develop the skill and confidence to access and use these services themselves as well as enhance the sensitivity of service providers. At first, the person seeking support is usually quite dependent upon agency assistance. It is important in the long run to foster independence.



A client of the VFST was a young mother who was very anxious and grieving for the loss of her son who was killed during the war in Bosnia. She was 8 months pregnant and extremely worried about the imminent birth of her baby. Having recently arrived in Australia, it was critical to introduce her to the medical system in Australia so that she would know what to expect as well as inform the hospital of her situation. Assistance was also provided in regard to finding suitable accommodation. Relatively soon after the birth of the baby, she felt able to make appointments herself, felt comfortable doing so and was actively seeking suitable housing.

Another mother who was a VFST client had arrived in Australia under the Women at Risk program with three young children. The family was extremely isolated, knowing no one in Australia and one child was thought to be developmentally delayed. Advocacy involved linking the mother with a community-based women's group, assisting with the involvement of children in the local school and arranging an assessment with the specialist children's service and a paediatrician. Once the children were enrolled, the case-worker assisted with establishing a relationship between the teachers and mother so that further communication could take place directly between them.

Torture and trauma survivors have a wide range of needs. Because they are highly interrelated, co-ordinated assistance is required. The worker as advocate will in the majority of cases be central to this process or at least will act in a consultative capacity. The benefits of linking to a broad range of community and health agencies can be extensive, the most obvious of which is that survivors receive maximum assistance from the full range of expertise available. Also, contact with other agencies will serve to educate and sensitise these agencies to the needs of survivors of torture. Particular emphasis is given to linking individuals to resources within their home localities, so as to initiate and develop the personal and social networks available to them and promote independence. The role of the individual worker in exercising effective collaboration is obviously vital. But links also have to be reinforced at the inter-agency level. (15)

Characteristics of a good advocate include flexibility to deal with complex and unexpected situations which arise. Good interpersonal skills are needed for working with people in a casework context but also for

establishing and maintaining good working relationships with key people in community agencies.

Some agencies, such as the VFST, have counsellor-advocates who are involved in addressing a range of needs (intrapsychic and interpersonal as well as employment, housing, medical, legal, transport, child-care etc.) using a range of skills (listening, providing information, facilitating access etc.). In addition to the above skills, advocacy requires an awareness of needs which may not be expressed by clients, an understanding of internal and external causal factors, an understanding of the way systems work, skills in formal and informal negotiation, an ability to identify coalitions of common interests, and a clear choice of a target audience. Good advocates are committed to thinking strategically, anticipating alternatives and achieving results. They think in terms of systems that operate in any interaction and they understand the need to work in partnership with other services. Their outcome usually has a social change focus, rather than short term individual change.

The counsellor-advocate can be involved in a number of interventions which can cover a range of areas including:

- Casework (counselling and advocacy)
- Community education (seminars and courses)
- Publications and media (books, articles, print and audio-visual media)
- Policy formation (legal and political lobbying)
- Resource development (library etc.)
- Networking (shared projects and personnel)
- Lobbying government
- Support efforts of common empowerment
- Research to contribute to policy change. (16)

As an advocate, the worker must recognise and uphold certain client's rights:

- the right to be believed
- the right to be treated with dignity, respect, sensitivity and understanding
- the right to receive accurate information regarding the worker's responsibilities and constraints; the agency's role and function; the part played by social, medical and legal systems
- the right to control decision making
- the right to privacy and confidentiality. (17)



3.3.2 *Advocacy at the Organisational and Structural Level*

Advocacy at the organisational and structural level involves a wide range of activities and skills and embraces many goals. Organisationally, goals include ensuring a high quality service, promoting clients' rights, addressing issues of availability, access and relevance of needed services, supporting staff adequately, and community education and training. At a broader level, facilitating recovery for survivors of torture and trauma also requires a commitment to protecting human rights and a commitment to a level of service provision which addresses the needs of a sufficient number of people from culturally diverse backgrounds. Access to interpreters, prevention of human rights abuses, enhancing awareness of such abuses and challenging attitudes such as racism are critical goals for social advocacy. Influencing government policy, legislative reform and media reports are all important areas to influence and can fundamentally affect the recovery of torture and trauma survivors.

To promote a relationship between practice and policy, links are needed amongst policy makers, social planners, researchers, front line practitioners, and trauma survivors themselves. One important principle is, whenever possible, to establish the common ground and build on it. Many of those engaged in planning do not know enough about the experiences of clients and the delivery of services. On the other hand, clients and many of those who deliver services do not understand administrative or bureaucratic processes. Practitioners need to understand the moral, social, legal, and political relationships operating in a given situation and be familiar with the language of the prevailing political climate and be able to adjust to policy changes. The service provider essentially needs to be policy sensitive. Policy work in turn requires good ideas, careful planning, leadership, vision, diplomacy, healthy relationships with people of influence, and an ability to follow things through to completion. (16)

SUMMARY OF ADVOCACY GOALS



INDIVIDUAL LEVEL

- *promoting skills of clients so that they can use services themselves*
- *enhancing client's control over decisions and actions*
- *enabling access to services which pose barriers due to insensitivity or lack of interpreting services*
- *co-ordinating a plan of assistance amongst services*
- *linking individuals to local resources and support networks*



ORGANISATIONAL LEVEL

- *ensuring high quality service*
- *promoting client's rights*
- *addressing issues of access*
- *supporting staff adequately*
- *community/public education and training*
- *collaborative relationships with service providers*



SYSTEMIC LEVEL

- *commitment to protecting human rights*
- *challenging attitudes such as racism*
- *influencing government policy*
- *influencing legislative reform*



An example of systemic advocacy, which developed from VFST counsellor-advocates' direct experience with survivors of torture and trauma from the East Timorese community is presented in the box below.

East Timorese Asylum Seekers

Over the years the VFST has helped many people from East Timor to document their claims for refugee status. In 1995, assessments were undertaken by the VFST of 17 East Timorese people who arrived in Australia by boat and who were held in detention in Derby, Western Australia. All were released on the basis of recommendations made by the VFST which highlighted the negative impact on their psychological well being if they remained in detention.

The East Timorese people form a community which has experienced great suffering and persecution over the past 20 years. They reveal stories of unremitting brutality and persecution since the annexation of their country by the Indonesian Government in 1975. For those lucky enough to have escaped many have sought refuge and safety in Australia.

Changes in the government's policy towards this particular group of asylum seekers has taken a significant shift since undertaking the project in Western Australia. This shift reflects a growing concern on the part of successive Australian governments not to offend the Indonesian government by being overtly critical of human rights violations perpetrated by the Indonesian military.

As a consequence, legal opinions have been sought to provide Australia with a means of refusing to consider the East Timorese as refugees and thereby lessening any offence to the Indonesian government. The advice which applies to the vast majority of East Timorese people seeking asylum in Australia is that they have a prior right to citizenship and protection by Portugal according to the Portuguese law. Therefore there is no requirement of the Australian government to consider them as people in need of Australia's protection. This position is ironic when to all other intents and purposes Australia considers East Timor to have been an Indonesian province since 1975 and the East Timorese do not consider themselves to be Portuguese citizens.

Our concern for their position has been so great that the VFST produced a confidential report which analysed 50 cases of past and present East Timorese clients. The purpose of the report was to provide information to senior government ministers and officials about the experiences of East Timorese people who have sought the protection of the Australian Government. The content of the report is considered to be of relevance to the development and implementation of government policy, as much of the information was obtained primarily for therapeutic reasons and would not ordinarily be available to people not engaged in such a process. (18)

3.4 Integrating Recovery Processes

For conceptual reasons, recovery processes and ways to facilitate them have been discussed separately. In practice of course, many problems are addressed simultaneously. This is increasingly possible due to the co-ordinated approach to care which services are currently adopting. In this section a case is presented which highlights an integrated approach to facilitating recovery.

Case Example:

The following case example demonstrates the way a number of interventions were used to assist in the recovery of a couple who were survivors of torture and trauma.

A couple were referred to the VFST for urgent assistance due to the husband's violence towards his wife. He had experienced a long history of harassment, forced labour, torture and repeated violent assaults at the hands of the military but had remained, in his own words, strong. He became violent towards his wife after she was raped by government officials. Mrs. E., his wife suffered from intrusive memories of the rape but the main cause of her distress was the deterioration in what had once been a loving and close relationship.

At the first contact, it was assessed that the husband was not in control of his violent outbursts and that his wife and children were at risk. It was therefore arranged that they temporarily separate.

In the course of therapy, many improvements in their psychological state occurred. Initially, Mr. E. had blamed his wife for the rape and saw her as tainted. Gradually he came to see that the rape had not been his wife's fault and that his anger was the result of his feelings of extreme helplessness. He understood that in raping his wife, the government in power, whom he had always resisted, were perceived by him as finally victorious. His anger then shifted from his wife to anyone identified as belonging to the oppressive faction in his country of origin. This meant that his wife was no longer at risk but Mr. E. remained debilitated by his feelings of rage. He stayed at home because he feared he would harm anyone he identified as belonging to the same racial group as his persecutors. Mrs. E. remained distressed and depressed for some time



because even though she felt less physically threatened, her husband was very withdrawn and paid little attention to her or the children.

Mr. and Mrs. E. on numerous occasions indicated that their counselling sessions were sustaining them. They described feeling secure at the VFST and felt understood. No one in their own families had been told about what had happened to them and they felt that they could not rely on anyone. After many joint sessions which focussed on their relationship, positive changes slowly occurred. They noticed how easily they misunderstood each other and how readily they thought that the other no longer cared. Gradually they were able to trust each other again, trusting the counsellor's judgement that they could achieve this. The instilling of hope was vital. They felt annihilated by the actions of their government, which had spanned a generation, and the destruction of their relationship and a cohesive family life, had been the final blow.

Both their levels of depression fluctuated with their material circumstances. They and their children lived with relatives in overcrowded conditions. Assistance to find accommodation was considered an important goal. Once achieved, a therapeutic focus on the relationship was possible. Mr. E. and Mrs. E.'s moods would deteriorate with financial hardship. Mr. E. felt that the future was hopeless and that he was totally inadequate because he could not support his family. Mrs. E. became suicidal. I learnt at this stage that she had cared for all her younger siblings since she was a young girl, after her mother had been assaulted and her father imprisoned. She could not see any way of continuing in the face of what appeared to be an endless struggle.

Mr. E. further deteriorated when he accepted a casual job. The job had a devastating impact on his well-being. He was required to work 12 hours a day for \$2.75 an hour and he was abused with racial taunts.

Very little time passed without financial hardship. Any illness placed enormous strain on the family and they were repeatedly exposed to exploitation. Recently they were persuaded to purchase expensive goods which they did not need by a door to door salesperson. Apart from the financial burden, they felt ashamed about having failed to resist sales tactics.

Both Mr. and Mrs. E. have made considerable progress. The relationship is much improved and this has had beneficial effects on their mood. Mr. E. still avoids people but ventures out more than before. Mrs. E. with her increasing English language skills is looking for work and recently successfully protested the poor treatment she received at a government office. Mr. and Mrs. E. also seem able to better tolerate uncertainty about future employment.

Figure 4 shows the goals which are central to recovery. As described previously, each goal is formulated to respond to components of the trauma reaction. The strategies used in this case example are also summarised.

Table 3 *Recovery Goals and Strategies used in Case Example*

RECOVERY GOAL	STRATEGIES
1. RESTORING SAFETY, PREDICTABILITY AND CONTROL	<ul style="list-style-type: none"> ➤ assessment of risk of violence ➤ relationship with counsellor/advocate and the VFST ➤ advocacy for material assistance in the early stages ➤ provision of ongoing accurate information about employment possibilities ➤ assistance with referrals to sensitive medical practitioners ➤ counselling for controlling anger, elucidating the meaning of symptoms, working through traumatic events, setting realistic expectations
2. FOSTERING CONNECTIONS	<ul style="list-style-type: none"> ➤ therapeutic focus on the marital relationship ➤ trusting relationship with counsellor/advocate ➤ links fostered with church, childrens' schools and local community health centre ➤ attendance at VFST for small group English class
3. RESTORING PURPOSE AND MEANING	<ul style="list-style-type: none"> ➤ counselling enabled integrating the past and understanding its impact on the present and on expectations for the future
4. ENHANCING DIGNITY AND SELF RESPECT, REDUCING SHAME	<ul style="list-style-type: none"> ➤ warm, genuine and trusting relationship restored self-value ➤ understanding the rape as an act of oppression, and in their case the most powerful weapon to be used against them by the oppressive regime, reduced shame ➤ acknowledgment of plight countered perceived indifference and denial in host country to persecution

3.5 *Indications for Counselling and Making a Referral*

Many problems if they are persistent and interfere greatly with daily functioning cannot be dealt with without a referral for counselling.

Any of the symptoms described previously in Chapter 2 suggest the need for a referral to counselling if they are persistent. Some of the symptoms are listed below.

INDICATIONS FOR A REFERRAL

The following, where persistent, suggest the need for a referral:

- ➔ *uncontrolled or frequent crying or other extreme reactions to mildly stressful events*
- ➔ *sleep problems - too much or too little*
- ➔ *depression*
- ➔ *anxiety*
- ➔ *anger*
- ➔ *stress-related physical illness: headaches, stomach aches*
- ➔ *inability to forget traumatic scenes*
- ➔ *excessive ruminating or preoccupation with one idea*
- ➔ *blunting of emotions*
- ➔ *suicidal thoughts/plans*
- ➔ *extreme dependency and clinging*
- ➔ *nightmares*
- ➔ *excessive physiological startle*



INDICATIONS FOR A REFERRAL

The following, where persistent, strongly suggest the need for a referral:

- ➔ *Fear or threats of harm to self or others*
- ➔ *Extreme withdrawal, no emotional response*
- ➔ *Self destructive despair*
- ➔ *Marked agitation*
- ➔ *Frequent retelling of a traumatic event*
- ➔ *Uncontrolled activity*
- ➔ *Inability to care for oneself hygienically*
- ➔ *Marked irritability*
- ➔ *Fits of temper*
- ➔ *Auditory hallucinations (hearing voices)*
- ➔ *Bizarre, irrational beliefs*

In making a referral for counselling, the following guidelines are recommended. Although as a worker you may see the need for a referral, it may not be possible to achieve one for some time. Where it cannot be achieved immediately, plan future meetings to discuss the situation again.

Making a Referral

- Begin with saying what you have noticed in the way of a problem. For example “I have noticed you have been crying a lot” and this has led you to wonder if there are ongoing difficulties.
- Ask them if there is anything you can do to make things easier in the setting in which they are in.

- Let them know that it is not unusual for people to feel that way, particularly if they have experienced hardships and violence before coming to Australia.
- Ask if they have had any bad experiences prior to arrival or since arrival which they may not want to talk about but they think might be affecting them. (Do not ask questions such as “Have you been tortured?”)
- Check if they know where to go for physical/medical problems.
- Indicate that if they are having problems which are not physical but are problems to do with not being able to concentrate or worries, or sleeplessness, that they can also see a doctor about them.
- Tell them about the VFST or other appropriate services which deal with problems that have resulted from trauma due to war, civil violence, and political oppression. Then their interest in the VFST can be ascertained or their interest in other relevant services in their state or country (if outside Victoria or Australia).
- If they indicate that they have had such experiences but are not interested in pursuing help, you could give them the required information for self referral at a later date. Show acceptance of their refusal and indicate that they can talk about it with you any time later.
- If clients indicate that they do want help and a referral say that you could refer them, if they agree or they could refer themselves.
- Ask if there are any questions they would like to ask about your contact with them or any other agency such as the VFST. If none are asked, reassure about confidentiality and advise that there may be a waiting period.

The above inquiries should not be made unless there is some time available to do so and follow up with a referral if necessary. It is also important not to offer more than can be delivered.



If you are making a referral to the VFST or another agency, agree to inform the client when you have actually made the referral. Tell them the outcome, such as whether they have been placed on a waiting list and how they will be contacted.

3.6 Conclusion

The forces toward recovery lie within survivors, their families and communities. Resilience is the struggle to forge a new meaning and purpose to life, to confront constant reminders of fear and uncertainty, to live with loss, to fight for dignity of the self and others in the face of degradation and humiliation, to suffer boundless horror and yet uphold the sanctity of life.

In presenting ways to facilitate the process, it is important to emphasise that it is the survivors themselves who rebuild their lives and restore a sense of control and reconnection with others. There are many skills which a worker requires to enhance the recovery process - they are the focus of the next chapter.



Introduction to Psychological Health

The following is part of an information session which is delivered to people who have recently arrived in Australia under the Humanitarian Program. It outlines the effects of trauma which may be experienced by adults and children.

The Session

The settlement process of the refugee is different to that of a migrant. The migrant chooses to come, expects to improve their life and opportunities for their family. They bring belongings and they usually prepare a long time before their departure. They face unexpected difficulties too - the shock of differences between Australia and their country, being misunderstood even when they have learnt English, and missing family members left behind, friends and ways of life.

Introductory comments reflect country of origin experiences. Some examples are provided in the box below.

A. Origin: Rafha Camp

Many of you have been in a refugee camp for many years - the Rafha camp - where the situation has been described by those who have arrived as terrible.

- The conditions there have been very harsh.
- The guards have been described as brutal.
- People have been denied contact with their families for many years.

B. Origin: Former Yugoslavia

Everyone has come from a war situation and you have had different experiences.

- Some of you have recently been released from concentration camps.
- Some of you have come from refugee camps.
- You have faced very harsh conditions and experienced personal tragedies.
- You have witnessed many terrible things.

C. Origin: Horn of Africa

Everyone has come from a situation of war and longstanding hardship. You have had different experiences which have involved tragedies, often unspeakable. Reaching Australia has usually taken a very long time with much uncertainty.

- Many of you have lost family members and loved ones under traumatic circumstances. All of you will have lost your home, culture, language as it was spoken in your homeland, normal life's hopes, security, safety and jobs.
- Some of you will also have been in extremely frightening situations, perhaps for very long periods of time and felt powerless to do anything about it.
- Some people have also been the victims of and witnessed extreme acts of degradation and humiliation.



It is normal for such experiences to influence the way people feel and think for a long time afterwards. Sometimes the emotional state which results from such experiences can be debilitating.

In the Western world, it was observed during and after wars that soldiers suffered nightmares, relived memories of terrible things that had happened and were readily startled by any changes in their environment such as loud noises. Tragically, wars and political turmoil have affected men, women and children on a large scale in the past decades and we know that everybody can be affected in a similar way to soldiers in combat.

The effects on people of terrible events such as war have been observed for some time. We know that certain reactions are typical and you may have noticed and experienced some of these yourself, such as:

- difficulty concentrating and
- difficulty sleeping because of nightmares
- pictures and memories of terrible events may intrude into your mind, sometimes it feels as if the terrible event is happening again
- it is common to feel worried, fearful, helpless in situations which on the surface look safe, such as travelling
- feeling hopeless about the future is usual, having trouble even imagining the future is common
- some people suffer terrible feelings of guilt for something they feel they should have done.

Most of these experiences are very disturbing especially if they start suddenly, or if they go on for a long time when you are struggling to get used to a new country. It can seem overwhelming.

Many people fear that they are going crazy and fear that they will never be all right.

The experiences we have described are a normal reaction to shocking experiences and people gradually recover from these emotional states, but it does take time.

You may have had some of these experiences, felt better and then found that they got worse again unexpectedly. The stresses of settlement can bring back difficulties even if you are trying to forget. Settling in a new country is very difficult and people worry about housing, employment, money, learning English and continue to worry about their families at home. If you think about all these

things at once, it is too much, it can be overwhelming. It helps to look at things one at a time. Taking things slowly is difficult too because you are eager to feel better and get on with things.

The present is also affected by the future. It is a time when people anticipate a lot and it can be frightening because people are rarely confident of what they can do. When the future is blank, that can be frightening too because you need to see something ahead. Planning a little ahead, a bit at a time is useful.

Everybody is different - some people do not seem to feel anything, it is like a feeling of numbness. Others feel extremely sensitive to any change in the environment. You can also shift from periods of numbness to periods of sensitivity.

The mind like the body needs time to recover. Your beliefs, values, personality can be wounded just as the flesh can be wounded.

We have emphasised the importance of time. But time is not always enough. The passage of time may not be enough to reduce persistent feelings of fear or other experiences such as nightmares, disturbed sleep, feelings of hopelessness, poor concentration. If such experiences have been going on for a long time or for a short time but are intense, there are ways to overcome them with assistance. The purpose of the VFST is to provide such assistance. The sort of work we do is talking to people about their problems, discussing and planning ways to overcome them. We suggest that you see us if you have any concerns or questions about the experiences we have been talking about.



Effects on Children

This section is presented at another information session.

Most of you, if not all, will have seen terrible things. Your children will have too. Some children develop difficulties before and after arrival in Australia. You may have noticed that your child has

- more nightmares than usual
- is frightened in situations which in the past did not cause any difficulty such as mixing with people
- bedwetting
- changes in school work are common - problems at school can be understood as a difficulty with a new language, which is certainly true, but children can also have difficulties concentrating, be worried and sad although they do not talk about it.
- other children become naughty, rebellious, overactive and difficult to manage and they have not been like this before.

Myth of children's resilience

- It is commonly believed that children do not notice the things that adults do and if they have seen terrible things or been frightened, they will get over it quickly. We now know that this is not true. Men, women and children have been affected by war to an unprecedented degree in the last few decades and this has led to a lot of knowledge about how war and atrocities affect young people as well as adults.
- We now know that children do not get over difficult experiences without help and support from their parents.
- Their young age can make things harder, because children develop false ideas about why things happen. For example we know that children think it is their fault when something goes wrong. A little boy in Sudan was present when his sister died. She had swallowed some medicine in a food drop over a refugee camp. He believed he should have been able to save her even though there is nothing he could have done. He carried this idea for a long time blaming himself and he was very sad but did not show it. He also became very upset if anyone criticised him. He was afraid of doing anything wrong and became very cautious in his behaviour.
- Children also notice if their parents are troubled and worry if their parents are sick. They may try very hard to fix things.



Fear

Children need to know they are safe. When people come to Australia, it seems as if they are safe - and they are from active persecution. However, memories come with you and everyday situations can remind you of something frightening that has happened in the past although on the surface it is harmless. A teacher told me how she noticed one of her 5 year old pupils crouching when he crossed the road with a group of children. When we got to know the child and the family better, we learned that in his country in Africa it was dangerous to cross an open space because you were at risk of getting shot.

Another little girl we saw used to only sleep under the window because she was afraid that bullets would come in through the windows at night and kill her. She had not told her parents why she had to sleep under the window and they somewhat naturally thought she was being stubborn about where she had to sleep.

Their worries may seem silly but it is useful to find out what they are, say that it is natural to be worried when you arrive in a new country, scary things have happened but they are safe now.

Sadness and Grief

Some children are very sad but they do not show their sadness like the little boy I spoke about. It shows in other ways. They may be withdrawn or forgetful - even about very simple things. Some children do not seem to enjoy anything even when they are doing something you would expect them to like.

Some children cry but others do not. Like adults, they can be frightened of being overcome by strong feelings and they become good at keeping things in. They usually do not know that they are keeping things in, because the mind will automatically protect a person from experiencing too much pain at times. So the sadness does not show but the other things I mentioned - withdrawal, loss of interest, also bad behaviour can be a sign of sadness.

If a child is separated from someone they love such as a grandparent or relatives who used to care for them, they will feel grief and miss that person. It is very helpful to tell a child it is all right to feel sad or ask them if they are missing somebody when you guess that they are sad. If people are back home, letters and other ways to keep a connection are important for a child or young person.

Learning difficulties

Learning difficulties are very common and often parents do not know about this. For example: a child we know used to memorise everything so he would have an answer for his teacher's questions.

There are lots of reasons the school situation can be difficult for a newly arrived person:

- the setting is unfamiliar, the classroom is full of strangers
- no language and feeling foolish
- new customs and habits. One difference that many people have commented on is the different level of discipline and amount of homework given. The system here has been described as slack. You will find that learning is very highly valued here too but the methods of teaching can be different.

Every new person to this country who goes to classes faces this and there are special difficulties if you have come from a situation of trauma:

- if you don't sleep you can't concentrate
- if you are worried you can't concentrate
- if you are sad you can't concentrate

This can happen even if the thing you most want to do is concentrate and learn.

Children as well as adults don't like to fail but it is hard to achieve and do well if you can't concentrate or can't remember things.

Someone in the class may frighten a child because they remind them of someone who frightened them in the past.

In adult classes, someone may anger you. It is easy to feel very sensitive about something unfair. It can remind you of injustice - something adolescents have antenna for. Usually there will always be something unfair which will occur in classroom or school situations.

As an adult you can adjust your goals for the situation you are in. For a child it is helpful to tell them that you expect it to be hard and that they will learn in time. You can ask to speak to a teacher if you think your child needs special help. A teacher may ask to speak to you and offer their help.

Invite questions here.

What to do

It is important not to give you lots of information all at once but I want to say that there are several things you can do if you suspect your child is troubled by their experiences.

1. If you notice behaviour which is new for them, ask them if they are worried about anything. Some children may not complain of anything but maybe you can guess.
2. Listen and believe what they say even if it seems foolish. When children can talk about feelings, express their fantasies, it enables them to master the feelings.
3. Offer your help - to come to you if they are very worried or sad or angry. Tell them it is normal to have such feelings in a new place after so many changes and bad things.
4. Ask them what they think would make it better and see what you can do about it. Understanding is usually enough. Many children ask for toys and things that other children have. This is natural and it can also mean they want emotional support.

What to do (for written handout only)

- check that children feel safe (at home, school)
- support them
- accept their emotions as valid, such as fear in seemingly harmless situations
- spend time, if you can, talking to them about school, new friends
- minimise unnecessary separation
- let them know you are all right and that it takes time to settle, especially after changes.



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4

WORKER SKILLS

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4

Worker Skills

In any professional context, many skills are needed. When working with survivors of torture and trauma, the quality of the relationship is paramount, along with the capacity to understand and listen, in the broadest sense, to what is being communicated. As a worker, one is exposed to trauma vicariously and affected by it. However, emotional reactions can enhance the quality of work if they are understood.

Characteristically, there is a constant tension between over-involvement and under-involvement. If not constructively dealt with, one of two extreme positions is adopted. The worker may take excessive responsibility for another person, promising more than can be delivered, or they do not take nearly enough responsibility, leading to neglect and denial of people's needs. Both attitudes represent a failure to respect and understand what the survivor of torture and trauma faces.

Understanding one's emotional reactions is therefore critical to acting in the best interests of the client and maintaining emotional well-being as a worker. This chapter looks at the skills required for establishing a quality relationship, working cross-culturally and dealing with emotional reactions.

4.1 *The Relationship between the Worker and the Client*

4.1.1 *Establishing the Relationship*

The quality of the relationship with a survivor of trauma is the foundation upon which the effectiveness of any intervention rests. A consistent predictable relationship where the worker is caring, genuine and warm provides the basis for allowing the person's sense of security, value and trust in others to grow.

Whether contact is brief or long, genuine interest in the well-being of the person conveys respect and helps restore dignity. Encountering an adult who offers assistance and seems to understand their feelings can rekindle a belief in the capacity of people to be caring and sincere.

4.1.2 *Fear of the Relationship*

The client's reaction to the worker can range from one of caution and suspicion to one of clinging and extreme dependency. Caution is often necessary as a self-protective mechanism because intense fear is evoked by the prospect of a new attachment. Renewed loss and rejection are feared. The person may also fear being overwhelmed by distressing emotions, if longing for people resurfaces.

With the self disclosure of painful, shameful and guilt-ridden experience, some level of dependence inevitably develops. Dependence and trust can alternate with distrust, anger and disappointment. Closeness is often followed by distance and failure to attend appointments. The capacity for the worker to tolerate such changes, understand them and discuss why they are occurring is necessary. (1)

4.1.3 *Communicating the Capacity to Understand*

Saying what your role is as a worker, explaining the purpose of your contact and indicating your availability are vital. Letting the person know that you have worked with others who have experienced terrible events and had to settle in a new country, conveys your capacity to understand and not be hurt by what they may choose to reveal.

4.1.4 *Validating rather than Dismissing Emotions*

Central to the counselling process is the exploration of emotions and their meaning, so that they can be assimilated and controlled when excessively intense. In most settings where extensive exploration and working through are not possible, it is nevertheless extremely valuable not to stifle the expression of emotions.

Expression of emotions is commonly avoided for fear that the feelings will get out of control. This is a fear for both the person and the worker. Where sadness, anxiety, anger and shame are persistent and intense and cannot be managed by the person, consultation with the family and/or counselling are required. Otherwise, emotional expression provides relief, and opportunities to express feelings through story-telling, art, drama and other special activities are to be encouraged.

4.1.5 *Availability and Predictability*

It is the responsibility of the worker to convey the nature of their availability and not promise more than can be delivered. In any context, the worker needs to be clear about the period of time that they will be available to a person. It is harmful to begin a process, which engages a person's trust, and then end it prematurely. Periods of separation which occur due to planned absences, such as leave, are important to prepare for. Explaining the effects of separation communicates to the person that their welfare is important.



4.1.6 *Maximising Control and Setting Limits*

Whatever the context, allowing the person as much control as possible in the relationship is important. They should be able to say as little as they like, have a role in saying how much contact they want, and importantly, they need to have control over the depth of the relationship. However, maximising their control, whilst setting appropriate limits on behaviour such as coming late or missing appointments, is delicate. Be explicit about the expectations you have, give reasons for them and ask the person you are seeing for their response to your expectations.

Where expectations are different, they need to be discussed so that fundamental agreement can be reached. A person may want far more contact than the worker can provide. The reasons may sometimes be readily understood - the person is isolated and afraid of being overwhelmed by anxiety due to memories of traumatic experiences. At such times, it is important to acknowledge the person's needs and look at ways in which they could get additional support.

4.1.7 *Dealing with Devaluation and Idealisation*

Due to the effect of torture and trauma experiences on relationships, it is not unusual for the worker to be perceived in an idealised way, as a saviour, or devalued as completely unhelpful. It is important not to take such reactions personally, although examination of how one's behaviour may have contributed to the emotions aroused, is important.

It is only in a counselling context that it is possible to explore emotional reactions in depth. In other settings, it is most appropriate to deal with feelings by acknowledging them. For example, a worker might say when faced with a client who is saying that the worker is of no use: "It would seem that I can do little of any use to you, when you are facing so many problems, that can't be solved quickly enough".

4.1.8 Active Listening

Good active listening, which is fundamental to a good working relationship, refers to understanding and suspension of judgement/evaluation of what is being said. Certain conditions are required - appropriate availability of time, place and space. Active listening does not mean offering answers, advice, solutions or assistance.

It requires **reflecting** what is being said, asking for **clarification** and giving back your understanding of what is being conveyed.

Consider a question from a client such as, "Do you keep a file about me?" You may understand it to mean, "I'm worried about others knowing that I'm here" or "Can I trust you?". Your interpretation will lead to very different responses. If you want to be confident that you have understood, ask another question such as "What is your concern about records being kept?". The notion of using questions to find out more seems obvious, but often workers think that they should be able to just know or guess what is on someone's mind.

In asking questions, the person must be permitted to not reveal any more than they choose to.

Clarification is aided by asking yourself, "What is the other person saying?". This also requires not only paying attention to someone's words but also noticing non-verbal behaviour such as facial expression, tone of voice, bodily movements and the emotional quality of what is said. Overly attending to what is said can be quite misleading and does not necessarily indicate what someone means.

The value of being listened to is not usually expressed directly by people, and the following example is rare.

"In talking to you, I feel that someone knows, that someone else has been with me. I feel lighter. Now I understand why I miss my family so much, because no one has spoken to me like this since I arrived in Australia."

4.1.9 *Gender Sensitivity*

The gender of the worker is an important factor influencing a person's perception of the worker's trustworthiness and capability to be genuinely supportive. In some situations though, gender is not the paramount issue for the person compared with the ethnic or political background of the worker.

In a counselling setting, the person should be given the choice of a male or female worker. In other settings, this may not be possible. Nevertheless, it is important to be aware that a person's reluctance to trust a worker could be the result of them having been sexually assaulted and this needs to be allowed for. Having recognised this potential barrier, the principles for forming a quality relationship apply. However, where there has been a history of sexual assault, gender is a critical consideration. Both males and females can be victims of sexual assault, although the majority are females. In virtually all reported cases, males are the perpetrators.

Generally, women who have been victims of sexual assaults avoid men out of fear. However, other women, especially those who are homeless, may become involved in relationships with men out of a need to avoid isolation. These relationships can be characterised by violence and other forms of abuse. Women in this situation have eventually revealed to their counsellors at the VFST that this is the only type of relationship they deserve. Their deep sense of self-hate, as a result of earlier rape, lies behind this predicament.

Gender-based considerations are also vital in the domain of service provision. Refugee women often have a reduced capacity to access support. It has already been mentioned that because of fears of ostracism, women are unlikely to disclose experiences of sexual assault.

4.1.10 *Respecting Confidentiality*

In terms of confidentiality, it is important to understand that refugees are effectively in exile, and have been forced to leave family and friends behind. This is, in fact, one way that the oppressing regime still manages to exercise influence and control over the survivor's life, a consequence that many survivors of torture are very conscious of. Naturally these factors will make survivors of torture very concerned about who hears their stories. Such fears are not unfounded. It is a fact that some foreign embassies are active in their pursuit of information and people who are critical of their government policies. (2)

Recognising the need for confidentiality, and its special importance to survivors of torture and trauma, can lead to 'promises' of confidentiality which cannot be kept, given the requirements of most services for some information. In order to avoid breaches of confidentiality which are damaging to trust, it is advisable to inform people of what their rights are in this respect. This is a significant issue for service providers who have case conferences, and it is a matter for agency policy to formulate clear guidelines.

Offering absolute confidentiality is rarely possible and it should not be given in circumstances where a person might harm themselves or others.

CHARACTERISTICS OF A GOOD WORKING RELATIONSHIP

- ➔ *Consistency and predictability of the relationship*
- ➔ *The worker shows a caring attitude, genuineness and warmth*
- ➔ *Accepting fluctuations in the person's behaviour which may include caution, suspicion, clingingness, dependency, 'testing' the worker, and anger*
- ➔ *Conveying knowledge of the refugee experience*
- ➔ *Preparing for separations*
- ➔ *Maximising the person's control in the relationship*
- ➔ *Limit setting*
- ➔ *Ability to listen*
- ➔ *Gender sensitivity*
- ➔ *Respecting confidentiality*

4.2 Cross Cultural Skills

Refugees represent a diverse range of ethnic, cultural and religious backgrounds. They also hold minority status within Australian society. Cross cultural skills refers to the skills required to work effectively and appropriately within a culturally diverse society including an awareness of the needs and issues which affect minority and disadvantaged groups.

The concept of cultural appropriateness is based on a recognition that there are differences in world-view, values, philosophies and experience between a helping professional and client which may impact on the effectiveness of the intervention. It is central to good cross cultural practice, that assessments of clients' problems and interventions take relevant cultural variables into account. When this is not the case, biased and ineffective responses occur, leading to negative outcomes.

A cross-culturally skilled practitioner recognises that an individual:

1. Shares with others universal experiences and needs as human beings. All life involves joy, pain and interaction with others. People experience a range of emotions in response to events but the emotional response to trauma is universal. Grieving is a universal response to loss and fear is a universal response to threat. Unless universality is recognised, one can be overly timid in approaching and communicating with others.
2. The way events are viewed depends upon cultural factors which include language, history, the nature of causal explanations, ways of knowing, and the place of religion and spirituality. The way problems are conceptualised and dealt with also varies across cultures. Cultural factors interact with what are commonly termed social factors - class, education, social status, rural or urban background - to influence responses.

3. The influence of culture is mediated by factors that are unique to each individual. Some examples of individual mediating variables are age, personality traits, genetic inheritance, and level of acculturation, that is, experience, knowledge of, and level of acceptance of the dominant culture in Australia.

“Cultural reality” is a useful term to use rather than “culture” alone or “cultural background” because it denotes that culture is a meaning system or frame for viewing the world, influenced by many factors which range from the universal, to the individual. Important aspects of a person’s cultural reality to consider when working with people towards recovery are:

- the person’s knowledge of Australian systems
- their causal explanations for events
- the meaning of healing
- the interpretation of emotional and physical distress and associated symptoms
- help-seeking behaviour.

Basically, few assumptions can be made about another person’s cultural reality and it needs to be discovered. Active exploration of differences can also overcome stereotyping. (3)

4.2.1 *The Person’s Knowledge of Australian Practices*

The sheer unfamiliarity with customs and services in Australia can provoke high levels of anxiety for the client and frustration for the worker if unrecognised.

Many medical procedures are completely alien. Knowledge of country of origin health practices are extremely useful in avoiding misunderstandings.

A client needed to have a gastroscopy but could not accept the procedure as a helpful one. When he saw the doctor in his apron, he thought he looked like a butcher and wanted to leave. He finally agreed to the procedure but when he awoke after the anaesthetic and the investigation, he could not accept that he had had the procedure after all.

A counsellor did not understand why her client was failing to go for pathology tests despite his good relationship with his doctor. After thoughtful questioning, it was discovered that it was customary not to give blood in East Timor because it was believed to seriously weaken the body. Even if small amounts of blood were given, the body needed to be replenished with specific nutrients, and they could not be afforded in Australia.

In Bosnia, specialists are routinely and directly consulted for gynaecological care and other health problems. Accordingly, in Australia, the expectation to see a specialist may lead to disappointment when referrals are arranged to general practitioners.

For many refugees, the concept of appointments is strange. Their experience has been to wait at a clinic, for example, until they are seen, rather than attend at an arranged time. Educational practices can address this issues. AMES¹ gives students a calendar and encourages services to enter appointments in it. It is worthwhile pointing out that there are also different systems here, which may include long waiting periods and queues. Essentially people need to be informed about practices, expectations and the reasons for them.

4.2.2 Causal Explanations

A worker's understanding of why torture and persecution occur can be quite different to a survivor's.

A Cambodian woman believed that the reason she and her family had been attacked and tortured was because she failed to seek permission from the "forest spirits" before entering the forest to collect food.

A Sri Lankan Tamil client viewed her experience of torture and rape as punishment from Jesus because she disobeyed her parents and joined a political party when she was a young woman.

¹ Adult Migration Educational Services

An Iraqi Shiite Muslim viewed his experience of torture as part of a divine plan that Allah had made for him. The client therefore did not experience the injustice of the torture, nor see its roots in repressive systems which deliberately use it to exercise control.

In the last two cases, religious factors were very important but the meaning that was found for the experiences was quite different. In one case, the woman had taken excessive responsibility for her torture and expected to be punished by God. In the other case, torture was the will of God and not viewed as a consequence of one's acts.

In the absence of a causal explanation for torture and trauma, survivors persistently ask "Why me?" and "What have I done to deserve such treatment?". The lack of meaning can, in such instances, intensify suffering.

In recognising cultural differences in causal explanations, it is important not to adopt an overly simplistic view which casts people as 'individualistic' or 'fatalistic'. People can hold different causal explanations for different aspects of living. Life and death may seem to be beyond one's control to influence, but simultaneously a person might take full responsibility for their effects on other human beings.

4.2.3 *The Meaning of Healing*

"When it comes to responding to the effects of violence, western style psychotherapy can have the effect of individualising the suffering of the person involved. Psychotherapy of this mode might be inappropriate and indeed harmful in more sociocentric societies where the individual's recovery is intimately bound up with the recovery of the main community".
(3)

With increasing awareness of the inappropriateness of psychotherapeutic interventions, it is equally important not to succumb to a prejudice against such approaches. Counselling is not restricted to talking and can and should take account of any person's cultural reality.

Culture-specific healing practices can be the most appropriate form of intervention.

A young East Timorese boy was terrified that the spirit of his aunt, who had been killed under violent circumstances in East Timor, kept visiting the house at night. The family would leave food and drink for the aunt at night and they would be gone in the morning. His fear was so intense he would not get up at night to go to the toilet or be alone in the house at all, even in daylight. The family called in a Catholic priest who blessed the house and the family prayed for the soul of the departed aunt. The young boy's fears were alleviated immediately with the belief that his aunt was at rest.

Childcare workers were involved with two African children whose mother died in a house fire. According to the cultural values and traditions about death and grieving in their community, those caring for the children were not going to tell them that their mother was dead. In fact, the childcare workers became aware that the carers had told the children that their mother would be coming soon. The dilemma for the childcare workers was to decide what would be the best response to give the children when they asked about their mother. Their view was that it was best to tell the children about their mother's death. The conflict was resolved when they discussed the dilemma with the carers who indicated that they would tell the children once they were safely settled with another relative.

4.2.4 The Experience of Distress

In some cultures, distress is experienced primarily as somatic complaints such as headaches, and stomach aches. Therefore interventions have to consider such complaints as the initial, if not the primary focus. It is useful to ask people what they think is wrong, what they think the cause is and whether they have found anything which helps. It is also helpful to be aware that asking too many questions may seem puzzling because they may expect you to know what the problem is and what would help. Some people may be reluctant to reveal traditional fears in case they are ridiculed.

4.2.5 Help-seeking Behaviour

Many cultures do not have a concept of a professional helper, requiring workers to clearly define their role and that of their organisation. (3) Even where the notion of professional help is understood, it may be initially rejected because it conflicts with belief systems about what is appropriate help to be sought.

A survivor of torture was a devout Muslim. He believed that it was his moral duty to passively accept his suffering and that to seek help was tantamount to refusing to bear what Allah had planned for him. Before these values were explored, there was an impasse between counsellor and client because the client rejected counselling, medication and other strategies which may have brought him relief from constant intrusive memories of his torture, nightmares and sleep disturbance. An exploration of the values that underpinned this client's world-view led to a discussion of injustice, restitution, recovery and healing from the client's view. Eventually counsellor and client were able to work together in improving his health because the client discovered that it was in fact mandated within his religion to do so.

Rape victims are unlikely to seek help from professionals, family or friends, because of shame. However this is by no means a universal response and it is important not to impose stereotypes regarding the help-seeking behaviour of survivors of rape.

4.2.6 Personal Cross-Cultural Skills

Cultural Self-Awareness

Cultural self-awareness refers to the practitioner's recognition of the influence of their own ethnicity on their values and belief system. This awareness underpins the ability to see how one's own culture influences the perception, labelling and response to clients' problems.

Cultural self-awareness also encompasses an awareness of the personal tendency towards ethnocentrism. Ethnocentrism is defined as **“the belief that one's own group is the centre of everything and the**

standard by which all other groups are measured”. (4) Ethnocentric attitudes contribute to the risk of insensitive, superior or censoring responses and overly helping interventions to culturally different clients. If a practitioner believes that their way is the natural (and therefore only) way, the intervention may not have any relevance to the client and therefore will ultimately be unhelpful. At worst, ethnocentric attitudes may limit knowledge of the practitioner’s range of options available for a specific problem.

A young Sri Lankan woman who had recently been raped was being counselled by an Anglo-Australian counsellor. The client felt that her life had been ruined by the rape. The rape had taken away her virginity and in her culture, she would have to prove her virginity by bleeding with intercourse. If she failed to do so, both she and her family would be disgraced in the eyes of her community. The client explained that the consequences for her would be grave as her family would hide her away from society. She told the counsellor that she would never marry because of this. The counsellor, who was not skilled in cross-cultural practice, had what she considered strong feminist views around rape and virginity. To her, a woman’s worth had nothing to do with her virginity, and an independent woman was responsible to no-one. The counsellor’s intervention was to share her philosophy with the client in the hope that this would empower her. The client did not find this intervention helpful and the client also felt devalued as the counsellor had implied that she was not independent because she cared about the honour of her family. Thirdly, the counsellor’s ethnocentrism led to a censoring of the range of options that were available to this client. Had the counsellor responded to the importance of virginity within this client’s culture, she may have raised the possibility of other options such as a hymen reconstruction.

Specific knowledge about different cultures and their values and practices is not usually possible to acquire, especially if working with refugees from many countries. Far more crucial is the openness to difference without judgement. If judgement is suspended, then it is actually easier to find alternative solutions.

A young female adolescent wanted to attend a group for young women at the community health centre. The worker thought it would be very helpful too, in reducing her social isolation. The parents however would not allow it and the worker felt extremely frustrated. She decided to meet with the parents and discovered that they were frightened to have their daughter attend a group that would finish after dark. They were also concerned that boys might be in the group and they feared what other people might think. The worker suggested that they accompany their daughter the first time, see who was there, meet the other workers and arrange for her to be accompanied home. This was not the worker's usual practice as she was accustomed to fostering independence. However, in this way the parent's fears were addressed and a potential impasse resolved.

One of the most important skills to have as a worker involved with people from many different backgrounds is the ability to explore the meaning of differences in perceptions, values, traditions and belief systems. This enables the survivor to have more choices and enables the worker to assist with the most appropriate interventions.

A client said that he had been very worried during the past week because he did not have enough money to make the yearly offering to honour his dead ancestors. He experienced not being able to do so as proof of his inadequacy. The worker's first response to this situation was to suggest that he make a smaller offering. This suggestion was rejected by the client. Then the worker asked what would be done in his country, when circumstances such as poverty or war would have prevented people from making the offering they needed to. There was a long pause, and he replied that he did not have to present an offering and that that would be all right. During subsequent contact he often referred to the time in the session when he had realised that life in Australia was not "normal" for his family and therefore he could not do what he would have normally done. He was destitute here and he had not been in his country. This meant relief for him, an acknowledgment that circumstances were different here and that it was not his fault.

As a broad guideline, it is useful to ask the person how a particular problem or conflict would have been dealt with in their country of origin.

4.3 *Working with Interpreters*

The ability to effectively and competently work with interpreters is essential to effective cross-cultural practice. Clearly, poor skills at working with interpreters will hinder the ability to make accurate assessments, frame effective interventions or develop positive relationships with clients who lack fluency in English. Effective communication is an essential feature of creating safety within a helping relationship for the survivor of torture and trauma.

Detailed guidelines for working with interpreters are presented in Appendix 1 of this module.

4.4 *Emotional Responses of Workers and Implications for Practice*

It is recognised that there is a range of feelings evoked by working with torture and trauma survivors which can powerfully influence ways of responding to the survivors as well as affecting the worker's personal life. Understanding their reactions and how to deal with them is vital for effective work.

4.4.1 *Helplessness*

Feelings of helplessness can arise when confronted with another person's helplessness and with the awareness of torture practices, other forms of state sanctioned violence and war atrocities. The sense of helplessness can lead to a loss of confidence in one's skills and knowledge and in the power of any intervention. It can also lead to an underestimation of the client's resources. (1)

Herman (1) points out in regard to psychotherapeutic encounters that the therapist can adopt the role of a rescuer as a defence against intense feelings of helplessness.

"As a defence against the unbearable feeling of helplessness, the therapist may take on more and more of an advocacy role for the patient. By so doing, she implies that the patient is not capable of acting for herself. The more the therapist accepts the idea that the patient is helpless, the more she disempowers the patient.

Many seasoned and experienced therapists, who are ordinarily scrupulously observant of the limits of the therapeutic relationship, find themselves violating the bounds of therapeutic and assuming the role of a rescuer.... . The therapist may feel obliged to extend the limits of therapy sessions or to allow frequent emergency contacts between sessions. She may find herself answering phone calls late at night, on weekends, or even vacation". (pp142-143)

Judgements about helping too much or “rescuing” can be difficult to make. If the situation of an aid worker who enters a war zone is considered, is this rescuing behaviour or a socially responsible act?

Nevertheless, awareness of personal limits is vital. Where an overprotective attitude or a need to solve everything dominates, it is usual to simply become exhausted from doing everything. It can also lead to a reluctance to let others do anything because they cannot do it as well. This can also develop into an intolerance of outsiders and of alternative approaches. (5)

4.4.2 *Guilt*

Guilt about being exempt from trauma and suffering and guilt about not taking enough action against the violation of others, can be experienced by workers. Danieli (6) refers to this as bystander guilt and describes the effects on one’s work. It can lead to viewing the survivor as extremely fragile and vulnerable, overlooking what they have done in order to survive. Therefore, one can do too much for them and take excessive responsibility, or one might avoid painful topics for fear of inducing more hurt. The worker’s reactions can mirror the client’s in that it is easier to feel guilty rather than helpless.

Herman’s comments about therapist apply to other professionals. “The therapist may feel that her own actions are faulty or inadequate. She may judge herself harshly for insufficient therapeutic zeal or social commitment and come to feel that only a limitless dedication can compensate for her shortcomings”. (1, p145)

Guilt as a problem for workers, comes to the fore for those involved in refugee aid. In the field they are allocated food and shelter and offered protection from infectious diseases while refugees are in receipt of less. In such a situation eating can be a source of discomfort and guilt when others are hungry. (7) Even in the absence of such stark contrasts, enjoyment of life can be impaired by this awareness of what others do not have.

Another source of guilt can stem from compromises that have to be made, such as not being able to provide the same level of attention for all in need. Compromises also have to be made in accommodating government policy and the ways government policy can be influenced.

4.4.3 Anger

Anger is also part of the worker's response to traumatic material - anger at the perpetrator, at bystanders, at society's lack of responsiveness and at the client. Anger can readily be followed by dismay. Initially some workers angrily ask how people, who appeared to have been bystanders could let atrocities occur.

For others, there is the shock of realisation as they begin to understand in human terms why people watched or overcomplied with orders - out of obedience, fear, or a need for power. This is in some ways similar to the distress experienced by workers who are able to "enter the mind of the perpetrator". McCarroll et al (8) report the case of a historian working on Holocaust archive material, who in attempting to understand the historical event, felt that he had succeeded in getting into the mind of the perpetrator. The ability to identify was traumatic.

A sense of mild hostility and alienation can also develop as a sense of disappointment with friends and colleagues who do not seem to understand. Social activity can come to look trivial and be declined. (8) A lack of trust in others and cynicism regarding their motives is not unusual. (1)

Anger at the client is the hardest to admit to but it can be provoked by clients making excessive demands or by the clients revealing their prejudices. As Herman points out, (1) some workers believe that individuals who have suffered so much at the hands of prejudice, hate and oppression should transcend such feelings in their relationships with others. There can be an expectancy that survivors be morally superior. A survivor with normal foibles can be difficult to accept.

4.4.4 *Dread and Horror*

Dread and horror are common reactions, as are sadness, disgust, shame and revulsion. There can be fear of being overwhelmed by such feelings and as Danieli puts it, workers can fear being drawn into blackness and despair. (6) “The survivor’s eyes have actually seen what is described. To look into eyes with that knowledge is not easy”.

Other forms of dread are the client’s anger, fear of not being able to help the client and fears of having personal painful memories brought back, memories of being humiliated or memories of regretted actions against others.

4.4.5 *Idealisation*

On occasions there is a tendency amongst helpers to view survivors as heroic, superhuman figures to be held in awe. This can lead to a feeling of inadequacy in the worker because they do not know the true secrets of survival. It can lead to neglecting and minimising their own pain and suffering. Idealisation can alternate with devaluation and anger.

4.4.6 *Personal Sense of Vulnerability and Intolerance of Violence*

“Life is no longer the same. If beatings, starvation, torture and mass killings can happen to our patients, they can happen to us. There is an increased awareness of the dangers of hatred and brutality that lie behind the mask of civilisation we all wear, a sense of being more vulnerable to life’s dangers” (9, p257). Kinzie describes the intolerance to violence which developed amongst psychiatrists at a psychiatric clinic for South-East Asian refugees in Oregon, USA. News reports of violence produced such distress that they had to be avoided. (9)

4.4.7 *Avoidance Reactions*

Helpers also can react to potentially overwhelming emotions associated with trauma by distancing themselves from people who are victims. Denial, detachment and withdrawal are characteristic responses. All workers are detached at times. Counsellors report noticing how they do not seem to feel anything at times. McCarroll et al (8) report that many of the workers involved in establishing the Holocaust Museum in Washington reported a lack of feeling in response to their work. This resulted in guilt and fear over a loss of sensitivity.

In the therapeutic context, detachment can be enacted by avoiding traumatic material, relying on medication (10) and by being excessively professional and intellectual.

4.4.8 *Fulfilment*

Growth, a deeper awareness of the human condition, a valuing of closeness, increased sensitivity and the capacity for sharing and living fully can be the benefits of being exposed to survival amidst the horror of war and trauma. As a worker, one also experiences the privilege of witnessing the power of courage and the strength of compassion and renewed hope. Being able to do something is immensely satisfying.

4.4.9 *Implications for Practice*

Many emotions are aroused by traumatic material and they can persist. In response to these emotions, one can suppress them, be distracted from them, or look at them further to see what they can tell us about the client or ourselves. Typically, workers predominantly engage in one of the following processes which reflect a wider position in regard to traumatic material - to move toward it by learning more, changing systems and accepting responsibility, or to move away from it by neglecting issues or diminishing awareness of the severity of problems. The figure below summarises ways in which workers move toward or away from trauma related issues.



Figure 4
The Overinvolvement–Underinvolvement Continuum

The far left and far right columns highlight extremes of such tendencies which result in over involvement or under involvement.

Taking excessive responsibility is probably the most common pitfall. There are many reasons for it: needing to do something to overcome feelings of helplessness, protecting the survivor from further abuse and the need to restore hope and faith in humanity. Awareness of the circumstances of the newly arrived migrant who has survived torture and trauma tempts anyone in a helping capacity to extend their efforts to improving systems they are part of and to increase community awareness. This is clearly desirable but the limits of personal responsibility have to be constantly examined.

The ideal position to adopt in regard to work which is emotionally intense and where personal commitment is strong, is in the middle band. It is crucial that workers develop a third eye or “observer ego” to see and understand what is happening between themselves and their client. Such awareness necessitates a degree of detachment which ultimately enables one to act in the best interests of the client. Along with maintaining a position as observer, being responsive with empathy, enables one to stay in the middle.

At times, despair and disillusionment can outweigh spirited efforts and lead to ‘burnout’. The risk factors are:

- too high demands from self
- too high demands from others and the situation
- lack of resources, personnel and time
- lack of control over the situation
- lack of support from leaders, organisations, colleagues
- unrealistic expectations
- lack of acceptance and acknowledgment. (7)

Several of these burn-out factors are best addressed at the organisational level which provides not only for amenities and administrative support but should also provide for physical security, professional development and clarity regarding values, tasks, responsibilities, accountability and sensitivity. (11)

To deal with emotional reactions to traumatic events, the following recommendations were made by Danieli (cited in 7).

1. To recognise one's reactions by developing awareness of the signals of distress and by trying to find words to articulate one's inner experiences and feelings.
2. To contain one's reactions by identifying the personal level of comfort, and by understanding that reactions are normal and unlikely to be overwhelming if their phasic nature is recognised.
3. To grow, accepting that being influenced is to be expected and to share trauma-related work with others. Allowing for relaxing self-expression is important.

In addition to the above, dealing with one's reactions involves recognising that it is an ongoing process of thoughtfulness and acknowledgment of conflict.

Most workers have different ways of coping which includes humour, relaxation, exercise, good nutrition, sharing emotions with close friends. Professional strategies are vital too. The following are mentioned by Yassen. (11).

- Balance in the variety and nature of work, pacing work.
- Boundary keeping: re overtime spent with clients, taking work home, understanding, self-disclosure boundaries, realism about the effect you have.
- Trusting professional relationships: peer support, supervision consultation, role models.
- Planning for difficult times.
- Professional training and replenishment.

4.4.10 *Debriefing*

Debriefing of staff arose out of the recognition that workers could be personally adversely affected by being exposed to demanding stressful work, such as dealing with clients/students/patients who had been severely traumatised or by being confronted with a life threatening situation at work. The usual aim of debriefing is to reduce staff stress caused by exposure to such situations. Debriefing is usually conducted in a group setting and facilitated by a debriefer. Debriefing processes include:

- Information and understanding of workers' emotional reactions and their "normalisation".
- Reducing stress by sharing experiences of difficult situations in a group or team setting.
- Learning stress management strategies.
- Reinforcing the value of one's work.
- Gaining understanding of the causes of one's difficulties, frustrations and learning what one can do through considering alternatives. A group consisting of members employed in doing similar work can be a very useful way for generating solutions because group members usually have the experience and the ideas to produce a range of alternatives.

The person who acts as a facilitator of a group formed for staff debriefing needs to be experienced in this area. He or she clarifies what is being said and elicits responses in order to increase understanding and generate alternatives. The facilitator needs to be someone who is not a participant in the day to day activities of the organisation, who is entrusted with the role of guide.

Costs however can prohibit the employment of an external debriefer to facilitate a group debriefing process on a regular basis. The alternatives are to have a number of structures and processes in place to deal with anticipated sources of staff distress. Suitable processes would include

case conferences to discuss difficult situations in say the classroom, planning days, clear lines of accountability and ways to disseminate as well as gather information, and one-to-one consultations with a designated person for discussing problems.

Preparation for Debriefing

Where a request for debriefing arises in an organisation, it is important to clarify what the goals are and whether the conditions are suitable for conducting it.

Goals

The stated goals are normally to reduce stress by supporting staff engaged in stressful work situations with clients/students, and dealing with critical incidents.

Establishing goals is a process in itself and requires time and facilitation.

It is crucial to anticipate what the sources of stress are because the strategies to deal with them may be something other than a debriefing process. Often, the main source of stress for staff pertains to organisational issues such as problematic relationships, changing work conditions, etc. If this is the case, boundaries for debriefing need to be set beforehand so that it is clear that it is seen as a forum to discuss stress emanating from work with clients. Organisational issues will still need to be dealt with, but in another way.

Debriefing also needs to be distinguished from supervision. Although both processes ultimately enhance the quality of services delivered and promote staff development, the focus of each is quite different. Debriefing assists workers to reduce stress caused by their work, whereas supervision is aimed at more effectively dealing with problems presented by the client. Supervision usually entails understanding the impact of worker's emotional reactions on work practices. In a counselling context, worker's emotional reactions are also utilised as a source of information to guide therapeutic interventions.

Conditions

Debriefing involves, to at least some extent, disclosure of personal reactions to difficult situations. Trust is very important in such situations and can be achieved by establishing “rules” for debriefing. These apply to an individual or group situation.

1. Confidentiality

There needs to be agreement that information disclosed during debriefing does not go any further without explicit discussion and agreement. If there are fears for the safety of a person, in that they may do harm to themselves or others, confidentiality may have to be breached. This can be included in the rules set for confidentiality.

2. Organisational support

The support offered to staff as part of debriefing requires organisational support for the time which will be given to the process and for its goals.

3. Consistency of personnel and designation of roles

The conditions which need to be met here are inseparable from goals. Where one-to-one debriefing is being aimed for, the debriefer needs to be someone who is clearly designated for this role and adequately trained. They in turn may need someone to debrief with. In a group situation, the debriefer cannot be a participant as well. Where an outside debriefer cannot be used for reasons of cost, it may be preferable to aim for a support peer group which focuses on dealing with difficult situations which arise in the work setting rather than dealing with overcoming worker’s personal reactions. The role for a “trauma support” person who can facilitate such a group needs to be clear. This would vary from being “on call” as difficult situations arise, to organising regular forums for staff.

Stages in Dealing with Staff Distress

Debriefing as a way of dealing with staff distress needs to be complemented by other workplace strategies.

Dealing with staff distress involves three stages, whether it is a one-to-one consultation or group debriefing. The conditions described above must prevail, ie explicit confidentiality rules, trust and available time.

1. The first stage is finding out more about the cause of distress. This can only be achieved by inquiry. As the person conducting the debriefing, you need to be able to ask the other person/s what is troubling them. Sometimes the person reporting stress is not sure about the cause. In fact this is usually the case. In such situations ask them what it might be.
2. The second stage is looking at ways to address the problems identified.
3. Follow up whether a satisfactory solution has been found. This applies to the one-to-one or group situation. The time period here can be anything from hours to months, depending on the issue.

These stages parallel those used in dealing with clients with a difficulty. That is, the first step, after creating an opportunity to discuss the difficulty, is to ask the client what they think is the cause. The second step is to look at what can be done to help, and the third is to check with the client whether things have improved.

An Example: Dealing with Stress amongst ESL Teachers

Different levels of stress can be identified:

1. Everyday, commonly occurring stresses such as accommodating the diverse needs of newly arrived refugees in the classroom.
2. Occasional but very difficult situations such as student disclosure of an extremely traumatic experience.
3. Crisis or emergency situations which may have dire consequences.

Strategies for dealing with those situations will of course vary but the principal ones are described below:

1. Training in understanding the needs of refugees and how best to assist them in the classroom situation is extremely useful. Ideally, all teachers and other staff benefit from this kind of training. To illustrate, part of such training involves learning to consider different hypotheses about causes of difficulty. For example, a student who discusses a personal experience of trauma may do so because of a number of reasons summarised below. The courses of action are also shown.

REASON FOR DISCLOSURE	POSSIBLE ACTION
They are desperately seeking help	Provide information about VFST and assist with a referral
The want to be acknowledged by someone they trust	Listen and say, "That is terrible, is there anything I can do in the classroom to assist?"
They are angry about what happened to them and 'demand' that others see the injustice too	Acknowledge their difficulties and offer assistance

2. Another important way to reduce stress is providing the opportunity for staff to meet to discuss such situations. This is supportive of staff and it provides an opportunity to learn more about "what works". Reinforcement and an opportunity to discuss and share what is useful in the way of strategies is important in maintaining levels of confidence and skill.
3. Development of protocols in advance is vital. These can be developed for emergency situations. It is also necessary after an emergency incident to have debriefing in the form of giving staff an opportunity to talk about what happened and what will happen. The person with responsibility for organising such a session should be part of the emergency protocol.

4. Reducing stress is enhanced when role, responsibilities and boundaries - essentially what one aims to do and what one cannot do - are clear. Knowing when to refer a problem to someone else is critical, and requires anticipation of distressing situations which are likely to arise.
5. The final way of reducing stress is the provision of adequate information where there are gaps in knowledge or procedures. This initially requires a forum where gaps can be identified.

Running a Group

It is beyond the scope of this section on debriefing to provide adequate background material on running a group, but two important considerations previously mentioned are:

A group process, which has as its goal debriefing workers, should be conducted by someone experienced in this role.

In the absence of such personnel, a group meeting is nevertheless an invaluable source of support for members and can be a forum for discussing and solving problems which arise in the course of work. Such a meeting can be coordinated by a designated person who takes responsibility for organising the agenda. Members of the group would participate in setting the agenda. Such a group is akin to a peer supervision group or a staff development forum where the focus is on learning what to do in problematic situations. The focus is not discussing worker's emotional reactions. As mentioned earlier, this would best be done in a one-to-one situation with a designated person whose responsibility is to be a point of reference for staff requiring assistance.

4.5 Conclusion

The intervention skills described in this chapter are the basis for enabling the recovery of refugees who have experienced torture or trauma. They apply when working with individuals in settings which include supported accommodation, community centres, recreational programs and schools. Certain principles of care need to be emphasised. They parallel those recommended for establishing a quality relationship.

PRINCIPLES OF CARE

- ➔ *Predictability*
- ➔ *Continuity of support*
- ➔ *Genuine interest in the welfare of the person*
- ➔ *Understanding the causes of behaviour based on knowledge of the reaction to trauma*
- ➔ *Maximising the person's control*
- ➔ *Setting attainable goals*
- ➔ *Validating emotions*
- ➔ *Working with due regard for the person's cultural reality*
- ➔ *Tailoring specific interventions to the nature of the problem*
- ➔ *Being aware of personal reactions and adhering to principles of responsibility and appropriate levels of professional involvement.*

Guidelines for Working with Interpreters

Recognise the Interpreter as a Co-professional

Interpreting is a highly skilled and demanding profession. In order to gain nationally accredited qualifications as an interpreter, an individual has to demonstrate proficiency in both English and their speciality language in a wide range of settings. It is not unusual for an interpreter to have to interpret at an engineer's conference, within a court setting, for a medical doctor and in counselling sessions. Accredited interpreters follow a code of ethics which outline their roles and responsibilities. It is very important for the practitioner to be familiar with the code of ethics so that they have correct assumptions and expectations of the interpreter.

Just as the survivor of torture or trauma needs to find the practitioner trustworthy and responsive, they have the same need to find the interpreter to be trustworthy.

Recognise the Impact of Interpreting Torture and Trauma Experiences

Interpreting when torture and trauma material is disclosed poses many challenges

- The account of torture and trauma can be overwhelming and evokes powerful emotional responses.
- An interpreter confronts knowledge about practices that may occur in their country of origin and these experiences may trigger personal responses that are linked to the interpreter's own experiences.
- Interpreters may inadvertently alter their interpreting because they are trying to cope with the material.

A client was describing instances of horrific torture. The counsellor noticed that the interpretation of what the client was saying was brief and without the emotion that the client seemed to be expressing. The counsellor asked the interpreter about this. The interpreter disclosed that he found that the description of the torture was making him feel sick.



A peasant woman was describing how the army raided her village, raped women and killed the men. The interpreter, through her body language and tone of voice, communicated a disbelieving and patronising attitude toward the client. This prompted the counsellor to terminate the interview. Debriefing with the interpreter revealed that the interpreter was the daughter of an army officer in the same country of origin as the client. She was from the upper classes and simply could not believe that the client was telling the truth.

Interpreters strive to maintain their professionalism and ethics at all times. The above examples illustrate that interpreting in torture and trauma cases arouses powerful emotional responses. In neither of these examples did the interpreter deliberately act inappropriately or unethically. Rather they tried to cope with confronting material and their emotional responses while interpreting. All of these situations should be viewed as a response to the traumatic material.

Pre-briefing the Interpreter

The interpreter will be in a better position to accurately interpret if they have a clear understanding of the practitioner's role, their method of working and terminology. Taking the time to introduce yourself and clarify your role also promotes a mutually respectful professional relationship. Interpreters work with professionals from a variety of disciplines. Each discipline has its own principles of practice, tools, jargon and forms of shorthand for complex concepts. It should not be assumed that the interpreter is familiar with such practices.

The pre-briefing should include information about the anticipated content of the interview. The interpreter will be better prepared to manage the traumatic nature of an interview if they are advised that they could find it upsetting.

Interpreting in torture and trauma situations is often a new experience for interpreters. It can be helpful to establish ground rules and expectations of the interpreter. On a practical level, a prior agreement regarding how the interpreter should clarify anything that they do not understand, should be explained.

Conducting an Interview with an Interpreter

Effective communication is based on speaking with a client in the first person through an interpreter. Professionals should avoid speaking directly to the interpreter as the client can feel excluded and powerless within this situation. Avoid for example, "Ask her why she has come.". It can take some getting used to, but communication has been demonstrated to flow much more freely if this practice is followed.

Whenever possible avoid jargon, complex words or highly technical words. It is best to use simple language or explain technical language. The interpreter is required to translate everything but not necessarily word for word if this were to create a misleading impression or distort the meaning of what is said. (11)

It may be necessary to remind the interpreter of the agreement you made during the pre-briefing. For example, if an interpreter oversteps their role you can remind them if it is interfering with the interview.

Informing the Client

Working through an interpreter is often a very new experience for clients. Because of clients' lack of knowledge about the interpreter's role and responsibilities they often have expectations that are contrary to the interpreter's code of ethics.

Simple statements about the interpreter's role, that they interpret everything that is said, and are bound by a code of ethics should be routinely explained to clients.

One client expected the interpreter to act as an advocate because the client had difficulty in accepting the advice of a solicitor.

A client approached the interpreter outside the interview and asked the interpreter for a lift home.

During a counselling interview with a married couple the husband expressed anger, using coarse language. The wife asked the interpreter not to interpret this.

Closing the Session

Before finishing the session, follow-up contact should be clarified while the interpreter is present. Where possible the client should leave the session first. The practitioner should explain that they have administrative or booking matters to discuss with the interpreter.

Debriefing of the interpreter after the session has concluded provides an opportunity for both the practitioner and the interpreter to discuss how communication went during the interview. This can include constructive criticism and suggestions for future work together. Debriefing time also allows the interpreter to ask any questions about the processes followed so that they have a clearer understanding for any future interpreting.

Debriefing regarding the emotional content of the session may also be necessary.



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5

PROFESSIONAL ISSUES

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5



5

Professional Issues

This chapter presents details of interventions which are suitable for specific professional settings - that of the health professional, the ESL teacher, teachers working with primary school age children and immigration officers assessing refugee claims of asylum seekers.

5.1 *Health Practitioners*

The health practitioner's role in alleviating suffering caused by injury, pain and disease requires no elaboration. Doctors also play an important role in managing psychological symptoms with the use of medication, support and attention to the overall well-being of the patient and in some instances through the practice of counselling.

The aim of this section is to provide guidelines for conducting a consultation with survivors of torture and refugee related trauma. Information about the psychosocial impact of torture and trauma and ways to facilitate recovery are covered in Chapters 2 and 3 of this guide. Applicable strategies which can be used by health practitioners to enhance recovery are summarised in Table 4.

Information sheets addressing the following specific areas and topics are available from the VFST on request:

- The use of Interpreters
- Physical Sequelae of Torture
- Country-specific Details about Common Illnesses and Health Concerns
- Other Services for Referral
- Tropical Diseases
- Immunisation
- Female Genital Mutilation
- Gulf War Syndrome
- On Arrival Case Co-ordination Model
- Tuberculosis
- Natural Therapies

Table 4 *Core Recovery Processes and Strategies: Health Professionals*

<p>1 RESTORE: CONTROL SAFETY</p> <p>REDUCING FEAR AND ANXIETY</p>	<ul style="list-style-type: none"> ➤ Restoring health through screening and treatment ➤ Establish patient's previous experience with health professionals to anticipate concerns ➤ Explain procedures ➤ Give choice about proceeding with investigations ➤ Provide information about diagnosis, prognosis ➤ Provide opportunity for patient to ask questions ➤ Use an interpreter ➤ Expect anxiety in patients ➤ Medication for anxiety and symptoms of PTSD (G.P.'s) ➤ Making referrals for counselling and other services
<p>2 RESTORE: ATTACHMENT CONNECTIONS</p> <p>OVERCOMING GRIEF AND LOSS</p>	<ul style="list-style-type: none"> ➤ Respectful treatment conveys possibility of meaningful relationship ➤ Expecting grief in patients ➤ Medication for depression (G.P.'s)
<p>3 RESTORE: IDENTITY MEANING PURPOSE</p>	<ul style="list-style-type: none"> ➤ Respectful treatment and genuine concern ➤ Acknowledgment of difficulties ➤ Expecting distrust, withdrawal, anger, demanding behaviour and accommodating emotional reactions ➤ Knowledge of human rights violations and effects
<p>4 RESTORE: DIGNITY VALUE</p>	<ul style="list-style-type: none"> ➤ Respectful treatment and genuine concern ➤ Anticipation of reluctance to self-disclose ➤ Respect for privacy ➤ Expecting fear regarding invasive procedures

5.1.1 *The Impact of Psychological Effects of Torture and Trauma on the Consultation between Doctor and Patient*

The psychological effects of torture and trauma can -

- detrimentally influence the relationship between health practitioner and client
- interfere with obtaining sufficient information for diagnostic purposes
- prevent procedures being carried out
- interfere with the maintenance of health.

1. It is typical for survivors of torture and trauma to show a conditioned fear response to reminders of the traumatic situation. The surgery can remind patients of the torture situation as can instruments. Doctors themselves can trigger a conditioned fear response because in many countries of the world physicians have collaborated in torturing victims. Where the fear response is intense, it would be very difficult to carry out investigative procedures. Figures in authority can also be experienced as threatening if they have come to be associated with persecution. Answers to questions may be offered with trepidation.
2. Feelings of helplessness and powerlessness can persist for a long time after traumatic circumstances have ceased. Any situation where the person has little control over events, such as occurs during procedures which are invasive, can evoke considerable anxiety associated with helplessness.
3. Sensitivity to unfamiliar situations, startled reactions to sudden changes in the environment such as noise, and hypervigilance, which are all features of the traumatic reaction, can make a consultation extremely distressing for a survivor. It is typical for the person not to understand that these reactions are caused by their experiences of trauma and their responses are usually interpreted as signs of weakness. This further contributes to the feelings of helplessness and anxiety which arise during a consultation.

4. Torture and trauma survivors, as a result of loss of appetite, energy and interest due to depression may fail to maintain an adequate diet or level of activity. A heavy intake of coffee or cigarettes, which is commonly used to regulate anxiety and other painful emotions such as shame, can also contribute to health problems.
5. Lack of trust in authority figures can interfere with disclosing information, following instructions or following-up on appointments. Patients who are survivors of torture are unlikely to readily disclose this fact. Anxiety, shame, fear of not being believed all contribute to reticence about disclosure. This is notably the case with female survivors of rape and it is recommended that they are seen by female doctors. It is part of the torturer's boast that no one will believe them and it is part of torture to use methods that do not leave visible traces. It can therefore be difficult to accept as true, the unthinkable fact of torture when visible scars are lacking. In order to protect ourselves, we mistrust what we are told. An openness to the possibility of torture is necessary when working with refugees.

Long waiting periods can be very traumatic. The recovery period after surgery is recognised as an especially vulnerable period, during which survivors are reminded of past situations in which they were helpless and subject to anticipating further violations.

6. Intense feelings of shame can make being physically approached and touched a disturbing experience. Again the survivor of torture and trauma may not know the basis for this reaction and feel embarrassed and self-conscious about their discomfort.
7. Some survivors are willing to provide information about their torture and trauma experiences but are unable to fully do so, due to memory disturbances and confusion. In such cases, information from a family member can be useful but permission must be sought. It is also helpful to indicate that you understand such difficulties are common.
8. When disclosure does occur, listening and acknowledgment are sufficient. (See pages 10-11, Chapter 3). It is important to be

aware of personal reactions to traumatic material. Chapter 4 describes common responses and how they can be dealt with.

9. The presenting problem may not be the main source of concern for the patient. A longer first consultation can be extremely useful to elicit a history which alerts the practitioner to other significant complaints. Awareness of country of origin information is an invaluable resource for conducting appropriate screening procedures and formulating diagnoses.
10. The settlement process can be retraumatising (see pages 32-36, Chapter 1).

5.1.2 *Specific Guidelines for Conducting a Consultation*

The primary goals of a consultation are to attend to a patient's presenting problems and to screen and assess anticipated illnesses. When a consultation is carried out with due regard to the patient's fears, to their sense of helplessness and to their lack of trust in people, additional benefits important to psychological recovery can also occur. A sensitive attitude to the patient has the power to rekindle trust in others to be caring, and can enhance the patient's sense of dignity and self-worth. This is of considerable value, particularly for torture and trauma survivors who are extremely vulnerable to retraumatisation and feelings of self-degradation. Medical examination and treatment are part of the rehabilitation program for survivors of torture and trauma.

The following guidelines enhance predictability and control, promote trust and reduce fear.

1. On first meeting a client, ascertain if they have any concerns about being seen by a doctor or nurse. Some people have never received medical attention, or if they have, they have had little experience of professional care. It is very useful (and helpful to the patient) if they are asked what their experience of health care has been.

2. Screening for illnesses and injuries can be invaluable because of previous lack of access to health care. So it is important to go beyond the presenting problem while not overdoing the number of screening investigations. Follow-up is also important to obtain further information, check on use of prescriptions, referrals, etc.
3. Staff at a health centre or private practice are the first point of contact for patients and they require some briefing about working with people who are refugees.
4. It is not advised to ask clients directly about their torture and trauma experience, but to ascertain what the likelihood is of their having been a victim. Survivors of torture and trauma rarely identify themselves but knowledge about the country of origin, their age, and knowledge of how long they have been in Australia are invaluable indicators. See Chapter 1, page 8 for questions which can be asked.
5. Give the client as much choice and control over the situation as possible. This can be done by explaining procedures. In our experience, most anxiety is observed when there are no explanations. Information may have to be repeated because anxiety can interfere with understanding. It is also useful to ask if there is anything you can do to make things more comfortable.

Reassurance about confidentiality also gives the client a sense of control. Consent should be obtained for information to go to a third party.

6. If anxiety appears very high, check if they want to proceed. If background information indicates that they are a survivor of torture, information about the VFST can be given. Torture with electric shock for example would make an ECG a terrifying experience. Gynaecological examination is especially difficult for victims of rape. It is quite common for counsellors to accompany clients for certain procedures and this may need to be planned.

7. Many clients do not speak English and you cannot follow the above guidelines without an interpreter. Use of an interpreter is essential unless the client indicates that they do not want to use one. In a face to face situation interpreters require some briefing about what they should interpret during the consultation. Some guidelines for use of interpreters are:

- ensure that they are professionally trained (do not use children of the patient)
- speak to the client directly in the first person
- avoid jargon and other complex words
- keep to one or two ideas, pause and allow for their interpretation
- tell the client, if it seems necessary, to pause sufficiently often to allow for interpretation
- be prepared to remind the interpreter of issues you raised in the briefing.

Clearly extra time is needed to conduct an assessment with an interpreter. More information on working with interpreters can be found on pages 28-33, Chapter 4.

8. Be prepared for strong emotional reactions - occasionally withdrawal, anger, and certainly anxiety. If you are aware that the reason for such reactions might be a history of torture and trauma, this can greatly assist in not taking things personally.

When treating children, parents can also be very scared of medical procedures and need explanations of what will happen and why.

9. Address misinformation. For example, some counsellors have observed that clients from the Horn of Africa have heard that one can be HIV infected at the dentist. Survivors of torture are told by their torturers that their hearts have been permanently damaged, so alertness to such things is needed. Such anxieties can be elicited by asking about specific concerns which the patient has.

10. Awareness of the immigration status of asylum seekers and their health entitlements is important. At the time of writing, asylum seekers are eligible for a Medicare card, but not health care cards, and as a result, they are not in receipt of any pharmaceutical benefits. This often prevents them from being able to fill expensive prescriptions and can lead to avoidance of follow-up appointments.
11. Be sensitive to cultural habits and practices but do not assume too much. For example, Indo-Chinese women reputedly do not self-disclose. However, it has been now widely observed that if asked specific questions they do.
12. The sequelae of torture include reduced concentration, memory, sense of time and reduced ability to be chronologically correct. Contradictions should therefore be clarified. (1)

5.2 *ESL Teachers Working with Adult Students*

The psychosocial impact of torture and trauma has been extensively described in Chapter 2. As indicated, the effects are far reaching, disrupting the ability to learn, work, maintain relationships and effectively adjust to a new environment.

Every migrant and refugee has the opportunity to attend English classes over an extended period. As a result, ESL teachers are the professional group which has the highest amount of contact time with newly arrived refugees. Over the years, teachers have observed, first hand, both the disruptive effects of trauma on cognitive, emotional and social functioning, and the courage of survivors struggling to meet the demands of settlement, the learning of English being a paramount task. As a result of these observations, teachers have expressed the desire to facilitate language acquisition and enhance the capacity of their students to adjust to a new country.

This section presents the blocks to learning and to participation in the classroom, which are the result of experiences of torture and trauma. Ways to overcome difficulties, those commonly occurring and more extreme problems are also described. An extensive discussion of dealing with the effects of torture and trauma is presented in Chapter 3. Worker's skills, the subject of Chapter 4 is also essential reading.

5.2.1 *Blocks to the Learning Process and Classroom Participation*

Table 5 summarises characteristic effects of torture and trauma experiences which block learning and participation.

Any one block can have a number of causes. Poor concentration, for example, can be the result of being disturbed by intrusive memories of traumatic events, feeling depressed, being numbed, feeling anxious or the result of brain damage. It is not critical to know the precise cause of a difficulty in order to deal with it. In fact, it is often impossible to determine the cause. If a student is obviously tense and looks worried it is

Table 5 *Blocks to the Learning Process and Classroom Participation*

BLOCKS		CAUSE
1	Poor concentration	. Depression
2	Memory problems	. Anxiety
3	Confusion	. Intrusive images and memories
		. Numbing
		. Brain damage
4	Anxiety	. Fear of authority figures
		. Fear of refugees from same country
		. Bad news from home
		. Trauma triggers
		. Increased arousal
5	Pain	. Physical injury
		. Anxiety
		. Guilt
6	Withdrawal	. Grief
		. Suspiciousness
		. Controlling anxiety
		. Shame about illiteracy
		. Depression
		. Numbing
		. Intrusive images and memories
7	Anger, Hostility, Disruptive Behaviour, Bullying	. Frustration over inability to learn
		. Asserting control
		. Grief
		. Sense of violation
		. Shame
8	Dissociative Episodes	. Exposure to trauma triggers
9	Low Self Esteem and Sensitivity to Failure	. Depression
		. Self concept shattered
10	Poor Motivation	. Depression
		. Grief
		. Social withdrawal
		. Avoidance of failure
		. Tiredness, exhaustion
11	Restlessness	. Over-arousal
		. Hypervigilance
12	Sadness, Depressed Mood	. Grief

reasonable to think that they are anxious. But if he or she is having concentration or memory difficulties it could be for any one of several reasons.

5.2.2 *Strategies to Deal with Commonly Occurring Blocks*

Without knowing the precise cause of torture and trauma related difficulties, it can be assumed that they are likely to be due to the effects of anxiety, depression, anger or distrust. Each of these emotions has visible signs, some of which are readily interpreted, other signs cannot be easily interpreted. Table 6 lists both relatively unambiguous and ambiguous signs.

Anxiety

There are several causes of anxiety, the occurrence of which little can be done to prevent. Images of past traumatic events, the receipt of bad news from the country of origin, family conflict, ill health of a child, the physical characteristics of the classroom which may remind the person of a dangerous situation they were in, etc, can all lead to high levels of anxiety. But it is possible to do something about avoiding predictable triggers such as individual-focussed questioning, pressure for personal disclosure and an overly authoritative manner.

The effects of anxiety can also be accommodated. Strategies to accommodate high levels of anxiety include being flexible about attendance, possibly extending the program for people very badly affected; utilising a variety of teaching tasks, some of which are less demanding of concentration. One centre rearranged classes. Two language classes were conducted for students who would normally be in one. One class was for students with a low educational background and one for students with a high educational background who were likely to learn slowly due to emotional blocks.

Provision of information regarding poor concentration and memory difficulties being common for recently arrived migrants is helpful, together

Table 6 *Common Emotional Blocks to Learning and their Manifestations*

	VISIBLE RELATIVELY UNAMBIGUOUS SIGNS	VISIBLE BUT AMBIGUOUS SIGNS
ANXIETY	<ul style="list-style-type: none"> · tension · restlessness · looks worried 	<ul style="list-style-type: none"> · cannot concentrate, memory difficulties · leaves the room · does not talk to others · blank spells · does not do work · appearing not to be 'with it'
DEPRESSION	<ul style="list-style-type: none"> · looks melancholic · expresses hopelessness · cries or appears sad · never smiles · weeping 	<ul style="list-style-type: none"> · withdrawal · fatigue · seeming lack of interest · cannot concentrate, memory difficulties · blank spells · does not do work · very dependent 'clinging behaviour' · fierce self-reliance, rejection of help
ANGER	<ul style="list-style-type: none"> · aggressive or disruptive behaviour · brusqueness · irritability · expresses hostility · challenging teacher's knowledge or style · excessive querying 	<ul style="list-style-type: none"> · withdrawn, little participation · restless · leaves room · does not do work · cannot concentrate, memory difficulties · showing off · refuses to sit with another student
DISTRUST	<ul style="list-style-type: none"> · nil 	<ul style="list-style-type: none"> · anxiety · sensitive to any failure · does not do work · cautious behaviour · challenging behaviour · social withdrawal · hostility

with setting achievable tasks and explaining as much as possible about the purpose of activities so that uncertainty is reduced. A central principle to follow in reducing anxiety, is to assist students in approaching difficult activities and tasks, including social interaction, in a gradual manner so that they have some experience of control, safety and achievement. In cases where anxiety is very high, this is not possible and other solutions need to be considered - such as an exemption from sitting an exam, or home based tuition.

The classroom situation provides an excellent setting for provision about expectations and demands of the educational and employment systems in Australia. Without such information, uncertainty about what is expected can maintain anxiety and feelings of helplessness. Where students are accustomed to school systems which emphasise discipline and compliance, they may actually devalue more flexible and open approaches to learning as not serious. (It is worthwhile acknowledging such differences with students.) Permission to express an opinion or disagree with someone may also need to be actively encouraged as students might associate the expression of a dissenting opinion with danger. Cautiousness would have been an adaptive strategy in previous school systems operating in oppressive and undemocratic political environments. Clarity about permissible ways to behave has significant benefits for enhancing control and thereby reducing anxiety.

Asking questions directly to a student can also provoke anxiety. Guidelines for doing this sensitively have been described and an explanation of teaching style can also be helpful. It is preferable to address questions to the group rather than any one individual. This allows those who are more comfortable with answering to do so and gives anxious students an opportunity to observe the process.

SUMMARY OF STRATEGIES FOR DEALING WITH ANXIETY IN THE CLASSROOM

- ➔ *acknowledge frustration*
- ➔ *set achievable tasks*
- ➔ *offer praise*
- ➔ *allow avoidance of tasks and activities which are too difficult*
- ➔ *plan for avoidance eg provision of quiet area*
- ➔ *give explanations of what you are doing*
- ➔ *give clear expectations about goals for achievement*
- ➔ *acknowledge effort*

Depression and Grief

Much can be done in the classroom setting to accommodate the effects of depression and grief and to foster connections, while recognising that the adjustment to loss is a very long process. Strategies include:

- showing genuine interest in well-being of students
- forming appropriate working pairs
- use of group activities
- inviting bilingual guest speakers

- providing information about clubs and activities
- having excursions to enable students in different classes to get together
- creating opportunities for students to get together, such as different classes meeting for morning tea
- enabling student presentations and participation using non-verbal tasks such as demonstrations of a skill
- using a variety of 'family' material which requires little personal disclosure. For example use sketch figures, dolls, lego
- giving students as much choice as possible with respect to disclosing personal family information or background history is optimal
- allowing time out.

Fostering opportunities for connections with others, needs to allow for fear and the need to avoid too much contact. The students themselves will choose what they are ready for if there is sufficient flexibility about whether to work with others or not. If the student is provided with choices, then it is not necessary to take excessive responsibility by being overly cautious and tentative in making suggestions.

Anger

Anger in the classroom is especially problematic because it is disruptive for other students and the teacher but may not seem to be a problem to the student showing aggressive behaviour. Before anger can be dealt with, it is important to be clear about what is considered unacceptable behaviour in the classroom. Recognising that anger may be an understandable response to grief, shame or frustration about the inability to learn should not preclude setting limits on inappropriate behaviour.

In isolation, however, setting limits may not be sufficient to manage recurrent anger. In such situations, it is useful to make some time to talk to a student to ascertain if there is something bothering them which is causing anger in the classroom. This can lead to the identification of a problem which may be solved with the assistance of the teacher.

In one such situation a student revealed that he was angry about the stupid questions which people asked him about his country and the ignorance he felt that some people showed when they confused Iraq with Iran. After saying what he felt, and the teacher replying that this seemed to happen often, thereby acknowledging the frustration, the student stopped being angry in class.

SUMMARY OF STRATEGIES TO DEAL WITH ANGER

- ➔ *Discuss anger in a one-to-one situation*
- ➔ *Listen to complaint*
- ➔ *Understand the cause of anger and validate if appropriate*
- ➔ *Indicate who might be an appropriate person to talk about it further*
- ➔ *Use an intermediary if there is conflict between teacher and student*
- ➔ *Set limits on unacceptable behaviour*
- ➔ *Harness anger, direct student to appropriate expression of dealing with a perceived violation eg making a complaint, writing*

Accommodating anger which does not necessarily lead to unacceptable behaviour is also important. People who have been violated readily perceive injustices and interpret minor provocations as serious threats. Being prepared to acknowledge deviations from absolute fairness, and provocations on the part of other students or workers, can moderate anger. As for anxiety, where anger is persistently disruptive and the student also recognises it as a problem, a referral would need to be facilitated.

Distrust

Distrust is emotionally close to anger and the same strategies for dealing with it apply. Further, it can be helpful to:

- encourage participants with positive reinforcement
- not apply pressure to participate
- allow for withdrawal and time out
- allow for practising conversation in small groups
- provide continuity of staff
- provide a noticeboard for students.

The quality of the relationship between teacher and student is important in fostering trust. A genuine interest in the well-being of students is an attitude which is conveyed in everyday behaviour and does not require the implementation of specific strategies. When further reflected in organisational attitudes and policies, students do derive a sense of feeling valued and accepted. This represents an extremely important contribution to the recovery process.

5.2.3 *Dealing with Highly Problematic Situations*

Where problems of anxiety, grief, depression, anger and distrust are persistent and severely disrupt the student's capacity to attend classes, learn or participate, a referral to the VFST, or another service which can offer help, may be necessary. How to make a referral is discussed in Chapter 3.

To determine a student's suitability for referral and their interest in obtaining further assistance, time needs to be made to discuss the student's problem. Concern has been expressed by teachers in regard to conducting such a discussion, mainly because they anticipate hearing about difficulties which they can do nothing about, or they fear that it is intrusive to probe. The following suggestions are very general but they can be used in most situations to discuss problems sensitively and to ensure that undue responsibility is not taken for student's emotional reactions.

1. In a one-to-one setting, share with the student your observations about what you have noticed in the classroom, eg "I have noticed that you are leaving the classroom quite often and not returning".
2. Ask if what you have noticed has anything to do with the tasks being set, other students' behaviour or if it has anything to do with what you are doing. At this stage, the student may reveal their concern or indicate, in some way, such as saying they are fine, that they do not want to discuss it further. In this way, the student is given an opportunity to control the amount of self disclosure.
3. Should they indicate directly or indirectly that they do not want to discuss it, one can let them know that other students in the past have shown similar behaviour (eg had to leave the room). Even if the discussion goes no further, it is an opportunity to convey that there can be difficulties for the newly arrived in the classroom situation, especially if they have experienced hardships before coming to Australia.

Time can be offered to speak with them again, should there be anything that would make things easier in the classroom.

Should the student say what the problem is, it has to be determined whether it is something that can be solved in the classroom situation or not. If it is not a problem which can be solved in the classroom, you are in a position to assess their interest in receiving assistance from another source such as the VFST, or from a counsellor at the centre. This can be done by following the guidelines presented on page 28, Chapter 3 of this manual. Some students when invited to speak of their difficulties in the classroom will disclose traumatic experiences they have been through. Guidelines for dealing with disclosure are described on pages 10-11, Chapter 3 of this manual.

Essentially, listening and acknowledgment are usually sufficient as a response when terrible experiences are disclosed. It is tempting to undo or compensate for the fear and loss which has resulted. This reaction can mirror the survivor's desire to be free of the legacy of their trauma. Recovery, however, requires a gradual assimilation of what has happened and premature attempts to begin again usually lead to disappointment and self-blame. As witness to another's trauma, the importance of allowing time for the survivor to forge a new future, needs to be embraced

4. It is possible to assist in the many ways which have been described. This includes recognising the difference between a person disclosing in order to have further assistance and someone telling in order to share something of their predicament so that they can be understood and believed. In order to know whether more should be offered in the face of disclosure, it is best to ask the student. It is certainly useful to indicate that if they continue to be troubled in a way which makes everyday functioning difficult, they can obtain further assistance from people who work with survivors of torture and trauma.

The signs listed on page 47, Chapter 3 strongly indicate the need for referral, although the student may not be ready to pursue it. Offering to help with a referral can lead to acceptance of further assistance. On occasions students may disclose some of their experiences to the class. Acknowledgment is sufficient in this context as well, with follow-up in private about whether further assistance is wanted.

5. A student may not be interested in talking further about their difficulties, but needs and is interested in receiving medical or dental assistance. This is best established by asking if the behaviour you have noticed in the classroom may be connected to any physical ailment. Whatever the response, you can enquire whether the student has a GP they can go to should they need to, and if not, appropriate information could be provided. Some centres have compiled information sheets regarding medical, dental and optometry services.

Emergency Situations

Events do occur which require an emergency response. To deal with such situations, each centre needs to have developed an emergency protocol.

Outline for Development of Emergency Protocol

Three emergency situations are:

1. **Imminent harm to self**
2. **Imminent harm to others**
3. **Psychotic and unable to self-protect but not violent.**

The following steps need to be taken in developing an emergency protocol:

1. Establish privacy and safety for other students

Ask students to leave classroom, getting a student to notify reception or another person of the situation. An emergency card already printed may be helpful here.

or

The teacher goes out with student to an area, preferably where there is a telephone.

2. **Contact** principal and/or designated suitable person
and
Contact friend or relative of student in Centre
and
Contact friend/relative outside Centre for whom there is an
emergency telephone number.

Note: Specific procedures for enabling each of the above contacts to be made need to be developed.

3. The 'suitable person' designated as such in a Centre assesses the situation with respect to whether the student is safe to return home or not. If the client cannot return safely home, options are
 - (1) Use physical restraint if the situation demands it
and
 - (2) Call the police if violence to self or others is probable
and
 - (3) Call the Crisis Assessment Team (CAT) Team.

To this end, the Centre should establish familiarity with the local police station and the area CAT Team. (Refer to H&CS Psychiatric Services Manual for area CAT Team)

4. Someone from the Centre should accompany the client to the hospital or police station as well as a friend or relative.
5. A senior person in the Centre is notified to attend or speak to the rest of staff, depending on the level of emergency.
6. Debriefing of staff and students.
7. Follow up plan for continued student participation needs to be discussed with staff and student.

Other issues which need to be considered are:

- Looking at evening classes from the security point of view (including 'panic' buttons to police or internal site)
- Participating in training for dealing with violent situations (self-protective behaviours etc)
- Provide information re emergency protocols for emergency teachers
- Clarity regarding responsibility for emergency situations is required. All staff in a Centre need to be included and be clear about who does what.

5.2.4 *Core Recovery Processes in the Classroom*

Apart from effectively dealing with emotional blocks to learning and highly problematic situations, teachers can enhance recovery in many ways. The goals of recovery and ways to achieve them were discussed in Chapter 3. Methods applicable to the classroom situation are summarised in Table 8.

Facilitating language acquisition is listed as a way to achieve each of the recovery goals. Apart from the obvious access language provides to employment, further education and a range of services, language acquisition is fundamental to forming connections with people, enabling control and restoring self-respect and dignity.

The learning of a new language, while using and experiencing the familiar language of one's home, can create conflict and confusion. It reflects the struggle for identity, adaptation, and integration of the old and the new. In the early stages of settlement, when the opportunity for learning English is most freely available, students are in the throes of the struggle which will show itself in the classroom. Some will need to stay with what they know and forestall the new, while others will hurry towards the new.

Table 7

Core Recovery Processes and Strategies: Teachers (ESL)

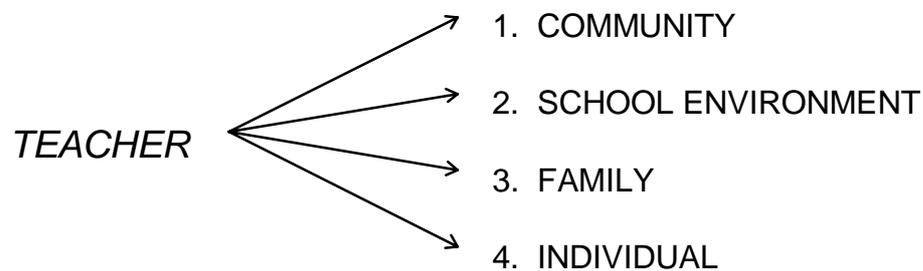
<p>1 RESTORE: CONTROL SAFETY</p> <p>REDUCING FEAR AND ANXIETY</p>	<ul style="list-style-type: none"> ➤ Facilitating language acquisition to enable mastery ➤ Offering a structured, predictable environment ➤ Providing routine ➤ Setting achievable goals ➤ Flexibility around tasks to reduce helplessness and enable success ➤ Information provision about Australian systems, settlement demands, education and work opportunities ➤ Offering explanations about what will happen and the purpose of tasks, excursions ➤ Realistic expectations around performance ➤ Giving choices about topics ➤ Not forcing participation in certain activities/tasks, selecting tasks with flexibility ➤ Accommodating the effects of anxiety by approaching difficult tasks gradually ➤ Accommodating blocks to learning
<p>2 RESTORE: ATTACHMENT CONNECTIONS</p> <p>OVERCOMING GRIEF AND LOSS</p>	<ul style="list-style-type: none"> ➤ Facilitating language acquisition for communication ➤ Group activities ➤ Choosing activities which enable the experience of pleasure and opportunity for laughter ➤ Physical activity to reduce depression ➤ Promoting potential for social contacts ➤ Enabling opportunity for sharing
<p>3 RESTORE: IDENTITY MEANING PURPOSE</p>	<ul style="list-style-type: none"> ➤ Modelling a human encounter which is predictable ➤ Developing a trusting relationship with respect for limits ➤ Conveying acknowledgment of difficulties ➤ Developing with students a wider perspective and sense of possibilities with learning ➤ Facilitating language acquisition and its expression as a way of restoring a sense of self or "I"

Table 7 *Continued*

<p>3 RESTORE: IDENTITY MEANING PURPOSE (continued)</p>	<ul style="list-style-type: none"> ➤ Building sense of future ➤ Promoting self-esteem through opportunity for use of coping skills ➤ One to one reviews which gives each student attention ➤ Listening ("third eye" listening) ➤ Being more aware as teacher of human rights violations ➤ Understanding the causes of anger
<p>4 RESTORE: DIGNITY VALUE</p>	<ul style="list-style-type: none"> ➤ Facilitating language acquisition as a way to restore dignity ➤ Provide opportunity for laughter, fun and experience of pleasure ➤ Respectful treatment eg correct pronunciation of names, listening to students ➤ Respect for privacy ➤ Having background knowledge of countries of origin

5.2.5 *A Model for Working with Survivors of Torture and Trauma*

Maximising recovery processes involves not only working with students more effectively but influencing the school and community environments. The teacher can contribute on many levels, summarised below.



Examples of what can be done at each level:

1. Community

- Links with other agencies such as community based ethnic workers, employment services and health services
- Public education, dissemination of information
- Influencing practice curriculum and policy

2. School Environment

- Provision of indoor areas which allow for small group contact
- Support structures for teachers
- Training and professional development for teachers
- Induction of new teachers
- Establishing emergency protocols
- Provision of resource material
- Monitoring student needs

3. Family

- Parent-teacher nights using interpreters.
- Contacting parents in ways other than notices.
- Adult classes.
- Orientation programs for parents.
- Volunteer program enabling inclusion of non-English speaking parents.

4. Individual

- Teaching practices and supportive environment which enhance recovery - examples: one to one student reviews, classroom activities which include dealing with the effects of settlement and previous exposure to trauma on learning.
- Setting learning and social goals which accommodate the blocks to learning and participation caused by trauma.
- Identifying students who require counselling or medical assistance.
- Being a model of a caring adult who respects the strengths of their students.

5.3 *Working with Children who are Refugees in Schools*

The reader is referred to the VFST guide “Working with Young People who are Refugees” for ways to facilitate recovery in the 12-20 year age range. Most of the information contained in that guide is applicable to younger children as well.

This section focuses on recovery issues for children between the ages 6-12 years which are not addressed in the guide or in the previous section on ESL teaching for adults.

5.3.1 *Classroom Activities (6-12 years)*

The central recovery principles underlying the use of classroom activities are that children can overcome the effects of trauma by expressing their feelings and telling about traumatic events and that children need the help of adults to do so. Children re-enact trauma in their play, drawings, verbally when they ask questions or tell stories, and when they show their feelings. An adult’s usual response to such expression is to deny them as no longer appropriate, because the trauma is in the past, or hastily reassure that it is all right now. Denial of children’s distressing feelings and attempts to reassure quickly are understandable because adults want to make things better for children, and it is distressing to acknowledge that children are suffering.

However, any activity which leads to the disclosure of traumatic material will not be beneficial to a child unless it is received by adults who can acknowledge distress as a normal response to trauma requiring understanding and support.

Children are afraid of upsetting adults by showing their fears, sadness and anger and therefore may be reluctant to show their feelings. The best possible response is for adults, including teachers, to:

- Listen to what a child is saying without moving on to something else too quickly.

- Admit that they also feel sad or angry at times but that these feelings are all right.
- Appreciate that children mix fact and fantasy when they recall events and that one does not correct fantasies - the important thing is to acknowledge the feelings associated with whatever is presented. This means saying things such as “that must have been frightening”, “that must have made you feel sad”, “you feel there was more you could have done to stop it happening”.

Teachers reported after a training session on working with children who were survivors of trauma that they had noticed reacting differently to their student’s play. Usually when children made guns with lego to play with they would point out that guns were not to be played with . They now thought that they would let children make guns and could ask “have you seen real ones used to hurt people?”.

To deal with children’s fears of being overwhelmed, offer your support. Say that they can come to you if they are feeling worried, sad or angry.

Recent understanding of the biological basis of trauma highlights the importance of children having the opportunity to express traumatic events. During trauma the whole organism is alarmed and in this state memories are stored differently - in what is termed implicit rather than explicit memory. Implicit memories cannot be reported but they can be triggered by reminders which are everywhere. Telling of the event or expression through play and drawing enables implicit memory to be made explicit, leading to integration of thoughts and emotions. (2)

Activities suitable for Classroom Use:

Letter-box

Students can ‘post’ letters to their teacher and the teacher writes back, ‘posting’ letters to their students.

Log book

A log book is a writing book with the student’s name in it. It is used to write personal things such as “what makes me sad” and the teacher



writes comments. The student can ask for their log book at any time to convey messages. Children should be able to write in their own language and have it translated.

Recreational activities

These build mastery, understanding of a new environment, facilitate sharing and build trust.

Cultural events

Events can be held to share customs and traditions and special days can be celebrated.

Story writing and diaries

These can be integrated with artwork, photography and other mediums to express feelings and narrate personal history.

Tapes

Children can also tell stories into tapes which are kept in a library for them to listen to.

Art

For students with language difficulties, artwork is extremely effective for expressing feelings and depicting aspects of life in the past, present or future.

The reader is referred to a publication produced by the British Refugee Council which is a rich resource book for classroom activities and discussion of topics relevant to the refugee experience. (3)

Table 8 *Recovery Process in the Classroom (Children)*¹

<p>1</p> <p>RESTORE: CONTROL SAFETY</p> <p>REDUCING FEAR AND ANXIETY</p>	<ul style="list-style-type: none"> ➤ Providing a secure environment - visibility and availability of teacher in the school yard ➤ Asking children if something is troubling them ➤ Acknowledging feelings and being available for support ➤ Discussing classroom rules and explaining them ➤ A room for students as an alternative to the playground ➤ Providing routine, giving explanations for tasks and activities ➤ Writing, art and discussion to enable expression of thoughts and feelings ➤ Flexibility about participation
<p>2</p> <p>RESTORE: ATTACHMENT CONNECTIONS</p> <p>OVERCOMING GRIEF AND LOSS</p>	<ul style="list-style-type: none"> ➤ Listening to students ➤ Providing a caring and supportive environment ➤ Providing for one to one discussions ➤ Fun activities, camps, excursions ➤ Promoting family involvement <ul style="list-style-type: none"> - information nights (education, health, laws) - inviting parents to school to help - showing parents around the school - meeting parents individually - afternoon teas ➤ Providing small group learning environment ➤ Visits to students in hospital
<p>3</p> <p>RESTORE: IDENTITY MEANING PURPOSE</p>	<ul style="list-style-type: none"> ➤ Group discussions regarding: <ul style="list-style-type: none"> - settlement - good and bad things in Australia - good and bad things in country of origin ➤ Cultural exchange activities ➤ Discussion about education, work, health, law, police, politics and rights in Australia
<p>4</p> <p>RESTORE: DIGNITY VALUE</p>	<ul style="list-style-type: none"> ➤ Listening to students ➤ Acknowledging feelings, thoughts and fantasies

¹See also page 23 of previous section for additional methods, many of which are applicable to children.

5.3.2 Involving Parents

Raundelen (2) has emphasised that parent's failure to protect their children from danger during traumatic events, leads to children feeling betrayed. Communities have an important part to play in restoring a parent's protective role by encouraging them to speak to children and hear them. Involving parents in some of the activities summarised in Table 8, can also contribute substantially to children feeling that parents are resuming an active role.

Parents attending the Foundation for assistance in overcoming depression reported that their son was repeatedly in trouble at school for aggression and theft. The father spent virtually no time with his son because he was withdrawn and had lost interest in everything. The mother reported feeling constantly irritable with her children for fighting. Some regular activities were planned whereby the father would play soccer with his son once a week, watch television with him and ask a few questions about school each day. Within a matter of weeks, the parents were reporting a dramatic improvement in their son's behaviour.

5.3.3 Groups

The activities described above can be part of everyday teaching practices and provide children with the opportunity to express their feelings and experiences while receiving acknowledgment and support. The school environment can also be ideal as a natural setting to conduct groups which have a special focus integrating past, present and future and understanding emotions. To conduct a group, the school environment would need to be a supportive one.

5.3.4 Conclusion

Children will reveal feelings and thoughts to adults if they expect to be listened to seriously, if they do not have to worry about upsetting adults, and if they are offered support should they feel upset. The opposite applies as well. It would be counterproductive to encourage expression of feelings if they are dismissed as an over-reaction or if the past is considered best forgotten.

5.4 *Immigration*

This section is most relevant to immigration officers assessing refugee claims of asylum seekers and for those interested in understanding how the effects of torture and trauma manifest in an interview situation. (Chapter 2 is essential background reading for this section.) This section focuses on three issues:

1. The retraumatisation of asylum seekers who are survivors of torture and trauma.
2. The manifestations of torture and trauma experiences in the interview situation.
3. The contribution of a psychosocial assessment to the refugee determination process.

5.4.1 *Retraumatisation of Asylum Seekers*

The way in which stresses of settlement can exacerbate and maintain the trauma reaction was presented in Chapter 1, pages 24-26. The same causal connection between stressors and effects applies to asylum seekers who are survivors of torture and trauma. However, the degree of stress is so much greater because one of the most fundamental causes of trauma, lack of security and lack of control, characterises the lives of survivors of torture and trauma seeking refuge. Figure 5 illustrates how the country of asylum can unwittingly subject asylum seekers to processes which resemble elements of a persecutory regime.

The Maintenance of Chronic Alarm

Most asylum seekers are forced to wait several years before they are granted residence in a safe third country or when applying 'onshore' in countries such as Australia. In this situation chronic alarm is maintained by the constant fear of forced return. Furthermore, threatening circumstances in the host country such as prejudice, direct assault and the exposure to news of continued persecution of family/community



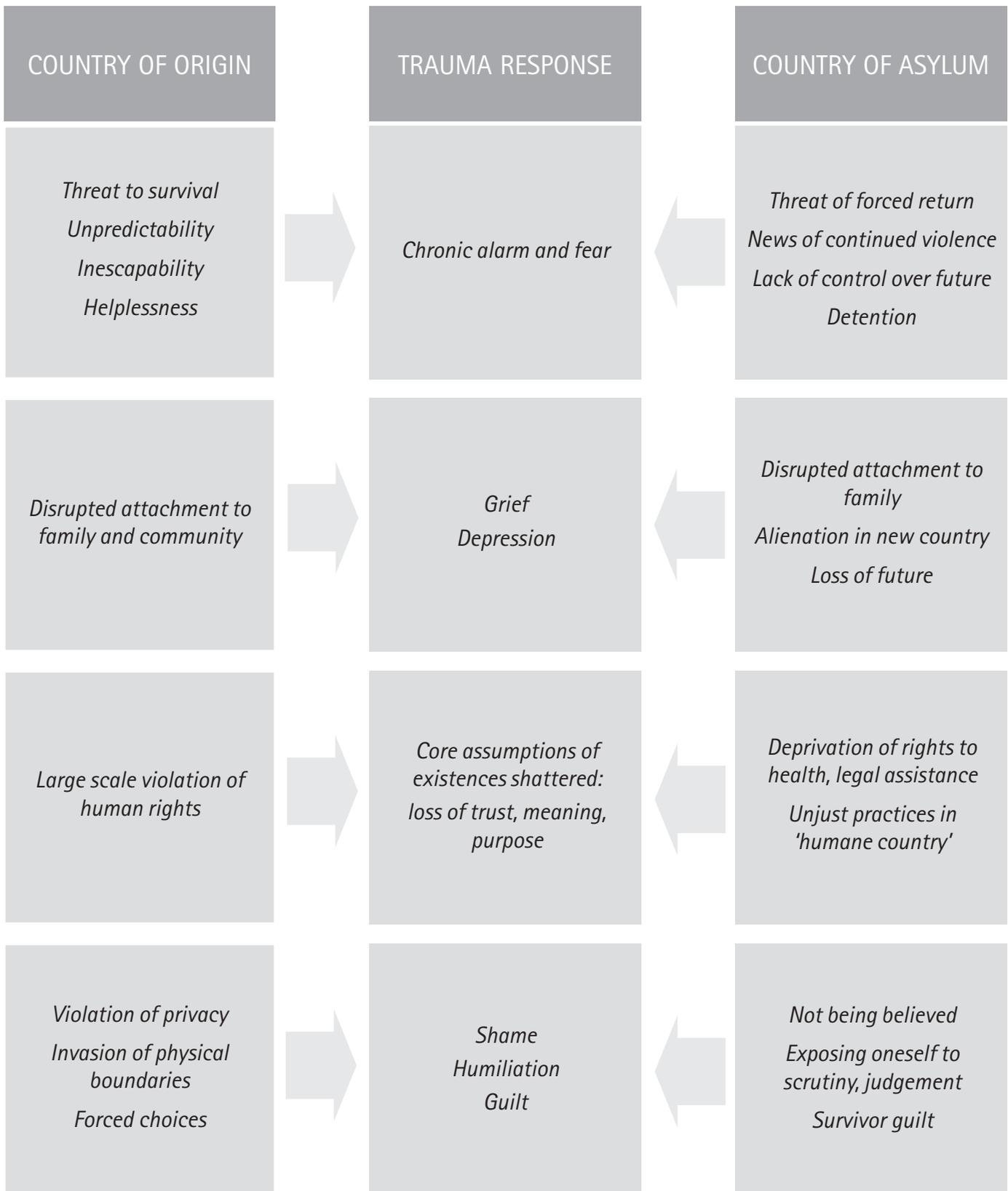


Figure 5
 The Causes of the Trauma Response and its Manifestations in the Country of Asylum

members in the country of origin sustain high levels of anxiety. Family and friends left behind in their home country may suffer harassment and imprisonment by the asylum seeker's political opponents in an attempt to force their return. (In some countries it is common for government authorities to imprison and interrogate family members until the person they seek comes forward). As a result, any reprieve they feel from further direct persecution is replaced by fear for their family's safety.

Asylum seekers constitute an extremely powerless group with far fewer rights than citizens of the host country and far fewer resources with which to ensure a safe and predictable existence. Their limited capacity to communicate in the predominant local language further compromises their ability to assert real control over their lives and contributes to an ongoing state of helplessness.

In countries such as Australia there is the detention of unauthorised arrivals until full processing is completed. If this results in a survivor of torture and trauma being detained for lengthy periods of time, the potential for retraumatisation is extreme. Confinement and the presence of uniformed guards stimulate past feelings of repression and represent ongoing punishment.

Loss

The sense of loss felt by the asylum seeker can become more intense while awaiting processing in the host country. They are often separated from family and friends and become a part of a minority culture co-existing in societies that know little of the circumstances from which they have sought refuge. Social systems and structures are often radically different to those they are familiar with. This dislocation continues to threaten their sense of identity and belonging.

As critical as the loss of family and culture is the loss of a sense of future which is essential for sustaining interest in life. The asylum seeker is robbed of their vision and hope for a new life by the insecurity of awaiting a decision about their future. One client who was tortured and raped described how being left alive meant she could start again. Two years after her arrival in Australia, as an asylum seeker she functioned

well, fully expecting to attain refugee status. When her application was rejected, the sense of hope was shattered and she became depressed, highly symptomatic and unable to cope.

Erosion of Core Assumptions of Existence and the Perpetuation of Shame

Central assumptions about human values and rights continue to be assailed in the host country. For example, inconsistent government policies for the granting of resident status promote a deep sense of injustice. People from one country who are rejected for refugee status while others are accepted as refugees or as residents under alternative categories created on their behalf, feel a deep sense of discrimination. Following the Tianenmen Square killings, 17,000 PRC nationals were granted residence status in Australia following a government commitment to do so. At the same time, Cambodians arriving by boat were held in detention. Lack of comprehension is augmented by the fact that the host government had been perceived as benevolent, publicly presenting itself as protective of human rights.

The violation of human rights and the injustice of subjecting people to degradation is the mark of the oppressor. Perceived acts of injustice in the host country are not mere triggers for previous trauma but are new stimuli evoking betrayal of human values. They promote distrust and suspicion of the host country.

Rejection of claims for protection is not merely a threat to basic security but typically induces shame and humiliation about not being believed. It can be perceived by the asylum seeker as punishment when guilt for having survived and leaving others behind is prominent. In the case cited earlier, the rejection of the client's application reinforced her sense of worthlessness and shame about being raped. She felt that her badness must have been the cause of such an outcome.

The persistent threat of return, sense of loss and acts of injustice can thus perpetuate a cycle of chronic anxiety and despair. The asylum seeker is therefore effectively trapped and the failure of developed countries to acknowledge the legitimacy of their plight affirms the original intentions of their persecutors.

5.4.2 *Manifestations of Torture and Trauma in the Interview Situation*

The psychosocial impact of torture and trauma related to the refugee experience has been extensively described in Chapter 2. This section details the ways in which cognitive, emotional and behavioural effects can manifest themselves in an interview situation.

From the following tables, it can be seen that various symptoms and signs produce many effects in an interview situation. For example, poor concentration can be the result of intrusive recollections of events, generalised fear, emotional numbing and depression. Anger can be the result of a reduced capacity to regulate tension or the result of grief, loss of trust, loss of identity and shame.

It is important to consider that torture and trauma caused by persecution does account for a variety of behaviours and emotions which otherwise might be misinterpreted as demonstrating a lack of credibility.

Memory difficulties are a special cause of concern to decision makers and can naturally cause doubt over claims, but they are one of the most common consequences of torture and severe traumatic events. In some cases, there can be extremely accurate recall of certain events and amnesia for others leading to inconsistencies in presentation. Retention of traumatic experiences as “compartmentalised, undigested fragments of perception” (4, p.424) is highly characteristic. Other forms of remembering are not conscious at all, such as occurs in nightmares or fugue states where events are relived in an altered state of consciousness which the person cannot report on. In such cases it cannot be expected that a coherent, chronologically intact account will be obtained. At the very least, a history needs to be obtained over a number of sessions. A legal representative can assist in the documentation of such cases. Where the situation is further complicated by shame about disclosure, professional psychological interviewing can assist further.

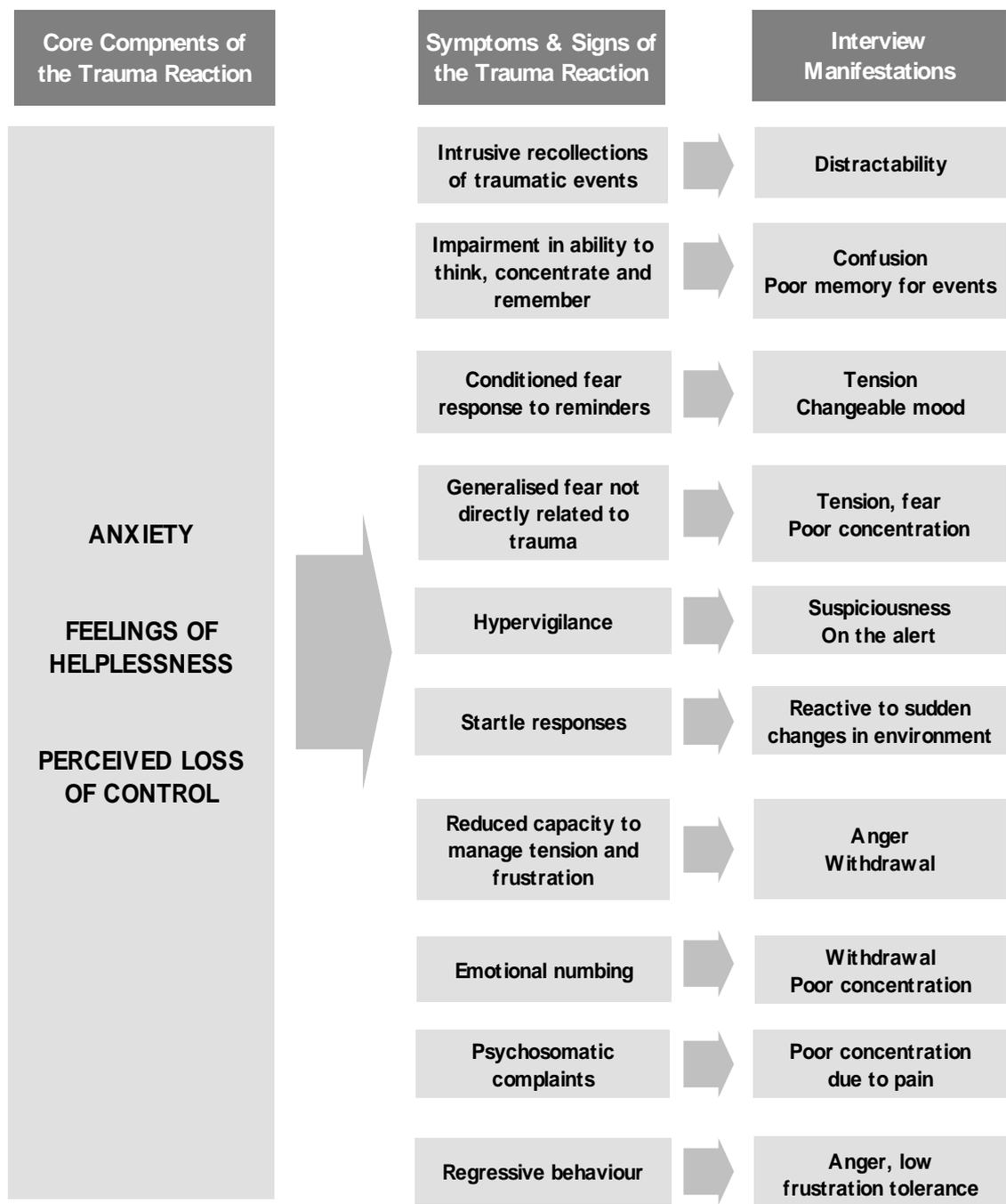


Figure 6
Interview Manifestations of Anxiety

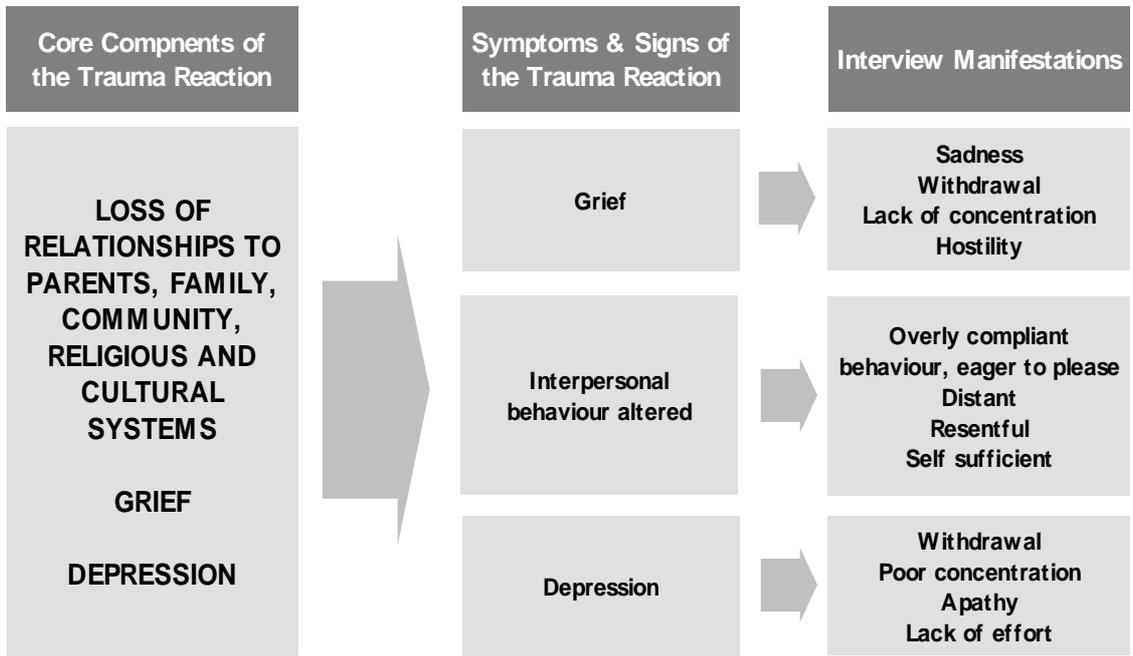


Figure 7
Interview Manifestations of Depression

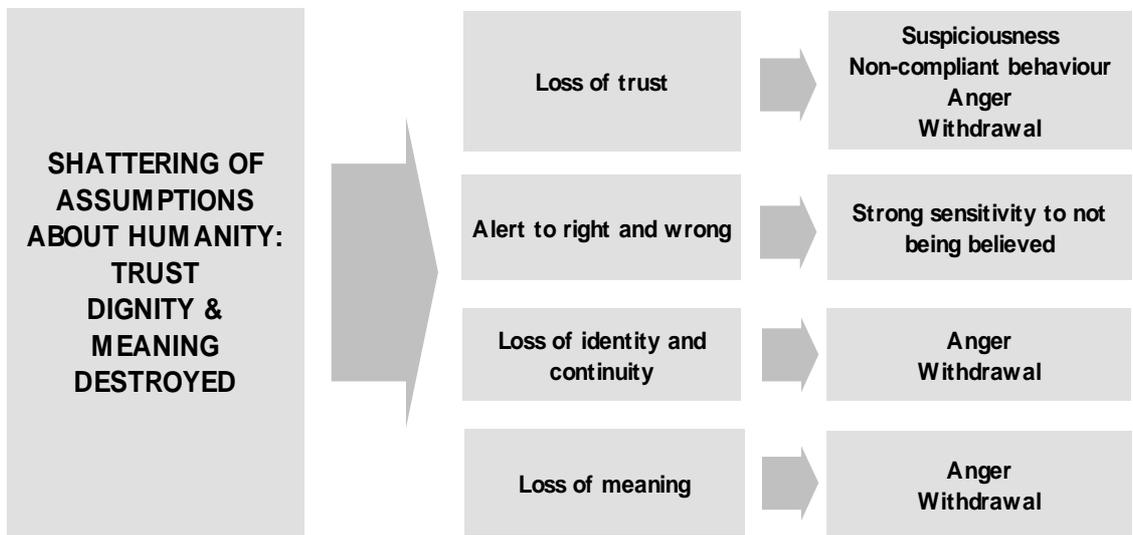


Figure 8
Interview Manifestations of Loss of Trust and Meaning

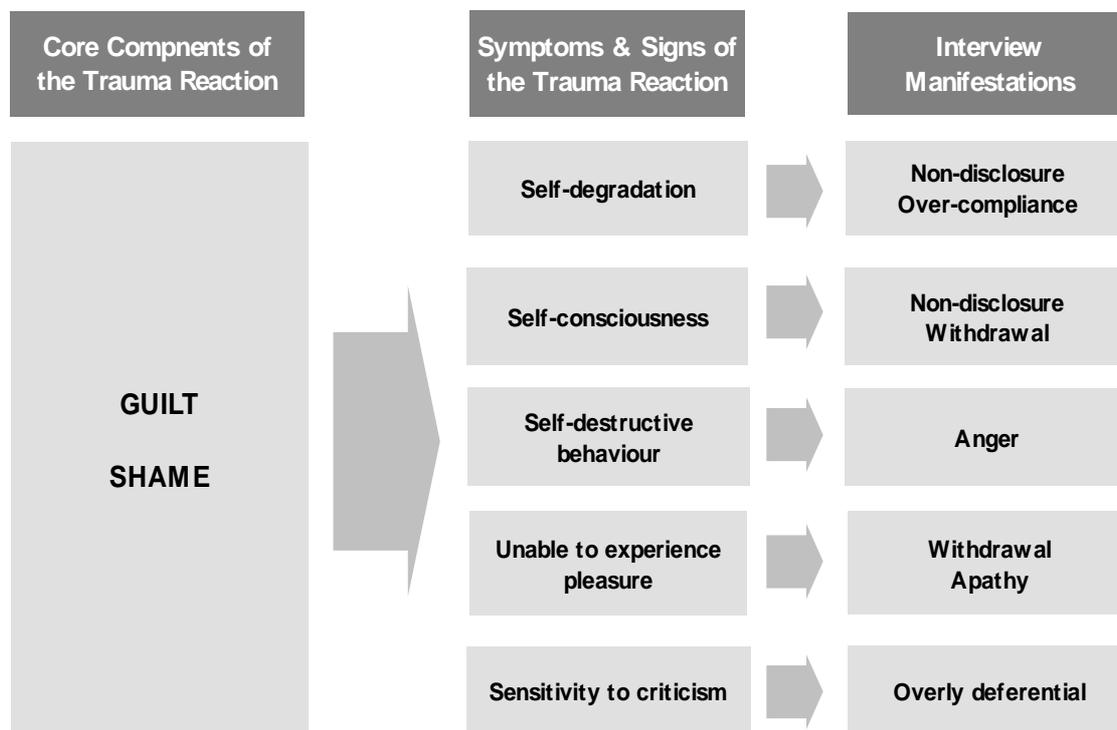


Figure 9
Interview Manifestations of Guilt and Shame

If a person is interviewed more than once about their experiences, changes in their account are to be expected. In some cases, more memories of events will be remembered. In other cases, where a previous telling has provoked intense anxiety, the person may “shut down” and fail to remember previously disclosed details.

Non-disclosure is another common presenting feature of torture and trauma survivors and can be an extreme problem for credibility. It has been widely observed at the VFST, while counselling survivors who are residents, that many only reveal details of what happened to them over a long period of time. They fear being overwhelmed by anxiety, should they disclose their experiences, because remembering does indeed involve reliving. Shame is particularly characteristic in women who have been raped. Their sense of being tainted and bringing disgrace to their families is so strong that disclosure is almost unthinkable. It is only

under circumstances of trust, fostered by a consistent relationship that experiences such as rape and other forms of sexual torture will be revealed. Sexual torture and rape is also only reported by men in the context of a safe, trusting and predictable relationship.

The level of disclosure is also strongly influenced by cultural factors. It is simply not acceptable in some cultures to disclose problems to a stranger, even if they are a professional.

Non-disclosure or understating a case is also the result of fearing disbelief. VFST counsellors have described the way survivors of torture and trauma do not expect to be believed whilst at the same time hoping they will be.

A counsellor during supervision described how a client repeatedly brought a video of atrocities committed in his country of origin. He wanted his counsellor to see it but kept postponing the day. After viewing it together, the client said that he had wanted her (his counsellor) to see it so that someone else knew what he had seen. He also said that he would know it was true if she believed it was, because it did not seem believable to him. This comment, which on the face of it seemed surprising, indicated the extent to which the atrocities he himself had witnessed could not be assimilated as true, it so defied his sense of what human beings could do.

Some clients will not disclose because they are angry about the necessity to prove that their experiences of torture occurred. The author has heard clients say that they refuse to disclose information to someone questioning their credibility. This occurs because anyone who asks a lot of questions is experienced as an interrogator.

Appearance of coping well

A client appearing to cope well can also be problematic because it suggests that the person is not suffering. What can be happening is that the person is detached and numb. In such cases, there will be evidence of a related difficulty such as the inability to be close to people.

It cannot necessarily be deduced that trauma or torture is the cause of visible or reported signs of distress such as anxiety, withdrawal,



suspiciousness, anger, self-consciousness and eagerness to please. Such signs can also be the results of current life stresses such as financial hardship, ill-health and major family conflict. Nevertheless it is possible to deduce causes of psychological symptoms and signs if one looks at the history of the development of the problems as well as the qualitative nature of the symptoms. A consideration of the totality of the picture is essential for doing this.

For example, an asylum seeker who was eventually granted humanitarian status presented as if he was coping very well. He worked extremely long hours, spoke English fluently and appeared to have good relationships with his family members. It appeared that he was not suffering greatly. The psychological assessment revealed quite a different picture. He could not sleep, look anybody in the face due to shame, and his work had him on a constant edge of explosive anger because his workmates taunted him for being so quiet. His work, in a hospital kitchen constantly triggered memories of 'work' he had had to do for his torturers. In the interview situation he would often go blank, then say "It shouldn't happen to anybody".

Reducing adverse effects arising from an interview situation

An interview situation evokes anxiety because much is at stake for the person making the application. For survivors of torture and trauma, anxiety can act as a trigger for intrusive recollections of traumatic events and feelings of helplessness. This can in turn lead to withdrawal or anger, or more fear. Interview conditions which are not unduly anxiety-evoking can reduce such potentially disruptive effects. Advising clients about the purpose of the interview, how long it will take, if they can ask questions, if breaks are permitted, is extremely helpful in this regard.

GUIDELINES FOR CONDUCTING AN INTERVIEW

1. MINIMISE ANXIETY AND FEELINGS OF HELPLESSNESS

- *inform the applicant about the purpose of the interview*
- *state their rights to:*
 - *ask for clarification*
 - *have a break*
 - *not answer questions*
 - *confidentiality*
- *do not use an interrogating style of questioning*

2. DO NOT TAKE EMOTIONAL REACTIONS PERSONALLY

- *consider the meaning of anger*
- *explain again the purpose of your questions*

3. ACKNOWLEDGE DIFFICULTIES

Example:

I understand that you may not want to talk about what happened

It is difficult to have to answer so many questions

4. CONSIDER VARIOUS EXPLANATIONS FOR BEHAVIOURS WHICH ON THE FACE OF IT SUGGEST A LACK OF CREDIBILITY

Typical features of the trauma reaction which undermine credibility:

- a) poor recall for events and inconsistencies in recall*
- b) non-disclosure*
- c) anger*
- d) appearing to cope well.*

5.4.3 *The Contribution of a Psychological Assessment to the Refugee Determination Process*

At the VFST, the aim of working with asylum seekers, as for residents, is to assist in their recovery. This usually involves counselling but also includes facilitating access to health services, English classes, accommodation and social support. Reports are prepared when they can contribute to the refugee determination process. The psychosocial assessment, on which reports are based, occurs in a therapeutic context. It is considered essential to establish a relationship between counsellor and client which is characterised by trust and rapport.

1. A psychosocial assessment may reveal information bearing on establishing the likelihood of persecution which may not be elicited otherwise by the legal advocate or tribunal member.

The information may be:

- Country of origin information which may otherwise not be known regarding forms of harassment and persecution.
- The assessment may reveal behavioural and emotional features which will increase the likelihood of persecution if the person were to return. For example:
 - people with a paranoid personality may draw attention to themselves by showing their suspiciousness
 - people with a 'crusader' mentality can insist on demonstrating against injustices which can lead to increased attention from authorities
 - for some people the level of dysfunction is so great that it would interfere with expected compliance in many situations.

2. An assessment bears considerably on credibility. The advantage of a psychosocial assessment is that the history of torture and trauma is elicited in the context of a therapeutic purpose which aims not so much at getting an account of what happened but enabling the person to work through the legacy of that experience. In this process, the connections between reported and observable symptoms and their causes can be assessed.

Essentially, an assessment of an individual's psychological functioning tells you what they are suffering from and the likely causes.

It is known that events which are life-threatening such as torture can evoke the reaction known as PTSD. Where symptoms of PTSD are present, it can confidently be concluded that trauma (single episode or cumulative) has occurred. However, the absence of PTSD does not mean the absence of preceding traumatic events. The reaction to trauma is far broader than the constellation of symptoms which characterise PTSD. This is one of the reasons for using the term "trauma reaction" to refer to the psychological sequelae of trauma (see Chapter 1). Prominent researchers in the field have also criticised the current definition of PTSD as too narrow. Van der Kolk (4) lists the associated features with what he terms "complicated PTSD" which usually results from chronic trauma. The list of features shown in Appendix 1 overlaps considerably with the features referred to in this guide as the trauma reaction.

A question which is often asked is how one can establish causes of symptoms which although typical of the reactions to torture and trauma, also occur in response to other stresses. Basically, analysis of content is critical, as is the development or course of symptoms. Course of symptoms includes when they began, what makes them better and what makes them worse.

The purpose of counselling is to establish the causes of symptoms for the person's benefit. It is common for torture and trauma survivors to fear that they are losing their mind. Looking at the significance of everyday events the emotions they give rise to, and their possible link to torture and trauma gives clients the means to understand their symptoms and establish connections for the therapist.

The prospect of a hearing usually worsens symptoms and the nature of thoughts occurring at this time is also revealing.

Analysing the nature of depressive symptoms enables one to establish if it is depression caused by torture or depression caused by other losses.

Guilt is a typical symptom with multiple causes. But guilt for having informed or guilt for having survived has distinctive content, and is different to guilt for say, having left family members behind or guilt for failing to adequately care for family members in Australia.

A lack of concentration may not have specific content associated with it. However if the lack of concentration is due to preoccupation with intrusive memories of past trauma, this does begin to suggest a trauma-based lack of concentration. The expression of worthlessness is another common symptom. Again content analysis can reveal whether it is trauma based or not. One would inquire into expressions of self-degradation. If the person talks of having been treated like an animal in detention this adds substance to a trauma based hypothesis. Phobias are very revealing: a fear at the sight of uniforms, the inability to take a bath (reminder of water torture) are examples which suggest trauma based symptoms.

Appendix 1

Complicated PTSD (4)

- 1. Alteration in Regulation of Affect and Impulses**
 - A. Affect Regulation
 - B. Modulation of Anger
 - C. Self-Destructive
 - D. Suicidal Preoccupation
 - E. Difficulty Modulating Sexual Involvement
 - F. Excessive Risk Taking
- 2. Alterations in Attention or Consciousness**
 - A. Amnesia
 - B. Transient Dissociative Episodes and Depersonalization
- 3. Somatization**
 - A. Digestive System
 - B. Chronic Pain
 - C. Cardiopulmonary Symptoms
 - D. Conversion Symptoms
 - E. Sexual Symptoms
- 4. Alterations in Self-Perception**
 - A. Ineffectiveness
 - B. Permanent Damage
 - C. Guilt and Responsibility
 - D. Shame
 - E. Nobody Can Understand
 - F. Minimising
- 5. Alterations in Perception of the Perpetrator**
 - A. Adopting Distorted Beliefs
 - B. Idealisation of the Perpetrator
 - C. Preoccupation with Hurting Perpetrator
- 6. Alterations in Relations to Others**
 - A. Inability to Trust
 - B. Re-victimisation
 - C. Victimising others
- 7. Alterations in Systems of Meaning**
 - A. Despair and Hopelessness
 - B. Loss of Previously Sustaining Beliefs

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