In Our Midst

Educational Aids to Work with Survivors of Torture and Organized Violence

A Reflective Interactive Approach

Edited by Christina Whyte-Earnshaw and Dieter Misgeld

Canadian Centre
for Victims of Torture

MANDATE

"Hope after the horror"

The Canadian Centre for Victims of Torture aids survivors to overcome the lasting effects of torture and war. In partnership with the community, the Centre supports survivors in the process of successful integration into Canadian society, works for their protection and integrity, and raises awareness of the continuing effects of torture and war on survivors and their families. The CCVT gives hope after the horror

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"Within a system which denies the existence of basic human rights, fear tends to be the order of the day"

Aung San Sun Kyi

... practices which had long been abandoned, in same cases for hundreds years – imprisonment without trial, the use of war prisoners as slaves, public executions, torture to extract confessions, the use of hostages, and the deportation of whole populations – not only become common again, but were tolerated and even defended by people who considered themselves enlightened and progressive.

George Orwell

PREFACE

Most Canadians think little about torture, disappearances and other human rights abuses. When the Canadian Centre for Victims of Torture (CCVT) was initially established as the first rehabilitation Centre in Canada (and in North America), many local residents and professionals were skeptical about the need for such programs. There was resistance to thinking about torture and its consequences.

Now, twenty-six years later, the CCVT has become an organization which is respected in Canada and abroad and is called upon to provide training, and to share its expertise nationally and internationally.

CCVT is a community-based agency. Its philosophy expresses the conviction that refugee survivors of torture and of war can be most effectively assisted through respectful partnership between their original cultural communities and their new Canadian community. CCVT recognizes that the individual survivor needs specialized services, as well long term support, which must include sensitive, and responsive host communities. To this end, CCVT's mandate states two organizational aims: direct service and public education. The public education programme is a service intended to increase awareness and develop support for survivors in the service community, governmental organizations and among the general public. It is with this goal that we have developed these educational materials to meet the needs of those involved in the provision of service to survivors of torture and their families and to share our expertise in this field.

Since CCVT's incorporation in 1983, other services and programmes for survivors across Canada, like the Vancouver Association for Survivors of Torture (VAST) and Réseau d' Intervention auprès des personnes ayant subi la violence organisée (RIVO) in Montreal have formed in response to demonstrated needs. Over the years the three Centres (CCVT, VAST, RIVO) have collaborated on a number of projects and have assisted others active in the provision of services and in training services providers that work with refuges and immigrants. These materials reflect continued cooperation between our centres.

The survivors we work with are individuals with their own family and cultural background, political and social involvement, spirituality and belief: to understand and assist them is to acknowledge and respect this diversity and uniqueness. We hope these materials will assist service providers to understand this guiding principle. They are offered in the hope that those who survived torture and trauma will not be alone in rebuilding their lives. The individuals we serve were not always victims or refugees, and they can be more than survivors.

These materials have been written by professionals actively involved in providing services to survivors of torture and trauma, so their flavour is practical and applied. They are designed to assist other professionals, human service organizations and community groups - in work place and neighborhood, in health, education and social service – understand and join these survivors

as they settle in a new country and culture.

The text reviews the experience of survivors of torture and ways they can be helped. Its primary purpose is to help service providers understand and care for survivors and their families. But we also hope a wider audience will read it and recognize the critical need to prevent abuse – no matter where in the world it occurs, and the need to help survivors overcome physical and psychological problems caused by their trauma. The fundamental message, so clearly articulated by these educational aids, will never be out of context.

The researchers have wisely chosen to review a range of psychological treatment methods being used, rather than to endorse only one approach. The materials are also ambitious in other ways. They draw not only from North American and European sources, but also from the important work with torture survivors which is ongoing in areas of repression around the world. Survivors of torture have a great need for solidarity as well as care. Thus the rest of us are faced with the need to do something to further the protection of rights of personal safety, human freedom and a life undiminished by terror.

If the torturer's purpose is deprive a community of its individuals, just as they deprive individuals of their community, by attacking the trust and confidence which makes the fabric of any society, then our goal must be rebuild and reclaim the community. We need to overcome our fantasies and fear of torture and build spaces of solidarity and support in ourselves and in our communities.

Toward this end, we would like to recognize and extend our gratitude to all health professionals, lawyers, social workers, volunteers and community groups who have assisted survivors of torture in their daily struggle to rebuild their lives. And we would also like to recognize our gratitude to all who have contributed their time and resources to the production of these materials, which we hope will be of help to many others.

Support and solidarity comes in many forms and the provision of funds is a critical part of the work we must do. Thus thanks are also due to Sandra Napoli and Robert St. George from Citizenship and Immigration Canada for their support and encouragement in the preparation of these documents. We also thank Fran Perkins, Chair of the Public Education Committee of CCVT. We are also grateful to Citizenship and Immigration Canada for their generous support over the years and for providing the funding necessary to prepare this educational aid. Finally, we are deeply grateful to all survivors of torture for sharing their painful memories with us. We have learned a great deal from them.

Mulugeta Gebremeskel Abai

Executive Director

Contributors:

This document has been prepared by:

Yaya de Andrade, Ph.D. Clinical Psychologist, Vancouver. Founding member, VAST, Vancouver
Didier Muamba Funakoshi, M.Sc. Administrative Coordinator, Training Modules Project
Laura Heller, M.A. Resource Librarian and Educational Resources Consultant
Cecile Marotte, Ph.D. Ethnopsychiatrist. Montreal and Haiti. Member of RIVO
Dieter Misgeld, Ph.D. Professor, Ontario Institute for Studies in Education and University of Toronto, Former Board Member and Volunteer, CCVT, Ex-Chair, Public Education Committee, CCVT
Dr. Cecile Rousseau, Research Psychiatrist and Therapist, Douglas Hospital, Verdun, Quebec, Founding Member RIVO, Montreal
Joan Simalchik, M.A. A.B.D. (University of Toronto) (post-residence doctoral student), Former Director of CCVT and former Community and Settlement worker
Christina Whyte-Earnshaw, M.Ed. Psychodynamic therapist and ABD, University of Toronto, (post-residence doctoral student)

We also acknowledge the help and advice of Mulugeta Abai, B.A., B.Ed., CCVT's Director, Adrienne Chambon, Ph.D., Board Member of CCVT and Professor, University of Toronto, Dr. Ana Maria Barrenechea, psychiatrist and therapist, member of CCVT's medical network, and of Mira Dodig who carried out the initial needs assessment research. We also appreciate Ramses Rivas' (CCVT) assistance in the production of this document.

Authorship:

The *Introduction*, the brief introductions and evaluations as well as *Interactive Pedagogy, an Afterword*, were written by Dieter Misgeld.

The units *Understanding Torture: Definitions and Myths* and *Settlement Services for Survivors of Torture* were written by Joan Simalchik.

The units *Assessment* and *Children's and Youth's Experience of Torture* were written by Cecile Rousseau.

The unit *Phenomenon of Torture, Effects and Consequences*, was written by Cecile Marotte.

The unit *The Impact of Torture Experiences on Families and Individuals: Intervention, Supports, Resources* were written by Yaya de Andrade and Christina Whyte-Earnshaw.

The unit on *The Experience of Service: Ethics and Support* was written by Christina Whyte-Earnshaw.

Laura Heller provided the general bibliography and several annotated bibliographies, as well as an extensive database to be published separately. She also provided information/data/resources for the writers.

Didier Muamba Funakoshi and Dieter Misgeld translated three texts from the French.

Christina Whyte-Earnshaw was the editor/writer revising/editing all the texts contained in this module.

Dieter Misgeld was the Senior Researcher in charge of the intellectual content of the entire project.

Dieter Misgeld and Christina Whyte-Earnshaw revised together parts of several texts.

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INTRODUCTION

I. The Basic Philosophy: Human rights, Care-Giving and the Resistance to Torture and Organized Violence

This collection of texts is meant to help caregivers in the field of socials services, health-care and education accept a particularly daunting challenge: the challenge of working with survivors of torture.

We call this collection "Educational Aids to Caregivers and Educators working with survivors of Torture." We give it this name, because we believe that we can only aid and support a work already begun. We want to be encouraging, helpful and informative, while also making clear what needs to be considered, examined and done.

We are convinced, indeed we know, that this work has merit and value, most of all, because it helps and can make a difference to many people who have been treated in the most contemptuous manner, who have been violated and practically trampled upon.

Much of what is discussed here describes the effects of these injurious actions. As such it is painstaking work, which has to be done carefully, and with calm. But we also believe that a strong sense of satisfaction can be derived from this work, and from the effort to face up the realities of torture.

The greatest satisfaction will surely lie in seeing a survivor of torture feel and manage better, after supportive intervention and/or treatment. There is also much satisfaction to be found in an educator's engagement with the realities of torture and organized violence, such that he or she can make a refugee family who has suffered such a fate feel a little safer in Canada. Little steps matter here. Victories are small.

Nevertheless they convey something to us, which has been expressed a long time ago in an ancient Maya (Central American Maya) saying, and written down in the famous Popol Vuh (the Mayan Book of the Dawn of Life): "remember us after we have gone. Don't forget us. Conjure up our faces and our words. Our image will be as dew in the hearts of those who remember us."

Perhaps this is the reward we seek: if remembered, to be remembered at least without horror. Not to be recalled as the vast number of governments and their agents in the world who have paid no heed to the old Maya saying, who appear not to care how they are recalled. Not to be remembered like those organizations and systems of organized violence or terror and torture

who have left profoundly destructive, debilitating traces in the minds, the hearts, the bodies of so many people.

As hard as many find it to believe: such forms of destructiveness are deliberate and intentional, often engulfing entire societies and regions on all levels, even far below the level of government (as the recent history of atrocities in Bosnia and Rwanda appears to indicate). We may indeed have lived and still live in an age of terror and torture-systems, of recourse to organized violence, which has reached proportions which give us great cause for concern.

It is important to keep this general historical and political background to our present global situation in mind, when attempting to help survivors of torture.

For one, torture has – not without reason- been called the "epidemic of the twentieth century"[1]. The scope and intensity of the application of torture has grown together with the institutions of modern states and their organizational capacities. Taking a broad historical view of this certainly has the salutary effect – important for those helping survivors- that they will free themselves from parochial concerns and the assumption that torture, genocide, the systematic spreading of terror are very uncommon occurrences and only typical of a few particularly "evil" regimes or movements.

Nazi Germany has for a long time played this role in the thinking of many. It, unfortunately, no longer stands alone, even if it may still remain the incarnation of evil for many for a long time to come. Yet the growing awareness of the global condition and the integration and encounter between cultures, races, societies and systems which we now witness, also tell us, that the history of atrocities is global. We, in Canada, and in North America, unfortunately have to admit to it as well: We also have "our genocides." The history of the conquest, subjugation and displacement of native peoples[2] is one such process, which took place over centuries and recently came to general awareness. The history of the enslavement of millions and millions of Africans is another[3]. Nevertheless, there also is Rwanda (a genocide perpetrated by Africans against Africans), there is Cambodia (and the Khmer Rouge). And there was, in the recent past, the cruel treatment of entire populations in the Republic of China and in the former Soviet Union. There now are newer ethic/political purges and wars.

The resort to massive force, and even to policies of "extinction" and extermination (of ethnic groups, a people, an educational class, officials, etc.) is an affliction on a global scale. We truly live in a post-colonial world in this sense: it is no longer only the European colonial powers, or

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1 This is phrase, which has been used by Amnesty International in its reports on Torture. For details see the unit *Understanding Torture: Definitions and Myths*.

2 This history of the devastation of the original peoples in the Americas has been chronicled in Ronald Wright's *Stolen Continents. The "New" World through Indian Eyes Since 1492*. (See bibliography)

3 There are numerous accounts, many recent ones written by African American writers, of the history of slavery, especially in the U.S. We often underestimate the extent of it. By 1800 there were two million slaves in the U.S. or twenty percent! of the population. In our conception slavery must be understood as a form of organized violence, including torture. For this dimension see Toni Morrison's famous novel Beloved. (See bibliography)

Stalinism, or capitalism, which are to be blamed. In the multiplicity of human rights disasters, which are upon us and have occurred, we are faced with a condition as common as the new environmental afflictions: we are faced with a condition not likely to go away given the economic and political uncertainties now engulfing us – and the lack of a clear moral response on the part of so many governments and powerful organizations.

Thus a new context is set for those working in support of the victims of organized violence. Underlying and informing all the concrete steps they will take can be the profoundly enabling, even empowering thought, that they are collaborating in the construction of a different ethic, an ethics and morality of compassion in response to actions and practices, which represent the opposite; an ethic of care and of the hope that one may be recalled if not "as dew in the hearts of those who want to remember", then at least without horror.

Whether we are health-care workers, educators or working in the field of social services, whether we are professionals or volunteers, this thought may inspire us.

It can take its inspiration from many places: a treatment successfully concluded, a survivor's desire to once again embrace life, the confirmation of a peoples' right to exist through sensitive international intervention.

And to speak with Aung San Sun Kyi, (kept in house arrest by the Burmese – Myan-Mar – military till recently): The ethics and the new global morality to be constructed can only have the reaffirmation of basic human rights as its content; the right to life and security of the person, the right to be protected from political, racial-ethnic and religious persecution, the right to be protected from persecution on the basis of sexual orientation, the right to be protected from genocide and systematic brutalization, and, of course, from torture or other terrible traumas produced.

Following a suggestion coming from South America we may think of this morality of caring as the active construction of a "human rights culture". And it is easy to define it in its basic outline: It is a culture in which massive human rights violations do not occur and which provides conditions discouraging recourse to them. It is a culture, which encourages constructive and supportive relations between people.

Caregivers working with survivors of torture and other forms of systematically practiced and organized violence are building this culture, even if they do not think of their work in this way. And the great majority of service providers and caregivers are, indeed, people, who care and want to be of help to their clients or those seeking out their services. We count on their willingness to confront the difficulties mentioned. We, therefore, wish to work with this willingness, and the commitment which it implies. And because we approach those whom we address in these materials with respect, we have designed the components of this set of educational aids in such a way that they remain to be completed and developed; just as the experience, reflection and forward looking thought of services providers is – hopefully – growing and unfolding.

But many among us will also have experienced what Yael Danieli, a therapist working with survivors of the Nazi Holocaust described thus: "I cannot directly connect with the Holocaust without intense pain. It is copeable with largely by avoidance. The Holocaust comes close to the ultimate of pain, ... I feel most identified with the victimization and the overwhelming powerlessness against the horror "

We may say that the crux of our entire enterprise of support is to be encountered here. It calls into question a most important conviction and hope: The belief that a profoundly motivated, knowledgeable and intelligent as well as morally committed approach to helping and healing may turn matters around (at least in part) and make up for the humanly designed and caused horrors of our century. However, given our knowledge of the extent of the practice of torture, we now have to pose this project in a new from, tempered by a necessary realism and the calm and courageous recognition that horrors will not go away.

Yael Danieli, the clinician and therapist just referred to, not only has extensive experience of work with holocaust survivors and their children, but also with therapists and researchers having worked with this group of victims. n the background of this experience, she speaks of a "narcissistic blow", which has struck the human species. This blow consists in the shattering of the "naïve belief that the world we live in is a just a place in which human life is of value, to be protected and respected". The experiences and their consequences, which those working with survivors of torture become aware of, certainly may affect one's belief in the possibility of justice most profoundly. For almost always these experiences are not only deeply disturbing by themselves, but they also are brought about by actions, which themselves are coupled with other equally vicious or even more terrifying actions: genocide, disappearances, executions, forced dislocations. And the vast majority of these remain unpunished or even untried.

But is this all there is to be said? Certainly not. Is there not a consolation to be found, a reassurance to be gained in *knowing* what the world like, *knowing* that this is who "we" are and facing this reality unflinchingly, but with the quiet determination to undo the damage in one or the other place, with one or the other person, one or other group? One philosopher subjected to Nazi-terror once said: "It is only for the sake of the hopeless that hope is given to us". To be able to maintain hope and faith in humanity our promises and encouragement must be realistic, emphasizing what *can be* done, even if inspired by what we hope can be done beyond what is being done.

It is for this reason, that our materials are aids for self-education and reflection. They do not tell the whole story. They are interactive. (See the unit Interactive Pedagogy: An Afterword, at the end).

They also acknowledge a changing condition in the world, in the richer countries and in Canada. A kind of collective "compassion fatigue," a being overwhelmed by a fear of the loss of economic well-being, sometimes almost coupled with resentment of the poor, the damaged, the persecuted, the "losers," as some grossly harsh voices would have it.

One cannot do our kind of work without being on the side of the "losers," of the displaced, the murdered and the tortured. We need to *validate* their experience. This is more important that anything else.

But one needs to do this work taking account of reality and the merciless logic of arrogance in power, to which caregivers in the fields of the helping professions, the social service professions and of education can only respond by humbly carrying out their persistent work of support and advice, of instruction, counselling and healing. From what we can know of the future to hold these activities and the dispositions required for their practice will be in demand more than ever, just as much as resources (material, financial) may be harder to come by.

And even if we have evidence of encouragement from governments and other powerful organizations, especially in the recent history of Canada, for example, we may still want to reflect on a sobering statement by the poet Stephen Spender:

"In our time the necessary measures to deal with an avertable disaster are never taken because the self-sacrifice, disinterestedness, co-operation and realism necessary to meet approaching dangers can never be achieved until nations are actually engulfed by them. Politics is, rather, a perpetual application of half remedies to disasters, which have been foreseen and which might well have been avoided. "

Caregivers concerned with victims of torture will appear on the scene as human rights disasters (massive violations) have happened.

Their courageous and thoughtful response may, indeed, prevent further such disasters from occurring – at least at times. This is our hope. We, nevertheless, need to approach our tasks with the utmost realism *and* determination to resist the evils, which realism cannot but acknowledge as occurring.

How then do we approach the practical issues of care, support and treatment in this set of educational aids (means of information and support) on this general background?

To begin with, a few conceptual clarifications:

II. Concepts

IIa) Users of our textual units very often find that we do not clearly distinguish the terms "victim" and "survivor." This is because there are no definite criteria for making this distinction. There is some agreement, however, that people who have been tortured and have been the object of assaults on their bodily and personal integrity due to organized violence must be regarded as victims, even if the care- giving effort has the intent of helping them deal with the effects of having been a victim and thus helping them become "survivors"" or "subjects" of their fate and lives who can shape it actively. We need to remember, however, that in vast ma-

jority of these cases, no full healing or even healing is possible. What is possible is that victims learn to live better with the effects of the injuries done to them, that they can find relief, and sometimes or even often they may come to terms with this terrible part of their life-histories and even turn "coming to terms" with in into a productive and creative engagement of world and life. There definitely is no reason here for a gloomy outlook. Many victims of torture who have become survivors have been found to have unusual capacities and many are active and leading in our field and in the struggle against organized violence.

It needs to be remembered, however, that some centres serving survivors prefer to use the word "victim" in their identifying name. Therefore it is a good policy not to insist too much on the difference between the two terms. It may sense to use both of them.

IIb) We use the terms "torture" as much as "organized violence" in our texts. The first unit to follow this introduction addresses "Definitions." Therefore there is no need to pursue the matter here in detail. Suffice it to say that one of the centres cooperating in the project, the *"Reseau díntervention auprès des personnes ayant subi la violence organisée, "* in Montréal, Québec, has deliberately avoiding using the term "torture" in its name, in order to avoid stigmatizing clients/patients. Organised violence is a broader concept than torture and refers to the activities of organized groups, be it a military command, police units or local militias, intended to systematically intimidate, terrorize and/or torture, abuse and intentionally and systematically injure and violate persons who can be subjected to their power. At least this is a summary proposed here of the meaning of definitions to be found in various documents (including a statement by the World Health Organization mentioned in our Unit on *Understanding Torture. Definitions and Myths*). Once again, it may be a good policy to operate with both concepts.

IIc) It may be useful to recall that the units reflect (in some measure) the work and orientations of three centres in Canada (see *Preface*). And there are differences of orientation and approach (See: *Interactive Pedagogy. An Afterword*). This also applies to the name. RIVO in Montréal, while VAST in Vancouver and CCVT in Toronto have kept the term "torture" in their names. However, this does not mean that there are major differences of philosophy and programme between the other centres and agencies in Canada, which are concerned with this area. At least, our needs assessment review has told us that there are no such differences in philosophy and outlook.

III. Intervention, Care and Support on the Background of a Global Condition of Organised Violence

IIIa) There are indications that the conditions which spawn organized violence and torture in so many countries around the world will not improve.

We have been asked again and again, in reply to our needs assessment questions and at other times: what produces these atrocious practices? And there is a professional literature attempting to answer it. There are many answers and more questions.

Most of the reasonable ones will point to specific conditions in particular countries or regions, rather than, let us say, "human nature."

Among these conditions are: extreme poverty and the frequent repression of any attempt to struggle against this condition, such as the repression of efforts by peasant organizations to achieve a measure of land-reform: the refusal of education to the poor or subjected and semi-enslaved populations, uncontrolled and/or uncontrollable power (dictatorships, one-party states, a police force out of control, etc.), and the systematic and deliberate exploitation of resentment and fear between groups. And there are other causes such as unyielding and uncompromising ideological and doctrinal attitudes, the determination (to the point of paranoia) on the part of ruling groups, or of a state to defend their interests at all costs, and also the hatred of and contempt for minorities (sexual, racial, religious). In all these instances individuals will be trained to torture or forced to torture by their superiors.

The issue of power and of its unrestrained use always lies at the back of all this. In the complex situation of our times we therefore need to be prepared for the recurrent use of torture, because:

1. Poverty is growing as are populations in many areas of the world; and an equitable and efficient distribution of food-stuffs has not been achieved yet. In many cases, it is also actively resisted by groups in control.

2. Governments and ruling or leading groups are disoriented (e.g., in the former Yugoslavia) and turn to facile solutions which require the suppression of complexities (such as claiming that an unregulated "market" can achieve every thing or turning to ethic homogeneity as a solution to variety.)

3. International organizations have not been providing orientation and/or successful solutions. They have been too reluctant to take on issues of human rights in their full range or they have divorced economic development strategies from questions of social justice.

4. The wealthier countries are increasingly unclear about their global role and insufficiently effective with respect to the treatment of minorities in their midst.

5. There is no strongly motivating form of international ethics at present, which could educate people toward a respect for life in a fundamental sense.

6. Clear air, clean water, access to space, these environmental factors have become hotly contested resources. And situations of desperate competition for scare resources commonly have the effect that measures are resorted to which are calculated to damage and destroy sections of a population or entire populations (especially often the economically weaker ones).

Thus we can no longer expect torture and organized violence to occur in the context of clearly identified conflicts (as was the case during the Cold War) or of a struggle to overcome an old and unjust order (such as the overcoming of colonial rule) met by violent force and repression (such as the one applied by France in Algeria, by Britain in Kenya, etc.). We now have to expect it to occur in a greater variety of situations and for greater variety of reasons. It will become harder to know with whom to identify as victims, as is happening now with respect to the situation in Bosnia, perhaps Rwanda, and also Sri Lanka.

IIIb) Thus caregivers concerned with victims of organized violence and torture need to be clear about their motivations and commitments: they are concerned with the alleviation of conditions for which there are multiple causes and in Canada at least, they are not concerned, may not primarily be concerned with living out a political commitment.

One needs to be very clear about this: victims of torture require care, just *because* they are victims, not because they are certain kinds of victims coming from certain places, even if there are those with whom one may prefer to work and others one would prefer not to work with. Our unit on *Service Providers: Ethics and Support* examines this issue of commitment, as do relevant reflections suggested in our unit on *Assessment.*

IIIc) Our needs assessment findings tell us that service providers and caregivers (in education, health care, social services) often believe they do not know enough about torture in general, or about specific forms of it (country-specific forms, for example). But questionnaire replies also indicates that respondents frequently are quite confident that they have *some* knowledge (e.g., of the physical effects of torture).

One might suggest that the problem of knowledge really is psychological; for it is easy to find all kinds of relevant information about the physical effects of torture (see our unit on *The Phenomenon of Torture: Effects and Consequences,* and the section attached to this introduction entitled, *A Comment on Manuals and Educational Aids for Working with Survivors of Torture*). The problem really is one's feeling of *uncertainty* in the face of the stark challenge which devastating human experiences such as the experiences of torture and of organized violence pose. To give an example: a caregiver wants to know what forms of torture are specific to which countries/regions so that "one will not be surprised."

The issue here is, one *will* be surprised, or shocked, or feel troubled/hurt/disoriented no matter how much objective information one has received. One very experienced clinician active in the field told us: "It is when you are no longer shocked, when you are no longer haunted by what you hear, when you no longer can respond emotionally, that you are in trouble."

It therefore is best to prepare one's interventions on the basis of the recognition that one will always, and frequently again and again, be startled (even feel hurt and be very troubled). Being thus prepared is a sound basis for appropriate interventions. Developing the appropriate forms of empathy also is important. One needs to say, at times: "what would I be like, who would I be, had this happened to me?" Without taking this step, in one's thoughts, feeling, imagination, one will not be able to care, just as much as one has to take steps "not to care too much"; one needs to avoid losing oneself in the other's distress. Thus the ability to give support *depends* on one's capacity to care in sincerity, but with some moderation and control. It is on this background of a reflectively clarified commitment that one can than look for the knowledge needed in order to better engage in one's practice of support.

We return to Danieli's statement: Knowledge of human rights disasters and of their consequences for people can shatter the belief, among caregivers, that "the world we live in is a just place in which human life is of value, to be protected and respected."

Many caregivers may unconsciously still want to maintain this belief and therefore want to protect themselves from the encounter with the victim/survivor. Here various, even hardly noticed impatient strategies of " blaming the victim" may arise (one may mutter to oneself, for example: Why don't these people learn to accept, that Canada is a different country? Or: They will have to reconcile themselves to their condition"). Here methods for the professional exploitation of survivors as material for research and advancing one's career may also arise, as well as other forms of not engaging with the troubling questions which they pose.

But actually, caregivers should be willing to face these questions as they often do or have (such as the survivors who now *are* caregivers): no adult can take for granted the world is a fair and just place in which human life is protected.

Working with survivors is better seen as part of the struggle to make the world such a place. This is the meaning of constructing a "human rights culture", as we said earlier. Caregivers also may commit the error of leaving no room in their lives for the fact that their own life being easier and happier (perhaps) that the survivor's life is a gift of life itself, which one should accept. One need not say, of course: I deserve to be happy. But one may very well enjoy one's feeling and being well and will then attempt to turn one's abilities to good use. This is a great temptation, in our field, to put on "ashes and sack-cloth." And at times people already having a penitent's attitude to life may be attracted to the work.

We need to remember, however, that caregivers want to inspire trust in life and some measure, however limited, of confidence that things can perhaps be good. This is impossible, if one is overcome by gloom or unhappiness oneself.

And there is reason to believe that victims/survivors primary want a tiny bit of their trust in life restored. An experienced psychiatrist working with one of our three centres has put it in this way, "People will come back for services if they feel they are relevant to their needs, if they feel *like they were being understood*, if they have some sort of rapport, and support... even if none of their problems are solved, people will continue to come." Thus caregivers in general, from volunteers and educators to professional therapists, may be encouraged to feel that even if they give "some" of themselves, they can make a profound difference. They can inspire a small measure of trust and confidence in life, perhaps a little more.

Thus helping form attitudes of this kind may be regarded as the major goal of our documents: attitudes shaped by one's wise recognition of limits as much as by a fundamental commitment, to help alleviate suffering and the effects of forced dislocation (exile). Presenting objective information and objectifiable knowledge about torture and organized violence must be seen as means to this purpose, not as the purpose itself.

Thus it is that these units and the case of writing, discussion and preparation which has gone into them may help caregivers' education, the education, which must arise from their own recognition and acknowledgement of their joys, pleasures, and apprehensions, in short form their own needs.

IV. The Individuals Units of "Educational Aids for Working with Survivors of Torture"

The units, which follow this introduction (and the information on manuals and the Bibliography attached to it) proceed from the provision of basic information on torture and interpretations of it in a broader socio-political context to more specific discussions rooted in community-oriented clinical and settlement work.

The final unit on *Interactive Pedagogy: An Afterword* is meant to help users/readers reflect back on all the texts assembled, especially as it also stresses the issues of culture and gender. The first two units (*Understanding Torture, the Phenomenon of Torture*) may be read in conjunction; for they deal with issues of definition and interpretation in the broad are of international agreements and of questions regarding the interpretation of torture as phenomenon of organised violence and of societies in a state of crisis.

The next three units dealing with *Assessment, Children's and Youth's Experience of Torture and with the Impact of Torture Experiences on Individuals and Families: Intervention, Supports and Resources* are all rooted in clinical practice, broadly conceived. But they neither exclusively rely on professions clinical practice nor do they avoid it.

In fact, the units on *Assessment* and *Children and Youth* develop a different from of clinical practice out of a community-orientation, thus making it possible for settlement workers, intake workers, educators and health centre staff in general to include elements of it in their own ap-

proach to clients/survivors. The unit discussing Intervention lays out a range of possible interventions recommending a holistic approach toward treatment and support, which we generally endorse. This approach may also be recalled an integrated services approach. But it would be presumptuous to say more about this at this point, because we still have some way to go toward the integration of our views across Canada. We may be able, in the future, to put forward a comprehensive model of care which could be widely accepted and which responds to the changing circumstances in the Canadian health care and social services field. But it is important to remember that several among our units, such as these and the unit on *Service-Providers: Ethics, and Support,* aim at an integration of professional clinical practice with a community-based approach, a strong community orientation reaching beyond clinical practice. This has been the tradition of all three centres directly or indirectly participating in this project.

The difficulty always is not to lose too much of knowledge, expertise and experience which professionals have to offer when one takes this step. Our units appear to have avoided this pitfall. It is apparent that we see much room for the development of professional practice in this field, a development hopefully still by be encouraged by governments in Canada and not be substituted for simply by asking for the goodwill of people and an exclusively community-oriented approach strongly relying on volunteers. It is the interaction between both, community activism and commitment, as well as professional knowledge and intervention, which is crucial to our field and distinctive of the Canadian tradition in it, as well as of a history of public and government support of which we hesitate to think that it might not continue.

V. A Final Word on the Units and Their Use

If readers/users want a guide to individual units, they best consult the brief introductions to each of the units, and possibly the suggestions for evaluation attached to each of them as well. For while we recommend that the units of this “module” be read in conjunction and have arranged them so that there can also be a development of understanding for the reader, it also is possible to work with each of the individual units independently from the order in which we have arranged them. One may consult them for one’s purposes at hand.

VI. Conclusion: A Word of Inspiration

Survivors come in many faces. Many may live quiet lives, keeping their despair to themselves. Some will kill themselves, others will remain unhappy. Still others will be successful and productive, they will have careers, resettle reasonably well, they may have families again. There are a vast number of life histories among survivors, some plain, other not so plain or hopeful. There are cases, among survivors, of outstanding individuals, struggling publicly against horror, making conscious what all this means.

We conclude by invoking an image, an image of a survivor, inspired by a real face. It is the face of Nadezhda Mandelstam, widow of the famous Russian Poet Osip Mandelstam who died in the days of Stalinist terror in 1938, and as a consequence of the terror.

Nadezhda is a survivor, a survivor-witness, to be precise. Her friends had been murdered, disappeared, members of her family as well, her husband had been exiled, betrayed, tortured, imprisoned, driven into an early death. She had been interrogated, exiled, betrayed, socially banished, lived at starvation level, passing the terrifying decades of Stalinist terror. Her biographer describes her this way: After conversations about her life, the injustice done to her, she "would clear the air with some spine-shattering oath and revert to her true nature: a vinegary Brechtian, steel-hard woman of great intelligence, limitless courage, no illusions, permanent convictions and a wild sense of the absurdity of life" (Clarence Brown in the Introduction to Nadezhda Mandelstam. *Hope Against Hope. A Memoir*, New York, 1970. Atheneum). We may not meet survivors like this exceptional woman. But perhaps we can be motivated and strengthened by the image of this one, the survivor who has a lesson to teach to all those who want to help: that they respect the strengths of those seeking their advice (and/or help) and learn from them, also about living and how to stay alive and responsive (when possible) in the face of adversity, even of extreme adversity.

Selected references

Beloved. A novel. Morrison, Toni. New York: Alfred A. Knopf, Inc. A. Plume Book, 1987.

This is one of the century's most powerful novels. It also is overwhelmingly beautiful. Nonetheless, the agony and pain of slavery and its consequences, as well as the systematically practiced torture of the slaves which came along with it, are movingly represented here. For anyone wanting to connect suffering abroad in the "Third World" with that on our own continent, this is an indispensable book.

Basic Documents on Human Rights. Brownlie, Ian, ed. Oxford: Clarendon Press, 1994.

The most complete collection of international documents on human rights. It contains all important United Nations "instruments" regarding Human Rights up to 1994, as well as other documents, such as documents released by the International Labour Organization, UNESCO and by Pan-European, Pan-Latin-American, and Pan-African organizations of the relevant states.

Freedom from Fear and Other Writings: Aung San Su Kyi. Harmondsworth, England/Toronto, Canada: Viking/Penguin, 1991.

This a collection of moving reflections and speeches by the 1991 Winner of the Nobel Peace Prize from Burma who had been held in house arrest for five years. Hers is a refreshingly direct voice in the argument for the defense of human rights.

Hope against Hope. A Memoir. Mandelstam, Nadezhda. Translated from th eRussian by Hayward, Max. With an introduction by Brown, Clarence. New York: Atheneum, 1970.

A moving and inspiring account of survival with integrity under conditions of Stalinist terror in Russia, which lasted for decades. The reader gains insight into some persons' unusual determination and will to resist terror, intimidation and torture.

Human Rights Education. Misgeld, Dieter and Brabeck, Mary Eds. Special Issue of the *Journal of Moral Education*. Vol. 23, Number 3, 1994.

This special issue of a major journal in educational research deals with the question of the prevention of human rights violations by educational means and what conditions have given rise to the need for prevention. It builds on Latin American experiences, as Dieter Misgeld explains in his lead-off article. The issue contains contributions by authors from Chile and Peru.

Human Rights in the World Community. Issues and Action. Claude, Richard Pierre and Weston, Burns H., Philadelphia: University of Pennsylvania Press, 1992.

The best reader available at present on international human rights documents and their interpretation. Contains a variety of articles by experts from various fields.

Imagining Argentina. A novel. Thornton, Lawrence. New York: Bantam Books, 1991 (1987).

> A writer's highly sensitive account of terror in Argentina, during the years of torture and disappearances. The book describes the emergence of the Mothers of the Plaza de Mayo, and the resistance of survivors, their determined refusal to yield to organised violence. Beautiful and painful to read.

I, Rigoberta Menchú. An Indian Woman in Guatemala. Burgos-Degray, Elizabeth, ed. London: Verso, 1992

> The moving account of Menchú's emergence into a position of leadership, in the Guatemalan Maya Peoples' Movement of Resistance to Genocide and organized violence. Rogoberta Menchú received the Nobel Prize in 1992. Her text as well shows the strength of a survivor and the unwillingness to let her spirit be destroyed by torture and terror.

On Human Rights: The Oxford Amnesty Lectures 1993. Shute, Stephen and Hurley, Susan. New York: Basic Books, 1993.

> Several philosophers and legal theorists have participated in these lectures. For human rights activists and caregivers in our field the most important lectures are by Catharine A. Mackinnon (She reviews the literature on the mass-rape of women in Bosnia and other issues), Richard Rorty, Jean-Francois Lyotard and Agnes Heller.

Psychotherapists' Participation in the Conspiracy of Silence about Holocaust. Danieli, Yael. In: *Psychoanalytic Psychology*. 1984, vol. 1, Nr. 1, pp. 23-47. (Also: *Countertransference, Trauma and Training.* Danieli, Y. in *Countertransference in the treatment of the Post-Traumatic Stress Disorder.* Wilson, J. and Lindy, J. eds., New York: Guilford Press, 1994).

> These two articles present Danieli's famous analysis of therapists' difficulties with holocaust survivors and the common tendency to "blame thevictim" even in these cases, or seek other avenues of escape from the gravity of the suffering and destruction therapists are conformed with. They may be regarded as the classic statement of the physiological difficulties to be encountered by caregivers in our field.

Stolen Continents: The New World through Indian Eyes since 1492. Wright, Ronald. Toronto, Canada: Viking/penguin, 1991.

> This book reviews the history of conquest by Europeans in Central, North and South America. Whenever possible it reconstructs the original Peoples' views regarding this massive intrusion. The Canadian writer and journalist has accomplished a panoramic summary of the enormity of organized violence practiced on the original inhabitants of the Americas by the Europeans, and the mercilessness of their economic pursuits, which led to the regular use of torture and genocide.

Storm and Sanctuary. The Journey of Ethiopian and Eritrean Women Refugees. Moussa, Helene. Dundas, Ontario, Canada: Artemis Enterprises. 1993.

> This is a beautiful study of the sorrowful journey of women from the Horn of Africa to Canada, women who are survivors of civil war, torture, organized violence and famine. The book also conveys something of the enormity of conflicts, which befell Ethiopia, Eritrea and Somalia during recent decades. Much of this is completely unknown in the "West". The findings offered are based on interviews with the women. We need more books of this kind on refugees and survivors coming from Africa and Asia.

The Drowned and the Saved. Levi, Primo, New York: Summit Books. 1988.

> This is a very disturbing book. It reflects on the condition of victims in the Nazi death-camps. It is a sequel to Levi's *Survival in Auschwitz*. In both books the central theme are the effects of the Nazis' effort to completely rob their victims of their humanness. The torture and evil imposed on the inmates make a majority of them literally incapable of caring for their fellows. This, as Levi describes it, as the most debilitating consequences of this form of extreme torture, and the perpetrators' unforgivable crime.

The Nazi Doctors: Medical Killing and the Psychology of Genocide. Lifton, Robert Jay. New York: Basic Books, Inc. 1986.

> The most accomplished study of doctors who have participated in torture, fatal experiments with human subjects, and practices of extermination (of the physically, mentally disabled) and genocide (against Jews, Gypsies, Homosexuals). A famous work, which must be considered in any further examination of the role of medical personnel in the perpetration of torture and organized violence.

A Review of manuals and Educational Aids For Working with Survivors of Torture

As this introduction has made clear, the "model", which we have been working with in our Canadian group (including Quebec) is grounded in the conviction that we cannot aim at exhaustive information and there is much to be left to the self-education of service-providers. Indeed, we believe that this is the best way to proceed in this field. For we need people who can dedicate themselves to the work on the basis of a clear understanding of their own capacities and motivations. Our texts are meant to help service-providers achieve this. They are designed to encourage the reflective approach required. A further elucidation of this approach can also be found in the middle-component entitled: *Interactive Pedagogy for Whom?*

Obviously, a text like ours cannot stand alone. One might say that it is a text to be supplemented by other, more introductory ones. Also, it is characteristic of our text that it reflects a community-based approach, which includes the significant participation of professionals.

As we reflect elements of the activities of three centres in Canada (Montreal, Toronto, Vancouver), we are bound to regard *our* contributions to education in this field as rooted in a recognition of diversity and will not conceal that there are differences in method and outlook accompanied by agreement on the most basic principle: that whatever we do is meant to serve the needs of survivors of torture and organized violence.

Thus it is best to regard our set of educational aids as belonging to a whole range of works, which are all useful and excellent.

The following is a guide through these documents, indicating how they can be used.

Canadian Materials

1. *Community support for Survivors of Torture: A Manual. Edited by Kathy Price. Canadian Centre for Victims of Torture.*

   This Manual is designed for community use. It contains contributions by a variety of professionals and community workers. It was edited by a former Canadian Broadcasting Corporation producer with a good sense of the requirements of "popular" education. Contributions can be read and selected, one by one, on the basis of topic and the reader's /user's interest. The text does not have to be read as whole.

2. *War Is Not a Game: Experiences of refugee Children.*

   This is a video produced by Frameline Productions, Toronto, for the Canadian Centre for Victims of Torture. The video is suitable for many audiences and contexts, lay and professional alike. It combines testimonies of refugee children with the comments of professionals who have developed expertise in this field, and also includes artwork by the children themselves.

3. *Treatment of Torture: Readings and References.*

   Edited and introduced by Ferne E. Atkinson, Ottawa. Privately published. Available on request (see general bibliography).

   Ms. Atkinson is a clinical social worker living in Ottawa, Canada, who has put together a Reader containing materials written by a number of professionals. Many materials are widely known and commonly used by health-care professionals, for example. They cover a wide range of topics, from specific forms of torture and its treatment to questions of culture, particular groups to each of the selections of her collection.

However, there is a problem with this set of materials: Atkinson does not offer a set of criteria in terms of which one could determine which approach is the most useful and adequate one. Her collection thus comes across as a resource where readers themselves have to develop their own criteria of selection and interpretation. Nevertheless, this is a useful collection, somewhat the opposite of a manual. Our own "Educational Aids" are best understood as neither such a collection nor a manual, and therefore preferable: they have virtues of both.

U.S.A. Materials

1. *Serving Survivors of Torture* by Glenn R. Randall and Ellen L. Lutz, published by the American association for the Advancement of Science, Washington, 1991.

   This manual was sponsored by Center For Victims of Torture in Minneapolis, Minnesota, a centre with which we collaborate. The manual has the subtitle: *A Practical Manual for Health Professionals and Other service Providers.*

   This is exactly what this manual is. As much it is most useful. It has a good index and helpful appendices, including a sample consent form to be presented to survivors before they agree to treatment, interviews or examinations. This manual is practically strong on the identification and treatment of physical effects of torture. It includes a vast number of references to the relevant professional literature at the end of each chapter.

   The sections on psychological treatment are not equally strong. But the "Introduction to Psychological Treatment" (chapter) gives a most helpful overview regarding the steps to be followed in the treatment process. It can be very useful for intake-workers, health-care workers in general, medical doctors and others who are concerned to be informed in this area, but are not fully trained clinicians or clinical psychologists.

Australian Materials

1. *Torture and Trauma. The Heath Care Needs of Refugee Victims in New South Wales* by Janice Reid and Timothy Strong. (A Report to the Western Metropolitan Health Region of the New South Wales Department of Health). Cumberland College of Health Services. Sydney 1987).

   This also is an excellent and very professionally done manual. Its first four chapters discuss torture and organized violence (which includes terrorism, experiences of violence and fear due to state actions) in detail. The text includes many testimonials and narrative accounts of the horrendous experiences made by survivors It also includes a superb discussion of the physical sequelae (effects) of torture, which makes very clear that

even "minor" physical assaults on a victim can have catastrophic consequences. For most community-workers, in-take workers, settlement-workers and teachers this may be the preferable text to read.

2. S.T.A.R.T.T.S. E*ye of the Needle Trainers' Kit.* This kit is a companion document to *Torture and Trauma.*

   It is the best trainers' kit which we have seen. As such it is most accessible, handy, usefully illustrated and sufficiently comprehensive to provide a general and basic introduction to the issues for lay-persons.

International Materials

Working with Refugees and Asylum Seekers: A handbook for Red Cross/Red Crescent staff and volunteers by League of Red Cross and Red Crescent Societies, Geneva, Switzerland, 1991.

This is well-done comprehensive and resettlement work. It contains well-arranged summaries under captions such as "Remember" or "Keep in Mind" which will help the settlement worker (or volunteer, for example) keep track of the many considerations relevant to their concerns.

This handbook is written for practitioners and volunteers who may not have any pertinent professional background. It should be understood that our methodology and the nature of our documents suggest the use of the various manuals listed in the review. Each has its own strengths and we cannot claim to have rendered superfluous any of the manuals, texts and other materials reviewed. We do claim a distinctiveness, however, which we have discussed. It should also not be forgotten that some Centres are very research-intensive, especially the Centre leading in research on torture: the *International Rehabilitation Council for Torture Victims (IRCT),* formerly known as the *Rehabilitation and Research Centre for Victims of Torture* in Copenhagen (Denmark). It publishes its own journal *Torture*. Its numerous highly professional publications are listed in a large database. The *Center for Victims of Torture* in Minneapolis, Minnesota (U.S.A.) also engages in professional publishing, as do associates and members of CCVT and RIVO. And there are other centres engaging in publishing of various kinds, such as centres in London (U.K.), Berlin (Germany), Nepal, Ethiopia, Chile and others. Some of their publications will be listed in our database. We therefore see our document as a part of an international network of cooperation, or as an element, a link in the building of international human rights culture. We hope that the users/readers of our documents will want to identify the strengths in our documents in order to search out the strengths on those produced by others. We will, of course learn from the criticisms, which they will also apply.

Evaluation of Units: General Principles

The evaluations presented here are meant to be evaluations of the materials, but also, and much more so, of your use of them.

They are meant to help you develop a reflective relation to your own thoughts and feelings arising as you make use of materials. They are not designed to be an objective evaluation, as if you were an independent consultant, planning a design of materials yourself. Rather they are designed to help you learn from and work with your subjective experience of the materials.

They are meant to lead you into the work more deeply and to help you determine the adequacy of the materials for you, that is to you as service-provider and as a person who needs to look at working with survivors of torture as task, which always remain emotionally demanding. The evaluation is to help to look at your own resources carefully, critically and where appropriate, confidently. Work with the materials presented to you in this document is to help you achieve careful thinking, critical capacities and justifiable confidence with regard to you work.

Please examine your thoughts and feelings from this perspective. And add reflections of your own regarding:

- What we have missed
- What makes sense to you
- What you find hard to accept or unconvincing, or
- What you regard as important in general

Evaluation of Introduction

1. Does this unit give you a reasonable sense of the educational materials offered in this module as a whole?

   Yes___
   No___
   Moderately___

2. Does this unit introduce you to major issues involved in working with survivors?

   Yes___
   No___
   Moderately___

3. How do you characterize the thoughts and feelings with this introduction suggests you entertain?

   As: (check any which appear to fit)

   Painful___

   Serious___

   Hard to bear___

   Surprising___

   Inspiring___

   Supportive___

   Realistic___

   (Your own word)_____

Chapter I

UNDERSTANDING TORTURE: DEFINITIONS AND MYTHS

Introduction

This first unit gives an overview of the meaning of torture, as it is linked with official and widely accepted definitions, which have been developed in the course of efforts to end torture. The purpose is for readers to situate their understanding of torture with reference to these publicly employed definitions, and to in this way align their own efforts with those of many organizations which work to stop the practice of torture and organised violence world-wide within the wider field of struggle against systematic human rights violations.

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For most Canadians, the reality of the modern practice of torture is brought home to us through the presence of refugees in our communities. In 1995, there were 23 million people externally displaced from their countries of origin and 27 million more people were internally displaced (figures from a Worldwide Institute report cited in the Globe and Mail, June 13, 1995). This was a marked change from the 1991 Red Cross estimate of 15 million refugees. The United Nations High Commission on Refugees had found the majority to be women and children.

Refugees are fleeing situations of war, including regional conflicts, such as found in the Middle East or in the former Yugoslavia and Soviet Union and civil wars as those in Somalia, Rwanda or Sri Lanka. Often, refugees are escaping from situations of massive social violence and extreme conditions of social terror such as those found in Guatemala, Iraq, or Pol Pot's Cambodia. Few among today's refugee population find themselves displaced through the actions of externally located foes. Rather, the majority of refugees flee their home countries because of civil conflict between armed domestic combatants or as a result of the actions of terrorism inflicted upon the general population by official and clandestine branches of government organizations.

The present global predicament demonstrates that countries in each continent have utilized various methods of violent social control against their own populations. Whether in Mexico, Peru, the Philippines, China, apartheid South Africa, Zaire, or in the former communist Eastern European states (in the recent past, before the collapse of Communism), a roster of human rights abuses have been found. Frequently among the examples are instances of the routine practice of torture.

It is a modern day paradox that while torture is rigidly prohibited on an international level, its practice exceeds that of any time in previous history. Indeed, Amnesty international cites torture as being "the twentieth century epidemic" and in its 1994 report (published in June 1995), the organization lists more than 100 countries that routinely employ torture. These figures are supported by the numbers of torture survivors who have sought assistance in Canada. In Toronto's Canadian Centre for Victims of torture (CCVT), 8000 people from 74 countries have been attended to in the last decade. Since 1986, the Vancouver Association for Survivors of Torture (VAST) has served people from 54 countries and Montreal's Reseau d'Intervention auprès des personnes ayant subi la Violence Organisée (RIVO) cites comparable statistics.

In the period following World War II, the international community formed the United Nations with the intention of preventing a repetition of the massive destruction, which World War II had meant. The 1948 United Nations Declaration of Universal Human Rights specifically outlaws torture in Article 5: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

In 1975, the United Nations General Assembly unanimously adopted the Declaration Against Torture which pronounced that "No state may permit or tolerate torture or other inhuman or degrading treatment. Exceptional circumstances such as state of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel, inhuman, or degrading treatment or punishment." Accordingly to this Declaration, there could be no justification nor any mitigating circumstances for the practice of torture.

Additional international efforts include the United Nations Convention Against Torture adopted in 1984 meant to make more effective its previous statements opposing torture. This Convention established the Committee Against Torture to monitor the situation in the countries which are signatories to it. The Committee Against Torture is composed of ten international experts in the field of human rights who serve in their areas of their practical capacities. Article I of the Convention defines torture: "For the purpose of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or a third person information or confession, punishing him for an act he has committed or intimidating him or other persons. It does not include pain or suffering arising from, inherent in, or incidental to lawful sanctions to the extent with the Standard Minimum rules for the Treatment of Prisoners."

Canada signed the Convention Against Torture in August 1985 and ratified it in July 1987. Canada's initial report to the Committee Against Torture was submitted in 1989 and entitled "Outlawing an Ancient Evil: Torture" (Ottawa: Multiculturalism and Citizenship Canada, 1989). The report itemized the measures taken by federal, provincial and territorial governments to incorporate the provisions of the United Nations Convention into domestic law. Examples included the Canadian Charter of Rights and Freedoms, legislative provisions; legal provisions governing police and security forces. It also set forth various methods for constitutional re-

course and restitution. By becoming party to the Convention Against Torture, Canada also undertook to agree to these provisions mandating training of security and medical personnel on issues relating to torture and its effects.

The continuing difficult, and at times desperate realities of the international situation with their direct impact on people's well-being have led other organizations to examine the implications of human rights violations. In 1981 the World Health Organization resolved "that the topic of violence and its effects on health be the subject of continuing professional discussions at national, regional, and global levels." In 1986, the World Health Organization formulated the "Concept of Organized Violence" and defined this as "The interhuman infliction of significant, avoidable pain and suffering by an organized group according to a declared or implied strategy and/or system of ideas and attitudes. It comprises any violent action that is unacceptable by general human standards and relates to the victim's feelings. Organized violence includes "torture…cruel, inhuman or degrading treatment or punishment' as in Article 5 of the United Nations Universal Declaration of Human Rights. Imprisonment without trial, mock executions, hostage-taking or any other forms of violent deprivation of liberty also fall under the heading of organised violence." The World Health Organization also took into account the situation of refugees in its formulation: "Uprooting and exile are closely associate with organised violence…[all] refugees must be considered victims." (Cited by Janice Reid and Timothy Strong in Torture and Trauma: the Health Care Needs of Refugee Victims in New South Wales, Sydney: Cumberland College of Health Sciences, 1987).

Events in the period following World War II required that the issue of torture be retained on the global agenda. Barely one decade after European Holocaust, France was using torture in Algeria. Evidence of torture was documented in apartheid South Africa, Franco's Spain, Salazar's Portugal, the colonels' Greece, the military regimes of Latin America, Africa and Asia and in the former European Eastern Block states. Clearly, the use of torture could not be relegated to history. Therefore, in present efforts to understand the issue it may be useful to remember that while the practice of torture is, indeed, an ancient one, so too are efforts to assist those who have been victimized by it. The Red Cross Museum in Geneva, Switzerland has a permanent exhibition which details the efforts of figures from every region and from various historical times, including Confucius and Alexander the Great, to mitigate the conditions of victims of war and violence. Henry Dumont who founded the Red Cross in 1861 is especially mentioned as an example of one who initiated support for victims of violence.

In response to the modern "epidemic" of torture, efforts to prevent its practice, to aid its victims and to understand the complexities of the subject have continued. Alongside the international legal instruments of the United Nations, health care professionals have developed principles of their own. In 1975 the World Medical Association adopted the Declaration of Tokyo as a comprehensive statement against the practice of torture. "For the purposes of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority to force another person to yield information, to make a confession, or for any other reason." The Declaration

continues to delineate the professional responsibilities of physicians to assist victims of torture and prohibits them from participating or facilitating the infliction of pain. (Cited in Torture: Human Rights and Medical Ethics and the Case of Israel, Neve Gordon and Ruchama Marton, eds, London: Zed Press, 1995).

Also in 1975 the International Council of Nurse adopted the Statement on the Role of the Nurse in the Care of Detainees and Prisoners, which specifically incorporates a prohibition against participation or facilitation of torture. The Statement "condemns the use of all such procedures harmful to the mental and physical health of prisoners and detainees" and affirms "that the nurse's first responsibility is toward her patients, notwithstanding considerations of national security and interest." (from Torture: Human Rights, Medical Ethics and the Case of Israel)

In countries under dictatorship, and even in those undergoing open warfare, health professionals and others have attempted to assist those who have been subject to torture. For example, underground treatment programmes were founded by church and professional groups in Chile in the period following the 1973 coup d'état in that country. Support for detainees and victims of torture were provided in South Africa during the apartheid period. Similar programmes were established in Argentina, throughout Central America, in Ethiopia, and the Philippines, to name but a few. Services continue to exist today in many of these same countries and other examples may also be found in Sri Lanka, Nepal, Cambodia, the former Yugoslavia and Lithuania. Many individuals continue to take great risks in their efforts to assist torture survivors under conditions of extreme violence; they frequently fall victim to the same forces which have created the traumatic circumstance. El Salvador's nongovernmental Human Rights Commission directed the Dr. Jose Martelli Clinic in the latter half of the 1980s to assist victims of torture in that country. Dr. Martelli was a physician who was "disappeared" for his efforts to aid Salvadoran survivors.

In countries where refugees find asylum, programmes for torture survivors were established. In the late 1970s, health professionals and settlement workers noted that newly arrived refugees from countries in Latin America's southern cone revealed particular problems due to prior torture experiences. By 1977, Amnesty International's Medical Network had initiated a series of conferences which provided a forum for those interested in developing methods for documentation and treatment. Out of these early efforts, centres were organized in Copenhagen, London, Paris and Toronto. Denmark's RCT was the first centre for torture survivors to be formally instituted in a country of refugee asylum and was founded in 1982. In Canada, Toronto's Canadian Centre for Victims of Torture was established in 1983, the Vancouver Association for Survivors of Torture in 1986 and Montreal's Reseau d'Intervention auprès des personnes ayant subi la Violence Organisée in 1993. Each of these programmes, and others subsequently developed in Edmonton, Calgary, Ottawa, Victoria, Kitchener, London and Quebec, were inaugurated by community members in response to demonstrated local needs of torture survivors. Newly instituted is the Canadian Network for Health and Human Rights for Survivors of Torture incorporating thirteen centres and programmes across Canada.

Much has been learned in and outside these centres during the past two decades and much continues to be learned about the nature of torture, its effects and methods of assisting survivors. Through practical interventions, it has been realised that many early perceptions about torture and its consequences were mistaken.

For example, even while specialized services were being established for torture survivors, the perception was that survivors would be a very small percentage of the refugee population in countries of asylum. But, the reality has been found to be different. The Red Cross and centres supporting survivors in Canada, Australia and Europe estimate that between *25* and 35% of the refugee population in their countries have experienced torture or organized violence. (Cited in Working with Refugees and Asylum Seekers, Geneva: League of Red Cross and Red Crescent Societies, 1991.) According to the United Nations definition of a convention refugee, a person need only to demonstrate that she/he is in danger of persecution based on a variety of established factors. It has been learned that people do not take the difficult decision to flee easily and, often, have been personally touched by torture before they are forced to make their escape.

Rather than being a random act arising from exceptional contingent circumstances, it has been learned that torture is a constituent part of mechanisms for social control. It is not an act practiced in isolation, but is situated within a continuum of repressive measures employed by governments or political groups, which could not maintain power through democratic means. Torture is a means used to discipline parts of or whole populations, and is usually accompanied by the suspension of constitutional and attendant democratic rights. Freedom of speech, assembly and association are replaced by executions, disappearances, imprisonment, banishment and expulsion from jobs and schools, in addition to systematic torture.

Torture is not intended to kill the body, but the soul. For this reason, torture has been called the "assassination of the ego". While it is true that many people die under the infliction of torture, it remains the explicit policy of the torturers to keep the person alive while attempting to destroy the mind. Torture is a practice used to deter real or suspected dissidents and as a warning to others. Medical personnel have participated in torture sessions in order to ensure that the victim will live long enough for this strategy to be effective. Captured Khmer Rouge documents compiled by the Cambodia Documentation Centre underscore this point. The Tuol Sleng Prison Interrogator's Manual graphically states that torture is used against people "...to break them psychologically and to make them lose their will. It's not something that is done out of individual anger, or for self-satisfaction. Thus we beat them to make them afraid but absolutely not to kill them. When torturing it is necessary to examine their state of health first and necessary to examine the whip." (Cited in The Politics of Pain: Torturers and their Masters, Ronald Crelinsten and Alex Schmid, eds., Leiden: Centre for the Study of Social Conflicts Publication #45, 1993).

Torturers continue to devise evermore diabolic methods for torturing. Technological advances intended to better human life, are employed for its detriment when for example torturers use scientific means to monitor the capacity of a human being to endure electric shocks. Sadly, as

advances in monitoring and documenting the horrors of torture have improved, torturers have grown calculating in their efforts to conceal the evidence of their crimes from the eyes of international observers and other potential critics. Dr. Philip Berger, a founder of the CCVT, states that when he first began to provide medical documentations in the 1970s he was able to identify physical signs left after electric shock torture. Two decades later, torturers have mastered their technique to the point where such scars can be rarely detected. Thus it would seem that while difficult to find a positive reduction in the use of torture due to international condemnation of these practices, a modification of means appears to have been effected.

Writing in a 1979 paper, "Current Concepts of Medical Aspects of Torture", cited in Torture and Trauma. the Health Care Needs of Refugee Victims in New South Wales, James Reid and Timothy Strong. Cumberland College of Health Sciences, Sydney, 1987, Dr. Berger noted that "The conception of torture fixed upon the idea of inflicting pain and suffering is not enough to cover all the elaborate and subtle methods of torture that the ingenuity of modern oppression mechanisms have invented. The subject of protection against torture in all documents is human integrity and autonomy. Therefore, what matters is not pain and suffering as such, but the extent to which torture affects the personality of the victim." The United Nations definition of torture, the World Health Organization Concept of Organized Violence and the definition contained in the Declaration of Tokyo each point to this factor: the infliction of pain is used deliberately in order to alter individuals' sense of themselves and their world.

The methods used to accomplish these pernicious aims cannot be described dispassionately. In the process of attempting to break an individual, the most degrading, humiliating and painful techniques are used. Survivor testimonies disclose examples of prolonged beatings, sensory deprivation or overload, electric shocks, mutilation of the body, starvation, sham execution, denigration and threats, sexual molestation and rape. Often common objects or materials are used as instruments of torture - pencils, cigarettes, water, fire, animals. Prisoners are also forced to witness the torture of friends or family, including children. Interrogation occurs simultaneously with physical torment.

The listing of types and techniques of torture does not, and cannot, adequately express the horror of the reality. Still, the unimaginable must be imagined in order to better perceive the experience, which affects so many people's lives. Thus, the example of starvation as a torture device assumes a deeper significance to the listener when a survivor reveals that fear of mice developed after having been forced to eat them raw during imprisonment. Sleep deprivation meant standing awake each night in Siad Barre's main Somali prison, Godka (the Hole). The cells were routinely flooded with water up to prisoners' chin levels, so that if they slept, they drowned. Pinochet's Chilean jails were notorious for the use of animals in torture. A special squad of dogs was trained to rape women. In Sri Lanka, the combination of fire and hot pepper has been used against men, women and children.

Torture frequently includes sexual humiliation and rape for both men and women. Centres serving survivors have learned of the habitual use of rape by torturers against male prisoners. Women are routinely raped during torture as a means of degrading and painfully alienating them from their social and familial roles as daughters, spouses and mothers. Inger Agger has analyzed the calculated distinctions that torturers make between women and men: "The ideology behind sexual torture of men can be said to be an abolition of political power/potency by the induction of sexual passivity, whereas the ideology behind sexual torture of women is rather the abolition of political power/potency by the activation of sexuality. The aim is to induce shame and guilt in the women for being a "whore" because, in this way, the authorities seek to identify political activity with sexual activity. Hence sexual torture seeks to reverse culturally defined gender roles." ("Sexual Torture of Political Prisoners: An Overview" in Journal of Traumatic Stress, #2, 1989.)

Armed groups of men have used women as political pawns for genocidal purposes in Bosnia and Rwanda. The use of mass rape against large numbers of women has been seen to be a particularly odious part of generalized socially organized violence in parts of Guatemala, Sri Lanka and Somalia. Women continue to be vulnerable to sexual violation during their escape and flight as typified by the predicament experienced by Vietnamese women in refugee camps and in boats besieged by pirates.

Children also are caught in the machinations of torturers. One woman who gave birth in prison deliberately refused to bond with her daughter so as to protect her from being a tool of the torturers. In Toronto, a number of Iranian children were referred to the CCVT for assistance when it was discovered that they had been born in prison and witnessed the torture of their parents; some had been tortured themselves. They had arrived in Canada without their families who remained behind in the jails. Parents' testimonies have revealed instances when their young children had been found playing with the heads of victims of Central American wars (confidential clinical communications).

For the person victimized, torture is life altering, and many of its effects are life-long. In countries of asylum, we are accustomed to regard the problem of violence and its aftermath in individual terms and torture does profoundly affect the person it has been used against. In addition, it has been learned that there are serious social consequences as well. Just as the practice of torture is a deliberate social occurrence, it has significant social results which are logically consistent with its nature, its effect on individuals and the intention of its perpetrators. Homes, neighborhoods and entire countries, along with individuals' interior worlds are transformed by conditions of generalized social violence. Thus the routine experience of going to work in the morning is horribly altered by the presence of the bodies of death squad victims in the streets. National sites of pleasure and pride become literally blood stained, as was the case when Cambodia's famous private school became the Tuol Sleng prison and Chile's National Stadium assumed the function of a concentration camp. Coastal waters are transformed into shark feeding grounds due to large numbers of murdered prisoners who had been disposed of in the ocean.

The trauma induced by gross violations of human rights produces ruptures in communities and feeds on the fear intentionally provoked by those promulgating the violence.

One consequence of these kinds of events is the splintering of societies into victims, bystanders and perpetrators. Members of each group become submerged in a dynamic of violent abuses of power, enforced silence, fear and trauma that leads to the distortion of social reality and to the creation of official perceptions and interpretations of events which obscure and mute unofficial lived experience.

The deliberate restructuring of society though the process of organized violence has profound effects on individuals, their families, social networks and the general population and is accompanied by the deliberate suppression and distortion of information about these violent events and their effects. Thus the "official story" clouds the truth and makes clarity about one's own experience difficult to achieve.

While the perpetrators conceal their crimes, the bystanders are frightened into silence and the victims are rendered outside of the social discourse without sanctioned space to express their experience. Just as the society excludes the voices of victims from sanctioned discourse, and thus from social awareness, individuals similarly come to exclude frightening thoughts, feelings, information and perceptions from awareness. This narrowing of awareness limits mental function and the capacity for both feeling and action, but serves to preserve a minimal level of coping necessary to the continuation of daily existence.

Societies thus rent are atomized and have no available "mirror" in which to see themselves fully and accurately reflected. Both individuals and groups lose mutually understood referents. The violence can become the social norm as people try to adjust, accommodate and protect themselves from the ongoing physical and psychological terror. The continued functioning of such terror states depends upon these kinds of responses to the terror they inflict.

Ignacio Martin-Baro was a psychologist and one of five Jesuits assassinated by the Salvadoran military in November 1989. His work posthumously published as Writings for a Liberation Psychology by Harvard University Press in 1994 details the process of social distortion. He described "circles of silence" which surround the practice of torture and massive organized violence. "A systematic screening of reality" is created and "facts are relegated to quick oblivion". In May 1995, a conference of the Victoria Coalition for Torture Survivors heard testimony from two Guatemalans who gave an example which illustrated the phenomenon to which this concept refers. They spoke of a massacre in a mountain village where the army killed the entire population, save one person who managed to escape. This witness was met with disbelief when he spoke about the massacre and was told that it could not have taken place because "there was no village there". It was twelve years later that a hidden grave containing the remains of the villagers was found and that his original accusation was accepted. But, for twelve years, this witness was not believed and he had begun to question his own memory. Truth is extremely difficult to maintain under conditions of deliberately inflicted terror and the accompanying collective "forgetting".

Socially organized violence intrudes into every facet of life; the private realm is invaded and personal life is severely altered. Typically under these conditions, all aspects of existence, including employment, housing, education and access to basic services are controlled. In some instances, people are excluded from participation as citizens due to religion, ethnicity or political beliefs. Ultimately, daily life becomes a mirage, surrounded as it is by examples of violence, which fear of imprisonment, disappearance, torture or execution preclude from acknowledgment, and habitual activity and choice become circumscribed. Social scientists have described "cultures of fear" which result from situations of extreme social violence, torture and trauma and where the effects persist long after the original causal conditions have been eliminated.

The capacity for social trust is undermined as justice and the rule of law is restructured by violence. Normal sources of responsibility and accountability deteriorate under conditions of extreme violence when danger and not protection is offered by institutions and persons of authority. Severe social disintegration accompanied by extreme civic violence creates sustained impressions of fear. CCVT's 1995 video, "War is not a Game", produced by Frameline Productions, contains testimony from children refugees which poignantly illustrates this point. One young Somali girl speaks of how difficult it is to understand the war when it is "Somali against Somali". A young Bosnian describes how hard it is to forget when "it is your neighbor who has done this to you".

Working in countries of asylum, we have learned that fear and debilitating "circles of silence" extend into the host communities. The nature of torture stimulates such fear that the word itself causes people to distance themselves, and in doing so, to ultimately distance themselves from the survivor. While this distancing may be a "natural" reaction for purposes of psychological self-protection, it reinforces social denial and contributes to the isolation of victims.

This is of particular concern when torture survivors are refugees and already facing situations of loss of language, family, country and culture. Isolated within the new and alien environment, torture survivors face a double barrier of trying to rebuild their lives while living in unknown and strange surroundings. Conditions of denial in the host community may resemble conditions in the country of origin where space is not allowed for the individual to be heard, believed or supported.

How we think about and talk about torture has enormous consequences for people who have survived torture and who are now our neighbours, fellow students and workmates. How we the Canadian community view torture will influence whether the modern practice of it is ignored or opposed. If Canadians consider torture to be only a historic practice, then, for example, wax museums will continue to display scenes of torture, as a form of entertainment.

How we use the word "torture" in everyday language is another measure of our need to modulate psychological proximity to its harsh reality, and illustrative of "distancing". Edward Peters in his historical text "Torture" (Oxford: Basil Blackwell Ltd., 1985) expands on this theme. Peters states that "The term torture now exists almost wholly in a generalized vocabulary. And be-

cause it does, it is easy for torturers to deny that what they do is torture...; on the other hand, it is difficult for people who use the term for anything that seems synonymous with cruelty to carry much conviction when they use it for something close to its original meaning.. Indeed, in the moral and sentimental universe, nothing may be torture, and, with a slight shift of perspective, everything may be torture: the electric prod, poverty, frustration, perhaps even boredom or vague dissatisfaction." (pg. 152-3)

Raul Hilberg first used the categories of "victims, bystanders and perpetrators" in his The Destruction of European Jews (Chicago: Quadrangle Press, 1961) in an effort to explain social dynamics during the Nazi Holocaust. Later, other writers have applied these same terms in attempts to understand other tragedies. Ervin Staub's The Roots of Evil: the Origins of Genocide and other Group Violence (Cambridge University Press, 1989) takes up the Nazi Holocaust, the Turkish genocide of Armenians, Pol Pot's Cambodia and Argentina's "dirty war". Staub examines the social forces at work in each of these catastrophes and provides some suggestion for caution. "Knowledge about the Holocaust and other mass killings and about torture and terrorism has a cumulative impact. Such violence represents worldwide steps along a continuum of destruction... Such interconnected change can lead to a worldwide lessening of moral concern and an increase in the ease of killing. We must take steps to counteract this process." (p. 241)

The prevalence of torture in today's world compels, or should compel, action against its practice. The work of Amnesty International in its ongoing Campaign against Torture can be supported. Other human rights organizations which monitor world trouble spots and provide early warnings for potential disasters such as the Watch Groups for Europe, America, Africa and Asia, can be promoted. Living in a "bystander" country such as Canada, we can urge the government to take firm international positions against the practice of torture and to provide support for Survivors through the United Nations Voluntary Fund for Torture Victims and through the programmes for refugee survivors located in this country. Our challenge is to construct and implement approaches, which establish connections between "victims" and "bystanders". In doing so, we will be able to break through the denial that prevents the realization of "circles of solidarity" as an antidote to "circles of silence". This is a vital step towards negating both the goals that motivate torture, as well as its consequences.

Evaluation: Understanding Torture: Definitions and Myths

1. Have you found basic and widely known international definitions and concepts of torture in this text?

   Yes__
   No__

2. Have they been made clear enough?

   Yes__
   No__

3. Are they sufficiently discussed for you to be able to distinguish them from “myths” about torture?

   Yes__
   No__

4. Do you now feel that you can help people understand that torture is not just any form of abuse or persistent suffering caused by another's actions?

   Yes__
   No__

Self-evaluation:

1. Do you think you could now explain this difference to others?

   Yes__
   No__

2. Please describe how:

Selected references

Agger, Inger. The Blue Room: Feminine Testimony from Exile. London: Zed Press, 1993.

This work presents an articulate description of how torture affects women and how this situation is complicated by the refugee and exile experience. Based on women survivors' testimonies, this volume supplies an eloquent recognition of the reality of life before, during and after the ordeal of torture seen through the perspective of the women who endured it.

Amnesty International, Torture in the Eighties. London: Amnesty International Publications, 1985.

This text supplies an authoritative overview of torture, a comprehensive global survey of evidence, and lists the actions taken to abolish the practice. It remains one of the fundamental collections on the subject. Amnesty's subsequent annual reports on human rights violations supplement and update the country conditions outlined in this volume.

Crelinsten, Ronald D. and Alex P. Schmid, eds., The Politics of Pain: Torturers and their Masters. Leiden, the Netherlands: the Centre for the Study of Social Conflicts, Publication #45, 1993.

This text is the result of a major study undertaken to examine the sociology and psychology surrounding the perpetration of torture. The volume contains a detailed bibliography on various aspects of torture and a comprehensive listing of definitions and legal accords and conventions.

Martin-Baro, Ignacio. Writings for a Liberation Psychology. Harvard University Press, 1994.

This volume of work by the slain Salvadoran Jesuit and psychologist was published posthumously. The introduction to the text notes that “His analysis focuses on problems of identity development with a system of social relations that are aberrant, alienating and dehumanizing.” Martin-Baro developed the term “psychosocial trauma” and applies this to Sections entitled “The Psychology of Politics and the Politics of Psychology”, “War and Trauma” and “De-ideologizing Reality”.

"Outlawing an Ancient Evil: Torture", Initial Report of Canada to the United Nations Committee against Torture. Ottawa: Multiculturalism and Citizenship Canada, 1989.

The government of Canada sets forth its position on torture with regard to international standards and enumerates the measures it has taken domestically in order to comply with them. Many useful items are appended including "An Act to Amend the Criminal Code (Torture)", a chronological listing of the measures adopted around the world, and the complete text of the Convention Against Torture.

Peters, Edward. Torture. Cambridge: Basil Blackwell, 1985.

Peters provides a historical summary of the practice of torture through the ages with particular application for social and legal understanding. The work contributes more than a detailed synopsis of human rights violations as it attempts to analyze the meaning of torture for past and present societies. The final chapter "To become, or to remain, human..." contains especially useful material concerning the language used to discuss torture and prospects for its eradication.

Staub, Ervin. The Roots of Evil: The Origins of Genocide and Other Group Violence. Cambridge University Press, 1989.

Staub undertakes to analyze four twentieth century human rights atrocities: the Nazi Holocaust; the Turkish genocide against the Armenians; Pol Pot's Cambodia and Argentina's "dirty war". He establishes a social framework for study and examines both the preconditions necessary for the perpetration of these crimes and the elements needed for "the creation of caring and nonagressive persons and societies". Much insight is given concerning the motivations of individual "perpetrators, bystanders and victims" in relationship to the larger social forces.

Weschler, Lawrence. A Miracle A Universe: Settling Accounts with Torturers. New York: Pantheon Books, 1990.

Presented is a constructive discussion of the issue of justice and impunity in the aftermath of socially organized violence. Much attention is devoted to the voices of torture survivors and their attempts to rebuild their lives in situations where truth has been forgotten or neglected and justice denied.

Chapter II

THE PHENOMENON OF TORTURE: EFFECTS AND CONSEQUENCES

Introduction

As service-providers giving support to victims of torture, we tend to look at our clients or befriended persons very much in the context of our individual and personal effort. “Victims” whom we are helping to become “survivors,” to put their lives on a new basis under new and hopefully helpful circumstances, come to us as individuals, without their culture, society and history. At least none of *their* world is as visible to us as is *ours* to them. This is even truer for teachers learning, perhaps for first time, that a child in their class or a young person whom they have met belongs to a family, some of whose members have had to live through the ordeal of torture. For no matter how much differences of language and culture are allowed for, it is a large part of the teacher's task to help the child find a place in Canadian society.

The effect of this singling out of “survivors” is to transform the social and cultural context of violence and repression which these people have experienced into a series of gruesome acts which produce individual pathologies and trauma. This unit is designed to help us overcome this tendency to relocate the experience of torture in society and culture.

It makes us recognize that people who have escaped the massive application of organised violence and torture and who may come from societies and cultures other than our own, often come from societies deeply transformed, at least for a while, by organised violence. The unit makes us see that torture is part of a system of terror producing ripple effects throughout a society.

The Reseau d'intervention auprès des personnes avant subi la violence organisée (Network of Intervention and Support on Behalf of Victims of Organised Violence) in Montreal therefore operates with the concept of organised violence. It indicates that torture is part of a culture of violence and builds on features in the society maintaining these cultural traits, which under unusual circumstances can be bent to the purposes of e.g. state-terror in any society.

The unit -- as our entire document -- leaves open the question, whether this dimension of terror has ever existed in Canadian society. But we may safely assume that aboriginal peoples in Canada do not find it far-fetched to interpret their history in Canada in these terms.

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1. Torture in the context of repression

One cannot properly speak of torture without speaking of organized violence. Organized violence occurs when the power of a government or a group can be arbitrarily and violently exercised over individuals or other groups, in the absence of negotiation or redress.

Law and power become confused: there is therefore no recourse to a system of justice. The imposition of force and repression cannot be controlled, and the perpetrators of multiple forms of violence are not held accountable for their actions.

Totalitarian states and dictatorships function in this way. They depend upon the use of violence and the manipulation of power in an organized and abusive manner in order to gain and sustain control over political, economic and cultural aspects of the lives of a targeted population. Torture is one of the culminating points of organized violence, and is part of a general context of repression.

For example:

> *In Haiti, the tonton-macoutes, a body of unofficial police, loyal to the dictator Duvalier, entered the homes of Duvalier's opponents by night in order to destroy them and to torture and kill. Constituted as a special body in 1958, their power grew until 1965, as did their impunity. For years, they were integral to a general repression of the population.*
>
> *In Germany, the Nazi concentration camps, or death camps were at their worst between 1941 and 1945. However, some of these camps existed already much earlier for communists or other opponents of Hitler. Indeed the first such camp (Dachau) was established in 1933. This type of very organized violence was part of a general repression from the beginning of Nazism, first imposed on the population of Germany to eliminate resistance to the regime, then extended to many countries in Europe.*
>
> *In Chile, after the military coup in 1973, the massive arrests and torture that took place in many "readied" locations had their place in a well coordinated system of repression involving the military, the police and the judiciary.*

The phenomenon of torture is connected to a repressive situation in its totality. Torture strengthens the total repression further. Everyday life is characterized by random and unpredictable expressions of violent power struggles between the representative of the repressive regime and those who seek to defend themselves from its arbitrary power, or to oppose it. The violence and climate of struggle, insecurity and danger grows. Individuals, families and groups are forced to progressively reduce their lives to the pursuit of mere survival.

They also necessarily become preoccupied with the need to take precautions regarding where they go, whom they visit and how they express themselves, especially within a social context. Thus the social sphere is increasingly constricted. This can become the way of life for entire populations. In addition to the chance of becoming a random target of torture, some citizens

are at particular risk either because they are actual opponents of the regime or merely relatives or friends of those who are opponents, and these citizens, including those who may have already been tortured, are driven to take ever more extreme measures of self defense and precaution in their daily lives.

While torture is rightly perceived as "the paroxysm of horror", it is not the abnormal product of an otherwise healthy society. Rather, it is the most extreme expression of social ill health, or cultural sickness.

As the culminating point of an already existing repressive system, torture reinforces the systematic control of individuals or groups by isolating and weakening them through the dissemination of a disorganizing fear. This extreme situation of systemic fear, or as some have called it "culture of fear" exists prior to attempts to constrain individuals and extract information from them through the use of individually focused physical and psychological violence. And "making people talk" through torture, really means making them renounce a number of norms, codes, ties and beliefs, thereby incapacitating them through imprinting insecurity and terror in everyday life.

The effect of this goes beyond the direct consequences, terrible as these are, for the individual victim and for those colleagues and friends the victim was forced to denounce. It affects the culture as a whole.

To give an example from Latin America (Uruguay):

Fear exterminated all social life in the public realm. Nobody spoke in the streets for fear of being heard. Nobody protested in lines for fear of being reported to the police. One tried not to make new friends, for fear of being held responsible for their unknown pasts. One suspected immediately those who were more open or less afraid, of being "agents provocateurs" of the intelligence service. Rumors about tortures, arrests, mistreatments were so magnified by our terror as to take on epic proportions. Many cafés closed their doors for lack of patrons" Carina Perelli quoted in L. Weschler (see annotated bibliography)

"... we found ourselves, one evening, looking at the pictures of our wedding, of a few years before - and we suddenly realized that hardly anyone in the pictures was still around: this one was in prison, that one had been disappeared, this other was in exile in Sweden, his girlfriend in Cuba, that one was dead... Meanwhile, our lives became increasingly constricted. The process of self-censorship was incredibly insidious: it wasn't just that you stopped talking about things with others - you stopped thinking them yourself. Your internal dialogue just dried up while your circle of relationships narrowed... as a reflex of self protection you found it was perhaps better not to extend affections to people who might at any moment be picked up and taken away". 'Ricardo' quoted in L. Weschler (see annotated bibliography)

Amnesty International has condemned a powerful and extremely anxiety-provoking form of repression practiced in Argentina. It has been claimed that between 1976 and 1978, approximately 30,000 people (were) disappeared by the military. Awareness of the disappearances was inescapable and affected the lives of a large percentage of the population in one way or another. Even while what had become of sons and daughters, brothers, fathers, mothers, sisters, colleagues and friends was unknown, disappearances, like rumors of torture and murder, struck terror and sorrow in the hearts of the nation. This form of generalized terror is now practiced in many countries, for example in Sri Lanka. It is now known that most of the disappeared of Argentina were tortured and subsequently murdered, thousands dropped, brutalized and drugged, from the air into the sea.

The isolation and the uncertainty of survival, the necessity of turning inward as well as a growing wariness of others all reduce the margins of the possible in work, family and social life and eventually in thought. It becomes hard both to plan and to dream - that is, to have 'life projects' in which one can invest one's emotions, energy and hope. Each person is constrained to change his or her way of life, behaviours and values: the personal universe grows smaller by having to adjust to the continuity of the repressive mechanisms confronting people everywhere.

Thus torture takes its place in the continuum of a repressive system and represents for its victims the pinnacle of organized violence, the "last warning" from those who hold and exercise power through violence. Torture is one of the most extreme experiences which human beings can encounter.

2. Organized violence, extreme situations and torture

Following his experience in the Nazi concentration camps in Germany, the psychoanalyst Bruno Bettelheim described the nature of extreme situations, of life organized through conditions of extreme physical and psychological suffering.

"We find ourselves in an extreme situation when we are suddenly catapulted into a set of living conditions where our values and our old methods of adaptation no longer work, and some of them even put the life that we were meant to protect, in danger. It can be said that we are stripped of our entire defense system and we hit bottom; we must build a new set of values and ways of life, in accordance with the new situation".

Some of the elements of extreme situations are: surprise arrests accompanied by physical brutalization (often severe beatings) and humiliations designed to disorganize and disorient; detention in unknown (victims are often hooded in transit and during interrogation and torture) or sadly notorious places, without access to family, friends, legal counsel, or information regarding charges or conditions for release; deprivations of the physical necessities of life including typically, water, food and sleep; interrogations accompanied by threats and brutalities; specific and specialized tortures.

Specific torture meant to break the body and mind follows systematic weakening of the individual through what has been called the 'immersion in anxiety', that is exposure to the extreme situation.

Tortures include:

- massive beatings to the whole body/e.g. using fists/batons/whips etc.
- beatings focused on particular parts of the body/e.g. feet/ears/genitals
- electrical current applied to sensitive areas of the body; e.g.: mouth/genitals
- application of other forms of heat/e.g. cigarettes, blow torches
- immersion in water to near drowning
- suffocation with hoods and chemicals
- manipulation and suspension of the body to cause extreme pain in muscles and joints etc.
- sexual torture including rape of men and women- may involve foreign objects and animals
- forced observation of the torture of others including family members
- partial dismemberments
- extended periods of sensory deprivation or over stimulation
- administration of paralyzing, hallucinatory and other drugs e.g. curae, penthotal, scopolamine

In addition to terrible physical suffering, the experience of torture puts the victim in a situation where progressively his or her moral, cultural and individual beliefs and values fail to sustain them. The aim of torture is to not only physically break the victim but to mentally break them as well. And it is indeed commonly reported that one feels broken mentally as one is broken physically in the process of torture.

Thus the experience of torture itself increases anxiety in a situation already orchestrated to sustain uncertainty and suffering. As values and beliefs fail and suffering continues, the victim may come to feel unsure of themselves and of the world they have known, including those people they have loved and felt solidarity with. And indeed, generation of this kind of doubt about self and other is one of the primary goals of torture. Regular reference points have already dis-

appeared and added to this is the loss of support normally found in belief in oneself and one's loved ones and community. In addition, the victim may be riddled with anxiety regarding the safety of family and friends, feeling not only powerless to protect them but vulnerable to endangering them, however unwillingly.

It is important to recognize that this uncertainty refers at its most fundamental level to the uncertainty of survival itself. Along with factors already noted, the victim typically has the experience of being immersed in an environment of death, - where death is an ever-present personal possibility and frequently an observed reality. Also, many of the tortures are designed to evoke the experience of death and to bring the victim as near to actual death as possible. In addition, the extreme suffering may not only convince the victim that death is at hand but may cause the victim to contemplate death as the only possible escape from the physical and mental torment that has become their lives.

This permanent confrontation with death, and the uncertainty evoked by the extreme situation, plunge the victim into a situation where the usual mechanisms used to diminish and to face fear can no longer work. This is one aspect of what has been referred to as the trauma of nonsense. It is as if the victim is forced through an irrevocable transformation of self in which all the reference points which are essential to identity are destroyed. There is no logic in life but that of destruction and death.

For those who survive the ordeal of torture, the consequences of this transformation may remain long after the body has healed. Recovery from depersonalization and dehumanizing effects of torture may be especially difficult for political refugees in exile.

Torture has long term physical, psychological and social consequences, some of which may be permanent. It aims to shatter defenses and to limit resistance and undermine agency through diminishing capacities required for normal human functioning.

3. A. Physical Torture

All victims of torture have undergone experiences of more or less calculated physical violence focused directly upon their bodies and accompanied by verbal abuse, threats and interrogation. Most victims are left with visible traces, although this is less likely as torturers continue to develop techniques in order to avoid subsequent detection of physical evidence supporting charges of torture.

In addition to refining “non detection” techniques, it is known that many victims of torture are subsequently murdered precisely because their bodies would testify to their suffering.

In addition to the extreme physical suffering, torture is accompanied by increasing physical exhaustion, unbearable anxiety, and often debilitating shame, despair and self hate. Fluctuating repeatedly between life and death, weakened, undernourished, and physically injured, overwhelmed by the inescapable immersion in the physical dimension of the suffering there is no chance to "realize" or comprehend the experience. One is often reduced to the mindless reflexes of terror and pain. Other dimensions of self and world fall away and may appear lost forever.

3. B. Consequences of Physical Torture

The majority of victims suffer from physical effects. These include:

from multiple beatings and blows, suspension by hands or feet etc. -

- severed tendons in feet, wrists, shoulders, elbows etc.
- dislocated vertebrae
- scoliosis and arthritis
- muscular pain
- dizziness and headaches including migraines
- auditory or visual disturbances, including distortions
- extreme fatigue
- muscular lesions

from sexual violence -

- menstrual disorders
- urinary and digestive disorders
- pain during both standing and sitting
- pain during intercourse

from electrical torture

- damage to muscular fibre
- visible alterations to the texture of the skin
- heart problems

from immersion in liquids and exposure to caustic substances -

- respiratory problems
- headaches including migraine

from burnings of various kinds -

- damage to surface and deep tissue
- disfiguring and debilitating scar tissue

from administration of drugs -

temporary - muscle paralysis, Parkinson like symptoms, unconsciousness, hallucinations, disorientation in space and time, disturbance of perception and short and long term memory

residual - depression, memory loss, psychotic like symptoms

Thus, all acts of physical torture create not only terrible, often excruciating suffering during the ordeal, they create the conditions for ongoing physical suffering. In addition, they may lead to the reconstitution of the physical identity as a 'body of suffering'. Instead of agency, power, competence and pleasure, the body is the site of pains, scars, deformations and physical dysfunction.

These effects and dysfunctions pursue the victim well after the torture as such has ended, the detention ceased. They serve to remind the victim of the violence undergone. With this in mind one can understand that it is difficult, even impossible to separate physical torture from its psychological consequences; for the memory is there and the victim is recurrently reminded of the prior cause of present pains.

It is also important to note that physical symptoms are often accompanied by related psychological symptoms, such as being overwhelmed by feelings of shame or guilt, despair, rage or a sense of disorientation and confusion.

4. A. Psychological Torture

The techniques of psychological torture are sometimes called “white torture”, because they do not leave any physical marks. Psychological torture effects may be observed, however, in the restriction of functioning, profound despair, mental disorientation and moral confusion from which victims suffer.

Psychological tortures include but are not restricted to:

- isolation: the prisoner is deprived of all outside contact for an indeterminate time, leading to mental disorientation and profound despair;
- sensory deprivation: environmental stimuli, such as light, sound and schedules which model the passage of time, are removed, leading to hallucinations and perceptual disorders;
- impossible moral choices: the prisoner is forced to choose between two (im)possibilities, as for example to save one person, they must denounce another. This leads to extraordinary mental anguish and guilt. Most perniciously, these experiences can undermine one's sense of a distinction between right and wrong and thus erode the victim’s conviction of the wrongfulness of what has been done to them. Bettelheim has suggested that “psychological survival” in extreme situations depends upon the survivor’s retention of the awareness that what has been done to them is wrong. Awareness of the injustice of one's fate may be the only link one has with a moral order in such circumstances. Psychological recovery and the return to life following liberation may depend upon this.
- variable, arbitrary rules: prison routines and standards of behaviour (even in the course of torture) which are linked to punishment or its avoidance are changed without notice, contributing to anxiety, hopelessness and a sense of “losing one's mind”;
- forced regressions: being required by conditions of detention or orders to behave in infantile ways, such as being forced to soil oneself, to defecate before others, to eat with one's hands, to be without clothing. These practices engender shame, humiliation and potentially rage which puts the victim at increased risk.
- diverse humiliations: such as being required to lick the torturers boots, laugh or cry on command, being incarcerated with, or shown photographs of, one's naked parents. These are designed to engender shame and humiliation, a sense of the meaninglessness of one's suffering and of one's complete powerlessness and to undermine any sustaining sense of meaning and order in the world.

4. B. Psychological effects of torture

These are numerous, and demonstrate the degree of mental suffering into which torture has plunged the victim. Victims of torture, in general, suffer profound psychological distress. This distress is related the lengthy encounter with death and the loss of one's known identity. Torture creates a breech of continuity, one can say dissociation, between what has been lived in the past and what must be lived following the experience.

One of the ways to conceptualize the psychological effects of torture is through diagnostic categories. Or of these categories is “post-traumatic stress disorder” and this diagnosis is widely used with survivors of torture.

In the Diagnostic and Statistical Manual of Mental Disorders IIIR (APA 1987), the American Psychiatric Association has described Post-Traumatic Stress Disorder (Syndrome) as follows:

(a) Existence of a manifest, stressful event which would provoke symptoms in most individuals.

(b) The person relives the trauma as demonstrated by the presence of at least one of the following symptoms:

- repetitive, intrusive memories of the event
- repetitive dreams about the event
- sudden agitation, as if the traumatic event were recurring

(c) Dulled reactions to or reduced contact with the outside world.

(d) At least two of the following symptoms which did not exist prior to the trauma:

- state of hyper-alertness: exaggerated fears
- sleep disturbances
- survivor guilt
- memory alteration
- concentration difficulties

Clear diagnostic categories have their obvious appeal. Nevertheless, torture also is a practice, which occurs in a context of organized violence which is meant to incapacitate the victim to a degree that it situates him or her at the border between life and death. The consequences of torture are the consequences of intentional human acts and part of its devastating effects are related to this shameful reality.

Therefore, we would like to recall several specific clinical symptoms, which testify to the fact that the present distress of the victim is a result of an "inhuman" experience perpetrated upon one person by another.

(i) rupture: the patient has difficulties with establishing links or chronological bridges between events before the detention and torture and those that came after it; he/she experiences his/her existence as discontinuous and ruptured

For example:

> *In Haiti, under the dictatorship of Duvalier (senior), kidnappings of very young children took place when the tonton-macoutes were unable to apprehend an opponent of the regime. These children disappeared and it is said that they were personally tortured by Duvalier.*

In these instances, surviving parents in exile have been found to have the greatest difficulties grieving or mourning their lost children, indeed it would seem impossible. This remains true even where they have adapted to their host country. It is felt that the self-blame associated with the loss can make the work of mourning unbearable. Mourning involves the achieved acceptance of the reality of a loss. The understandable inability to accept this too harsh reality can mean that unresolved grief will shadow one's life. Typically, mental life and especially emotional life and relationships, which depend upon emotions for their richness, will be constricted.

Also, life before the horrendous event of torture appears to be absurd and the memory of it become unbearable: the peace, happiness and security which marks normal life has not only been lost but rendered ridiculous. Understandably enough, it may seem better to be able to forget it and yet to do so completely is impossible. So one feels threatened and trapped and betrayed by not only one's suffering body, but also by one's suffering mind.

To give another example:

> *In Argentina, during the period of massive disappearances, many people could not bear the state of confusion between lift and death which disappearances create. This unbearable state of the confounding of life and death may resolve into a rupture between past and present, resulting in inhibited functioning in the present.*

(ii) Personality splitting: the victim experiences themselves as "unrecognizable"; they may speak a themselves as if they were speaking of "an other" and feel a sense of strangeness with regard to themselves. Adaptive strategies that were useful in the past are now inappropriate or useless and actions thoughts and behaviours may appear to belong to someone else.

(iii) Aggressiveness: some survivors report being surprised by their own aggressiveness, over which they feel no control and which is like a new trait of their personality subsequent to the

experience of torture The emergence of aggression is another source of the sense of being unrecognizable to the self.

(iv) Profound fatigue: survivors who suffer nightmares, disturbed sleep, unnamable and numerous fear may reach a state of extreme fatigue. Fatigue may also be related to the considerable energy spent in efforts to control aggression or memory.

(v) Breaking point and guilt: this refers to the survivor from whom names or other information were extracted during torture.

In this case, the victim may experience an identity destroying sense of guilt regarding "betraying" friends, colleagues or family and one's own values and beliefs.

Terror as well as shame may remain associated with the experience since the knowledge of the potential to be transformed by extreme suffering of torture remains. That is, the victim may have a sense of having "become someone else", someone who can be made to "do anything" under torture, perhaps even become a torturer. Where convictions and felt loyalties have failed to protect one from suffering and from betraying self and others, the destruction of identity can feel as if complete - and the question "who am I" too painful to answer.

Thus the manner in which an individual came through torture will effect the nature of the psychological consequences of this horrific trauma. But these are mere variations on a theme of suffering - to survive fully intact and unchanged is impossible.

The goal of both physical and psychological torture is to "break" the individual and to manufacture a modified identity. The torturer makes a very real effort to destructure the identity of the victim, including destroying capacities, beliefs, ways of behaving and thinking which constituted the 'known self' of the victim. The effects of this 'restructuring' are devastating and long lasting, and in some instances irreversible.

4. C. Social consequences of torture

When torture occurs in a repressive social and political climate, those who are targeted as political opponents will be somewhat aware of the risks they run and their persecution will not be unexpected by others.

What is not anticipated is the general targeting of others who are closely or distantly associated with the activist through family, friendship or collegial ties. The family is often used as a means of blackmail, to discipline, threaten or demoralize the activist. Family members may be "disappeared", although they were uninvolved with anti-government activities. This creates feelings of profound guilt in the victim who has survived persecution, including torture, but who could not insure the survival of others.

There is often persecution at the level of the family:

The family is meant to be affected by the very mechanism of torture itself in all aspect of life. This is meant to undermine the victim more thoroughly.

Children are frequently used as the means of blackmail by torturers. They may be arrested, even at very young ages, or they may be placed in the presence of the tortured parent where the threat of their torture is made (Chile, Nazi Germany).

They may also be tortured out of sight of the parents but so that the parents can hear their screams (Chile). There are reports of children and their parents being forced to have sexual relations with one another (Zaire).

Children of activists may also be completely isolated by compelling schools to expel them and neighbours to shun them (Argentina, Haiti). Also, spouses, siblings and parents may be harassed, blackmailed and subject to various threats. Many victims report giving information to the torturers in hopes of preventing their family members from being detained and tortured.

Families of victims also experience dislocation and disorganization. Family members often have to hide, even constantly changing places of residence. This causes great anxiety for the individual undergoing torture as well as for those who are able to flee but who had to leave their families behind.

Many refugees from Zaire and Rwanda express anxiety and a sense of guilt concerning the consequences of their pre-exile activities for their families left behind. Many who fled were unable to warn their families of their impending flight and have been unable to achieve contact subsequently. In these circumstances, adaptation to the host country may remain superficial.

Families may also suffer progressive isolation. Family members often lose their jobs, and entry into university becomes impossible. Because of fear, neighbours are likely to be silent and distant rather than supportive.

People are often tortured where they have been identified as being politically active, where they have been denounced or where they have been used as a random victim meant to instill generalized terror in a population.

Where individuals were politically active, their political, group and ideological commitments may not have been shared with or by their family. Group identity may nevertheless have been central to individual identity.

For such individuals, isolation from the group and the planting of doubt concerning their solidarity with the victim, like isolation and planted beliefs concerning the abandonment by one's family, has an extraordinarily destabilizing effect. These forms of attack on group and familial identity is known to undermine the capacity to resist the effects of torture and frequently characterize the early 'softening up' stage of the process of torture.

The internalized social group, ideological reference points and systems of belief in general play an essential role as psychological supports for withstanding torture.

When the integrity of these supports is successfully undermined, victims will more rapidly be pushed beyond their capacity for toleration: the torturer's goal is reached; resistance has been broken. The victim is broken in the course of destroying the precious sense of what is valuable and meaningful about life, including most particularly familial and social links and systems of belief.

For example:

> *One victim has reported that at a particularly low point in the ordeal of torture, when it seemed it might not be possible to resist or to survive, evidence of the solidarity of colleagues on the outside made it possible to continue. Hooded and in terrible physical shape and suffering with no expectation of relief the victim reports surmising from the unusual presence of the odor of clean linen and expensive aftershave that there was an "outside official" newly and briefly present in the torture chamber. From this he concluded, correctly it turned out, that pressure from family and friends had resulted in someone with some power "looking into his case". Buoyed by support and with the glimmer of some possibility of a change in his circumstances, he was able to struggle on against death and despair some while longer. Days later, he was dumped naked but alive on his wife's doorstep.*

When pushed to the limit of physical and psychological suffering it is no longer possible to retain a perspective regarding the torturer's manipulation of information and normal human emotions of love and social solidarity for the goal of destruction of one's trust in life.

In a related manner, the manipulation of the human inclination for trust can also be devastating.

For example:

> *In Chile, some detained prisoners underwent neither physical torture or brutal interrogations. They were detained in secret for an indefinite period, isolated from family and colleagues. They were released through expulsion from the country. As they prepared to leave, they were asked, without brutality and in an off hand manner, what they would like most before leaving the country. Many spontaneously expressed a wish for the people closest to them, for whom they wished to be able to arrange departure as well. When the time came for the detainees to leave the country, they were informed that there was now an order specifically prohibiting the people they had named from leaving the country. Thus, it was through the manipulation of their human capacity for trust, through deception, that those they cared for most were identified and put under surveillance.*

Feelings of powerlessness, guilt and intense depression are reported by victims who were, in one way or another, made to give information.

5. Risk Factors and Unusual Attempts to Cope with Torture

There is an unusual factor of risk involved in the situation of those victims of torture who have been "broken" under torture: their previous system of values is shattered and the logic of the torturer may appear valid. This remaking of values refers most significantly to the value or worth of the self. This is associated with an enormous sense of guilt and a rupture in the community of self which is very difficult to face and to repair.

This remaking of values and associated breaking of personality is one of the objectives of extreme pressure techniques employed by the torturer. The victim is thus intended to lose the capacity to maintain distance from the torturer and to name the torturer as such. Once the ability to mount some form of resistance to the torturer, if only in one's mind, has been lost, the personality structure is at risk of collapse and a kind of “brainwashing” may take place. The loss of the awareness of the moral distance between victims and torturer appears to be related to two factors.

Guilt in response to a too harsh judgment of the self under torture for example, that one should have been stronger etc. - or as part of a complicated defensive reaction to the annihilating experience of complete powerlessness appear to underlie an obscuring of the important and realistic distinction between themselves and those who have tortured them. This can then create in its place a terrible equivalence of horror about self and others in the survivor's mind. What may then be shared by the victim and the torturer is the torturer's view of the victim as despicable, less than human and somehow deserving of what has happened to them. This compliance of mind is distinguished from compliance in behaviour and speech where mental awareness persists that what is happening to oneself is wrong and what one is being made to do and to say is against one's will. Thus in extreme situations the will of the torturer may come to replace the will of the victim even insofar as this refers to the destruction of the victim him or herself. This is a form of forced mental compliance which has been suggested to be the psychological precursor of some victims being transformed into aggressors in extreme situations and others in those situations becoming suicidal or otherwise giving up the struggle for life, no longer taking the critical actions upon which the preservation of life may depend, such as eating, and sinking into death.

If the victim does survive, these responses to a completely unbearable situation may also transform interpersonal relationships following release. The victims may suppress their hatred of the torturer with a hatred of self, which may in turn be turned against those around them in an attempt to be rid of such terrible self-loathing. Understandably then, this destruction of self contributes as well to the destruction of critical supports for the self in the family and community. However, this phenomenon is rarely complete and treatment can be offered, although diffi-

cult.

Thus the terribly malicious attempt to destroy the personalities of those tortured can have the extremely hurtful and totally debilitating effect on them, such that the distinction between torturer and tortured, abuser and victim, begins to be blurred or disappear for them. This is a most distressing dimension of the post-traumatic experience of some survivors of torture. Or the reaction may be one of a feeling of the loss of one's personality, to the point of feeling like a hollowed out, emotionally dead human being. This effect has been described in literature, in George Orwell's famous Nineteen-Eighty-Four. “Personality-remaking” is there described as the explicit aim of O'Brien, the figure of the master-torturer and completely unfeeling designer of torture-strategies, an engineer of human psychological destruction.

The practice of total personality destruction has been followed in several countries, from Latin America (Guatemala) to the former Soviet Union.

Particular kinds of training torturers also imparted during the Cold War as part of counter insurgency training (e.g. by some sections of the U.S. army stationed in Panama, and elsewhere) have been based on the knowledge that in order for torturers to be able to assault those features of their victims' personalities which are indispensable for maintaining their personal integrity, torture-trainees themselves have to be deprived of these features. This explains why some victims may have been exposed to some of the most pernicious and calculated efforts to rob them of everything, which they regard as “themselves”, their own personality. To many this fate has appeared to be “worse than death” and for good reasons. For most of us, writers and readers of this text for example, having one's self-dismantled totally constitutes the ultimate dread.

6. Mourning and the Working Through of Trauma

Some victims of torture manage to escape or are released and find a county of refuge, where they settle. Thus they live in exile and have to undertake the work of recovery, including grieving and mourning under extremely difficult circumstances. The following are some steps in this process:

6. A. The Paradox of Forgetting: Forgetting and the Inability to Forget

It is known that the after-effects of torture are long lasting, painful and often debilitating. In most cases the experience of torture is not easy to forget.

The victim's settlement in the host county is founded on a paradox:

- the victim *cannot forget* the trauma due to the fact that his/her newly acquired refugee status depends upon one’s identity as a victim of torture and this depends, in turn, upon

the account of the torture endured in the past - thus on remembering the trauma. In Canada the account of the trauma is submitted to a Special Immigration Commission (Immigration and Refugee Board) as part of the process of achieving refugee status.

- the victim *cannot forget* the trauma because the physical and psychological after-effects of the violence endured will continue long after the victim has left his/her country of origin, thereby reminding the refugee of the torture experience;
- the victim *needs to forget* in order to facilitate his/her adaptation and integration in the new society. To forget means to put past events into perspective and link the past and present: a difficult and painful task, but one that is unavoidable.

Also, if the victim remains in her/his country of origin, let us say because there is a change of government or a new interim government, then the task may be even more difficult, because the past keeps interfering with the present.

In Cambodia, for example, many teenagers lived in refugee camps before they were reunited with the remaining family members located after many years during which they had been missing. And although their stay in the refugee camps helped them rebuild their physical health, forgetting was impossible and everything that had been done to them remained very much present for them, while they had to stay in the camps.

And in Haiti, after the younger Duvalier's fall and departure, the transitional period of "democracy" was even worse than the last years of the dictatorship. This was due to the fact that the level of violence, of massacres, disappearances, and torture increased once again in the struggle to overthrow the rule of death-squads, of the paramilitary and secret police, and of powerful supporters of the dictatorship. Thus it was extremely difficult, for previous victims of organized violence, to leave their sufferings behind.

6. B. The Integration of Victims of Torture into the Society of Refuge

The process of integration and reintegration into society, be it a host country (we may call it the "society of refuge") or their own changed and less violent country, is difficult and problematic, because this other post-terrorist society expects persons to be able to "turn the page" and get on with their lives.

But for survivors of organized violence the springboard into the future is made of violence and horror: their experiences have changed these people internally (as they would anyone) and they have forced them into developing reservations, blockages, and suspicions regarding the institutions in the society of refuge. This is part of the known problem of trust, to which we refer repeatedly in this document. The level of this lack of trust, of not being able to feel safe and confident in the new country, definitely is an indicator of the insidious consequences which torture has, long after its occurrence.

Torture produces changes of personal identity in its victims, which prevents them from perceiving themselves as fully alive or really alive. This, really, is the worst and potentially permanent consequence of torture, a consequence which had lodged itself on the inside of the victim's being and which they need to come to terms with again and again.

We also know, of course, that several circumstances in the receiving countries or "host-countries" make the condition of exile difficult for the survivor. Among these are: lack of understanding of their condition, hostility and ignorance, possibly discrimination on unexpected or completely arbitrary grounds, such race or customs.

Nevertheless, there are countries, which have made considerable effort to become countries of real *refuge*. And there have been valuable attempts made in Canada during recent decades to do just that.

Our discussion shows how important it is to strengthen these efforts: successful *settlement*, or the offering of a real refuge, of a place to be and feel secure, may be the most important step in a process of healing for victims of torture - a process whereby they may come to be and understand themselves as survivors, and no longer victims. We shall address these additional issues in the section on settlement.

Evaluation: The Phenomenon of Torture: Effects and Consequences

1. Is this wide-ranging discussion useful?

   Yes__
   No__
   Can you briefly say why (for your own future use)?

2. Can you think of societies for which this description of torture occurring in the context of organised violence would fit (other than Haiti)?

   Yes__
   No__
   Which are they?

3. Is the unit informative enough on the effects of torture (physical, psychological, social)?

   Yes__
   No__
   If not, in your view, what appears to be missing?

Selected references

"Les Anciens Torturés Sont de Gens Malades". Genefke, Inge. Libération (1982).

Genefke is the founder of the International Rehabilitation and Research Centre for Torture Victims (IRCT) in Copenhagen, Denmark, and a pioneering researcher and therapist in the field of the diagnosis and treatment of the effects of torture. In this article, as in many others, she describes the almost irreversible effects of certain forms of torture (physical and psychological) and how torture may cause long-term psychosomatic difficulties and problems.

"Approche Ethnopsychiatrique des Victimes de Torture." Sisoni, F. Nouvelle Revue d'Ethnopsychiatrie 13 (1989): 67-88.

This is a review of research in ethnopsychiatry, a new orientation, interdisciplinary in nature, which has arisen in France. The article reviews research on mechanisms of depersonalisation and of the forcible deprivation of their culture experienced by victims of torture. It is examined how torturers are "made". A new look at the links between psyche and culture, especially as they exist among victims of this kind.

"Conflict Armé et Trauma: Une Étude Clinique chez des Enfants Réfugées Latino-Américains." Rousseau, Cecile, et al., Revue Canadienne de Psychiatrie 34 (1989): 376-385.

This is an analysis of the relation between traumatisms (traumatic experience) and symptoms displayed by refugee children in Montreal in the ages 8-12. Clinical assessment (scales) or instruments ("Dominique", "Achenback") are used, in order to measure clinical symptomology.

Exil et Torture. Vinar, M. Paris: Denoel, 1989.

This text contains articles on torture in Latin America using life-historical materials. The attraction of death, the lived reality of terror, the elimination of memory and remembrance by administrative means, all of these are themes represented here; psychoanalytic psychotherapy has worked on these for a generation.

"Incidences Psychopathologiques de la Post-Dictadure en Haiti." Marotte, Cecile. Psychologie Clinique et Psychopathologie (1990).

This is an analysis of an extreme situation and of dilemmas which it gave rise to: organized violence continues to exist in Haiti, even after the end of the Duvalier dictatorship, arbitrary practices of detention are continued, torture as well and there is no room left for mourning and a working through of the disastrous experiences made.

A Miracle: A Universe: Settling Accounts with Torturers. Weschler, Lawerence. New York: Pantheon Books, 1990.

This is an impressive book written by a journalist and author working with the magazine "The New Yorker". Weschler carried out extensive interviews in Brazil, Uruguay and Argentina (less so) with survivors of torture and terror and sometimes also with perpetrators or their protectors. Much of what he writes is a testimony to the courageous actions of those who resisted the terror and made it possible to document the violations which had been perpetrated.

Survivre et autres Essais. Bettelheim, Bruno. Paris: Robert Laffont, 1979.

Translation from the English: See Bettelheim, B. The well-known psychologist (psychiatrist) builds on his lived experience when he analyses the concept of extreme situation and survival with reference to history: the Nazi death camps. He also refers to the institutional treatment of psychotic children: their survival behaviour, expressions of affect, withdrawal symptoms and mechanisms of defense.

"La Vie Quotidienne sous un Régime Autoritaire." Barraza, X. Cahiers Confrontation 5, 81-95.

In-depth analysis of changes in every day life due to the effects of organised violence and repression. Mentioned are: incapacity to make projects, restrictions of social relationships, perpetual worrying, concentration on material survival.

Chapter III

ASSESSMENT

Introduction

This unit is carefully designed as an introduction to clinical practice. But it is designed in such a way that an experienced clinician's preferred method becomes more widely accessible. There are four features, which primarily characterize the prismatic method of assessment presented here:

1. It describes a step-by-step procedure which one can either follow directly, taking account of all the perspectives mentioned and considered here, or one selects what one can include in one's practice, given the constraints only the service-provider using this unit knows.

2. This unit is written by a professional psychiatrist. But it is written for clinicians as well as for other service-providers. It entails a critique of professional practice, but it also reflects a strong community orientation. Nonetheless, it is important to try to do justice to the rigor and care of thinking represented

3. The most salient feature of the unit is its emphasis on the diversity of perceptions (how service-providers, clients, etc. interpret experiences) and on the importance of culture and cultural differences. This is why it is beneficial to consider the examples given.

4. This unit recommends group-specific assessments, even in areas where no methodology has been developed yet. This is an invitation to service-providers to make additions of their own.

Assessment is the first step in intervention or prevention. It is a process which makes it possible to identify the different people or groups involved in intervention and how they *perceive* and *understand* the situation of organized violence or torture they are dealing with as well as how they *react* to it.

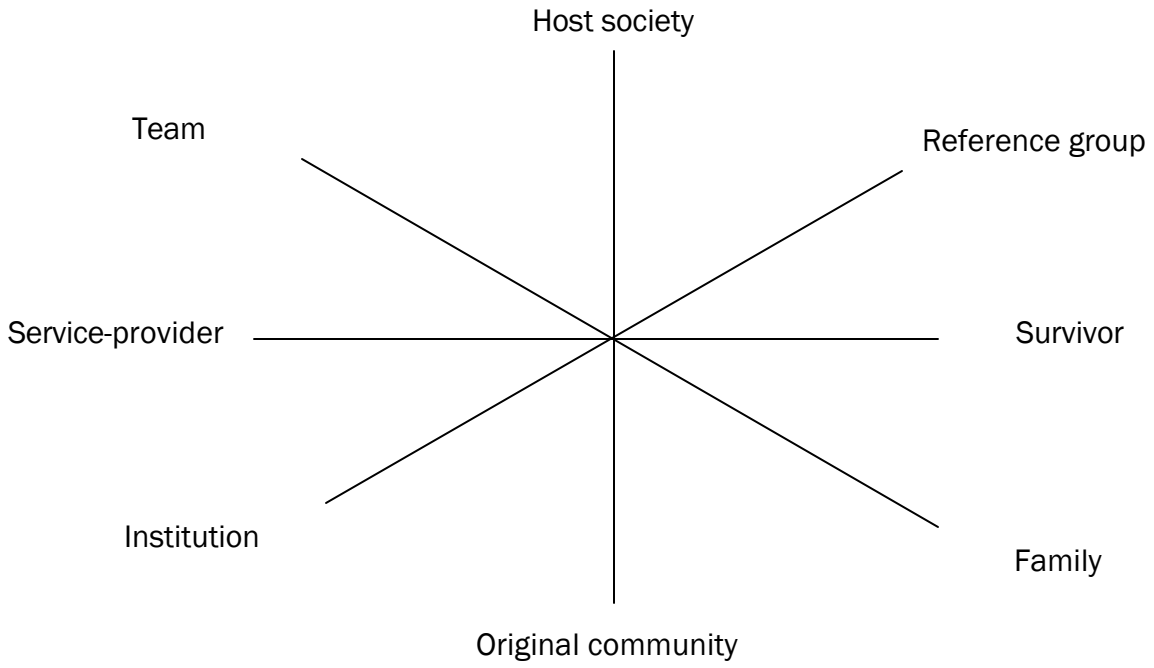
A. The Prismatic form of assessment

Since organized violence and the resulting problems can be perceived and interpreted differently by people, their families, the communities… and service providers, assessment will be based on clarifying the views of the key actors. There are at least two perspectives to consider in an assessment: the perspective of the service provider and her/his team, and the perspective of the person seeking help and her/his group of reference. Too often, we tend to forget that we need to take a critical look at our own perception of organized violence. Our understanding of it and reactions to it are essential components of the assessment.

These two perspectives can be broken down into:

Service-Provider's perspective

Perception of the person or group we want to help



A complete assessment thus involves a multitude of viewpoints. Each viewpoint provides information on one aspect of the event.

Exercise:

Beginning from a case in which there was reason to intervene, we identify:

1. who were the people or groups involved,
2. what were their respective interpretations of what had happened;

B. <u>The content of the assessment</u>

To evaluate a case we need to be able to determine:

1. What is perceived as a problem

For example:

In a refugee family, parents may not regard their own symptoms of anxiety or depression important. Rather, they give priority to the learning difficulties of one of their children (and yet the anxiety and depression of the parents may be a factor in the learning difficulties of children).

There are people who experience nightmares as a serious handicap. To others, such as Khmers, they may be a normal phenomenon, corresponding to the return of the deceased, which the Khmer expect- particularly if the burial of the deceased had not been properly carried out.

Thus we can conclude that there are very distinctive and divergent interpretations of the problem.

2. The meaning given to the problem:

What meaning do people or groups ascribe to the problem once it is identified? What do they see as the problem, symptom or precipitating cause?

What is for them, the relationship between the traumatic experience and the observable problems resulting from it?

One needs to ask: Do people all uniformly regard these problems as a direct consequence of the traumatic experience itself or are they accounting for them in some other way?

For example:

> *A Laotian family has left their country by boat and undertaken a perilous journey across the seas risking capture by pirates. One of the children in the family later falls ill and is seriously disturbed. We can only understand this event with reference to the social and political environment in Laos at a specific time directly after the Vietnam War. Knowing this we can make sense of the state of psychological disorientation (disorganization) afflicting the child, one of the family's sons. We call this illness "short reactive psychosis." For the family, however, the son's illness appears to be a punishment, because the ancestors and the spirits had not been sufficiently honored during the flight.*

Thus the question is: how would this differential perception impact on intervention and assessment?

3. Reactions to the problem

Here we deal with the issue of how to document the different ways of responding to a problem.

- Reactions aimed at solving or relieving the problem by attempting to reduce the severity of the consequences.

For example:

> *Family members may understand the traumatic experiences of one of their relatives and provide him/her with adequate support. They may be particularly tolerant of her/his irritable behavior or exhibit respect for his/her needs for privacy.*

- Reactions aimed at empowering the person or the group without focusing on the problem.

For example:

> *Community members gather for religious and traditional celebrations. These kinds of meetings help recreate a bond between community members and reduce feelings of isolation. They also provide an opportunity to build a bridge to the past and reconnect people to old ways of coping in difficult situations.*

- Negative reactions (rejection, blame, abandonment, etc.), aimed at reestablishing group cohesion. B mostly they entail the exclusion and blaming of a number of people who have been subjected to organized violence.

For example:

A raped young woman may be blamed for the act of rape, even if this was committed as part of a campaign of terror and intimidation directed to other family members. It was a crime committed in the context of political persecution. As a result of this rape, the young woman could be considered unfit for marriage in the community, she would have been excluded from it in this sense.

4. We also need to be able to identify the expectations and requirements of the different people involved.

For example:

A refugee family may seek help from a mental health professional. The mental health professional might feel that family or couple therapy could be good for the family and consider it a priority However, a community worker may have a different idea: He/She may want the family participate in community gatherings and social events if he/she believes this will help the family get better and stay together.

C. <u>The process and the practice or assessment</u>

C. 1. Assessment consists in three main stages:

i) An analysis of the perception of the situation of organized violence and torture by those who have suffered it, as well as by those close to them (relatives, friends, associates);

ii) An examination of the service provider's and his/her team's perception of the situation;

iii) The articulation of a plan, which includes:

- a determination of priorities and possibilities;
- a definition of the intervention strategy;
- and an examination of the procedures of assessment applied to the intervention.

Let us review in detail these different stages.

C.1.(i) Perception of the situation by the person or group affected by organized violence and/or the individuals or groups close to them.

Here a first principle applies for practicing assessment:

a) We need to listen to people who have suffered under the experience of organized violence.

- In so far as victims of this kind of aggression have the capacity and wish to talk about their ordeals, it is important to know their recent and more distant traumatic experiences as well as the consequences for their subsequent lives. What is their perception of the experience of violence they lived through? Which ideas, images, feelings does the experience bring up?

Quite often however, victims of organized violence of torture find it too painful to talk about what happened to them with a member of the services providers' team and it is very important to respect their silence. Of course the service provider often can obtain information from other people who know the victim. These are people who know what happened. However, it is not absolutely necessary to pursue this. And it can only be pursued with the explicit consent of the survivor. It is more important to recognize that something happened in the past, which is so painful that one cannot speak about it.

- It is at least as important to understand how the person understands what happened to her/him. Why in their own view did it happen?

- What are the survivors' views of the consequences of the violent experience on themselves, their relatives and friends (consequences on her/his personal abilities, her/his social life, etc.)?

Together with the person or the group who endured torture or repression we also have to identify the resources available to them: personal, family, social group resources, etc. Too often we overlook the fact that these people do have important *strengths* and that the intervention ought to draw upon them rather than trying, at all costs, to graft other resources.

b) The perspective of the family and of the victim's social group.

Together with the victim and the group who have been subjected to organized violence we need to identify the persons and groups most important to them. Contacts with these other people or groups may only be made with the explicit consent of this person or this group. They

are the ones who have suffered from the violence. It is important they retain control of the experience and of the information about it.

Among the most significant persons or groups may be:

- marriage partners
- the family;
- friends;
- members of a social group (union, social club, political party, clan, alcoholics anonymous, etc.);
- members of a religious group.

These people may share with the survivor the same understanding of what happened or have a different one. All these viewpoints are important in order to get as thorough as possible a picture of what happened.

For example:

> *In order to comprehend the situation of street kids in Brazil, it is necessary to consider their own account of the facts; but also of importance is the opinion of organizations working with them, people in their neighbourhood, and even the opinions of their persecutors and tormentors.*

For example:

> *To evaluate the situation of refugee groups in Canada, it is important to understand how these groups perceive themselves and how they perceive the host society; it is also important to consider how they are perceived by community organizations and institutions (schools, health centres) serving them, and by public opinion in the host society (which may perceive them as victims or as frauds and abusers of the refugee admittance system).*

In the case of all these people and groups one needs to document: what they perceive as a problem, the meaning they give to the problem, their responses and expectations.

C.1. (ii) The service provider's perception of the situation and his/her team's perception of the situation

It is very important to take one's time in order to determine as many elements as possible of one's own perception; for they are likely to influence our intervention.

The issue is *not*: to eliminate these perceptions; for this is not possible. Rather, service providers need to be aware of their perception of the problem in order to differentiate between their understanding, their emotions, their attitudes and dispositions, and those which come from other actors, including most particularly the survivors.

It is important that each individual team member think about how s/he perceives organized violence. Also, there needs to be a forum for members to share their views regarding resemblances and differences of perception within the team as part of ongoing team and team-member development. Here undertaking a reflective exercise may help. In order to initiate the process of reflection and communication, one may begin from the following questions:

Exercise:

The group (or the individual) seeks to address the following questions:

- Which forms of violence do we consider intolerable?
- What causes the greatest fear in us? What causes the greatest anxiety among us?
- What are the situations, which we ourselves regard as violent at the individual or group level. within our own community, our own institutions, our own country?
- How do we perceive organized violence?
    - Which individuals/groups do we feel the closest to?
    - Which individuals do we feel uneasy or uncomfortable with?
- What do we think is the origin of organized violence and how does it get perpetuated?
- How do we react?
- What are our expectations?

And further: it is also interesting to try to understand where differences in views held by different team members are coming from: personal history, politics, professional training, gender, age, etc.

Through this process of discussion, team members will become aware of *their own social membership*. They reflect on the groups and institutions with which they have the strongest bonds and for which they feel responsible.

It is important to answer these questions. We need to recognize our commitments and beliefs and the limits and possibilities they create in order to choose the most fruitful form of intervention. This process of reflection will also help us to recognize powerful feelings associated with these social and professional identifications, personal histories and political beliefs. We want to avoid being guided by fear, guilt, etc. We need to pay attention to these feelings, so that we will not be misguided by them. First we must acknowledge their existence.

These questions are also important because, by recognizing our own anxieties and fears, we are more able to take care of ourselves, and to find ways of regaining our capacities, thus avoiding paralyzing fears and feelings of helplessness.

In order for us to be able to draw upon our strengths and to intervene with self-assurance, we therefore need to acknowledge these feelings, on the one hand, and, on the other hand, we need to face our own attitudes regarding persons who have either suffered or perpetrated organized violence. It is important to ask ourselves which players in the conflict we identify ourselves with, since this is going to influence our work of intervention. Upon reflection, we will find that we tend to identify ourselves in part with either the aggressor or the victim.

The assessment of our perception of violence will be more complete, if we also identify how our *ideological position* and our *culture* can influence our understanding of violence.

For example:

> *A traumatized Iraqi soldier may be perceived as an aggressor or a victim depending on one's social and political understanding of the situation in Iraq.*
>
> *In the case of war in ex-Yugoslavia, ethnic membership (Serbian, Croatian or Bosnian) often determines to whom in the populations we attribute the status of aggressor or victim.*

We need to be alert to the effect these various attributions have upon our personal and treatment responses to the individual we are meant to serve.

For example:

> *In cases where the majority of the survivors of torture are from a culturally different background than service providers, it becomes necessary to take into account the issue of racism. We need to determine, and not in a dichotomous way, whether we ourselves, our team and the host society are racists or not. Rather, our misconceptions, positive or negative, of certain racial, ethnic or religious groups need to be examined. Racial bias may be detected in jokes, insignificant remarks, comments, the way we address people and how we value their opinions. In Canadian society, racism does not affect all groups of refugees equally. For some groups, it is an important reality. It is important to acknowledge the magnitude of this stress which cannot be reduced to a trauma which was caused in the past.*

Exercise:

Groups and individuals may initiate a process of reflection with the following questions:

- What country/groups/people do we view as aggressors?

- What country/groups/people do we regard as victims?

- In our society and community, which groups are presented as victims?

- Which groups are presented as aggressors?

We also need to recognize the importance of *culture*. Culture affects the meaning we give to situations of violence.

For example:

> *The word torture comes from "torquere", which means to cause or inflict damage. That means that in cultures influenced by Roman law, torture is perceived as an attack originating from outside.*
>
> *However, in Khmer (Cambodia) culture, the concept equivalent to torture is called karma Tierun. The word "Karma" indicates that what has happened is part of the person's destiny and can be understood from within the internal context of that person's*

history. The violence experienced is seen as a necessary part of that history as arising from within the person, at least in part.

These two ways of understanding the same phenomenon can modify the intervention strategies of service providers and their impact:

For example:

For Latin-Americans the intervention may focus on the rebuilding of meaning by participating in solidarity groups involved in political struggle. For Cambodians the intervention may rather be centred on promoting Buddhist rituals to heal the wounds and mourn the dead and disappeared.

What is important here is *not* so much that we should identify all of the elements of our position or everything which may influence our intervention. It is rather important to keep in mind that our position is just one among several possible ones and therefore has its limits.

After reviewing all these possible points of view, the service provider and her/his team are faced with a mosaic made up of the many different ways of perceiving or understanding the situation of organized violence they want to address.

None of the positions taken by individuals or groups involved in the conflict can claim to bear *absolute or complete truth*. Each point of view brings part of the truth. What is true is seen to be true depending on a variety of factors, including context, perceptions and proximity to, as well as role in the event.

From this mosaic of information, which includes the viewpoint of the service provider and her/his team, an *intervention strategy will be identified* by the team, bearing in mind that the intervention has *already* begun.

C.1. (iii) Design of a plan of intervention:

Definition of Priorities

The service provider and her/his team need to establish priorities.

- What are the most urgent problems we have to deal with? The most urgent problems are always the most important. They are rather the ones we must resolve first, in order to be able to tackle the rest.

For example:

In the case of attempted suicide by a survivor of torture, one needs to first be concerned with security and survival of the person. This takes priority over trying to sort out the problems that led to this attempt, even if these are perhaps at the heart of the dilemma. Later on, we will try to understand what happened and what can possibly be done.

- Service providers need to determine priority by asking which groups have been most affected organized violence in order that supportive interventions may be geared to them first.

For example:

We may have chosen to intervene and help women and children of a community that survive a massacre. The decision could be based upon the following kinds of reasons:

1) we think that this group should be dealt with urgently because of the nature, severity and urgency of the consequences related to the events,

2) it is possible (given resources) for us to work with this group and anticipate having a positive effect;

3) it is the only group we feel comfortable working with;

4) we do not want to work with men.

Any of the above reasons may influence our decision, what is important is to clarify what the reasons for the decision in fact are. One needs to be certain that priorities established on the basis of explicit, shared, justifiable reasons.

In order to do this it is necessary to examine whether the priorities for intervention are based on:

- prior experience of the team,
- a political belief,
- a personal decision;
- a decision reached by the team;
- the mandate of a care giving institution.

One also needs to explore, express, clarify and examine the *motives* underlying these decisions.

Exercise:

The following questions can help individuals and groups reflect upon intervention priorities:

- Am I or Are we, on a personal level, or as part of a team/organization, working with targeted clientele?

- Which factors determined our primary choice, in its initial phase?

- Is our understanding of priorities and of the choices to be made between them developing? If yes, what has brought about this change?

D. Review of assessment: defining what can be done

To define what can be done is to keep in view the limits of our action: how much can we accomplish? What are the advantages? What are the risks?

Frequently, when dealing with organized violence, we may feel helpless ("I cannot do anything") or we may want to become saviours, therefore omnipotent ("I can do everything"). To examine what we can do is precisely to bear in mind the limits within which the intervention will be carried out and to rest the notion of an ideal intervention.

These limits are:

a) limits of the service provider, his/her team and his/her institution: this includes personal limits ("I cannot work with this type of client"), geographical limits ("this is outside of our sector"), limits of and resources, and economic limits;

b) limits due to the Canadian context (immigration policy, economic problems, public attitude, media)

c) limits related to one's professional role: the service provider can help a client or a group face an experience of organized violence in the past. But he/she cannot act in their place; the service provider must clearly keep in mind the boundaries between her/his role as service provider and as a member of a political group, union, or a religious group, etc.

Exercise:

As a team, let us try to evaluate ourselves and summarize our limits, taking into account the following variables:

- staff (size and composition)

- type of institution arid level of professional training

- general context

After completing the evaluation, we have all the elements we need to:

- define our strategy of intervention;

- think of an evaluation mechanism for the intervention.

It is important to think of the evaluation early before starting: what are the feedback schemata available to us, in order to determine whether what we are doing is useful, useless or damaging?

For example:

> *Family violence may occur within a refugee family living in Canada. Intervention methods proposed by social service agencies may (more or less) be appropriate: drawing upon community resources or relying on family counselling, voluntary measures or forcible removal of the children. Feedback from family members and the community, before, during and after counselling is important in order to assess and possibly change the intervention process or in order to establish that it is well-founded.*

It is detailed and highly specific questions like these which, when raised by a team, can make all the difference; they will help it focus its efforts and bring to bear intervention to bear where it is needed.

E) Group - Specific Assessments

E.1. Children and youth

Modes of assessment for children and youth must be geared to their stage of development. One needs to respect the modes of expression practiced in the culture from which the young people come - just as in the case of adults.

E. 1(i) Children of pre-school age:

One best assesses pre-school children by watching them play. This is the least intrusive way. Traumatized children play simple and repetitive games that frequently reproduce the traumatic event.

Some people suggest that one can ask these children to build an imaginary world by using animals, or imitating persons, by building houses, or making other structures. Children who directly have experienced organized violence and subsequently developed problems will show it by their ability/inability to build such imaginary world: they tend to build an empty, disorganized and confused world.

EI (ii) Children of school age:

School age children are usually able to speak and provide an elaborate account of what their family and themselves have suffered. Nevertheless, these children may not spontaneously raise these matters. It is therefore inadvisable to have them explore their traumatic memories directly. If one does encourage them to do so, one needs to be ready to help the child face these memories.

One has to be capable of accompanying them in this difficult journey.

E.I (iii) Adolescents:

In this case, it is very important that service providers consider the adolescents' status in their community of origin, in order to avoid imposing on these youngsters' expectations that correspond to the behaviour of North American youth, and to relations between adults and youth in North America.

For example:

> *A Somali youth may be offended in his personal dignity if one acts in an overprotective manner toward him, as if one was someone with parental authority.*
>
> *A young Asian girl will feel pushed around and assaulted in her dignity if she is asked to be assertive. To her this means being asked to ignore the code she was brought up to follow. She doesn't understand being assertive as a manifestation of her personal independence.*

It remains important, also with adolescents, to work with connections between verbal and non-verbal expressions. Often this is very useful. But in the case of adolescents there exist more inhibitions and they are preoccupied with their self-image and with their place in society. This is why it is harder to work with non-verbal expressions in their case.

E.2. The Elderly:

It is known of elderly refugees that they suffer the worst fate. In many cases they may be without spouse or may have lost their relatives and children or had to leave them behind. If they have suffered permanent physical damage or are ill, age will compound these troubles. Learning to make a new country their home is an enormous challenge to them.

Yet they may have a capacity for self-irony and humour which is rare among the young. Nevertheless, assessment has to be geared to their specifically troubled condition and to the effort to find at least some, often very limited, forms of support.

Here one needs to consider that in many cases the aged had a secure place in their home-societies which may not be easy to replace. On the other hand, one has to guard oneself against idealizing the treatment of the aged in these societies.

Exercise:

a) In most, perhaps all, African societies there existed respect for the aged. There was a definite place for them, especially in the extended family (even if frequently more men than women).

   How will this situation have been affected by a condition of almost permanent civil war, as in Somalia? By the all-engulfing nature of the murderous conflict in Rwanda?

b) In many areas in India women who had lost their husbands were made to live a most retiring life as widows. They were marginalized and placed outside the boundaries of life as it existed for the younger members of their families. What does coming to Canada mean to them, assuming that their families suffered tremendously from either the terror of armed Sikh-groups in the Punjab or massive repression by Indian federal government troops?

E.3. Women:

Forms of assessment specific to women have hardly been developed as part of professional practice in our field. They may exist in a non-formalized way, as part of women's support groups, as they exist for example at the Canadian Centre for Victims of Torture.

Again, culture is a central issue. In many societies women will be treated differently than men without necessarily feeling that they are being discriminated against.

As wives or mothers, they may have a secure place in the social structure. But young women coming Canada as refugees and victims of torture, will frequently have a most difficult time, finding employment, a safe place to live or pursuing their education. In some cases they may be without family. There are cases of their resorting to prostitution in order to survive.

Age is a crucial factor in their case. In the case of women having undergone sexual torture, assessment has to be geared to the fact that women are made to feel particularly vulnerable and as having no power at all to live as they regard as right, by this form of torture.

Torturers know that very often young unmarried women will have lost their standing as potential marriage partners in their own community due to rape and sexual abuse. Particular kinds of assessment also need to be developed for women who are widows or have lost a child or several children. In these cases desire to survive may be very weak, as has recently been reported from Bosnia and the experience of mass-rape. Again, identifying possible community support is crucial. Support groups of women with similar experiences may be a good solution.

It is also known, however, that women may prove to be more resilient in exile than men. Several authors have explored this, among them the Toronto psychiatrist, Marlinda Freire.

E.4. The Handicapped:

This is an almost completely unexplored category. It is hard to draw a line, for example, between a person physically damaged by torture (broken bones, permanent nervous damage, damage to nerves, tendons and muscles in feet (soles), legs or arms, back problems, damage to the spine, infections of the uterus and vagina) and a person who already had a physical disability and then found this disability compounded by torture.

Cases of this nature have hardly been explored and it is unlikely that specialized forms of assessment exist.

Nevertheless, in all these instances, it is advisable that group-specific forms of assessment be developed. The unit on Children and Youth will give relevant examples for how to proceed in age and group-specific assessments.

Evaluation (self-evaluation) of Unit on: Assessment

Please evaluate this unit from the perspective of your particular concerns, as:

a) a clinician,
b) a service-provider in health-care (not trained as a clinician)
c) a teacher or educator
d) a befriender/volunteer

For all service-providers:

Has this unit been informative and thought-provoking?

Yes__
No__
Moderately so__

Specific Evaluations

I. For clinicians/therapists:

1.1 Does this unit help you achieve an appropriate diagnosis?

1.2 Is it possible for you to put a team together, adopting the prismatic model discussed here?

1.3 Can you incorporate volunteers in such a team? How?

1.4 Does this unit help you come to terms with the variety of demands survivor-patients present you with, directly or indirectly?

II. For intake workers, counsellors (non-clinical):

2.1 Does this unit help you to reconsider your counselling practice?

2.2 Can you reorganize your practice in conformity with its recommendations?

2.3 Can you imagine getting a team together on the basis of the prismatic model?

III. For social workers, educators, befrienders:

3.1 Have you found it possible to incorporate this unit into how you approach clients, survivors?

3.2 Can you detail some ways of introducing elements of a clinician's method into your way of speaking with clients-survivors, e.g. when giving them advice, discussing with them what to do, interviewing them for various reasons?

3.3 Can you see how a real assimilation of the methodological caution and care built into this model will help you engage in supportive, understanding forms of conversation?

3.4 Using this model, can you keep track of the difference between you and a trained clinician (e.g. psychiatrist, psychologist)? Or do you feel you can or ought to proceed as if you were a clinician? (The latter question refers to your self-evaluation, your evaluation of your use of the document and of training needs.)

IV. Question for all service-providers:

4.1 Has this unit helped you gain a better understanding of the skills involved in working with survivors, of the various dimensions at issue, the principle of respect for them and the force of the cruel experiences which they have made? Do you see possibilities of personal learning here as well?

Open comments: (especially addressed to yourself)

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Chapter IV

CHILDREN AND YOUTH

Introduction

Our needs assessment findings have told us that care-givers and service-providers are very concerned to learn much about this area. Victims of torture and organised violence who are children and youth are generally understood to be severely affected by these experiences in highly specific ways. But it is insufficiently known, in our field, what these effects are.

This unit continues the method of assessment presented in the previous unit on Assessment and offers large set of examples which detail the effects of this violence upon children and youth in various situations and under various conditions.

The sections of the unit are:

1. The Experience of Organised Violence
2. Consequences
3. Factors of Risk and Protection
4. Cultural Integration
5. Implications

It is important to work through the examples given, one by one, and thus to get a good sense of the care required for making assessments specific to each case at hand.

● ● ●

Children do not immediately come to mind when one considers torture, repression or organized violence. It is as if they are affected somewhat accidentally by this violence, which appears to be an adult preoccupation. However, children have always suffered from war, and suffer no less today than in past. In fact, it is increasingly civilian populations that are the direct targets of war and repression, amongst these are a growing number of children and youth.

Magnitude of the phenomenon

- Half of the world's refugee population are children experiencing organized violence, directly or indirectly.

- Most families of refugee children in Canada have experienced a significant number of war-related traumata or have been traumatized by civil war and internal armed conflicts.

Organized violence can affect children and youth in many ways. First we will consider various aspects of children's and youth's experience with violence, then the short, medium and long-term multiple consequences of this experience.

We will pay particular attention to what may protect children or make them vulnerable. Finally, we will discuss possible methods of intervention and prevention.

1. THE EXPERIENCE OF ORGANIZED VIOLENCE

Organized violence for children and youth can be observed in three different forms:

- direct trauma
- family trauma
- social trauma: disintegration of the child's environment

1. A. Direct Trauma

Children of all ages can be a direct target of organized violence and repression. These include kidnapping, torture, rape and forced labor and executions. These practices are intended to:

(i) blackmail or pressure parents or other family members,

(ii) indoctrinate or eliminate groups of youth (as seen in forced labour under Pol-Pot and the elimination of street children in Brazil);

(iii) instill horror within the population in order to “paralyze it” (this was done in Guatemala during the 1980's, when Maya children were systematically murdered in some villages).

The majority of children living under conditions of war or repression witness scenes of extreme violence, such as witnessing murder, rape, beatings or torture. This can be regarded as a case of direct trauma.

For very young children, separation itself is a form of trauma. Whether it is temporary or permanent, separation from parents is very traumatic and frequently more traumatic than external traumatizing circumstances. The latter usually play a more significant role for adults. In fact the capacity of children to cope with external traumata, such as witnessing violence, is related to the availability of parenting figures. Thus separation from parents is itself traumatic and also makes children more vulnerable to other forms of trauma.

For example:

> *Children who were evacuated from London and separated from their parents during the bombing campaign of the second world war were more traumatized than those who, despite the bombing stayed with their parents.*

1.B. The traumatized family

Of course, children and youth are subject to the trauma which affects the whole family. The trauma has disorganizing effects on the family. This type of trauma is more frequent than is direct trauma.

Even children born after the war, or after repressive conditions have passed, are affected by the trauma, which had engulfed the family, since the effect of the trauma upon the family continues beyond the occasion of the event itself.

Trauma in the family before or after a child's birth can limit or corrode the parenting skills of the parents who are themselves too wounded to be able to take adequate care of the child. Parents may be preoccupied, depressed, anxious, in mourning or otherwise rendered incapable of properly parenting as a result of the trauma.

For example:

> *A Chilean mother severely tortured before the birth of her children declared: "I have so much hate and resentment that I cannot love my children".*
>
> *Parents who had survived the Nazi holocaust in part by numbing themselves emotionally have been found to be emotionally unavailable to their children born after the war.*

The trauma can also cause family disintegration, geographical or psychological, and may be accompanied by conflicts and tensions between family members.

For example:

> *In Latin America or Sri Lanka, the disappearance of a child for political reasons may mobilize and remain the central subject of the parents, attention for years. The remaining children may feel abandoned as well as angry that the whole life of the family is focused upon the missing child. However, it is difficult for them to express these feelings, since they experience guilt about being angry at someone who is probably dead.*

The trauma can also damage or destroy family values and beliefs.

For example:

> *Under torture, some people lose their original beliefs and their faith. Someone who has lost his/her faith after torture may pass on to their children the feelings of emptiness and absurdity which they themselves have been left with after these events.*

The trauma may make communication within the family virtually impossible: it will produce secrets and taboos.

For example:

> *Some children are born because of rapes during wartime. Such children are often rejected by family and community. Very often, the circumstances of their birth are kept from them even if a member of the family or the community is aware of them. This makes it difficult or impossible for these children to understand why they are rejected.*

The trauma may radically change the child's role in the family by making him/her assume parental responsibilities and adult status.

For example:

> *In a case where the father has been killed, in many cultures, the eldest son, regardless of his age will practically or symbolically replace him within the family. This may entail a heavy burden of responsibility for these children who come to maturity prematurely*.

Even where families remain intact but have been unequal to the trauma and unable to sustain a sense o security and protection for their children, children typically take on responsibilities for themselves and their siblings which normally fall to parents. They may become preoccupied with finding food, shelter, safety and other necessities.

The trauma may modify parents' expectations with regard to which needs the child is to fulfill for them.

For example:

> *Parents who think of themselves as survivors may transmit to their children a heavy responsibility to "make amends" for events for which they are not responsible and over which they had no opportunity for influence.*

Further, the general limitations in functioning and normal coping resulting from torture, along with other consequences such as physical and psychological disabilities of a parent, can in and of themselves place a heavy burden upon the child who must "fill in the gaps", and who in this manner may be deprived of a normal childhood and the experience of a normal nurturing parent.

1.C. Social Trauma

Even in those rare cases where, under conditions of organized violence, the family has not directly experienced repression, the child is still affected by the social tension, created by such things as constriction of civil liberties, increased militarization and escalation of fear within the social space, and by the eroding of the culture around him/her.

Most often children are exposed to a range of different types of trauma, which have a cumulative effect upon them.

The social climate created by organized violence affects children and youth:

1. C. (i). by generating relationships based on fear and sometimes accusations and denunciations.

For example:

> *Children learn at a very young age to identify taboo subjects about which it is dangerous to speak. They tend, as well, to generalize a relational pattern of taboos and defensive deception. Thus, confiding in others, and trust in general, may be systematically perceived as a potential danger since "no one knows where and who the enemies are".*

1. C. (ii). by forcing them to make some accommodation of personality to the values which surround them, thus either to live in fear of what might happen and what they have heard of, or to normalize the violent circumstance through taking such violence as the "model of life".

For example:

> *It has been reported that children in Northern Ireland speak of the events of the ongoing war as part of normal life and no longer express "upset" about them. This attitude is a form of denial and an attempt at self-reassurance.*

1.C. (iii). by producing generalized feelings of insecurity and uncertainty, thus making it almost impossible for children and youth to feel that they have a future.

For example:

> *Even if they were not personally traumatized, children living in countries at war or who lived in circumstances of war tend to see the future of their country, the future of the world and their own futures in very bleak terms.*

1.C (iv) by forcing children to adopt survival strategies, which are so extreme that they become problematic, at least in the long run.

For example:

> *When facing precarious situations, some children will steal food to feed themselves, siblings or other family members. To escape death, children and adolescents will take up arms in combat. This recourse to violence and delinquency, necessary as it is at times, persists after peace returns or during asylum in a host country.*

2. CONSEQUENCES

Direct or indirect organized violence can provoke changes within children and youth alike. We may distinguish three types of consequences:

- indications of not being well, or of being ill (symptoms),
- changes in the normal path of development;
- changes in the realm of meaning and values.

2. A. Indications of not being well (symptoms)

Not all children who have lived through a direct trauma will develop symptoms of trauma. Also, children who have experienced indirect trauma often primarily show symptoms of psychological distress. This distress may be expressed in a number of ways, which may be understood in general terms as “internalized” as in anxiety and depression or as “externalized” as in aggression and delinquency.

Thus children and youth exhibit a wide range of symptoms. Their variation is a function of:

- the nature of the trauma itself (i.e. whether it involved: single or repeated trauma; separation from parents; deprivation of necessities of life such as food and water),

- the child's culture and the preferred and acceptable ways of expressing emotions in that culture;
- the child's developmental stage;
- the child's gender;
- dynamics of the child's family;
- the child's premorbid personality.

For example:

> *A Rwandan adolescent presents dissociative episodes, every time he faces significant stressful situations: he starts talking in his mother tongue and becomes visibly afraid and confused. Taken aside by the teacher, he gradually reestablishes contact with his present reality. Concerned with his situation, the school personnel then realizes this youth must have witnessed atrocities in Rwanda and fled his country under extremely terrible conditions.*

But in most cases, the consequences of the trauma may be much more subtle and difficult to detect. Thus trauma may cause daydreaming, lack of interest and withdrawal. But it is hard to be certain, in these instances, that the trauma is the cause.

In general, symptom formation and disturbances can appear in all areas of functioning, development and behaviour. Thus we may find sleep disturbance, eating disturbance or disorders and disturbance in urinary and bowel function, somatization as in stomach and head aches, abnormal play and inhibited learning, extreme separation anxiety and phobias, including school phobias. We may find as well resistance to authority, aggression and other forms of acting out or anti-social behaviour such as stealing. We may observe difficulties in state regulation reflected in uncontrollable anger, emotional outbursts apparently disproportionate to stimulus accompanied by difficulty in 'settling down'. We may observe depression, risk taking behaviour and a tendency to be accident-prone. We may observe a preoccupation with death, social isolation and a persistent sense of insecurity reflected in the hoarding of food and hypervigilence.

During the past decades, attempts have been made to describe these children's suffering in diagnostic terms, using western psychiatric classifications. The diagnostics most frequently utilized include:

- post-traumatic stress syndrome,
- major depression;
- adjustment difficulties;
- anxiety problems.

There are advantages is making use of such diagnostics:

- one can make use of a common language familiar to western professionals. It provides a shared basis of reference.
- a diagnosis may help make a forceful argument when consulting to institutions such as immigration, social services and schools by conveying to the agency the nature and seriousness of the child's lived experience and condition.

Diagnostics also have disadvantages:

- their categories tend to exclude from consideration a very large range of variables affecting the child,
- the transcultural validity of these diagnostics is not established;
- they carry a significant stigma within many communities;
- they tend to make the individual and the family bear the responsibility of “deviance”;
- they tend to divert attention away from the root of the problem to its observable manifestations.

For example:

> *Invoking the “National Security Doctrine” leaders of several South American countries established a parallel between “subversive political activity” and mental illness. Therefore, we must be aware in host countries that subjecting refugees from these countries to a psychiatric diagnosis merely reinforce the notion that it is they, the refugees that are the problem and no repressive regime they fled.*

The most frequent signs of psychological distress observed in children and youth are:

Traumatic symptoms	nightmares, sleeping problems, episodes of reliving the trauma, traumatic games, distrust, startle reactions, regression.
Symptoms of depression	inability to envision the future, sadness withdrawal, social isolation, loss of appetite, suicidal thoughts and gestures, overdependency, excessive fatigue, disinterest and forgetfulness, constricted play or inability to play, flat affect, clinginess, immaturity.
Symptoms of anxiety	somatization (stomach pains & headaches, etc.), multiple fears, enuresis, soiling, separation anxiety, dissociation, phobias, disturbance in play.
Symptoms of reaction formation	aggressivity, opposition to authority, delinquent behaviour, extreme risk taking, precocious independence, expressions of distrust, contempt and bravado, underdeveloped empathy.
Cognitive symptoms	difficulties with concentration & memory retention, school failure, academic and other learning problems, constricted creative imagination, disturbed problem solving, concrete & magical thinking
State regulation symptoms	Hyperactivity, restlessness, emotional outbursts, hypervigilent and hyper-reactive, easy emotional arousal & difficulty returning to prearousal state

Contrary to popular opinion, frequently encouraged by the media, that abused children are likely to become violent, in fact children and youth who have lived through organized violence are much more likely to suffer from depression and to exhibit withdrawal than delinquency.

Learning difficulties are partly linked to the psychological stress experienced by the child; if the child is preoccupied with events of the past or anxious about events likely to occur s/he obviously cannot concentrate on learning.

For example:

> *Let us consider the situation where a number of refugee children, in a Canadian school, have learning difficulties. Assigning them to special classes may be an option. However, a lack of culturally valid resources, including culturally sensitive staff, may prevent the school from accurately determining the intellectual capacities of the children and properly identifying the emotional difficulties underlying the presenting academic problems.*

Other factors may play a role in school performance:

- level and condition of the child's prior education,
- quality of present education environment,
- manner in which the child or youth is perceived by their peers and by school personnel (is the child welcome or discriminated against),
- the perception of education in the child's community and culture of origin.

2. B. Development

Organized violence can retard the emotional, cognitive and physical development of children and youth. The following three phenomena have been observed:

(i) Some children regress to a former stage of development and act like children much younger than they are in fact.

Such children seek protection by wanting to be babies again when they were taken care of and did not have to face external reality. This occurs when the lived reality is experienced as overwhelmingly difficult.

For example:

A ten year old who had witnessed the ransacking and burning of her home, as well as the beating inflicted on her family, regressed to the point where she started sucking her thumb again and talking like a baby; she wanted to be cradled and required much more attention than before.

(ii) In quite the opposite way, other children attempt to be too "grown up" for their age. It is as if they had aged prematurely and had become a sort of miniature adult. Typically, at least one child in a traumatized family will assume this position, once parents have become highly vulnerable due to the trauma or when the family has been scattered. Depression, suicidal tendencies, and somatizations are predictable consequences of a child assuming the parents' responsibilities.

For example:

An eleven year old refugee boy, the eldest of his family, was acting like a responsible adult by taking care of his brothers and sisters, by supporting his mother and by talking just like an adult about immigration issues. Nevertheless, he had attempted suicide three times.

(iii) Finally there are other children who have become reluctant to grow with time; it is as if time had stopped at a given moment and nothing can change for them. This is very common in families whose members have disappeared. In the situation of waiting the whole family may be paralyzed both practically and emotionally. The child cannot develop toward the future because the future is terrifying beyond imagining. This "arrest" in development can manifest physically as well as psychologically.

For example:

A small six-year-old girl whose father had disappeared when she was three years old repeatedly said: "My dad is in heaven... but he is not dead." She and her mother sus-

tained a routine of daily life, which was remarkably unchanged since the time of the disappearance. It was in fact as if they were expecting the home coming of the missing father at any time.

Similar phenomena can be observed in adolescents. But there are two aspects which are specific to this group.

(i) At this stage in their lives, adolescents are undergoing important internal changes, including sexual and psychological maturation and the passage to adulthood. If there are too many external changes and stress during this period they may find it very difficult to make the expected transition to adulthood They may therefore try to put their development on hold, in order to deal with the matter of survival.

(ii) When reaching adolescence, the youth is faced with two tasks: separation and individuation. These developmental challenges can revive childhood experiences of trauma associated with separation.

For example:

A female teenager who had lost her entire family when she was only one year old had been raised by her aunt, herself a refugee in Canada. At an age when her classmates were exhibiting independence from their parents, she began to experience phobias, refusing to leave her home.

2. C. Consequences in the realm or values

Experience of human violence and collective hate do not only affect the level of psychological distress and the process of development in children and youth. In addition, the meaning which children and adolescents give to human life and death, as well as to human society as a whole, may be profoundly transformed.

To have “passed through” death may destroy the child or insure that their lives will be marked by suffering and hardship and the need for recurrent social supports. Others will achieve essentially 'normal' lives following a period of recovery and self renewal which was supported by family and community to various degrees. However, for a limited number of children, the personal

experience of suffering and survival may bring out great strengths and creative skills. As with some adults, having "seen the worst" and survived, these children may feel freed of illusion without suffering debilitating bitterness or despair. In these individuals, energy and determination to participate in creating or recreating a better world may be stimulated and help them to embrace life. The challenge is, as always, for the society to support and sustain these life affirming and reparative potentials in children.

For example:

> *Many children who have experienced war-related trauma express a wish to rebuild the world and save people whose lives are threatened. One small boy said: "I am going to be a sailor or a pilot who flies out to rescue people from the sea in a big plane, one that could take people to another country".*

The meanings of the world, which surround the child in family and community, may also change.

- painful losses, unmourned deaths, extensive humiliations and constant fears often generate family and societal secrets. There will be many subjects which family members cannot talk about, things which become taboos. These taboos may be shared and reinforced by the community.
- in other situations, however, life becomes organized around the memory of past traumatic events. Memory is one way of facilitating the integration of one's past life with the future and of finding, sustaining and reinforcing assigned meanings. This process of integration can create different messages:

Thus, potentially – "we have to remember to avoid the repetition of what happened," or "we have to remember in order to take our revenge."

For example:

> *The enormous tragedies in Rwanda and former Yugoslavia are sad illustrations of collective transmissions of old resentments and conflicts. Conversely, the Holocaust Archives Project is an attempt to use memory of past events as a way to caution and thus a form of protection against the repetition of the horror which human beings can produce.*

- for some parents who are survivors, their children become the repository of many expectations. It is as if, because they have survived, they have to compensate through their children for the loss of all those who died. Thus, their children are assigned an implicit mission.

For example:

> *One phenomenon that has been observed among children of Holocaust survivors has been called "overcompensation". Children who overcompensate feel that they must succeed and make up for/to those who did not have their opportunity for life. Thus, their performance, - and it can seem, their whole lives - represents a tribute to all those who died. It is meant to honour them. One can imagine the burden of guilt and resentment, which such a life conscripted, as it were, by parents to the memory of others, may engender in their children.*

These are some of the consequences of the social fabric in the child's country of origin being torn asunder. Children and adolescents will be detrimentally influenced by an environment in which collective solidarities have been either reinforced or dissolved through social trauma and its aftermath.

3. Factors of risk and protection

3. A. Period preceding exile

3. A. (i) Characteristics of traumata

The impact of traumatization experienced by the child and his/her family depends upon:

- the character and nature or intensity of these traumatisms,
- their frequency of occurrence, i.e. whether there has been a single trauma or repeated traumatization;
- the meaning of the traumatizing events;
- the vulnerability of the victim;
- the context of recovery.

There are three levels of meaning one needs to take account of here: the meaning for the child, for the family and for other people close to the child. A convergence of these meanings may offer protection to the child.

For example:

> *During the Apartheid regime in South Africa, imprisoned African National Congress activists were viewed as heroes by their families and their community. This meaning given to imprisonment provided consolation to the children, even though they had to endure their fathers' absence.*

Thus the meanings given to events can give value to the child's social reference group and to the child's family and to the child's own experience. But a convergence of meanings can also have the opposite effect, and deny or ascribe irreconcilable meanings to the experience.

For example:

> *The rape of a family member is mostly regarded as a shameful experience and a taboo subject. This makes it very difficult for children to share the emotions generated by this experience and thus to construct a meaning which makes sense and with which they can reconcile themselves. The meanings derived through this kind of non-response implicitly attach unacknowledged negative value not only to the event, but to the family member who suffered it and to the family as a whole.*

Familial meanings may converge with public opinion in the host country or they may be incompatible with it.

For example:

> *Refugees from some countries may be viewed as cheaters, particularly if these countries enjoy a good relationship with the host country. Public opinion may ignore the fact that these countries have internally repressive regimes, as when they are ruled by dictators. A child may easily notice these negative sentiments about refugees in the new school environment.*

It may be a particularly damaging experience when it is not possible to connect an event with a sensible meaning. Such a “meaningless experience” will strengthen a sense of absurdity about life and of the inevitability of violence. If we cannot understand why something happened then it becomes unpredictable and can conceivably happen again at any time and to anyone.

When the meaning of an event is concentrated in one person, or one family, that person assumes responsibility for the event. This can be overwhelming. Severe feelings of guilt may settle in, especially for children who normally tend to consider themselves responsible for what is happening around them.

For example:

> *When a mother had to flee, in order to escape persecution, her child feels responsible for this event, which s/he does not understand. The child thinks that the mother fled because he/she had been a bad child and that she/he deserved to be abandoned.*

Thus the developmental level of the child is also an important factor in the creation and effect of meanings. Children can be helped to understand that the vulnerability of their parents, and their own suffering has sources, which go beyond themselves.

When the meaning of an event is recognized to be more independent from the individual, it is at least somewhat easier to face the event.

For example:

> *A Sri Lankan teenager, a boy, tries to understand why his house was searched repeatedly and why his sister has been killed. As he becomes conscious of the political reasons for this persecution, he becomes very angry. However, having gained understanding relieves him, at least in part, from the anxiety he had experienced in the face of the initial absurd situation.*

Children and youth who have directly taken part in a conflict, by mounting resistance of some form or another, tend to be relatively more protected than those who found themselves powerless in the conflict and powerlessly subject to it. Thus it makes a significant difference whether children play an active or a passive role.

For example:

> *In the occupied territories in Palestine, children directly involved in Intifada activities reportedly were mentally healthier than those who merely passively observed these events.*

This raises a sensitive question, for one must consider the implications of this for children in political or religious or other kinds of conflicts. It appears that children should neither be placed in a position of supposed neutrality, nor should they be made into actors in these conflicts, the latter being already too common and an increasing trend.

3.A. (ii) Separations

Just as in the case of direct trauma, various dimensions of separation experience will either increase or reduce its impact. These are some of the dimensions:

- cause of separation

In general, separations, which have a traumatic origin, have more severe consequences than other types of separation. However, in some cultures a separation of one of the parents merely due to divorce may be more severe. This is because there exists strong societal disapproval of divorce in that culture.

- length of separation

A child who has been repeatedly separated from parents or separated from them for an extended length of time tends to be more vulnerable than the child who has experienced just one separation of brief duration.

- age of child when separation occurs

Separation is always difficult for children. But it appears to have the most severe consequences when children are less than three years of age. For it is up to this age that the child's general development depends upon the security of a primary form of attachment to parental figures.

- availability of a substitute parent figure

The traumatic effects of separation from parents will be diminished when a substitute parent figure who adequately provides dependable nurturing is available to the child.

- the individual, familial and collective representation of separation

For example:

> *Separation is conceptualized differently in Somali culture. It was part of the nomadic tradition and way of life that herders, often relatively young children, went with their herds or flocks. Over time this tradition had developed into a form of customary mentorship or supervision of the children of a community by its adults. This makes it possible, in contemporary Somali culture for youth to go away to study for example. As war came, these youngsters were, in a certain fashion, better prepared than others for the separations from immediate family which many of them faced. This is because they had previously been away from their families within a context where an extended caretaking community represented the proximity of both nurturing and security. The traditional representation and management of separation of children from parents offered this limited protection in times of trauma.*

3. A. (iii) <u>unaccompanied minors</u>

A small number of refugee children are not accompanied by parents or parental figures when they flee their home country. These are children whom we have to regard as 'at risk' from a mental health perspective. These children have lost previous reference points and their bonds of attachment basis of security have been broken. It is because of this that social agencies may be approached by the child as if they were, or could be, representatives of the absent parents. But even then the gap, which exists between the society of origin and the host country, makes the transition difficult for the child or adolescent. Thus it may help considerably if these children, and perhaps also adolescents, are given the opportunity to join foster-families who share the same cultural origins. Maintaining a connection with their former culture and society may be expected to ease the experience of multiple losses and to support the necessary work of mourning.

3. A. (iv) <u>the reunited</u>

During flight or because of it, a great number of families encounter the risk of separation. Indeed, in many instances family members are separated from one another. After escaping from

danger, family members eagerly and impatiently expect reunification, even in the face of numerous bureaucratic and financial obstacles.

However, family reunions following exile are hardly ever easy. During what are frequently long periods of separation, each member of the family has developed in their own way, and often quite differently. Very often, and painfully, the children do not recognize their parents when they meet again, and parents may be shocked to find that they do not recognize their children. And, understandably, each family member is seeking for the other as they have been remembered. They may want to rediscover family' members as they were in the past or as they imagine them to have been. Very often the encounter with reality can be very harsh and the wonderful dream is not only unfulfilled but may seem to have become a nightmare.

3. B. The family

The family is the main influence upon children. This turns out to mean that refugee children will be primarily influenced by the host country through the impact which the new environment has on their family. For adolescents, the external world, particularly peer groups, play an increasingly significant role. The family environment nevertheless remains crucial, including in particular its influence upon the adolescents' movement into that larger world.

During childhood, a harmonious family life that is represented by internal harmony and harmony between the family and the external environment is particularly important. During adolescence, becomes increasingly important that the culture of the family and of the surrounding milieu are compatible and mutually complimentary. If too far apart, there is reason for concern regarding the development of the adolescent. Adolescents who are refugees must shape an identity for themselves which makes it possible to integrate three elements: their past traumatic experiences, the values of the families, and the requirements of the host country.

Therefore, when one considers the impact of the family, one needs to consider whether it provides protection to the children and adolescents and support for normal development or whether it is debilitating and undermining of normal maturation processes. Here the following three questions may be considered:

- What is the overall quality of the parent-child relationship?
- Are the parents in a good state of mind or do they exhibit tension and psychological distress?
- Is family life "harmonious"; that is, is there enough cohesion in the family or is there a strong tendency toward conflict?

The parent-child relationship

When parents and their children had a good relationship before the traumatizing events occurred, the positive quality of this past relationship will provide a protective factor which will somewhat diminish the negative effects of these events. This preexisting positive parent-child relationship will also make the child more resilient and thus support recovery. Such children have made the notion that relationships of trust are possible a part of themselves: this notion forms part of their internal system of beliefs, meanings and positive expectations regarding others and the world in general. Such children have internalized a sense of security which can sustain them through much subsequent hardship without shattering fundamental beliefs in others and the world. These children will be somewhat better able to come to terms with situations of persecution without becoming so embittered that revenge and aggression seem the only viable life option. A foundation of positive experiences and supportive relationships make it possible to imagine a positive future, including good and loving relationships.

Conversely, a history of abuse in the family makes the child more vulnerable to long term negative effects of extrafamilial trauma, including the destruction of the capacity for trust in others and for hope about the future. Children with prior histories of being subject to abuse will tend to view traumatizing external events as yet another confirmation of the dangerousness of the world and the viciousness and untrustworthiness of human beings. Such a child may become deeply convinced of the impossibility, even foolhardiness, of attempting to build relationships based on trust and solidarity.

For example:

> *A child severely beaten during his childhood by an alcoholic father has been forced in his teenage years to join the armed forces at a time of dictatorship and widespread human rights abuses. Abused and beaten in the military as well, he sees only one way out of his position as a victim: he becomes like them (and like his father). Then a torturer himself, something occasions a sudden recognition and revulsion at what he has done, and what he has become. As a consequence, he himself is tortured by his former colleagues. Following release he collapses psychologically and takes refuge in intense and terrible mental suffering. He cannot trust anyone, including himself.*

The state of mind of the parents: well-being or physiological distress

Traumatic symptoms and problems of depression and anxiety are frequently observed in parents who were subjected to torture and other forms of organized violence. This can increase the vulnerability of the children and will take various forms, depending on how the parent's suffering is expressed. These include:

- transferring feelings of anguish, fear and insecurity to the child
- making the child feel that despite his/her existence, life is too sad and not worth living. As a consequence, the child will feel guilty, and will hold him/herself responsible for making the parent happy. This "project" can be overwhelming and have the quality of a life or death endeavor for the child, since the implicit threatened loss of even such a limited parent will be terrifying.
- parents being so intensely preoccupied with the traumatic experiences that they are emotionally unavailable to their children.

In any of these circumstances the normal needs of a developing child may be intolerable for the wounded parent and arouse frustration, anger and even rage.

For example:

> *Parent-child violence has been reported in numerous families of Vietnam veterans, who, feeling ashamed and rejected by society, suffer from drug and alcohol abuse.*
>
> *Feelings of shame and rejection, however unrealistic, are frequently found among refugees who have been tortured, and substance abuse is also a widely recognized problem in sectors of this population.*

Traumatized parents often experience a lot of anger about their experiences, but because the real, and possibly deserving, targets of this anger are absent, parents may "take it out" on their children.

Internal dynamics of the family

In the case of families who have suffered trauma from organized violence, one has to begin by considering the general climate within the family before the traumatic experience, and how this family climate has changed since the traumatizing events. In general, family cohesion, before and after the traumatic event, represents a strong element of protection for the child. If the family successfully remains cohesive after the traumatic experience, it will be like a fortress of stability and a great source of security for the child.

For example:

> *It is reported that Vietnamese children in Hong Kong refugee camps were protected from past adverse circumstances, due to sustained family cohesion.*

It is very typical, however, for organized violence to change the ambiance of the family and to generate tensions, which may erupt in conflicts among family members.

For example:

> *In Montreal, observations of Central American refugee populations indicate that the more the family had been traumatized, the greater the probability of conflict within the family.*

The climate of conflict makes children and youth considerably vulnerable; they in turn view the family as far from a "safe haven". They may, in fact, see their home as an environment on the verge of becoming as threatening as the external world.

4. Cultural Integration

Children and youth who have survived organized violence and have been forced to go into exile must deal, on the one hand, with the loss of their cultural reference points, and on the other, adjust to a new and different culture.

We will not discuss this issue of social and cultural integration and adjustment in detail. We will, however, mention some specific aspects, which may jeopardize children and youth, and some others which may protect them.

4. A. Because children and adolescents are growing and maturing, they experience ongoing major internal changes. For this reason, their overall capacity to adjust is greater than that of adults with respect to language skills, codes of behaviour and even values. In the case of youth in particular, the desire to identify with a group of peers is a powerful force and one which supports integration.

However, the pressures of social and cultural integration can sometimes make children and youth more fragile.

an intense and rapid process of integration into a new society and culture may make it very difficult for them to mourn the losses they have suffered or to work through the traumatic experiences. The youngsters may be cut off from valuable resources that support the mourning process in their culture.

For example:

> *It has been found that young unaccompanied Cambodian refugees did better when they were given opportunities to access their traditional rituals and healers than when they were subjected to intensive cultural integration programmes.*

- if cultural integration creates too great a gap between parents and children, communication will become difficult and this can be expected to increase children's vulnerability.

For example:

> *Some children express themselves better in the language of their host country than in that of their homeland. This restricts dialogue and limits communication, thus diminishing understanding between parents and their children.*

To the extent it does not create rupture between the child and the child's family and community, cultural integration can also protect the young:

- by opening up new perspectives, and suggesting the possibility of new beginnings,
- by permitting entrance into an environment that may feel more secure than the family or the exile community.

4. B. Characteristics of the host country

A number of features of the host country, including fundamental beliefs in it, may either protect the child or increase vulnerability. It is important to keep in mind that a risk or protective factor for the children of the host country may not have the same impact on refugee children.

For example:

> *Canadians regard living in conditions in which there are many people in a small room as undesirable overcrowding. This is considered to be harmful to children and youth. Cambodian children, by contrast, see a comfortable form of protection in such proximity.*

In addition, impact of different aspects of the host country may vary from one community to another.

For example:

> *In Canadian culture and society, autonomy and individuality are highly valued and young people are educated to value them as well. To some other cultures this may appear to be a form of self-indulgence or luxury. Still others may consider it to be a threat to the family, the community and thus in turn, to each person who comprises a part of that community.*

There are no easy answers to the challenges created by the forced merger of values and identities that the refugee child must face. Nevertheless, where service providers have some knowledge of the complexities and difficulties of the process they may be more sensitive and more truly helpful in their efforts to support the children and young people who must reconcile different worlds of experience.

5. IMPLICATIONS: Development and the Transgenerational Transmission of Trauma

At present, very little is known about the long term development of children who have lived through war and organized violence. It remains an important issue to be followed and studied in the future. For we do need to better understand what changes in the lives of such children are due to the impact of conflict and organized violence.

At present we do know that there are three means of transmission of trauma from parents to children and on to subsequent generations, even while the process of transmission is not fully understood. We know that there is transmission of symptoms, transmission of implicit and explicit memory and the transmission of collective dreams.

Taking account of this context of intergenerational interaction, we may recognize that all of our interventions need to be considered with regard to prevention as well as treatment. An inter-

vention meant to help a child or a family, also has an effect, which will be passed on from one generation to the next. What is transmitted or 'handed down' is all of significant lived experience, with all of its consequences, good or bad. This can and perhaps should be both a sobering and an encouraging thought.

Evaluation of: Children and Youth

1. Having read this unit, as well as the unit on *Assessment,* do you now have a good sense of the clinical methodology employed?

   Yes__
   No__
   Moderately so___

2. Do you think you can work with this method or in a similar way?

   Yes__
   No__
   Moderately so___

3. If yes, how would you develop it further?

4. What are your most critical questions, objections?

5. If you cannot work with this method of making assessments, why not?

6. Can you suggest how it should be changed so that you can work with it?

7. Does this unit teach you enough of what you need to know about children and youth as survivors of torture and organised violence?

   Yes__
   No__
   A little__

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Chapter V

THE IMPACT OF TORTURE EXPERIENCES ON INDIVIDUALS AND FAMILIES

Interventions, Supports and Resources

Introduction

In this unit you will find a review of several, if not most, forms of intervention, the principles, which must guide them, and the conditions, which they are designed to help remedy. There also is a discussion of who may intervene, who does intervene, from volunteers to professionals. We also consider what they can achieve.

The unit is based on experiences made at the Vancouver Association for Survivors of Torture. This organization is smaller than the Canadian Centre for Victims of Torture in Toronto, but structured along similar lines. The chapter, while written by two clinical psychologists, nevertheless reflects a strong community-orientation.

The unit concludes with a useful review of models of care and a "Composite Case Example," which every user of these materials should read. It assembles most major issues of intervention around one case. The unit should be read as background to the more specialised unit on assessment and the specific suggestions made in the unit on "Children and Youth." The theme of intervention and support is continued in the next section entitled "The Experience of Service: Ethics and Support."

In all types of interventions, support and provision of services to survivors of torture, it is important to consider three principles:

The Principle of Individuality

This principle addresses the reality that each individual is unique and will respond to a similar event, such as torture, in different ways. One survivor may show patterns of Post Traumatic Stress Disorder (PTSD), while another may experience dissociative episodes or severe depression. We have to carefully assess each individual traumatic pattern. This principle also addresses the reality that each person, and each family has a unique path towards recovery after a traumatic event such as torture. We have to respect each person's style and pace of recovery, and ensure that s/he has control over what to say, how, to whom and how much. Martin-Baro's ideas express this principle well.

One's trauma depends on the unique life of each individual, which is conditioned by one's social milieu, by one's degree of participation in the conflict, as well as characteristics of one's personality and experience.

Torture remains an individual experience. We have to consider individuals not only in terms of current and particular needs and symptoms, but also as whole persons, with personal approaches to development and coping. We may encounter survivors with intense physiological reactions. For example, someone who trembles every time she encounters a policeman as she was raped by two uniformed men. Or someone else, who has flashbacks, dizziness and nausea in response to particular odors while working as a janitor. We may treat a group of survivors of torture with ongoing injuries that cause chronic physical pain.

Every survivor is a complex person in ongoing development, with features that are unique. Individual families have their own ways to evaluate experiences, and unique styles of coping with them. The individual's family and cultural experiences and beliefs will influence the meaning given to torture. These will interact with individual differences within families. For example, two individuals in the same family may have learned different survival skills. This was the case of two brothers who were tortured. The political involvement of one led him to perceive and appraise the situation very differently from his brother. While the first was quite expressive about his experiences, the other preferred to deal with its impact upon him in a more private fashion, in the privacy of his family and his own heart.

The Normalizing Principle

This principle balances the emphasis upon the uniqueness of each individual represented by the principle of individuality. It does this by asserting, and drawing attention to the reality that we all grow up in quite specific cultural contexts, which establish particular patterns of adjustment. These patterns of adjustment are established through cultural affirmation of those behaviours, which are considered “normal”, relative to age, gender and so forth. To learn one's own ethnicity and cultural identity is not only essential, but is in fact inescapable.

In a similar manner, within different cultures, mental health practices are perceived and provided quite differently. Therefore, it may be inappropriate to assign a young female mental health worker to an older man, because this will be perceived to reflect a lack of respect.

Service providers are wise to learn not only from survivors, but also *through* them by close observation of responses to all aspects of intervention, about culturally salient areas and issues. Issues of social class, age and gender are important norms in every culture and may vary significantly, not only from your own but across different groups your serve and also within apparently homogeneous groups. The effectiveness of treatment may be limited if these issues are not taken into consideration. Thus rape, diminished status or physical capacities resulting from torture and forced migration, while terrible for everyone, will be terrible in some different ways and to some different degree depending upon the cultural context in which the individual sufferer's life has been made and given meaning.

Post Traumatic Stress Disorder (PTSD) is a diagnostic category currently in use in North America as a way to label a set of “normal” reactions of survivors to abnormal traumatic experience of torture. It is, then, an attempt to refrain from pathologizing the victim and to emphasize the pathology or 'sickness' of the perpetrator through care in the use of language. However, this gathering of symptoms into a syndrome in conjunction with emphasis upon the precipitating cause may tend to obscure the particularity of individual responses to trauma and similarly obscure the significance of the different sources of trauma. It is important, for example, to retain clarity about the difference between trauma which results from torture, and trauma which results from say, a car accident. To lose sight of such a significant distinction is to foreclose possibilities for increased understanding.

The Empowering Principle

This principle emphasizes the need for survivors to have active roles in, or to be agents of their recovery. This active engagement is meant to insure that survivors regain, or retain, dignity and a sense of agency and control over their lives, their pasts and the current context in which they live. Many survivors feel that someone else must have the “something” that will resolve their suffering. Some survivors have sadly concluded that they cannot overcome a traumatic past, or that to do so would require a kind of miracle. Others have concluded that no help is possible and that they must accept their experience alone and silently.

For many survivors it is important to participate in the articulation and clarification of their problem, the planning of their treatment, including consideration of the kind of help which would be most useful and the source from which this help should come. This requires the intervenor to both be informed about the range of realistic options for service, including community based programmes, and to be willing and able to inform the survivor of such options. Then the intervenor needs, in addition, to have the capacity and time to sift through options with the survivor, lending support and help through information, recommendations and 'thinking together' about what is best.

This consultative approach can also contribute to the creation of conditions which make it possible for the survivor to speak about the experiences of torture and migration if they wish to do so, or not, should this be their choice. While there has been considerable emphasis placed upon the importance, or healing function, of survivors disclosing their traumatic experiences through "testimony" or otherwise "breaking the silence", it is important to remain aware that this is not always the case. Not all situations or survivors require it and where it appears this would be helpful, as with other treatment options, the decision regarding this therapy must remain with the survivor. Clearly, many interventions, whether case planning, or service delivery in nature, neither require nor occur in contexts in which it is appropriate to elicit the trauma story. While refugee lawyers, physicians, intake workers and psychotherapists may need varying degrees of access to this information, (and therefore need to create conditions and develop skills which make this possible), many others, including settlement workers, teachers, social workers generally do not. Intervernors need to work to insure clarity in themselves and their institutions on this issue. Most mistaken is to pressure survivors to disclose information "for their own good", a situation and interaction strikingly analagous to interrogation. Survivors should not be made to feel they must "take their mental or emotional clothes off" every time they seek help. Also mistaken is the failure to gather information related to torture which is pertinent to planning of treatment or other types of interventions (documentation, for example) due to a failure to create the preconditions for this, such as sensitive interviewing or by silencing the survivor who is ready to tell his or her story. Where a limit of training and experience or where the nature of a particular context (an ESL classroom for example) mitigate against the proper management of the telling of a trauma story by a survivor, sensitivity and care in making an appropriate referral is needed. Service providers, as well as needing to know the areas of their own role requirements, strengths and limitations, are well advised to seek training and consultation to develop their capacity to listen and to tolerate hearing the trauma story and to develop skills in the sensitive management of situations where either too little or too much information is forthcoming from the survivor.

Nevertheless, it should be recalled that not all survivors, at all times, can shoulder the full burden of the responsibility for decision making and may need help in delegating or sharing some of this responsibility with others (either in their families, ethnic community or other preferred contexts). But these always have to be people whom they can trust. Thus consultation may include a quite broad spectrum of expert supports of various kinds - living and familial as well as caring and professional. Treatment and service planning can be enriched and supported through integrated consultation of this type. The relative weighting of responsibility can be expected to shift and reshift within the consulting system over the course of any intervention, particularly those which are long term.

Interventions

Different kinds of interventions are focused on different kinds of goals, including: reducing the impact of torture - such as distressing and debilitating physical and psychological symptoms;

restoring meaning; restoring trust; reducing impact upon the family and community; connecting or reconnecting the survivor to systems of support and strengthening these familial and social links; fostering survivors' integration of past experiences and fostering the integration of survivors within the community; fostering agency through the remobilization of prior and present capacities and the development of new ones.

The identification of goals, like that of problems, should result from a consultative process in which the survivor participates. Except for those situations in which the survivor's life or the life of others is in danger, interventions must only be implemented with the informed consent of the survivor following a process of participatory consultation.

In general, those helping survivors address the main effects of torture through the categories of physical, psychological and social sequelae.

Physical Effects

Torture involves physical injuries, deprivation of basic physical necessities, and sexual abuse. Beatings may permanently injure a variety of organs and cause fractures and dislocations including loss of teeth, as well as loss of hearing and disturbances in sight. Some lose limbs or parts of limbs, or are otherwise permanently disabled or disfigured. Electric shock may leave permanent scars and damage to muscles, nerves and other tissue. Malnourishment can produce serious cognitive and physical consequences. Sexual torture results in long term suffering of both physical and psychological kinds. It is essential that medical and non medical staff learn about the range of experiences and effects of torture and approach a consideration of survivors needs through an integrated understanding of their interaction with one another and their implications for the challenges of everyday life. The recovery and integration of torture survivors depends on professionals', community workers' and volunteers' ability to carefully provide appropriate care. An integrated model of care for survivors has, for example, to consider not only the physical, but also the psychological and social impact and implications of physical torture. Animal studies have shown that inescapable shock in a situation of helplessness decreases motivation for learning, increases the probability of chronic distress, increases vulnerability to illness and essentially extinguishes even the most basic self preservative responses of “fight or flight”.

Many survivors develop somatic conditions such as gastritis, ulcers, headaches, heart palpitations, insomnia, arthritis, asthma. Most of these may be related to beatings, incarceration conditions and other forms of torture. Physical relief is essential and treatments such as physiotherapy, acupuncture occupational therapy, massage, exercise and medication are a few possibilities to be considered. It has also been shown that physiological therapies are correlated with reduction in some physical symptoms. These treatments help diminish physical and associated mental distress as well as help survivors to develop body awareness and to regain a sense of familiarity and control over their body, if not complete comfort.

Physicians and those providing medical or physical therapies to survivors need to be aware of the possible implications of any techniques which may increase physical discomfort or the use of equipment which may resemble torture equipment since both may stimulate flashbacks or have other counter therapeutic effects. It is important to inform survivors about proposed interventions and their purposes. In some instances extensive periods of preparation may be necessary. In others alternatives may need to be found. Nor is it always possible to anticipate possible negative effects, even with careful and throughout preparation, and is therefore important to remain prepared moment by moment throughout an examination or a procedure to recognize and respond reassuringly and helpfully to disruptions resulting from flashbacks etc. which may arise.

Interveners are also wise to be aware of relevant cultural practices, which may ease the experience a difficult treatment intervention. For example, the presence of a family or community member may or may not be helpful. Thus a Khmer man may be helped by having access to a Buddhist monk before his surgery. A professional's sensitive understanding of cultural specific practices and efforts to incorporate some, where possible, into his or her own methods of treatment will at the very least convey respect and caring and ease a patient's mind - an important support for physical as well as spiritual emotional recovery.

Psychological Effects

The experience of torture also involves direct or indirect psychological injury. Abuse and threats lead to overwhelming fears, helplessness, hopelessness, disturbances in memory, cognition and affective functioning, and, although survivors may react somewhat differently to the abuse they suffer, it is impossible to remain unscarred psychologically. Intervention aimed at psychological recovery and support for emotional needs of survivors is critical.

A careful assessment of survivor's psychological condition may be essential to the development of a treatment plan that works, as important as determining the survivor's own priorities in this area. PTSD is a commonly used diagnosis, which embraces a number of symptoms recognized as common to the experienced after-effects of torture. Others include depression, anxiety, dissociation, psychic and affective numbing and psychosomatic symptoms.

Torture not only causes observable and measurable physical and psychological damage but may also shatter basic assumptions of self worth, and basic trust in others. These are hard to quantify and to address. The terrible awareness that torture exists and the experience of being subject to its horrifying realities may constrain one's sense of one's own future and that of one's children, and engender despair for humanity in general. Thus, with great caution, we may seek to insure that we do not perpetuate survivors' existential suffering by submitting them to depersonalizing, insensitive, soul destroying experiences through intrusive, judgmental or impatient interviews and interventions. And when survivors must be involved in court proceedings or hearings where such experiences can unfortunately be expected, survivors may benefit from

the support of community, family members or others, especially since these situations may trigger traumatic memories, debilitating anxiety, anger or sorrow. Survivors may suffer mental intrusions, (unwanted thoughts and memories) as well as physical reactions, such as sweats, nauseas, body pains, and headaches while preparing for, following or in the course of speaking about their experiences of torture and migration - thus during medical and legal examinations, refugee applications, disability claims, or in the course of psychotherapy. Such symptoms may emerge or become more pronounced in even less obviously taxing situations, such as applying for housing, meeting with the principal of one's children's school, or assignment in an ESL class to speak about one's homeland. Symptoms may emerge in the most supportive environments, stimulated by unavoidable and unexpected triggers.

Symptom constellations of this kind may also be expected to be associated with anniversaries of the bleakest kind, such as the date of one's incarceration or flight, the loss of a colleague or loved one, the seizing of political power by those forces responsible for one's suffering. Symptoms may also develop or be exacerbated in response to news about home through communication from friends and family or news reports.

Service providers need to be able to recognize such distress, and the differences between the need for support, which will enable the survivor to endure and continue with the difficult task before them, or the need to terminate a particular interview or treatment or line of exploration. The capacity to recognize the time to make appropriate referrals, to seek consultation or other collegial support is very important.

Social-cultural effects

Torture has not only physical and psychological but also social consequences. As torturers are usually officials who represent authority and state power in a country, their actions contribute significantly to survivors' mistrust of government officials and often to generalized despair about society and justice. Thus service providers may also be mistrusted because they are seen to represent government power and authority within Canadian society.

Social adjustment is vital to survivors' recovery. Community based programmes are important for this reason. The impact of torture is buffered with the help of workers and programmes within colleges, schools, churches, and other institutions within the community. Such institutions may also represent a different quality and capacity of government power and authority and thus over time tend to disconfirm the expectation of injustice and harm from government institutions and figures of authority.

Who Will Intervene

Survivors have needs that can be provided for by many people: their families, the community, non-governmental organizations, social services, health organizations, mental health professionals.

The community can provide significant support in many forms, ranging from the local level to large government funded institutions, such as hospitals and schools. Torture is a product of social political practices within societies, and similarly, the effect of torture can be perpetuated or diminished by societies' response to its victims. Those working with survivors in the community often face obstacles which require resolution through cooperation between governmental and non-governmental agencies. Such joint advocacy can be expected to ultimately lead to some improvements to our society, which are both specific to the needs of survivors but also more generally beneficial to all citizens.

Many survivors who were supported through the Vancouver Association for Survivors of Torture are now active members of the community, and have effectively contributed to a better understanding of the impact of torture and of the possibilities of healing. Professionals such as physicians, psychologists, social workers as well as community workers, volunteers and lay people, have to consider information, social support and professional assistance as all are necessary at different stages of survivors' adjustment in Canada. Only a comprehensive model of care will help survivors to deal with the complexity of the impact of torture on themselves and their families.

Information

Survivors' symptoms can be very distressing to themselves, their families, friends, school and the community in general. Lack of understanding of the effects of torture can impede recovery. Education about common responses to torture is needed for service providers, survivors, their families and the community. The provision of accurate information concerning these matters can provide considerable immediate relief and diminish confusion and shame for the victim and the victim's family, facilitate understanding, planning and decision making for survivors, families and service providers and the community as well. It can raise competence in service providers and increase general treatment effectiveness.

Social support

Networks in the community can provide critical support to survivors and their families as well as lend considerable support to interveners. Social support buffers against acute and chronic post-traumatic stress. There is a need to promote, develop and utilize social support in our communities. Existing ethnic groups can be important sources of support to survivors, providing a context for recovery (or elements of it), which is both familiar and sustaining.

Professional assistance

Skilled professionals in the areas of physical and mental health are also essential to survivors' recovery from torture. If individuals and families who are severely affected by torture experiences do not receive proper professional assistance their problems will typically worsen and become more acute and complex. The demands of daily life create stress which cannot be met but which rather are compounded by interaction with existing vulnerabilities in the torture survivor and which in turn worsen those vulnerabilities.

However even if very distressed, survivors may be reluctant to ask for professional psychological assistance and indeed may not be aware of the potentials of this kind of help. It is also important to be aware that the recommendation of psychotherapeutic treatment may be unappreciated and perceived as both intrusive and judgmental. Some survivors may be unaware of the availability and role of such assistance because in their homelands physical and mental health were conceptualized as quite separate.

Community workers may help in educating survivors and their families about symptoms in situation of crisis and those treatments which are available in their new communities. Such community workers need to be sensitive to culturally specific ways in which survivors may accept such assistance. Thus in certain cultures, emotional and mental health support is provided by monks or elders or other community members rather than professionals.

At best, our work with survivors should develop through an on-going dialogue with them, one which incorporates careful listening to their experiences, their knowledge and thoughts, their priorities, concerns and hopes. One can discern which strategies, of what you have to offer, they consider most helpful, and which resources they most desire access to and would most benefit from. Important information can be gained on these questions where evaluation of problems, interventions and supports is done by both service providers and survivors.

Offering appropriate and effective care will involve professionals, lay people, social institutions such as schools and hospitals, community and ethnic groups, and multicultural centres. All have a significant role in providing support, training, treatment and advocacy to survivors of torture and consequently all contribute to the healing from torture experiences. Even while there is no consensus about what is the best treatment for the effects of torture, and even while each experience and response is quite individual, there are general issues which health, mental health, and social service interveners must consider in putting together a multimodal response.

Mental health services

Survivors of torture should be properly and realistically informed about the types of general health and mental health services which are available to them. It would be helpful if refugees immigrants were given written materials, in their first language, about the long lasting impact of

trauma experiences such as torture, on individuals and families, as well as the names and phone numbers of support services in their areas.

By offering a picture of the possible choices, we will convey not only useful information but understanding that there is no single answer to every survivor's problems. This may provide the basis for a dialogue about needs and plan of treatment and support with each survivor. This approach will facilitate trust, implies genuine interest and care and can itself help symptom management and recovery.

Government sponsored programmes

At first glance, refugee survivors coming to Canada may seem especially fortunate, particularly in light of our justifiably admired health care system and extensive system of social services. However, the absence or limited nature of training and knowledge about torture in many areas means that resources may not be used to their best advantage and that survivors will not get the help which they need.

There have been initiatives in our major cities to promote training and education concerning torture and its impact. These have at times been supported by non-governmental organizations and are often stimulated by the real and special demands which survivor refugees have begun to place upon institutions, such as schools and hospitals, in our communities.

In hospitals and clinics many physicians, nurses and social workers have helped individual survivors by listening carefully and evaluating symptoms in a comprehensive way, consulting with other professionals and intervening and referring appropriately. Unfortunately, others continue to exhibit what appear to be considerable lack of awareness of the existence and implications of torture in the population they serve, and are reported to respond to survivors in insensitive ways through fragmented rather than integrated approaches.

And there continue to be sporadic reports of retraumatization experiences when the intentional or unintentional insensitivity of staff in the performance of test procedures or interviewing exceeds the bounds of what a survivor can tolerate.

There are as well reports of positive changes in procedures and models of care where increased knowledge from the larger field of practice, including that offered by non-governmental organizations have been integrated to positive effect.

And precisely because survivors are often reluctant to seek help - especially mental health services - due to a variety of fears associated with past experiences and current insecurities (in particular refugee status), cooperative links between professional institutions and non-governmental services may be crucial to insure that survivors get the help they need and which is in fact available.

Non-governmental organizations

At present, there are three main centres for survivors of torture in major Canadian cities - Toronto, Montreal and Vancouver. Also many smaller centres and clinics offer ongoing support, in many forms, to survivors. Many of these centres also offer support, consultation and training to professionals from health and mental health organizations, and the community in general, about both the impact of torture on survivors and their families and the impact of such work on service providers. They also offer assistance to the development of programmes for survivors within institutional settings.

Direct services in such non-governmental organizations may include individual and group counseling, English classes, focused support groups, training programmes, settlement support and referral, and social activities. Some centres sponsor school-based programmes and ethnic programmes. For example, in Vancouver, a local school board has co-sponsored a support programme for children concerning psychosocial trauma. In other places, a local community centre may co-sponsor a programme for Somali widows or Spanish speaking male survivors.

Those involved in the provision of health and mental health services to survivors of torture in centres are wise to remind themselves that torture is not a medical illness, even while it often creates medical problems, but is a bio-psycho-social injury inflicted on one person by another person, usually one who represents the government of the society of which the victim was a member. Some workers in this field have suggested that we have to shift our way or looking at survivors' problems; away from seeing them as indicators that "something is wrong with this person", to "something wrong has happened to this person." This is most useful when considered in a context in which time and effort is taken to find out "who that person was" and "what was the nature of their lives" prior to their experience of torture, not only subsequent to it.

Some survivors of torture have internalized the violence to which they were subject and subsequently engage in behaviours which are either overtly destructive to themselves (alcohol and drug abuse for example) and others (abusive of partners and children) or passively undermining of those aspects of themselves and others which represent and support health and life - such as disconnecting from friends and loved ones, declining help, shunning effort, spurning contact and communication- preserving a silence and passivity, a lifelessness, imposed upon them by their torturers.

To talk about torture with service providers may be a difficult task for many survivors, especially when their emotional responses to people in positions of authority has been altered by past abusive experiences. Nevertheless, it is suggested by many service providers that "breaking the silence" that is, speaking of their torture experiences is therapeutic to the individual survivor and to the community. However, other practitioners report that for many survivors this is not what is most helpful and indeed can be harmful for some. Therefore, extreme caution needs to be exercised in this area. As always, theory and shared knowledge must be balanced against practical experience of one's own and that of colleagues. In the end, judgments must

be made and treatment plans developed and implemented. Safeguards against abuse and error always include balance, common sense, sensitive reflection, consultation, the shunning of ideology, a skepticism of "trends" and yet an appreciation of new knowledge and innovation, but most importantly a careful consideration of the particular client in all their individual complexity. It is critical that survivors not be turned into cogs in either the "efficient running" of a health or social service agency or of an organized political response to injustice.

Some clinicians have pointed out that it is not necessary to "break the silence" since the mere presence of a sympathetic ear brings about disclosures in a manner which suggest that these clients are compelled to tell their stories - indeed over and over again. This, they point out, should be respected and attended to and provided for, as should the preservation of privacy and silence to which other survivors feel, perhaps equally, compelled. In between is the very common experience that, with time and the building of trust, a once very private client may take the decision that they wish to begin to speak about their torture experiences. It is important that an intervener can respect silence, wait with patience, listen with care and compassion and thus remain "present" for the survivor in all of these stages of healing.

Thus the risk of pushing survivors to talk is that, at the least it demonstrates disrespect and undermines trust, (indeed can make survivors feel they are "performance specimens") and more perniciously can replicate interrogation experiences or humiliating episodes in which privacy, self control and decision making powers were denied. Most immediately serious are those instances where pressure compliance brings about decompensation and psychotic episodes or breaks. Thus the respect of the survivors' right to set the pace and pattern of their own recovery is not only an ethical but a treatment issue. Clients' so-called "resistance" is often more properly recognized as defenses which are necessary to retain, a sometimes precarious integration of the personality.

Ideally, when a survivor comes to a centre or a clinic, service providers will be alert to the complexity of consequences and needs of the survivor and his or her family and will have access to an integrated assessment and service delivery system.

At VAST (Vancouver Association for Survivors of Torture), an intake worker may initiate a process of support service to a survivor of torture that may involve one or more persons in the VAST team, community professionals and the mobilization of local support from community organizations.

Depending upon initial presentation of a survivor, a physician in the VAST network may be the appropriate choice to provide a comprehensive physical evaluation of problems, symptoms or complaints of the survivor. This physician may interview the survivor at the VAST office, at his/her private practice or at a local hospital, depending on the survivor's level of comfort with such settings and the specific goals of the examination.

For another survivor, it may be decided that the survivor and his family need to talk to a social worker, because problems involving housing and financial assistance are central.

In another circumstance, a psychiatric evaluation or a psychological assessment may be offered first due to a specific need of the survivor, such as ongoing sleep problems, intrusion of thoughts or anxiety attacks. Both medical and psychological referrals may be made where the needs of the survivor include or are restricted to documentation for legal or disability claims.

The service provider, the location, and the specific interventions offered to survivors will depend on the considerations described above. Assistance has to be tailored not only to the needs and wishes of the survivors and their families, but also upon the reality of resources within our communities.

Survivors of torture and their families will continue to suffer more than they need to unless the underlying causes of their symptoms are addressed and unless we all learn abut the complexity of their traumatic reality, its lived experience and after-effects. We also hope to provide survivors with new experiences of humane contact through which they may regain some trust, restore some control over their lives, as well as improve their general adjustment to our society. By attaining such goals, survivors will remain productive members of our communities.

By intervening in appropriate ways, by, for example supporting survivors' access to hospitals and mental health centres, by improving the training and use of interpreters, by developing school-based programmes, expanding community support and increasing public awareness we will decrease, to some extent, the ongoing impact of torture.

Models of Care

When we develop models of care, which involve assessment and treatment interventions and supports to survivors of torture we need to consider four main points. We may consider whether:

i) treatment interventions are based upon an assessment of specific needs and characteristics of survivors and their families across time and context. Unfortunately survivors have been shown to be more than usually vulnerable to the stressors, which continue to be present in all of our lives. Awareness of this reality needs to be part of any service delivery plan and included in the information provided to survivors as they look to make plans for their futures since services may need to be added at future points. For example, survivors may develop symptoms and temporarily require additional support in response to the illness of a child, loss of work or the death of a friend. While not necessary for all survivors, in many instances, discussion of and planning for long-term effects are needed.

ii) interventions are based upon professionals' training, experience and expert knowledge and are focused upon identified specific need in the areas of physical, psychological and social recovery with the informed participation of the survivor. Networks among

professionals, interdisciplinary teams, and inter-agency consultation make work with survivors significantly more efficient and effective. Each survivor is also an important “”specialist” source of information regarding their experience, suffering and situation and is appropriately considered a part of such multi-faceted teams.

iii) interventions and supports are informed about and attentive to the cultural and political context of the survivors past and present life. While it is very important that service providers are sensitive and respectful of survivors' background and belief system, it is also clear that service providers cannot be expected to “know everything” about every cultural and political group from which those seeking their help will come. The most important source of such information is in fact most often the survivor before you. Sensitive interviewing and taking sufficient time can be critical here. Additional efforts to become informed through reading and consultation can also be extremely helpful here. Overall, an attitude and approach which reflects and expresses genuine interest and respect for these important aspects of your client is at least as important as the possession and demonstration of bits of information about cultural practices and political history. It is possible to develop and to educate one's sensitivity.

iv) interventions and supports make sense, and are acceptable to survivors and their families in terms of focus, type and course. For example, a survivor may want first to ensure that her children are enrolled in school before engaging in therapy to help her work through the experience of torture, while another survivor may want specialized individual counselling before enrolling in an English class. Seemingly simple questions, which need clear answers, can guide the development of treatment plans.

What needs to be done - determined by diagnosis, priorities and needs.
Who will do it - whether team, peer, family member or community professional.
Where will interventions be done - considering settings, resources, referrals.
When and how the intervention will be evaluated - goals, duration, follow up and continuing supports and referrals.

Composite Case Example

Thus one survivor may have a diagnosis of PTSD and depression, but first on his list of concerns is winter clothing for his children and the securing of refugee status. Contact with community agencies and securing the appropriate level of government support will therefore take priority along with referral to a refugee lawyer and a physician in the medical network who will do the physical examination for documentation of torture. The physician is also asked to screen for possible physical sources of what appear, at initial observational assessment by an intake worker, to be psychosomatic headaches and breathlessness.

In order to support the survivor and his family during the strenuous refugee application process and to help alleviate distressing psychological symptoms, the survivor is offered psychiatric

counselling and recommended to a men's' survivors support group. Both recommendations are declined, in the first instance it appears because of fear of jeopardizing his refugee application and the stigma associated with 'mental illness' in his culture. In the second instance, a combination of realistic and mildly paranoid or excessively untrusting responses may be present in the survivor's fear of encountering in the men's' group men from his home country who were instrumental in his detention. He knows at least one who is living freely in the same city and besides he does not want to talk about it since it makes his nightmares and breathing problems worse.

The assessment team affirms the reality of the survivors concerns as real possibilities - that he might encounter someone he wished to avoid in the support group. They explore with him what his options would be in such a situation, affirming his right to leave any form of treatment at any time. This reassurance and affirmation appears to all team members to lessen the then observable symptoms of mounting anxiety and rage. The alternative recommendation of a single volunteer befriender is made, discussed and ultimately accepted. That this friend would introduce him to the city, tell him about Canada - what to do and what to expect - is anticipated as very helpful by the survivor and on the assessment of the team the least threatening alternative of support.

The survivor is referred to a general practitioner with a practice, which included refugee clients and involves informal counselling. The physician is advised of the client's beginning application for refugee status as well as his difficulty in accepting a psychiatrist referral and the team's assessment that psychological effects are nevertheless evident. The team also advises the coordinator of volunteers at the community centre that they recommend that one of the more experienced volunteers be assigned to this survivor since they anticipate that crisis management is likely and the development of trust a particularly salient issue. In addition the befriender is advised that for this survivor the needs of his children are primary. Thus introduction to resources for the children is a good means of support as well as a medium for the development of the volunteer's relationship with this survivor.

The client is advised by the intake/assessment team that the offer of a referral to a support group and psychiatric counselling is something that he might like to try at a later time if it seemed possibly helpful then. He is reminded that he could also contact the centre in the future if there are any other ways in which he feels they might be able to help him or his children. He is mailed an invitation for himself and his children to the centre's upcoming annual picnic.

Follow-up by the intake/assessment centre reveals that over time this survivor could accept help -for his children and for the securing of refugee status and that the settlement and refugee application process is proceeding. While this survivor never does join a support group, on the basis of his two self identified needs (help for his children and gaining refugee status), he does join a mixed ESL class and appears to experience subsidiary gains from this experience, such as developing some friendships. Ultimately, case management had fallen to the general practitioner who prescribes medication temporarily, and physical exercise long term, to break

the cycle of insomnia. Discussion of the insomnia problem, and the development of some trust in his physician, makes possible some exploration of the experiences behind the nightmares and anxiety related breathlessness. Headaches are found to be related to head injuries sustained during beatings and what can be done in this regard, has been. Headache medication irritates what has become a sensitive stomach and as with many things, he feels he must choose between two kinds of suffering. In time he does accept the suggestion of his doctor for visits from a public health nurse who drops by periodically to discuss his children's health and adjustment to school and to Canada. He is concerned about the immodest modes of dress and disrespect he sees in children toward their elders in his daughters' school chums. The nurse is a good listener. The survivor occasionally makes an appointment with his general practitioner to discuss similar issues as well as his physical symptoms. His English is quite good now and his confidence in dealing with both officials and daily life has increased correspondingly. Perhaps sometime in the future, possibly after the refugee claim is settled, he will choose to accept the still standing offer of psychotherapeutic referral, perhaps not. He has reforged links to his ethnic community through attending cultural events for the sake of his children, and appears to have found some pleasure and some support in this way.

He and his friend meet for coffee now and then these days and also share holiday meals marked by both their traditions. They still talk about politics, about the progress of his refugee claim, and about his children. He knows he will feel better when he can return to work that he was good at in his home country. The refugee process is difficult and slow and at times anxiety and despair overwhelm him. But some things are better here and his children are safe. The loss of his wife has not yet spoken of, though he has referred to her some times now in relation to a few beautiful items about the apartment from his home country. And he has explained how her dishes of their traditional meals tasted much better than his own.

Evaluation: The Impact or Torture Experiences in Individuals and Families: Intervention, Supports and Resources

1. After reading this unit, do you have a good grasp of:

a. the forms of intervention?

Yes__
No__
Moderately so___

b. The reasons for it?

Yes__
No__
Moderately so__

c. the most important goals?

Yes__
No__
Moderately so___

2. Do you agree with the principles listed?

Yes__
No__

3. If not, what principles would you put forward?

4. Having read the "Composite Case Example" section, can you put a similar case-history together, now that you understand the issues (or as you have already understood them for some time)? Please try.

Selected references

Against Forgetting: Twentieth Century Poetry of Witness. Forche, Carolyn, ed. New York: W.W. Norton & Co., 1993.

An anthology of poems written by survivors of torture from the Armenian genocide to Tiananmen Square. They deal with courage, suffering, and brutality. At the same time, it is also a book about hope. An important perspective on the issue from survivors themselves.

The Blind Spot: Denial of After-effects in Victims of Interhuman Violence. Knumperman, Andre. The Hague: Ministry of Health and Cultural Affairs, Health Care Centre for Refugees, 1982.

This is the paper of a presentation by the author on the issues of denial and avoidance by health care workers when working with survivors of torture. He makes suggestions about the need for such caregivers to improve their listening skills and their ability to care for those who may tell stories that generate revulsion and anger.

The Blue Room: Trauma and Testimony among Refugee Women: A Psychosocial Exploration. Agger, Inger. New Jersey: Zed Books, 1994.

This work presents an articulate description of how torture affects women and how this situation is complicated by the refugee and exile experience. Based on women survivors' testimonies, the author represents and interprets women's experiences through metaphor, especially those dealing with boundaries, the transgression of norms, and destructive patterns. These women's testimonies are a powerful voice in the denouncement of torture in today's world.

The Body in Pain: The Making and Unmaking of the World. Scarry, Elaine. Oxford: Oxford University Press, 1985. vii, 385 p.

This extraordinary book forces the reader to reconsider the very essence of torture. Torture primarily a physical act - the infliction of pain, but it also entails a verbal act - the interrogation. The author's description of the structure of torture improves our understanding of the sadistic potential of language. Her analysis addresses the “unmaking” of the individual's world through torture, and the potential for subsequent action and creativity in survivors' “remaking” of it.

Counselling and Therapy with Refugees: Psychological Problems of Victims of War, Torture and Repression. Veer, Guus van der, Victor Viadar Rivero, and Mia Groenenberg. Chichester: John Wiley and Sons, 1992.275 p

This book offers a practical guide to the treatment of psychological problems encountered by refugees. It brings together the author's own experience and the available scientific literature and thereby builds a bridge between theoretical knowledge about the problems of refugees and clinical practice. This pragmatic use of theoretical knowledge is illustrated in chapters about the practice of counselling in general, and in a section on special groups such as children and adolescents and special problems such as the risk of suicide, and male and female sexual violence.

"Political Violence and War as Causes of Psychosocial Trauma in El Salvador." Martin-Baro, Ignacio. International Journal of Mental Health 18 (1989): 3-20.

This article emphasizes the need to change the role and views of mental health professionals who have tended to conceptualize trauma as isolated and limited to a specific person or family. He argues that it is important to analyze the structural contexts and the abnormal realities of social systems. Psychosocial trauma, for Martin-Baro, is a normal result of an abnormal, dehumanized context in which violence, institutional lies, and social polarization, all characterized by him as psychosocial destruction, affect not only individuals, but countries and societies as a whole.

"Psychological Stages of the Refugee Process: A Model for Therapeutic Interventions." Gonsalves, Carlos J. Professional Psychology: Research and Practice 23 (1992): 382-389.

The purpose of this article is to increase understanding of the processes refugees use to forge links with a new culture, using the concept of cultural sojourners, but applying it to refugees and asylum applicants. This article describes five stages through which refugees generally tend to pass. Typical examples and interventions are offered for each stage. While Latin American refugees were the focus of the study, the findings are applicable to other refugee populations.

Serving Survivors of Torture: A Practical Manual for Health Professionals and Other Service Providers. Randall, Glenn R. and Ellen L. Lutz. AAAS Publication Series ; no.91-42S. Washington, D.C.: American Association for the Advancement of Science, 1991.218 pp.

This manual reviews what has happened to survivors of torture and the ways in which they are presently being helped. This book helps readers to recognize the critical needs

of survivors, prevent abuse, and assist them in overcoming problems resulting from the torture. It is a comprehensive manual which covers the impact of torture and treatment methods. It also offers a good list of resources, particularly for North America.

“Therapy with Victims of Political Repression in Chile: The Challenge of Social Reparation.” Lira. Elizabeth, David Becker, Maria Isabel Castillo, Elena Gomez, and Juana Kovalskys. Journal of Social Issues 46 (1990): 133-149.

This article describes the work of a mental health team confronting the individual and social consequences of human rights violations by the military government in Chile from 1973 through 1989. It examines three forms of repression - torture, disappearance, and death - and the consequences these have had for victims and family members. Damage to victims is conceptualized in terms of “extreme traumatization” and psychotherapeutic work with the victims has required radical rethinking of the nature of the therapeutic bond that is necessary with these patients. Grief processes have special relevance in this work, as does the relationship between the personal experience or repression and the sociopolitical context.

Trauma and Recovery. Herman, Judith Lewis. [s.l.] Basic Books, Harper Collins Publishers, 1992. xi, 276 p.

This book deals with important aspects of the experience of trauma survivors including those who have been tortured. The analysis is an attempt to restore connections between the individual and the community, or between the private and the public contexts. The author provides an extremely useful framework for psychotherapy, as she explains the dialectic of trauma and how to help survivors overcome intrusions and constrictions.

"Traumatic Stress and the Bruising of the Soul: The Effects of Torture and Coercive Interrogation.” Simpson, Michael A. In International Handbook of Traumatic Stress Syndromes, ed. John P. Wilson and Beverley Raphael, 667-684. New York: Plenum Press, 1993.

Based on the chronic tragedy of his homeland, South Africa, the author addresses the experience of survivors of torture; the nature of stressors; the relationship between torturer and victim; the pathology of traumatic stress; and aspects of the treatment of survivors.

Chapter VI

SETTLEMENT SERVICES FOR SURVIVORS OF TORTURE

Introduction

Nothing is more important for recovery of survivors than a successful process of settlement. And the obstacles are great. One woman survivor says: “You get a job and work hard to be accepted. But you have this feeling that you can't live up to other people's expectations. You try hard not to be rejected but you are aware that you have no Canadian experience, that your Social Insurance Number immediately signals that you are a refugee.”

This unit reminds of the experiences, feelings given voice in this quote. It reminds of the ordinary, frequently commonplace obstacles refugee-survivors encounter when they want to settle successfully. It suggests what service-providers need to remember, the many ordinary and not so ordinary steps to be taken, in order to assist with settlement; a matter, which requires common sense, stamina, determination and sensitivity. There are qualities of the service-provider quite different from the honed skills of the clinician, but equally important.

The issues of culture and cross-cultural understanding run through this unit. It may be useful to compare the discussion here with the one to be found in the unit on *Assessment* and the concluding one entitled *Interactive Pedagogy: An Afterword.*

THE PROCESS OF FLIGHT AND CONDITIONS FOR ASYLUM

The vast majority of persons who have survived torture and who have entered Canada do so as refugees. The United Nations Convention definition of a refugee states that a person needs to have a genuine fear of persecution based on race, religion, nationality, membership in a particular social group or political belief in order to be granted asylum.

THE UNITED NATIONS 1951 CONVENTION CONCERNING THE STATUS OF REFUGEES states that "the term refugee shall apply to any person 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, unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it."

According to this established definition, people need only demonstrate that they have a legitimate *fear* of persecution, in order to gain asylum. However, many refugees have already suffered actual persecution, including torture before they take the difficult decision to escape. Europeans and Canadians cite the high numbers of persons who have experienced torture within the refugee populations of their countries. Centres for survivors in Montreal, Vancouver and Toronto estimate that 25-30% of refugees in these cities are survivors of torture. (1994 meeting of Canadian Network for Health and Human Rights for Survivors of Torture). European Red Cross groups concur: among asylum seekers in Sweden, 25-30%; in Denmark, 31%; and, in Britain, more than 50% have experienced torture. (Working with Refugees and Asylum Seekers, Geneva: League of Red Cross and Red Crescent Societies, 1991) Refugees do not take flight easily, many have already been directly affected by repression before they escape their homelands.

The decision to flee does not involve free choice; refugees are forced to depart their countries through the experience of persecution. Some have been forcibly expelled and denied the right to live in their homeland. Some have been imprisoned and suffered torture and gross ill-treatment or have had family members or close friends and associates persecuted and threatened. Others leave only because they fear death or injury. In no case, is the decision to become a refugee, the refugee's own resolution, but, rather, it is a decision made by the force of circumstance, under extreme duress. The deprivation of the basic right to live in one's own country, guaranteed by the United Nations Universal Declaration of Human Rights, is one of a series of intense and multiple losses for the person who becomes a refugee.

Most refugees endure arduous escapes from their countries of origin and often must undergo enormous hardships during this first stage of flight. A secret passage through the countryside, often at night, while attempting to avoid discovery by dreaded police or army officials who would at the very least prevent their escape, is the characteristic beginning of a sustained period of great stress and insecurity for the asylum seeker. Nor is asylum found easily; frequently, people will have been through refugee camps and/or other countries in their efforts to find refuge. Fear of being sent back to the country of persecution is a daily reality. Disruption of life and any pattern of normality can persist for years and perpetuate periods of prolonged stress.

REFUGEE ADMISSION TO CANADA

Although the legal definition of “refugee status” has only come about in the second half of the twentieth century, many of the peoples who settled Canada could be termed refugees. In the eighteenth and nineteenth centuries, United Empire Loyalists and enslaved African Americans escaped to Canada. Jews fleeing Europe's pogroms and Scots forcibly removed from their lands by the highland clearances came as settlers to this country. We are a “settler” society, and a young one in terms of world history. With the exception of the aboriginal peoples, the people who make up Canadian society have all entered our country as immigrants or refugees.

It can be helpful to trace on a world map the location from which your ancestors originated, to note the dates of the event, and consider why the emigration occurred, if known. This activity has been very successful with groups when directed by the volunteer coordinator as part of the Canadian Centre for Victims of Torture's volunteer orientation sessions.

World War Two had displaced millions of Europeans from their homelands. This prompted the drafting of the United Nations Convention on Refugees. The term “refugee” was given legal meaning and an elaborate protocol established to determine the process through which people could obtain asylum; Canada signed the UN Convention in 1969. During this period, Canada granted asylum to dislocated people under a special category of immigrant because there was no designation in immigration law for refugee. Granted admission by special Cabinet exception were Hungarians in 1956, Czechs and Slovaks in 1968, Ugandan Asians in 1971 and a small group of two hundred Tibetans in 1972.

During the early 1970s, the government of Canada determined to devise a new immigration policy. A federal Green Paper outlining prospective policy was circulated and submissions from the public were invited. A coalition of church, labour, women, academic and civic groups who were actively engaged in lobbying the government to admit refugees from the 1973 coup d’etat in Chile responded. This incipient refugee support constituency participated in the process and pressed for a distinct category by which persons could be admitted into Canada as refugees under the conditions determined by the United Nations Convention. This marked the birth of the Canadian Council for Refugees, now composed of one hundred and thirty groups. It was first named the Standing Conference of Organizations and Individuals Concerned for Refugees.

In 1976, Canada passed a new Immigration Act, which was enacted in 1978 and which incorporated many of the suggestions submitted by the public through the consultation process. For the first time in Canadian history, a special designation for refugee status now existed in law. A system for determining asylum claims was established along with a regular programme for government sponsorship. A special provision for the authorization of “private sponsorships” by groups who would assume financial responsibilities for specified persons who were unselected as refugees by the government and who were also unable to make an asylum claim at a Canadian border point was included.

The provision accorded for private sponsorships came into force at the time when the plight of Indochinese “boat people” caught the world's attention. Men, women and children using their only available means, took small boats onto the high seas in order to flee the conditions in post-war Viet Nam. Fewer numbers were able to escape from Cambodia and Laos. Frequently stranded on the open water without food or fuel and beset by pirates who further persecuted them by robbery, beatings, rapes and murders, the “boat people” became symbols of a population in desperate need of protection. Canadians responded by organizing local groups, which initiated private sponsorships, and these were then matched by government admissions. Through these means, 60,000 Indochinese refugees were ultimately received into our country.

The provision in Canada's new law that allowed for refugee claims to be made at border points, meant that genuine protection was a real possibility for persons who had the means to get to Canada. By the early 1980s, persons from El Salvador, Guatemala, Honduras, Iran, Ethiopia and Sri Lanka had established successful refugee claims for asylum in Canada.

These foundational policies are present in today's practice. Canada now admits people as refugees by three different and distinct routes. Quebec is mandated to govern its own immigration policy and follows these same three refugee admission methods. Each stream has its own separate level of support and service: through government sponsorship from an overseas point; through private sponsorship from an overseas point; through making a claim of refugee status from within the borders of Canada.

Government sponsored refugees are entitled to full-time language instruction, health and social support and the services of an immigration counsellor for referral and settlement needs. Often people are housed within government-provided refugee reception centres for the initial term in the country where they have recourse to in-house settlement services.

Privately sponsored refugees are dependent upon the resources of the sponsors, whether a church, community organization or group of relatives or friends. Settlement assistance is conditioned by the knowledge of existing services by the group and access to them. Sponsored refugees are not eligible for government or social assistance for a fixed period of time, usually five years.

Refugees who make a claim from within Canada reach our borders from every conceivable location and make a claim for asylum at the time of arrival. Some come directly from their homeland; others have passed in transit through “third” countries. Still, others arrive after having secretly moved through the United States on foot. One Salvadoran arrived in Ontario after having carried his adolescent son whose spine had been severed during torture, on his back from Mexico to Buffalo. Claimants remain without status until their immigration hearing and, as official non-residents, are forbidden to receive federal government funded settlement services or language instruction. In some provinces, refugee claimants are entitled to education, health care and social support; in others, they are barred from assistance. It may take many years for a claim to be determined and settlement cannot genuinely begin until a person has acquired the security of refugee status and need no longer fear deportation.

The different levels of services available to refugees in different immigration categories can cause confusion for both the person seeking assistance and the service provider. From the perspective of refugees, it may seem inexplicable that some may enroll in a certain programme while others may not. Service providers may feel that these differences contribute to increased bureaucratization, fragmentation of services and injustice. For example, federally funded full time language instruction for government sponsored refugees, accompanied by childcare and transportation allowances, is not available to other classes of refugee claimants. Some boards of education, which do provide English as a second language instruction for refugee claimants do not have the resources to provide childcare or transportation and frequently have long waiting lists for these courses. Federally financed skills training programmes are not available to the refugee claimant, thus agencies must seek alternate funding in order to provide any services to them. And, it was only the then Minister of Immigration, Sergio Marchi, who permitted refugee claimants to receive work permits.

Reunification with family members is also differentiated by these categories with each accorded a distinct route to follow. For the refugee claimant, there is no possibility of reuniting with spouse or children until refugee status is determined. And, for the service provider, it may prove to be a challenge to find sufficient resources for them in the community.

This situation may create additional, and very particular difficulties for torture survivors. For refugees who were singled out for persecution in their homeland, abused as an "outcast", and rendered an outsider through gross violations of basic human rights, the experience of being institutionally segregated in the refugee process can have uniquely deleterious effects. For some refugees, institutional limitations imposed in the country of asylum may perpetuate a sense of isolation and exclusion. The settlement worker can help by candidly explaining the situation, stressing the temporary nature of the distinction, and by providing information regarding methods and timelines for change in status. The immigrant or refugee category of the individual should be clarified prior to making a service referral in order that eligibility can be properly determined and unnecessary difficulty avoided. Efforts should be made to ensure that needed services can be provided for all refugees and asylum seekers regardless of funding sources. This may require considerable efforts to find sufficient alternate sources of support. Ideally, settlement programmes should be determined by demonstrated individual need, not category or classification. Volunteer supports may need to be arranged to fill gaps in service caused by funding regulations and limited resources. These challenges will no doubt continue to be confronted by settlement workers as funding for all refugee and immigrant services continues to be reduced.

REFUGEES AS DISTINCT FROM IMMIGRANTS

All three groups of refugees share similar backgrounds even if they receive different levels of support within Canada and are classified differently. Members of all three groups have fled per-

secution and/or war, often without time to prepare for the journey. The refugee experience is distinct from that of the immigrant because of the nature of the conditions under which the decision to leave one's home has been made. Refugees did not elect to leave their countries voluntarily and often are forced into flight without family members, possessions or official papers. Immigrants choose to come to a new country with the hope for a better life and are, in general, more prepared to encounter anticipated challenges. Immigrants may have established friends or relatives who receive them while refugees rarely do. Refugees, by definition, do not immigrate but escape. Thus, they face all the same challenges as immigrants but in addition are burdened by the legacy of past oppression, dangerous flight and difficult searches for asylum.

THE STATE OF EXILE

The right to live in one's homeland is universally guaranteed by the United Nations Declaration of Human Rights. Refugees are deprived of this right. In contrast to immigrants, some refugees do not view the country of asylum as a permanent home. Rather, it may be viewed as a temporary respite from persecution, one which provides genuine protection until such time as they can return home. Precisely because they neither chose nor prepared to leave their country of origin, refugees may continue to feel profound long-term and unresolved grief for the loss of their homeland. A rather poignant joke Spanish Civil War refugees told on themselves expresses this ambivalence. They noted during their forty-year exile that they had the shortest index fingers in the world - a result of adamantly pointing the fingers down while exclaiming “this year we go home!”

The yearning to return when conditions in the home country allow, can have significant implications for refugee life. Hope that the return will be sooner rather than later may impede settlement. Aspirations and dreams may be focused on a future return and present necessities neglected. There can be an ambivalent approach to mastering a new language and culture; in these circumstances, an exile may learn only that which is absolutely necessary for daily subsistence.

Even where a refugee views his forced resettlement as permanent, and decides to remain in Canada, consequences of the conditions of escape, flight and asylum will make the settlement process a particularly difficult one.

THE COURSE OF SETTLEMENT

The process of settlement is a life-long one and requires constant adjustment and negotiation between cultures. The inordinate amount of loss (of culture, community, language, networks,

families) forces upon refugees an emotional reinterpretation and practical reconfiguration of self and society. The impact of resettlement is enormous for all refugees and even greater for persons who have suffered torture. Rebuilding a life within an alien context involves challenge and suffering for all, but torture survivors must, in addition, rebuild their lives in an unfamiliar territory when their personalities have been deliberately harmed and their capacities compromised to a greater or lesser degree.

Torture victims sustain further hardships as they live with the exquisite scars of the past. The effects of torture are manifold and life altering. However, depending on a number of factors, including length and intensity of the ordeal, support received or denied, the effects have different degrees and kinds of impact.

Not all persons who have survived torture require specialized assistance or will ask for it. Some find sufficient support within their own inner resources, their family or their exile community. Others may not recognize their difficulties or the sources of their difficulties or know where to find help even if they do. Also the need for specialized attention and service may vary over the course of a lifetime.

The experience of torture influences people differently and, consequently, types of service should also be distinguished on the basis of differential diagnosis or need. One such model is proposed in the 1991 study by Dr. Federico Allodi, “Torture Victims and Services Evaluation” (delivered at a seminar of the Canadian Centre for Victims of Torture). Dr. Allodi identifies three different levels of affect in people who have survived torture and argues that these differences reflect different degrees of harm and of corresponding need for support. The first group manages to contend with the consequences of torture through their own coping mechanisms or informal support. The second, and largest group, manifest difficulties which required specialized support and understanding in order to overcome the experience. The third group, much smaller, exhibits long lasting effects from the torture ordeal which prevent them from rebuilding their lives.

Complicating this picture is expert experience and anecdotal reports which suggest that survivors may move from one group to another over the course of a lifetime. A person in crisis may require specialized counselling before any benefit can be derived from English classes or skills training. For others, these programmes themselves can assist in integrating the torture experience with resulting settlement needs. Still others may concentrate on learning to negotiate the new culture and set aside consideration of the effects of the persecution experience until comprehensive settlement and a sense of security is achieved, sometimes many years later.

For some refugee survivors, some conditions in the country of asylum may be harder to understand than those of persecution in the country of origin. For example, while living under a dictatorship, or in wartime conditions, one may hold diminished expectations for democratic rights, whereas racism experienced in the new democratic community may be more shocking to encounter and profoundly undermining of one's hopeful expectations.

The consequences of torture do not remain isolated within a person's psyche. They affect the survivor's worldview and self-identity. A holistic understanding of the factors that influence a survivor's well-being should be part of an integrated approach to service and support.

No standard profile of a torture survivor is possible; each survivor proves to be and remains unique. Culture, age and gender as well as the singular nature of individual personality, world-view and life experience combine to provide varied outcomes to the torture ordeal. Still, some similarities in the experience of torture may be drawn and thus education and experience can inform the settlement workers task and improve services to survivors.

STRATEGIES FOR SUPPORT SERVICE

Organized settlement services may be found throughout Canada although their number and kind differ across regions. Language classes, skills training, women's groups, children's projects and counselling programmes are provided in a variety of models. Some programmes are carried out institutionally through boards of education, hospitals and religious organizations. Others are provided by smaller community based agencies, both ethno-specific and multicultural. The types of design and delivery of settlement programmes range across a continuum of service models that often blurs the distinction between “mainstream” and “nongovernmental”.

Settlement service in this sense is relatively new in Canada. Many of the present programmes were founded in the 1970s when large groups of refugees began to be admitted to our country. A number of these services originated from the informal work that was conducted in the newcomer communities and which continues today. Efforts to find appropriate housing, employment and education often originate in the living rooms of community members. Large agencies such as COSTI (Centro Organizzativo di Scuole Teeniche Italiane) developed from the mutual aid groups formed by Italian immigrants. Now they serve the entire immigrant community in Metropolitan Toronto and beyond, offering services in 30 languages. Latin American, African and Asian organizations have used the skills brought by immigrants and refugees and assisted already existing organizations to design and implement settlement programmes.

Increasingly, settlement workers from both “mainstream” and “community based” agencies are seeing survivors of torture in the course of service delivery. Each can play vital roles in both the short and long-term settlement needs of torture survivors by combining professional and grass roots knowledge and expertise concerning torture and its effects.

Service providers can “buffer” the impediments produced by torture and support positive actions. A fundamental step is to acknowledge the survivor's situation and to consider the torture experience and implications with regard to the whole person. Service providers may see the survivor only when they are in crisis or in need. This can obscure sight of survivors' general

level of functioning and their real abilities. The survivor can take on the sole identity of a "needy" person because the settlement worker only encounters them when she/he is in need. Other features of the survivor's life may therefore become obscured and they may be diminished to a one-dimensional figure – "client" or "patient". Aspects or areas of the survivors' strengths may remain overshadowed by their ongoing service requirements. Dr. Donald Payne, who remains associated with both Amnesty International and CCVT, has often cautioned persons who work with torture survivors to avoid seeing the survivor as only a victim. He has related an incident in which he was called for crisis intervention by a counsellor because a survivor reported depression. The person referred did not arrive for the specially arranged appointment with Dr. Payne, who later discovered that the survivor had felt better and attended a party instead. Workers need to be able to determine when a survivor needs to talk and when intervention is required due to a serious crisis. Help in making such determination comes from careful appraisal of not only the weaknesses but also the strengths of the survivor.

A refugee survivor of torture comes to Canada as a fully developed person with a particular worldview. Respect for the individual, including cultural background should be demonstrated in the provision of any service. By affirming the demonstrated strength of the refugee who has survived torture, flight and the search for asylum, one can facilitate settlement, support recovery and diminish loss.

Learning about different cultures, societies, and personalities is important for all settlement workers. How do survivors understand and reconstruct their interior and exterior worlds? How do they see things? Is this different from one's own customary assumptions? By anticipating the possibility of difference and preparing for this, better communication and understanding can be established.

One needs to remember that a survivor is more than a sum of the torture experience. Multiple factors, only including the torture experience, affect people's lives. Past achievements and current interests are an important part of a survivor's total history. Present successes of family members, including children, and accomplishments in the host community should be affirmed and strengthened. Personal interests such as in film, literature or sports can provide the basis for the development of connections with and within the new society.

Build on survival skills and motivations and assist by providing support and solidarity rather than pity. It can be helpful to examine your own understanding of the difference between solidarity and pity. How does this difference manifest in the provision of service? Most importantly, consider what worked for the survivor in the past and what should be avoided? Identify, preserve and expand any proven coping skills.

Remain aware of the position of power and privilege you as a caregiver have in relation to the survivor. Your position of authority may resemble that of others who had power over the life of the survivor and who used such power to harmful ends. This "likeness" may stimulate feelings of powerlessness and fear in a refugee survivor.

Be aware of the risks to which all care givers in the field are vulnerable. In particular, avoid over identification with the survivor experience and the development of a "saviour" mentality. This also reinforces the survivor's sense of powerlessness. Your need to be a saviour may confine the survivor to the role of victim. Recognize and resist creating dependency; remember that the goal is not dependency on you or your agency's service. The aim is for you to assist the survivor to develop coping mechanisms, strengths and knowledge in order to function independently. This may take time but is the ultimate goal. There is a difficult balance to find and maintain where sensitive support does not slip into “doing too much” and efforts to reinforce independence do not turn into callous insensitivity and not doing enough.

Take care in the use of language - avoid terminology imbued with militaristic or violent connotations Even vernacular expressions can have double meanings for newcomers unfamiliar with common usages, Ensure that any written materials used are also carefully screened for bias and violent imagery.

It is vital to develop methods of sensitive interviewing. Avoid methods of questioning which replicate the torture interrogation. Accept that you may not obtain all the information you require in one session and prepare for this possibility. Also recognize that in many societies it is considered rude for “business” to be conducted before an informal friendly conversation takes place. Where possible, examine and improve your interviewing techniques through role play of an interview of a survivor with co-workers.

Remember that through the process of torture a person has been rendered an “other”. The situation of a refugee in a host society can closely resemble this condition. Service providers can diminish this objectification by increasing their own and others' awareness of discrimination, and taking action to prevent it.

RETRAUMATIZATION

Be aware of the potential triggers of retraumatization and prepare for this possibility. Some can be predicted and prevented, but others will remain unforeseen. Thus one must remain aware of their ongoing potential, and insofar as possible prepare oneself to recognize and manage its occurrence. Incidents have occurred when, for example objects used in torture or places of torture are seen in new contexts. Elevators may prove intimidating for those who were tortured in one. Basements or windowless rooms may evoke images of jail. Sights, sounds and smells linked subliminally with the experience of persecution may stimulate flashbacks of the torture experience. Eventually, many survivors will anticipate these events and will develop the means to cope with them when they do occur. Some instances of potential risk can be foreseen and thus largely prevented, such as the provision of services in environments which suggest safety, openness and freedom of movement. But risks will remain for survivors. One man who was

buying his city transit pass suffered a serious flashback during the process. The procedure of being photographed by a man in uniform in a windowless tiled room closely replicated the conditions of his arrest and detention by police.

COUNTRY CONDITIONS

Many elements combine to influence the process of settlement. Individuals do function based on their own experience, but they also participate in a larger community and social structure which in turn influences the conditions of their lives and thus their functioning.

The nature of the settlement environment is decisive for the degree of success of the resettlement and for the future well-being of the individual survivor. Many survivors have passed through countries in which they have had to remain underground or in which they may have experienced additional persecution. Survivor centres have heard testimonies from persons who fled their country of origin only to find themselves in situations where they were tortured or abused again. Vietnamese boat people who escaped their country were further victimised during their flight when attacked by pirates on the open seas. Persons who sought to escape persecution from one side during a war have sometimes been attacked again by those on the opposite side of the conflict. This experience has been suffered by Iraqis, Iranians, Kurds, Ethiopians, Somalis, among others, and doubly undermines their sense of security and ability to trust and thus compounds the difficulties inherent in organizing their resources and rebuilding their lives.

Countries of asylum demonstrate different attitudes of either support or hostility to the presence of refugees at different times. The prevailing sentiment of the host community is a significant factor for the settlement process. Whether the dominant atmosphere is one of general support or rejection obviously affects the refugees' capacity to settle. Media reports and public positions taken by governments do affect the reception refugees receive from the populace at large. In Canada, the generally positive response to the predicament of Southeast Asian refugees in the early 1980s is radically different from the current general attitude to refugees. The current largely negative images appear to both reflect and shape hardening public and institutional attitudes, even while there is some continued support demonstrated at the local community level. Private sponsorships of refugees continue to be undertaken by religious and community groups. Throughout the country, schools have exhibited support for refugee children through the delivery of innovative programmes. Numerous cases of persons who informally assist newcomers by providing housing, employment or friendship continue to be brought to the attention of service providers. And services for torture survivors now number more than one dozen across Canada.

However, it must be faced that the present climate for refugee reception is more negative when compared to the previous decade. The predicament of the boat people prompted active government and civic support in the 1970s. This can be contrasted to the response in the 1980s when Tamil refugees landed in boats on Canada's eastern shores. Parliament was recalled and a new more stringent refugee policy was enacted against what was then perceived to be a threat to the country.

Conditions of global economic uncertainty may lead to a crisis of compassion in Canada. Increasing incidents of racism in Canada have direct influence on all refugees who live in our country by reducing their sense of safety and security. During 1993, for example, numerous incidents of violent racial attacks against Tamils took place in Toronto and undermined the community's sense of the possibility of integrity and peace.

It is important for settlement workers to explore their own attitudes toward refugees. Are there too many refugees in the world? Does Canada have a responsibility to assist them? Why?

INITIAL SETTLEMENT NEEDS

Requirements of settlement during the initial phase are mainly practical, consisting of needs for housing financial support, language skills, immigration status, medical attention and possibly family reunification. During this period, sometimes called the “honeymoon” stage, survivors may set aside thoughts about the consequences of torture. The “flight” response remains operative when the need to obtain sanctuary and protection of life is primary. Practical problems may overshadow those caused by the torture experience and all energy is devoted to efforts to establish asylum, to reunite family and to survive.

LONG-TERM SETTLEMENT NEEDS

After the initial phase, and the accomplishment of primary objective of tasks of settlement, long-term concerns may develop. With the paramount matters of immigration status and basic subsistence resolved, issues related to long-term employment, education and family life arise. As the "flight" sequence is closed, unaddressed or unidentified issues from the past can interrupt a seemingly steady progression toward settlement.

Rebuilding identity in the long-term becomes a focus as the reality of exile begins to 'sink in'. The disruption of refugee survivors' previous lives because of persecution and flight is more keenly felt during this stage. A deep sense of loss can be suffered when present lives are compared to those past and fundamentally different ones.

Some problems cannot be solved by either the survivor or settlement worker. Both need to recognize what can be accomplished and what cannot be and where systemic limitations persist. There are barriers which often preclude professionals from resuming their careers. Poor economic conditions lessen chances of securing employment. Racism and systemic discrimination relegates many survivors to the margins of the new society and prevents full access to the mainstream.

Realistic expectations and methods of pursuing them should be explored jointly by survivor and settlement worker and both should identify where individual efforts alone are insufficient. Many barriers may be addressed in conjunction with other settlement agencies, community groups and civic associations. Refugee support organizations such as the Canadian Council for Refugees, the Ontario Council of Agencies Serving Immigrants and the Canadian Network for Health and Human Rights for Survivors of Torture can amplify your concerns and the concerns of survivors.

There is a need to both preserve and combine cultures in rebuilding identity and incorporating the new reality. In one testimony, a man who survived torture eloquently relates how his universe was displaced when he “was removed from his mountains, his neighborhood and his family and put into a cell that was just two by two by two... the person that was me disappeared.” The significant factors that constituted his notion of reality were removed and replaced by a reality comprised of various forms of brutality. For a survivor who has been deliberately and brutally separated from the images which construct identity, piecing together the past in a still unfamiliar context poses additional challenges. Issues of loss come into sharp relief and are exacerbated by continuing restrictions of choice in those areas of life, which shape and reflect identity and influence well-being, such as dwellings, work and leisure. This may reawaken feelings of worthlessness and powerlessness, strongly experienced during torture.

A settlement worker can help by contributing to the creation of conditions where some choice and success is possible. In an unfamiliar environment, settlement workers can assist by helping to decipher the social codes that cause confusion for the newcomer. Clear and repeated explanations of how systems operate, how regulations are implemented, and what is needed for access to service add to newcomers’ accumulated pool of knowledge and diminish anxiety.

Comprehensive and complete directions provide for the survivors' need for information on how things operate in the new culture. For example, instructions on how to use public transportation need to include all possible details, including the use of transfers. Settlement workers can provide fundamental information and promote successful adjustment by “decoding” the seemingly incomprehensible new behavioural norms. It is also helpful to explore with survivors what options for action they have should something unexpected, or unwanted occur. This helps to support and develop the survivor's capacity for problem solving.

USE OF INTERPRETERS

A major impediment for both support workers and survivors is the need to use interpreters. Frequently necessary in the provision of service, interpreters can create a barrier to the creation of a trusting relationship. The flow of conversation should be between the settlement worker and the client with the interpreter facilitating this critical relationship. It is crucial for interpreters to be properly prepared and trained for the supportive nature of their role. An appreciation of differences and some cultural understanding aids in the process of “interpreting” often highly nuanced meanings of language in health care, counselling, social services and settlement experience.

There are problems inherent in relying on friends or family members, especially children, for translation and interpretation. Close associates of the survivor may not know the details of the torture suffered and the survivor may not wish them to, and thus avoid conveying this information. Even in situations where this material is significant, as for purposes of obtaining refugee status during an immigration interview, the survivor may not reveal it. Important issues of confidentiality and ethical standards for interpretation should be identified and observed.

Working well with interpreters takes practice for all service providers. Settlement workers can prepare for the eventuality of needing interpreters and agencies can assist by providing for the training needs of people who will function in this capacity. In-service training can be very helpful.

CULTURE

Survivors arrive in our country with fully developed belief systems. Their background and experience will inform how they view their new situation. No one settlement worker will be able to be an “expert” on each culture but can acquire a general understanding and appreciation that the survivor may hold a different world view. For the settlement worker, it is vital to remember that there are community resources to draw upon. Also, programmes should incorporate culturally sensitive services, which reflect their diverse constituency.

As part of a mutually respectful relationship, the service provider should recognize the survivor's values and avoid imposition of one's own culture bound opinions. Recognizing differences does not mean they will disappear. Some differences are not easily tolerated and indeed some come into conflict with laws of the host country. Social practices such as polygamy and female genital mutilation will remain unacceptable in Canada and a vast number of other countries. It

may help to know that such practices are not totally accepted in the countries of origin and that there are others from that same culture who oppose them. It may help to acknowledge that all cultures, including our own, have practices which can be detrimental to the human rights and well being of men, women and children.

WOMEN

The refugee flight and resettlement process disrupts family and social networks and interferes with customary support mechanisms. Conventional behaviours with regard to friend and kinship relationships may lose relevance and practical application in the environment of the refugee camp, during flight, and in the host country

According to the United Nations High Commission for Refugees, women and children form the majority in refugee camps. Often they have lost, or lost contact with fathers, husbands, brothers and older sons. Or frequently, they remain in the camps for lengthy periods of time while a male family member seeks asylum. Afghan refugees, for example, have lived in such conditions in Pakistan and Iran for fifteen years. Somalis have experienced the same conditions in Kenya and Ethiopia. Fear of further persecution is an ongoing and substantial concern. The fracture of the family unit increases the loss of stability. In some cases, the flight is sudden and family members, including children, are separated from one another. The Red Cross plays a vital function for refugees by tracing missing relations.

In some instances a woman may be the first to find asylum. Efforts to reunite families may be prolonged due to war conditions or bureaucratic regulations. Continuing feelings of fear and insecurity affect settlement prospects for the refugee whose family remains in jeopardy. The often long process of family reunification is a common and yet an often unanticipated obstacle to settlement.

How people view the family differs from culture to culture. In many countries, the “family” is regarded as more than the “nuclear” unit of spouses and their children. Grandparents, siblings, cousins, aunts and uncles form an intrinsic part of the family unit. Each member holds specific obligations and functions within this unit. These realities may not be recognized by the country of asylum. Canada has specific, and by some standards, relatively narrow definitions of who may be considered a relative requiring family reunification. This classification generally includes spouses and minor children.

The consequent changes in basic social and familial arrangements have particular implications for women. Women’s testimonies have revealed that separation from elders in the family; particularly mothers, grandmothers, and aunts leave a gap in usually available supports. Traditional methods of solving problems and observing celebrations no longer exist and efforts are

expended to, wherever possible, create alternative networks. Reliance on members of the community who are more established in the host country is a typical first step to settlement.

Women accustomed to finding support within the family unit are often placed in the unfamiliar situation of seeking service from agencies or institutions. Women characteristically fulfill their responsibilities for family welfare within the privately constructed sphere of the family. With this arrangement no longer available, women are obliged to turn to public social services. This situation is complicated for the woman as she must contend with the pain of the past while trying to establish herself and her family in the country of asylum. Personal consequences and needs due to torture and rape may be overshadowed by present necessities and responsibilities.

The particular needs of women as they attempt to adjust to the new country conditions has implications for the planning and delivery of settlement programmes. Issues of access to services are fundamental. The need for assistance may exist, but the potential client may remain unaware of available support. Outreach efforts are particularly important and need to be flexible and innovative if successful contact is to be made.

The provision of childcare remains an essential ingredient in programmes for women, whether language classes, skills development, counselling or orientation. Because of the prior experience of family separations, childcare is best provided at the same site as the service to the mother.

Women who have been tortured, including sexual torture in particular, may feel more comfortable with gender-specific programmes, especially initially. English or French language classes exclusive to women and conducted by a female instructor, for example, may provide the conditions necessary for a feeling of safety and security. Within these specially designed programmes, women can also form bonds, which help overcome isolation and uncertainty. Opportunities for survivors to form bonds of trust and to foster mutual support are as valuable for women as they are for all survivors.

AGE

The experience of torture is not isolated to a particular age group. Centres serving survivors have assisted people who have been tortured from every generation, infants to seniors. Many children who have become refugees have been born in prison or have never experienced civic peace. In these instances, deprivation of normal cultural and familial experiences precedes the process of migration, and can make such children particularly vulnerable.

Elderly survivors of torture are sometimes, and mistakenly, not regarded as viable prospects for settlement. Countries of asylum may judge that senior survivors will not be able to find employ-

ment and may have difficulty in adjusting to a new country. However, for the majority of the world's cultures, older relations provide a central source of family stability and cohesion. They have been seen to form the core of the refugee community. In the home, they assist with practical tasks such as childcare and domestic duties, which allow younger family members to be employed. More profoundly, they provide a vital link to the culture and country left behind. In the larger social realm, they contribute substantially to the social fabric as volunteers to community schools, ethno-specific associations, religious congregations and other diverse networks. Seniors make notable contributions in the creation of support mechanisms and the sustaining of cultural practices within the country of exile and thus ease the process of transition.

Since much of this work remains within the confines of the refugee community, it may not be recognized and thus remain unappreciated by the larger host society. The presence of seniors within the refugee population and their need for services may also fail to be recognized in the wider social framework. Paradoxically, the contributions made by seniors to the settlement process of their families and communities may render them invisible.

Premigration experiences of torture compound the sense of loss during settlement. The loss of culture, profession and personal identity is not mitigated for the senior refugee by the usual opportunities for re-education and work. Loss of social position, power and prestige spans economic rank and gender and has particular implications for the elderly population. Lack of employment opportunities and the difficulty in penetrating the mainstream of the new society may mean that for seniors, many of the losses will be permanent. Isolation from the mainstream for may also prevent seniors from accessing essential services.

Health, social and settlement services can help by designing programmes in which the needs of seniors are recognized and provided for. Attention to specific cultural preferences will facilitate genuine access.

For example, some food services for seniors have recently included foods from a variety of countries, thus encouraging a diversity of people to take part.

Programmes which address the particular losses experienced by senior survivors could enhance the ability of this group to moderate the effects of past ordeals. Services can be formulated which reawaken and support hope for the future within a context of realistic expectations for life in the country of asylum.

Evaluation of: Settlement Service for Survivors of Torture

1. Has this unit given you information of the basic issues in settlement?

   Yes__
   No__
   Moderately so__

2. What are the basic issues of settlement, as you see them having read this unit? Please list and describe the basic issues.

3. How important is this information for you, as

   i. a settlement worker?

   ii. an intake-worker?

   iii. a counsellor?

   iv. a medical doctor?

   v. a trained clinician (psychiatrist, clinical psychologist)?

4. Does this unit help you appreciate, in an overall sense, how traumatic a process settlement can be, and frequently is?

   Yes__
   No__
   Moderately so___

5. Does this unit give you some of the advice needed in order to assist survivors appropriately?

   Yes__
   No__
   Moderately so__

Selected references

After the Door Has Been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada: Report of the Canadian Task Force on Mental Health Issues Affecting Immigrant and Refugees. Ottawa, Ontario: Health and Welfare Canada; Multiculturalism and Citizenship Canada, 1988, 2 vol.

> A seminal work which synthesizes the perspectives of the hundreds of written and oral submissions, as well as research on the issue of the mental health of immigrants and refugees. It focuses on a series of "recommendations which will help to provide comprehensive, effective and sensitive approaches to meeting the needs of newcomers". One section deals specifically with victims of catastrophic stress. A comprehensive bibliography has been published as an accompanying volume.

Amidst Peril and Pain: The Mental Health and Well Being of the World's Refugees. Marsella, Anthony J., Thomas Bornemann, Solvig Ekblad, and John Orley, ed. Washington D.C.: American Psychological Association, 1994.390 p.

> This volume provides a comprehensive set of materials, which address major issues concerning forced migration and its impact on individuals. Situating mental health concepts within an historical framework, the authors discuss cultural diversity, specific regional challenges and conditions within countries of asylum in order to construct methods for treatment and support of refugees. Sections entitled "The Applicability of the Posttraumatic Stress Disorder Concept to Refugees", "Training Health and Medical Professionals to Care for Refugees: Issues and Methods", and "Ethnocultural Diversity and International Refugees: Challenges for the Global Community advance the debate on topics identified during the previous decade."

Beyond Words: A Training Video for Cultural Interpreters. Produced and directed by Luis Garcia. 28 mm. Ontario Ministry of Citizenship and Culture, 1987. Videocassette, with accompanying users' guide.

> This training videotape uses a docudrama format to illustrate the need for cultural interpreters in all aspects of service provision with immigrants and refugees. In addition to the role-plays which demonstrate aspects of the role and skills of cultural interpreters, the video also uses charts and narration to explain what cultural interpreters do and what they need to know in order to do their job well. The tape is accompanied by a 39 page users' guide.

Community Support for Survivors of Torture: A Manual. Price, Kathy, ed. Toronto: Canadian Centre for Victims of Torture, 1995.

This text contains practical suggestions for the creation of appropriate services for torture survivors within the Canadian context. Contributions are given by service providers from various regions of the country. Insight and advice is offered in such areas as "Developing Understanding", "Therapeutic Approaches", "Supportive Caring for Children", "Meeting the Cross-cultural Challenge" and "Towards Prevention."

Counselling and Therapy with Refugees; Psychological Problems of Victims of War, Torture and Repression. Veer, Guus van der, Victor Vladar Rivero, and Mia Groenenberg. Chichester: John Wiley and Sons, 1992. 275 p.

This book offers a practical guide to the treatment of psychological problems encountered by refugees. It brings together the author's own experience and the available scientific literature and thereby builds a bridge between theoretical knowledge about the problems of refugees and clinical practice. This pragmatic use of theoretical knowledge is illustrated in chapters about the practice of counselling in general, and in a section on special groups such as children and adolescents and special problems such as the risk of suicide, and male and female sexual violence.

Hope after Horror: Helping Survivors of Torture and Trauma. Hosking, Peter, ed. Sydney: Uniya, 1990. 180 p.

This volume, drawn from the experiences of centres for torture survivors in Australia, assists by portraying the global problem of torture through the problems encountered by individual refugee survivors. It presents a sensitive analysis of the conditions necessary for service and addresses the problems in the host country, which can retraumatize torture survivors.

"Paraprofessionals in Refugee Resettlement." Ivry, Joann. Journal of Multicultural Social Work 2, no. 1(1992.): 99-117.

The role and function of indigenous paraprofessionals in refugee resettlement are discussed. With training and supervision, such paraprofessionals - who share a common background and experience with the client population - can bridge cultural and linguistic barriers, and serve as role models. For illustration, the experience of the recent Soviet Jewish refugee resettlement program in Boston, Mass. is examined.

Refugees: The Trauma of Exile: The Humanitarian Role of Red Cross and Red Crescent. Miserez, Diana, ed. Dordrecht: Martinus Nijhoff Publishers, 1988.340 p.

Based on a Red Cross Workshop at Vitznau, Switzerland, October 1987, this work describes the health and psychological problems of refugees within a context of human rights abuses. The collection assembles contributions, which illustrate the process of settlement and adaptation for refugees and provides suggestions for support and service.

Social Work & Refugees: A Handbook on Working with People in Exile in the UK. Finlay, Rosalind, and Jill Reynolds. Cambridge: National Extension College, Refugee Action, 1987. 225 p.

This handbook is intended for the use of people working in any agency which provides personal social services. It is the outgrowth of the British Department of Health and Social Security's Refugee Action Project. Each section begins with a short introduction and materials at different levels to promote discussion, give factual information, provide suggestions for action and supply questions and checklists for further consideration. Useful material on the various responses to the refugees' needs; establishing of working partnerships; specific guidelines for practical problems, such as dealing with stress, working with families and individuals, training and resources. Helpful reading and audiovisual lists are also included.

Torture and its Consequences: Current Treatment Approaches. Basoglu, Metin, ed. Cambridge: Cambridge University Press, 1992.527 p.

A comprehensive work, which includes contributions from primarily European service practitioners. Contains extensive references.

"Under Many Fires." Barrenechea, Ana Maria. Canadian Woman Studies/ILe Cahier de la Femmes *15,* no.2-3 (1995): 30-33.

This paper succinctly catalogues the numerous stressor situations which female torture survivors face in the country of origin, during flight, and in the country of asylum.

Women Refugees from Bosnia-Herzegovina: Towards Developing a Culturally Sensitive Counselling Framework. Filice, Ivana, Christine Vincent, Amina Adams, and Fersada Bajramovic. Ottawa: Carleton University, Centre for Immigration and Ethno-Cultural Studies, Research Resource Division for Refugees, [1995].

A recent tool for developing culturally and gender sensitive counselling programs, with a particular emphasis on women who have been victims of sexual violence. This manual includes guidelines for such programs as well as a cultural profile of Bosnian women refugees recently arrived in Canada. The guidelines are relevant to counselling programs in a variety of settlement and other agencies

Chapter VII

THE EXPERIENCE OF SERVICE: ETHICS AND SUPPORT

Introduction

The reflections, analyses and exercises offered here revolve around the central problem of service provision to survivors of torture.

How is one to come to terms with the tendency to, on the one hand, subordinate one's own life and interests to the victim's/survivor's needs? How is one to avoid, on the other hand, the distancing from the survivor's experience, which makes us indifferent and unresponsive? The chapter (unit) shows that there is no easy resolution to this. In fact, these two attitudes designate inescapable tensions in this kind of work. Working through this section will help you situate yourself in relation to this unavoidable tension. It will help you anchor yourself in an ethics of care (and of care-giving) rooted in a depth-psychological understanding of your situation as a care-giver. This is a much-neglected dimension of our work, but one which requires on-going and serious reflection, as well as communication and review with qualified and supportive "experts." We have to realize that we ourselves have to take the decisive steps toward coming to terms with the experiences which our work provides, no matter how much support we will be receiving.

For it is in the internal or inward dimension that the crucial transformations take place with respect to this work; we learn to discover, for example, whether we unconsciously and involuntarily resent our work or whether we are ignoring warning signals, telling us that we need to have some balancing content in our lives, some enjoyment, so that we do not make survivors' suffering exclusive content of our lives, thus losing the capacity for the "objective" and careful judgments required.

In many respects this is the most demanding and difficult unit in our context and one that might have to be approached with the willingness to let oneself be challenged as a care-giver, just as much as with the warranted expectation to receive suggestions for support.

• • •

For most of us in Canada, torture is something about which we know very little and this is also true for mental health, education and social service workers. For the vast majority of us, neither our training in our chosen field, our personal life experiences or the common knowledge we share with other citizens of our Canadian society has introduced us to torture - its occasion or its effects.

It was not until the winter of 1994, with the revelation of the torture killing of a Somali teenager by a member of our armed forces, that torture came crashing through the public media into the shared consciousness of our country.

Torture now is something that has significance for us as Canadians, not just with regard to the provision of shelter from it within our borders, or humanitarian and peace keeping efforts meant to lessen its occurrence and consequences outside them, but also as a practice in which we are implicated. This is a fact of our history which is neither easy to think about nor to make useful sense of.

However, rather than consign this momentary recognition of Canadians as “torturers too” to the realm of the unusual, the incomprehensible, the isolated aberration, we may decide to do our best to 'keep it in mind' through individual and shared reflection. In this way we may alter what turns out to have been a rather privileged ignorance about the potentials of human nature and the realities of human history, including our own.

Situating Ourselves in Two Kinds of History

Upon reflection we may recognize that the building of our country has in fact always been linked to terrible realities of human history and human nature. Canada has always been a country of asylum: waves of emigration have reflected political and economic strife in the larger world. Asylum seekers have brought with them memories and other consequences of the various kinds of trauma that human beings visit upon one another under such circumstances. Torture is one of these and has recently been recognized to be part of the premigration experiences of a significant number of our newest Canadians. A wide variety of service agencies and practitioners are struggling with this reality.

Perhaps it is this shared history of building from remains, from what has been salvaged from war and political and economic turmoil around the globe, - our history as an asylum culture - that may give Canada the capacity to sustain its previous commitment to do the ethical and humane thing, to offer asylum to refugees, in these ever difficult times.

As events in a far away land are requiring that we “rethink” ourselves, we are already engaged in a difficult process of “making sense” of terrible events within our own borders - the scandalous and horrifying treatment of native children in residential schools and of other children or-

phaned or otherwise troubled in church affiliated or administered institutions meant to provide care. Some combination of faith, disinterest, racism and dependence upon an ill-informed but shared “common sense” knowledge in the general population contributed to the social abandonment and institutionalized brutalization of these children.

Many of the things inflicted upon these children are properly understood to be torture in either the narrow sense or in the broader sense of organized violence, which we use in this document. The feelings we have when we learn that such things have been done by one Canadian against another, by representatives of institutions whose purpose, we have been taught, was to protect and minister to us, are disturbing and complex. Upon reflection, we may consider that such feelings may be not unlike the initial shock, disbelief and shame that citizens of other countries feel when they become aware of torture in their midst, when those brutalizations which characterize new and old dictatorships overwhelm their countries and their lives.

It is disquieting to learn, through work in this field, that not infrequently it has been countries which had prided themselves in or had taken for granted a certain level of social stability, freedom of democratic practice and civil restraint which transformed themselves into societies of institutionalized civil rights abuse and civic terror. This was true of not only Germany and Chile, but also of Ethiopia and Sri Lanka. There are citizens of other countries, such as Haiti, or apartheid South Africa, for example, who have suffered under longer histories of institutionalized brutality, but who suffer no less for its familiarity. As Canadians, we may use the knowledge of such possibilities of history and societies which our refugee citizens bring to us as a basis for reflection upon not only that larger world beyond our borders but also upon our mostly more fortunate circumstances - how shall we preserve and how would we improve the conditions of human rights, democratic practice, civil restraint and social responsibility in our country? It is likely that each of our refugees could tell us a cautionary tale.

One can find support for thinking about these questions and doing work in this field by also being mindful of some Canadian history about which we need feel neither shame, shock nor regret. An obituary in the Toronto Star dated March 16, 1995, in recording the death of Professor John Peter Humphrey, made note of a fact which it is fair to guess 'all Canadian school children', unfortunately *do not* know, (even while they may know who wrote the American Declaration of Independence). Humphrey, born in New Brunswick in 1905, professor emeritus of law at McGill, and first director of the United Nations human rights division, is the principal author of the Universal Declaration of Human Rights (accepted by the General Assembly of the United Nations in 1948), that document which marks the formalization of a beginning internationally shared understanding of the minimal conditions for the living of a decent and peaceful human life. This document is a benchmark of human progress - of at least what we aspire to, even if not what we can insure.

Another fact of our history which it is reasonable to assume is also not widely known is that in the late seventeen hundreds, John Graves Simcoe, the first lieutenant governor of Ontario, wrote and orchestrated the passage of the first bill ever to outlaw slavery. This act predated

Abraham Lincoln's action on this issue in the United States (1863-5) and William Wilberforce's instigation of the passage of a bill to free all slaves in British Colonies by the British House of Commons in 1833.

These facts of our history, among others, have significantly contributed to the evolution of this country as an asylum nation and a nation, which has with some justification been internationally regarded as committed to humanitarian endeavors.

Each service provider who works with refugee survivors of torture in whatever capacity participates in this history. They are given the responsibility and opportunity to remake it on a daily basis as they respond to the needs, and facilitate the integration of survivor refugees into our society. Robert J. Lifton's (History and Human Survival, Random House, N.Y., 1961/70) has argued that *affirmation of one's ethical commitment to this kind of work is critical to sustaining oneself in it*. Lifton's own commitment to ethical practice in psychiatry, and professional academic life, his sense of being located within an international community and tradition of humanitarian endeavor has its source in aspects of *his* personal history and social identifications: each one of us will find important support by identifying those sources of commitment which are our own. It is likely that Lifton himself has become an inspiration to many others.

Exploration of the sources of your own commitment to this work may lead you into interesting places, in the history of your family as well as that of your country, your ethnic culture, and your own personal past. Most Canadians have been shaped (knowingly or unknowingly) by family stories of migration reflecting varying degrees of duress and hardship in the more or less recent past.

Such a search may lead you into the future as well as the past if you find, as many have, a sustaining source of inspiration and commitment in your capacity to imagine things differently - just a bit better - than you have come to known them to be.

It can be helpful to develop a conceptual relation to those parts of your profession, culture, society, individual history and human history in general which represent ethical practice to you.

> Thus our <u>first principle</u> for support for service providers is:
> *Reflect upon the source of one's own motivation and commitment to this work.*

Awareness of those elements of our history, both bad and good, which have formed us as a nation and as individuals may strengthen our efforts to make the best possible decisions, and to take the best possible actions when we seek to directly serve survivors of torture in our working lives, or merely to make room in our minds, our hearts and our county for those who have suffered so much at the hands of others.

Thoughtful reaffirmation of a commitment to those who seek asylum here may also help us to accept the awesome responsibility to gain a thorough understanding of this terrible human practice of torture. It may help us when we must think about this 'unthinkable' thing, - as we listen to survivors or read the work of others who have studied, researched and thought carefully about this subject. It is not an easy task, this one that is before us. We know little and there is much to be done.

Considering the Experience

There is another side to the feelings created by the experience of this work, one which is quite different from the sense of fulfillment, of participation in a worthy endeavor and of being joined to a history and international community of humanitarian practitioners. Working with survivors of torture creates the difficult task of facing and dealing with the encroachment of feelings and thoughts which tend to undermine one's capacity to sustain one's effort, to do a good job and to find fulfillment in one's work. Experienced and inexperienced practitioners alike have consistently reported that they consider their work with this population the most challenging both professionally and personally.

Beginning to work with survivors is a disturbing and humbling experience for a number of reasons. We may find that we think less of ourselves as we try to do this work, less of those who have suffered it and are at times hard to understand and to help, and less of human beings in general, who could do such things to one another.

A recurrent sense of newness, of ignorance, of inadequacy, of a kind of professional disorientation can be particularly difficult for the professional practitioner who is highly trained and already highly competent in his or her field. This sense of not knowing “what to do” may be additionally painful where experience has shown that the help one wishes to offer has been positive and significant in the lives of many others one has served.

Community-based, non-professional practitioners, even with a wide range of front line experience, will also be puzzled by the difficulties and troubled by the encounter with survivors in their work. They may as well be less aware of the help to be found in formal training, have fewer opportunities to obtain such training, or to access the kind of supervisory support which would help them better serve this 'hard to serve' population.

It is with *the nature of the response made by the professional and other practitioners to these feelings of ignorance, frustration and displeasure that we are concerned and with regard to which we believe we can offer some help*. Since it is our assessment that service providers need primarily to develop resources within themselves, we recommend (in addition to the principle stated above) that service providers of all kinds working with survivors strive to do the following:

(i) Increase Knowledge

(ii) Develop Reflective Capacities

(iii) Build a Support Network

(iv) Establish Regular Supervision and Consultation

(v) Consider Complimentary Advocacy or Proactive Work

(vi) Incorporate Activities for Rest and Renewal

(vii) Evaluate and, where possible, Improve Working Conditions

Each of these recommendations will be considered briefly in turn.

We propose a *model of professional development* in which service providers are assisted in their efforts to develop capacities and resources within themselves. To begin, we do not even imagine that we could anticipate the range of interesting, complex and challenging cases and problems, which any single practitioner will encounter in the course of their work. We do hope, however, to help you gain some knowledge and some practices which we think will help you to remain open to learning from these ongoing experiences, to think clearly and constructively about the task and the client before you, and to develop the best possible intervention given that task, that client and the nature of the resources which are available to you.

We will see that factors in the practitioner, in the survivor and in the conditions in which they come together can interact in a manner which may derail the seemingly straightforward project to offer and to receive help, to make good use of what is already known through a practitioner's prior experience and training, and through the experience made and the understanding gained by the survivor.

One of our more experienced practitioners has suggested that we are, or should be, largely concerned with the need to learn what *not* to do, to avoid mistakes, which, as it were, lay in wait. The challenge is then to recognize, prepare for, and insofar as possible, avoid well-recognized and perhaps preventable errors. This negative way of thinking about training and learning in this field is, in part, due to the absence of a universal model of the phenomena of torture, of its victim or of "*the* right" intervention response. In this field, relevant expertise exists in a limited way, as for example in knowledge of the physical effects of torture. With regard to an explanatory model of the social and psychological effects of intervention strategies, of the consequences for practitioners working with this population, there are many, or pieces of many, things that have been said and done which do increase understanding, which do improve service and which do diminish suffering in some circumstances, under some conditions. However, there are not only different approaches, but also important and interesting debates about these differences.

Such a “negative” approach is also related to the caution to 'do no harm’ while engaged in efforts to do good. It is related in turn to the fact that it appears to be easier to fall into error, and to risk doing well intentioned harm, when working which survivors than with many other groups. Experienced practitioners have repeatedly related their sense that work with survivors presents the most serious and sustained challenge to their knowledge and expertise and to their professional development. There are some ways to meet this challenge. Increasing general knowledge about torture, and about that aspect of the phenomena which is specific to one's field of practice are among these.

Finding one's way as a practitioner is made easier by becoming familiar with existing knowledge and with some of the issues and debates. Once informed you may select what is most useful and what makes most sense to you when considered in relation to your own experience of practice and the task before you.

The acquisition of knowledge is essential to the process of developing personal and professional resources in the self.

> Thus Increase Knowledge is the second principle of support for service providers.

From a State of War to a State of Peace

Increasing one's knowledge through reading the literature presents a particular challenge to Canadian service providers. Some of the most interesting and important thinking and writing in our field, the work of Elizabeth Lira for example, has arisen out of the experience of doing treatment and delivering service under conditions of chronic political unrest, state terror, and social deterioration, that is, within what has been referred to as cultures of fear. In such circumstances the very work of caring for survivors puts service providers themselves at risk of persecution.

For service providers in Canada there is, then, the need to translate lessons learned in a state of war to a quite different context, a state of peace. And this is so even while we remain mindful that survivors may not be able to make such clear delineations; for many refugee survivors the conditions of both their internal (i.e. mental and affective) and external (i.e. their situation as refugees in an alien culture[1]) worlds bear a considerable resemblance to states of terror and cultures of fear.[2]

[1] This has implications for the service relationship. Survivors in exile may be envisioned to be in many ways existing in a world between - culturally, psychologically and physically. They are between the world they have lost, one which was in fact taken from them, and the world that they have not in fact gained and yet by which they are 'surrounded'. They both are and are not the person they were before physically and psychologically. Prior to the integration of their experiences, many feel not so much changed as unrecognizable. Refugee survivors may appear to function in a kind of ad hoc manner in both practical and relational matters - relationships may appear

Thus, reading the relevant literature can, at the very least, make one aware of the nature of the experiences that survivors carry with them, experiences which influence the quality of their perceptions and approach to life. This knowledge can be critical to developing an understanding of the clients you serve and to developing an appreciation and toleration for some of the recurrent issues you will face in your work with people who have been tortured.

Thus our unique circumstances of being an exile culture and a nation long at peace means that to a degree we must make out own way as Canadian Practitioners, just as we do as practitioners of particular kind of services, as part of particular kinds of teams and as individuals who seek to offer help from a particular position and moment in the world's long history of migration. However, general knowledge of what has been done and thought in this field, both far away and near at hand, is critical to doing better work and finding the most satisfaction in whatever particular circumstances we find ourselves.

Some of the issues facing service providers are specific to the kind of work one is doing, the role filled, the task performed. The tasks of needs assessment and referral by intake workers, of documentation for purposes of refugee claims and medical treatment by physicians, of legal counsel and representation, of finding housing and other material supports by settlement workers and the provision of psychotherapies by psychiatrists and psychologists, each have their own tensions, challenges and limitations which are more or less specific to the job at hand. And it is important to be informed about those to which your particular role makes you more subject.

Other experiences, tensions and challenges appear to be common to all workers with survivors, even while their intensity and significance for task performance may vary across contexts, individual survivor and individual service provider. Knowledge of these common issues is important. In addition to the sense of ignorance and ineffectuality already mentioned, shared issues include, but are not restricted to, mistrust and ambivalence in the service relationship, difficulties in developing a working alliance with clients, difficulties in maintaining role boundaries and

superficial and manipulative and personal lives erratic, including for e.g. frequent moves. This is a function of the ongoing unsettled and in-between nature of their lives along dimensions deeply linked to security and identity as well as of the experience of torture itself. Torture and refugee migration experiences have often required the survivor to unlearn or otherwise leave behind much of what was known and valued as part of an integrated picture of self and world and to acquire instead some pieces of knowledge, and some practices which make it possible to survive and to get by in one way and another. The continuity of knowledge, context and identity are disrupted. Psychological elements of such an ad hoc approach may include hypervigilance and mistrust, situational aggressivity or passivity, and dichotomized thinking. While only psychotherapists will be specifically engaged in interventions designed to alter such characterological changes resulting from trauma experiences, all service providers will benefit from gaining some appreciation of these types of effects. This knowledge can be expected to increase understanding, toleration and the proper management of cases, illuminating in particular one's sense of a survivor's tenuous commitment to the treatment relationship, to language or other training and education programmes, and to the whole process of settlement in Canada. Thus, it can inform treatment planning, intervention approaches as well as illuminate issues of boundaries and burnout.

2 Implications of this knowledge for the practitioner include the need to recognize the manner in which features of the service encounter, including their own behaviour, may resemble those of detention, interrogation or torture and to remain alert as well to the possibility of unanticipated stimulation of painful associations to past trauma.

realistic goals and limits, the lure toward overidentification, enmeshment and omnipotence, and alternatively the risk of retreat into denial, numbing and avoidance. Workers also report grief, fatigue, isolation, guilt, burnout, despair, anger, and a recurrent sense of irresolvable dilemma.

Let us consider the manner in which knowledge can contribute positively to work in this field by taking up one of the issues, which crosses the whole field of practice when working with survivors - trust. We should already observe that the identification of trust as a broadly experienced issue is itself a piece of expert knowledge developed through experience and reflection.

Trust

Our needs assessment identified the practitioners' need for help in establishing and developing a workable relationship with survivors. Initial contact and the mere establishment of a working alliance through which needs can be assessed, services recommended and delivered is often difficult with survivors. This can often mean that survivors do not receive services that are in fact available. Things can go “off track” quickly and unexpectedly.

Especially in the initial stages, but also recurrently and for some survivors, always, there will be many hesitations and resistances in relationships - mostly connected with the difficulty of feeling or sustaining a sense of trust. Where practitioners are aware of this reality, of its sources in the common experiences of survivors of torture and of the way in which it manifests in service relationships, they will be better prepared to respond appropriately and helpfully. Informed service providers are more likely to intervene in a way which will support the development of some tentative and initial trust or which facilitates the delivery of services even in the face of continuing mistrust. Where this is not the case, the consequences for the service relationship of disturbances in the survivor's capacity for trust can be quite serious and lead the uninformed practitioner astray in a variety of ways.

It is important for all service providers to, insofar as possible, create and maintain conditions of service delivery which can reasonably be expected to alleviate mistrust, fear and anxiety and which foster the development of at least the foundations for the reachievement of trust and a sense of security in relationships.

Mistrust in relationships, especially those involving or symbolizing dependency or a differential in social power, is an almost universal effect of surviving torture.

Thus it cannot be expected that survivors will take at “face value” the offer of help, which is extended by a health care worker, for example. It is indeed likely that mistrust, covert if not overt, will characterize the early stages of all intervention relationships and will recur subsequently due to a variety of factors in the environment of the survivor, events in his or her personal life, actions taken by the service provider, or emergent psychological material.

Service providers working in mental health fields are more likely to be aware of the theme of trust, or more properly, mistrust, and to expect it to be a recurrent issue within therapeutic relationships, in particular with patients who have suffered trauma. Even experienced professionals in this field note the central saliency of this issue in work with survivors. Service providers in other fields are less likely to be informed on this issue and may find little or no supervision on this issue.

Viewed interactively, across time and situations, 'mistrust in relationships' is both an effect (of torture) and a cause (of subsequent difficulties in all kinds of relationships).

A lack of trust can contribute to avoidant behaviours such as vagueness in answering questions or describing past events or present plans, an inability to make decisions or accept guidance, failure to follow through on advice given and apparently accepted, frequent forgetting or cancellation of appointments or arriving late, etc. All of these avoidant behaviours can suggest to the practitioner that their help is considered inadequate, or insufficient or otherwise not good enough by the survivor, and indeed may cause them to doubt themselves. They may alternatively be understood by the practitioner to suggest ingratitude, laziness or incompetence in the survivor. Different practitioners will react to these experiences of practice in different ways: some will try to improve their service, work harder to do better, others will tend to dismiss the survivor as unhelpable. Realistic reappraisal of the adequacy of what is being offered (and brought into question), confidence in one's work where justified, and the capacity to read and respond to the subtext of the client's behaviour communications (i.e. "I do not feel safe") in such circumstances is a kind of competence which requires both knowledge and learning through experience.

Others who feel mistrust may present as hypervigilant, paranoid, scornful and belittling, or even boastful, threatening and intrusive as if they needed nothing from you and had all the answers and all the power. The contradiction between this picture of bravado and the very real needs of the survivor may be difficult to reconcile. You may once again find yourself feeling doubtful about your adequacy, even to understand, and remain uncomfortably confused. Some practitioners will feel resentful of or even angry with such clients. The challenge is to find a way to offer and deliver services in a way, which does not imply questioning the survivors' competence or autonomy. This considerable challenge is not likely to be met if service providers are unable to examine their feelings and to use them to increase understanding of the client.

Finally, some survivors may appear to be <u>overtrusting</u>. They express positive expectations of help, which are unrealistic in kind and degree and undifferentiated in their reference. An undifferentiating positive expectancy in the survivor's approach to you and others may raise a number of questions and concerns for you. This style of relating may suggest a lack of judgment, immaturity and overdependence as well as vulnerability in the survivor. You may find yourself afraid that in one way or another they are 'riding for a fall', since no one, including yourself, could be so good or so giving as they appear to anticipate. With such a client you are at risk of either sharing in the excessively positive view of yourself and of trying to live up to all the ex-

plicit and implicit expectations, or of feeling uncomfortable and dismissive since the clients needs clearly exceed what you or your service could ever offer. Indeed, you may oscillate between these two sets of feelings. Paradoxically such a client may contribute to your feeling both that “only you” can help them and alternatively that you are “never doing enough”. With such a client you have the task of helping them identify those needs which they have which can be realistically met by you and the institution for which you work in such a way that the client can tolerate the limits or “imperfections” of you and your agency without feeling so betrayed or let down that they become incapacitated by rage or despair. Humour (and the joke must always be on you) and commiseration with them about your limits and imperfections, as they see them, may make it possible to sustain contact with such a client and for them to accept what you can in fact offer. This is because you have become neither judgmental of their perhaps excessive neediness (implicit in their suggestion you have everything) nor participated in the illusion that nothing less than everything will do - while not perfect and everything, you may become “not bad” and “at least something”. The other risk with such clients is to join them in the collapse of what was their defensive over idealization into an equally totalistic negativity - where you concur that you, your agency, your country and the world, as it were, is just too terrible, useless, etc. to be borne. At such times of collapse in your client it is critical, while remaining empathic, to retain sight of the distinction between your client’s feelings and thoughts and your own. While acknowledging the truth of their being, much which is terrible in the world, and indeed in all of us, you must remember those things about your shared world, your client and yourself about which one can feel good - including your continuing willingness to try to help. We do caution against the temptation to lecture or otherwise “inform” such a client of “really how lucky they are” etc. including their being “lucky to be in Canada” (unfortunately, we gather, too frequently done), but rather simply that you do not participate in the negativity. It is worth knowing that emergence from a protective psychological confusion often manifest in the failure to differentiate between good and bad in subjective experience may require passage through a period of extremely dichotomized thinking where the world and the people in it are rigidly and passionately split into either all good or all bad. This is a developmental dimension of healing, which places particular pressures upon practitioners to align themselves with the client (often in “us vs. them”). To do so will merely serve to fast the client in this psychological position and interfere with further development of a more nuanced, tolerably ambivalent, but more realistic picture of self, other and world. This is particularly difficult in highly politicized situations which tend to invite split constructions. This caution should not be confused with your failing to acknowledge the wrong which has been done the survivors by those who tortured them and may often be only as active as recalling, for yourself, those things about your client and your world about which it is possible to remain hopeful. Your willingness to continue to work with such a client, like your capacity to refrain from joining in their dichotomized world view can represent a much needed hope to which they may, in time, make their way. Dichotomized thinking is often an early phase of remaking meaning out of a world (internal & external) which has gone mad, of reestablishing values following experiences which tore one's world of meaning asunder. Some things are good and some things bad: it begins from there.

The experience of torture, detention and exile, of flight across nations and continents is fraught with experiences which have taught the survivor hard lessons that are difficult to unlearn. The fear of being harmed yet again, of trickery, entrapment, abandonment, may affect not only the survivor's perception of the services, but more fundamentally the relationship itself, which you offer. The simple truth is, they may not trust you, or not trust that what you offer is worth having or, if worth having, will not be ultimately withheld or withdrawn or will not have to be “paid for” through some other kind of suffering.

Understandably, these reactions and behaviours, and the suspicions and fears they convey, can be experienced by the practitioner as referring quite directly and personally to them. The more uninformed and inexperienced the practitioner is, the more likely this is to be true. These manifestations of an absence of trust can come as quite a shock and an insult, and at the very least can feel terribly unfair. At a deep level one may feel as if you do not exist for the survivor as the person you are. Not only can this stimulate anger, it can even be frightening because such experiences have an element of annihilation disappearing within them since who one is, is not recognized or affirmed by the other.

Those who are experienced in this area will recognize that many of the types of feelings, which one has in such encounters, mirror feelings of the survivor.

Work from clinical researchers in the field has enlarged the discussion of the issue of trust further. It has suggested that in some instances, symptomatic behaviour, which suggests an absence of trust, may have quite a different meaning. For at least some survivors the disinclination to “regain” life may manifest in both passive and more active resistances to being helped and to establishing a relationship with a service provider. This is because the service provider offers and represents an opportunity to reconnect to the world and to rebuild their life. Even the contemplation of such possibilities can arouse guilt and be experienced as a potential betrayal of the people and the homeland one has loved and lost. When memory is populated by those one has cared for and lost and the world one has also loved and lost, beginning over can feel like a betrayal not only of others but of oneself.

So the same set of symptoms can reflect survivors' fear of hope and belief as well as guilt about “coming back to life”. Each service provider must sort through what particular meaning, or range of meanings, are represented in any given set of client reactions and behaviours. And this is one of the reasons why there are no “recipes for success” or simplistic symptom-meaning equivalencies in this text, even while there are some general guidelines. In the end, you must use yourself, and your understanding of the general phenomena and of the individual client, to tell you what is going on and what to do about it.

There are two other relationship consequences of working with a client who lacks basic trust which are important to note, you may find that you do not trust your client and you may find yourself tempted to or in fact breeching a trust with your client. In sum, you may feel tested too or even tested beyond your limits.

Manifestations of mistrust, such as client resistance, may make the practitioner feel incompetent, confused and professionally humiliated to such a degree that it appears the only solution is to leave the work, “for the sake of everyone”. Another response to the same sense of failure can be a tendency to overextend oneself or to otherwise breech the usual parameters of one's practice.

Difficulties in the delivery of services, including disturbances in the capacity for trust, often raise the issue of “readiness” - that is whether the client is “ready” to be helped or not.

Work with survivors can at times seem like more trouble than its worth, to the survivor and to the practitioner: “If they really needed help... or “If they were ready to accept help... they'd - turn up for the appointment, come to the ESL class on time, respond to my questions, call the agency I told them about, accept the offer for Art Therapy class... etc. etc....” And, one might wonder, “why bother, when there are so many others in need who *do* want what I have to give”, or conclude, they're “just not ready” to be helped. As can be imagined, these kinds of reactions can slip into various forms of client blaming.

Practitioners with even limited training and experience are likely to be aware of the issue of “readiness” when assessing need and designing service delivery. To know that this is also the case in work with survivors is, shall we say, a start.

However, to also know that assessing “readiness” with survivors involves issues of trust, control and often requires preliminary “testing for conditions of safety” by the survivor is to know substantially more. This should be enough knowledge to make us cautious about conclusions made in haste.

To acquaint oneself with what has been learned by others in the field about the issues of trust and safety, control, and ambivalence in the lives of survivors and how these affect all relationships including, in particular, relationships with those who represent authority or dependency, is to know considerably more.

To learn how to evaluate the likely influence of these factors in the development and maintenance of a helpful working relationship with an individual survivor is to know more again. And then to design delivery service programmes, which take this knowledge into account, is to integrate and develop knowledge into practice.

Finally, to learn how to monitor and factor in one's own feelings through each stage of this process is to understand one of the least recognized but most important elements for success in this work.

In combination, such knowledge and developed expertise will help us avoid simplistic formulas regarding “readiness” which can contribute to missed opportunities for the delivery of services or their inappropriate allocation. It can help us to create conditions for service delivery in which both the provider and the survivor feel “ready”.

All Service Providers will be subject to testing for conditions of safety[3] by survivors. The vulnerability of the service provider/therapist to 'failure' of such testing by survivors will be determined by 5 factors:

(i) the role performed, (whether e.g. physician or immigration officer) - some relationship contexts & configurations will be more difficult than others because they will stimulate stronger negative expectations;

(ii) the practitioner's level of knowledge, training and experience, and his/her capacity to integrate this knowledge into practice in the form of verbal and non-verbal intervention strategies and adaptation of overall treatment design;

(iii) practitioner's self reflective capacities - thus the ability to recognize various communications of mistrust and to respond appropriately, both in terms of effects upon one's own feelings and upon functioning;

(iv) the strength of the working alliance - where it is strong, some failures can be tolerated by the client and form the basis of greater understanding. Preferably, however insecurity and mistrust should not have to be relived, to be recognized;

(v) access to collegial consultation or supervision.

Trust and Role Definitions:

Role definitions, and associated responsibilities and powers will affect the expectations which both the survivor and the service provider bring to any interaction.

These sets of expectations and associated fears and hopes will not always converge. Some will tend to facilitate trust, others to stimulate mistrust. Thus it has often been noted that anyone in uniform, such as police officers, or those invested with quasi-military or judicial authority, such as immigration officers, are likely to evoke fear and mistrust. Depending upon the nature of the experience in the home country for some survivors, even physicians can evoke fearful and painful associations.

Clarification and maintenance of roles is critical, and yet for a variety of reasons, difficult in our work. Your title, role and the domain of your area of service should be clarified with your client at the outset and may well need to be reiterated throughout your working relationship. It may need to be reaffirmed not only with your client but with yourself.

[3] See Weiss and Sampson (1986) The Psychoanalytic Process:Theory. Clinical Observation & Empirical Research, Guilford Press, N.Y. for description of research into and discussion of this phenomena in the therapeutic relationship.

It is important for the individual to know that, for example, as an ESL worker, you have no say regarding the achievement of refugee status, or that as an examining physician, the reason you must ask these questions and make these examinations, is to clarify information that is related both to the achievement of refugee status as well as general health.

And as an ESL teacher it is important to remind oneself that, while achieving English language competence may be the single most important factor in the settlement process, you have no power in the refugee claim process. Service providers who step out of clearly delineated roles may undermine trust. The potential transformation of the apparently harmless into the harmful is one of the harshly learned expectations which may underlie a pathologically generalized fear and mistrust which disrupts service relationships. For some survivors the fear that you “may not be what you appear to be” can be reinforced by your well intentioned breeching of role boundaries.

Thus you must both carefully examine any motivation to alter role behaviours and carefully monitor the reaction of survivor clients to such changes. If it 'feels like' you have made a mistake and that your client does not appreciate, or even appears angry or alarmed by the alteration, it probably was a mistake. Attention to limits is important - excessiveness of one kind, even kindness, can be suggestive of the potential for excesses of another kind, since they both imply a loss of control and model unpredictability

The pressure to “do more” is often very powerful and tends to invite well meaning abuses of this type. Both you and your clients must learn to accept the limits of what your role and experience and domain of influence enables you to do. This clarity of boundaries and role is known to be an important part of the creation and maintenance of a sense of security for the survivor. This is not to say that a careful conscious and often 'consulted' development of one's role parameters is inappropriate. Indeed, work in this area has historically demanded theoretical and technical innovations, but rather it is that such decisions for innovation should not be made on an 'ad hoc' basis but with full awareness of the reasons and potential risks.

It is also important not to make promises you cannot keep, and this may be very difficult when you feel you could do more. Creating expectations for support or help, which you cannot follow through on, either because of the limitation of resources in yourself or the institution you work for, can be extremely undermining to the working alliance between yourself and your client. It can, as well, deal a devastating blow to the client’s general and often already fragile sense of trust and security.

In some circumstances, depending upon the particular role of the service provider and the service being provided, it is appropriate and possible to “circumnavigate”, as it were, the symptom of mistrust by *active adjustment of elements of service delivery and content*.

Adjustments which have been found to be helpful with some clients experiencing difficulties with trust include placing control of the relationship and terms of service delivery in the hands

of the survivor, insofar as this is possible (while respecting other essential principles of practice with this group).

For example:

(i) setting time limited treatment contracts - the length and timing determined by the client - for e.g. twelve meetings with the final one being a 'review' in which a decision will be made by the client as to whether to continue with another 'set' of meetings or not.

(ii) flexibility in scheduling - not being hard nosed about the client arriving on time, missed appointments, or leaving before time is up, or changing appointment times - even frequently where this is possible.

(iii) try to respond positively to even minimal overtures that suggest a request for help (e.g. asking to use your phone book to look up a number) by similarly minimal responses which nevertheless symbolically communicate willingness to help

(iv) do not flood the client with unasked for help

(v) follow the lead of the client. This can mean different things depending upon your service role. In assessment and treatment planning this may mean the meaningful participation of the survivor (and his or her family members if desired) in the consultation and treatment planning process. This would include respecting the survivor's identification of "their problem" and their decision-choice regarding a range of options proposed. In psychotherapy, this may mean accepting the client's pacing and decisions regarding the content of discussion. This is particularly important to respect with regard to what Mollica has called the "trauma story" (see annotated bibliography). What with non-traumatized clients may appear to be resistance in need of interpretation, with clients who have suffered severe trauma may (in addition to the possibilities already noted) reflect a deeply felt sense of what they can and cannot tolerate without decompensating or otherwise "coming apart". Respecting the limits set by the survivor in this regard also demonstrates your respect for their right to privacy and autonomy, aspects of identity, which were severely infringed upon during torture. It is with regard to such issues where the survivor may test for conditions of safety.

It will be inappropriate for most practitioners to do more than try to disconfirm their client's belief in their untrustworthiness through meaningful acts and gestures - sometimes by not doing something rather than doing something. For most it would be inappropriate to address the symptom of "unreasonable mistrust" directly. Thus while a psychiatrist or psychologist working to alleviate the relationship consequences of the psychic trauma of torture may "think together" with the survivor about the dissonance between the survivor's fear and mistrust and the actual present circumstances in which he or she lives, and to explore the experiences which generated such generalized mistrust, *it is potentially dangerous for an intake settlement worker, career counsellor or ESL teacher to do so*. It is nonetheless important for these latter practitioners to be able to "think about" their client's mistrust of them and how to best respond

to it through adjustments in scheduling, office arrangements, interactive style etc. which tend to disconfirm fearful expectations and which build trust through stability, security, honesty, openness and safety.

And as well, the continuity of experiences of dependable, unintrusive help given by all practitioners as a function of their role and practice can be expected to, over time, diminish feelings of mistrust for most survivors. With others, the effect will be so slow or minimal as to be virtually nonexistent during the course of your service relationship with them. It should be noted however, that many practitioners have had the experience of being contacted, even years later by survivors who they had found particularly difficult to help due to an insurmountable lack of trust or some other inhibiting factor, but for whom some apparently insignificant factor had been recalled as representing help, and thus provided a basis for their return at a later date. Where such a promise can realistically be expected to be kept, it is important to communicate to these more difficult clients that while you accept their reluctance to accept help, the door is open.

It should also be recognized that you cannot talk the survivor “out of it”, that is, convince him or her verbally of your trustworthiness. As with abused children, words are at best empty promises, mostly lies and often malignant “set ups” or temptations to drop one's guard only to become more vulnerable to the next onslaught of cruelty. Acceptance of your client, the torture survivor, includes acceptance of their honest feelings about you, including their mistrust. Acceptance, and toleration of this difficult part of your client may help to forge an important beginning link between you based on the understanding, which is implicit in your acceptance.

In addition to the experience of “feeling understood”, you can provide the conditions for other kinds of experiences, which recurrently disconfirm the “working hypothesis”, that “nobody can be trusted”. This will take different forms in different areas of the field and in accordance with different role definitions. Such corrective relationship experiences “speak volumes” where words fail.

Thus knowledge, of even a single issue such as the one under discussion here - trust - can help us in our thinking and acting with survivors. In order to gain a truly supportive knowledge base, it has been important to become informed regarding what and how things can go wrong as well as right. A considerable amount has been learned regarding pitfalls from the experience of others. But learning about what can go wrong is additionally facilitated by learning about ourselves. It turns out that some of us are more vulnerable to certain pitfalls and some of us to others. In general, practitioners' errors tend to take the form of either overidentification or distancing responses. (See Danieli; Wilson & Lindy).

Reflecting back upon the words of our expert practitioner, noted above, we are concerned, among other things, with learning not to make mistakes. In our efforts to guard our clients and ourselves against error we may, in addition to increasing our knowledge base of the experience, research and advise of others, learn to think about ourselves, to reflect upon who we are and what our experiences have been in the past and how these experiences might interact, or

have interacted with the demands of our work and the particular issues which have been identified by others.

We will find help, as well, in developing the capacity to reflect not only on past experiences but also the moment to moment experience of ongoing practice. The development of reflective practices and their integration into our daily working lives will help us in a number of ways: to access and make good use of the information and knowledge which we work so hard to acquire; to learn through experience the “something new” that doesn't fit into existing knowledge and to recognize the “familiar and known” where what you are observing or experiencing in relation to your client converges with, enriches and elaborates existing knowledge.

Simply and importantly, reflective capacities help you to grow with your work, feel enlivened and enriched by it and to do a better job, and thus in addition to feel good about it. Some of what you will learn, about yourself and your clients and your world through reflection will be painful and difficult. It will nonetheless enrich your life and your work. There is no getting around the fact that, as a number of our experienced practitioners, from clinicians to lawyers, have reported - this work will change you. The capacity to reflect on one's experience is part of the way we can insure that we remain aware of this process of becoming and that it include conscious and thoughtful choices.

> So it is that the third principle of support for service providers is the development of reflective practices and their integration into our working lives

In considering the task of developing reflective capacities we may continue with the issue of trust. We may recognize that working with an individual who has a profound problem with trust will have effects upon us which are likely to be mostly negative and which will make our work more difficult.

With reference to the development of reflective capacities you may begin by examining the effect that trying to help, or have any kind of a relationship, with someone who distrusts you has upon you. To put it bluntly, you are likely to “take it personally” and to in one way and another feel insulted, hurt, angry unfairly judged, unjustly treated, misunderstood, and unappreciated. At bottom you may feel that you are not being “recognized” for who you really are - a trustworthy person. And the unfortunate paradox is that these feelings, if not brought into conscious awareness, recognized for what they are, considered with regard to their implications for you and the patient, may contribute to your feeling so uncomfortable about yourself and your work and your client that you may well behave in ways which justify the initial mistrust of the survivor. You may in fact find that you do in fact fail him or her in ways you would not likely fail others. At the extreme, you may find justifications for getting rid of this client as “untreatable” and

"unhelpable" - or "just not ready". Thus you may get caught up in what psychotherapists call an enactment, i.e. a recreation in the treatment relationship of prior relationship failures, betrayals, and breeches of trust. You will in this way confirm for many clients their existing suspicion.

In this type of interaction the survivor and practitioner become involved in a metaphorical recreation of a prior experience of a traumatic breech of trust. And you become "like all the rest."

As Weiss and Sampson have demonstrated, the motivation behind such recreations of past in present, i.e. the "testing for conditions of safety" provides a therapist, and service provider in general, with the positive opportunity to disconfirm mistrust, model trustworthiness and thereby facilitate the growth of relationship. In fact the client is looking for a new ending to an old (and unhappy) story. Weiss and Sampson found that when tests are passed, the treatment relationship strengthens and deepens.

The unfortunate fact is that without a knowledgeable understanding of this feature of survivors and without self-reflective awareness, the likelihood that the service provider will fail such tests is high. Such testing will constitute a part of not only the beginning of the relationship, but is likely to recur at various points when either events in the service relationship or in the survivor's personal life contribute to a sense of insecurity and vulnerability. So it is, for example, that the long period of undetermined refugee status, with its familiar recurrent stress and crisis points, will impact powerfully upon the ebb and flow of the treatment relationships. Service providers will need to develop the capacity to both recognize and to tolerate this rhythm of work with survivors in exile.

When it is clear that no measures will be sufficient for the survivor to accept help at this time, the sage advice of an experienced practitioner is to attempt to plant some seed of "remembered compassion" in the mind of the survivor which may in the future help make it possible for them to return.

Another experienced practitioner has described the manner in which a very mistrustful client can in turn make you, the service provider, feel untrusting of the client.

Thus, she points out, you may find yourself doubting the things they tell you about their past or present life, including their persecution, or about whether they really need the kinds of help or services they request (or demand). This can be critically significant in the situation where, for example, intake workers must make decisions regarding the legitimacy of requests for referrals to network physicians for examinations for purposes of refugee claims, for refugee lawyers and for examining physicians. Consultation with colleagues is particularly important in such instances. Understanding that some of the things you feel about your clients may be reflections or, as it were, a kind of communication from them about how they are feeling about you and the world in general, is also important.

It should also be noted that there can be a general disinclination to trust in clients' believability regarding past or present suffering, often accompanied by personal theories about "how a real torture victim would act"[4]. This is a well recognized and documented practitioners' defense against integration of the knowledge of the reality of the existence and experience of torture and/or of the feelings aroused by exposure to such information (see Y. Danieli).

Trust and Confidentiality

The issue of confidentiality has obvious links to the issue of trust. And while this may seem a fairly straightforward issue, as with all others when working with survivors, things are somewhat more complicated than usual.

Central to the issue of confidentiality when working with survivors is that of "containment"[5]. Practitioners, in particular therapists, and medical doctors, but potentially all those who provide services to survivors, will become privy directly or indirectly to information, images, feelings, which comprise parts of the trauma story. All service providers are required by explicit or implicit contract and the standards of ethical practice to "hold onto it", that is to keep it in one's own mind, memory and thoughts and not "pass it along" to anyone else, unless explicitly required and/or given permission to do so by the survivor (as in supervision and consultation).

But the fact of the matter is, that this is no easy task, especially for those new to the work. (As with limit setting, experienced practitioners report improved capacity to "contain" material over time.) The feelings are powerful ones. Service providers report feeling that the survivor has dumped or poured into him/her unbearable memories, images and feelings - has in some strange way "got rid of it into me". Typically, the service provider will feel a similar and also powerful inclination to pour it into someone else - to rid themselves of these terrible images, mental contents, and the thoughts and feelings associated with them. The pressure to rid oneself of such mental contents can be so powerful as to have an almost physical dimension, i.e. you may feel *compelled* to tell someone, almost anyone, else. Practitioners speak of having no room left in their brain, of being populated or filled up by horrible images; they must "get it out", pour it out, even pour it all over someone else. One service provider reports "leaking out" over family and friends when she began work in this field.

By this she referred to saying things, "letting things slip" unintentionally or otherwise breeching confidentiality.

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[4] For example, that they would (or would not) want to tell the world about the terrible things that were done to them and that they would (or would not) cry and express strong emotion when doing so.

[5] This is a psychological concept, which can be particularly illuminating and helpful in work with those who have suffered severe trauma. For quite readable work on the practical application see Donald Winnicott on "holding"; for more complex theorizing and sophisticated clinical application see the work of Wilfred Bion and Donald Meltzer.

The reality is however, that there are only a limited number of circumstances under which it is not a breech in professional ethics to pass on information shared with us by the survivor. *So it is important to know where to go for support with such feelings. These include supervisory relationships, one's own therapy and collegial consultation where strict standards of confidentiality are maintained*. Your client should also be informed of the measure taken by you and your agency to insure client confidentiality. Their interest in this issue is likely to be pronounced and indeed may appear extreme, but must be respected. Testing on issues of confidentiality is very likely.

With regard to professional development, we must ask the question: Why is it so hard to hold on to this stuff - to "keep it in mind"? And why, when we breech confidentiality in these circumstances, do we feel not only a professional, but often a personal shame. We may remind ourselves that torture is not only impossible to bear, it is impossible to bear in mind.

It turns out that "testing for conditions of safety" are likely to occur with regard to issues of confidentiality, precisely because confidentiality is a central issue for feelings of security and safety for survivors. It is important to understand that when errors are made they occur because a need in the client comes into conflict with a need in the practitioner. Perhaps an example will help.

In one Canadian centre the issue of confidentiality was raised by a consulting team in response to the desire expressed by a group of ESL teachers to "know about what had happened to them"" (i.e. the nature of the trauma suffered by their students). They expressed the opinion that this would help them better understand and thus better serve their students. On the surface this may appear quite a logical and reasonable request, but it in fact raises many interesting issues and opportunities for reflection and discussion. The first was why language teachers would need to know the details of an individual survivor's torture experience in order to teach him or her English. There is of course much known about the general effects of torture on psychological and cognitive functioning, including memory, attention span, the occasion of flash backs, and the issue we addressed above - the problem of trust. All this information was available to the teachers, much of it known by them and much of it already taken into account in the specially designed programmes through which they taught. So what was really at issue?

One possibility, occasionally referred to in the literature, is prurient interest. In this reading it would be that the teachers were salaciously, if unconsciously, interested to hear about torture and had found a way where hearing about such details would be made legitimate because of "the demands of their job". This is a suggestion which is perhaps too frequently made these days, rather like a "sack cloth and ashes" reflex, and evokes such anxiety and guilt by its mere suggestion that it tends to obstruct all further productive reflection. The consultants' sense was that, in any case, something else was at stake for these teachers. Fear rather than excitement seemed evident. Further discussion brought more information forward: sometimes in class students begin to tell their stories, and the some teachers feel overwhelmed, and unclear about what is the right thing to do, how to help. And they find it distressing in all the same ways that

others do when hearing the trauma story. These disclosures came “out of the blue” as one teacher put it, and they clearly felt unprepared for these unpredictable events and the feelings aroused by them. Finally our sense was that the teachers who, unlike therapists, are not trained, and do not expect to deal with such material after all, were trying to find some way to prepare themselves for, or guard themselves against, as it were, subsequent events like these. What better way then to know “all about it” before hand. There would no longer be any unpleasant surprises, or at least this seemed to be the hope.

Once this was understood the issue of confidentiality could be discussed including recalling policy that any access to information regarding students must be formally requested and formally given. Discussion of why this general rule was particularly important for survivors could follow and thus issues of trust, control etc. could be touched upon. Finally discussion of what it felt like to be subject to such surprise disclosures and how best to respond could follow[6]. It became clear from the discussion that some members of the ESL team had developed some strategies to manage the occasion of disclosures (often they pointed out stimulated by intrusive flashbacks) in their class, had reflected on their experience and were fairly comfortable with their different solutions. In one instance a teacher reported finding ways to maintain boundaries in the classroom, including providing opportunities for the survivor to leave the class when feeling overwhelmed, and to make referrals to other staff of the facility who provided counselling. Another teacher reported striving to find ways to provide support, which enabled the survivor to remain in the classroom at such times.

In the example just given above, it can be seen that both some knowledge and access to consultation can help resolve or prevent problems. Less obvious but at least equally important in the example is the practitioners' and consultants' exercise of reflective function - mobilizing certain ways of thinking about problems and solutions.

In further reflection upon one's vulnerabilities to error, we might turn to a very general and well recognized problem of overextension and the difficulty with limits. It is commonly recognized that the pull to “do more” should be considered with regard to the risk of undermining the agency of clients. It is important to be mindful of the survivor’s need to reclaim a competence and agency in the world which the experience of torture and the process of exile may have severely damaged. The balance between supporting the development of agency, by providing necessary supports, and undermining it must be carefully considered and reconsidered throughout the process of any intervention, short or long term.

Reflections upon these issues of balance will inevitably lead to reflections upon your motivation for doing this work, including some of the more practical, and perhaps less comfortable, ones. One of our consulting clinicians has stressed the importance of all practitioners examining those aspects of their motivation to do this work, which indicate self-interest, rather than those

[6] It is an obvious point that a teacher already informed about the details of a student's experience, without the student's knowledge and permission, is very vulnerable to being revealed to have breeched a trust in the course of interactions with the student.

civic minded, humanitarian motivations referred to in the initial discussion on sources of commitment. She suggests that earning a living, increasing professional status and the sense of doing something unique and unequalled, (thus a sense of specialness), opportunities for experiences of tremendous personal learning and growth exist alongside less "enlightened" types of self interest, such as the pursuit of what we might call "rebel" status (another kind of specialness), the need to be idealized, to access secret knowledge, to pursue prurient, masochistic or sadistic interests or saviour identifications.

Another question which has been raised in the literature and which is current within the "talk" within institutions of care concerns the different vulnerabilities of survivor-practitioners as compared to others working in the field. Our research suggests that in order to assess or even discuss the question of the possible special vulnerabilities of practitioners who are also survivors as compared to other practitioners, one would need to factor out the effects of those practical factors mentioned above, and others, which are associated with being an immigrant and which can be expected to confound with others more specifically related to being a survivor. This is an area in which there has been considerable speculation but which as of this date has been insufficiently researched.

The fourth principle we recommend to practitioners is that they *build a network of support.*

One theme that recurred throughout our survey and our interviews with practitioners was the importance of support from others. Discussions and responses related to this issue were frequently accompanied by what was perhaps the most explicit advice offered to others in the field – "don't do this work alone." In one way or another, practitioners expressed their learned experience and strongly held belief in the need for support from others while doing this work. Support from others can come in a variety of forms, from a colleague or coworker near at hand with whom one can share one's own immediate feelings and thoughts about the general or particular experiences and demands of this work, to others working in the field but more distant geographically and emotionally, with whom one can discuss shared issues. Practitioners have also pointed out that it is not always necessary to "offload" onto someone else; sometimes the mere presence, understanding gaze, and shared conversation about anything but, for example, the intake interview you have just done and been shaken by, is the most helpful. Sometimes merely thinking your own painful or tumultuous thoughts in the presence of a silent but empathic friend is the most helpful. What is important is that there be some one or some others from whom you can find whatever kind of support it is that you find most helpful.

It can also be wise to participate in, or establish if not already in existence, regular opportunities for social interaction with co-workers, team members and others in your community, including volunteers, who are working in related areas of the field (from settlement to law to nursing),

and who you may occasionally come into contact with though making or receiving referrals, or working in different capacities with the same clients. Depending upon the size, interests and composition of the group more regular or less regular contact will be optimal - from annual to monthly.

Seek out the advice and support of more experienced practitioners, both within and across disciplines. For example, a public health nurse or network doctor may be the best person to advise a social worker, legal advocate or translator on general issues: the experience in particular refugee communities, what to expect, what is most and least helpful both to the client and to their own work, what reading materials or contacts offer further help. Make contact with the nearest survivors support centre, even if it is provinces away. Introduce yourself to them by phone, fax, e-mail or regular post, and tell them of the nature of your work, experience and wish for support. Organizations in your own community, in particular church organizations, may have been quietly working in support of refugees, including survivors, directly and indirectly for years. Make contact with them. Local chapters of Amnesty International can be another vital source of support, as can the Canadian Council of Refugees as well as local ethnic and cultural centres. Where possible, attend conferences and put yourself on the mailing list of those organizations, which offer information and support for refugees, survivors and those working in the area of resistance and response to torture. There are also journals which can be helpful and which will provide a sense of the individuals and range of issues in the field and which may suggest to you individuals or institutions with whom you wish to make contact.

Round letters, which travel the circuit of a small group of practitioners across great distances or within the same community take some time for all who participate, but provide the opportunity for participation in a group even at considerable distance.

Processing your own experiences or thoughts in order to express them in written form to others, and participation in the development and clarification of thinking and issues through the circulation of ideas and experiences can provide a sense of community and support.

The fifth principle of support is *establish regular supervision and consultation*.

Regular supervision and access to consultation may be the most critical form of direct support to practitioners. For many, it may also be one of the most difficult to put in place. While it is standard practice in psychiatry and some of the psychologies to have regular supervision, at least during training, and to seek consultation in a variety of circumstances subsequently, this is a less common practice in other disciplines. Good supervision can be the single most important factor in raising the quality of your practice, your understanding of your clients and yourself and in increasing your pleasure in this work. Supervision can also be very helpful in learning

and developing reflective practices. The confidentiality, dependability and the focused nature of a period of attention to your issues in your work are among the characteristic ingredients of a supervisory relationship which make it among the most helpful. Work with survivors raises important issues of both a personal and professional nature for everyone who does it. A thorough, productive and supportive exploration and resolution of these requires access to expert attention in an environment of security and support. Also the ability to both expresses one's experience and related feelings while ensuring confidentiality for one's clients and one's self is arguably easiest within a supervisory situation. In our research, practitioners have attested to the central positive role which individual and group supervision has played for them. It is not uncommon, for example, for intake workers to go from quite regular and intensive individual supervision as they begin this work to find sufficient support through group supervision after some time, while continuing to access individual supervision on occasion when new personal issues emerge or difficult ones return. Group supervision should be led by a senior clinician experienced in work with survivors specifically or trauma generally and in group dynamics.

The recommendation for supervision is not restricted to psychotherapists, but is made to all practitioners in the field, especially including social and community workers, medical doctors and nurses. Teachers, legal advocates and others, especially where part of one's role is to gather information or provide a sympathetic ear for the survivors' story, will find supervision particularly important and helpful. Individual and group supervision can be especially significant for successful role performance as it can bring into awareness one's own biases and other personal characteristic which may interfere with both job performance and the capacity to find pleasure and a sense of accomplishment in one's work. Such personal characteristics will include the particular psychological strategies you use to defend yourself against the fear and horror which hearing and thinking about torture generates in all of us. Understanding your own reactions to information about torture, what it does to you and what you do in response to it, will also increase, in some measure, your understanding of what the experience did to the survivor. Reflecting upon and working through these kinds of reactions will make this increased understanding not only tolerable but available to use in your work as knowledge.

Good supervision can be very supportive of reflective function and the development of reflective capacities. For example, our first recommendation that practitioners explore their motivation for working with survivors is an exercise which can be most productively and richly explored and insightfully supported in an individual supervision setting, although by no means only there. For most of us such journeys into our own internal world of thinking and feeling are easier when we are not alone, but are rather, accompanied.

Good supervision and access to consultation is important in other ways as well. The opportunity to check in with more experienced practitioners regarding issues of assessment, intervention and case management is critical. This is particularly important when one begins to do this work, but remains an ongoing need with all practitioners for new kinds of cases or new issues, which arise. It continues to be true that the emotional dimension of this work can obscure objective

facts and obstruct normal functioning for all practitioners, no matter how experienced, though this risk can be expected to diminish with experience in the normal case.

The challenge of finding good supervision outside of large centres is considerable and may not even be possible. Where this is the case, other supports such as consultation, self reflection and an extended support network will be even more important.

The sixth principle of support we recommend to service providers is that they *consider complimentary advocacy or proactive work.*

With this recommendation, it is important to make some qualifications. It is clear that this is a quite personal decision since not all practitioners find involvement in advocacy activities or other proactive measures necessary to, or supportive of their work. On the other hand many do and our own research brought to our attention how important involvement in advocacy work can be for some practitioners. For example, a refugee lawyer reported that taking some time out from a busy practice to do political advocacy work was essential to sustaining his efforts and keeping his work in perspective. Without it, he reported, he was subject to a profound discouragement associated with a feeling of futility in the face of a seemingly endless stream of refugees who had been tortured into his office; there seemed to be no end in sight to the kinds of political horrors which continued to produce such terrible suffering. Participating in political advocacy provides him with an opportunity to work to stem that tide of suffering. Many others have reported similar kinds of positive effects from becoming active in advocacy activities, such as Amnesty International.

Finally, involvement in advocacy activities can also lessen the sense of isolation that often accompanies work with survivors by reinforcing the link between one's own work and that of others nationally and internationally.

The seventh principle of support to service providers is *incorporate activities for rest and renewal.*

This seventh principle of support may seem both obvious and easy, but it turns out that making time and developing routines for rest and renewal is one of the more difficult pieces of support advice for workers in the field to follow. There are a number of reasons for this, some of which are a function of external factors and others which are a function of factors internal to the individual service provider or most often an interaction of the two types. Thus, for example, the re-

alities of underfunding interacting with a deep sense of commitment may lead to the expenditure of ever increasing amounts of time and energy to one's work and correspondingly less for private life.

Understaffing and underfunding in a situation where great and serious needs exist understandably may call forth a recurrent redoubling of effort, of trying to do more with less, from committed and caring practitioners. The wish to help others and the need to do so in the face of obvious need is a combination which often stimulates self-sacrifice in many areas, including personal time for leisure, rest and other forms of personal renewal. Also, the recurrent sense of crisis in the situation of refugees in general and in the lives of survivors in particular creates an additional pressure to “be there” for others despite the effect upon oneself. The pressures to do a little bit more in combination with the often present if not always expressed question “If I don't do it, who will?” can result in the increasing encroachment of work into one's personal life and diminish the time available for the kinds of recreational, familial, spiritual or leisure activities which we all need to balance the pressures of even the most mundane working lives. And work with survivors is by no means mundane. We suspect that, paradoxically, the need for opportunities for rest and renewal for those who work with survivors is greater than it is in the ordinary case and yet appears to be less likely to be found or taken.

What workers in the field may consider to be a question of morality and dedication is more properly considered one of personal and professional survival. The risk of physical, emotional and spiritual exhaustion is high for those who work with survivors. There is personal tragedy in this, and there is also tragedy for the field as the experience and knowledge of some of the most dedicated workers is lost to it. In these instances workers will often have struggled for a considerable length of time with cumulative fatigue, a growing sense of futility, sometimes cynicism and a nagging sense of incompetence and diminished interest. In some instances, it appears that an idealization of one's work, one's clients and to some degree oneself appears to collapse into boredom, hopelessness and even contempt. And indeed the “burned out” or “burning out” practitioner does tend to lose his or her attunement with clients and can become ineffective and incompetent, although this is not always the case. However, any amount of these kinds of developments are always very disturbing and can in fact be frightening to a practitioner. Without awareness, feelings of this kind about one's work and one's self can and often does lead to a form of flight, where practitioners in considerable numbers solve these problems by leaving the field.

There would appear to be something about this work that stimulates in many people a sense that there must be an all or nothing relation to it. The notion of bringing the kind of realistic parameters of time, effort and commitment to bear on organizing one's working and private life when in this field, as one would typically in others, seems very difficult or impossible for many people. Unfortunately institutions, and in some circumstances coworkers, can reinforce such unrealistic, and ultimately counterproductive, notions. Also the manner in which funding of services to survivors and to refugees in general is arranged in our country, also reinforces this “state of crisis”, all or nothing mentality. Thus, for example, the already heavy responsibilities

which normally accompany all types of work in this field, from intake to psychotherapy, may be compounded by worries about, or even responsibilities for finding or renewing often piecemeal, temporary and recurrently threatened funding.

Nevertheless, it remains true that the most important factors in implementing this recommendation is whether one believes in one's entitlement to a “separate peace” -whether time, place or activity - and whether one is convinced of its ultimately protective function of both one's self and one's work. In addition it is necessary to develop insight into the ways of sabotaging oneself on this issue - whether because of one's own need to be a savior, overestimation of one's own capacities, or one's vulnerability to intimidation or the excessive demands of others. It is important to clarify, to keep in mind and to come to terms with the limits of what one can do. In part this appears to require being able to take a longer view of one’s work - to conceptualize oneself as a part of history of efforts over time, place and persons, to combat the occasion and the effects of injustice. One makes a contribution to an ongoing worldwide effort, in response to ongoing worldwide need. Such a perspective upon yourself and your work will be supported by practically linking yourself to the larger community of practitioners who are engaged in similar efforts.

One must face the reality that injustice and suffering existed before one's own life began and that it will continue to exist after one's own life is ended as will human effort to diminish both injustice and suffering. To remain mindful of this should help somewhat to diminish the kind of burdensome omnipotence and unsustainable selflessness to which workers with those in extreme need of all kinds are vulnerable. While we are here there is much that each of us can do. And we should extend to ourselves at least some measure of the concern we feel for others.

The activities which practitioners have found helpful cover a very broad range reflecting, as they should, individual needs and solutions. However, one can observe in general two types: there are those activities which put one in touch with others and there are those which are solitary, and as it were put one in touch with one's self. Thus they range from listening to music, reading novels, running, yoga and gardening to dinner and theatre with friends, team sports and meeting old school friends at a pub. It should be noted that many practitioners have noted that since working with survivors their choice of recreational and entertainment activities has changed. In particular, violence in any form no longer appears to be “entertaining” and in fact many spoke of taking particular pains to insure they did not come into contact with such material, for some even refraining from watching television news.

A number of practitioners have noted the difficulty and importance of protecting and preserving time for and with family. One practitioner described how grateful she now feels for the instinctive good sense of her husband who years ago insisted she not “bring her work home”, a demand she initially resented and found unsupportive. She now credits the feeling of “sanctity” of her home life, and its affirmation of the mother, wife, sister, neighbour parts of herself for her ability to remain a front line worker with survivors for many years. For the fortunate, home and family life provides a kind of sanctuary of its own.

The eighth principle of support for service providers is *evaluate and, where possible, improve working conditions.*

External restrictions upon practitioners' implementation of the recommended principles of support may be most pronounced here.

One senior practitioner has stressed the practical realities behind the motivation to do this work. Her own experience as a supervisor to front line workers in the field has suggested that most are women who for one reason or another are relatively vulnerable in their working lives, either because they are immigrants required to work below their achieved professional level in their home country, or because they are single parents or responsible for the support of extended families here or in their country of origin. These realities, she points out, not only make these service providers particularly vulnerable to burnout since they have little job mobility, security or bargaining power in an underfunded and ununionized field but that these realities also largely determine the nature of working conditions in the field as a whole. There are, she points out, many underemployed women ready to take the place of those who succumb to burnout. So while all workers in the field will, depending upon factors of personality, training and supervision, be more or less vulnerable to patterns of working behaviours, such as overextending themselves and overidentification, difficulties with limits and role boundaries which contribute to burnout, others will be more vulnerable because of the nature of working conditions over which they have little or no control.

While there is some appreciation of the special pressure which work with survivors brings, and some understanding of what conditions of work are needed to retain competence and prevent burnout, it is clearly not possible for all practitioners to access anything that approaches optimal working conditions. One of our medical practitioners has thoughtfully suggested that he has found that the examination of survivors for determination of refugee status is best limited to one a week within a general practice. As with other practitioners, personal factors can inhibit medical practitioners within similar practical and material circumstances from following such sound advice and it is possible to observe working styles in physicians which put them at risk of burnout. It nevertheless remains our impression that a majority of practitioners would maintain saner and “burnout resistant” working patterns if the conditions of their employment permitted this. This is obviously a large issue and one which is likely to become more pressing as the traditional sources of government funding for services to refugees in this country, including survivors, become more limited.

Our experienced clinician has gone on to suggest that some organizations knowingly or unknowingly exploit the practitioners’ practical vulnerability. Such a situation obviously has implications for the realistic possibilities of improving working conditions. Nevertheless, it will always remain significantly helpful to evaluate the conditions of one's working life and to determine those conditions which contribute positively to competence and job satisfaction and those

which undermine these. It is also important to clarify those conditions with regard to which there is some possibility for change and those where there is not. Another practitioner has pointed out that it is important to be aware of those parts of the philosophy and approach to practice of the institution where one works which converge with one's own values, goals and way of working and those which do not. Thus reflection upon all forms of one's relationships with others - individuals and institutions/groups can be expected to clarify, improve and enrich one's work in this field.

Evaluation: The Experience or Service, Ethics, and Support

1. Has this unit helped you understand better how reflection and a careful monitoring of your way of working with survivors can make a difference to your work?

   Yes__
   No__
   Moderately so__

2. Have you come to see the importance of being attentive to affect and emotion?

   Yes__
   No__
   Moderately so___

3. If you are not a clinically trained therapist (psychologist, psychiatrist): what kind of support would you be looking for, given the information presented here?

4. If you are an ESL teacher: is the account given in this unit of a situation in an ESL class plausible to you and do you find the recommendations given here helpful?

   Yes__
   No__
   Moderately so___

5. As a professionally trained clinician, do you find that the account of practice given here can help you improve your practice?

   Yes__
   No__
   Moderately so___

Selected references

The Breaking of Bodies and Minds, Torture, Psychiatric Abuse and the Health Professions. Stover, E. and E. Nightingale (eds.), W.H. Freeman & Co. N.Y. (1985).

This text provides information regarding one of the most disturbing realities of torture and terror - the complicity of individual members and institutions of medicine and psychiatry in the functioning of terror regimes, including torture. This text is both sobering and informative and creates a particular power and poignancy through testimonials and case narratives of individuals, including health and mental health practitioners, who resisted and were caught in the grip of these forces. Photographs of some of these individuals and institutions add a powerful dimension to the text.

Clinical Observations on the Survivor Syndrome. H. Krystal, & 6. Niederland in Massive Psychic Trauma, International University Press, N. Y.(1968).

This seminal paper has both historical and continuing significance. It reports the findings of two medical practitioners with twenty years of experience with immigrant-survivors of the Nazi Holocaust. On the basis of this work and a detailed study of over one hundred survivors an outline of the particular nature of the suffering of this group is organized into a meaningful and informative clinical and symptom picture. On this basis, Krystal and Niederland make a subtle and cogent argument for a separate diagnostic/ syndrome category thereby challenging then contemporary tendencies to suppress recognition of the unique cause of this suffering and the special needs associated with them through a fragmented symptom picture subsumed under a variety of diagnostic categories. There are notable resonances with current efforts to preserve recognition of the sources of torture specific trauma within the PTSD diagnostic category and striking similarities across the two symptom pictures.

Counselling and Therapy with Refugees, Psychological Problems of Victims of War, Torture and Repression van der Veer, G., John Wiley & Sons, N.Y. (1992).

This is a good general text, which would introduce those new to the field to the variety of issues and treatment models as well as clarify and enrich the understanding of the experienced counsellor or psychotherapist. Links made between theory and practice are a particularly helpful aspect of this text.

Countertransference in the Treatment of Post Traumatic Stress Disorder, Wilson, J., and J. Lindy, Guilford Press, N.Y. (1994).

This text contains: Agger, I., and S. Buus Jensen, Determinant Factors for Countertransference Reactions under State Terrorism; Kinzie, J. D., Countertransference in the Treatment of Southeast Asian Refugees; Danieli, Y., Countertransference Trauma and

Training. Wilson and Lindy propose a very useful model for conceptualizing the familiar types of emotions and thinking which create difficulties in work with severely traumatized patients. Their identification and exploration of two major classes of responses in psychotherapy which obstruct empathy and understanding is very helpful. Happily, they also propose measures to address these problems. Additional issues touched upon include the communicate potential of countertransference. A most important paper for professional development is that by Danieli in which a well tested procedure for monitoring countertransference and developing self-reflective function is described, with examples. Agger and Jensen sensitively contribute to the discussion/debate on techniques of therapy currently active between torture treatment centres internationally. Kinzie realistically and sensitively describes some of the errors and some of the successes of beginning and continuing work in this field, with particular attention to cross cultural issues. Other interesting papers are included.

Countertransference in Working with Victims of Political Repression. Comas-Diaz, L., & A. Padilla, Amer. Journal Orthopsychiatry, Vol.60 No.1. January, (1990).

This is an interesting paper, which discusses the experience of doing therapy with victims of political repression in Chile during the dictatorship. It considers in particular the countertransference issues in such a context of pervasive fear and insecurity. This paper thus provides a basis for a consideration of the differences between practice under these and more favorable conditions and also considerers these issues.

Human Adaptation to Extreme Stress. J. Wilson, Z. Considerers, B. Kahana (eds.). Plenum Press, N.Y. (1988).

This text contains: Danieli, Y. Confronting the Unimaginable: Psychotherapists' Reactions to Victims of the Nazi Holocaust; Robert J. Lifton Understanding the Traumatized Self; Y.D. Kinzie The Psychiatric Effects of Massive Trauma on Cambodian Refugees. This is a very good text, which includes papers by some of the most experienced and thoughtful practitioners in the field. Of particular importance is Lifton's paper, which provides a detailed discussion of central concepts, including “psychic numbing”, and the “death imprint”. The paper also discusses the search for meaning, trauma and moral dilemmas, and briefly considers the psychology of perpetrators. Danieli's paper reports research into countertransference themes in therapists working with Holocaust survivors and their families. She explores these and links them to the experiences of others working with similarly traumatized populations. Of note is her exploration of manifestations of the “conspiracy of silence” in the treatment relationships.

Handbook of Post-Traumatic Therapy, M. Williams & J. Sommer (eds.) Greenwood Press. Connecticut, (1994).

This text contains: Chester, B., “That Which Does Not Destroy Me”: Treating Survivors of Political Torture; Y. Danieli Countertransference and Trauma: Self-Healing and Trauma.

This text contains a number of useful papers. Of particular interest is Chester's very well informed and thoughtful discussion of the challenges to therapists of work with survivors and of the emotional, political and intellectual context in which this work takes place. Danieli's paper contains the author's most recent thinking on the imperative need to work through "crippling effects of countertransferences which often renders the therapist unable to listen" and general countertransference themes in working with victims of extreme trauma. The paper also includes a consideration of implications for training and exercises for processing "event" countertransference, which is adaptable to individual use and to other contexts.

International Handbook of Traumatic Stress Syndromes. Wilson, J., and B. Raphael (eds.), Plenum Press, N.Y. (1993).

This is a truly comprehensive and excellent work, perhaps the best single and up to date text containing the work of the most important authors on the most important issues. For Example: Agger & Jensen, The Psychosexual Trauma of Torture; Cunningham & Silove, Principles and Service Development for Torture and Trauma Survivors; Y. Danieli, Diagnostic and Therapeutic Use of the Multigenerational Family Tree in Working with Survivors of the Nazi Holocaust; J. D. Kinzie, Post-Traumatic Effects and Their Treatment among Southeast Asian Refugees; H. Krystal, Beyond DSM-III-R. Therapeutic Considerations in Post-Traumatic Stress Disorder; J. D. Lindy, Focal Psychoanalytic Psychotherapy of Post-traumatic Stress Disorder; M. Simpson, Traumatic Stress and the Bruising of the Soul. The Effects of Torture and Coercive Interrogation; M. Simpson, Bitter Waters. Effects on Children of the Stresses of Unrest and Oppression.

Interacting with Trauma: Children's Responses to Treating Psychological Aftereffects of Political Repression. Fischman, Y., Amer. Journal Orthopsychiatry, 61(2), April,(1991).

This interesting paper takes up the issue of the interaction between the experiences and feelings of survivors of political repression and the "intense emotional responses" of clinicians who seek to serve them. It discusses these and the establishment of a therapeutic alliance as well as the importance of awareness of the sociopolitical context in which the trauma of the patient occurred.

Psychology and Torture, P. Suedfeld (ed.). Hemisphere Pub. Co., N.Y. (1990).

This is a quite mixed text containing some very good papers and others which raise questions regarding the ethics of the author's practice and of academic publication, including in particular a philosophical justification of torture in some instances. The latter paper is a concerning exercise in the dangers of the pursuit of academic objectivity. However very valuable papers are also in this book, including: Bustos, F., Dealing with the Unbearable: Reactions of Therapists and Therapeutic Institutions to Survivors of Torture. and Chester, B., Because Mercy Has a Human Heart: Centers for Victims of Torture.

Psychotherapy with Severely Traumatized Refugees. Kinzie, J. D., and J. Fleck, Amer. Journal of Psychotherapy, Vol. XLI, No 1, January. (1987).

This is another seminal and continuingly informative paper. Kinzie and Fleck report on their work at the Oregon Health Sciences Clinic for Indochinese refugees. The paper considers problems of the therapist, experiences and needs of the clients and effective therapeutic strategies, through a number of informative and moving case examples.

The Trauma Story: The Psychiatric Care of Refugee Survivors or Violence and Torture, Mollica, R., in Post-Traumatic Therapy and Victims of Violence. F. Ochberg, (ed.). Brunner/Mazel Pub., N.Y. (1988).

This is a very important and useful paper, and one which should be read by all workers in the field. It describes sensitive cross-cultural work with refugee survivors of trauma, considering issues and experiences of both patient and practitioner. In particular it discusses the place of the trauma story at the centre of psychotherapeutic treatment and the different cultural meanings of trauma and torture. It includes three illuminating and powerful case examples.

Chapter VIII

INTERACTIVE PEDAGOGY: AN AFTERWORD

Introduction

Besides providing materials and information we have emphasized throughout that we regard these Educational Aids to Service-Providers as "interactive" with the user. By this we mean: we ask the user to make an active effort of appropriation and response. The subsequent text explains our method by setting out the pedagogy implicit in our units: just as much as the textual construction of the units collected in this module has been a process of self-education for all the writers involved, and not merely the receiving or giving of information, so we expect it to be for the users - who then would be able ("theoretically") to continue the document and develop it on their own.

I. Interactive Pedagogy: For Whom?

Service-providers and all those who have glanced at this document or made use of it will have made a number of decisions regarding it. They may also have made some decisions, even if minor ones, regarding their work, their practice, their relation to survivors. You may have discovered in the past that many of the documents presented to you as manuals confirm what you already understand or what you believe you know. You may have decided that, in contrast, our document leaves you feeling a little less certain of your knowledge. And you may have discovered that one or the other section or unit you have read here confirms a feeling you have had that torture is a multi-faceted phenomenon, not easily grasped by simply responding with heartfelt concern to the enormous suffering which it consists in for the victim. Nor may it be enough to affectively grasp the pain, horror, and human destruction involved in it. Knowledge also matters. This is what is suggested in our text. Our document also suggests some of the ways in which knowledge matters, often in response to the findings of a needs-assessment review undertaken by us.

Just how knowledge matters, what questions it responds to, is disclosed by the users of this document through what they decide they need to know, on the basis of their own knowledge, of their own experience, of their practice. And this is the point of an interactive pedagogy: our document interacts with you, the service-providers, with the knowledge, which you already have, with the need for understanding to which you decide to respond.

This is why we believe in incompleteness and the representation of different orientations to our work with survivors. You will, for example, have noticed a significant difference between the way the units on assessment and settlement have been written.

This is the reason for placing these observations on an *interactive pedagogy* at the end of this document. We invite you to use this section in order to reflect back on the entire document and to hear the different voices speaking and writing here, reflecting -- each of them -- their own distinctive approach to their practice. Yet practice is always the same in a fundamental sense: coming to terms with, acknowledging, again and again, the profoundly disturbing reality of torture and its consequences, as well as what it says about human societies and human beings.

It is in this manner that you can take another glance at the field, the whole field of working with survivors of torture and organized violence: one can become aware of the variety of institutions, practices, and services involved, also of the variety of trainings, knowledge, and understanding. In the unit on assessment *a prismatic model* is proposed. You may take it as a guide to an interactive pedagogy: the prismatic model of assessment recommends that you play through, in your own mind and in group discussion, the different points of view available on the experience and survival of torture - first of all and most of all, the perspective of the victim/survivor. Then, you are asked to consider many other perspectives: the one which the survivor's family may have, his/her social group, friends, political associations; or the point of view taken by an experienced service provider, a counsellor, an immigration or welfare official or a landlord.

The prismatic model of assessment, suitably modified and used flexibly and open-endedly, is intended as well to help you play through the possibilities of treatment and support, determining where you need help and advice, where you can proceed on your own, whose perspective you ought to privilege at a given juncture and in a given situation.

An interactive pedagogy means that you keep present the variety of cases and situations which you have come across, and which you may have been told of by others who are more experienced. It is designed to encourage you to be and remain attentive to the specificities, of each survivor or group of survivors, of situations and care-giving contexts. It helps you to anticipate situations which are new, and gives you room for your own construction of them. This is why an interactive pedagogy is no more than the self-education you do as you glance at these texts, taking what they say back to your experience and helping you acknowledge this experience, and then revising what you have read or considered, as well as what you might have previously thought.

Were you the service-providers/reader of this text to communicate with the writers and designers of these units, you would know that none of them would claim to have the final word, nor it is hoped, would you, the service-providers. But we would want to pool our knowledge, as much as our doubts; we would also want to voice the always overriding question - what to make of a world in which all this happens. This kind of communication can provide much encouragement and support.

Thus this text is for all those struck by the fundamental questions raised by torture and organized violence and how they make us search vigorously for communities of knowledge and care, no matter how fragile. An interactive pedagogy reflects a community-based approach toward care-giving, service-delivery and knowledgeable conduct in this field. It is equal to the effort to construct this community and to keep it alive; it has a fundamental concern on this basis, rather than being a listing of all the practical contingencies, and issues and answers which you might encounter.

II. Interaction: Service-Providers' Questions and this Document

The questions you have, as care-givers and service-providers, may be functions and consequences of the use you make of our document, whether you glance at it occasionally or regularly, read all of it, criticize it, etc. But most of all they come from your practice.

We encourage you to step back from the premises of your practice for a moment, to let the different experiences and feelings which are part of it speak to you, together with our document (parts of it) and whatever else you consult to help you, including the music, the literature perhaps, the human words that calm or encourage. Thus the pedagogy proposed here, the programme of education for self-aware practice which it intends, can only “happen” as it works on (and off) the questions which you already have, the ones which you most productively work with.

Situating these questions and your reflections within the materials, which we offer gives them a dimension and strength, which they do not have on their own. With this in mind, some features of our document stand out.

the units in this set of educational aids have been written by different people, and the distinctive voices and perspectives have not been homogenized. Most manuals give an impression of unity, coherence, and completeness. In this text, multiple voices speak to you with their differences, as much as with what they have in common. They reflect the undeniable fact that torture and organized violence are a complex phenomenon, to which several perspectives may apply. And this holds, even if at the bottom there is only one overwhelming fact: the horrendous injuriousness, pain and destructiveness which torture and organized violence mean to those who have been made their victim.

The different voices represented here also reflect the reality of our country, Canada: a country of many pluralities, pluralities of geography and enormous physical distance, of language and culture, of history and settlement. They also reflect the fact that the team involved in the production of these materials comes from three centres dedicated to giving support to survivors of torture -- centres in Montreal, Toronto, and Vancouver. In each case the structure and organization of centre or network are different, even if the fundamental purpose and concern is the same. Each is linked to the world outside Canada in a slightly different way, and it is important to remember that three among our texts come from Quebec and do, at times, reflect connections with the world of "Francophonie."

What are *you* to make of these different voices? How do they *help* you, the service-provider? If suitably arranged, they help you make use of their lack of exhaustiveness. They help you appropriate it to your advantage. They help you see that for proper training and education to occur, one does not merely need texts, kits, documents, materials, videos, etc. (the standard fare of the milieu of care-giving, education, and social service). One *also needs* the experienced practitioner, the committed human rights advocate, the thoughtful and reflective communicator and educator, the research-oriented psychiatrist and psychologist, and especially the survivors themselves. There is no education in this field which is not willingly entered into. Curiosity and interest are required. There is no education in this field which can just be carried out by oneself. One *needs* the other, the presence of others, one *needs* to be accompanied. One *needs* to have others as a sort of refuge (support), as survivors need others and need *countries* of refuge, and need all this a hundred times more, of course, than does a service-provider who has not suffered a similar fate (although some, even many, have). These are the conditions an interactive pedagogy responds to. It thrives on a lack of exhaustiveness, while reaching for depth of understanding (and strength of commitment).

Difference and incompleteness is also meant to preserve a space for your voice within your thinking about what has been said and done by these others.

But here we best present an example, or kind of case-study. It is designed to illustrate how the different voices and textual units to be found in this set of "educational aids" can be brought to bear upon experience in the field.

III. A Case Study: Refugee Existence and the Service-Provider

You may be a teacher (we urge those who are not to put themselves into her/his place) in an elementary school. In your grade four class, let us say, there is a young person from an African or South-Asian country. The young girl or boy always sits apart, does not want to interact or only sullenly, and after much avoidance, responds to your questions or your efforts to make her/him part of the class. This child makes you feel frustrated, helpless and at times incompetent and at times both angry and guilty.

Slowly you find out that the child does understand English reasonably well. You also learn that she/he has come to Canada two or three years ago and you know which country it is that the child has come from.

You wonder how all this is connected, the classroom behaviour, the shyness and reluctance to talk, the time of departure from the home country, and the name of the country.

Then, it strikes you as evident. Of course, this country -- let us say Angola, or Somalia, or Sri-Lanka, or Cambodia -- is not a country from which we receive immigrants in Canada. The people who come here from these countries usually are refugees. Here, at this point, you might want to speak with the parents of the child, and involve the school guidance counsellor. The conversations, which take place, may make you wonder whether there is not something special to the refugee experience, the experience of these people you talk to. You begin to wonder whether they have not had to deal with extraordinary violence, with frightening terror and unbearable pain. Here you might also wonder if torture is something, which has happened to them - beside deaths, dislocation, etc.

What can our texts/documents/materials if referred to do for you in this context? There is one thing, which they *cannot do* for you: they cannot help you take the step from recognizing someone as a refugee to clarifying whether that refugee has also been tortured.

The refugee experience is not a direct theme of our materials, although it is always in the background. All torture victims whom we meet are refugees, according to the standard United Nations definitions and pertinent conventions (see our units on Understanding Torture and on Settlement). But not all refugees have been tortured (up to 30%, perhaps more, may have been). And while there are Canadians, for example, native Canadians, who have been abused, even tortured by other Canadians (e.g. in residential schools), we do not regard these cases as equal to those of victims who also are refugees from abroad. This at least is the prevailing tendency.

It is important to remain mindful that it is *exile*, which is frequently, and for many by far the most overwhelming experience, even for survivors of torture. Survivors' profound sense of uprootedness is something you need to be aware of in pursuing a solution to the pupil's alienation from you and your classroom. You need to be responsive to it and our documents encourage you to make its recognition part of your understanding of many students in our schools, who come from many countries where terrible experiences are made on a daily basis -- as they are once again, in 1995 being made in Bosnia. This experience is addressed in our texts, from the Introduction to the unit on Settlement, to the one on Children and Youth. Reading through these sections should help you to grasp a context for responding to survivors of torture, that of the experience of exile.

You might want to ponder, together with the great Italian Renaissance poet, Dante Alighieri, what exile means?

> "All that you held most dear you will put by and leave behind you; and this is the arrow the longbow of your exile first lets fly.
>
> You will come to know how bitter as salt and stone is the bread of others, how hard the way that goes up and down stairs that never are your own."
>
> *(Divina Commedia. El Paradiso)*

We cannot convey to you the bitter meaning of refugee existence and exile. We cannot make you aware how frequent it is, how much of it lies in the background of Canadian history and the history of the Americas in general. We cannot give you the knowledge of what is occurring in the world: the civil wars, and wars between nations, the monstrous strategies of ethnic cleansing; the systematic intimidation of women in certain countries (with respect to certain conditions), the persecution of homosexuals; the organized violence of genocidal oppression or the mass-terror of some revolutionary states. All these are the contexts in which torture occurs. What we can do is make you aware of the existence of this connection and of its effects (see "The Phenomenon of Torture: Effects and Consequences"). And then there is your part, your thinking and your doing. If you do not read the newspaper, with an eye attentive to the vagaries of international politics, the often confusing efforts of the United Nations and to human rights issues generally and globally, then you are likely to lack a background which we presuppose and really must presuppose and which you need to have. Often, just following television news may be sufficient. But it does help to receive information from organizations in Canada dealing with such issues (e.g. Amnesty International, Inter-Church-Committee on Latin America, South-Asian Working Group, Canadian Survivors of Torture Network, Canadian Council of Refugees). It does help to belong to such organizations, and to have available to you the experience, information and considered reflection they embody.

Our interactive pedagogy thus challenges you to attend to international events, to consider how Canada is implicated in them (for example, by not challenging Mexico, its NAFTA partner, on the frequent occurrence of torture practised by the Mexican police forces and by the Mexican military in Chiapas, or by continuing to permit a considerable volume of trading in arms).

It challenges you to recognize that our country, on the one hand, may with some justification, have presented itself as a haven for refugees. But, on the other hand, Canada also sometimes contributes to the maintenance of conditions of conflict under which torture and organized violence may occur, such as with respect to Indonesia's occupation of East-Timor, or Turkey's persecution of its large Kurdish minority. Both are countries which are hardly ever criticized or taken to task by Canada in international organizations.

And our pedagogy challenges you further. It asks you to look into torture as an aspect of organized violence. Organized violence is the systematically practiced transformation of a country or society through terror (by the state, or by armed groups, etc.) who use fear of physical and psy-

chological violence practised beyond, outside and above the force authorized by law (see the definition by the World Health Organization in our unit Understanding Torture) to establish and maintain their control over it.

Our text entitled The Phenomenon of Torture. Effects and Consequences will have provided you with some steps toward understanding torture from this perspective.

It is important to consider this broader political and historical background because survivors, as your clients (or your pupil and your pupil's parents), or as your patients, will become aware of whether you have learned to comprehend the world in terms of such events. They will know whether you can understand the world a little as they do and will be affected by the presence or absence of your understanding.

If you are the teacher with whom we began this narrative, then you may want to think about how you could develop, elaborate and extend your teaching in order to reach such children. And this may include what and how you teach. Your pupil's family will look at you and the school differently if you were to permit into your classroom some of the more sophisticated understandings of world events. For example you or others (including parents or children) might explain the horrors of the former terror-regimes in Ethiopia and Somalia in terms of the history of the Cold War, in which war, both countries were used by the super-powers. Obviously, this sort of material and approach must be pursued with considerable caution. Much consultative discussion and careful review is required. It is for these reasons that teachers, social workers and others not working in the health-care field may want to consult our units coming from health-care, settlement-work and clinical practice.

For in each of these units, the details of practical interaction with survivors are addressed. They give the opportunity, overall, to transfer the insights from clinical practice into your own interactions with survivors of torture. They help you understand, value, and examine every step you take, every utterance you make. They make you realize the enormous importance of building up a network of support. Most clinicians (psychologists, psychiatrists, some medical practitioners, clinical social workers) in this field will have had to face the dreadful realities of torture and the emotional hardship which learning about these experiences have meant for them, the care-givers themselves. Our unit on The Experience of Service: Ethics and Support discusses this in some detail, from a clinical point of view.

But most other people, teachers, for example, will not have been helped to prepare themselves for the jolting shock provided by the awareness that the possibilities of human cruelty are endless, even if also monotonously the same (and can arise in a vast variety of circumstances).

In our interactive pedagogy, you may read the materials which we have prepared as always revolving around this awareness. We also address a possible tendency among care-givers, to attempt to cope with this uncomfortable awareness by either completely immersing and in some

sense losing themselves in the distressing realities encountered, or alternatively by "numbing" themselves, and avoiding their feelings, and thus losing access to feelings in their response to these horrors.

This is the domain of clinical knowledge which you might want to include in your own reflections on torture, organized violence, and their survivors. This dimension of practice is what you might want to raise when seeking competent, helpful advice (from a solid friend or a professional).

As we now return to our narrative, the teacher encountering survivors of torture, we now want to say: weigh in your mind and heart what happens to people in Canada, who have had to leave everything behind and who may now live in a basement apartment, may not understand English, may not ever have been in a major supermarket, may never before have been called into the office of a "guidance counselor" and who rarely in the past have seen women and men dressed in minimal clothing during the summer in the streets, have never seen children or teenagers encouraged to form their own cultures and semi-autonomous worlds. All this would be so new to them, alien, possibly frightening, and possibly even unattractive, sometimes -- perhaps -- attractive at others.

How much help do they need? How important is it that they have accompaniment - steady support by people who are used to, comfortable in, and familiar with, the Canada of our times? This is why we feel that having a solid programme of befriending volunteers is so important. We speak of this in the units on The Experience of Service: Ethics and Support and in Settlement Service Provision for Survivors of Torture.

IV. Case Study Continued: The Issue of Culture

Here then, we once again encounter the issue of culture. Among all the "special" issues discussed in this document this one stands out. The teacher, the medical practitioner, the nurse or social worker will know how much of an issue this is.

Many among us, in Canadian society, have learned much about the special difficulties women face, in a variety of ways, in our society and in others. We will no longer readily subsume their experience to that of men. We also have an awareness of the special difficulties to be encountered by the elderly, and can easily imagine -- if we lack the experience -- how bereft of all support and abandoned many elderly survivors of torture and of forced dislocation (refugees) will feel, unless they have strong family support around them. And children and youth already have a special place in our culture. But "culture" is a difficult and endlessly rich matter. And the most inviting feature of this topic is that it entices us to learn more, to move into it with curiosity.

Take, for example, our friend the teacher to whom I had referred. If the pupil who has come to her/his attention, is a Somali girl, she may wear the now familiar head-scarf and dress in the

traditional manner. If our teacher is a woman of feminist inclination, she may find this offensive. To her this manner of dressing may appear to represent the oppressed condition in which women are kept in many societies. And as we know, other more serious challenges lie ahead in this area (e.g. the notorious issue of “genital mutilation”). Or if the child's mother is Bosnian, she may express her concern for her men-folk, husband, sons, who have been captured. She herself may have suffered terribly, have been raped mercilessly after being pulled out of a refugee column, she nevertheless will express this concern. The same emphasis on family connections, including men-folk, can be found among Ethiopian and Eritrean refugee women (see the beautiful study be Helene Moussa, Storm and Sanctuary. The Journey of Ethiopian and Eritrean Women Refugees. Dundas, Ont. 1993. Artemis Enterprises). All of this may cause conflicts, give rise to disturbing questions for the teacher, for other service-providers and care-givers. How far to go in familiarizing survivors and their families with the prevailing attitudes of Canadian society, the differences which exist in it, the noticeable conflicts and uncertainties, even among people born in Canada, not to speak of the great number of service-providers who have come to Canada as immigrants or refugees, as survivors themselves, perhaps? A gentle process of introduction, a slow process of communicating the realities, through support groups perhaps, a patient waiting attitude are in order here, for everyone to slowly find their bearings. In most cases there are no ready-made solutions, and if the service-providers believe there are, their solutions may not have been sufficiently tested against survivors' expectations, hopes, fears, conflicts.

Interactive pedagogy comes into play here once again: between the service-provider (caregiver) and the survivor(s), their family (families) - if there is one. This time it means the creation of a situation, in which the issues at stake can be explored, individually and in group-communication. One takes one's clues from the reactions, the cautions or enthusiasm expressed by the survivor. Always it matters to them that their experience, even their sense of antagonism to or exclusion from parts of Canadian society be validated by being responded to as informative, important, and material. It is important for service-providers (e.g. those working in the education and settlement fields) to understand themselves as working with survivors toward the making of a bit of Canada, of Canadian society, of its diverse and enticingly complex new realities, its way of passing beyond its older history, into something new and unknown.

V. Interactive Pedagogy and Research

Finally, like many among us, care givers, service-providers including volunteers, and other interested and concerned persons, will turn to research and expect to find the certainty there which may be missing in practice. Interactive pedagogy once again emphasizes that practically useful knowledge can only be gained in the interaction between such specialized research findings and the service-provider's “reading” of the survivor's (and their own) situation. To give two examples:

It used to be common (among therapists and clinical researchers) to believe that South-East Asian survivors and refugees, such as Cambodians, generally express depression and other psychological suffering somatically, while North-Americans (especially of Caucasian origin) elaborate these experiences psychologically.

A lot of assumptions are built into this view. Among them are the belief that South-East Asians (and East Asians) will not admit to being "psychologically disturbed" or emotionally troubled, or that they will only admit to this among close family members and a traditional community person in charge of "mental health," such as a monk. However, recent research by Dr. Morton Beiser, head of the programme in Culture, Community, and Health Studies at the Clarke Institute in Toronto, says that his findings indicate almost the opposite. North Americans (i.e. people mostly of Caucasian origin born on this continent), somatize distress more than South-East Asians (see M. Beiser, M. Cargo, M. Woodbury: A Comparison of Psychiatric Disorder in Different Cultures... etc. Int. Journal of Methods in Psychiatric Research, Vol. 4, 157-172, 1994).

Service-providers will thus have to take note of these debates, when they can, and attempt to find out, in a most discreet way, to what extent a South-East Asian survivor may be open to psychological advice, counselling or therapy. A traditional healer *may be* the solution, or a Buddhist monk. But there now are Laotian or Cambodian psychologists and doctors who believe that this step only maintains ineffective forms of intervention.

We have to remember that all cultures in the world are in transition in our times and that there are frequent clashes between old and new beliefs in each of them. There is no escaping this and the necessity to sort this out remains. We all need to collect information in this area. It does not help to fabricate a conception of a traditional culture, for example of Somali nomadic society, when many of the refugees/survivors from Somalia are well-trained professionals, mostly coming from an urban setting.

A similar comment may be made about gender. While some would emphasize the special trauma of women, other researchers (e.g. Dr. Marlinda Freire, staff psychiatrist with the Toronto Board of Education) report findings that survivor-women frequently cope better with the stresses of exile and settlement than do many men. They appear to be more resourceful, suffering less from loss of status and social recognition (M. Freire and X. Fornazzari. "The Experience of Refugee Women" Paper. 2nd International Conference of Centres concerned with cases of victims of organized violence. San Jose, Costa Rica 1989).

It is frequently claimed that this is due to the fact that refugee women's aspirations already were lower than those of refugee men, because they had primarily been concerned with the survival and well-being of their families rather than careers. This implies that women carry a greater burden for familial and social relationships than do men, and this may be the case in some cultures and societies (for example, Freire's sample primarily consists of Chileans). But one also needs to take account of the fact that for many male refugees, status and social recognition linked to careers is associated with the fulfillment of responsibilities related to the sur-

vival and well being of their families. Thus survivors from South East Asia suffer terribly for not being able to bring their families to Canada or to provide fully for them materially once they are here. They experience a profound loss of self-esteem, because they cannot help their families (their women-folk included, of course) as they are expected to. In these cases their familial responsibilities are experienced as very strong. And this is also the case with many others.

Thus, it may be the case that Chilean refugee-women may manage better in exile than the men connected with them by experiencing a new freedom to act, to show initiative. But the corresponding loss of social and family status for men may provide some explanation for the inhibited coping they demonstrate relative to women. Certainly, young Vietnamese and Cambodian men coming to Canada as refugees/survivors hardly have access to such a sense of freedom, bound as they are by overwhelming family obligations.

Thus the service-provider will have to explore these issues in many conversations and by becoming familiar with as wide a range of cases as possible from within a range of cultures. Such an interactive consideration of research will teach him/her to avoid forming opinions too quickly and to keep on learning about the vast variety of attitudes and circumstances, which matter here.

Therefore, interactive pedagogy suggests that service-providers develop the qualities of open-mindedness, flexibility, non-directiveness. It also recommends that they not be judgmental, but empathetic. And beyond all: that they be accepting of and curious about the vast variety of ways human beings have designed and live in, their various surroundings. It can be fascinating and enormously rewarding to educate oneself about the world by doing the work of the cross-culturally sensitive care-giver and service-provider.

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