Uncrossing a Crossed Line: Psychological Treatment of Survivors of Torture

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Abstract

The natural instinct for survival among victims of complex trauma such as torture is immense. However, many victims are unable to find this strength on their own and must turn to psychological support to regain functioning. This paper provides a discussion of the background of survivors of torture, and factors to consider in therapy. It also investigates the neurological explanations behind traumatic memory, which form the underpinning of so many therapeutic methodologies. Finally, it offers concrete techniques of therapy through an exploration of existing theories and models, and an exploration of the interconnection between these three facets.
This paper is dedicated to Roy Grow, who first inspired me to do more than just listen to the news of the world in which we live. It is also dedicated to my family, who has always encouraged my own education and exploration.
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Uncrossing a Crossed Line: Psychological Treatment of Survivors of Torture

In the autumn of 2014, horrific videos of the beheadings of American journalists James Foley and Steven Sotloff and British aid workers David Haines and Alan Henning were released by the Islamic State. Viewers around the world were shocked by the heinousness of these acts, and terrified by the threats made against other potential victims. (Goldman & Witte, 2014). Yet the real terror in these deeds lies in the reality that they do not stand alone. Every day, acts of terrible violence are committed by humans for the purpose of securing power, intelligence, or safety. These acts are not always so publicly broadcast, and so it is easier to ignore their existence.

The terrible truth is that torture has existed in one form or another since the beginning of humanity. Over the past few centuries, the prevalence of documented torture worldwide has risen and fallen, and today it is reaching an unsettling high as international conflict mounts. The nature of torture follows certain patterns in all countries. In his article, The Rise and Fall of Torture: A Comparative and Historical Analysis, author Christopher Einold discusses those patterns, stating that “torture is most commonly used against people who are not full members of a society, such as slaves, foreigners, prisoners of war, and members of racial, ethnic, and religious outsider groups” (Einold, 2007, p. 102). Though it is impossible to pinpoint precise reasons why the use of torture is on the rise today, Einold posits that it is due to the increase in number of wars worldwide as well as changes in the nature of jurisdiction which have expanded the definitions of treasonous acts that might instigate torture (2007, p. 103). Regardless of the precise reasons, it is clear that torture is a violation of human rights that has become rampant.
The effects of torture on individual victims are truly terrible. For those who survive such brutal treatment, lasting physical, emotional, and psychological symptoms often persist with such intensity that it is impossible to reestablish any kind of a normal existence. Post-traumatic stress symptoms can take many forms: hypervigilance, re-experiencing, and avoidance. Many survivors of torture are also forced to relocate to foreign countries as refugees, further adding to stress and trauma as they struggle to get by in a strange new society. With torture so prevalent worldwide, the need for mental health practitioners to address the needs of these survivors is dire.

Yet this is a challenging population with which to work. Effective clinicians must be fully aware of the difficulties associated with these complex traumas. They must also understand how those challenges have impacted clients, and approach them with care and insight. Strong therapeutic alliances and deep psychological connections are crucial when working with these survivors, but this can be difficult to achieve when clients have grown to fear any practitioners in a position of authority.

Another important element of working with trauma survivors is an understanding of the neurological makeup of traumatic memories. Experiences of trauma are stored differently within the brain as are experiences of routine life. Where typical memories can be recalled at will and placed within a general timeframe and location, traumatic memories are often recalled without warning and are devoid of specifics regarding time and place. Those memories do, however, contain very vivid sensory details such as sound, smell, or taste. By learning about the ways in which these two types of memory are stored and retrieved, psychologists can more fully understand how therapy must work to help clients restructure such recollections.
In order to provide the most effectual care to survivors of torture, practitioners must be able to apply these concepts of neurology through multiple modalities of treatment. Therapeutic theories such as individual psychology, narrative exposure therapy, cognitive behavior therapy, and stress inoculation training have all developed as a means of treating post-traumatic stress symptoms. Through a thorough working knowledge of these theories and others, psychotherapists can successfully tailor treatment to specific clients. This paper outlines the most important issues surrounding work with survivors of torture, and offers an outline of several therapeutic methodologies for treatment of this population.

A Background on Torture and Survivors

The United States Government has always stressed its opposition to the use of torture. In 2004, President George Bush reiterated, “America stands against and will not tolerate torture. We will investigate and prosecute all acts of torture and undertake to prevent other cruel and unusual punishment in all territory under our jurisdiction” (Nowak, 2006, p. 817). The U.S. further underlined this position in 2005 in its report to the UN Committee Against Torture, stating:

No circumstance whatsoever, including war, the threat of war, internal political instability, public emergency, or an order from a superior officer or public authority, may be invoked as a justification for or defense to committing torture. This is a longstanding commitment of the United States, repeatedly reaffirmed at the highest level of the U.S. Government. (p. 819)
What is Torture?

This is not an uncommon stance on torture: it is regarded throughout the world as one of the most atrocious violations on human rights. Yet although most countries outwardly reject all forms of torture, the legal definition of what constitutes torture varies by government, making this a challenging ideal to uphold. In the United States, for example, section 2340A of the United States Code defines torture as an “act committed by a person acting under the color of the law specifically intended to inflict severe physical or mental pain or suffering (other than the pain or suffering that is incidental to lawful sanctions) upon another person within his custody or physical control” (U.S.C § 2340A, 2006). The U.S. specifically highlights the importance that torture must be committed “under the color of the law,” implying not just government officials but also those operating outside of official governments. However, this in no way addresses the specific intent of torture as a component of its definition.

The definition of torture as used by the United States is notably different from that used even by the United Nations (of which it is a part). The United Nations defined torture in Article 1 of the Convention Against Torture as follows:

For the purposes of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidation or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence
of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. (CAT, note 1, art. 1(1))

Like the United States’ definition, the definition outlined by the U.N. accentuates the fact that torture is primarily determined by the infliction of severe physical or mental pain or suffering. The U.N. also explains that torture must be committed by someone acting in an official capacity, a different phrasing of the U.S. term “under the color of the law.” However, the U.N. further addresses the intent of torture as an important element in its definition. It must be committed for a specific purpose and not simply at random in order to constitute torture. This is the key difference between these two definitions.

The definitions of torture as presented by the United States government and by the United Nations are complicated and highly subjective, and these are just two definitions from two closely related organizations. Every country and government views torture through a different lens, and so the measurement and control of this worldwide cruelty is extremely difficult to manage. The complexity of these definitions make it possible for officials to search for loopholes and bend words to work in their favor. “Color of the law” can be interpreted in many ways, as can the specific level of pain and suffering necessary to be deemed “severe.”

Because of the complicated nature of the definition of torture, it can be hard to prevent. Even countries like the United States, which state so unequivocally their opposition to torture, have at times been guilty of committing torturous acts. In 2014, President Barack Obama addressed the United States’ use of torture upon al Qaeda detainees after the 9/11 attacks, stating, “When we engaged in some of these enhanced
interrogation techniques, techniques that I believe and I think any fair-minded person would believe were torture, we crossed a line. And that needs to be … understood and accepted. And we have to, as a country, take responsibility for that so that hopefully we don’t do it again in the future” (Sanchez, 2014). President Obama’s remarks are chilling—even the U.S. government, outwardly so dedicated to the preservation of human rights, has committed torture in the recent past. Organizations such as The Center for Victims of Torture continually advocate for better governmental acknowledgment of these actions.

The discussion of the ethicality of torture is extremely complicated. The reason for committing torture is reliant upon precisely the extremity of the act. In her article, Why Torture? Ruth Blakely (2007) examines the purpose behind torture, identifying security or stability of governments as the two primary reasons for its use. Advocates for torture argue that it is necessary for defeating security threats. In extreme situations, acts of torture are the only hope for coercing victims to respond, as it is believed that victims will choose to give away information rather than submit to torture. Yet many prisoners provide false information under torture, or reveal nothing at all. Furthermore, Blakely ascertains that torture is only used for security purposes in a small proportion of cases and most of the time torture is committed in order to promote stability. Weak governments and political groups torture victims in order to intimidate and cause fear, thereby solidifying power. Blakely argues that these instances of torture used for governmental stability are also rarely effective, and often simply result in further discontent with the groups in power.
However, in all cases, Blakely (2007) also admits that the nature of torture “does, to an extent, lend itself to the intended functions of its use” (p. 389), which is to say that it can, in fact, be effective even if it is unreliable. In extreme instances, it can facilitate information gathering that otherwise would not be possible. It does, indeed, create fear and intimidation. It is for this reason that torture continues to be used by so many governments, in spite of its inherent cruelty and transgression of human rights. Without a clear, universally accepted definition and regulation against it among governments, torture will always exist as a uniquely effective method of bringing about certain outcomes.

This paper is not intended to discuss the ethical or legal implications of torturous acts committed by various governments. However, it is important to recognize the complicated nature and the appalling pervasiveness of torture worldwide in order to appreciate the necessity for studying consequences of these acts. Bearing this in mind, the focus of this paper is on the devastating personal effects of torture upon survivors as individuals, and how professionals in the psychotherapeutic field can work to heal victims through knowledge and understanding.

There are countless methods of torture in existence today, and those committing such acts are continually devising new, horrific methods for inflicting pain. Torture methods are often distinguished between physical and mental torture, but this differentiation can often be complicated. For example, a victim may experience physical torture during electrocution of the genitals, while simultaneously experiencing mental torture as they are told that this torture will result in sterility and impotence (Rasmussen & Lunde, 1989). The most frequent methods of physical and mental torture as outlined by
DIGNITY Danish Institute Against Torture (formerly, The Rehabilitation and Research Centre for Torture Victims) are the following:

Physical Torture:
- Beating and kicking
- Electrical torture
- Burning, e.g., with cigarettes
- “Submarino” or “banera” (submersion of the head in water until partial asphyxiacion occurs)
- Forced positions, e.g., prolonged standing
- Rape and other sexual assaults with foreign objects
- Exposure to extreme cold
- Dental torture
- “Telefono” (repeated blows to the ears with the palms of the hand)

Mental Torture
- Witnessing torture of others
- Sham executions
- Threats
- Sleep deprivation
- Continuous exposure to bright light or noise
- Solitary confinement
- Total sensory deprivation (p. 124)

Just as the methods of torture themselves can vary widely, the sequelae, or consequences, of torture can vary as well from both physical pains to mental symptoms. Among the most frequently reported symptoms are muscle and joint pain due to beatings or forced positions. Many survivors also report severe mental symptoms, ranging from anxiety to sleep disturbances, and sometimes even resulting in a change of personality. As stated by Rasmussen et al., “‘Open’ people become ‘closed’; the active become passive; the independent, dependent; the optimistic, pessimistic; etc.” (1989, p. 128).

DIGNITY outlines the most frequent examples of physical and mental sequelae of torture as the following:

Somatic and psychosomatic sequelae
- Muscle and/or joint pain
• Gait disturbances
• Pains related to specific trauma
• Skin lesions
• Gastrointestinal disorders
• Cardiopulmonary problems

Neurological or mental sequelae
• Reduced memory
• Inability to concentrate
• Anxiety, depression, fear
• Lability, introversion
• Lethargy, fatigue
• Sleep disturbances
• Nightmares
• Headaches
• Visual disturbances
• Vertigo
• Paresthesia
• Sexual disturbances
• Changed identity (p. 125)

Because of the variation in how effects of torture manifest among individuals, survivors of torture who seek psychotherapeutic treatment can present in widely different manners. They may not even mention the torture they have experienced to begin with, and may begin therapy by focusing on their immediate symptoms. Many survivors of torture are simply unaware that the symptoms they are experiencing are even related to the torture they have experienced (McCullough-Zander & Larson, 2004). It is therefore crucial for professionals to be aware of the many forms that torture can take and to recognize potential symptoms of its effects in order to successfully work with these clients.

**How Do Therapists Approach Victims of Torture?**

Because of the dramatic effects of torture upon victims, it is critical for psychotherapists to learn how to appropriately approach these clients. Survivors of torture who are also refugees or asylees face a multitude of challenges once they arrive in a new
country. They face many of the same challenges shared with other immigrants, such as acculturation stress, minority status, disruption of family and social ties, lack of knowledge of the dominant language, discrimination, and lowered socioeconomic status. Yet in addition to those struggles, they also face many challenges that are specific to their experiences. They may have also lost loved ones, and their decision to leave was forced rather than personally chosen (Behnia, 1997). As these losses build on top of one another, the resettlement process becomes utterly overwhelming. Psychotherapists working with survivors of torture must be respectful of these struggles when seeking to work with them.

Perhaps the largest struggle that professionals face when working with torture survivors is the task of building a trusting relationship. Without that trust, no therapy can take place. This is true to an extent in all therapeutic relationships, but is especially critical when working with survivors of torture. Yet victims of torture have a distinct reason not to place trust in figures of authority, no matter what the role. It may take years working with professionals in a new context before a refugee survivor feels confident enough to open up to anyone. The very act of self-disclosure involves admission of helplessness and need for assistance. In his article, Trust Building from the Perspective of Survivors of War and Torture (2004), Behnam Bhenia writes that “in order to trust professionals, survivors need information that confirms the truth of the professional’s claims regarding competence, caring, and respect” (p. 36). In other words, professionals must strive to prove their trustworthiness to individuals in all that they do. Listening to survivors without judgment, and offering understanding and compassion is certainly a
piece of this trust building, but so are smaller details like maintaining appointment times. Every small aspect of the relationship contributes to the overall level of trust.

For many survivors, the first step to building trust among helping professionals is simply receiving the aid that they need. Refugees often need help obtaining basic necessities such as food, housing, and clothing. Learning how to appropriately navigate a complicated new health system, access public transportation, enroll children in public schools, or use a new banking system are all immediate needs to these survivors. Without establishing these basic needs, they cannot begin to address the effects of torture (McCullough-Zander & Larson, 2007). On the other hand, some clients suffer from such severe post-traumatic stress that they may fail to care for themselves even with if all of these amenities are easily available. As a psychotherapist working with these populations, recognizing the most critical current needs of clients is necessary to building a trusting relationship.

Above all else, it is crucial for torture survivors to be treated respectfully and with understanding. In her book, The Mental Health Consequences of Torture, sister Dianna Ortiz explains on behalf of survivors of torture, “We readily acknowledge that the trauma we have endured has altered our lives … We want to be recognized as normal people, people who were tortured and who have survived with tenacity, grace, and dignity” (Ortiz, 2001, p. 18). Ortiz emphasizes this desire to be viewed as normal: survivors have experienced appalling atrocities, but they are still normal people. As professionals seeking to help these victims, connecting with the normal person within the tortured survivor is key to establishing a therapeutic relationship.
Once a trusting relationship has been established, it is often helpful for torture survivors to learn that their symptoms are a direct result of the torture they endured, and not because they are “crazy, possessed by spirits, or weak in character” (Laurenc, 1992). This information may seem obvious to professionals, but knowing their current symptoms have a definitive cause is a relief to many survivors, as is learning which symptoms are likely to be permanent and which could heal with treatment. From this basis professionals can help clients begin the process of healing through methodologies based on a variety of theoretical models, including cognitive behavioral therapy (CBT), narrative exposure therapy (NET), individual psychology, and stress inoculation training (SIT).

There is no one secret to establishing a functional therapeutic relationship with survivors of torture, but with care and attention it can be done. Professionals must be cognizant of the experiences of their clients and they must acknowledge that those experiences require extra care in establishing trust before disclosure can occur. They also must be careful to address their clients’ actual needs, particularly at the most basic level. Finally, they must remain respectful of survivors, acknowledging that they are still normal people and helping them to understand the direct correlation between the torture they experienced in the past and the symptoms they are experiencing currently.

The Phenomenon of Resilience

Given what we know about the many lasting psychological consequences of torture, it is hard to imagine that anyone could recover from such experiences on their own and without the aid of a trained professional. Yet many survivors of torture are not able to access professional help, and simply have to learn to go on by themselves. In fact,
humans actually possess an amazing ability to overcome trauma and to reestablish their lives without much guidance at all. This is a phenomenon known as resilience. Resilience is the “dynamic process encompassing positive adaptation within the context of significant adversity” (Luthar, Cicchetti, & Becker, 2000, p. 544).

Until the last decade or so, it was believed that resilience only occurred in people who were either remarkably healthy or especially pathological. The reasoning was that people showed resilience if they were quite emotionally strong, or if they were so pathological that they merely coped using extreme denial. These responses were viewed as a deviation from normal: the expected response to trauma was one of suffering and the inability to live productively.

However, recent studies have shown that resilience is actually much more common than previously thought. George Bonanno’s article, Resilience in the Face of Potential Trauma, discusses this fact and Bonanno’s own research regarding the prevalence of resilience as a result of trauma. In his studies, Bonanno examines four possible reactions to trauma, based on amount of disruption in normal function. He labels these different reactions as chronic disruption, delayed disruption, recovery, and resilience (Bonanno, 2005). Chronic disruption is characterized by the presence of constant severe disruption in normal functioning over the course of two years. Delayed disruption typically presents with moderate disruption in normal function initially, with disruption levels rising to severe amounts by the end of two years. Recovery occurs when disruption is initially severe to moderate and gradually declines to a mild level over two years. Resilience is defined when disruption levels remain relatively mild from the occurrence of the trauma onward.
What Bonanno’s study demonstrated was that out of each of these four possible emotional outcomes following trauma, resilience occurred the most frequently in 35-55% of the people studied. Recovery occurred in 15-35% of those studied. Chronic disruptions were measured in 10-30% and delayed disruptions only occurred in 5-10% (Bonanno, 2005, pp. 136). Where it had once been assumed resilience only occurred in a minority of survivors of trauma, Bonanno’s study showed that resilience actually occurred in the majority of people.

This particular study works with survivors of general trauma, not specifically victims of torture. Survivors of torture may contend with significantly different disruptions in their lives compared to survivors of other kinds of trauma due to the nature of torture. Many torture survivors are facing trauma on multiple levels—bodily or emotional damage, harm to family or loved ones, or displacement from home to name a few—and so it may seem that resilience would occur much less frequently. However, other studies which examine the phenomenon of resilience in torture survivors actually demonstrate just the opposite. In their article *The Effects of Torture: Two Community Studies*, Ibrahim Kira et al discuss two studies from 2001 and 2003 that examine the effects of torture compared to the effects of other kinds of trauma. These studies revealed “that although tortured individuals have a significantly higher trauma dose, they are more resilient, are more socioculturally adjusted, have more posttraumatic growth, and practice their religion more” (Kira et al., 2006, p. 205). Interestingly, the occurrence of resilience is actually more prevalent in survivors of torture compared to survivors of other kinds of
trauma. For this reason, when working with torture victims it is especially important to understand what factors lead to resilience, and how it functions in survivors.

The explanations behind the phenomenon of resilience are so far mostly hypothetical. Bonanno (2005) suggests that resilience occurs due to several different factors. On a very general level, the same characteristics that promote healthy development would also result in resilience. A supportive family environment, secure relationships, and a strong sense of self would help contribute to the ability to be resilient. On a more personal level, adaptability and flexibility in new situations would also facilitate resilience.

Kira et al. (2006) propose several additional theories to understand the prevalence of resilience in torture survivors. One theory proposed was that of religiosity. Practicing religion can help survivors find meaning in even horrific experiences, and many of the torture survivors in this study turned to religion for support. Kira et al (2006) also demonstrated that religiosity was positively correlated with “sociocultural adjustment, general forgiveness, respect of other races, and belief that he or she survived because of looking to the future and for his or her strong political beliefs” (Kira et al., 2006, p. 207).

This study also suggested that retributive justice (in this case, the fall of the Saddam Hussein regime) contributed to improved mental health conditions. Knowing this justice had been served, victims felt more in control and regained better functionality. Victims of other kinds of trauma could not necessarily experience this kind of justice,

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1 It is important to note that in the Kira et al studies, the differences in characteristics of populations examined could have affected results. Torture survivors by definition did not include people who were killed in the process of their treatment. Therefore this study may not be fully representative of the entire tortured population.
which Kira et al. (2006) suggest was one reason why torture survivors demonstrated more resilience.

Ultimately, resilience as a reaction to trauma is a mechanism that humans have developed out of sheer necessity. The world is full of so many potential traumas that most adults will experience one or more traumatic events in their lifetime (Bonanno, 2005). Without the option of resilience, nearly all people would find themselves debilitated by grief and the struggle of coping at one point in their lives. There are a great number of elements that contribute to the phenomenon of resilience, but psychologists have yet to determine any indisputable formula to predict when it will occur. However, we can pinpoint some characteristics that may elevate the likelihood of resilience, and using those factors we can begin to construct treatment strategies for helping torture survivors.

Many survivors of trauma react with astounding resilience and strength on their own. However, many more survivors struggle to regain control of their lives and psychological well-being. This struggle is the impetus that often drives trauma survivors towards seeking counseling. It is important for therapists to recognize these clients and their needs, because survivors of trauma are among the most challenging clients to treat successfully in therapy. To work effectively with survivors of compound traumas, such as torture survivors, therapists must possess an immense amount of skill and understanding regarding the process of trauma recovery.

Babette Rothschild is a M.S.W., body-psychotherapist, and specialist educator in the treatment of trauma and P.T.S.D. She has written numerous articles and books regarding the subject of how to work effectively with trauma survivors as a mental health professional. The works of Rothschild explain the degree to which therapists must
understand the process of trauma recovery, and outline guidelines for how to conduct therapy. Rothschild (2003) presents the theory that there are ten foundations which counselors must follow in order to practice safe trauma therapy:

1. *Establish safety for the client within and outside the therapy* (p.17). As discussed earlier, the first concern for many torture survivors is that of safety. This may refer to basic needs such as shelter, food, and health care, and it may also refer to the feeling that the client is safe in the room with the therapist.

2. *Develop good contact between therapist and client as a prerequisite to addressing traumatic memories or applying any techniques—even if that takes months or years* (p. 17). Building a trusting relationship with clients, as also outlined previously, is a crucial component to doing effective therapeutic work. With torture survivors, this step of relationship building may truly take years to establish.

3. *Client and therapist must be confident in applying the “brake” before they use the “accelerator”* (p. 18). This refers to Rothchild’s own metaphor about putting on the “brake” during therapy to back off of painful emotions, as opposed to using the “accelerator” to press forward into challenging memories. What she means is that it is important that the client and the therapist have established effective methods of retreating from unpleasant emotions and soothing before they attempt to delve into more complicated memories.

4. *Identify and build on the client’s internal and external resources* (p. 19).

   Resilience is a phenomenon also discussed previously, and this foundation of therapy refers to the therapist recognizing a client’s internal ability to cope. It also
refers to external resources, such as family or friends, and their supporting community.

5. **Regard defenses as resources. Never “get rid of” coping strategies/defenses; instead, create more choices** (p. 20). This can be a challenging foundation for therapists to work with, because some defense strategies may simply seem unhealthy. Yet working with trauma effectively requires that practitioners do not criticize the way in which clients handle their trauma, and instead find ways of building upon those natural tendencies to find more strength.

6. **View the trauma system as a “pressure cooker.” Always work to reduce—never to increase—the pressure** (p. 20). Though this particular foundation may seem like common sense, the simplicity of it is deceiving. It is important for therapists to keep this basic principle in mind at all times during sessions.

7. **Adapt the therapy to the client, rather than expecting the client to adapt to the therapy. This requires that the therapist be familiar with several theory and treatment models** (p. 20). Clinicians must have a wide variety of “tools” in their toolkits of therapeutic models. Once they begin to know their clients better, they can carefully select which techniques to use for each case.

8. **Have a broad knowledge of theory—both psychology and physiology of trauma and PTSD. This reduces errors and allows the therapist to create techniques tailored to a particular client’s needs** (p. 21). Additionally, therapists must do their diligence to understand the fundamental background of what is occurring in clients suffering from PTSD. Without this knowledge, it could be easy to misunderstand a symptom and to treat incorrectly.
9. *Regard the client with his/her individual differences and do not judge for noncompliance or for the failure of an intervention. Never expect an intervention to have the same result with two clients* (p. 21). Understanding that every client will react differently to each intervention is crucial. Practitioners must pay close attention to clients to monitor what models are most effective for each.

10. *The therapist must be prepared at times—or even for a whole course of therapy—to put aside any and all techniques and just talk with the client* (p. 21). Ultimately, a therapist can do great harm in pushing therapy upon a client. There are times when the most therapeutic intervention at the time is simply for the client to feel heard. It is important for counselors to recognize when this is necessary.

These main foundations of therapy as presented by Rothschild are a helpful starting point for learning how to work with torture survivors, and echo the beliefs of many other specialists in the field of trauma, such as Judith Herman and Bessel van der Kolk. To safely undergo therapy, clients must feel safe and secure both in therapy sessions and outside. Next, the therapist and client must build a strong, trusting relationship. The therapist must have a solid understanding of the psychology and physiology of trauma as well as knowledge of multiple treatment methodologies. They must then work carefully to use appropriate treatments for individual clients.

**The Neurology of Trauma**

The psychological distress caused by torture is not just a theoretical concept measured only by emotions and feelings. Post traumatic stress disorder was once viewed as an inexplicable illness, but today brain scans illustrate the fact that trauma actually alters the neurological structure of the brain. Storage of traumatic memories occurs in an
entirely different region of the brain than storage of non-traumatic memories. The
neurological details involved in trauma are immensely complex and there is extensive
research available for further reading on this topic. However, for the purposes of
theoretical application, this paper focuses on more general explanations of neural
networks.

The basic structure of the brain divides functionality across three main systems:
the frontal lobes, the limbic system, and the brainstem (Corey Jr., 2000). The frontal
lobes are responsible for reasoning, analyzing, problem solving, and planning. They also
control verbal expression, and contain memories of specific events and facts. The limbic
system is responsible for non-verbal experiences, including emotional responses and
feelings. This is the section of the brain where memories of traumatic experiences are
stored. The brainstem is responsible for control of basic instinctive responses, such as
heart rate, breathing, blood pressure, or body temperature (MacLean, 1990). To further
simplify: the frontal lobes are where reasoning and verbal experiences take place, the
limbic system is where emotional responses and non-verbal experiences take place, and
the brainstem is where instinct takes place.

In times of normal neurological functioning, all three sections of the brain operate
simultaneously. During traumatic experiences, the frontal lobes shut down altogether as
the body undergoes a fight-flight-freeze response, and the brain is flooded with the
hormone cortisol (Siegel, 2010). This reaction occurs in order to save time in situations of
survival. In evolutionary terms, a human who is being chased by a predator would not
need to use his reasoning frontal lobes to assess the situation. It would be far more useful
for him to quickly use an emotional response (fear) and an instinctual response (elevated
heart-rate and running away). Humans have maintained this neurological response to trauma precisely because of its evolutionary advantage.

When the frontal lobes shut down, more energy is diverted to the other two sections of the brain. Within the limbic system, the amygdala is activated to register emotions of shock, horror, and terror. In this moment, the amygdala also registers bodily sensations such as smells, sounds, sights, and tastes. At the same time in the limbic system, the hippocampus also shuts down. This section of the brain is responsible for placing a “time and date” stamp on normal memories, allowing them to be recalled based on this categorization. During traumatic events, because this section is shut down, memories formed do not contain typical time markers to establish when they occurred in the context of larger memories. As these processes occur, the brain stem reacts to the alarm triggered by the amygdala. This prompts instinctive responses: heart rate may increase, breathing rate may increase or stop altogether, muscles may become tense, and digestion may increase or stop (L. Valerian, personal communication, October 28, 2014).

These neurological responses elicited by traumatic experiences are measurable, which offers a first step in understanding the operation of post-traumatic stress symptoms. Because the brain functions in an entirely different manner as it gathers daily experiences as opposed to traumatic experiences, the storage of each kind of memory also occurs differently. As a result, later recall of those memories also operates differently. Normal, non-traumatic memories can be accessed voluntarily while maintaining a firm sense of time and place, and a logical beginning and end. Associated sensory memories can be recalled, but are relatively weak compared to the actual experience. Often involuntarily triggered recall of traumatic memories, on the other hand, results in a
person losing a sense of time and place. Rather than being clearly ordered from beginning to end, these memories return in the form of flashbacks, laced with vivid sensory perceptions that can feel just as real as if they are occurring all over again. Through brain scanning technology, the difference in recall of these two types of memory can be clearly measured (MacLean, 1990).

**Explicit and Implicit Neurological Networks**

Normal and traumatic memories are distinctly different, and neurological evidence further proves this fact. The question then becomes, how do we as clinicians use this information to help clients? In his book, *Mindsight: The New Science of Personal Transformation*, Daniel Siegel explores precisely this question. Siegel bases his discussion of memory, trauma, and recovery on the principle that normal, non-traumatic memories are coded in the brain in two ways. One type of memory is the kind that influences behavior in the future without having to be intentionally recalled. The memory of how to do things, like riding a bicycle, falls into this category. When a person gets on a bicycle, his brain automatically recalls the memory of doing so in the past and retrieves instructions for how to do so again. The second type of memory requires an awareness to be retrieved. The specific memory of learning to ride a bicycle, perhaps falling and being hurt, or experiencing joy after riding down the block successfully, falls into this second category. These are the memories that we can consciously choose to retrieve and reflect upon.

This first type of memory, those that are retrieved unconsciously in daily life, is referred to as implicit memory. The second type, memory that is accessed at will regarding specific events, is called explicit memory (Siegel, 2010). Implicit memory is
encoded constantly throughout life. These are the memories that very early on form a person's perceptions, emotions, and sensations to the world around them. Implicit memory is also responsible for giving humans the ability to generalize previous experiences and form appropriate reactions in new experiences. It is implicit memory that "primes" humans to respond to specific triggers in a given manner. For example, if you have learned how to swim, putting on a swimsuit primes the behavioral repertoire for swimming, and you will be prepared to engage this system upon jumping into the pool (Siegel, 2010, p. 150).

Where implicit memories are gathered beginning when a person is in the womb, explicit memories tend not to be measurable until around age two. This is the point when children begin to recall previous experiences, and parents automatically reinforce this capacity by asking them to talk about things they have done. In retrieving explicit memories, we are aware that we are calling to awareness a past event. Explicit memory itself can be further categorized into factual and episodic memories. Factual memories are those which a person knows to be true about his or her life in general—for example, remembering the name of a second grade teacher. Episodic memories are specific recollections of a certain moment in life—for example, remembering the outfit you wore on the first day of second grade.

**How does PTSD Occur?**

Post-traumatic stress disorder can at a first look seem extremely contradictory. Traumatic memories retain little to no details regarding time and place, but are flooded with extremely intense sensory details. By applying the concepts of implicit and explicit neural networks and what we know about the structure of the brain, the phenomenon of
PTSD begins to make more sense. During the traumatic experience, the frontal lobes and the hippocampus are shut off and the brain does not retain verbal reasoning or a sense of time. This is why these disturbing memories lack specifics in regard to time or place. It is also why so many survivors struggle to find words to describe what they can recall. There are very few explicit memories retained from extremely traumatic experiences.

At the same time, activity in the limbic system and brain stem is elevated during these experiences. Victims are acutely aware of sensory input, as well as their own bodily functions. This is why survivors so vividly remember those implicit memories. The power of implicit memories also seems to be linked to incidents of flashbacks. A flashback may be “the result of the action of an implicit-only memory of a traumatic experience” (Siegel, 2010, p. 156). In these flashbacks, perceptions, emotions and bodily sensations are fully in a person’s awareness, but they are not properly tagged with the hippocampal markings that signify they occurred in the past. This is why flashbacks feel as though they are happening in the immediate present.

Other key features of PTSD are persistent sleep disturbances during the rapid eye movement (REM) cycle and recurring nightmares. These symptoms, too, indicate the potency of deeply buried implicit memories. In order for explicit memories to become fully integrated into the cortex, and thus written into permanent memory, they must go through the process of “consolidation,” which is closely tied to the REM phase of sleep. People suffering from PTSD have REM sleep interrupted regularly, which offers further explanation for why these memories remain implicitly coded and are experienced as nightmares or waking symptoms instead of being fully consolidated (Siegel, 2010, p. 159).
Some of Siegel’s conclusions about implicit and explicit neural networking, like these suggestions about REM sleep and nightmares, are speculative and unproven. However, the majority of these explanations are based on neurological observations and scientific fact. The concept of implicit and explicit memory is a useful simplification of the complex processes that occur in the brain as memories are gathered. This categorization of memory type also offers a logical framework for understanding the symptomology of post-traumatic stress disorder.

**Overlap with Methodologies of Therapy**

Understanding the neuroscience behind traumatic experiences is the first step towards treating post-traumatic symptoms. Indeed, many methodologies of therapy address the very principles of implicit and explicit memories. Even before psychologists were fully aware of the neurological explanations for traumatic memories, many of these theories centered around the notion of converting painful implicit memories into more manageable explicit memories. Understanding what is happening to clients on a basic, neurological level is helpful to clinicians as they strive to apply more theoretical concepts to real life situations.

Unexamined painful implicit memories can infiltrate a client’s mind, shaping beliefs and expectations. They seem so innate that many clients cannot even distinguish these memories from their naturally born “intuition” about the world. Through therapy, counselors can help clients to recognize that these implicit memories are not providing useful intuition, but instead they are tying them to painful memories of the past.

Ultimately, the goal is to help clients to reroute neural networks associated with their trauma. The established networks primed through traumatic experience are
powerful, and combatting them takes patience and mental strength on the part of the client. By reintegrating implicit memories into a conscious awareness, instead of allowing them to operate as though they are reasonable intuitions or rational decisions, clients can begin to gain control of their own mental wellbeing. Different therapeutic methodologies approach this goal using various methods, but the desired results are ultimately the same.

**Facilitating Recovery of Torture Survivors**

Working with torture survivors may at first seem daunting to therapists because the traumas involved in torture are complex and multi-layered. Many psychologists have developed ideologies for how best to work with this kind of compound trauma. As clinicians, the best way to provide effective therapy to clients is to be well-versed in as many treatment theories as possible. This chapter explains the importance of understanding multiple theories and knowing when and how to apply specific methodologies with clients. It outlines the basic principles underlying a few of the most generally accepted theories in practice today. It is important to note that this is far from a comprehensive overview of all of the techniques in use today, as this is a rapidly growing field in terms of the research being produced. However, the theories presented here were chosen as they are among the most highly researched and proven techniques available.

**Four Therapeutically Useful Methodologies**

In order to better explain the principles of each of the methodologies presented here, the application of each theory will be demonstrated with a common case study. This case study will demonstrate how different theories and techniques may be applied to the same client. The following is the account of an individual torture survivor taken from the
article *Producing evidence of a miracle: Exemplars of therapy conversation with a survivor of torture* (2012) by Laurie Charlés. This article follows the therapy process of a client in the United States, and documents specific conversations and techniques used.

Timothy (a male asylum seeker in his sixties) had been a successful businessman in his home country, prior to the start of the war in a neighboring country that spilled over its borders and into the capital city where Timothy lived. One day, he was forcibly taken from his office by rebel soldiers, who falsely accused Timothy of participating in a recent political protest. Beaten and tortured by the soldiers, Timothy was also threatened to not ever return to his home or office. One of his children was kidnapped and another family member was killed on this day. Later, Timothy’s home was attacked by rebel soldiers, looted, and burned to the ground. Timothy and his wife, Simone, now homeless, were pursued by rebels who had identified them as being part of a minority ethnic and religious group, as well as supporters of the current government. Timothy and his family eventually fled to a third country in their region of Africa, where for 5 years they lived in refugee camps before arriving in the United States. (2012, p. 28)

Timothy’s story is not uncommon. He suffered great physical torture, as well as the emotional torment of losing family members. Now, as he struggles with the trauma from those experiences, he is also navigating the rules and language of a new and confusing country. With each of the following methodologies, Timothy’s story will be used as a demonstration for how to apply the theories. Though this story is real, the following theoretical applications of the story are conceptualized for the purpose of the explanations.
Individual psychology. As a contemporary of Freud and Jung, Alfred Adler was one of the founders of the psychodynamic approach to therapy. His own concepts, termed Individual Psychology from the Latin *individuum* (for indivisible), form the basis for many more modern branches of therapy today (Corey, 2013, p. 103). For this reason, a thorough understanding of Adlerian theory is immensely useful for the comprehension of nearly all later theories. Adlerian therapy employs a holistic view of the client, who is both the creator and the creation within his or her own life (Sherman & Dinkmeyer, 1987). This theory emphasizes the purposeful nature of all behaviors and therefore focuses more on present and future conflict rather than dwelling on past experiences. Though the effects of the past are real, they do not necessarily dictate a client’s ability to find change in the future. For clients overcoming great trauma this can focus can be liberating, as they can imagine a future in which they are not held back by the past.

Adlerian psychology is rooted in the belief that the individual creates his or her “lifestyle,” or set of expectations about the world, within the first five or six years of living (Mosak & Maniaci, 2011). The lifestyle defines what an individual believes about men, women, himself or herself, and life in general. Those early perceptions are an example of a persons first formed implicit memory, and they shape the way an individual moves throughout the rest of his or her life. Adlerian theory also stresses the importance of “social interest,” or a desire to be a part of a community in a productive and helpful manner. In working with torture and trauma survivors, building a healthy sense of belonging within a community is key to fostering long-term recovery.

The therapeutic process in Adlerian psychology is a collaboration between counselor and client. During this process, the therapist assesses the client’s lifestyle,
identifies mistaken goals and faulty assumptions, and then reeducates and reorients the client towards a more useful style of living. The ultimate goal of this therapy is to develop a stronger sense of belonging within the community, and to promote behaviors that benefit others, in keeping with the ideal of social interest. All of this is done by increasing the client’s self-awareness, and helping him or her to modify problematic mistaken beliefs (Dreikurs, 1953).

The process of identifying a client’s lifestyle is accomplished through multiple conversations. General questions about his or her current life and childhood as well as the nature of his or her family can provide a good base of information. Therapists may also gather information through “early recollections” told by the client. These are defined as “stories of events that a person says occurred [one time] before he or she was 10 years of age” (Mosak & Di Pietro, 2006, p. 1). Early recollections are specific memories tied to emotions, thoughts, and feelings. A summary and assessment of those recollections can reveal important beliefs within the client’s lifestyle.

Individual psychology places great weight on the importance of encouragement of clients (Mosak & Maniaci, 2011). Encouragement takes place when the therapist helps the client identify personal assets and strengths, and builds self-confidence. It is the most powerful tool for helping a person to change. Encouragement quite literally provides clients with the courage to take steps towards emotional growth. Torture and trauma survivors often come to therapy in a place of great discouragement and fear. It may not even be possible for them to accept words of encouragement at the beginning. Gradually, as the therapeutic alliance is strengthened, these words of encouragement will provide the base for healthy change.
There is not much existing research regarding the application of individual psychology methods in a trauma context. However, it is still possible to apply basic Adlerian methods to this case, and could provide very beneficial insights to both clinician and client. An Adlerian approach to working with Timothy would begin by establishing a working therapeutic relationship based on “a sense of interest that grows into caring, involvement, and friendship” (Corey, 2013, p. 113). Because Timothy is not likely to want to share important information about his life, let alone the details of his very complicated trauma with a complete stranger, this phase of therapy is crucial for later phases to succeed. By creating a warm atmosphere, rather than immediately delving into the problem at hand Timothy can slowly start to trust his counselor. Timothy was tortured by soldiers operating under rebel law, so he may be particularly wary of people acting in positions of any type of authority. He may even be cautious around a new therapist, so establishing this trusting relationship is absolutely necessary.

The next phase of Adlerian therapy is where the counselor will explore Timothy’s individual psychological dynamics. Here, the therapist will build a better understanding of Timothy’s lifestyle. By assessing Timothy’s social and cultural context, the therapist can begin to understand the environment in which Timothy exists, rather than assuming that he fits into some preconceived identity. Through a subjective interview, in which Timothy will try to tell his life story as completely as possible, and an objective interview, in which Timothy begins to relay the most pressing troubles that have arisen in his life, the therapist will gather information about how Timothy moves in life (Dreikurs, 1997). During this phase of exploration, the therapist will use an assessment of Timothy’s
family constellation and early recollections to build a more complete understanding of Timothy’s lifestyle.

Having begun an assessment of Timothy’s psychological dynamics, the therapist will then begin to encourage more complete self-understanding and insight in the third phase of therapy. This phase will entail building Timothy’s awareness about himself and his lifestyle tendencies. It will also involve psycho-education regarding trauma and post-traumatic stress. If Timothy is struggling with various post-traumatic symptoms in his daily life, he may find great relief in learning that these reactions are normal. By helping Timothy to understand and interpret his own reactions he can begin to explore possible alternative reactions (Corey, 2013).

This leads seamlessly into the fourth phase of Timothy’s therapy, in which the therapist will begin the process of reorientation and reeducation. Here, Timothy will choose to adopt a new style of life based on the insights gained in his first three phases of therapy (Corey, 2013). He will begin putting into practice alternative thought patterns and reactions in life. Adlerian therapy focuses primarily on changes in awareness rather than changes in behavior. Shifts in thinking with sessions eventually translate into shifts in actions outside of therapy. During this phase, it is especially important for the therapist to continue to give Timothy much-needed encouragement to make these changes. The therapist will also help Timothy during this phase to gain courage and inner strength as well as connections with others. By the end of therapy, Timothy will have gained better self awareness, understanding of his symptoms, and ability to change his patterns of thinking. He will also feel simultaneously more self-sufficient, and better connected with those around him.
**Narrative exposure therapy.** Narrative exposure therapy (or NET) is a particularly useful type of therapy for short-term treatment of post-traumatic stress disorders. The theory behind this type of therapy is based on the neurological functioning of the fear/trauma network, and the differences between traumatic implicit memories and non-traumatic explicit memories. As discussed previously, non-traumatic explicit memories are structured such that they can be remembered in a kind of chronological order, with a beginning, middle, and end. People can easily recall these innocuous memories in a narrative fashion. Traumatic implicit memories, on the other hand, are much more fragmented. When recalling those memories, people may struggle to put together a logical narrative. The base principle of NET is that allowing a person to narrate their traumatic experiences repeatedly will allow them to sort through the logistic details of the memory, and reconstruct the memory with a more firm sense of time. As the client builds a more concrete version of this memory, it becomes less painful to recall. Eventually, recalling the traumatic memory does not cause such intense emotional response as those memories no longer elicit the response part of the fear network (Schauer, Neuner, & Elbert, 2011, p. 32).

During exposure therapy, the client is asked to recall and talk about their traumatic experiences in great detail. In doing so, the client experiences all “emotions, bodily sensations, and implicit memory parts associated” (Schauer et al., 2011, p. 34) with the events described. By attaching “hot implicit memories” of the story to “cool declarative memories” about the details, patients experience a conditioning of the emotional response to the memory, and often find that anxiety symptoms are alleviated.
Typically, exposure methods of therapy are designed to help a client focus on the one worst event in his or her life. Survivors of torture, however, often contend with multiple traumatic memories. In these instances, NET does not target one specific event for therapy, but rather relies on the chronicity of the client’s entire life. Examining the client’s life story from birth to present, while focusing on the details within traumatic events, allows this therapy to address a broader range of memories and put them in a larger context.

Narrative exposure therapy is most effective when the number of sessions is predetermined at the onset of therapy. The number of sessions ranges from about four to twelve, depending on the context of the therapy and the resources available. Particularly complex trauma, such as torture, may require up to twenty or more sessions. Knowing that the number of sessions to be had is limited can be helpful in the healing process, as clients cannot avoid processing painful experiences and must confront them within the time frame allotted (Schauer et al., 2011, p. 38).

In the instance of the case study with Timothy, NET could prove particularly useful to address Timothy’s anxiety surrounding multiple experiences in his past. NET could be quite useful for him in the immediate future, as it could take place in a relatively short number of sessions. To begin with, the counselor would start by determining specific diagnoses for Timothy. This would help build the structure for the narrative exposure therapy as well as any types of therapy that might be useful afterwards. Next, the therapist would give enough psycho-education to Timothy so that he could understand the basic concepts of NET and the therapy process in general.
The most important aspect of NET, as with most treatment of trauma, is the strong relationship between therapist and client. A NET therapist working with Timothy could build a relationship during the telling of happier memories from before the traumatic events of his kidnapping. During this time, the therapist could observe Timothy’s beliefs about himself, and his own personally identified strengths. These observations are important to use throughout later therapy.

In following sessions, Timothy would be asked to construct a general timeline of his own biography, beginning with his childhood and his school and work experience that led him to work in business. This would form his “lifeline.” In the third session, Timothy would begin the narration of specific memories, including traumas. He would outline the most traumatic memories that have taken place in his life, perhaps including the day when he was forcibly taken from his office by soldiers; when he was beaten, tortured, and threatened; when one of his children was kidnapped and another family member was killed; when his home was attacked and burned; and when he and his family were forced to flee and live in refugee camps. Timothy would examine each of these traumatic memories with a therapist, and create a written narrative account of the events, extending from the beginning of the threat, the terrifying events themselves, the history of escape, and his life thereafter. Throughout the process of recounting these events, the therapist would keep track of Timothy’s more emotionally charged “hot memories” as opposed to the chronological narrative, and strive to weave the two together.

After sessions in which Timothy has experienced some habituation, he would need to go through a “cognitive restructuring process,” as he cools off from the intense session of therapy. This process could allow Timothy to gain new awareness about the
meaning of the traumatic events. It could also allow him to better understand his own behavior during the event. Having processed these insights, Timothy and his therapist can later discuss the comparison of the “once hot memory to the now cool memory” and the implications of this transition (Schauer et al., 2011, p. 54).

During the first sessions as Timothy’s narrative is told, the counselor would write a short version of this account. In successive sessions, Timothy would correct the narrative and add details that he may have missed. Finally, by the last session Timothy’s biography would be complete. In his last session, he would read through the biography together with his therapist. The biographical records compiled through narrative exposure therapy can be used by human rights organizations as documentation of the events that occurred, as long as the client gives explicit permission and is assured that no harm will come to him for doing so (Schauer et al., 2011, p. 38).

**Cognitive behavioral therapy/cognitive behavioral modification.** Cognitive Behavioral Therapy (or CBT) combines elements of cognitive and behavioral principles in a relatively short-term treatment, and is one of the most extensively researched methodology of clinical practice. The most important attributes of CBT are:

1. A collaborative relationship between the client and the therapist
2. The premise that psychological distress is largely a function of disturbances in the cognitive process
3. A focus on changing cognitions to produce desired changes in affect and behavior
4. A present-centered, time-limited focus
5. An active and directive stance by the therapist
6. An educational treatment focusing on specific and structure target problems (Beck & Weishar, 2011)

This methodology is structured around the psycho-educational model of therapy, which emphasizes the client’s responsibility in initiating change with “homework” to do between sessions. In CBT, therapists help clients “examine the manner in which they understand themselves and their world and to experiment with new ways of behaving” (Dienes, Torres-Harding, Reinecke, Freeman, & Sauer, 2011). Ultimately, CBT allows clients to take a large amount of control in the therapy process.

CBT and narrative exposure therapy fit together seamlessly. One of the founding psychologists in the development of CBT, Donald Meichenbaum, specifically used CBT principles to change clients’ self-verbalizations, recognizing as NET does that the narratives clients maintain about themselves are key to promoting change. Meichenbaum’s methodology, called cognitive behavior modification (or CBM), stresses the importance of client self-statements and the ability to change behavior by altering those statements (Corey, 2013, p. 310). By interrupting those patterns of thoughts, clients can then evaluate their behavior more consciously. Together, the client and the therapist use role-play situations to replicate problem situations and to gain new coping skills.

Meichenbaum’s model of CBM consists of three phases of therapy which address the interaction of inner speech, cognitive structures, and behaviors and their resultant outcomes” (Meichenbaum, 1977, p. 218). The first phase of CBM is that of self-observation. In this step, clients learn how to observe their own behavior. Clients must recognize their own role in their internal dialogue, and acknowledge how they react to others. By learning that they are not “victims” of negative thoughts, but rather that they
are adding to their negative feelings through the things they tell themselves, clients can begin to accept responsibility for their emotional well-being. Victims of severe trauma often feel completely at the mercy of their flashbacks and emotions. Helping them to understand that they do in fact have control of these feelings can be simultaneously painful and empowering.

Simply recognizing how negative thoughts impact their well-being is not sufficient for clients to initiate change. The next step in CBM is for the client to notice opportunities for adaptive behavioral alternatives (Corey, 2013, p. 311). In order to initiate a different internal dialogue, the client must begin by starting a new behavioral chain. By restructuring how they respond behaviorally, the client also learns how to lessen any inner psychological distress that is intrinsically linked to “cognitions, emotions, behaviors, and resultant consequences” (p. 312). Survivors of torture who suffer from guilt and flashbacks surrounding their traumatic memories can learn to recognize what thoughts trigger these painful episodes, and can start to construct alternative responses that are not so upsetting.

The third and final phase of Meichenbaum’s CBM is the phase of learning new skills. In this phase, clients implement resources they have identified in therapy within real-world situations. They interrupt the spiral of thoughts, feelings, and behaviors with more adaptive reactions. Clients also learn how to rework inner dialogues, and assess the results. As they use these new, more adaptive reaction techniques they typically find new results in life, which enforce these new behaviors and thought patterns. Over time, these new skills become engrained and do not have to be forced but come naturally.
In the case study with Timothy, the first step of CBT therapy would be to identify the inner thoughts plaguing Timothy in his day-to-day life. He may ruminate on the horrors of his torture and his inner dialogue may consist of self-blame. If he blames himself for the kidnapping of his child and the death of his family member, he may easily blame himself for other incidents in his present life. In this first step of therapy, the clinician would assist Timothy to recognize these types of negative thoughts. Together, they would look for a pattern of negative thinking. Timothy’s therapist would also educate him about the compounding effects of these negative thoughts on his internal processes as well as his behavior. As Timothy gained an awareness of his patterns of thinking, he could then begin searching for ways in which those patterns could be interrupted. Together with his therapist he would notice his pattern of thoughts, feelings, and behaviors and suggest ways to adjust the thoughts that begin that cycle. In the final stage of CBT therapy, Timothy would practice implementing these changes. As he adjusted his negative thought patterns, he would begin to see changes in his feelings and behaviors, as well as the outcomes of those behaviors. Initially these changes may feel foreign, and not like a genuine representation of how he would react. However, over time as Timothy experienced better outcomes through this altered thought/behavior cycle he would gradually accept this new methodology as truly his own.

Cognitive behavioral therapy has been used extensively in the treatment of trauma, and there are a great number of studies which address both its efficacy and effectiveness. Trauma-focused cognitive behavioral therapy (TF-CBT) has been developed to treat post-traumatic stress disorder (Webb, Hayes, Grasso, Laurenceau, & Deblinger, 2014).
**Stress inoculation training.** Donald Meichenbaum also developed a treatment strategy related to cognitive behavioral modification called stress inoculation training (SIT). SIT is a complex process, consisting of multiple aspects which contribute to both treatment and prevention of psychological distress (Meichenbaum, 2008). Over the course of SIT treatment, clients practice dealing with relatively mild stimuli in a controlled therapy setting. Rather than discussing cognitive changes to make in theoretical situations, they try those changes in real but safe scenarios. The goal of SIT is to teach real-life coping skills using the following procedures:

- Expose clients to anxiety-provoking situations by means of role playing and imagery
- Require clients to evaluate their anxiety-level
- Teach clients to become aware of the anxiety-provoking cognitions they experience in stressful situations
- Help clients examine these thoughts by re-evaluating their self-statements
- Have clients note the level of anxiety following this re-evaluation (Corey, 2013, p. 313)

Much like the structure of cognitive behavioral modification, stress inoculation training follows a three-phase model. The first phase of this therapy consists of conceptual education, in which the client and therapist build a solid working relationship. During this phase the therapist educates the client about the nature of stress and how to reconsider stress in social-interactive terms. The therapist and client work together to rethink the very nature of the client’s problem. In this stage client learn how to theoretically create new cognitive and emotional responses to situations, through guided
questioning and introspection. Often, clients enter therapy believing that they are victims of their suffering, and do not see the role they play in perpetuating their unhappiness. In this phase of therapy, the counselor assists the client in starting to recognize the way in which their internal narrative affects their emotional well-being.

In the second phase of SIT, the skills acquisition and consolidation phase, the therapist strives to coach clients in new coping skills for their life. In this training, clients “acquire and rehearse a new set of self-statements” (Meichenbaum, 1986). This is also the phase of therapy in which clients are exposed to practical scenarios in order to practice the application of these skills. This direct teaching allows clients to examine their newfound reactions in a safe setting, and to practice where they go wrong. For clients dealing with severe trauma, this setting is a crucial buffer before they can practice these new skills in an often scary outside world.

The third phase of SIT is the application and follow-through phase, in which clinicians and clients carefully transfer the skills learned and practiced in therapy to everyday life situations. More roleplaying and rehearsals are important in solidifying newly learned skills. Clients complete more and more behaviorally demanding tasks outside of therapy, continually setting goals together with the therapist (Corey, 2013, p. 314). When working with torture survivors, it is important that counselors are especially careful in the transition from skill acquisition to application in real life. Clients who are not yet ready to practice skills outside of sessions may shy away from therapy that pushes them to make changes too quickly.

A therapist working with the case study of Timothy may choose to use stress inoculation training in order to help Timothy put theories and skills into practice. Because
of the extent of Timothy’s trauma, he is likely struggling with many intrusive thought patterns and behaviors. Additionally, because he was forced to move to the United States after living in a refugee camp he may be struggling with many challenges in his day-to-day life even outside of his cognitive processing. Applying theoretical changes to his life outside therapy may simply not be possible for Timothy at the beginning of therapy. SIT would allow Timothy to explore new cognitive responses with his therapist, and to practice implementation in the security of a therapy session. As he grew comfortable with these new reactionary techniques, he could begin to apply his newly learned methods in real life.

SIT could also be a useful methodology to employ in the case of Timothy because the nature of the therapist/client relationship is very collaborative. This helps to develop a very trusting atmosphere within therapy, which Timothy could especially appreciate. Knowing that he is in control of his therapy—both in terms of the new skills that he chooses to learn, and how he practices implementation within sessions—could also be reassuring to Timothy. This reassurance would translate into confidence outside of sessions as well. Stress inoculation training is particularly useful with clients who have suffered trauma, like Timothy, precisely because of this opportunity for confidence building.

Therapeutic methodologies such as individual psychology, narrative exposure therapy, cognitive behavioral therapy, and stress inoculation training can all be effective in working with this population. There are also many additional methodologies and theories that can also be used, many of which have been thoroughly researched and tested in the field. The theories presented here are just a sample, and provide an example of how
further methodologies might also be applied to working with torture survivors. As practicing therapists, the best way to provide successful individual treatment is to be well-versed in many methodologies and to understand when to use which therapy.

**Cross Cultural Application of Theories**

It is impossible to discuss treatment of the population of torture survivors without also engaging in a discussion of multicultural concerns within counseling. This is a vast subject in itself, but for the purposes of this review it is condensed to basic principles. Within the field of psychology, a great deal has been written by American authors about American subjects. The vast majority of the field is dominated by a Western, and primarily an American, methodology. Yet psychology as a field claims to be the study of the human mind as a universal, not merely of those within the narrow dimensions of Western civilization (Arnett, 2008). Thus, it is rather problematic to assume that the studies of one small corner of the world answer questions about human nature as a whole.

As practitioners, we must therefore be aware of the assumptions inherent within these problematic psychological conclusions, and the limitations that exist as a result. This becomes a discussion of cultural universality versus cultural relativism. All theories of human development arise from a cultural context, and imposing Western values of any sort may constitute cultural bias (Sue & Sue, 2013). In working with refugees, it is important to recognize that cultural values are likely different. Pushing a client to uphold Western values (such as female independence, democratic parenting styles, or individualism and autonomy) may be asking the client to accept thoroughly foreign concepts. Therapy will be more effective when counselors are able to work within a client’s own set of cultural values.
Aside from understanding cultural bias, working with this population also requires a certain amount of understanding about the difference in psycho-education worldwide. Though Americans are far from perfectly informed about mental illness, there is still generally a higher level of understanding about psychological disorders than in many other places in the world (Sue & Sue, 2013). Many immigrants, therefore, take a somatic view of psychological disorders, and believe that their physical problems are causing their mental distress. It may be helpful for therapists working with refugees to begin by addressing those somatic symptoms first. Similarly, education about disorders like PTSD may provide refugees great comfort, as they learn that they are not simply “going crazy” (p. 468).

The most important factor in working successfully with clients of different cultures is seeking better understanding of those differences. By doing diligent research about the ethnic, religious, national, racial, or sexual identity of each client, therapists can broaden their own views and learn to practice within the scope of the individual. This is not a concept strictly true for immigrants or refugees alone; indeed, no client will ever come from precisely the same cultural context as anyone else. We must always strive to learn as much as possible about the background of those with whom we work. However, in the case of refugees this becomes especially important because even a minute cultural misunderstanding can lead to failure within therapy.

**Issues of Therapist Self-Care and Transference**

As a practicing psychotherapist, it can be easy to fall into a routine seeing clients on a regular basis. Ongoing sessions, client notes, and consultations can fill up a workweek quickly, leaving very little time for regular reflection and introspection. It is
important for all therapists to monitor their own mental wellbeing, but for those working with survivors of acute trauma this kind of self-care becomes absolutely crucial. Listening to others’ stories about torture is in itself a traumatizing experience. The effects of hearing about trauma may seem trivial compared to the pain of actually living through such events, but they are measurable especially when compounded by multiple sessions, and if left untreated can become intrusive in both work and personal life. This phenomenon is referred to as vicarious trauma, and is a form of psychological transference (Shapiro, 2010).

The impact of vicarious trauma has been examined both quantitatively and qualitatively in recent studies. These effects can range from negative emotions, to stress, anxiety, and somatic symptoms (Figley, 1995). For vicarious trauma to occur, three components must be present: secondary exposure to distressing or traumatic material, experience of distress, and shifts in cognitive schemas to integrate the traumatic material into the therapists’ ways of viewing themselves (Aparicio, Michalopoulos, & Ulnick, 2013, p. 204). The Vicarious Trauma Scale (VTS) was designed to measure these effects on workers in two dimensions: affective and cognitive impact. Results from the 2013 study show that the scale is able to accurately measure the first two components of vicarious trauma (secondary exposure and distress) but not necessarily the third (shift in cognitive schema). Measurements scales such as the VTS are one way for employers and clinicians to monitor effects of working with trauma, but they are certainly not perfect indicators.

Interestingly, the dramatic effects of working with trauma survivors are not necessarily all bad. A 2013 journal article in Psychological Trauma: Theory, Research,
Practice, and Policy reported that in fact the effects of positive emotional growth are just as measurable as the effects of negative emotional impact, explaining that “the two processes of vicarious trauma and vicarious posttraumatic growth stem from an empathic engagement with traumatized clients and occur as a result of challenges to current cognitive schema that lead to their adaptation” (Cohen & Collens, 2013, p. 577). Though posttraumatic growth can be a beneficial experience, it is also extremely important that clinicians be wary of this tendency, and are careful not to use client sessions to process personal issues. What is certain is that working with survivors of great trauma is a tremendously impactful experience.

In order to counter the negative effects of working with trauma survivors, techniques of self-care can take many forms. These approaches can include professional, organizational, and personal strategies (Figley, 2002). Professional strategies of self-care include licensed supervision and informal peer discussions. Therapists and other workers with trauma should always undergo regular supervision to ensure that they have a chance to process their own thoughts and feelings. Organizational strategies of self-care require limiting exposure to traumatic material as necessary. Working with trauma may simply be a part of a therapist’s job, but it is important to recognize how much exposure is too much. This is especially true for clinicians working abroad in the field with refugees, where it is not just work within sessions but also daily life in or around refugee camps that contributes to stress. It is important for practitioners to recognize when they reach a limit of exposure, and must take a step back from intensive practices.

Personal strategies of self-care can be further divided into categories of physical, relational, and cognitive strategies. Physical strategies include activities such as sports,
running, yoga, walking, and dancing. Relaxation techniques such as meditation and mindful breathing also fall into the category of physical self-care strategies. Even making the effort to eat and drink healthy and enjoyable foods and getting sufficient sleep contributes to physical wellbeing. Relational strategies refer to a clinician’s ability to process feelings with friends, coworkers, and mentors. This does not have to occur in formal supervision, as long as no personal details about clients are divulged. Journaling is another technique for processing emotions apart from sharing with others. Cognitive strategies involved specific techniques of distraction. Watching television, going to see movies, reading books, or going out with friends are all options for cognitive strategies of self-care (Shannon, Simmelink-McCleary, Im, Becher, & Crook-Lyon, 2014).

Proper monitoring of emotional wellbeing is critical for those working with trauma and torture survivors. Vicarious trauma and transference of emotions is a very real and potentially dangerous result of this kind of work. In order to help others in this field, clinicians must monitor themselves for these symptoms. There are a large number of self-care techniques available to help counselors who struggle with vicarious trauma, and keeping up with such strategies can sufficiently combat these issues of transference. This kind of mindfulness is necessary in order to maintain clinicians’ mental and emotional wellbeing, and also to ensure that they continue to be grounded and effectual practitioners.

**Methodology**

The references for this paper were compiled from a variety of resources. Fifteen journal articles were obtained from the Adler Graduate School’s EBSCO Host database for students. Ten other articles were obtained from Carleton College’s JSTOR database
through alumni access. Eleven of the books referenced were purchased off of Amazon.com in paper or electronic versions, and six were bought through the Adler Graduate School bookstore. Other references were obtained online through newspaper websites including The Washington Post and CNN. Others came from public websites including the United States Code of Laws and press releases from The White House Office. Many resources were suggested through instructors of AGS classes, and others were recommended by Paul Orieny, PhD, LMFT, and Linda Valerian, LPCC.

For the purposes of this paper, the term “torture” is defined using the interpretation of the United States code of ethics, as an “act committed by a person acting under the color of the law specifically intended to inflict severe physical or mental pain or suffering (other than the pain or suffering that is incidental to lawful sanctions) upon another person within his custody or physical control” (U.S.C § 2340A, 2006). To this end, torture must be committed under the color of the law, meaning that domestic violence and relational abuse would not fall under the category of torture. Victims of trauma incidental to war and unrest are also not necessarily victims of torture unless the trauma is specifically directed towards them.

Additionally, the terms “counselor,” “therapist,” and “clinician” are used interchangeably to refer to mental health practitioners performing psychotherapy with torture survivors. The paper was written primarily for practitioners working in the United States, though it also addresses some of the concerns of those working abroad in or around refugee camps.

This is an extensive topic of study, and admittedly the length of this paper is not sufficient to thoroughly examine all aspects. In light of these limitations, the information
presented was chosen to provide a broad overview of the most important factors of working with the complicated population of torture survivors.

**Summary, Conclusions, and Recommendations**

Torture is a vastly complicated subject, and every government struggles with its existence. Even the United States, a country which loudly declares torture as an abomination against human rights, is guilty of committing acts which were inarguably torturous. In December 2014, reports from the CIA were made public which described the inhumane practices committed in response to the 9/11 attacks. Responding to these documents, President Barack Obama declared in a statement to the press that these techniques were “inconsistent with our values as nation” (The White House, Office of the Press Secretary). If it can happen in a country that claims to be opposed to the use of torture, it seems impossible that torture could ever be eradicated from countries with rebel governments and far less order. Torture may be inevitable to some degree, so long as humanity exists. As long as this is true there will also always be survivors of torture, struggling to piece together fragmented lives. With this dark truth in mind, there is a great need for mental health practitioners equipped with skills to treat these survivors.

**Summary**

This paper sought to identify the fundamental concepts most important to the psychotherapeutic treatment of survivors of torture. Understanding the very definition of torture as well as the history of its use worldwide provides a necessary context for the complexity of the trauma that survivors have endured. A deeper examination of the neurological functions associated with trauma allows clinicians to comprehend the way implicit and explicit memories are stored and why post-traumatic stress symptoms occur.
Finally, mastery of a wide variety of therapeutic methodologies as well offers clinicians many techniques for work with torture survivors. Yet thorough knowledge of these factors alone is not sufficient for true success in this field. Effective psychotherapy relies on the nuance within this research and the deep connections between each of these separate components.

The nature of torture results in multiple traumas. Survivors often face the loss of loved ones, limbs, physical health, jobs, and homes. Any of those losses alone would result in major life transitions, and could require significant therapy to gain coping skills. Compounded, the effects are truly devastating. On a neurological level, the memories associated with each of these losses affect survivors because of the way in which they are stored. Traumatic events, stored as implicit memories, can be recalled without warning or triggered by present occurrences. As those memories are recalled, survivors experience sensory and emotional reactions as though they are truly happening again.

Understanding what is occurring on a neurological level as these traumatic memories are triggered is the premise to all therapeutic methodologies. Successful therapy allows clients to gain conscious control over how and when they access these memories. In doing so, painful implicit memories are converted to explicit recollections. Explicit memories can be recalled at will, and are not nearly as emotionally potent as the actual experience. Narrative exposure therapy allows clients to tell and re-tell stories about traumas they have experienced, and in putting words to the episode and ensuing emotions they gradually transform implicit recollections into more manageable explicit memories. Cognitive behavior therapy offers clients the power to consciously identify
problematic thought patterns surrounding traumatic memories and to make changes to elicit more productive thoughts, ultimately converting implicit to explicit as well.

These methodologies of therapy are also directly linked to the nature of torture and its effects. While addressing neurological functions, therapy must respond to the personal consequences of torture as well. Individual psychology stresses the importance of encouragement within the therapy process. For clients who are struggling with a new society and a foreign language on top of multiple serious traumas, encouragement is key to building a trusting relationship and beginning healing. Furthermore, the reality of day-to-day struggles often means that these clients could have trouble applying therapeutic concepts outside of sessions. The methodology of stress inoculation training allows clients to put new skills into practice within sessions themselves, learning both theory and practice at once.

**Conclusions**

Work with survivors of torture is unique among work with trauma for many reasons. Often, torture survivors have been forced to leave countries of origin, and are navigating a new society. Clinicians must be aware of these challenges, and recognize that clients can only address psychological trauma once they have also addressed more basic needs such as secure housing and food. Referring to Maslow’s hierarchy of needs can help therapists structure goals appropriately. Without assistance acclimating to a strange new country, the trials of daily life can sometimes cause ongoing minor trauma for victims who have already experienced immense traumas.

A clinician may also find that survivors of torture frequently have great reason to mistrust those in positions of authority, including therapists. A trusting relationship is
crucial in all therapy with survivors of trauma, but this fear is particularly notable in torture survivors. For this reason, clinicians must be prepared to spend a large amount of time—perhaps months or years—building a solid foundation for the therapeutic relationship. Through consistency and patience an alliance can be built, but clinicians must be prepared for this step to happen slowly.

Another unique aspect of working with torture victims is the presence of cultural barriers within therapy. Assumptions are dangerous, and cultural biases can occur even when a practitioner is diligent. The author of this paper experienced the danger of such assumptions in working with a survivor of torture who spent the majority of a session looking at the wall and making very little eye contact. It seemed, initially, that this woman wanted nothing to do with the therapist, and was avoiding connection. However, upon being asked if her eyes were bothering her, she replied that the overhead fluorescent lights were disturbing her. After those lights had been switched with a softer floor lamp she grew much more comfortable, began to make eye contact, and eventually confided that her eyes were sensitive because she had experienced torture with severe bright lights. Though the assumption that a client avoiding eye contact was unwilling to engage in therapy seemed like a benign reading of her body language, had it not been addressed this client may never have felt comfortable opening up. It is critical for practitioners working with survivors of torture to notice even the most minute assumptions, and be sure to clarify all potential misunderstandings.

Survivors of torture present a unique challenge to psychotherapists. Their traumas are complex, and in the case of many refugees some trauma is still occurring every day. There are additional challenges in forming a therapeutic alliance, and there are constant
cultural barriers and assumptions in the way of clear communication. It is only through a highly nuanced understanding of all of these factors that clinicians can formulate effective treatment plans for individual clients. There is no pre-determined script for how to find success with each case. Rather, each survivor must be focused upon uniquely, taking into account an understanding of torture, but ultimately forming a solution based on communication and trust.

**Recommendations**

This is far from a comprehensive study of the most important factors and methodologies in working with survivors of torture. For further research, the author of this paper would recommend a more thorough examination of the question of reintegration with society. Integration does not occur separately from therapy, rather it should happen simultaneously. Therapists can provide great support for refugees finding their place in new cultures, but there is also more need for societal support in forms such as education, financial support, or housing. Reintegration is an important piece of emotional healing which warrants further investigation.

Additionally, there are many methodologies of therapy which have been proven to successfully treat post traumatic stress symptoms beyond the four which are illustrated in this paper. Clinicians working with survivors of torture may find further research into these theories useful:

- Psychodynamic theory
- Transactional analysis theory
- Gestalt therapy
- Attachment theory
• Dialectical behavioral therapy (DBT)
• Eye movement desensitization and reprocessing (EMDR)
• Levine’s SIBAM model
• Ego state therapy
• Sensorimotor and somatic techniques

As stated throughout this paper, the most effective treatment for victims of torture is a personalized model for every individual rather than a prescribed method applied blindly to all clients. Becoming familiar with a great number of methodologies offers more techniques for individualized therapy. Furthermore, the field of psychotherapy and trauma is a rapidly growing area of research, and there are constantly new therapies being tested and modified. Effective clinicians must stay aware of new information in order to revise and perfect their own practices.
References


Convention Against Torture, *supra* note 1, art. 1(1).


