Preface

Once people have decided to eliminate evil, they may discover that to some extent they also suffer from the very thing they are trying to combat in others. This realization is a great challenge to one’s own professional intellectual makeup, and requires good colleagues.

I have interviewed several torture survivors and their therapists. An important part of the therapeutic process is for the evil to penetrate both of the individuals involved, for the therapist must also feel the torture, in a figurative sense, in order to be able to eliminate its effect. This is a great and often superhuman task, but I have seen myself how torture survivors, together with their therapists, have in the end found a new meaning in life, enabling the survivors to keep going.

I have taken part in this process as a supervisor. My most important functions were to create an environment for reflection and to establish a professional culture in which the therapists could protect their work. This required a special combination of comradeship and professionalism.

Together with the psychologist Rasmus Jordan and the psychotherapists at the Rehabilitation Center for Torture Survivors in Copenhagen (RCT), I took part in establishing a supervision room from 1988 to 1995. We called it the “fifth province” to indicate a group of people who met to create their own culture. The death of Rasmus Jordan in 1992 was a great loss; we had to continue on our own.

Supervision takes place in a closed room. One big problem is that such a room can feel too closed, can detach itself from the life of the institution as a whole; such isolated work can appear like a form of subversive activity. However, the psychotherapists at RCT were extremely generous in allowing me to interview their clients about the results of their treatment. It is rare for therapists to allow someone to intrude on their work. It was my task to accept this generosity and to return it by way of professional feedback, a contribution to their difficult work. This book is the result.

The book is written for professionals and may therefore at times be difficult to understand for those without a psychotherapeutic background. But with
Torture is among the most gruesome of human manifestations, particularly because it does not have its origin in animals, primitive man, or pre-culture. On the contrary, it is planned, and it stems from social order. It is a display of force, the aim of which is to break an individual’s judgment. As a consequence, it breaks down parts of the victim’s personality. The greatest challenge to the torture survivor is therefore to remain a human being under these inhumane conditions.

Torture gives an insight into some terrifying contradictions. For instance, torturers are not particularly perversely sadistic; they are often “normal” people. Their crime is a consequence of a social order that often has mutual popular support. The victims themselves are dehumanized by the crime, inform against their friends and families, and admit to crimes they may never have committed. All these contradictions are so difficult to sustain that they cause the worst repressions of all—silence and indifference. Either we deny the problem and leave the torture survivors to their own self-healing, or we ascribe the torture trauma to ordinary psychological/pathological reactions, to be treated the same as in ordinary patients in crisis. It has become one of the orders of the day to talk about being in a crisis, and crisis intervention has become everyone’s property.

It is disheartening to confront this silence or generalization. Even clinical psychology has been hit by this mental block, and the most gruesome subjects—violence and terror—escape our research interest and are surrounded by silence, though subtopics such as trauma syndromes and the treatment of post-traumatic stress are dealt with. Of late we have also seen some publications on torture survivors, and there are many ongoing treatment activities. But the topic of “torture survivors and their treatment” needs to be taken on by the academic world for a clarification of concepts and theories in relation to other research and development within psychotherapy and for cross-cultural understanding.

There are several reasons for the torture survivors’ silence and mental block. In the transition of the welfare state we have become survival artists.
the psychological results of war and flight and their psychosocial con-
sequences. This subject will be mentioned here only briefly; fortunately some
clear-sighted researchers and clinicians have already begun to give it top pri-
Willingen 1993).

The practice of state-organized violence, including torture, constitutes a
worldwide epidemic (Basoglu 1993). This book focuses on torture survivors,
but it also has relevance for prisoners of war (POWs) and for those exposed
to the multitraumatic situation of the consequences of wars, especially flight
and emigration. Former prisoners of war and refugees number several mil-
lion people in the United States and more than 20 million refugees world-
wide. Health records of POWs imply that acute or subacute sequelae of tor-
ture are presented infrequently to clinicians in the United States. More com-
mon are the chronic medical, neurological, and psychiatric disorders that
recur over a lifetime and manifest themselves in later life. Refugees and
POWs from wars half a century ago may not relate their current health
problems to trauma, malnutrition, and losses that occurred decades ago.
Clinicians must compensate for such oversight (JAMA 1996).

Historical Background

A number of scientific papers have already been published about torture sur-
vivors and their treatment. A rehabilitation practice has been developed, and
treatment centers have started to appear. By 1995, sixty-seven centers for the
rehabilitation of torture survivors had been established in forty-three coun-
tries (Torture 1995). Some centers focus more on the medical aspects, oth-
ers on the psychotherapeutic, and some take a psychosocial approach in-
volving a cultural and social network.

Psychotherapy of torture survivors as an institutionalized practice origi-
nated in the Danish rehabilitation center for torture survivors (Rehabilita-
tion Center for Torture Victims, or RCT), founded in 1982. It was estab-
lished as a result of the experiences of treating survivors from the concen-
tration camps of World War II. Another important basis for psycho-
therapeutic rehabilitation was found in the treatment in the United States of
veterans of the Korean and Vietnam wars. Symptoms such as flashbacks and
uncontrolled outbursts of anger stimulated treatment research and the de-
approaches can no longer be used as models. Nevertheless, both have had a conceptual effect on the treatments that have been carried out elsewhere, although usually each new center has built on or adapted to the existing knowledge and limitations (see review in Cunningham & Silove 1993, Landry 1989, van Willigen 1992). In London, as in Toronto, a decentralized network was created, but it specialized in forensic medicine. In Paris an integrated medical, social, and legal system was created, which in the beginning focused less on psychological treatment. In Holland the treatment became part of the official national health system, and one could concentrate more on cultural and psychological rehabilitation since the survivors had been invited to the country and therefore did not have the problem of applying for asylum. In Belgium a group of therapists was formed that consisted of exiled psychologists and social workers united by political and cultural convictions. In Boston a group was established that had close contact to Harvard University and was therefore given status as a hospital unit, although the therapists were exiles and did not want to create the atmosphere of a medical institution.

The financing of these centers varies but is considered insufficient in all cases. Some are government financed, others rely on donations from volunteer organizations. Amnesty International, the International Rehabilitation Council for Torture Victims, and the United Nations Voluntary Fund for Torture Victims send representatives to meetings and evaluate treatment initiatives as projects. Although these organizations cannot finance the creation of treatment programs and centers, they make a contribution by giving international attention that may lead to financial donations. Some centers within the torture survivors’ own domiciles survive without economic support of any kind and are even persecuted by the local governments.

It is difficult to give a fair account of the variety of treatment activities. To evaluate them comparatively is completely impossible, since they work under such varied conditions. Van Willigen has written a detailed review of treatment and rehabilitation activities, in which she divides the centers into three broad categories: those situated in the survivors’ home countries in which torture is or has been practiced; those in Western countries; and those in countries of the same cultural region as the torture survivors’ home countries (van Willigen 1992: 280).

Political repression is usually a very real threat for the centers working in the torture survivors’ own country. Their similarities are therefore greater and are marked by strong political involvement and acts directed toward
Definition of Torture and the Fight for Democracy

“Torture” is relatively simple to define, and in practice there is seldom any doubt as to whether a person has been exposed to torture (Genefke 1993a, b, Montgomery & Foldspang 1994).

In the United Nations Convention of December 1984, torture is described as follows: “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 intimidating 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 another person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.”

There are some aspects that are not included in this definition, but which the treatment of torture victims has revealed. The aim of torture is not always to make the victim confess and give information. The primary aim is more to break down the identity of the victim. The pain consists in particular in this breaking down and in the destruction of the personality.

Cassel (1982) writes in an analysis of the nature of suffering that it reaches its maximum when it threatens to dissolve the person’s integrity. Even if the suffering is caused by physical pain, it is the psychological component which is the actual core of the suffering and which culminates when the pain threatens to destroy the person’s intactness and integrity (Cassel 1982: 640). In discussing a theory of violence Gilligan (1996: 96) wrote: “The death of the self is of far greater concern than the death of the body.”
ing a dog, self-defense, road fatality, contract killing, homicide, murder, dropping an atomic bomb, etc.” (Kuschel 1991: 17). In order to understand an act of violence one needs to look at the conditions that start and maintain the action, and at the conditions that make its control difficult.

Similarly, it may also be difficult to make use of concepts about aggression and violence when describing the conditions to which severely traumatized patients have been exposed. It is therefore important for a definition of torture to be relatively simple and to be applicable in various cultural contexts. If imprecise definitions of violence and aggression are attached to its practice, one may well change their meaning so that an action, seen from various cultural perspectives, may be misinterpreted. For instance, “to beat one’s wife” may be considered “wife battering” in one context, but in another context it may be a manifestation of a husband’s interest in his wife. This was the case described by Chagnon among the Yanomami Indians, where “women expect that kind of treatment and where many of them measure their husbands’ interest in them in relation to the number of small strokes they use for ‘a kiss’” (Chagnon 1977: 82, from Kuschel 1991: 26).

To understand torture survivors and their therapies, we must be prepared to redefine some central concepts. What Western societies consider as torture does not necessarily have the same meaning in other societies. For instance, the Western world’s great attention to torture and other violations in developing countries has been called an act of indulgence in order to obscure the fundamental problem of the economic inequality between rich and poor countries. When in June 1993 Amnesty International introduced the concept of torture at the Vienna Convention and applied for help to document it and to treat torture survivors, several developing countries reacted by claiming that the real problem was one of development. To end torture, they preferred development aid to equalize the economic differences rather than humanitarian aid.

The use of torture may thus be considered a symptom of a more serious underlying problem. While some forms of torture are considered harmless in some countries and not as violations of human rights, in other countries they would call for an unambiguous appeal for humanitarian and human rights intervention.

It is therefore important to be prepared to understand the cultural, social, and political context in which our concepts about torture and treatment were formed. As with the concept of torture, our psychological concepts of violence and aggression may be of no value for our understanding of, or as guidelines for, a theoretical development, because these concepts were de-
years and I’m not interested in it any more. It’s very interesting the first 50 times or the first 500 times when you have the same phobias and fears. Now I can’t get so worked up any more” (Herman 1992: 195).

I stress this repetitive immobility here in the beginning to emphasize the danger of being led astray and perhaps of being attracted by the external drama that makes one react with anger and indignation. Engagement is important for scientific work, but one should not succumb to the indignation of the moment or one’s culture but be able to penetrate the mobility and try to get to the underlying, predictable, and constant structures.

In the same way, in the real work with torture survivors, it is necessary to understand that treatment demands a lot of patience and perseverance from the therapist. Again and again the therapist must work with the personality structures that have been destroyed by torture and that continue to appear on the therapeutic scene with monotony and obsessive repetition.

Torture’s Three Partners

When we hear about violence and torture, they are typically described in different ways, according to the person’s position and role in relation to them. The words “violence” and “torture” are used only by those who are witnesses or by the victims themselves. Those who practice violence, on the other hand, use other forms of description and look at their deed as a necessary and justifiable action. For instance, a terrorist will argue that his actions are legitimate while a victim considers them illegitimate. Both refer to social norms and values, and each of them assert that justice is on their side.

As the anthropologist Riches has said: “When the term ‘violence’ is being used, attention should crucially be focused on who is labelling a given act as such and most especially their social position. It follows that violence is a concept which can easily be manoeuvred into an ideological ambivalence, coming particularly to symbolize moral impropriety in a range of actions and policies” (Riches 1987: 4).

Torture has three partners: the torturer, the victim, and the witness. Each has his own language to describe the same external occurrence. It is typical that the different actors—the military and the torturer, the victim and the survivor, and the therapist and the human rights activist—emphasize different aspects of the torture scene.

Elsewhere I have analyzed how an attack was described by the different actors involved in it: the military, the guerrilla, the government, and the peo-
• The structure of violence contains the paradox that some of the qualities the therapist tries to fight in others become an essential characteristic of the therapy. For example, the therapist may unwittingly harm the client by emphasizing that he should recount his traumatic story in order to relive and work through it, similar to the situation in which the client was forced by the torturer to undergo the worst kind of humiliation and devastation.

• The treatment institution may to a large extent repeat the same repression mechanism if it does not clarify its own background and methodology, for example in supervision. The survivor’s pathological reactions are transferred to the therapist, who may project them onto his organization, so that several parallel situations arise within the institution. A paranoid attitude among the staff and suspicions of seeking power and control, as well as authoritarian forms of leadership may suddenly stop a spirited debate. Machiavellian techniques are then used to stop criticism.

• Other ways of transferring the trauma of the torture scene may be by politicizing it, so that the survivors are considered almost as heroes. The consequence is that those survivors who do not appear as heroes feel guilty and weak because they broke down and confessed. The opposite reaction may be an isolation and separation from the survivor’s social and political milieu, and the survivor is transformed into a patient with a pathological syndrome and therefore the therapist resorts to traditional clinical methods.
The number of scientific articles on which we have been written about the psychological and social sequelae of torture are increasing at great speed. For example, a “MEDLINE Psychinf” search by Somnier et al. (1992: 36) gave about 151 references in 1992. The same search in 1994 produced 221 references and in 1996, 303 references. Furthermore, from their work with torture survivors, psychotherapists have reported on their experiences in their own practices (see review in Bustos 1992: 334, McIvor & Turner 1995). Some of these reports have been given the status of textbooks, for example, Basoglu (1992), Danieli et al. (1996), Herman (1992), Hjern (1995), Kleber et al. (1995), and van der Veer (1992). Thus there is sufficient psychiatric and psychological literature to give a detailed description of torture’s sequelae and their treatment. But there are few systematic research results. It is as though this very engaging and absorbing work has given researchers a moment of advocacy that has removed them from their academic attachment to other psychotherapeutic research.

Some therapists are ambivalent about undertaking a traditional course of treatment because they believe that torture is a political phenomenon and the victims should not be classified as psychiatric patients (Kordon et al. 1992: 451). This ambivalence reflects an important problem: research should not only describe, understand, and explain torture and its sequelae, but it should also provide effective strategies to fight it. The question is whether these two roles—the traditional scientific role and the political advocacy role—can be combined (Hastrup & Elsass 1990). Mollica (1992: 30) writes that “torture treatment advocates here failed to critique their own clinical services through well conducted evaluation research.”

The following discussion is therefore not based on systematic research re-
Stress as a Psychopathological-Provoking Factor

Most PTSD conditions are easy to treat, and professional involvement is often not necessary. But Horowitz showed that the prognosis is poor when there is a latent period of more than six months from the time of the trauma to the appearance of the most pronounced symptoms, just as when there has been no change in the symptoms for more than six months. Thus, delayed or chronic PTSD conditions are difficult to treat (Horowitz 1986: 244).

The many empirical studies do not give any clear guidance for predicting which psychodynamic personality structure may give rise to specific reactions. However, Horowitz (1986: 241) has found that some personality structures present special reactions to serious life events, but these results are not particularly conclusive. There are even examples of the same personality factors being predisposed to greater resilience in some cases and to greater vulnerability in others. It is remarkable that in population studies, the larger the exposure to serious life events such as natural catastrophes, the more stress disorders there are. But these studies do not give a better understanding of the psychodynamic content of stress disorders (Horowitz 1986: 241).

Some empirical studies show the relationship between trauma and mental disease. It is known that in general about 60 percent of patients with a psychiatric disorder have experienced a stressful situation two weeks before the start of the disease. By comparison, 20 percent of the population without the mental disease have experienced a similar stressful event (Brown & Harris 1978). Paykel (1978) concluded that in the period after a traumatic event there is a sixfold increase in suicides, a twofold increase in depressive disorders, and a somewhat smaller risk of developing schizophrenia-like conditions. But it can be concluded in summary that most serious losses, injuries, and disasters do not lead to the development of psychiatric disorders.

The empirical studies of the relationship between stress and psychopathology cover victims of violence as well as survivors of natural disasters, concentration camps, and torture (Horowitz 1986: 245, Elklit 1993: 75). Horowitz appears to be the only one who gives empirical examples that preexisting functional deficits are able to explain a person’s reaction to trauma, but he notes that it is not always in a predictable way. For instance, some people with anxiety and depression can sometimes be surprisingly resistant to traumatic events, perhaps because the post-traumatic condition is well known to them, much more so than to people without psychological problems. Furthermore, Horowitz’s empirical work shows that neurotic impediments to processing stressful life events can cause great vulnerability. For
Beal (1995) has demonstrated that for many veterans who were taken prisoner of war, PTSD has lasted fifty years.

Herman (1992) and Lansen (1993, 1994) have extended the PTSD diagnosis with a “complex PTSD-syndrome” that can include extremely traumatized clients, such as torture survivors. Others have stressed that torture is only one of a series of traumas and therefore characterize the torture syndrome as an “ongoing traumatic stress disorder” (Straker 1987).

**Extremely Psychotraumatization**

(Lansen 1994)

- Chronicity of symptoms (also called “complex PTSD”).
- Parallel diagnoses such as depression.
- Clinically difficult to classify personal suffering, for which the diagnosis “depression” or “dysthymia” is not satisfactory, and to which sometimes the diagnosis “existential emotional syndrome” is used.
- Severe affect regression, with reduced affect tolerance, anhedonia, and alexithymia.
- Proneness to new traumatization by seemingly innocuous events or normal life events.
- The internal representational world may be permanently affected by elementary patterns of aggression and victimization. It concerns cognitive-affective schema’s that appear to lie dormant but have a tendency to dominate in interpersonal interaction. This may especially harm the relationship in intimate interpersonal processes: with partners, children, and also therapists.

Based on their experiences with severely traumatized clients, Ramsay et al. (1993) and Turner & Gorst-Unsworth (1990) have suggested four themes they consider unique for torture survivors: (1) incomplete emotional processing, (2) depressive reactions, (3) somatoform reactions, and (4) existential dilemmas. Incomplete emotional processing includes many of the types of reactions of PTSD. The depressive reactions, however, are different, since PTSD as a concept is put in the same category as anxiety conditions, but because of torture’s many losses, the depressive conditions will often overshadow the anxiety. The somatoform reactions are also known from many stress-related conditions, but torture survivors often complain of several physical symptoms that partly suggest real sequelae of torture. They also in-
pression, not only because of the lack of “abreaction,” but also because the
cognitive process becomes distorted.

The phenomenology of the trauma is a paralyzed, overwhelmed state
with immobilization, withdrawal, and with a probability of depersonaliza-
tion and disorganization. The trauma challenges the person’s evaluation of
his own strength and questions how close he is to helplessness. Freud em-
phasized that it was the subjective experience of helplessness that decided
whether a situation would become traumatic, compared with another dan-
gerous situation. In this connection, the helplessness includes surrender and
giving in (Krystal 1988: 143).

Many torture survivors describe how the most traumatic event was that at
a certain point they surrendered; from active resistance they gave in and con-
fessed. In the same way, there are also Holocaust descriptions of how the Eu-onean Jews obeyed orders in an automatic way, took off their clothes and,
together with their children, lay down on top of the corpses of mass
graves and waited to be shot. In another sense, it is just the passive surrender
that marks many of the survivors many years later when suddenly they also
collapse physically and have no resistance against insignificant infections.

The Stimulus Barrier

The concept of “the stimulus barrier” can further qualify the nature of the
psychological trauma in torture survivors. Originally, the concept referred to
the perception and threshold for the outlet. Anna Freud’s viewpoint was that
the organization of the defense mechanisms of the ego created a protective
shield, and that any event in which the defense mechanism did not present
sufficient competence could be potentially traumatic (A. Freud 1942, 1967).

But it is not necessarily the intensity of stimuli that decides whether a sit-
tuation becomes traumatic for the individual. Even though many studies
have shown the severity of the traumatic stressor as a significant predictor of
post-traumatic stress disorder, few investigations have studied the stressor
dose–response relationship in torture survivors (Basoglu 1995). A unique
study has shown that despite the severity of a trauma, the number of expo-
sures to torture did not predict post-torture psychological problems,
whereas ratings of perceived distress did (Basoglu 1995). One reason is that
the challenge to the integrity of the ego comes rather from the meaning and
the resulting affective reactions that the situation presents.

We should not be seduced by the fact that Freud was originally inspired by
Newtonian physics when he founded his psychodynamic theory, but we must always remember that it is the subjective meaning of an external situation that is decisive for the understanding of the kind of situation that becomes traumatic for the individual. Thus Krystal refers to a study on psychic trauma in children by Terr (1979, ref. from Krystal 1988: 217), in which a group of children were kept hostage in a school bus for 27 hours. Even if they were exposed in this way to a seemingly traumatic situation, several of them did not experience the situation as traumatic and did not react with PTSD symptoms.

The severely traumatizing situation is characterized by the helpless surrender to what the person sees as an unavoidable danger. From this viewpoint the reactions can be expressed in “the psychogenic death” or be stopped at an early stage and manifest itself as an automatization or robotization of the person’s functions. The person who remains in this state for a long period of time can have continuous and specific symptoms of psychopathology, the so-called torture syndrome. From this viewpoint the symptoms will not have a purely traumatic origin but are a result of the mental changes and adaptations to the trauma. The defense mechanisms will be efficient in repressing the trauma, but in the long term they can give some permanent changes of the defense structure, resulting in psychopathology. These changes should prevent new traumas from breaking down the personality and can be looked at as an immunological reaction to prevent further traumatic experiences.

It is typical that the torture survivor asks for treatment because of the symptoms caused by a deficient defense system such as poor concentration, nightmares, and experiences of depersonalization and derealization. These reactions have “defense features” when seen retrospectively, and they should prevent experiences that are even worse than the unpleasantness of the altered ego structure. The stimulus barrier protects the person against reexperiencing the previous psychological trauma by blocking some functions, such as the imagination and the ideational representation. In the same way, the person’s capacity for pleasure, happiness, and satisfaction can be inhibited and result in anhedonism. These costs are thus the price for being able to block the intense and extreme pain. But it is just this same stimulus barrier that can block psychotherapeutic work.

Two Trauma Models: “Strain Trauma” and “Shock Trauma”

Freud emphasized that there was a difference between traumas of adult life and of childhood, and he worked with two separate models; one was “the
arousal in the torture survivor shows itself by marked physiological manifestations in the form of increased somatic illness such as high blood pressure (van der Kolk et al. 1984). Psychosomatic complaints are part of Niederland’s “survivor triad,” consisting of sleeplessness, nightmares, and psychosomatic complaints (Niederland 1968a, b, ref. from Herman 1992: 94). These symptoms give associations with the psychosomatic conditions in which the therapist, as an external regulating factor, must replace and re-create the destroyed homeostasis in the client.

The Visitation

As in all other psychotherapeutic work, the visitation is very important. The task with the torture survivor is the same as with other psychotherapy candidates—that is, to get an impression of the quality of mental functioning, in particular with respect to the strength of the ego. In this way the therapist may get an idea to the degree of the extent to which he should emphasize supportive or explorative working methods.

By tradition, the ego function includes reality testing, intelligence, verbal skills, evidence of object relations, a good work or school history, and being psychologically minded. Suitable candidates for psychotherapy should therefore be attentive to their feelings, be able to verbalize them and to tolerate them even if they are painful, and furthermore they should have enough “basic trust” in order to be able to enter into a therapeutic relationship. Werman (1981, 1992) emphasizes the importance of a high degree of motivation in clients, an autoplastic conviction in the sense that their psychological liberation primarily depends on changes that will occur in them and will come about only if they strenuously try to effect those changes.

It is evident that many torture survivors cannot at all live up to these requirements. If they could, they would probably not be in need of psychotherapy.

However, it is not the primary aim of the visitation to separate the unsuitable from the suitable. It is rather to obtain a psychodynamic understanding of the torture survivor that may form the basis of later therapeutic work. Ideally, therapy should take the shape of an examination in which the therapist lets herself be guided by hypotheses, with some of them already formulated during the visitation. An important hypothesis in the work with torture survivors is the question of the fragility of their ego structure, and the extent to which torture has made them approach the borderline psychotic state.
**Pitfalls in Using Supportive Therapy**

With respect to supportive psychotherapy, three conditions should be emphasized as big challenges and pitfalls.

First, the method demands great therapeutic experience. One of the basic mistakes is that this therapy is left to less experienced therapists because of its manipulative and suggestive techniques. It is wrong to assume that it can be left to a younger therapist, since there may not be room for refined psychoanalytic interpretations and clarifications.

Two other problems are the establishment of treatment goals and termination, two closely linked conditions. Especially when there is a cultural difference between therapist and client, it may be difficult for the therapist to accept that psychotherapy is an exclusively Western phenomenon that includes a clear demarcation of the difference between a friendly and a professional relationship. The precondition of the treatment is that both parties find at least some common treatment goals to work with. Different goals will lead to delay while the parties' unexpressed expectations are left in the air, sometimes in an atmosphere of “killing with kindness,” which may be broken by confrontation and perhaps by a traumatic end to the therapy. Therefore, supportive therapy requires an explicit and direct communication about the goals.

The paradox of the termination of treatment is that an attachment to the therapist should have developed because it is a precondition for the therapeutic work. But it is a two-edged sword because this attachment can also become a hindrance to the clients, making it difficult for them to liberate themselves from the therapist and to develop the necessary autonomy. One of the problems is that the therapist is more talkative and active with the supportive approach than with the explorative one. This can make some therapists lose their grasp on their professional position, making it difficult for them to find the correct balance between therapeutic intervention and ordinary advisory functions. The therapeutic relationship can develop into a social relationship in which the professional status is lost. “The friendly relationship, which permits the therapist to function as an agent of support, is transformed into a relationship of friendship in which the auxiliary role of the therapist is lost” (Werman 1981: 156).

Thus, supportive psychotherapy has some characteristic techniques that provide a special “holding environment” in which the therapist establishes a space to give protection not only against external dangers, but also against the survivor’s own impulses. The therapist should be able to discover exter-
A therapist, therefore, needs a broad, overall understanding of torture and its conditions. It is not enough to adopt the usual existential cognitive attitude in which the goal may be to obtain causality understanding, control, congruence, and an overall meaning of life. The work with torture survivors is itself a challenge to the therapist’s own existential beliefs, since the essential quality of torture is the meaningless and the unpredictable.

In therapeutic work with torture survivors, the doctrine about the importance of reality and self-knowledge must be taken with reservations, because illusions in this field may be difficult to demarcate and break down.

Causality understanding is not necessarily the same as finding a meaning, and one can, like Molin Jørgensen (1992), distinguish between the meaning of life and the meaning of the event. The nature of the traumatic situation can therefore rightly lead to the development of some negative basic concepts, in which, for instance, an attitude of mistrust and rejection can be considered as a “good” adaptation. All the therapy’s goal is that this attitude should include only the meaning of the torture, not the more general “meaning of life.”

Summary and Clinical Applications

• Therapy may not simply focus on post-traumatic stress disorder (PTSD), although this may be one of many elements in an individual response. Retelling the trauma story is a common element that is independent of the particular therapeutic orientation. But it is essential not to overwhelm the patient by covering too much material in one session. Often other aspects are more important.

• The work with relationship and attachment bonds between client and therapist is of the greatest therapeutic importance, more than the content between the parties, the interpretations and the clarifications.

• Psychotherapy of torture and Holocaust survivors is difficult and may give limited results because of the destruction of the survivors’ “basic trust” and their inability to relive and describe their traumatic situation. The survivors’ way of blocking and suppressing the overwhelming traumatic affects by means of psychological “closing off,” “affective anesthesia,” “psychic numbing,” and “psychic death” might especially create problems in a therapeutic context. Other therapeutic difficulties are due to the survivors’
These techniques can give immediate relief of symptoms, after which the survivors’ otherwise healthy personality will be able to take over and continue the remaining work. But the severely traumatized survivors have had such fundamental parts of their personality destroyed that psychotherapy may take a long time and perhaps result only in modest improvements of function. The therapist must therefore resist an omnipotent position from which she gives too much optimism with respect to the effects of treatment. This may have a positive supportive effect in the first part of therapy, but it will quickly be replaced by despair in the survivor, which may make him stop the treatment.

• The technical neutrality must be distinguished from the moral and political neutrality. Many therapists have chosen to work with survivors because it allows them to work in an engaged and political context. But if the political aspect becomes too prominent in the therapy, they may go beyond the bounds. It may therefore be an advantage for some of the “advocacy” work to be delegated to the relevant institution. The treatment center’s involvement in the fight against torture may be a necessary precondition for the neutrality of the therapist.

• Just as it is a mistake to avoid dealing with traumatic material, it is also wrong to focus on the torture experiences too quickly and prematurely, that is, before the creation of a therapeutic space in which the torture survivor can feel safe and prepared. The therapeutic work must therefore proceed in stages, decried as, for example, (1) “establishment of safety,” where the therapist fulfills the survivor’s need for control and safety; (2) “remembrance and mourning,” which starts the process of recalling and retelling the trauma with tact and understanding for “timing” and “pacing”; and (3) “reconnection,” which includes reintegration and return to a daily routine.

• Cognitive therapeutic methods with desensitization and relaxation techniques combined with a gradual and hierarchically arranged exposure to traumalike situations may work when the treatment alliance and the first stage of “basic trust” are established. But the work with cognitive structures such as various schematizations and coping mechanisms is difficult to place in a larger existential context. The work of meaning is important.

• The importance of reality and self-knowledge must be taken with reservations, because illusions in this field may be difficult to demarcate and break down. Old-fashioned heroism has often failed as an appropriate coping mechanism for survival. It was not always the spirit that conquered the body;
The Cultural Psychology of the Torture Syndrome

A Distinction between What Is Universal and What Is Culture-Bound

Forced migration because of war and political persecution leads to a confrontation with cultures that are often quite different from the Western context, in which psychotherapy was created and developed. More than three-quarters of the world’s population live in non-Western cultures, and more than 90 percent are not familiar with our psychotherapeutic constructions.

Torture survivors come mainly from non-Western cultures, and the problems that we have dealt with in the previous chapters may therefore be fictive. The demarcation of the torture syndrome from post-traumatic stress disorders, the special supportive method, and the treatment stages is based on a dubious assumption, that is, that the main principles in the psychodynamic and psychoanalytic-oriented approaches are universal.

The few who have dealt with the problem of cultural insensitivity in the psychodynamic approach (Dahl 1989, Devereux 1980, Kleber et al. 1995, Prince 1980) have claimed that only a small and exclusive group will benefit from psychotherapy, and that many cultures will not live up to the visitation requirements in general. Many cultures take no interest in the form of introspection that psychotherapy takes for granted; they are ashamed of talking about psychological problems and do not speak about intimate personal matters with strangers outside their family. Usually they do not have the understanding of a “professional friendship,” which psychotherapy implies.

Some of the difficulties that arise during treatment courses for torture survivors may be due to our cultural conventions of how one should “express one’s problems,” rather than being a result of traumatic and developmental difficulties. But on the other hand, not all therapeutic problems can be ascribed to culture specificity. Ordinary human understanding is based on
Culture-Bound Disease Entities

Based on cultural psychology, the previous chapter’s focus on symptoms and treatments will be replaced by a consideration for the possibilities and action.

If a hypothesis is to be advanced about the existence of a torture syndrome as a diagnostic category, one has to start with the definition of a diagnosis in the cultural-psychological perspective. Is it possible, for instance, to have a diagnosis with different meanings in various cultures?

A diagnosis is a semiotic action in which the client’s perceived symptoms are interpreted as signs of a certain pathological condition. By convention, all diagnoses are made in the same way, regardless of whether the condition is a stomach ulcer, a fractured knee, or a post-traumatic stress disorder. In practice, therefore, it means the transfer to mental diseases of the same attitude that is applied to medical diseases, namely, that the diagnosis refers to an “underlying” process that a high diagnostic activity is said to be based on a “hypothetico-deductive” method (Kleinman 1988a: 8), there is an element of self-confirmation because as a rule the diagnosis is tested within the same diagnostic system as that in which the clinician has been brought up, to get order into his or her observations.

Some of the symptoms we consider to be signs of mental disease are ascribed in other cultures to moral and religious problems. But with us the diagnostic interpretation is an activity limited by the taxonomic system, with which we have been brought up, and we will therefore make interpretations within the same ordinary taxonomy. In practice, it has led to the medicalization of social problems; for example, many forms of alcoholism and criminality are labeled diseases. Despite the possible existence of some genetic and physiological factors in such processes, the problem is that increased medicalization, whether or not scientifically founded, may become a form of social control. The social system has been accused of medicalizing poverty problems, unemployment, and lack of education, and the therapeutic institutions of replacing some of the legal and religious institutions that used to function in society (Kleinman 1988a: 9, Stone 1984). In the same way, psychiatric diagnoses have been used by state authorities to control dissidents.

Culture is the unwritten social and psychiatric dictionary that we have memorized and then repressed. Increasing cross-cultural understanding, then, becomes the two-part task of bringing our own dictionary to the level of a fully conscious awareness, and then memorizing the dictionaries of others so that we can shift easily from one to another (Landrine 1995: 744).
A usable model must contain a dialectic interplay between biological and cultural processes. Sometimes one of them will have more influence on the disease’s manifestations than the other, but it is the relationship between the two factors that is more important than the factors separately. The dialectic interplay changes the view of disease physiology in such a way that it becomes an inseparable part of the personal experience and the social and cultural interaction.

Cultural Psychology: More Than Direct Translation

Unfortunately, psychiatry is a theoretically underdeveloped area, because of difficulties in integrating anthropological theories and concepts (Kleinman 1988a). The cross-cultural field has therefore been characterized by very prosaic translations. Questionnaires, rating scales, and psychometric instruments have been translated by bilingual experts, and the validity has been examined by translating “blindly” back to the language from which they originated, to see if there was still agreement. Reliability is checked by examining whether the correlation coefficients are the same in the new version and in the original, and the validity by conducting some thorough qualitative interviews (Flaherty et al. 1988).

But in anthropological and cultural-psychological research, the translation work has another priority: it is, in a much wider sense, a description of ways of thinking, categories, types of communication, and behavior patterns that are always placed in a context that will give a valid understanding. It is much more than linguistic translation; it is an attempt to place observations and structural categories in a context in which the translation itself adds to increased theoretical knowledge. In the research interview it is therefore necessary to operationalize one’s concepts and transform them into a series of questions in which the phenomenology and meaning of the symptoms are examined and not only crossed off on a check list (Mishler 1986).

There are several examples of how questionnaires lose their validity and meaning through translation without additional culture analysis (Kleinman 1988a: 29). Some ethnic groups, such as Latin Americans, southern Europeans, and Asians express more pain, anxiety, and depression than is the West European standard (Kleinman 1988a: 31). But it is difficult to draw conclusions as to whether such foreign cultures are more expressive and symptom-producing. There are, for example, epidemiological studies that show that blacks in the United States, despite their socially worse situation, report
nation with depression is mainly a Western phenomenon (Murphy 1982), and suicide is less common in depressed clients in the Third World (Headley 1983, Kleinman 1988a: 43). Persons with psychological depression are preoccupied with guilt and negative ego experiences, which lead more easily to suicide than in the client with somatic symptoms. One can therefore suggest the hypothesis that somatization per se protects against suicide, and that somatized depression has an easier course than psychological depression.

One of the big problems in working with torture survivors is to know whether their anxiety and depressive symptoms are signs of pathology (Torture 1993). Western psychiatry has made great progress in demonstrating well-defined biochemical changes, in particular in depressive conditions, and has developed several very potent psychoactive drugs. It would not be irresponsible not to use this knowledge in the therapy of the culture foreign client. But developments within biological psychiatry should not lead to culture-conditioned arrogance on the part of Western therapists.

Transcultural research shows considerable variation in depressive emotional levels, symptoms, and diseases in different cultures (Kleinman & Good 1985). The biologically orientated psychiatrist in particular would be interested to know whether her nosological categories are the same in different cultures. But if we have only established psychiatry as the professional starting point, we run the risk, as mentioned before, of arguing in tautological circles, because we describe the disease with the same machinery of concepts toward which we turn later to make it more likely that our treatments are correct (see page 30). It will be of more interest for the cultural psychologist to investigate how depressive symptoms reveal a person’s relationship with society, and the influence of society on the individual. Here, for instance, depression will manifest itself as grief, which has to be translated and interpreted in order to identify a hidden meaning in a hidden system, that is, a sort of social arrangement that produces its own meaning in a society. In this perspective, the medical treatment of depressive symptoms presents a problem because it isolates the client from his social and cultural context.

 Learned Helplessness and the Meaning of Symptoms

Many torture survivors describe how they were broken down by the unpredictability of the torture and its lack of consistency (see pages 10 and 43). Among the most frustrating aspects were the unpredictable changes in atti-
displacement of the inner private world to a social ideology and further on to a public world of meanings and symbols.

Even though depression in the Western world has a looser attachment to a social context than in other parts of the world, Western ideology has also been gradually developed with respect to its treatment. Within crisis therapy intervention, we often consider depression as the result of an unfinished and unsuccessful grief-work. Loss is followed by grief, but if it does not come to an end, it leads to pathological grief reactions with weakening of the ego-feeling and subsequent hopelessness. Quite correctly, there is a difference between grief and depression, but if grief becomes chronic, pathological reactions will follow. Reactive depression arises because the client is no longer able to identify the real loss. In a psychodynamic sense, the client attempts to compensate for an object loss by transforming his or her previous attachments to new objects. In a certain way it can be said that the person’s inner and original object relations will always be the same, but that their shape changes. An object is exchanged with another, the shape changes, but the inner psychodynamic balance remains the same.

Grief therapists in Western cultures must appeal to this inner constant in the person, because there is no external constant as in other cultures, for example in the shape of a conviction about something immortal and reincarnated. Depressive symptoms, particularly according to biomedical concepts, are interpreted without any reference to internal or external constants. By surrendering to the biological treatment, which can be very effective in certain contexts, one of the great costs will be renunciation of the meaning-giving in the “culture work.”

**Guilt and Shame Cultures**

Terms relating to feelings appear so often in our language that it is tempting to date them to Adam and Eve; this is widespread in all cultures. Such widespread terms include guilt and shame, but to try to uncover the phenomena to which they refer, and look at them in a cultural context, provides a key to the understanding of foreign cultures.

Psychological problems such as bad conscience, suicide attempts, introverted depressions, and lack of self-promotion are seen as the result of the “culture of guilt” in Christian, Western culture. By contrast, Middle Eastern and Arab societies have been called “the culture of shame,” with psychological problems that are characterized by somatic expressions, fewer suicides,
other attitude. Before Christianity, a man had full command over himself and his body, but after the Fall came uncontrollable instincts and desires. Today this unruliness is seen particularly in relation to our sexuality, which has become full of problems and a source of guilt and remorse. In Japan and several other cultures, sexuality is not an area that can generate guilt and shame in the same way; nakedness is not shameful, and erotic lust is quite legitimate when it is kept in its correct place. The Japanese language has no word for perversion (Vanggaard 1991: 167).

Differences such as this between guilt and shame cultures may have a decisive influence on psychotherapeutic work with torture survivors. People from guilt cultures depend on an inner power. They can feel relief for their bad conscience by revealing it to others, for instance if they have informed against friends under torture. People from shame cultures depend on the attitude of the surroundings and may feel it is unimportant or at worst defamatory to have to find some inner motive and feelings for a situation in which they have been humiliated during torture, for example.

Aggression, Suicide, and Morals

The different attitudes toward guilt and shame are reflected in relation to aggression. Open person-to-person aggression will more often be conscience-ridden and cause inner conflicts in guilt cultures than in shame cultures. Thus, the demand of psychotherapy to work with inner conflicts in a closed, confidential room is more in agreement with West European culture and with torture survivors who belong to the educated middle class and are used to our psychologized ways of interpretation.

In a comparative study of Greek and Danish women who had attempted suicide, the Greek group was more marked by shame, and their suicidal actions were directed toward others in a more aggressive or appealing way. By contrast, the Danish women were a less visible group, marked by guilt feelings and self-reproach, and the suicidal attempts were to a much lesser extent directed toward others (Arcel 1986).

The feeling of shame is used as a tool of child-rearing in the Arab world. The child is brought up to unconditional acceptance of parental and teacher authority and is sometimes untouched by the content of what is taught, because he is busy reproducing and repeating. If the child says or does something wrong, he may be corrected by being ridiculed. The effect of being laughed at is just as painful as being beaten, and it is an effective way of being
understand, for example, of the neocolonial restoration of the bad conscience; an ennobling of the primitive (Elsass 1992a: 114).

In all cultures, the content of treatment depends to a large extent on interpretation. Outside of psychoanalysis, the healer must take part in interpreting the client’s complaints and illness narrative in agreement with an underlying theory. This background is exposed more or less explicitly and is very different in various cultures. In some cultures, the treatment consists of teaching the client a disease taxonomy that is part of a complex ethno-theory about healing herbs in an ecological system. In other cultures, for example in our own psychoanalytic practices, the theoretical reference point for interpretations is more implicit. In many non-Western healing rituals, emphasis is put on emotional arousal with catharsis, psychophysiological changes, and religious manifestations, prayers, persuasion and confessions. Exorcism is used in many places as a symbolic expulsion of evil, thus giving a concrete expression of hope and expectation with respect to healing. Introspection is also conceived. In contrast to our insight-giving therapies, it more often makes use of irony, paradox, and rhetorical questions as effect mechanisms.

Translation and Cooperation with the Interpreter

Language is an important tool in psychotherapy, and it has great importance even in most of the nonverbal therapies. However, translation, both in diagnostic work and in treatment, is a great problem, and wrong diagnoses and treatment occur frequently because of problems in interpretation (Westermeyer 1990).

There are many examples of how misunderstandings can arise from language problems. Psychiatric practice has many standard terms, which are completely misleading if they are translated word for word. Thus, the question “Do you hear voices?” may be misunderstood by the client, who may think that her hearing will be tested. Furthermore, there are several abstract ideas that are difficult to translate, but which nevertheless may be essential for the understanding of the torture survivor’s situation and subjective condition. Pain, for instance, may have many more different meanings in languages other than our own, and may refer to both mental and somatic conditions. By contrast, several psychological conceptions are more differentiated in Western Europe than in other cultures, and many circumlocutions may be needed to explain the difference between sadness and depression, or
The naive method. Therapist and client are together with a fairy tale, and one of them reads aloud to the other. The therapist refrains from real interpretations, but one talks about what one has experienced; the hope is to be able to stimulate the client’s inner imagination. In a sense, they go on a journey together, but it is for the client to decide if he wants to continue with his experiences. The therapist does not put them in relation to the client’s situation.

The interpretation-oriented method. The client relates his associations with the fairy tale. The tale functions as a sort of transitional object, and the therapist tries to give insight to the most important effect in the same way that dreams are used in insight-giving psychotherapy.

Fairy tales as play therapy. The client is given the opportunity to identify himself with a fairy tale figure, from which he may create another. Therapist and client remain in the make-believe world, using the protection that may come from using fairy-tale language, even if both know what it’s all about.

Fairy tale production. The client writes his own fairy tale, and, as in drama therapy, the therapist is an instructor or helper to narrate it. The client may choose to play the hero’s role and will be helped by the therapist with questions about his clothes, which room he is entering, etc. The therapist can also introduce various supporting characters and give them an entry line on the fairy-tale stage.

The associative technique. Brun describes how this technique can be used with brain-damaged patients, and how she develops symbols with a group of patients. One of the exercises is about a tree; the client must recount his first memory of a tree and the qualities he thinks of when he hears the word tree, and what the tree can symbolize.

There are thus various ways in which work with fairy tales can liberate energy and create better contact with the unconscious. For torture survivors the fairy tale is a good way to establish a culture-specific form of treatment and to create a distance from the traumatic situation, which may be very difficult to talk about.

Constructing a Meaning

The ultimate goal of psychoeducation, of the testimony method, and of work with fairy tales is to construct a new meaning and story for the tor-
The Trauma Story as Explanatory Model

The process in which the story is structured, interpreted, and told is called an “explanatory model.” It is usually the explanatory model that forms the plot of the narrative presentation and is the important structure from which the rest of the story is constructed. If it has a disease or trauma as a central subject, the life story will turn into an illness narrative or a trauma narrative. Such an explanatory model is created both by clients and by therapists; it “gives explanations about the trauma and treatment that provide guidelines as to which therapist and treatment one should choose, and which furthermore gives the trauma a personal and social importance” (Kleinman 1980: 104).

Seen from the professionals’ position, the client’s explanatory model may often appear vague with many-sided meanings, be variable, and have unclear limits between idea and experience. When speaking about their disease and trauma, many clients include professional psychological terms, but they use them in entirely flexible, and sometimes irrational ways from those used by the therapist. The client’s self-experience does not have the character of a theory and model, which the professional can use as a fixed given feature. For the therapist, however, the descriptions are clearly structured and built up around scientific causal relationships. The meeting between client and therapist may thus be seen as an exchange, a transaction between the explanatory models of laymen and professional. This exchange depends on several psychological, social, and cultural conditions. Sometimes a power struggle will arise between the two types of explanatory model, when the therapist’s model intermingles with the client’s and makes the professional concept part of the client’s self-experience, rather than the other way around.

One way of understanding the explanatory models of laymen is to start with the types of question they pose when they feel ill or traumatized. The answers to these questions are often interwoven into a life story context (Helman 1990: 96):

1. What has happened? The answer results in the organization of the symptoms in recognizable patterns with a name and an identity.
2. Why did it happen? The answer suggests the etiology of the condition.
3. Why did the trauma hit me? The answer results in making an association between the trauma and the client’s behavior, for instance in relation to personality and social conditions.
The torture survivor’s perspective may be distorted when it is processed and filtered by the professional. The considerations about the specific torture syndrome and supportive treatment have all been developed within a closed therapy room. The culture-psychologic approach certainly tries to put the psychodynamic working method into a larger perspective that respects the client’s cultural background and can recommend some culture-specific treatment methods. But these reflections are those of the professional, and it cannot be taken for granted that they respect the clients’ interests. If one is unable to involve the torture survivors in the development of professional knowledge and let them have a sort of user influence, the result may be institutional self-confirmation. Treatment centers that want to avoid stagnation and development in the wrong direction must be open to ideas from outside, for example, in the form of supervision and research.

In order to obtain a form of reflection in the daily routine, an “atmosphere of inquiry” (Main 1957), a follow-up examination, has been carried out. Its starting point was the situation that many therapists desire but rarely achieve; namely, to call the torture survivors back about six months after their treatment and ask them to give an account of “what they got out of the psychotherapy.” The study was carried out as a combination of supervision and research.

**Supervision**

Supervision can be defined as an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person (Loganbill et al. 1989, ref. from Lansen 1993). The overall purpose is to protect the client’s in-
"To feel better without being cured" / "More courage to face life." The client: I find it difficult to say what I got out of it. I don’t think one can be cured by just talking to a psychotherapist. That means that my attitude is that a client can never return to his normal pre-torture condition. But looking at myself, I think I am feeling better than before. I don’t think I can say what I have found out. I can only say that I feel better than before.

The therapist: My patient was both intelligent and well functioning socially, and then it usually goes well. The symptoms have disappeared and he has more insight, more courage to face life, and has fewer complaints.

Discussion

The statements of the clients and therapists support, to some extent, the hypothesis about the existence of a torture syndrome, and they point out the helpful factors in the psychotherapy, in particular a specific supportive attitude of the therapist. But this presentation of the clients’ experiences is not necessarily a direct expression of what “really” happened during the therapy. The way in which the clients construct their stories about the psychotherapy—how they put it into words—may reflect many of the unspoken motives and feelings they relive when they have to talk about the therapy. Furthermore, it may give a picture of how they want to present themselves to the investigator. The same may hold for the presentation by the therapist (Finn & Sperling 1993). The clients’ “putting into words” reaches far beyond some psychodynamic conditions in the therapy room.

“Putting into words” means that something does not need to exist as a real physical object but gets a presence and features that are constructed in speech. Analysis of “putting into words” usually implies a detailed and thorough understanding of how a speech and a text are built up, and an examination of the conditions under which they were produced (Elsass 1994a, Elsass 1995, Elsass et al. 1995).

One party’s evaluation and selection of significant situations in the therapy must be seen in relation to the other party’s, because together they constitute the conditions of the parties’ choice of words. But apart from that, they should also be seen in connection with the therapy that is practiced, the therapist and her methods, and in a broader sense with the professional setting and the culture in which the therapy takes place.
proved more than others, and there were no significant differences between the evaluations made by torture survivors and therapists.

Comparison of Therapeutic Courses with High and Low Outcome Scores

There were no differences in the distribution of the scores of the therapeutic course when the material was divided into two groups, that is, above the median, and below (and equal to) the median.

Narrative Signatures

The narrative course was drawn as lines between the different scores for categories and dimensions of the narrative about the psychotherapy. Figures 1–4 show such courses for the four groups: the torture survivors (A) and their therapists (B), the anxiety patients (C) and their therapists (D). The categories are numbered 1–10 (in italics) and the dimensions within each category are numbered 1–4 (in circles), as in table 1. A line was drawn for the torture survivors and their therapists between the various scores when two points were connected two or more times. The lines were drawn for the anxiety patients and their therapists when two points were connected four or more times. The more connections between two scores, the thicker the line. The arrows on the lines indicate movement from a higher to a lower category number; no arrows indicate the opposite movement.

These figures illustrate that the torture survivors move around more than their therapists between the various scores. Furthermore, the survivors were more occupied than their therapists by extra-therapeutic factors, in particular the conditions before the therapy. By contrast, the therapists were more occupied than the survivors by the process.

Though the narrative signatures for anxiety patients and torture survivors cannot immediately be compared because of the difference in number, one nevertheless had the impression that there was more similarity between clients and therapists in the anxiety group than in the group of torture survivors, a fact that was confirmed by calculating the narrative similarity coefficients. The Danish patients and therapists were more occupied by the process, while the torture survivors were relatively more occupied by the symptoms.
Figure 4. Group D: The anxiety patients’ therapists.
than their therapists by the torture and psychodynamic process. Compared with anxiety patients, the torture survivors were more fixed on symptoms and on what happened outside therapy in the “extra-therapeutic room.” Furthermore, there was less agreement between clients and their therapists in “putting into words” the psychotherapeutic process among torture survivors than among anxiety patients, possibly because of cultural differences. But all the torture survivors and therapists said that the talks had had a positive effect.

- Ten psychotherapists participated, each with one or more torture survivors, in all twenty torture survivors. Furthermore, twelve general practitioners and twelve psychologists participated, each with two clients with an anxiety disorder, a total of forty-eight patients. All interview data were analyzed using a combination of quantitative and qualitative methods.

- All the torture survivors and their therapists said that the therapy had had a positive effect on one or more of the items listed on an outcome scale. However, three clients expressed that the treatment had resulted in little progress.

- The narratives about therapy showed that the torture survivors talked less about the process in the sessions than their therapists and mentioned the torture experience more seldom. The survivors gave more attention to the framework of the therapy, the technique and methods, than their therapists and also to the conditions outside therapy such as changes in their work situation and political circumstances in their homeland.

- In contrast to the anxiety patients, the torture survivors talked more about their symptoms and problems. The anxiety patients where more familiar with the psychodynamical way of thinking than the foreign survivors and gave more attention to the process in the sessions.

- The differences between the narratives of the torture survivors and their therapists were larger than for the anxiety patients and their therapists. But this cultural difference did not have any connection to how the outcome of therapy was rated.

- All torture survivors mentioned that the torture had very much influenced their attitude toward what they considered “most important in life,” and said that of most importance to them now was the family and close relationships with friends and acquaintances. Only a few answered that it was most important to “create peace on earth.”

- All the torture survivors said that they felt revengeful against the regime and their torturers, but that after torture they could no longer be physically violent toward others. They usually react passively and have a tendency to isolate themselves.


References


