

Secondary trauma in treating refugee survivors of torture:

## Assessing and responding to secondary traumatisation in the survivors' families

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### Abstract

The paper deals with the exploration of the theoretical basis of different kinds of secondary traumatisation in general and specifically in torture. The analysis is focused on the effect of torture on the survivors' families. This presented analysis with the author's clinical and personal experience is basis for developing a framework for assessing secondary traumatization in torture survivors' families. A family typology of six types, in which each may need different approach in intervention, is proposed. Clinical case studies that represent some of these typologies are reported. The goal intends to provide a holistic and multidimensional wraparound approach to torture trauma in order to ensure a truly effective intervention towards the full recovery of the survivors.

*Key words:* torture survivors, secondary traumatisation, family dynamics

### Introduction

In this paper I explore the theoretical basis of different kinds of secondary traumatisation in general and specifically in torture. After this, I will focus my analysis on the effects of torture on the survivors' families. Based on

the presented analysis and on my clinical and personal experience, I develop a framework for assessing secondary traumatisation in torture survivors' families. I propose a family typology of six types in which each may need a different approach in intervention. Finally, I provide clinical case studies that represent some of these typologies. The goal is to provide a holistic and multidimensional wrap-around approach to torture trauma in order to ensure a truly effective intervention toward the full recovery of the survivors.

### The theoretical basis of secondary traumatisation

Figley<sup>1,2</sup> and others, by introducing the concept of secondary trauma, started a revolution in trauma theory and research. Traumas can have similar or different effects on persons in relationships, or within a strong collective identity, even if they did not suffer the trauma themselves. The concept of secondary trauma in model I is based on few assumptions. The *first assumption* is that a human individual does not exist alone. He or she is part of a network that is structured and connected through different ties and mechanisms. He or she is part of a course of activities and systems that continuously moves in space and time, and that is governed by the systems' dynamics. Any significant event, negative or positive, that affects him/her can

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have equal or different effects on the system and networks, their activities and the dynamics that he/she is part of, and the other individuals who are members of this system or group. The *second assumption* is that the degree of closeness in one's relationship to others, within these systems, will determine the mechanism of such transmission and its effects. The *third assumption* is that the transmitted effects can have systemic and ripple effects that go through space and time, beyond the initial impact. This systemic perspective presents one level of analysis. Individuals co-exist in a system or a network of interlocking relationships that transmit the effects of different significant events horizontally and vertically within time and space. The other level of analysis, which is the trauma-focused perspective that negatively defines the significance of events, concentrates on which kind of traumatic events happen: is it personal, interpersonal or collective. This moves us from the abstract system thinking level to the concrete clinical experiencing level. The individual exists in relationships, interpersonal relationships, families, groups and communities. He or she belongs and develops affiliations, attachments, feelings of belonging, and personal and group identities. What affects him/her significantly, negatively or positively, can affect those who are in a relationship or those with whom she or he identifies. Moreover, whatever affects negatively the group members he identifies with, e.g. in an ethnic or national group, may secondarily traumatise him.

Trauma is transmitted to those in relationships, and in some instances across generations or different levels, and through different mechanisms of transmission. Examples of such mechanisms that channel transmission of trauma are symbiosis, empathy, attachment, enmeshment, personal or collective identification, projective identification,

introjection, dependency and codependency and interdependency. An extreme example that gives validity to this assumption is shared psychotic disorder (Folie a Deux). In this disorder, a delusion develops in an individual in the context of a close relationship with another person(s) who has an already established delusion (DSM IV, 297.3). In this context, secondary trauma can happen not only to one person, but also to a family, to a primary or secondary social group, to a community, or sometimes, to a whole nation or ethnic group, e.g. genocide, September 11.<sup>3</sup> However, the transmission of trauma does not always occur. Moreover, the mere experience of the most extreme traumatic event does not necessarily result in a disorder.<sup>4</sup>

We can find two main kinds of transmission:

- A. *One step transmission of trauma:* The transmission can happen from one person to another or from an individual or individuals to a connected group or vice versa. For example, domestic violence is a direct trauma to the parent, and indirect trauma to the child or children. Sexual abuse of the child is a direct trauma to the child and an indirect trauma to the parents.
- B. *Multiple steps of transmission:* In this case trauma is transmitted cross-generationally. This kind of secondary traumatising may be sub-divided into two categories:
  - a. *Cross-generational family trauma transmission:* In this kind, traumatic practices and their effects are transmitted within a family system across generations. Examples are the vicious cycles of violence, physical abuse and incest that go from one generation to the next in some families.
  - b. *Cross-generational collective identity trauma transmission:* There are at least

two kinds of collective identity traumas: 1. *The historical trauma*, for example the slavery of black Americans, the Armenian genocide in Turkey, the Jewish Holocaust, the Palestinian trauma and the American Indian experience of genocide. September 11 is a historical collective trauma. This type of trauma is rather a collective complex trauma, as it is inflicted on a group of people that has a specific group identity or affiliation to ethnicity, colour, nationality or religion. 2. The second kind is the *social structural trauma*: Multigenerational transmission of structural violence constitutes extreme social disparities.<sup>5</sup> The effects of the chronic and pervasive condition of societal structure or social violence, created by generating extremely deprived social classes, are traumatic to the parents and their children. Recognition of such extreme discrepancy in social power results in a sense of relative deprivation.<sup>6</sup> Differential status identity (DSI) that is generated by the critical differences in social standing from the ordinate group, as suggested by Fouad et al.,<sup>7</sup> may demonstrate the case of such collective identity trauma and its transmission. The effects of deprivation by poverty and demoralisation are passed on from parents to their children and may cause collective terror that contributes to the kinds of conduct problems, violence and drugs that are more prevalent in some inner-city communities.

Table 1 summarises this classification of secondary trauma.

### **Torture trauma and its transmission**

Torture is any systematic act by which severe

pain or suffering, whether physical, emotional or mental, is intentionally inflicted on a person for any reason, by or at the instigation of, or with the consent or acquiescence of, public officials or another person acting in an official capacity (cf. The Declaration of Tokyo of the World Medical Association, 1975). It can potentially yield cumulative trauma disorders. Severe physical pain, a type of bodily trauma in torture, is overwhelming and obliterating, and can produce lasting mutilation and disfigurement, and serious physical, mental and emotional impairment. Torture is a multilateral trauma and has multilateral transmission channels. While it affects one person directly, it is transmitted multilaterally to his/her family and to his/her social group or community. Torture can lead to family traumas that can cause different forms of family dysfunctions and disruptions in the course of family development.<sup>8-9</sup> The effects of the torture of one parent on the other spouse and their children are well documented.<sup>10-11</sup> On the other hand, the torture of a son or daughter may traumatise his/her parents and his/her siblings. Children of tortured parents reveal more psychosomatic symptoms, headaches, depression, learning difficulties and aggressive behaviour. They manifest more severe ADHD, enuresis and trauma congruent or incongruent psychotic symptoms, developmental arrest or delays.<sup>12-14</sup> Family assessment is one of the missing parts in most torture assessments. Assessing the effects of torture on the survivor's family members and family dynamics is an important part of torture assessment.<sup>15,16</sup>

We conducted two studies on the effects of torture, one among Iraqi refugees,<sup>14</sup> which is a population study, the other one was conducted on clinic clients.<sup>17</sup> We found in the population study that tortured persons present significantly fewer symptoms and are

**Table 1.** *Classification of secondary trauma.*

Person to person Person to system System to person	Kind of trauma	Mechanism of transmission	One- step	Multi-step	Possible outcome	System response/ corrective dynamics
Therapist/client Worker/co-worker	Any kind	Empathy	***	NA	Compassion fatigue	Supervision
Member to pre-established family	Personal Inter- personal	Attachment – projective identification	***	Family cross- generation transmission	Triangulation, switching symptoms, reversing roles	Individual and family therapy, Models of intervention
Member to a group or group to member	Collective	Identity	***	Family and social cross- generation transmission	Social/structural dysfunction, gangs, underground group terrorism	Socio-political activism and action, group dynamics, interventions

more adjusted than other refugees who had been cumulatively traumatised but not tortured. However, in the clinic study, we found that those who had been tortured present significantly more symptoms. Tortured persons are more resilient, probably because they have suffered for a cause, however, when they collapse, they present the worst effects of cumulative trauma.<sup>17</sup> In either case, the traumatised family is probably more affected. Another fact that supports our argument is that, in our clinic, we have more spouses and children of tortured refugees than those of regular refugees.

### Assessing and treating the effects of torture on the family

Family therapists dealing with traumatised families presented cogent arguments about the effects of such trauma on the interpersonal system of the survivors and the family dynamics that tend to perpetuate the symptoms.<sup>8,9,18</sup> Classical exposition of the family dynamics and structural models alert to the potential shift of attention to the spouse, or one of the children, as the presenting prob-

lem defocuses attention from the patient (e.g. the survivor) and refocuses on another component in the larger system.

The family system should be looked at from at least three different perspectives:

- Family, either as a part of the support system of the survivor, or as another added stressor.
- Family as a traumatised system by the torture of one of its members.
- Family dynamics as perpetuating the symptoms of the survivor, or shifting the symptoms around.

Family therapy is a missing part of torture treatment. Torture treatment will not be effective if it ignores family dynamics and the long- and short-term effects of the transmission of torture effects to the spouse and children. Family therapy should be part of a multi-systemic, multi-modal approach to torture treatment.

The effects of torture on families present themselves in different typologies that are observed in our clinical practice:

1. *First typology:* The tortured person has survived the torture without presenting significant symptomatology; however, family members are affected more and present different symptoms. The transmission mechanism in this model is mostly attachment. The focus of treatment will be more on the members affected.
2. *Second typology:* The tortured person has been presenting symptoms, but he is either in the state of denial, has projected them, is coping by withdrawal, gets over-involved obsessively in religion or self-medicates by using drugs. In this example, we encountered family dynamics similar to alcoholic families. The dominant mechanism in this model is projective identification and codependency. In this case, family therapy will help diffuse codependency, and individual therapy and other modalities with affected individuals are warranted.
3. *Third typology:* The tortured person has completely collapsed, and the wife or another member of the family takes over responsibility, while presenting different kinds of symptoms with different family dynamics for the children and spouse. In this case intensive work with the survivor is crucial, as well as providing more supportive interventions for the spouse and affected family members.
4. *Fourth typology:* The tortured person is a single parent, either by divorce, death of the spouse, or the spouse has run away with another man or woman, leaving him or her to handle him/herself and the children alone. The tortured person can be in any of the previous three categories, but ends up having and taking responsibility for the survival of his/her family. Supportive interventions are helpful, as well as other needed services.
5. *Fifth typology:* The tortured person gets married after the torture has taken place. This marriage may be his choice or an arranged marriage by his family or his tribe or another group who care about him. Marital problems can erupt. A diagnosis of relational dynamics will determine the treatment strategy.
6. *Sixth typology:* In this case, the tortured person is a son or a daughter. The dynamics in this typology may be significantly different. The loss of a son to torture can cause debilitating depression of the parents. It may affect their decisions and ability to function and to attend properly to their other children. It may terrorise other children with varying response.

In the first three or four typologies, the extent to which he/she has been tortured, the resiliency of the family members and the damage caused to the tortured person will contribute to the outcome. However, in the fifth typology, the dynamics will vary depending on the tortured person's damaged condition upon marriage alone, not on how much he/she has been tortured. Each case presents different dynamics and outcomes and requires different interventions on both the individual and the system dynamic level. While typology is helpful, there are cases that present themselves in a more complicated manner and present overlaps and different dynamics. Within each typology there are different sub-typologies.

*Whether the therapist works with a tortured person, his spouse or one of his children, he or she should conduct a comprehensive family assessment and determine the family dynamics related to torture. Comprehensive family assessment is needed to appraise the effects of torture on the spouse and children, to determine the affected family dynamics, to address them in therapy, and to provide the children*

and spouses with the necessary services. The goal of family therapy is to diffuse dysfunctional dynamics and return the family to being supportive to its members, including the tortured person.

**Case example 1:** This case is an example of a *sub-type of the second typology* in the previous classification. The identified client is a daughter of a torture survivor. Her school, her family physician and the mother's therapist have referred her. Her mother brought her to therapy. The client is an eight-year-old girl who has been diagnosed as having PTSD with psychotic features, ADHD and R/O atypical psychosis; on top of that, she suffers from partial complex seizure. She receives Tri-leptal for the seizures, as well as Ritalin and Respridal. She has an average IQ. The mother herself is a client diagnosed with PTSD and the psychotic disorder NOS; she is on Xanax, Zoloft and Zyprexa. Nevertheless, she is the one who takes care of the family and drives the child to her appointments. The client has seven siblings. In the family assessment, mother has indicated that the father had been severely tortured. He is withdrawn (spending most of his time at home reading his religious books), does not participate in family life, is very obsessed with religion, and does not work, since the torture resulted in a serious back injury. He thinks he does not have any problems. He refuses to ask for help. The child was very resistant, refused to open up, and was very difficult to establish rapport with. With all the medication, she was not very responsive to treatment. When the therapist asked the mother to bring the father as part of family therapy, she said that he did not get out of their home, and refused to drive them or to go anywhere. After five sessions with no progress, I asked the mother to tell the father that the therapist wanted to learn more about his religion. During the next ses-

sion, the father came with a few books in his hand, and in this way we started an interesting dialogue that lasted a few sessions. He was looking forward to every session. Every session was scheduled for two hours. He started driving his family, not only to therapy but also to various places, and started to be open to talking about his experiences in life, including the torture and his political beliefs and anger. At a certain point, he asked for help for himself, and was referred to another therapist. This intervention was a breakthrough for his daughter, she started to open up and bonded with the therapist, and her symptoms significantly reduced. In this case, once the father started to be more active, taking upon him his role as a parent and asking for help, the role of the patient shifted back and the identified patient was released from her role.

**Case example 2:** This case is an example of *the first typology* in the proposed classification. The identified client is a 15-year-old daughter of a torture survivor. The court had referred her and her family for evaluation and treatment. Her story started by her running away, after which she contacted the police and alleged that her father tried to lead her to a sexual act. After a few days of foster care, she denied the whole story and alleged lying. The judge, unable to decide on the case, ordered the father out of the home for at least 90 days, only being allowed back home after written permission from the therapist. The whole family, including the parents and seven children: 17-year-old daughter, 13- and 12-year-old sons, and four other younger daughters, and the client underwent a thorough psychosocial evaluation. The father and the client went through a thorough psychiatric evaluation as well. The father was evaluated separately by three therapists and by a psychiatrist, and the consensus was that he was

a symptom-free, caring and fully functioning father whom torture did not significantly harm. The mother was determined as suffering from mild to moderate symptoms of depression. Assessing the client, she agreed to having been depressed for a few years, and also to having severe nightmares related to war and to being afraid of sleeping alone. She stated that she sometimes sees or hears voices. She felt a lot of guilt. When she was six years old, the client had begun hearing voices and seeing things that did not exist, after her father had returned from jail, and after one incident in the Iran-Iraq war when she returned from a bomb shelter to find their home demolished by a rocket. The family's history revealed that the father fled from Iraq for his life, to Saudi Arabia and then to the USA, and had been separated from his family for over six years when they joined him four years ago. Because of the stigma of mental illness, the family did not ask for help for their daughter. The other children displayed some symptoms of depression and academic problems, but not as severe as the client. The client was diagnosed with PTSD and major depression with psychotic features, ADHD inattentive type, and R/O psychotic disorder NOS. The client was repeating her grade and had clear behavioural difficulties in school. After intensive individual and family therapy and medication (Zyprexa 2.5 mg twice daily, Concerta 18 mg, and Paxil CR 25 mg), the client became an A-student and was able to move up two grades at once. In this case, the torture and other cumulative trauma did not affect seriously any of the parents, but the children suffered in varying degrees.

**Case example 3:** This case is an example of the *fifth category* in the proposed typology. The family was referred by the child protective services as the father, who was a torture survivor and currently had serious marital

problems, had the habit when he got angry with his wife to grab his baby and severely hit him or push him against the wall. The client (55 years old) was 30 years older than his wife. After he had been sentenced to death for being part of the political opposition, it was decided that death was less of a punishment. Instead, he was tortured to the extent that damaged his sexual ability and caused serious damage to his spinal cord, after which he was released. His tribe wanted to compensate him by arranging for him to marry his young cousin. When he came to the USA, his wife was not satisfied sexually, was involved with other men and gave birth to a black baby. Whenever his anger towards his wife escalated, he hit and abused the baby, who he realised was not his. The marital problems after the torture were not directly related to the torture, but to the incompatibility of the arranged marriage. The intervention focused on several goals, including creating a better supportive system for him and even divorce.

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