Preface

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The National Partnership for Community Training (NPCT), a program of Gulf Coast Jewish Family Services, Inc., with its partners, the Harvard Program in Refugee Trauma and the Heartland Alliance Marjorie Kovler Center for the Treatment of Survivors of Torture, led a project to identify and disseminate best, promising and emerging practices impacting the torture rehabilitation field. This project, funded by the United States' Office of Refugee Resettlement, commenced in the fall of 2008. Leading experts in the field were identified as authors and peer reviewers to ensure the collaborative and holistic vision was fulfilled. An extensive literature review was conducted focusing on the following domains: Medical, Psychiatric, Psychological, Expressive Therapies, Social Services, Legal and Spiritual. Findings reveal a growing body of evidence related to service provision with torture survivors. However, substantive gaps remain across these domains. Authors discuss the current evidence available in the literature and identify peer reviewed articles for practitioners' future reference. Research among the torture survivor populations is rife with challenges, yet the importance of utilizing evidence-based practices, anecdotal or outcomes from a rigorous randomized control trials, continues to grow and be emphasized. The project editors intend this body of work to be a guide for those working with survivors of torture as they assess and evaluate appropriate, safe and effective practices to incorporate into day-to-day programming.

Key words: Evidence-based practices; literature review

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Introduction

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"I am not traumatized at the level I [once was]… what is more, something that comfort[ed] me a lot in this country and gave me hope and helped me to live was the people who cooperated to improve my situation."

– Female Torture Survivor and Client of the Florida Center for Survivors of Torture

The scope of study in the torture rehabilitation field is increasingly representative of the services available to torture survivors around the world. While substantive scientific gaps remain, a foundation specific to torture treatment is emerging. Related fields, including the health disparities and trauma related fields, have and continue to be examined formally and informally for potential models of care and interventions. Yet, for providers who are serving survivors in their day-to-day work, a pressing question remains: *What interventions work with torture survivors?*

The purpose of this compendium is to highlight evidence-based practices for working with torture survivors. A *practice*, in this context, refers to the specific interventions, services or approaches taken with a survivor. It does not necessarily include a programme model or a system of care, but rather services provided within a given system of care. A *torture survivor* is an individual who has been physically and/or psychologically tortured by a state or government sponsored entity. *Torture*, defined by the United States, is "an act committed by a person acting under the colour of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person with his custody of physical control."[1]

This compendium of practices is intended for providers working with refugee, asylum seeking, asylee and other immigrant populations either in a funded torture rehabilitation programme or within a mainstream organization. Providers will find this guide to be a useful tool to assess specific approaches in the provision of services as well as a reference for literature related to the torture rehabilitation field.

The Approach

National Partnership for Community Training (NPCT), a programme of Gulf Coast Jewish Family Services, Inc. (GCJFS), is a technical assistance provider funded by the Office of Refugee Resettlement (ORR) under the Torture Victims Relief Act (TVRA). GCJFS and ORR have a cooperative agree-

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ment to provide training and support in communities where there are no federally funded torture treatment programmes. To help inform our technical assistance, NPCT setout to identify evidence-based practices impacting the torture treatment field.

The project has been a collaborative effort among the NPCT partners – the Harvard Program in Refugee Trauma (HPRT) and the Heartland Alliance Marjorie Kovler Center for the Treatment of Survivors of Torture. Together, with ORR, a process was outlined to identify evidence-based practices. Over the course of many months, the partners regularly conferred and made appropriate adjustments to the project, as needed.

In the fall of 2008, NPCT began a systematic literature search. First, databases such as MedLine, JSTOR, PubMED, PsychInfo, Wiley and Cochrane Reviews were searched using a combination of keywords based on practices identified by existing torture treatment centers and common torture-related terms as keywords. Second, cornerstone publications in the torture treatment field were consulted and references were identified. And, finally, resources developed over the course of several decades were reviewed highlighting many of the classic literature informing this field.

In the spring of 2009, the identified literature was once again reviewed and screened for two criteria: 1) Literature had to measure or systematically evaluate one or more practices or interventions and 2) Literature needed to be published in a peer-reviewed publication. Articles meeting both criteria were included in this phase of the project, and literature that did not meet the criteria was set aside and will be included in future stages of this ongoing project. Once the literature was identified for this project's specific purpose, it was determined to be *best, promising*, or *emerging* practices based on the following definitions:

- A *best practice* is defined as a practice, service or intervention, tested using randomized controlled trials (RCTs). The relevant evidence, tested under carefully controlled conditions, establishes the efficacy and effectiveness of the practice, service or intervention.
- A *promising practice* is defined as a practice, service or intervention, shown to be effective based on pre and post measures where clients have been surveyed prior to and following the practice, service or intervention. The outcome of the pre and post evaluations establishes the relative efficacy and effectiveness of the practice, service or intervention.
- An *emerging practice* is defined as a practice, service or intervention, with potential to be considered promising or best but for which objective evaluations have not been done. The emerging practice has shown to be beneficial to a specific client or population in a somewhat systematic way. The practice is generally accepted as appropriate for use with torture treatment survivors.

Following this screening process, the NPCT partners met in Cambridge, MA to assess the literature search and determine next steps. Based on the findings, the group identified the following categories or services domains: Medical, Psychological, Expressive Therapies, Social Services, Legal and Spiritual. The Psychiatric domain was identified as an additional area later in the process. In conjunction with ORR, NPCT and its partners identified experts in the field to synthesize the literature and address effective practices in the torture rehabilitation field within a given domain.

In the summer of 2009, authors were provided literature specific to their domain. They were also invited to include additional

literature they felt was useful to the discussion of evidence-based practices within the project's parameters. The literature and first draft papers were provided to peer reviewers who were asked to review the paper and share additional material they deemed appropriate for this project. Each author had the opportunity to incorporate the reviewers' feedback. NPCT with HPRT and Kovler, in the fall of 2009, reviewed each paper and worked with authors on edits and revisions as needed. Final edits were overseen by NPCT.

The Literature

This extensive literature review is a culmination of expertise from torture treatment centers and practitioners from around the United States. Seven current and former torture rehabilitation programmes and four mainstream academic and service organizations contributed to this project. It is a well represented sample of US geographical regions: Northeast, Southeast, Midwest, Southwest, and Pacific regions. Each author and peer reviewer brought not only critical analysis to the literature but also their extensive professional expertise, which clearly informs each paper. Approximately 200 articles have been included in this resource with the vast majority of the literature being clinically-based.

Each paper is a synthesis of existing literature for a given domain with a concentration on practices, interventions and approaches. At the conclusion of each paper, authors have provided targeted *Learning Points* and *Highly Recommended Readings* for readers. Furthermore, an extensive bibliography follows each article which is divided into types of interventions and treatments. The authors have made a determination for best, promising or emerging practices based on the evidence presented in each of the articles.

For the Medical domain, Dr. Richard Mollica provides an overview of medical practices ranging from best to emerging. In medicine, intervention begins at the point of diagnosis. Yet, research has shown that physicians generally do not inquire about experiences of extreme violence when taking patients' histories. By acknowledging the possibility of trauma, screening can be more thorough and accurate, thus increasing the effectiveness of the medical treatment. Mollica emphasizes patient-centered approaches during a clinical interview including direct inquiry about torture experiences. In the medical setting, Mollica also recommends a mental status exam and offers several screening instruments which can help to ease patients as the subject matter can be very difficult to discuss. Health literacy and compliance guidelines, medical interventions and specific health-related conditions such as depression, PTSD, insomnia, traumatic head injury, pain and physical rehabilitation are also presented.

In the second article, Dr. J. David Kinzie discusses the psychiatric field in relation to refugee populations and survivors of prolonged traumatic stress. Syndromes common among torture survivors are described as well as the neurobiology of PTSD and depression. Culture plays a strong role in the way individuals not only access healthcare but also how they engage in health practices such as medication compliance. Kinzie describes the chronic nature of the torture experience, the probability of remission and the specific issues related to psychopharmacology drawing from the literature and his professional experience. Medication recommendations are made.

Dr. Mary Fabri, in a thoughtful analysis of the psychological literature, raises important methodological challenges pertaining to research among torture survivors while

highlighting a small but important evidence-based treatment modalities specific to torture survivors. Areas of discussion include psychotherapy and psychiatric medication, cognitive behavioral therapies (CBT), family interventions, psychosocial community interventions, testimony therapy and psycho-legal approach and other modalities such as thought field therapy, group work and hypnotic therapy. Much of the literature included in this domain assesses traumatized populations (e.g. sexual abuse victims, refugees, political prisoners), though certain lessons can be derived and applied to the field of torture treatment. Key findings include adapting approaches to be culturally meaningful and appropriate particularly with CBT-guided treatment, an evidence-based approach for survivors of torture.

Alternative or "non-verbal" therapies are increasingly practiced among survivor populations and there is a growing body of literature that is supporting its efficacy. Amber Elizabeth Lynn Gray presents a thorough overview of the expressive therapies ranging from art-based therapy to dance and movement therapies to drama, music and sandtray therapies. Throughout her discussion, the importance of ritual and ceremony is evident. Such modalities honor and incorporate cultural tradition. Gray acknowledges expressive therapies are implemented in programmes around the world despite the limited evidence. And while the use of such practices are growing, she suggests that those practitioners with specialized training be given consideration to implement these approaches.

The social services domain is arguably the broadest of the domains covered in this compendium. Unlike the previous papers, the evidence-based literature is very limited. Ann Marie Winter presents a range of services including social support, English language, employment and housing. Given the multidimensional approaches in social services, Winter highlights facets central to service delivery: establishing trust and cultural competence. While social services not only attend to the most basic of needs (food, shelter and clothing), this area has the potential to shape identity, facilitate a sense of belonging and to foster independence and self-sufficiency. Winter calls for increased documentation of services in these and other areas such as education and vocational rehabilitation to establish evidence-based approaches to social services.

The literature in the legal domain, synthesized by immigration law attorneys Regina Germain and Leslie E. Vélez, captures broader service delivery rather than a targeted legal approach. Partially borrowed from human rights and domestic violence fields, the emerging practices describe holistic and collaborative delivery models where access to legal services is a critical though not a singular component. As the authors discuss, impact of legal services is present in the form of advocacy, psychological evaluation for asylum seekers, mediation and through multidisciplinary services. While evaluation of legal services for torture survivors is extremely limited in the literature, lessons learned from the international fieldwork suggests survivors of torture not only can benefit from integrated approaches to legal needs, but access to the legal system can empower and increase self-esteem for individual regardless of the legal outcome.

Dr. Marcus McKinney, in the final paper, provides an assessment of the spiritual literature. There is increasing evidence in the healthcare field that spirituality can have a positive effect on health indicators. Practically, for helping professionals, spirituality can be supported in a variety of ways. McKinney emphasizes the importance of

storytelling, and how a story acts as a window into a person's life, his or her sense of order and his or her meaning system. As providers of care, our role is to listen. He discusses the manifestation of spirituality through community support, social support and advocacy. McKinney offers very concrete and practical approaches to enhance service delivery through listening, building community and establishing collaborative approaches.

Given the nature of the practices, the social service, legal and spiritual domains are in nascent stages of scientific study among torture survivor populations compared to the clinical domains (medical, psychiatric, psychology and to a lesser degree expressive therapies). Yet, the synthesized literature across the seven domains represents a holistic perspective, covering the multitude of factors and complexities faced by survivors and the helping professionals who work with survivors. The survivor experience is a dynamic one and is unique for every individual. Approaches increasingly focus on the treatment of the whole person often requiring an ecological approach incorporating contextual understanding of culture, community and support systems as well as the physical, mental, social, and spiritual needs.

Limitations

Several limitations in this project are important to recognize. First, the compendium of evidence-based practices does not address specific vulnerable groups including children, adolescents and the elderly. Second, despite the parameters for this undertaking, inclusion criterion may be considered a subjective process, and may leave practitioners wondering why certain references were not included. The collaborative approach was our attempt to minimize the subjectivity, yet we recognize classic literature may be absent.

And finally, this is a time-sensitive product. Since the extensive literature search formerly concluded in the spring of 2009, new research has been published and the scientific knowledge in the field continues to evolve. NPCT plans to not only maintain this effort of gathering and disseminating evidence-based practices in the torture rehabilitation field, but the programme intends to expand upon this foundation to look at more expansive models of care, programmes and recovery models.

Conclusion

Measuring and evaluating the torture rehabilitation field is fraught with challenges. US-based torture treatment programmes see incredible cultural diversity among survivors served in their programmes. Confounding factors such as previous trauma, acculturation or resettlement issues cannot easily be controlled for. Despite the significant challenges, science and anecdotal evidence reveal effective practices and are featured here.

As providers working with survivors of torture, we have a responsibility to be aware of scientific evidence impacting the field. Not only is research imperative in direct services, but it also informs advocacy efforts, grant proposals and community, regional, national and international responses to the refugee, asylum seeker, and asylee experience. NPCT and its partners encourage readers to be aware of new and emerging data, and to seek consultation about service delivery. Regularly accessing peer reviewed journals by investing in access to academic databases or developing partnerships with local university libraries are useful activities.

The torture rehabilitation field has been described by survivors in one word: Hope. With increased knowledge about effective practices, the survivors' healing and post-traumatic growth will be fostered and sup-

ported by professionals with an appreciation of the whole individual, not just his or her parts.

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Reference

1. United States TITLE 18, PART I, CHAPTER 113C, § 2340.

Medical best practices for the treatment of torture survivors

Richard F. Mollica, M.D.*

Introduction

Accurate identification of torture survivors, including a history of the torture experiences and injuries, is essential for the medical care of torture survivors. This remains a challenge, although the importance was definitively described in the late 1980's by Goldfeld and her colleagues.[1] An accurate diagnosis, of course, is mandatory to implementing cultural and evidence-based treatment.[2,3] Traumatic life events, including the torture events of the patient must be a central focus of clinical thinking. This entails considering the effects of the patient's trauma story on the medical history, review of symptoms, physical examination, and laboratory studies.[4] A comprehensive review of symptoms in each major body system should not only be guided by the information obtained during the preceding medical interview but also by the patient's torture history.[5] The patient's traumatic experiences will help direct the physician to possible areas of the body that may have been damaged. For example, a potential rape victim will need detailed questions related to gynecological problems. A head injury might become evident during the neurological review and the physical sequelae of a burn injury will emerge during questioning on the skin.

The early historical focus on the discovery of a "torture syndrome"[1] which failed to materialize in the 1980s and 1990s has fallen away and has been replaced by a mounting interest in caring for survivors of torture using "best practices" that are also culturally efficacious in culturally diverse populations.[6,7] The latter is no small task since little research that meets the highest standards of a randomized control trials (RCT) have been conducted testing the effectiveness and cultural validity of specific forms of treatment for torture survivors.

The following review of the care of the medical problems of torture survivors includes mostly anecdotal studies in this new field that primarily meet the criteria for promising (P) and emerging (E) best practices as well as the best practices (B) established in related and overlapping medical areas. These studies are listed in accompanying Table 1.

Specialized Clinics for the Care of Torture Survivors

The most clinically effective and cost-effective approach at the clinic and systems levels for the care of torture survivors have not

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Table 1. *Medical Best Practices*

	Article	Type of Practice
Specialized Clinics		
1	Adams KM, Gardiner LD, Assefi N. Healthcare challenges from the developing world: post-immigration refugee medicine. British Med J 2004; 328(7455):1548-1552.	Best
2	Allden K, Baykal T, Iacopino V, Kirschner R, Özkalipçi O, Peel M, Reyes R, Welsh W, editors. Istanbul Protocol: manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Geneva: United Nations. Office of High Commissioner for Human Rights, 2001.	Best
3	Babamoto KS, Sey KA, Camilleri AJ, Karlan VJ, Catalasan J, Morisky DE. Improving diabetes care and health measures among Hispanics using community health workers: results from a randomized controlled trial. Health Educ Behav 2009;36(1):113-126.	Best
4	Boehnlein JK, Kinzie JD, Ben R, Fleck J. One-year follow-up study of posttraumatic stress disorder among survivors of Cambodian concentration camps. Am J Psychiatry 1985;142(8), 956-959.	Promising
5	Carlsson JM, Mortensen EL, Kastrup M. A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. J Nerv Ment Dis 2005;193(10):654-7.	Promising
6	Cathcart LM, Berger P, Knazan B. Medical examination of torture victims applying for refugee status. CMAJ 1979;121:179-84.	Best
7	Grigg-Saito D, Och S, Liang S, Toof R, Silka L. Building on the strengths of a Cambodian refugee community through community-based outreach. Health Promot Pract 2007;9(4):415-25.	Promising
8	Harlacher U, Jansen GB, Kastrup M, Madsen A, Montgomery E, Prip K, Sjölund BH. RCT Field Manual on Rehabilitation. Sjölund BH, editor. Copenhagen: The Rehabilitation and Research Centre for Torture Victims, 2007.	N/A
9	Kinzie JD, Fredrickson RH, Ben R, Fleck J, Karls W. Posttraumatic stress disorder among survivors of Cambodian concentration camps. Am J Psychiatry 1984;141(5):645-650.	Promising
10	Kinzie JD, Riley C, McFarland B, Hayes M, Boehnlein J, Leung P, Adams G. High prevalence rates of diabetes and hypertension among refugee psychiatric patients. J Nerv Ment Dis 2008;196(2):108-112.	Promising
11	Kinzie JD, Tran KA, Breckenridge A, Bloom JD. An Indochinese refugee psychiatric clinic: culturally accepted treatment approaches. Am J Psychiatry 1980;137(11):1429-1432.	Promising
12	Mollica RF, Wyshak G, Lavelle J, Truong T, Tor S, Yang T. Assessing symptom change in southeast Asian refugee survivors of mass violence and torture. Am J Psychiatry 1990;147(1):83-8.	Promising
13	Moreno A, Piwowarczyk L, LaMorte WW, Grodin MA. Characteristics and utilization of primary care services in a torture rehabilitation center. J Immigr Minor Health 2006;8(2):163-71.	Promising

	Article	Type of Practice
Medical Assessment and Screening		
14	Gurr R, Quiroga J. Approaches to torture rehabilitation: a desk study covering effects, cost effectiveness, participation and sustainability. Torture 2001;11(suppl 1).	Best
15	Rasmussen OV, Amris S, Blaauw M, Danielsen L. Medical physical examination in connection with torture (Section I). Torture 2004;14(1):48-55.	Best
16	Rasmussen OV, Amris S, Blaauw M, Danielsen L. Medical physical examination in connection with torture (Section II). Torture 2005;15(1):37-45.	Best
17	Rasmussen OV, Amris S, Blaauw M, Danielsen L. Medical physical examination in connection with torture (Section III). Torture 2006;16(1):48-55.	Best
Assessment and Screening		
18	Buchwald D, Manson SM, Brenneman DL, Dinges NG, Keane EM, Beals J, Kinzie JD. Screening for depression among newly arrived Vietnamese refugees in primary care settings. West J Med 1995; 163(4):341-345.	Promising
19	Mirzaei S, Knoll P, Lipp RW, Wenzel T, Koriska K, Köhn H. Bone scintigraphy in screening of torture survivors. Lancet 1998;352:949-51.	Best
20	Mollica RF, Caspi-Yavin Y. Measuring torture and torture-related symptoms. J Consult Clin Psychol 1991;3(4):581-7.	Best
21	Mollica RF, Caspi-Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. J Nerv Ment Dis 1992;180(2):111-116.	Best
22	Mollica RF, Wyshak G, Lavelle J, Truong T, Tor S, Yang T. Assessing symptom change in southeast Asian refugee survivors of mass violence and torture. Am J Psychiatry 1990;147(1):83-8.	Best
23	Oruc L, Kapetanovic A, Pojskic N, Miley K, Forstbauer S, Mollica R, Henderson DC. Screening for PTSD and depression in Bosnia and Herzegovina: validating the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist. Int J Cult and Ment Health 2008;1(2):105-116.	Best
24	Thomsen AB, Eriksen J, Smidt-Nielsen K. Chronic pain in torture survivors. Forensic Sci Int 1998;108:155-63.	Best
Medical Interventions		
25	Albucher RC, Liberzon I. Psychopharmacological treatment in PTSD: a critical review. J Psychiatr Res 2002;36(6):355-367.	Best
26	Arroll B, Elley CR, Fishman T, Goodyear-Smith FA, Kenealy T, Blashki G, Kerse N, MacGillivray S. Antidepressants versus placebo for depression in primary care. Cochrane Database Syst Rev 2009, Issue 3. Art. No.: CD007954. DOI: 10.1002/14651858.CD007954.	Best
27	Basoğlu M, Marks IM, Sengün S. Amitriptyline for PTSD in a torture survivor: a case study. J Trauma Stress 1991;5(1):77-83.	Promising
28	Berger W, Mendlowicz MV, Marques-Portella C, Kinrys G, Fontenelle LF, Marmar CR, Figueira I. Pharmacologic alternatives to antidepressants in posttraumatic stress disorder: a systematic review. Prog Neuropsychopharmacol Biol Psychiatry 2009;33:169-80.	Promising
29	Bisson JI. Pharmacological treatment to prevent and treat post-traumatic stress disorder. Torture 2008;18(2):104-6.	Promising

	Article	Type of Practice
30	Cohen JA, Mannarino AP, Perel JM, Staron V. A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. J Am Acad Child 2007;46(7):811-9.	Best
31	Cooper J, Carty J, Creamer M. Pharmacotherapy for posttraumatic stress disorder: empirical review and clinical recommendations. Aust N Z J Psychiatry 2005;39:674-82.	Best
32	DeMartino R, Mollica RF, Wilk V. Monoamine oxidase inhibitors in posttraumatic stress disorder: promise and problems in Indochinese survivors of trauma. J Nerv Ment Dis 1995;183(8):510-5.	Promising
33	Fernandez M, Pissiota A, Frans O, von Knorring L, Fischer H, Fredrikson M. Brain function in a patient with torture related post-traumatic stress disorder before and after fluoxetine treatment: a positron emission tomography provocation study. Neurosci Lett 2001;297:101-4.	Promising
34	Stein DJ, Ipser JC, Seedat S. Pharmacotherapy for post traumatic stress disorder (PTSD). Cochrane Database Syst Rev 2006, Issue 1. Art. No.: CD002795. DOI: 10.1002/14651858.CD002795.pub2.	Best
35	Stein DJ, Pedersen R, Rothbaum BO, Baldwin DS, Ahmed S, Musgnung J, Davidson J. Onset of activity and time to response on individual CAPS-SX17 items in patients treated for post-traumatic stress disorder with venlafaxine ER: a pooled analysis. Int J Neuropsychopharmacol 2008;12:23-31.	Best
36	U.S. Department of Health and Human Services. Chapter 2: The Fundamentals of Mental Health and Mental Illness. In Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. 1999.p.27-116.	Best
Insomnia		
37	Buysse, DJ. Chronic Insomnia. American Journal of Psychiatry 2008;165(6): 678-686.	Best
38	Buysse DJ, Reynolds C, Monk T, Berman S, Kupfer D. The Pittsburgh sleep quality index: A new instrument for psychiatric practice and research. Psychiatry Research 1989;28(2):193-213.	Best
39	Fürstenwald U. Group therapy for severely traumatized refugees with a focus on sleep disorders. Hemi-Sync J 2005; XXIII(3-4):v-vi.	Promising
40	Glovinsky PB, Yang CM, Dubrovsky B, Spielman AJ. Nonpharmacologic strategies in the management of Insomnia: Rationale and implementation. Sleep Medicine Clinics 2008;3:189-204.	Best
41	Krakow B, Hollifield M, Johnston L, Ross M, Schrader R, Warner TD, Tandberg D, Lauriello J, McBride L, Cutchen L, Cheng D, Emmons S, Germain A, Melendrez D, Sandoval D, Prince D. Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: a randomized controlled trial. JAMA 2001;286(5):537-545.	Best
42	Krakow B, Johnston L, Melendrez D, Hollifield M, Warner T, Chavez-Kennedy D, Herlan MJ. An open-label trial of evidence-based cognitive behavior therapy for nightmares and insomnia in crime victims with PTSD. Am J Psychiatry 2001;158:2043-7.	Best
43	Silber MH. Chronic Insomnia. New Engl J Med 2005;353(8):803-810.	Best

Article		Type of Practice
Head Injury		
44	Mollica R, Lyoo K, Chernoff M, Bui H. Lavelle J, Yoon S, Kim JE, Renshaw PF. Brain structural abnormalities and mental health sequelae in South Vietnamese ex-political detainees who survived trauamatic head injury and torture. Arch Gen Psychiatry 2009;66(11):1-12.	Best
Physical Rehabilitation		
Psychotherapy Massage		
45	Danneskiold-Samsøe B, Bartels EM, Genefke I. Treatment of torture victims – a longitudinal clinical study. Torture 2007;17(1):11-7.	Emerging
Meditation		
46	Krisanaprakornkit T, Sriraj W, Piyavhatkul N, Laopaiboon M. Meditation therapy for anxiety disorders. Cochrane Database Syst Rev 2006, Issue 1. Art. No.: CD004998. DOI: 10.1002/14651858.CD004998.pub2.	Promising
Exercise		
47	Grodin MA, Piwowarczyk L, Fulker D, Bazazi AR, Saper RB. Treating survivors of torture and refugee trauma: a preliminary case series using qigong and t'ai chi. J Altern Complement Med 2008;14(7):801-6.	Promising
48	Mead GE, Morley W, Campbell P, Greig CA, McMurdo M, Lawlor DA. Exercise for depression. Cochrane Database Syst Rev 2009, Issue 3. Art. No.: CD004366. DOI: 10.1002/14651858.CD004366.pub4.	Promising
Acupuncture		
49	Madsen MV, Gøtzsche PC, Hróbjartsson A. Acupuncture treatment for pain: systematic review of randomized clinical trials with acupuncture, placebo acupuncture, and no acupuncture groups. BMJ 2009;338:a3115.	Promising
50	Smith CA, Hay PPJ, MacPherson H. Acupuncture for depression. Cochrane Database Syst Rev 2010, Issue 1. Art. No.: CD004046. DOI: 10.1002/14651858.CD004046.pub3.	Promising
51	Sutherland JA. Getting to the point. Am J Nurs 2000;100(9):40-5.	Promising

been demonstrated. For years there has been a debate whether torture survivors need to be treated in their own specialized clinics or mainstreamed into conventional psychiatric and primary health care settings. It has not been proven that primary health care and community mental health centers can readily identify survivors of torture and provide them with the services they need. In contrast, Kinzie et al[8] and Mollica et al[9] along with the Danish Rehabilitation and Research Center for Torture Victims have shown that specialized clinics have promising results.[10]

The ethical protection of torture survivors and their need for a comprehensive medical and psychiatric examination has been well established in the Istanbul Protocol.[11] And there exists a large body of medical experience on the identification and treatment of the wide range of medical problems affecting resettled refugees, mainly those who have been tortured.[12,13] This body of work provides best practice baseline for all clinics initially approaching the assessment and care of torture survivors mostly under the broader designation of refugee

who now generally fall under statewide and local public health services for newly arrived immigrants.

While acute care for newly arrived refugees, including those who are torture survivors, now receive their greatest attention and government funding, chronic care models such as those used for diabetes are being applied to refugee communities and their subset of torture survivors. This seem to be a promising practice since a number of randomized trials have demonstrated in Hispanic and African American communities the effectiveness of community health workers, along with other adaptations of primary care, prompted improved diabetes control. Outcome studies of chronic disease control for diabetes, heart disease, stroke, hypertension and the metabolic syndrome in torture survivors are still necessary.[14-16]

Assessment and Screening

Over the past three decades extensive scientific data on the most frequent medical and psychiatric disorders affecting torture survivors have been well documented.[16-20] These references provide more detailed information beyond the scope of this review, and must be studied by any medical provider caring for torture survivors in order to be aware of the major medical and psychiatric sequelae associated with torture. At this time few medical findings are definitely pathognomic, except for biopsies of skin lesions associated with cigarette burns and electric shocks[1] and bone scans to assess damage to the alleged area of injury secondary to torture.[21] Chronic pain assessment and management in torture survivors is a promising area of development.[22]

Screening instruments that assess the traumatic life experiences of the patient in a yes/no format and that can be given as a medical 'test' have been demonstrated to be an ideal addition to the physician's clinical assessment of the torture survivor. It is very difficult for highly traumatized patients to present their symptoms of emotional distress to the doctor in any coherent fashion without being emotionally re-traumatized.[23]

Simple screening instruments, such as the Hopkins Symptom Checklist-25 (HSCL-25) and the Harvard Trauma Questionnaire (HTQ), are almost mandatory in the clinical assessment of torture survivors.[24-26] The Harvard Program in Refugee Trauma (HPRT) has had extensive experience training PCPs in the use of screening instruments such as the Hopkins Symptom Checklist-25 (HSCL-25) and the Harvard Trauma Questionnaire (HTQ) in PCP. The HSCL-25 is a 4-point Likert scale (1=*not at all*, 4=*extremely*) that measures 15 symptom items of depression in the past week. Based on previous research on the optimal cut-off point that maximizes sensitivity while maintaining high specificity, scores greater than 1.75 indicate the presence of major depressive disorder. The HTQ was originally developed by Mollica and colleagues as a companion measure to the HSCL-25 to assess traumatic events and trauma-related symptoms. The HTQ also makes a DSM-IV diagnosis of PTSD at a cut off of 2.0. The HSCL-25 and the HTQ are highly reliable and culturally valid instruments.[27]

The Vietnamese Depression Scale, one of the first culture-specific screening instruments for depression[28] has not been widely used as a model for other torture survivors in spite of its excellent ethnographic features.

Medical Interventions

Proven best practices (BP) for the care of medical problems of torture survivors is limited and relies heavily on the accepted standard of care found for mainstream medical problems in the Cochrane Reports (www.cochrane.org). To-date not a single RCT

exists on the medical care of torture survivors. The following is a review of anecdotal clinical reports as well as related practices from mainstream medical care.

Depression and Posttraumatic Stress Disorder

Turning our attention to direct medical interventions, the effectiveness of psychotropic drugs have been anecdotally described for refugee and torture survivors[29] and definitely demonstrated for depression and posttraumatic stress disorder (PTSD) as best practices in mainstream populations.[30-38] One caveat, however, clearly exists. Special attention must be given to the proper dosing of psychotropic drugs in culturally diverse populations. This field of ethnopsychopharmacology is revealed in Chapter 2 of the Surgeon General's Report on Mental Health[39] and a scientific toolkit guide for medication and depression is available from Harvard Program in Refugee Trauma upon request (www.hprt-cambridge.org).

Insomnia

Chronic and severe sleep problems have emerged as a major medical problem in survivors of violence and torture.[40,41] Extensive research has revealed the effective non-pharmacological strategies for sleep disturbances regardless of whether it is of primary or secondary to a medical or psychiatric disorder.[42-46] Randomized trials demonstrating the efficacy of non-drug treatment of nightmares secondary to rape trauma (common in tortured women and crime victims) is noteworthy.[40,44]

Neuropsychological problems of Traumatic Head Injury (THI)/ Traumatic Brain Injury (TBI)

TBI has been well known and described as a common and major sequelae of torture.[45,46] TBI results from traumatic blows to the head and other forms of traumatic head injury (THI), strangulation, anoxia secondary to waterboarding, and near drowning, and suffocation (e.g. placing a plastic bag over a person's head).

Mollica et al.[47] in their landmark study of torture survivors have demonstrated the deleterious effects of THI on the brain of torture survivors and its correlation with depression. The neuropsychological literature on THI in mainstream patients suggests that these THI patients can be successfully rehabilitated through specialized psychosocial and cognitive training.[47] In addition, it is possible that depression and PTSD secondary to THI may be associated with chronic post-concussive symptoms that may be difficult to treat with standard approaches using psychotropic drugs and counseling.

Physical Rehabilitation

Massage,[48] physical therapy,[48] meditation,[49] diet and exercise,[50,51] and acupuncture[52-54] are promising and emerging best practices in the physical rehabilitation of torture survivors.

Future Directions

The medical care of torture survivors has made enormous scientific advances over the past three decades in documenting and describing the major medical and psychiatric sequelae of torture. The health impact of torture can be severe and chronic and lead to major disability and even premature death. Clearly, since there are not enough specialized clinics to care for torture survivors in the United States and abroad, mainstream primary care practitioners and certain specialists such as psychiatrists need to be taught how to identify and treat the medical problems associated with torture. Evidence-based medicine from mainstream approaches to patient care must be applied to the medical care of tor-

ture survivors. However, every diagnosis and treatment must be contextualized not only to the cultural and social environment of the patient, but to those unique barriers to treatment and healing that affect individuals who have experienced cruel and degrading human abuse of a horrific and unspeakable nature by other human beings. Longitudinal studies of the medical impact of torture overtime on survivors as well as specific hypothesis based RCTs need to be conducted to determine what standard best practices need to be modified in order to maximize clinical outcomes in the care of survivors. At the minimum all current clinics that care for survivors need to carefully monitor their treatment outcomes and in partnership with research institutions scientifically evaluate their treatment outcomes. The findings would be strengthened if they could be compared against suitable control groups. Each torture treatment center must measure up well in comparison to the "best" general medicine has to offer, and ideally even do better in adapting current best practices to the unique cultural, social and psychological realities of the torture survivor.

The "best practices" for treating the medical problems of torture survivors remains the "best practices" available to-date for caring for mainstream patients with more conventional causes of their medical and psychiatric illnesses. As with all medical and mental health problems, the bio-psycho-social model remains the most promising manner of thinking about cause and effect and linking the latter to treatment.[55,56] The special conditions that characterize the torture experience and which may have a major impact on adapting standard medical best practices to the care of survivors has been widely discussed and need to be considered in caring for all those human beings that have suffered extreme violence.[4]

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Guidelines for psychiatric care of torture survivors

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"I had terrible nightmares of the war every night until I came to the clinic and got treatment and medicine. Now they have stopped."

49-year-old Bosnian male

Review of the evidence for best psychiatric care of torture survivors

In describing the best psychiatric practices for the treatment of torture survivors, it is necessary to provide background on the various syndromes the survivors suffer and their corresponding neurobiology. There are also well known clinical aspects of these conditions and unique social and cultural considerations of survivors who usually come from very different cultures than the clinicians treating them. This will be briefly discussed in this section.

Syndromes among torture victims

A great deal of epidemiological data, both in countries of origin and in the United States, has indicated a high degree of psychopathology among torture victims and refugees.[1] A recent study of 1,134 Somali and Oromo refugees in Minnesota found a high torture prevalence (25 to 69%, depending on ethnicity and gender).[2] Using the Post-Traumatic Stress Disorder (PTSD) checklist (PCL-C), the authors found suspected PTSD in 25% of those exposed to torture. Clearly, PTSD has been found to be the most common diagnosis, though the prevalence varies from study to study. However, the diagnosis in epidemiological studies rarely translates to those which will be found in a clinical setting. The barriers to see a psychiatrist for many refugees is quite high. Patients often only come after coercion from family, or with severe social or physical problems, or at the urging of their immigration attorney. This means that the diagnosis one sees from studies may not be reflected in the clinical data. A recent study of 239 Bosnian and Somali patients found approximately 65% had PTSD and 60% had Major Depressive Disorder. In about 80%, the two conditions combined. Additionally, the study found that about 12% had major psychosis, including schizophrenia.[3] These diagnoses are of course a psychiatrist's summarization of various symptoms patients give and may not reflect the real concerns of the patient. Usually patients present with pain syndromes, very poor sleep, nightmares, and agitation. Best practice requires screening all torture survivors for PTSD, depression and psychotic symptoms. This is done in a

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face-to-face interview at intake and includes simple questions about mood, appetite, sleep, nightmares, irritability and auditory hallucinations.

Symptoms of anxiety and panic attacks are frequent but are often accompanied or associated with PTSD and depression. Permanent personality change by a traumatic event, as listed in ICD-9, does occur and patients who are extremely impacted may present with severe social withdrawal, avoidant behavior, and paranoia. In aging populations of traumatized refugees, patients may present with signs of dementia, reflected in being unable to maintain their own daily living, agitation at night, wandering away from home, and requiring a great deal of family service. This also needs to be evaluated and handled by a psychiatrist.

Neurobiology of PTSD and Depression

PTSD and Depression can be manifestations of central nervous system (brain) dysfunction (for review, see chapter by Southwick & Friedman, 2001[4]). The stress response of the hypothalamic pituitary adrenal axis is a normal response. However, under prolonged stress there can be serious consequences for health. It can cause plasticity in the brain and systemic hormones to produce structural as well as functional changes. Under extreme conditions, permanent damage may occur, not only through adrenal steroids but local tissue may be involved.[5] There are changes in neurotransmitters involving hyperactivity of the adrenal pituitary axis, autonomic reactivity and differences in brain structure and functions, which has been well documented.[6] This may be mediated through the amygdala. With the normal fear response, there may be a failure of other networks to regulate amygdala activity, resulting in the hyperactivity that is seen in many PTSD patients. Cortisol levels have been found to be reduced in some PTSD patients but recent work was not able to replicate these findings.[7] The hyperarousal response of the autonomic nervous system likely reflects epinephrine hyperactivity in the locus coeruleus area.[8] Others have found a reduced size of the hippocampus which corresponds to lowered recent memory and working memory for PTSD patients. This has led to a search for treatments for PTSD which would be directed at the brain disorders. Paroxetine (Paxil), for example, has been approved for the treatment of PTSD.9 After 10 weeks it was found that many of the PTSD symptoms and physiological reactivity measures did improve.

Unique Aspects Related to Treatment of Posttraumatic Stress Disorder and Depression in Refugees

There are several unique aspects to traumatized patients. First of all, most conditions are chronic. The nightmares, depression, and avoidant behavior will last for years. This has been studied among Cambodians in California where the symptoms were shown to be chronic decades after the Pol Pot regime.[10] A study of treated Cambodians indicated that a large percentage have chronic symptoms with ten or more years of treatment. Some of these symptoms are less problematic, (e.g., ongoing avoidance) but in others the full syndrome of PTSD may persist.[11]

Remissions and exacerbations are a second major feature of traumatized individuals. Any traumatic event can reactivate the full spectrum of PTSD. For example, a patient population of Vietnamese, Cambodians, Bosnians, and Somalis experienced almost complete reactivation of symptoms following observing on T.V. the attacks on the Twin Towers on 9/11.[12] The implication from this is that these patients need long-term care. Periods of remission, or improved function-

ing, does not mean it cannot reoccur. These patients may need ongoing treatment for the exacerbation of symptoms. Medication and support can ameliorate the effects of the exacerbation.

A third area of concern is regarding ethnopsychopharmacology,[13] which indicates that there are ethnic differences in the metabolism of various medications. This is true at a group level; however, the individual differences within groups are much greater than the means of the group. Therefore, one cannot take a group as a whole and determine what level of medication a patient will need. Individual variation is too great and trial and error become part of finding the correct dosage.

Social and Cultural Aspects of Psychiatric Medication

Many patients, especially from developing countries, come with little knowledge or information about psychiatric disorders and are even afraid that seeing a psychiatrist implies that they are "crazy." It takes a great deal of individual, family and community education to overcome these barriers. In addition, psychiatric treatment may be viewed as similar to antibiotic treatment – that is, short-term treatment and the disease is eliminated. A study of antidepressant compliance using blood levels found very high rates of no detectable medicine in their blood, i.e. not taking any medicine.[14] This did improve, as did their symptoms, with education. Maintenance treatment is not understood or followed for many with psychiatric conditions. Providers cannot assume that the medication is taken as prescribed and repeated education is often needed. Providers must ask about medicine use and side effects (absence of side effects probably means subtherapeutic dose). The most useful approach in addition to education is having patients bring their medicine bottles to each appointment and pills can be counted.

Specific Psychiatric Medication Information

Evidence-based medical practice has become a standard for evaluating treatment outcomes in medicine. This implies using rigid controlled studies to compare various treatment methods to determine which is most effective. There has been a great deal of criticism of the application of such studies for psychiatry on the basis of lack of criteria for diagnosis, individual differences in the patients, and the underlying assumptions on treatment methodologies.[15-18] The criticisms are somewhat irrelevant since there are no scientific, rigorous studies of comprehensive rehabilitation programs for torture survivors. One study which did evaluate treatment outcomes found no difference.[19] This study did not use medication which may indicate the lack of efficacy in treatment without a psychotropic drug. A recent review summarized treatments for PTSD among refugees and asylum-seekers.[20] Ten randomized-controlled studies were reported but no treatments were firmly supported. These randomized-controlled studies (efficacy studies) rarely are confirmed or translated in actual practice (effectiveness studies).[21] Reasons for this are complicated but clearly a study of refugees and asylum-seekers that only looks at PTSD and not depression or other medical disorders is very limited. In addition, only two of the studies used medication.[20]

Despite the lack of rigorous controlled studies in the torture treatment population, there is considerable data on treatment of PTSD, depression and psychosis in civilian and veteran populations. In addition, there is other e-based information available besides evidence-based. That is, experience-based and expert-based practices. Our clinic has

treated traumatized refugees for 33 years and our clinicians have accumulated considerable experience and expertise in the psychiatric treatment of torture survivors. Therefore, this review will focus on information from non-torture studies as well as our own long-term experiences. Currently we have 1,200 refugee patients, half of which have experienced torture, under our psychiatric care.

Before reviewing specific treatment guidelines, it should be emphasized that medication treatment does not exist in isolation. It occurs in the context of a complete psychiatric evaluation and an ongoing psychotherapeutic relationship which meets the psychological, social, legal, medical, and spiritual needs of the patients. Also, only guidelines can be given since specific treatment depends upon the patient's special symptoms, medical history, previous response, tolerance of side effects, and all the factors physicians consider in prescribing a medication.

Many of the medications that treat PTSD also treat depression, which is fortunate due to their frequent co-morbidity. Paroxetine, a selective serotonin reuptake inhibitor (SSRI), has been approved for this, though there is no reason to think it is any better than other SSRIs. It has a distinct disadvantage in the high rate of sexual dysfunction that patients experience as a side-effect, which even modest patients complain about. Other newer antidepressants, such as Effexor, have problems such as getting people off the medication due to withdrawal symptoms.

Clinical practitioners have found that fluoxetine (Prozac) and citalopram (Celexa) are two easily tolerated medications, given once a day. Fluoxetine has the advantage of a long half-life and a patient can miss a day or two without any recurrence of symptoms. This is not true of the other SSRIs. They are not particularly sedative and for patients under 65 who have trouble sleeping, anecdotal evidence has found the tricyclic medications the most useful. The cheapest one (a month's supply available for $8 at local pharmacies) is doxepin, which greatly aids sleep and is a powerful antidepressant. It has side-effects of drowsiness and constipation. It also has been worrisome for some because hoarding several months supply then taken at once could result in death. Imipramine, which some clinicians consider a slightly superior antidepressant, is more expensive. A dosage of 50-100 mg is usually adequate. However, patients from diverse ethnic groups are taking 200 mg without any side-effects and with a noticeable improvement in sleep and depression.

The alpha-adrenergic blocking agents clonidine and prazosin are extremely helpful for the nightmares and some of the agitation. These agents tone down the nor-epinephrine effect in the central nervous system that has been used for high blood-pressure treatment and are very effective in stopping nightmares.[8,22-25] These medications are routinely prescribed by providers at our torture treatment center with reports of 45-50% of patients seen taking medication. A related medication, doxazosin, has recently been found to be helpful in posttraumatic stress disorder.[26]

Anecdotally, it is usual to start patients immediately on an antidepressant such as fuoxetine in the morning and clonidine 0.2-0.4 mg hs. If sleep is a huge problem, clinicians may prescribe a medicine such as doxepin 50-100 mg at night in addition to clonidine. Nightmares are usually reduced and sleep is increased within one or two weeks.

A continual problem among many patients is irritability and hyperarousal which

contributes to interpersonal stress and may result in agitation and sometimes violence. Low doses of the atypical antipsychotics like Risperdal have been used to decrease irritability.[27] In a recent study, about 46% of patients were getting an antipsychotic medication and less than half had psychosis, the remaining received it for symptoms of agitation.[3]

People who have been traumatized can also have psychosis. The effect of auditory hallucinations and bizarre behavior is disruptive for the individual, family and the community. This may be related to severe torture but, in many cases, it is an effect of a large population – i.e. about 1% will have schizophrenia in any population. The atypical antipsychotic medications vary in their usefulness. Patients have responded to atypical medications such as Seroquel and Abilify. Many failures have been reported with these medications and so therefore we see the use the older ones, such as Perphenazine, in moderately high doses (32-64 mg).

With an aging population in some refugee groups, there is an increase in the number of people presenting with dementia, usually managed with a great deal of difficulty for their family. They often will wander at night, erratically get irritable, and may be unable to maintain some of their own daily activities. One of the first symptoms to address is to help them sleep at night. Low doses of antipsychotic medicine have been used, recognizing some of the difficulties of these medicines, to help them get a good night's sleep and allow the family to rest. Agitation may also be decreased with the use of medication. Risperdal 3-4 mg has often been helpful. Seroquel, which is more sedative, has been needed as well. Perphenazine 8-32 mg at night is a typical dose. Recently, a study has found that prazosin has treated the behavioral symptoms of agitation and aggression in patients with Alzheimer's disease.[28] We have used it with several demented torture survivors and found it very helpful. There is now evidence of increased rates of dementia in U.S. Veterans with PTSD.[29] We are now seeing increasing dementia among older tortured patients.

Pain is often a common complaint and some people have genuine symptoms of arthritis. It is tempting to use a narcotic, but experience has shown this is unwise. Ibuprofen and Naproxen, both non-steroid anti-inflammatory agents, have controlled such symptoms. The main side-effect has been stomach upset which may need to be addressed with omeprazole (Prilosec).

Studies have found a high rate of hypertension and diabetes among patients.[30] This is alarmingly so and represents a huge public health problem of increased heart disease, strokes and other complications of these two diseases. New patients who do not have a regular physician are strongly recommended to get blood pressure measurements at admission and periodically. Rate of hypertension in patients is 45%, about three times the national average for age group. Rate of diabetes is about 17%, which is also much higher than the national American average.[30] It leads to the problem of what to do with people who do not have regular medical care and cannot afford medication. Clearly the conditions are best treated by an internist or a family physician. Patients have not always had these doctors available for reasons of no insurance, language barriers, or long waiting lists at community clinics. Procedures are to routinely do blood pressure measures at the first visit and periodically thereafter if there is no other physician involved. If there is a risk of diabetes in obesity, age, or family history, clinicians can do a fasting glucose or Hem A_{1C} which is easier to do since it does not require fasting. If it is necessary to begin

Table 1. *Guidelines for Psychiatric Care for Torture Survivors.*

	Article	Type of Service
Syndromes among Torture Victims		
1	Steel Z, Chey T, Silove D, Marnane C, Bryant RA, van Ommeren M. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. JAMA 2009;302(5):537-49.	Best
Neurobiology of PTSD and Depression		
2	Bisson JI. Pharmacological treatment to prevent and treat posttraumaticstress disorder. Torture 2008;18(2):104-6.	Emerging
3	Boehnlein JK, Kinzie JD. Pharmacologic reduction of CNS noradrenergicactivity in PTSD: the case for clonidine and prazosin. J Psychiatr Pract 2007;13(2):72-8.	Best
Social and Cultural Aspects of Psychiatric Medication		
4	Kinzie JD, Leung P, Boehnlein JK, Fleck J. Antidepressant blood levels in Southeast Asians: clinical and cultural implications. J Nerv Ment Dis 1987;175:480-5.	Promising
Specific Psychiatric Medication Information		
5	Boynton L, Bentley J, Strachan E, Barbato A, Raskind M. Preliminary findings concerning the use of prazosin for the treatment of posttraumatic nightmares in a refugee population. J Psychiatr Pract 2009;15(6):454-9.	Best
6	De Jong J, Wauben P, Huijbrechts I, Oolders H, Haffmans J. Doxazosin treatment for posttraumatic stress disorder. J Clin Psychopharmacol 2010;30(1):84-5.	Promising
7	Foley KF, Quigley DI. Pharmacogenomic potential of psychiatric medications and CYP2D6. MLO Med Lab Obs 2010;42(1):32-4.	Emerging
8	Kinzie JD, Riley C, McFarland B, Hayes M, Boehnlein J, Leung P, Adams G. High prevalence rates of diabetes and hypertension among refugee psychiatric patients. J Nerv Ment Dis 2008;196(2):108-12.	Promising
9	Kinzie JD, Sack RL, Riley CM. The polysomnographic effects of clonidine on sleep disorders in posttraumatic stress disorder: a pilot study with Cambodian patients. J Nerv Ment Dis 1994;182(10):585-7.	Best
10	Laika B, Leucht S, Heres S, Steimer W. Intermediate metabolizer: increased side effects in psychoactive drug therapy. The key to cost-effectiveness of pretreatment CYP2D6 screening? Pharmacogenomics J 2009;9(6):395-403.	Emerging
11	Loovers HM, van der Weide J. Implementation of CYP2D6 genotyping in psychiatry. Expert Opin Drug Metab Toxicol 2009;5(9):1065-77.	Emerging
12	Ramey-Hartung B, El-Mallakh RS, Reynolds KK. Pharmacogenetic testing in schizophrenia and posttraumatic stress disorder. Clin Lab Med 2008;28(4):627-43.	Emerging
13	Wang LY, Shofer JB, Rohde K, Hart KL, Hoff DJ, McFall YH, Raskind MA, Peskind ER. Prazosin for the treatment of behavioral symptoms in patients with Alzheimer disease with agitation and agression. Am J Geriatr Psychiatry 2009;17(9):744-51.	Promising
14	Wexler R, Feldman D. Initiation of therapy for patients with essential hypertension or comorbid conditions. Prim Care 2006;33(4):887-901.	Promising
Summary		
15	Kinzie JD. Combined psychosocial and pharmacological treatment of traumatized refugees. In: Wilson JP, So-kum Tang C, editors. Cross-Cultural Assessment of Psychological Trauma and PTSD. New York: Springer; 2007. p. 359-69.	Best

treatment for hypertension the guidelines for initiation of therapy for essential hypertension are very helpful.[31] There are specific indications for use of diuretics, β blockers, and ACE-I medications. The standard of care for diabetes has been well described by the American Diabetic Association.[32]

Related to the probable ethnic differences in metabolizing medication,[13] new methods of pharmacogenetics testing may make it possible in the future to analyze prior to treatment the major metabolizing enzymes such as P-450 2D6, which could give the dose of an antidepressant or antipsychotic that a patient would need.[33,34] This in theory would avoid the lengthy trial and error method psychiatrists now use. There are problems associated with this, such as co-medicines use and diet[35,36] as well as expense, which places this in the emerging practice category which may be part of standard care in the future.

Summary

Refugees and asylum seekers who are torture survivors have a high risk of psychiatric disorders. A great deal is known about the biology of these disorders and their treatments. Psychotropic medications can provide rapid improvement in symptoms and therefore need to be initiated early in treatment.
All survivors who have positive symptoms should have a full psychiatric evaluation including current history, past psychosocial history, medical history, mental status examination, and a 5-axis diagnosis. Psychiatric care can be successfully combined with psychotherapy and social support.[37] Trauma related symptoms may be chronic and require long-term care, but the health and quality of life is greatly improved with the appropriate use of psychiatric medications.

There is very strong evidence that associated depression of torture victims may be effectively treated by antidepressant medication. There is good evidence that nightmares and sleep disturbance may be relieved by adrenergic blocking agents, such as clonidine and prazosin. There is some evidence that low doses of an antipsychotic medication, such as risperidone, helps agitation and irritability. There is no evidence that medication can help avoidance and numbing symptoms or prevent exacerbations of symptoms after new trauma. The promising and emerging psychiatric practices are listed in Table 1 on the previous page.

Learning Points

Many refugees who have been tortured have major psychiatric disorders including depression, PTSD, and psychosis.

These disorders cause changes in the central nervous system and can be successfully treated by appropriate medicine in the therapy.

These disorders are subject to remissions and exacerbations and medical treatment needs to begin early to provide immediate relief and continue long term.

Highly Recommended Readings

- Boehnlein JK, Kinzie JD. Pharmacologic reduction of CNS noradrenergicm activity in PTSD: the case for clonidine and prazosin. J Psychiat Pract 2007;13(2): 72-78.
- Kinzie JD. Combined psychosocial and pharmacological treatment of traumatized refugees. In: Wilson JP, So-kum Tang C, editors. Cross-Cultural Assessment of Psychological Trauma and PTSD. New York: Springer; 2007. p. 359-69.
- Marshall GN, Schell TL, Elliott MN, Berthold SM, Chun CA. Mental health of Cambodian refugees 2 decades after resettlement in the United States. JAMA 2005;294(5):571-9.

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34. Ramey-Hartung B, El-Mallakh RS, Reynolds KK. Pharmacogenetic testing in schizophrenia and posttraumatic stress disorder. Clin Lab Med 2008;28:627-43.
35. Foley KF, Quigley DI. Pharmacogenomic potential of psychiatric medications and CYP2D6. MLO Med Lab Obs 2010;42(1):32-4.
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37. Kinzie JD. Combined psychosocial and pharmacological treatment of traumatized refugees. In: Wilson JP, So-kum Tang C, eds. Cross-cultural assessment of psychological trauma and PTSD. New York: Springer, 2007:359-69.

The Inge Genefke and Bent Sørensen Anti-Torture Support Foundation

The foundation was established by the OAK Foundation in 2002 as a non-profit foundation:

1. to support work against torture
2. in particularly to support travel that is associated with the work against torture
3. every even year to honor a person, which has carried out particularly commendable work against torture with the Inge Genefke award of 10.000 euro.

Everybody can apply for a grant from the foundation. Send an application to the manager Bent Sørensen at bs@atsf.dk. The time for decision is normally less than one week.

Everybody can donate to the foundation: Bank details: Danske Bank, Danske Forvaltning, Strødamvej 46, DK-2100 Copenhagen Ø. IBAN: DK9030003946133744, SWIFT code: DABADKKK

Best, promising and emerging practices in the treatment of trauma:

What can we apply in our work with torture survivors?

Mary R. Fabri, Psy.D.*

"To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. The study of psychological trauma means bearing witness to horrible events."

Judith Herman, Trauma and Recovery (1992, p. 7)

In 1997, the National Institute of Mental Health convened a working group to address the mental health consequences of torture and other related traumas. Their approach was to review related traumatic stress research and practice areas.[1] Specific studies focusing on the treatment of torture survivors was then a small body of literature. More than eleven years later, in 2008, an international conference was co-sponsored by the Rehabilitation and Research Centre for Torture Victims and the Centre for Transcultural Psychiatry in Copenhagen, Denmark. A Special Report, *Rehabilitating Torture Survivors*, summarized the conference presentations by invited experts.[2] Notably, the status of rigorous scientific studies of interventions utilized[2] by torture rehabilitation centers continue to be lacking in the literature.

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Many torture treatment centers annually provide services to survivors from more than 50 countries who are presenting with diverse cultural and linguistic backgrounds, thus posing obvious research challenges. Studies focusing on refugee camp populations or in-country nationals share similar backgrounds and also post-conflict, highly stressful living conditions. Refugees may or may not have a torture experience. It is an important consideration for researchers that the research may contribute to a survivor feeling like a research object, much like the object of torture they were, a passive rather than active participant. Torture survivors often feel disempowered by the experience of torture where they were under the control of the perpetrator. Research that empowers the survivor as a participant who is contributing to a body of knowledge that will help others seems particularly important to emphasize. Additionally, there are many confounding factors in trauma research, such as multiple traumas, previous mental health conditions, lengths of time since the trauma, and the difficulty in conducting controlled studies that make reliable conclusions.

The Complexity of Studying Psychological Healing

Many of the early accounts written about the treatment of torture survivors are clinical narrative accounts of case examples, lessons learned by clinicians. They are classic ac-

counts of the development of working with trauma survivors suffering from PTSD.[3] An instructive example of the importance of considering different factors, such as culture, in developing and studying treatment outcomes can be made by comparing two articles, Group Treatment of Exiled Survivors of Torture by Fischman and Ross[4] and Individual and *Group Treatment and Self and Other Representations Predicting Posttraumatic Recovery Among Former Political Prisoners* by Salo, et al.[5]

The 1990 publication is a description by two therapists of a group therapy process with Central and South American refugees with a focus on torture related symptoms of PTSD. The authors describe assessment interviews to select a homogeneous membership based on torture and subsequent symptoms. Six male and two female group members, all survivors of torture, completed a six month, once a week group therapy intervention at a hospital-based community mental health center. The first sessions focused on building group cohesion through trust building that stressed confidentiality and privacy. Thematic concerns were identified and addressed, including, but not limited to: psychoeducation about posttraumatic stress disorder, the strategies of the use of torture, identifying distressing triggers in their current environment and techniques to better manage symptoms. Additionally, "group members prepare[d] individual written testimonies of their experiences of torture and then organize[d] them into a collective document" (p. 57).[5] The authors believed that the collective testimony process, better understanding the strategy of torture and its psychological consequences, provided an important "sociopolitical context" for the group members. Based on the authors' clinical impressions, reports from group members at follow-up sessions, and then informal telephone follow-ups, the group therapy intervention provided the survivors with a "new perspective" that allowed them to understand their symptoms in a sociopolitical context and to feel "less alone and less disturbed" (p. 57).[5]

The 2008 publication compares individual therapy (19 participants), group therapy (20 participants), and a control group (76 members) of Palestinian former political prisoners at a community mental health clinic in Gaza. PTSD was measured using the Harvard Trauma Questionnaire and trauma events were documented using a check list of 30 commonly used interrogating techniques. Post traumatic growth measures were also collected but will not be discussed here due to the nature of the comparison being offered. The individual therapies were conducted by trained, degreed trauma specialists who utilized several psychotherapeutic techniques, including, but not limited to: systematic desensitization, coping skills training, affect regulation, and addressing family and social problems in the context of the therapy. Four male and one female BA level counselors led groups with five members each. The groups focused on creating mutual support by providing psychoeducation, sharing and validating each member's personal account of trauma, and creating social interaction. Additionally, the group addressed socioeconomic problem solving. The authors report that PTSD symptoms decreased for those who participated in the individual therapy and that no decrease was measured in the group therapy and the control group over a one year period. The authors state, "Our results caution the use of group therapy" (p.57).[5]

The 1990 study found group therapy to be a useful intervention with torture survivors from Central and South America; the 2008 study did not find improvement with Palestinian former political prisoners. These

examples provide different results and also utilized different methodologies of assessing, reporting, and conducting the group interventions. Can both be accurate? What are the critical differences? Both sets of authors are respected in the field of torture treatment. Is it culture? Is it living in exile versus being in the country of origin and trauma? Was it components in the treatment design? Was it the therapist's educational and experience level? Currently there is a focus on evidence-based practices which measure improvement. We must remember, however, that the lessons learned with clinical experience contribute to our body of knowledge as well.

After reviewing the selected literature (64 articles) on torture and other related traumas, multiple categories of interventions for discussion emerged: psychotherapy and psychiatric medication; Cognitive Behavioral Therapy (CBT); family interventions; psychosocial community interventions; oral history/testimony/psycho-legal work; other therapeutic techniques; and therapeutic considerations and cautions. This paper will discuss the literature within the context of these categories, provide a review of current literature, and make a determination as to its best, promising, or emerging practice status, specifically for treatment of survivors of torture.

Psychotherapy and Psychiatric Medication

Models of care and treatment issues are the primary focus of this category. Studies generally had small samples and mostly without control groups. Other write-ups were case analyses outlining the course of treatment with one torture survivor. Multidisciplinary care of torture survivors was generally promoted and reflected a bio-psycho-social model. The role of culture was mentioned in most studies noting that culture mediates how survivors may interpret, express, and cope with the trauma. Treatment models included individual psychotherapy, group therapy, and intergenerational groups and integrated cognitive-behavioral, insight-oriented, and short-term therapy strategies. Several of the reported interventions were in conjunction with psychiatric medication and care.

There was a general consensus in several articles that multidisciplinary care which included access to care in all domains of health was an important part of caring for torture survivors. Although clinicians often promote treatment that includes psychotherapy and psychiatric medication, there is no empirical research as to its efficacy in the treatment of trauma to consider it more than a "*Promising Practice*." Clinical experience is often anecdotal and the need for data that provides an evidence-based conclusion is needed and recommended.

A subset of these articles looked at specific psychological functions of torture survivors in the context of psychotherapy. One article by Kanninen et. al.[6] examined attachment patterns and the development of alliance with the therapist and noted that the interpersonal nature of torture results in extra difficulties in developing a trusting relationship. In another paper by Kanninen et. al.,[7] the authors suggested that understanding the survivor's appraisal of their trauma will help the therapist understand their coping processes and that facilitating a reappraisal can assist in improving coping strategies. These studies, however, may not be generalizable as they had small sample sizes and the subjects were all Palestinian male former political prisoners.

Cognitive Behavioral Therapies (CBT)

The largest percentage (30%) of articles fall into this category of intervention with sub-categories of study populations: general PTSD populations; female rape victims;

adults who were child sexual abuse victims; child sexual abuse victims; and refugees. Although trauma victims share many commonalities, especially of possible resulting symptoms, they also have unique contextual characteristics which are important to understand.

In the general PTSD studies, most were randomized trials with control groups of wait-listed participants or participants receiving care as usual. These trials looked at different CBT strategies with PTSD patients. Generally, CBT interventions, such as exposure and cognitive restructuring were compared with relaxation and eye movement desensitization and reprocessing (EMDR) with consistent finding of a CBT strategy being the most effective therapeutic condition, even when as in one study it was conducted via videoconference.[8] A multi-site study of female rape victims[9] treated chronic PTSD with random assignment to prolonged exposure, prolonged exposure plus cognitive restructuring, or wait list found that prolonged exposure alone reduced PTSD in the sample when compared to the other two groups. A randomized trial of CBT for chronic PTSD in women survivors of childhood sexual abuse was compared to a problem-solving therapy and to a wait-list.[10] CBT participants were more likely to no longer meet the criteria for PTSD than the other two groups with a sustained symptom reduction on follow up. A meta-analysis of research comparing the use of psychotherapy in treating PTSD with Trauma-focused CBT (TF-CBT), EMDR, stress management (SM) was conducted by Bisson and Andrew in 2007.[11] Combining the data from thirty-three studies, they found that TF-CBT, EMDR, and SM all were effective in reducing the severity of PTSD symptoms. Other forms of psychotherapy were not found to be effective.

Despite the success reported in case studies and in controlled studies, EMDR remains controversial among clinicians, with strong proponents and equally strong critics. There is consensus, however, that the use of EMDR in the context of a therapeutic alliance, following the full protocol which utilizes other cognitive techniques can be helpful in the treatment of PTSD. What component of EMDR effects improvement is an ongoing point of clinical discussion.[2,12,13] Additionally, the scientific rigor and populations studied is variable.

Judith Cohen and Anthony Mannarino at Allegheny Hospital in Pennsylvania and Esther Debliner and colleagues at the Center for Child Support in New Jersey have advanced the study of CBT's use with sexually abused children. Their efforts have resulted in Trauma-informed Cognitive Behavioral Therapy (TF-CBT) as an evidenced-based practice. Findings in randomly assigned treatment studies found TF-CBT more effective than non-directive supportive therapy or treatment with medication. Non-perpetrator parent(s) are part of the treatment plan as well, thus adding a family therapy component. Documentation of CBT used with refugee groups living in the United States,[14-16] the United Kingdom,[17] and in camps in Uganda[18] all improved functioning with the reduction in PTSD symptoms. Sensitivity to torture and war trauma events as catastrophic and cultural adaptation was stressed by each study, along with the importance of training interpreters to assist in the therapy. Additionally, sample sizes were small, so the results are to be considered as promising. The various modules frequently used in CBT include: psychoeducation; relaxation training; cognitive restructuring and affect modulation; and narrative construction. These components are often an integral part of treatment that torture survivors receive at

specialized treatment centers over a period of time, but not in a time-limited structured (4-16 weeks) intervention.

Disrupted sleep patterns are common to trauma survivors who are often plagued by nightmares with content of the traumatic event. Management of nightmares is often part of PTSD treatment. Imagery Rehearsal Therapy (IRT) has been successfully shown to resolve nightmares in a crime victim population. IRT is a four session up to eight hours intervention which includes an educational, cognitive restructuring element that emphasizes the nightmare as a learned behavior. Treatment emphasizes changing the nightmare into a new dream by rehearsing new imagery. It is a staged approach to decreasing nightmares. Authors cite the limited generalizability to other populations such as war veterans, refugees, and disaster survivors.

The body of empirical evidence in well-designed and executed studies conducted with diverse trauma populations is sufficient to consider CBT-guided treatment as a "*Best Practice.*" This suggests a strong probability that a trauma-informed CBT-guided treatment that is flexible to the unpredictable stressors, cultural diversity, and varying worldviews of torture survivors being treated in settings located in host countries is an effective treatment approach. There is again the need and recommendation for sensitively designed research with torture survivors to contribute to the growing base of evidence-based studies on the use of CBT-guided treatment.

Family Interventions

Many torture survivors enter the United States as individuals and apply for political asylum. Upon being granted asylum, the survivor starts the lengthy process of family reunification. Refugees are often resettled with family members. Families can be an important factor in facilitating mental health services. Multiple family groups were conducted with refugees from Bosnia-Herzegovina in the community as an alternative to agency delivered services. One-hundred and ninety-seven adults and their families were randomly assigned to the intervention group or a control group which met with an interviewer to complete measures. The multiple family groups brought families together for conversation and information and potential referral to appropriate services.[19] This method was found to provide support and increased access to needed services. Other family approaches were reviewed in an article by Froma Walsh[20] with a focus on family resiliency by promoting greater understanding of a family's belief systems, organizational patterns, and communication processes. This framework provides the structure to assist families as they encounter challenges and distressing events in their life cycle such as losses, illness, traumatic events with a focus on family strengths and how they can meet these challenges effectively. Strength-based interventions are an important part of trauma work that promotes wellness.

Promoting the practice of cultural and religious rituals by displaced families promotes the maintenance of their beliefs and traditions and helps maintain an emotional connection to "home." Case studies were used by Woodcock[21] to illustrate how incorporating the use of ritual into the therapeutic work can help families transport their culture into their new home and provide a familiar system of strength and support. Family practice of rituals may also lead to community celebrations.

Taking into consideration the strong role of family in most cultures and the impact torture has not only on the survivor, but also his family, these studies are important, but do not reach the needed rigor to be considered more than an "Emerging Practice." It

is important to consider the circumstances of torture survivors: are they resettled as a refugee with their family, or are they an individual asylum seeker who is seeking refuge alone and entering the long and arduous process of asylum and reunification. Family interventions are not always possible with torture survivors.

Psychosocial Community Interventions

Several studies conducted in post-violence countries addressed the needs of survivors of political violence and torture with community interventions. The cited programs included: internally displaced refugee mothers with young children in Bosnia who were provided psychosocial support groups and medical care;[22] discussion groups to address community psychosocial problems in the Peruvian Andes;[23] community workshops on personal and interpersonal empowerment in Namibia;[24] and facilitated community reflection groups in Guatemala.[25] The studies all reported achieving successful outcomes that focused on rebuilding trust and social support networks through education and discussion at the community level.

Psychosocial interventions as cited in the literature have been projects that have been unable to demonstrate more than clinical anecdotal information. While these projects suggest potential for psychosocial community interventions, it is an "*Emerging Practice*" for consideration.

Testimony Therapy, Oral History, and Psycho-legal Work

Case study reports about the use of testimony as therapy with Aurohuaca Indians in Colombia;[26] and with former political prisoners in Chile;[27] and an oral history group with Cambodian women living in Chicago[28] document successful interventions which broaden the context of healing. The subjective, private pain from torture was described as transformed into objective, political statements which provided the context for creating meaning in the survivor's life. The therapist as listener bears witness and is responsible for facilitating an authentic account of what happened to the survivor in a responsible and therapeutic manner. Anthropologist Kelly McKinney[29] objects to the stance that trauma victims need to tell their story in order to heal. McKinney states that psychological, cultural, and political beliefs are not universal and cautions about assuming the rehabilitative aspects of narrative.

Authors with a more geo-political perspective assess political activism as therapeutic and included testimony as part of historical construction in Peru[30] and legal action against police torture in India.[31] The victim is empowered with the support of legal advocates and therapists as they navigate legal arenas in an effort to expose the injustice, be heard in a court of law, and seek reparations. Justice is viewed as the therapeutic agent.

While interesting and suggestive of potential, the papers that describe the use of narrative within the context of testimony, oral history, or psycho-legal collaborations are projects that are anecdotal and therefore an "*Emerging Practice*."

Other Therapeutic Techniques

Within the context of trauma treatment, clinicians often find therapeutic techniques that are effective with some of their clients. These reports tend to be case studies or studies with small samples in a clinical setting. The International Rehabilitation and Research Centre for Torture Victims in Copenhagen addressed pain among torture survivors by combining physiotherapy (massage, exercise, and balance training) within a multidisciplinary treatment approach and demonstrated a significant decrease in mus-

culoskeletal pain.[32] A refugee clinic that is part of a Family and Community Medicine Program in Arizona reported in case studies the successful use of hypnotic ego-strengthening with an interactive metaphorical story telling approach that indirectly promotes improved self-efficacy. The authors caution that metaphors must be culturally meaningful.[33,34] Thought Field Therapy (TFT – mechanical stimulation of energy meridian points combined with bilateral optical cortical stimulation) was reported to have improved emotional suffering from trauma symptoms in 105 ethnic Albanians from Kosovo in 2000.[35] The authors recommend that more studies should be done using TFT with trauma victims.

While these papers share successful lessons learned at sites where skilled clinicians implemented treatment interventions that they clinically observe and report improvement, they lack scientific rigor to consider them more than "*Emerging Practices*." See Table 1 on next page.

Therapeutic Considerations & Cautions

Several general cautions appear throughout the literature regarding psychological treatment of survivors of war, political violence, and torture. Culture, religion, and gender ideologies are important considerations in treatment. The therapist is an important agent of assistance no matter what the intervention.

The studies reviewed on the psychological treatment of trauma covered a broad range of trauma populations. The evidence-based studies with control groups were not conducted with a torture survivor population. There are significant challenges for conducting research with torture survivors living in exile (diversity of languages and cultures seen at torture treatment programs) and with displaced refugees (acuteness of trauma and access). Most of the torture survivor studies are Promising and Emerging Practices that have utilized pre- and post-measures after treatment without a control group and case study reports. PTSD as a shared diagnosis is not enough to generalize best practices from a general American population to a culturally, religiously, and ethnically diverse refugee population. The scope of empirical evidence that has been well-designed and implemented studies of the use of CBT-guided treatments merits being a Best Practice. The obvious caveat is the need to modify and adapt CBT components to be appropriate for use with the culturally diverse torture survivor population. There is much to be learned and considered from the review of the literature on the treatment of trauma. As ethical and responsible clinicians we have the responsibility to remain versed in the latest treatment studies and thoughtfully consider them as we meet torture survivors in our treatment settings.

Learning Points

Post-traumatic stress disorder (PTSD) as a shared diagnosis is not enough to generalize best practices from a general American population to a culturally, religiously, and ethnically diverse refugee population.

The scope of empirical evidence that has been well-designed and implemented studies of the use of CBT-guided treatments merits being a Best Practice. The obvious caveat is the need to modify and adapt CBT components to be appropriate for use with the culturally diverse torture survivor population.

There is much to be learned and considered from the review of the literature on the treatment of trauma.As ethical and responsible clinicians we have the responsibility to remain versed in the latest treatment studies and thoughtfully consider them as we meet torture survivors in our treatment settings.

Table 1. *Treatment of Trauma*

	Article	Type of Practice
1	The Mental Health Consequences of Torture. Gerrity E, Keane TM, Tuma F. Editors Kluwer Press: Plenum Publishers;2001.	n/a
2	Sjölund BH, Kastrup M, Montgomery E, Persson AL. Rehabilitating torture survivors. J Rehabil Med 2009;41(9):689-96.	n/a
Complexity of Studying Psychological Healing		
3	Fischman Y, Ross J. Group treatment of exiled survivors of torture. Am J Orthopsychiat 1990;60(1):135-142.	n/a
4	Haley S. When the patient reports atrocities. Archiv Gen Psychiat 1974;30(2):191-196.	Emerging
5	Salo J, Punamaki R, Qouta S, El Sarraj E. Individual and group treatment and self and other representations predicting posttraumatic recovery among former political prisoners. Traumatology 2008;14(2):45-61.	Best
Psychotherapy and Psychiatric Medication		
6	Berliner P, Mikkelsen EN, Bovbjerg A, Wiking M. Psychotherapy treatment of torture survivors. The Int J Psychosoc Rehabil 2004;8:85-96.	Promising
7	Holmqvist R, Andersen K, Anjum T, Alinder B. Change in self-image and PTSD symptoms in short-term therapies with traumatized refugees. Psychoanal Psychother 2006;20(4):251-65.	Promising
8	Kanninen K, Salo J, Punamaki R. Attachment patterns and working alliance in trauma therapy for victims of political violence. Psychother Res 2000;10(4):435-49.	Promising
9	Kanninen K, Punamaki R, Qouta S. The relation of appraisal, coping efforts, and acuteness of trauma to PTSD symptoms among former political prisoners. J Trauma Stress 2002;15(3):245-53.	Promising
10	Kastrup M, Genefke IK, Lunde I, Ortmann J. Coping with the exposure to torture. Contemporary Family Therapy. 1988;10(4):280-7.	Emerging
11	Kidron CA. Surviving a distant past: a case study of the cultural construction of trauma descendant identity. Ethos. 2004;31(4):513-44.	Emerging
12	Kinzie JD. Psychotherapy for massively traumatized refugees: the therapist variable. Am J Psychother. 2001;55(4):475-90.	Emerging
13	Mollica RF, Wyshak G, Lavelle J, Truong T, Tor S, Yang T. Assessing symptom change in southeast Asian refugee survivors of mass violence and torture. Am J Psychiatry. 1990;147(1):83-8.	Promising
14	Momartin S, Coello M. Self-harming behaviour and dissociation in complex PTSD. Torture. 2006;16(1):20-9.	Emerging
15	Peltzer K. An integrative model for ethnocultural counseling and psychotherapy of victims of organized violence. Journal of Psychotherapy Integration. 2001;11(2):241-62.	Promising
16	Stultz J. Integrating exposure therapy and analytic therapy in trauma treatment. Am J Orthopsychiatry. 2006;76(4):482-8.	Promising

	Article	Type of Practice
Cognitive Behavioral Therapies		
17	Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database Syst Rev 2007, Issue 3. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub3.	Review
18	Coalson B. Nightmare help: treatment of trauma survivors with PTSD. Psychotherapy Theory, Research, Practice, Training. 1995;32(3):381-8.	Emerging
19	Cohen JA, Mannarino AP. Interventions for sexually abused children: initial treatment outcome findings. Child Maltreat. 1998;3(17):17-26.	Best
20	Cohen JA, Mannarino AP, Perel JM, Staron V. A pilot study of modified cognitive-behavioral therapy for childhood traumatic grief (CBT-CTG). J Am Acad Child Adolesc Psychiatry. 2006;45(12):1465-73.	Promising
21	Cohen JA, Mannarino AP, Perel JM, Staron V. A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. J Am Acad Child Adolesc Psychiatry. 2007;46(7):811-9.	Best
22	Deblinger E, Steer RA, Lippmann J. A two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. Child Abuse & Neglect. 1999;23(12):1371-78.	Best
23	Foa EB, Hembree EA, Cahill SP, Rauch SAM, Riggs DS, Feeny NC, Yadin E. Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: outcome at academic and community clinics. J Consult Clin Psychol 2005;73(5):953-64.	Best
24	Germain V, Marchand A, Bouchard S, Drouin M, Guay S. Effectiveness of cognitive behavioural therapy administered by videoconference for posttraumatic stress disorder. Cogn Behav Ther 2009;38(1):42-53.	Promising
25	Hinton DE, Pham T, Tran M, Safren SA, Otto MW, Pollack MH. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. J Trauma Stress 2004;17(5):429-33.	Best
26	Hunot V, Churchill R, Teixeira V, Silva de Lima M. Psychological therapies for generalized anxiety disorder. Cochrane Database Syst Rev 2007, Issue 1. Art. No.: CD001848. DOI: 10.1002/14651858.CD001848.pub4.	Promising
27	Ilic A. EMDR in the treatment of posttraumatic stress disorder with prisoners of war. In: Torture in war: consequences and rehabilitation of victims – Yugoslav experience. Špiric Z, Knezevic G, Jovic V, Opacic G, editors Belgrade: IAN;2004. p.281-291.	Review
28	Krakow B, Johnston L, Melendrez D, Hollifield M, Warner T, Chavez-Kennedy D. An open-label trial of evidence-based cognitive behavior therapy for nightmares and insomnia in crime victims with PTSD. Am J Psychiatry. 2001;158;2043-7.	Emerging
29	Krakow B, Zadra A. Clinical management of chronic nightmares: imagery rehearsal therapy. Behav Sleep Med. 2006;4(1):45-70.	Emerging
30	Macdonald G, Higgins JPT, Ramchandani P. Cognitive-behavioural interventions for children who have been sexually abused. Cochrane Database Syst Rev 2006, Issue 4. Art. No.: CD001930. DOI: 10.1002/14651858.CD001930.pub2.	Best
31	Marks I, Lovell K, Noshirvani H, Livanou M, Thrasher S. Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring. Arch Gen Psychiatry. 1998;55;317-25.	Promising

Article		Type of Practice
32	McDonagh A, Friedman M, McHugo G, Ford J, Sengupta A, Mueser K, Demment CC, Fournier D, Schnurr PP. Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. J Consult Clin Psychol 2005;73(3):515-24.	Best
33	Neuner F, Schauer M, Klaschik C, Karunakara U, Elbert T. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. J Consult Clin Psychol 2004;72(4):579-87.	Best
34	Regel S, Berliner P. Current perspectives on assessment and therapy with survivors of torture: the use of a cognitive behavioural approach. Eur J Psychother and Couns 2007;9(3):289-99.	Emerging
35	Schulz PM, Huber LC, Resick PA. Practical adaptations of cognitive behavioral processing therapy with Bosnian refugees: implications for adapting practice to a multicultural clientele. Cogn Behav Pract 2006.13:310-21.	Promising
36	Schulz PM, Marovic-Johnson D, Huber LC. Cognitive-behavioral treatment of rape- and war-related posttraumatic stress disorder with a female, Bosnian refugee. Clin Case Stud 2006;5:191-208.	Promising
37	Schulz PM, Resick PA, Huber LC, Griffin, MG. The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. Cognitive and Behavioral Practice. 2006.13:322-31.	Promising
38	Sikes C, Sikes V. EMDR: Why the controversy? Traumatology 2003; 9(3):169-181.	Promising
39	Stultz J. Integrating exposure therapy and analytic therapy in trauma treatment. Am J Orthopsychiat 2006;76(4):482-8.	Promising
40	Tarrier N, Pilgrim H, Sommerfield C, Faragher B, Reynolds M, Graham E, Barrowclough C. A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. J Consult Clin Psychol. 1999;67(1):13-8.	Promising
41	Taylor S, Thordarson DS, Maxfield L, Fedoroff IC, Lovell K, Ogrodniczuk J. Comparative efficacy, speed, and adverse effects of three PTSD treatments: exposure therapy, EMDR, and relaxation training. J Consult Clin Psychol. 2003;71(2):330-8.	Promising
42	Wittmann L, Schredl M, Kramer M. Dreaming in posttraumatic stress disorder: a critical review of phenomenology, psychophysiology and treatment. Psychother Psychosom. 2007;76(1):25-39.	Emerging
Family Interventions		
43	Walsh F. A family resilience framework: innovative practice applications. Fam Relat 2002;51(2):130-7.	Emerging
44	Weine S, Kulauzovic Y, Klebic A, Besic S, Mujagic A, Muzurovic J, Spahovic D, Sclove S, Pavkovic I, Feetham S, Rolland J. Evaluating a multiple-family group access intervention for refugees with PTSD. J Marital Fam Ther 2008;34(2):149-64.	Best
45	Woodcock J. Healing rituals with families in exile. Am J Fam Ther 1995;17(4):397-409.	Emerging
Psychosocial Community Interventions		
46	Berliner P, Mikkelsen EN, Bovbjerg A, Wiking M. Psychotherapy treatment of torture survivors. Int J Psychosoc Rehabil 2004;8:85-96.	Promising

Highly Recommended Readings

- Berliner P, Mikkelsen EN, Bovbjerg A, Wiking M. Psychotherapy treatment of torture survivors. Int J Psychosoc Rehabil 2004;8:85-96.
- Fabri MR. Reconstructing safety: Adjustments to the frame in the treatment of survivors of political torture. Prof Psychol-Res PR 2001;32(5): 452-457.
- Hinton DE, Pham T, Tran M, Safren SA, Otto MW, Pollack MH. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. J Trauma Stress 2004;17(5):429-33.
- Kinzie JD. Psychotherapy for massively traumatized refugees: the therapist variable. Am J Psychother 2001;55(4):475-90.
- Neuner F, Schauer M, Klaschik C, Karunakara U, Elbert T. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. J Consult Clin Psychol 2004;72(4):579-87.

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2. Sjölund BH, Kastrup M, Montgomery E et al. Rehabilitating torture survivors. J Rehabil Med 2009;41:689-96.
3. Haley S. When the patient reports atrocities. Archiv Gen Psychiatry 1974;30:191-6.
4. Fischman Y, Ross J. Group treatment of exiled survivors of torture. Am J Orthopsychiatry 1990;60:135-42.
5. Salo J, Punamaki R, Qouta S et al. Individual and group treatment and self and other representations predicting posttraumatic recovery among former political prisoners. Traumatology 2008;14:45-61.
6. Kanninen K, Salo J, Punamaki R. Attachment patterns and working alliance in trauma therapy for victims of political violence. Psychother Res 2000;10:435-49.
7. Kanninen K, Punamaki R, Qouta S. The relation of appraisal, coping efforts, and acuteness of trauma to PTSD symptoms among former political prisoners. J Trauma Stress 2002;15:245-53.
8. Germain V, Marchand A, Bouchard S et al. Effectiveness of cognitive behavioural therapy administered by videoconference for posttraumatic stress disorder. Cogn Behav Ther 2009;38(1):42-53.
9. Foa EB, Hembree EA, Cahill SP et al. Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: outcome at academic and community clinics. J Consult Clin Psychol 2005;73:953-64.
10. McDonagh A, Friedman M, McHugo G et al. Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. J Consult Clin Psychol 2005;73:515-24.
11. Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database Syst Rev 2007, Issue 3. Art. No.: CD003388. DOI: 10.1002/14651858. CD003388.pub3.
12. Ilic A. EMDR in the treatment of posttraumatic stress disorder with prisoners of war. In: Špiric Z, Knezevic G, Jovic V et al, eds. Torture in war: consequences and rehabilitation of victims – Yugoslav experience. Belgrade: IAN, 2004:281-91.
13. Sikes C, Sikes V. EMDR: why the controversy? Traumatology 2003;9:169-81.
14. Stultz J. Integrating exposure therapy and analytic therapy in trauma treatment. Am J Orthopsychiatry 2006;76:482-8.
15. Schulz PM, Marovic-Johnson D, Huber LC. Cognitive-behavioral treatment of rape- and war-related posttraumatic stress disorder with a female, Bosnian refugee. Clin Case Stud 2006;5:191-208.
16. Hinton DE, Pham T, Tran M et al. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. J Trauma Stress 2004;17:429-33.
17. Regel S, Berliner P. Current perspectives on assessment and therapy with survivors of torture: the use of a cognitive behavioural approach. Eur J Psychother and Couns 2007;9:289-99.
18. Neuner F, Schauer M, Klaschik C et al. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. J Consult Clin Psychol 2004;72:579-87.
19. Weine S, Kulauzovic Y, Klebic A et al. Evaluating a multiple-family group access intervention for refugees with PTSD. J Marital Fam Ther 2008;34:149-64.
20. Walsh F. A family resilience framework: innovative practice applications. Fam Relat 2002;51:130-7.
21. Woodcock J. Healing rituals with families in exile. Am J Fam Ther 1995;17:397-409.
22. Dybdahl R. Children and mothers in war: an outcome study of a psychosocial intervention program. Child Dev 2001;72:1214-30.
23. Snider L, Cabrejos C, Marquina EH et al. Psychosocial assessment for victims of violence in

Peru: the importance of local participation. J Biosoc Sci 2004;36:389-400.
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25. Berliner P, Dominguez M, Kjaerulf F et al. What can be learned from "crazy" psychologists? A community approach to psychosocial support in post-conflict Guatemala. Intervention (Amstelveen) 2006;4(1):67-73.
26. Agger I, Jensen SB. Testimony as ritual and evidence in psychotherapy for political refugees. J Trauma Stress 1990;3:115-30.
27. Van Dijk JA, Schoutrop MJA, Spinhoven P. Testimony therapy: treatment method for traumatized victims of organized violence. Am J Psychother 2003;57:361-73.
28. Herbst PKR. From helpless victim to empowered survivor. Women Ther 1992;13(1):141-54.
29. McKinney K. "Breaking the conspiracy of silence": testimony, traumatic memory, and psychotherapy with survivors of political violence. Ethos 2007;35:265-99.
30. Laplante LJ. Women as political participants: psychosocial postconflict recovery in Peru. Peace and Conflict: J Peace Psychol 2007;13:313-31.
31. Agger I, Ansari F, Suresh S et al. Justice as a healing factor: psycho-legal counseling for torture survivors in an Indian context. Peace and Conflict: J Peace Psychol 2008;14:315-33.
32. Danneskiold-Samsøe B, Bartels EM, Genefke I. Treatment of torture victims – a longitudinal clinical study. Torture 2007;17:11-7.
33. Edmunds D, Gafner G. Touching trauma: combining hypnotic ego strengthening and zero balancing. Contemp Hypn 2003;20:215-20.
34. Gafner G, Benson S. Indirect ego-strengthening in treating PTSD in immigrants from Central America. Contemp Hypn 2001;18:135-44.
35. Johnson C, Shala M, Sejdijaj X et al. Thought field therapy – soothing the bad moments of Kosovo. J Clin Psychol 2001;57:1237-40.

Expressive arts therapies: Working with survivors of torture

Amber Elizabeth Lynn Gray, M.P.H., M.A., L.P.C.C., A.D.T.R., N.C.C.*

Movement, to be experienced, has to be found in the body, not put on like a dress coat. There is that in us which has moved from the very beginning: it is that which can liberate us."

Mary Whitehouse

The small but growing body of literature pertaining to torture treatment includes an even smaller body of literature dedicated to the expressive arts therapies – modalities often categorized as "alternative treatment" and/or as "non-verbal therapies." By definition, torture treatment denotes work with an extraordinarily diverse group of people, whose cultural backgrounds, socio-economic, political and cosmological contexts comprise a globally inclusive scope. Over the years, attempts to quantify best practices have focused on principles of treatment, and have not yet investigated the merits of the steadily increasing types of therapeutic modalities available.

Torture practices vary globally, and many methods of torture are found worldwide. The impact on individuals, however, must be understood through that person's context. Treatment for survivors of torture is increasingly appreciated as necessitating a holistic approach, i.e. one that includes the whole person – physical, mental, emotional, social, spiritual, contextual, cultural, familial, etc. The movement towards evidenced based practices creates an opportunity to broaden our understanding that what works must be both documentable and relevant at all levels of human experience to all those survivors we treat.

The 26 articles and papers reviewed as emerging, promising and best practice potentials for torture survivors can be classified according to the modalities: art therapy, dance/movement therapy (including body-oriented therapy combined with brief therapy), drama therapy, music therapy, sandtray therapy, and ritual. Body-oriented therapy and brief therapy are somatic therapies that share clinical principles for treatment with expressive arts therapies. Ritual is a valued approach to healing in many cultures that has a place in this body of work as many of the world's rituals incorporate drumming, chanting, dancing and other creative mediums into the ritual and/or healing process. Additionally, many of the articles reviewed cite ritual as a core healing mechanism at play in the interventions described.

The use of drama/theater, dance and even other physical activities (i.e. sports) are also discussed in some of the literature. It bears noting that dance/movement therapy, music

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therapy, drama therapy and art therapy are all licensed professions that require training, integrating psychological knowledge with the expressive, creative and healing aspects of the art form. This paper distinguishes these therapeutic modalities from their integration as pure art forms into broader psychotherapeutic, psychosocial or community-based interventions for survivors of torture.

The non-verbal aspect of these modalities is gaining attention in the area of current neuropsychiatric research, which increasingly endorses the use of therapies that are not dependent on verbal communication, exchange and understanding. Research demonstrates that the impact of trauma on human experience is multi layered (physical, emotional, psychological, social, physiological, etc).[1-3] Terr[4] and Herman[5] describe traumatic memory as being based in imagery and body sensation and lacking verbal narrative, and therefore "resembling the memories of young children" (p. 38).[5] The impact of trauma on memory is described from the biological perspective by van der Kolk[2,3] who posits that human ability for linguistic encoding becomes inactivated by high sympathetic nervous system activation, so that the central nervous system reverts to sensory and more primitive memory forms.[5] Regulation of normal bodily states[5] interrupted by childhood and adult traumatic experience calls for the development, implementation and research of clinical interventions that address the multiple realms of traumatic and human experience.

Art Therapy/Creative Arts Therapy

Creative Arts Therapies including art therapy, sandtray therapy and psychodrama are described in Scott[6] from a psychodynamic clinical orientation. Case studies are used to illustrate the therapeutic process and outcomes. While these case studies describe work with survivors of trauma (vs. trauma secondary to torture) the traumas experienced by the clients include early childhood abuse and sexual abuse, and a house fire. Given the small body of writing that exists specific to expressive arts and somatic therapies with survivors of torture, any anecdotal, outcome or clinical trial research on these modalities with survivors of trauma may be useful when determining a course of treatment for torture survivors.

Another article[7] focuses on the use of art therapy to document children's memory of war and violence, and post-conflict situations. Art is described as a powerful medium for young survivors who may not have words to describe what they have been through and their ideas and hopes for the future. Art is a direct portal to the symbolic realm, and as such may be a useful medium to access both traumatic and resource-based memories in children, and in adolescents and adults with earlier trauma exposure. The language of childhood is the imaginal realm, and art allows safety and containment when accessing memories underlying the traumatic response. Greenberg et al.[8] describes the use of painting with a client who has been assessed using standardized neurological and psychiatric tests. The article does not include data on client improvement, other than to state that the use of drawing and painting benefits the client's recovery.

The limited references to art therapy should not minimize its use with this population. Art therapy is used world-wide with survivors of torture in many contexts and cultural settings. The lack of clinical outcome research and reliance on anecdotal information and case studies limits this modality to an emerging practice. Hopefully, future research will earn art therapy its place as a promising practice in clinical work with survivors of torture. See Table 1.

Table 1. *Expressive Arts Therapies: Working with Torture Survivors*

	Article	Type of Practice
Introduction		
1	Herman J. Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books; 1997.	n/a
2	Porges SW. Music therapy & trauma: insights from the Polyvagal theory. In: Stewart K, editor. Symposium on Music Therapy & Trauma: Bridging Theory and Clinical Practice. New York: Satchnote Press; 2008.	Promising
3	Terr LC. Too scared to cry: psychic trauma in childhood. New York: Basic Books; 1990.	n/a
4	van der Kolk B, Greenberg M, Boyd H, Krystal J. Inescapable shock, neurotransmitters, and addiction to trauma: toward a psychobiology of posttraumatic stress. Biol Psychiat 1985;20(3):314-25.	n/a
5	van der Kolk B. The body keeps the score: memory and the evolving psychobiology of posttraumatic stress. Harv Rev Psychiat 1994;1(5):253-65.	Promising
Art Therapy/Creative Arts Therapy		
6	Greenberg M, van der Kolk BA. Retrieval and integration of traumatic memories with the "painting cure." In: van der Kolk, BA, editor. Psychological Trauma. Virginia: American Psychiatric Publishing, Inc.; 1987. p. 191-215.	Emerging
7	Janzen RK, Janzen JM. "Ayiwewe": war-traumatized children draw their memories. Can J Afr Stud 1999;33(2-3):593-609.	Emerging
8	Scott E. A model of creative arts therapy: eight essential processes. Sierra Tucson Progress 2005;Summer/Fall:1-2.	Emerging
Dance/Movement Therapy		
9	Amone-P'Olak K. Mental status of adolescents exposed to war in Uganda: finding appropriate methods of rehabilitation. Torture 2006;16(2):93-107.	Promising
10	Berliner P, Mikkelsen EN, Bovbjerg A, Wiking M. Psychotherapy treatment of torture survivors. Int J Psychosoc Rehabil 2004;8:85-96.	Promising
11	Callaghan K. Movement psychotherapy with adult survivors of political torture and organized violence. Art Psychother 1993;20:411-21.	Emerging
12	Callaghan K. Movement psychotherapy with adult survivors of political torture and organized violence. Art Psychother 1993;20:411-21.	Emerging
13	Callaghan K. In limbo: movement psychotherapy with refugees and asylum seekers. In: Dokter, D, editor. Art therapists, refugees and migrants: reaching across borders. London: Jessica Kingsley Publishers; 1998. p. 25-40.	Emerging
14	Gray AEL. Dancing in our blood: dance movement therapy with street children and victims of organized crime in Haiti. In: Jackson N, Shapiro-Lim T, editors. Dance, human rights and social justice: dignity in motion. Maryland: Scarecrow Press; 2008. p. 222-36.	Emerging
15	Gray AEL. Dance movement therapy with a child survivor: a case study. Dialogues. 2001;6(1):8-12.	Emerging
16	Gray AEL. Rituals of healing encountered among street children in Haiti. Stress Newsl Int Soc Trauma Stress Stud 2002;16(3):8-9.	Emerging
17	Gray AEL. The body as voice: somatic psychology and dance/movement therapy with survivors of war and torture. Connections 2001;3(2):2-4.	Emerging

Article		Type of Practice
18	Gray AEL. The body remembers: Dance movement therapy with an adult survivor of torture. J Dance Ther 2001;23(1):29-43.	Emerging
19	Harris D. Sudanese youth: dance as mobilization in the aftermath of war. In: Jackson N, Shapiro-Lim T, editors. Dance, human rights and social justice: dignity in motion. Maryland: Scarecrow Press; 2008. p. 253-5.	Emerging
20	Harris DA. Pathways to embodied empathy and reconciliation after atrocity: former boy soldiers in a dance/movement therapy group in Sierra Leone. Intervention 2007;5(3):203-31.	Promising
21	Singer AJ. Interactions between movement and dance, visual images, etno and physical environments: psychosocial work with war-affected refugees and internally displaced children and adults. In: Jackson N, Shapiro-Phim T, editors. Dance, human rights, and social justice: dignity in motion. Maryland: The Scarecrow Press, Inc.;2008. p. 237-52.	Promising
Drama Therapy		
22	Schininà G. "Far away, so close" psychosocial and theatre activities with Serbian refugees. Drama Rev 2004;48(3):32-49.	Emerging
Music Therapy		
23	Jones C, Baker F, Day T. From healing rituals to music therapy: bridging the cultural divide between therapist and young Sudanese refugees. Art Psychother 2004;31:89-100.	Emerging
Sandtray Therapy		
24	Toscani F. Sandrama: psychodramatic sandtray with a trauma survivor. Art Psychother 1998;25(1):21-9.	Emerging
Ritual and Ceremony		
25	Johnson DR, Lahad M, Gray A. Creative therapies for adults. In: Foa E, Keane T, Friedman M, Cohen J, editors. Effective treatments for PTSD: practice guidelines from the International Society for Traumatic Stress Studies. 2nd ed. New York: The Guilford Press; 2009. p. 479-90.	Promising
Concluding Considerations		
26	Foa EB, Keane TM, Friedman MJ, Cohen JA. Effective treatments for PTSD: Practice guidelines from the international society for traumatic stress studies. 2nd ed. New York: The Guilford Press; 2009.	n/a

Dance/Movement Therapy

Dance/Movement Therapy ("DMT") is both a somatic and an expressive arts therapy. A primary theoretical underpinning of this psychotherapeutic practice is that movement is a primary language for all human beings and, as such, is a powerful means to access implicit memory and stored history, trauma-related or not. From a developmental perspective, DMT acknowledges the non-verbal roots of all human language, communication, and experience, and therefore may be particularly suited to work with survivors of torture who have literally experienced the unspeakable directly to their bodies. Dance may be considered the creative or expressive aspect of movement, and for many cultures where the creative process is included in ritual, healing and daily life, DMT may be more appropriate than conventional talk

therapy. The non-verbal and pre-verbal nature of trauma also supports the use of this modality.

Callaghan[9,10] has written extensively on the use of movement therapy, a term she chooses to acknowledge the predominance of movement over dance in her work. Using case material, the author describes the application of this modality to work with survivors whose bodies are affected through pain, internal tension and conflict, shame and guilt. For those whose bodies have been deconstructed, movement may be more palatable, than dance, which requires a measure of safety or cultural congruence with expression. A primary message of the case studies, group and individual, is that mind and body exist on a continuum so all injury secondary to torture affects the body.

Gray[11-15] and Harris[16,17] expand the application of DMT to acknowledge the roots of this form in ritual and traditional practices in Africa and Haiti. Harris[17] includes references to pre-and post- intervention symptom (i.e. anxiety, depression, elevated arousal, intrusive recollection, aggression) assessment based on self-report, with positive outcomes in discharging aggression and restoring interpersonal connection. While the majority of the writing on dance/movement therapy with survivors of torture and related traumas relies on case studies, the cross-cultural adaptability of these expressive arts therapies is particularly highlighted in all the works reviewed. Gray describes the cultural considerations of using DMT on a continuum from individual to group and community illustrating the broad application of this form. Her articles describe DMT in not only clinical settings, but in community settings such as massacre sites and on the very streets where street children who are also survivors of violence and human rights abuse reside. The adaptability of DMT to multiple and low resource, insecure settings is a worthwhile consideration in relation to its application to survivors of trauma and torture.

Ritual is the primary emphasis of Amone-P'Olak,[18] although drama and dance in their traditional forms are integrated into a psychotherapeutic setting. This cross-sectional research design uses self report and observation to measure mental states and war experiences. The use of traditional cleansing rituals by recognized traditional healers is enhanced with the traditional practices of dance and drama. Due to the research design the data is not generalizable beyond the scope of this study of war-affected youth in Uganda.

Singer[19] describes the use of an ecological model of dance movement therapy and storytelling in post-war Serbia for adult and child refugees and internally displaced people [IDP] exposed to brutalities and violence. Her work, also descriptive and based on case material and participant observation, clearly illustrates the importance of culture as a determining factor in deciding how to integrate the arts and the arts therapies into community-based psychosocial interventions. This work is conducted in collaboration with a center that is explicitly devoted to expressive potential and etno, a term denoting a communal resource of traditional creative arts form such as dance, storytelling, and crafts. The arts are a meaningful variable in a relationship-focused process that consciously works with the present-time physical environment and imagery to build relationship and express and process memories.

Berliner et al[20] combine brief therapy with body-oriented psychotherapy so that clients can gain new insights into their life stories. The focus of body-oriented therapies in this case is mastery over difficult

symptoms to create safety, which facilitates processing of traumatic histories and memories and potentially installing new meaning about the experience. While not an expressive art therapy per se, the integration of body-oriented therapy with brief therapy is a creative approach to the complex layers common to survivors of torture, many of whom not only witness and experience horror, but are forced to participate in committing horrible acts of violence. Although an outcome assessment was conducted, the results are not included due to unnamed "practical complications."

Because the literature does include some outcome research, DMT can be considered a promising practice in this field. Additionally, the increased endorsement of somatic or body-based therapies for survivors of trauma by neuro-psychiatric researchers merits its serious consideration as a promising practice, and further research to establish it as a best practice.

Drama Therapy

Of the articles reviewed, one emphasizes the integration of theater and other activities (health education, sports, theatre, storytelling and various artistic activities) with admirable cultural sensitivity to the socio-political situation in Serbia, and emphasis on the need to thoroughly assess the socio-cultural context prior to "imposing" theater or any activity in psychosocial programmes.[21] This article, also descriptive, makes a strong case for cultural congruency and sensitivity in the use of expressive arts therapies. The author, working closely with local counterparts, emphasizes community building and communication prior to any community-based psychosocial (broadly defined) programme. Like Amone-P'Olak,[18] drama as an art form is utilized in conjunction with traditional rituals, or in the case of Schinina,[21] drama and storytelling also become a significant part of creating rituals of anger and mourning.

Again, while the literature on this expressive arts modality is brief, drama therapy is used increasingly with survivors, including at The Trauma Center in Boston and as part of a past programme for refugee children at The Center for Multicultural Human Services in Virginia. It therefore can be categorized as an emerging practice treatment.

Music Therapy

Case studies and one systematic review of music therapy for depression were reviewed. Jones et al[22] discuss adaptations in the techniques of music therapy for cross cultural work, citing specific adaptations made for Sudanese youth. This article recommends that therapists become more familiar with the music of clients' regions and cultures. Despite the "universality of music", there are limitations in the assessment tools and techniques of music therapy which have primarily been used in mono-cultural settings. The importance of understanding clients' cultural frameworks for music, the meaning and place of music as healing, expression and play is emphasized. This discussion of music therapy with Sudanese youth recommends the inclusion of body movement into music therapy interventions, and suggestions are made for future research to determine the applicability of standard music therapy assessment tools. The systematic review presents four of five studies in which music therapy for depression is feasible and supports further research. The objective of the study was to compare music therapy to standard care for depression. The greater reduction in symptoms of depression in four out of five studies of patients receiving music therapy warrants further research and consideration of Music Therapy in torture treatment.

Music therapy is supported by a systematic review of clinical research, as well as case studies, and so may be the most evidenced-based of the expressive arts therapies covered in this paper. Given that the research is not extensive, it may be considered a promising practice.

Sandtray Therapy

One article on the use of psychodrama and sandtray therapy with a trauma survivor[23] was included in this review. Sandtray therapy, a therapy in its own right, was used as a warm-up, transitional and containment tool for action methods and psychodrama with survivors of long-term sexual abuse. The emphasis of this work is bridging the conscious realm with the unconscious, and the potential for this symbolic realm to restore the "broken link" between the experience of trauma and the narrative that provides a cognitive framework of meaning and understanding. On a more personal note from the author, sandtray therapy has been used in several torture treatment centers across the United States, including the authors own, and was an integral component of many survivors therapeutic process. The very physicality and tactile quality of the work may merit consideration of its place in torture treatment, as it is easy to theorize how the reconnection to the sensorial capacities of survivors can benefit any survivor of trauma whose senses have been overwhelmed. Since there is little literature available specifically on sand tray therapy and trauma, it is best categorized as an emerging practice.

Ritual and Ceremony

The use of ritual is mentioned in many of the articles discussing DMT, drama therapy, and music therapy. David Read Johnson[24] writes about the use of ritual and ceremony in structured programmes for Vietnam veterans and their families. This work is a useful reference for how ritual and ceremony, familiar healing mechanisms in so many cultures, can be adapted to deal with issues such as separation from loved ones, exposure to violence and atrocity, and intense emotions evoked by traumatic reminders and memories. Rituals hold a potent place in many cultures and assist individuals, families, groups and communities to move through life's varied events, from the most painful to the most joyful. Since the literature on ritual is limited to case material, as an expressive arts therapy it can be considered an *emerging practice*. It bears noting that as an ancient practice occurring regularly in many of the home-countries of survivors of torture, it might merit delineation as an evidenced based practice outside the strictness of scientific paradigms.

Concluding Considerations

While research on the use of expressive arts therapies is still thin, all the works reviewed reference the cultural familiarity of the creative process and/or the link between these arts forms/therapies and rituals, which may serve as a strong enough argument to make them more available to survivors of torture and to creatively research the outcomes and healing impacts of these modalities. It bears noting that the most recent Second Edition of the International Society for Traumatic Stress Studies "Effective Treatments for PTSD"[25] includes two papers on the creative arts therapies: one for adults and one for children. The inclusion of the creative or expressive arts therapies in this seminal PTSD treatment manual signifies greater awareness among practitioners, clinicians, academics and researchers of their value. The extraordinary continuum of human experience, meaning and behaviour necessitates a multiplicity of possible therapeutic skills, techniques,

practices and approaches. Therapies that acknowledge the body at the center of human experience and the age-old importance of the creative process in human expression, communication and civilization are an important component of comprehensive treatment. Neuroscience offers insight into why the expressive arts therapies may allow unique access to trauma and resource-related content that may not be accessible through language. Research in this area may best elucidate the strengths of these therapies.

On a cautionary note, the power that is inherent in the creative process indicates discretion and careful consideration in how and when these modalities are used, by whom and with whom. It is recommended those who are appropriately trained and credentialed in the therapeutic practice of the expressive arts, or those working as artists, work closely with other experienced clinicians, community leaders or healers in cross cultural contexts to ensure that safety. Containment and processing of painful traumatic histories need to be titrated and respectful of personal and cultural boundaries. At minimum, the expressive arts therapies offered as adjunct (or primary) therapies with more "mainstream" therapies ensures that the therapeutic process is inclusive of the whole person. As a category of clinical modalities and practices, all of the expressive arts therapies might best be described as emerging clinical practice that offer tremendous promise.

Learning Points

The range of expressive therapies and techniques is growing in the trauma-related fields and effectively incorporate the body, the human experience and creative processes in expression and communication.

Neuroscience offers insights into why the expressive arts therapies may allow unique access to trauma and resource-related content that might not be accessible through language. Research in this area may best elucidate the strengths of these therapies.

The power inherent in the creative process indicates discretion and careful consideration in how and when these modalities are used, by whom and with whom. It is recommended to work with those who are appropriately trained and credentialed in the therapeutic practice of expressive arts.

Highly recommended readings

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Social services: Effective practices in serving survivors of torture

Ann Marie Winter*

"The belief in the dignity and worth of each individual and the corresponding belief in individual and collective strength and potential can not be realized fully in the midst of concerns about assessing liabilities. A belief in human potential is tied to the notion that people have untapped, undetermined reservoirs of mental, physical, emotional, social and spiritual abilities that can be expressed."

Weick, A, et al. (1989). A strengths perspective for social work practice. Social Work, 34 (p.352)

A torture survivor's traumatic experiences may influence their ability to manage their daily lives and capacity to heal. A survivor may have a pressing hierarchy of practical needs for food, shelter, employment and transportation in addition to medical, legal or mental health needs. The provision of social services plays an integral role in promoting a survivor's well-being. Social services can help make the pieces of their daily life puzzle fit together in a manageable way. These services focus on the survivor's place in society, promoting health in the broadest sense, and are not solely focused on symptom reduction.[1] Social, medical, mental health, spiritual and legal needs are interconnected for the survivor. For example, a client on the verge of losing his job and income, a social problem, may experience feelings of inadequacy and despair and an increase in depression, a mental health problem. Prolonged exposure to combined stressful demands and the inability to meet personal goals impacts the well-being of a survivor and can contribute to feelings of insecurity about their new living environment.[2] While attending to the important medical and psychological needs of the survivor, it is important for the provider to be aware of problems the survivor may be experiencing in coping with their fundamental daily tasks. An inter-disciplinary approach to services allows survivors to utilize their inherent capacity for coping and healing.[3]

A review of 29 articles which either evaluate specific social services or document them through case studies reveal that there are several promising and emerging social service practices that contribute to the healing process of torture survivors. One randomized controlled trial, considered a best practice, is described in the literature, and much of the other published material on interventions is descriptive reports by clinicians, case studies or small cohort studies without control groups.[4] Some of the articles

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describe social services provided to asylum seekers who have experienced severe war trauma but not necessarily torture. Table 1.

Creating a Safe Environment

Establishing trust and creating a safe environment are underlying themes in many of the articles that were reviewed. The absence of trust interferes with healing and can aggravate the emotions associated with previous separations, losses, and traumas. For example, establishing and maintaining trust takes time and includes being honest, clear, realistic and precise in receptive and expressive communications.[5] The relationship between a known, trusted adult who regards the survivor as a whole person is described in an article about unaccompanied asylum seekers in the UK. The authors note emotional engagement takes time to develop, is based on trust, and is effective in promoting well-being. Consent and information sharing formed two of the threads of a trusting relationship. When working with survivors of torture, trust needs to be reciprocally valued by both the provider and the survivor.

Dr. Mary Fabri examines the notion of trust in an article about adjusting the therapeutic framework to accommodate the needs of survivors. She posits "the reconstruction of trust in another person is the first task of treatment. By believing survivors as they describe the horrific acts of torture to which they were subjected, the therapist becomes witness through the process of listening and validating the broken silence."[6] Establishing trust can occur by maintaining culturally appropriate eye contact with the survivor rather than speaking to the interpreter, maintaining a positive and open communication style by having attentive and relaxed body language, not being judgmental, allowing the survivor to share their trauma story at their own pace, and actively listening and asking appropriate and non-threatening questions.[7]

Cultural Competence

Understanding cultural norms and traditions of the diverse cultures that are served by programmes for torture survivors in order to deliver effective services is well-described in the general literature. There are several definitions of cultural competence. For the purposes of this paper, culturally competent care is defined as a system that acknowledges the importance of incorporating culture, assessment of cross-cultural relations, awareness of possible dynamics that may result from cultural differences, expansion of the torture survivor's cultural knowledge, and adaptation of interventions to meet culturally unique needs on all levels of service.[8] Cultural competence includes awareness of political and human rights conditions of the countries where torture survivors come from. Cultural competence helps inform service delivery. Understanding a survivor's cultural needs, traditions and norms and promoting cultural and ethnic identity is an important aspect of holistic services and is a common theme in the reviewed articles.

In an article that uses an ethnographic participant-observation methodology to explore Buddhism as a support system, services are designed and delivered in ways that match specific religious, linguistic, psychological and social organizational characteristics of Southeast Asian refugees.[9] This strength-based perspective focuses on the empowerment of the survivor by supporting their positive attributes, coping skills and self-help resources. The services provided are not categorized in western terms, i.e., mental health, medical, social or educational. The social services are combined with traditional services, such as religious celebrations pro-

Table 1. *Social Services: Effective Practices in Serving Survivors of Torture.*

Article		Type of Practice
1	Bower Jr. RD, Pahl L, Bernstein MA. Case presentation of a tattoo-mutilated, Bosnian torture survivor: using a community-based, multidisciplinary treatment network model. Torture 2004;14(1):16-24.	Emerging
2	Carlsson JM, Mortensen EL, Kastrup M. A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. J Nerv Ment Dis 2005;193(10):654-7.	Promising
3	Ingleby D. Forced migration and mental health: Rethinking the care of refugees and displaced persons. Springer Science + Business Media, Inc. 2005; 13.	Emerging
4	Ryan D, Dooley B, Benson C. Theoretical perspectives on post-migration adaptation and psychological well-being among refugees: Towards a resource-based model. J of Refug Stud 2008;21(1).	Emerging
Creating a Safe Environment		
5	Fabri MR. Reconstructing safety: Adjustments to the therapeutic Frame in the Treatment of Survivors of Political Torture. Prof Psychol- Res Pr. 2001;32(5):452-457.	Promising
6	Kohli RKS. The comfort of strangers: social work practice with unaccompanied asylum-seeking children and young people in the UK. Child & Fam Soc Work 2006;11(1):1-10.	Emerging
7	Potocky-Tripodi M. Best practices for social work with refugees & immigrants. New York: Columbia University Press, 2001.	Promising and Best (compilation)
Cultural Competence		
8	Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep 2003;118:293-302.	Promising
9	Canada ER. Buddhism as a support system for southeast Asian refugees. Soc Work 1992;37(1):61-7.	Promising
Social Supports		
10	Engstrom DW, Okamura A. A plague of our Time: Torture, human rights, and social work. Fam in Soc: The J of Contemp Soc Sci 2004;291-300.	Emerging
11	Goodkind JR. Promoting refugee well-being: a community based advocacy and learning intervention. Ann Arbor: Michigan State University, Hmong Center, Multicultural Resources and Education, 2002.	Promising
12	Gorst-Unsworth C, Goldenberg E. Psychological sequelae of torture and/organized violence suffered by refugees from Iraq. Brit J Psychiat. 1998;172:90-4.	Best
13	Jaranson JM, Kinzie JD, Friedman M, Ortiz D, Friedman MJ, Southwick S. Assessment, diagnostics, and intervention. In: Gerity E, Keane TM, Tuma F, editors. The mental health consequences of torture. New York: Kluwer Academic/Plenum Publishers; 2001.	Promising
14	Quiroga J, Jaranson JM. Politically-motivated torture and its survivors: A desk study review of the literature. Torture 2005; 15(2-3):1-112.	Promising
15	Ramaliu A, Thurston WE. Identifying best practices of community participation in providing services to refugee survivors of torture: A case description. J Immigr Health. 2003; 4(5): 165-171.	Promising

Article		Type of Practice
16	Thrasher S, et al. Social support moderates outcome in a randomized controlled trial of exposure therapy and (or) cognitive restructuring for chronic posttraumatic stress disorder. Can J Psychiat 2010; 55(3):187-190.	Best
English as a Second Language		
17	McBrien JL. Educational needs and barriers for refugee students in the United States: A review of the literature. Rev Educ Res 2005; 75(3): 329-364.	Emerging
18	Olsen L. Learning English and learning America: immigrants in the center of a storm. Theor Pract 2000;39(4):196-202.	Emerging
Employment		
19	Beiser M, Hou F. Language acquisition, unemployment and depressive disorder among southeast Asian refugees: a 10 year study. Soc Sci Med 2001;53:1321-34.	Promising
20	McBrien JL. Educational needs and barriers for refugee students in the United States: A review of the literature. Rev Educ Res. 2005;75(3):329-364.	Emerging
21	Mollica RF. Assessing symptom change in southeast Asian refugee survivors of mass violence and torture. Am J Psychiat 1990;147(1):83-8.	Promising
22	Pittaway E. "We are sad, not mad": the role of social work in the successful resettlement of refugee families who have experienced torture and trauma. Women in Welf Educ 2002;4:63-72.	Emerging
Housing		
23	Mateman S. Good practices guide on the integration of refugees in the European Union, 1999. Retrieved from ECRE http://www.ecre.org/resources/Policy_papers/516.	Promising
24	Millenial Housing Commision. Millenial Housing Commission Report, 2000. Available from http://govinfo.library.unt.edu/mhc/MHCReport.pdf.	Emerging
25	National Housing Coalition. Something's gotta give: Working families and the cost of housing, 2005. Available from http://www.nhc.org.pdf7pub_nc_sg_z0405.pdf.	Emerging
26	Olsen L. At home with refugee housing; Mercy Housing, 2006.	Promising

vided at the temple which is considered a safe environment in the community.

Social services include educational activities offered on weekends to teach traditional language, arts and religion to youth. Recreational activities such as community meals, traditional dance and art classes are offered. Temporary shelter is provided to those who demonstrate a serious need for it. Physical activities and traditional meditation techniques are offered to help focus the mind and body on the healing process. Food and other donations from the community to benefit the monks at the temple are shared as an expression of generosity, a highly valued trait of Buddhist culture. Social services are planned with the involvement of family members and bi-lingual case workers at refugee assistance agencies. This promising practice of incorporating a client's cultural and religious identity into the social services can be applied to other faiths and cultures.

Social Supports

Establishing or enhancing social support networks has shown reductions in the severity of depressive and post-traumatic symptoms. The ability of torture survivors to support each other can increase understanding of their post-torture world. Survivors of torture are often isolated and disconnected from social relationships. Social service providers can attend to the macro task of rebuilding social and community ties.[10] A UK study interviewed eighty-four male Iraqi refugees in London and measured adverse events and levels of social support. Various validated measures for psychological prevalence of depression were applied and the study found that social factors in resettlement countries, particularly the level of "affective" social support, were important determinants of post-traumatic stress disorder and depressive symptoms, particularly when combined with a severe trauma/torture. The study also found that poor social support is a stronger predictor of depression than trauma factors. The authors concluded that depression in refugees may be alleviated by planned, integrated rehabilitation programmes that include social support and family reunion.[11]

Other research includes strength-based community support interventions. Addressing the identified barriers of limited free time and language skills allowed greater multiethnic community participation and resulted in decreased stress levels.[12] Several effective, promising community approaches are cited in Quiroga and Jaranson's desk reference which reviews psycho-social community-based interventions by geographic region.[13] Support groups that meet on a regular basis, promote positive social interactions, regularly model appropriate expression of emotions, and promote family and cultural values have proven to be effective.[14] Trained volunteers and mentors can be effective social supports for survivors and is a promising practice described in a review of a Canadian torture service programme.[15] In the absence of a random clinical trial, this would be considered a promising practice.

A UK study investigated whether or not social supports predicted treatment outcome in a randomized clinical trial of 77 male and female patients being treated for chronic PTSD. Participants were randomly assigned to either an active treatment of cognitive restructuring, and/or exposure therapy or relaxation therapy facilitated for the control group. The authors concluded that patients with 'relatively improvised social support relating to their trauma' receive relatively less immediate therapeutic benefit than those with higher level of social support."[16] The inclusion of social support as part of a healing approach that includes psychotherapy is therefore considered best practice.

English as a Second Language

Learning English provides survivors with the ability to understand what is happening around them and to be a participant in their new community. English language instruction is provided at some torture treatment centers and at many refugee resettlement agencies providing reception and placement services to newly arrived refugees. A review of the literature indicates that, in at least two studies, there is a positive correlation between English language skills and adjustment to life in the United States. In studying alienation in Vietnamese and Laotian refugees, a study found that participants who demonstrated better English proficiency tested lower on alienation measures than those who were not proficient in English.[17] To help enhance adult learning, ESL instruction is most effective when tied to the daily lives of learners and reflects their experience as family, and community members.

Service providers are encouraged to enroll clients in ESL classes, orient ESL teachers about working with survivors of torture, and identify peer mentors of the same culture to provide ESL tutoring to clients. English classes can be arranged in homes or community centers, rather than in formal schools.[18] Role play using basic language skills can help teach survivors how to use the bus, call the doctor, apply for a job, and undertake other daily life tasks. English language increases employability, another social service that contributes to refugee well-being and is considered a promising practice.

Employment

Ability to participate in the labour force affects the healing process. Torture survivors who are undocumented may be exploited by the labor market[17] because of their immigration status. Some trauma survivors may not physically or mentally be able to work. The type of work a torture survivor is involved with may help or hinder the healing process. Dr. Richard Mollica in his book, "Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World", describes work as a "psychological life raft", assuring the survivor that he or she is not completely helpless. He describes how work gives survivors an opportunity to have an income and be productive and also provides a concrete time and place where they regularly report, the camaraderie of fellow workers and an overall sense of purpose and value.[19] Dr Mollica's work also illustrates the nexus between social supports and employment and the importance the latter has on the former. In a 10 year study conducted on language acquisition, unemployment and depressive disorder among Southeast Asian refugees in Canada, researchers concluded that for men in particular, unemployment increased risk for depression.[20]

Housing

Securing and keeping a place to call home is a universal need. Affordable and safe housing fosters self-sufficiency, brings stability to families and supports overall growth.[21] Inadequate housing is a common problem presented to social service providers by torture survivors and refugees. The issues range from housing shortages, discrimination by landlords, long travel distances to appointments, schools, employment, services, groceries, etc and the expenses incurred by moving in and paying rent. Housing is often expensive and according to a 2005 study, represented upwards of 50% of an immigrant family's monthly income.[22] More often than not, survivors rent the least expensive apartments they can find in areas that may already be economically depressed and crime-effected. Housing stressors may contribute to the maintenance of psychological symptoms and hinder the acculturation process. No significant evidence-based studies on social service housing practices for survivors of torture or refugees have been conducted. Mercy Housing, a refugee housing assistance agency, has published a guide of promising practices, "At Home with Refugee Housing Resettlement to Integration." The guide provides case studies, a list of housing resources and helpful ideas on how to identify safe, clean and affordable housing.[23] Similarly, the European Council on Refugees and Exiles' (ECRE) Good Practice Guide on Housing provides a snapshot of several European refugee housing programmes and methods to find housing for clients.[24] In the absence of evidence-based housing practices for torture survivors, such guides can be useful to inform providers about enhancing survivors' sense of safety and belonging and to grow a social network and community connection.

Summary

The available literature suggests the importance of implementing a variety of social measures with special emphasis on social supports, employment and housing. These services contribute to a torture survivor's healing process by addressing practical needs and reducing the stressors of everyday life that can affect even the most resilient. They can also help torture survivors function and regain self-sufficiency. An inter-disciplinary approach which includes a strong social service component has been documented in a number of studies to be most effective and considered a best practice. The need exists, however for research to evaluate the effectiveness of most practices in various social service domains, including vocational rehabilitation, education, food security and nutrition. The systematic documentation of social service practices will provide valuable contributions in the areas of programme evaluation, policies and procedures, and evidence-based practices.

Learning Points

The provision of social services plays an integral role in helping torture survivors heal. These services are inter-connected with a survivor's medical, mental health, legal and spiritual needs. It is important for the provider to be aware of problems the survivor may be experiencing in coping with their fundamental daily tasks. An interdisciplinary approach to services allows survivors to utilize their inherent capacity for coping and healing.

Cultural competence must be a guiding principal in our work with survivors of torture. Being knowledgeable about and acknowledging the importance of a client's cultural heritage, conditions in their county of origin, individual educational level, norms and traditions and perceptions about social services must all be taken into consideration when developing and providing services. Culturally competent services must be adapted to meet the individual needs of the client.

The sense of trust for most survivors of torture has been broken because of the physical and mental trauma to which they have been subjected. Creating a safe environment is an important first step in establishing a healing relationship with survivors of torture. Trust takes time to develop and includes being honest and open in your communication, allowing clients to share their trauma story at their own pace, and being non-judgmental. Establishing and maintaining trust creates a safe environment which allows the healing process to manifest itself.

Highly Recommended Readings

– Carlsson JM, Mortensen EL, Kastrup M. A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. J Nerv Ment Dis 2005;193(10):654-7.
– Mollica RF. Assessing symptom change in southeast Asian refugee survivors of mass violence and torture. Am J Psychiat 1990;147(1):83-8.
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Legal services: Best, promising, and emerging practices

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"True peace is not merely the absence of tension: it is the presence of justice."

Dr. Martin Luther King, Jr.

This paper discusses legal processes and the critical need for torture survivors' access to seek justice. The focus is on the psycho-social benefits of various forms of legal intervention as part of a multi-disciplinary approach of recovery. Six studies on current promising and emerging practices from the U.S. and other countries which document the therapeutic effect of law in the treatment of survivors of torture and other traumas are reviewed. The authors have analyzed these articles with the intent of providing insight into practices that have proven to be effective and can be replicated and built upon. At the very least, these studies give deeper meaning to the positive effect that legal intervention, delivered in various forms, can have on the life of a torture survivor.

Mental health and healthcare providers have known for many years, through informal observation, that the mental and physical health of torture survivors seeking refuge in the U.S. improves upon the granting of an immigration benefit. A temporary work permit, which serves as both an identity document and a pathway to self-sufficiency in the U.S., boosts survivors' mental and physical well-being. A grant of asylum, of course, which is a more permanent benefit, has an even more dramatic effect. As one article boldly proclaims "Winning asylum is essential to recovery for a torture survivor in a country of refuge."[1]

For refugees entering this country with certain benefits and formal access to services, family reunification and adjustment of status can increase the sense of stability and security. In addition to the asylum seeking and adjustment of status processes, justice and access to the pursuit of justice can bring additional therapeutic effects.

Advocacy

For many torture survivors, legal redress may be nearly impossible, but other efforts which facilitate a sense of justice through legal means have had a positive psychological and/or physical impact on the survivors.

The long-term effects on survivors of being in limbo have been documented in a study entitled "Liminal legality: Salvadoran and Guatemalan immigrants' lives in the United States."[2] This article articulates the negative psychological effects of legal limbo. An undocumented status "can affect anything from the immigrants' health risks, their vulner-

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ability in the streets, and their ability to combat domestic violence, to their health-seeking behaviour, their chances in the labor market, their wages and their identities" (see Menjívar for Guttmacher 1984; Hirsch 2003; Salcido and Adelman 2004; Menjívar 2002b; Simon and DeLey 1984; Uriarte et al, 2003; Massey, Durand and Malone 2002; Rodriguez and Hagan 2004).[2] The individuals in this study have resided in the U.S. for twenty years or more after fleeing violence in their home countries, yet many still remain in a legal limbo where they are protected from returning to their home countries but are not granted a permanent status that allows for reunification with family and assimilation within the United States. This legal limbo has had a negative effect on their family and social networks.

One legal, therapeutic outlet for this population has been their advocacy and organizing efforts "to work with the law as a means to obtain justice".[2] Advocacy and community organizing has helped transform victims of political manipulation to a group empowered as a collective to contest, redefine and reinterpret the law.[2] Indeed, their efforts created enough political pressure to change the law in their favour. Older arrivals welcomed their more recent compatriots to the community, redefined familial relationships due to forced separation of family members, and reconstituted social and faith networks. The lessons of this promising practice have been replicated with different ethnic communities, including torture survivors, who have been resettled in the U.S.[3] Intentionally building upon this promising practice to benefit torture survivors can create a powerful means to help improve their health, functioning and productivity through community building and empowerment. Table 1.

Psychological evaluation

The benefits of taking affirmative actions to seek legal redress for survivors can be realized even though there may not be an immediate legal resolution. An emerging practice in the realm of multidisciplinary approaches is captured in an article which discusses the therapeutic effects of the psychological evaluation process for torture survivors who are seeking asylum through the cumbersome legal process in the U.S.[1] A majority of the torture survivors in federally funded rehabilitation programmes in the U.S. are seeking legal protective status to avoid a forced return to their offending country where their lives may be at risk. An important aspect to seeking this legal protection is the need to document torture to support the legal claim to humanitarian protection.

The article observes that survivors typically make efforts to forget the torture experience and argues that the psychological evaluation process has been beneficial to them in several ways. First, the evaluation is critical to their asylum cases because it corroborates their claims, describes their symptoms, and can address issues of inconsistencies or memory lapses which impact credibility. Second, the evaluation process itself may have a therapeutic effect on the survivor by assisting the survivor in verbalizing his or her narrative in a consistent manner, in informing the survivor that current symptoms are the result of past trauma, and in empowering the survivor to testify in court. Finally, the evaluator could assist the survivor by helping the survivor manage arousal or symptoms that emerge during the evaluation session.[1]

The benefits[1] of the psycho-legal partnership cannot be ignored as having an impact on a torture survivor's health, functioning and productivity, particularly considering that in most instances empowering a survivor to take affirmative steps to seeking legal protection bestows to them a means of taking control and an opportunity to be a key participant in

Table 1. *Legal Services for Torture Survivors*

Article		Type of Practice
1	Gangsei D, Deutsch AC. Psychological evaluation of asylum seekers as a therapeutic process, Torture 2007;17(2):79-87.	Emerging
Advocacy		
2	Menjívar C. Liminal Legality: Salvadoran and Guatemalan immigrants' lives in the United States. AJS 2006;111(4):999-1037.	Promising
3	Newland K, Tanaka H, Barker L. Bridging divides: The role of ethnic community-based organizations in refugee integration. Migration Policy Institute & International Rescue Committee, 2007.	N/A
Psychological Evaluation		
4	Gangsei D, Deutsch AC. Psychological evaluation of asylum seekers as a therapeutic process. Torture 2007;17(2):79-87.	Emerging
Mediation		
5	Snajdr E. Gender, power, and the performance of justice: Muslim women's responses to domestic violence in Kazakhstan. Am Ethnol 2005; 32(2):294-311.	Emerging
Multi-Disciplinary Approach		
6	Agger I. Justice as a healing factor: Psycho-legal counseling for torture survivors in an Indian context. Peace and Confl: J of Peace Psychol 2008;14(3):3315-33.	Emerging
7	Tol WA, Komprow IH, Jordans MJD, Thapa SB, Sharma B, De Jong JT. Brief multi-disciplinary treatment for torture survivors in Nepal: A naturalistic comparative study. Int J of Soc Psychiat 2009;55(1):39-56.	Best

the process. While this study recognizes that further studies are warranted, the emerging practice demonstrates the many forms and benefits of multidisciplinary approaches.

Mediation

An emerging practice in Kazakhstan which seeks solutions for victims of domestic violence through a form of mediation and counseling outside of the formal legal system highlights the importance of understanding cultural and religious norms within the affected population. It is an illustrative example of a psycho-social approach to accessing justice.[4] This practice is a departure from formal methods of legal redress and contributes to systemic legal change by focusing on the foundations of evolved legal systems and the formation and impact of societal norms.

Little confidence exists in the Kazakh legal system as it is a newly formed and developing system. As a result, the availability of legal redress of domestic abuse violations is limited. Cultural norms and traditional gender roles are not reflected in the formal legal system, and the local perception is that governmental enforcement of domestic violence abuse is ineffective at best and often counter-productive.

The Society of Muslim Women (SMW) is an informal, grassroots religious movement, or, as a founding member describes it, a spiritual self-help organization for Kazahk women.[4] The organization offers not only assistance for victims of domestic violence, but also offers prayer meetings, engages in charity work, publishes a magazine, and arranges traditional Muslim marriages in a matchmaking capacity.[4]

SMW operates to give victims an option to seek "justice" and reconciliation through

community mediation. The members serve as mediators, listen to both the husband and wife, and even to their families[4] to determine best solutions in keeping with cultural, religious and social norms. This method intends to empower women to seek resolution to a personal and private situation in a way that respects their own culture, traditions and gender roles. The methods employed provide an alternative to a public and many times counter-productive governmental response to domestic violence. While not conclusive, this article is an example of an emerging practice that access to justice in an emerging government through informal quasi-legal mediation tends to not only have a therapeutic effect on the victims and their families, but also on shaping the ways legal systems are imagined, constituted and legitimized.[4]

Through this approach the study found that women gained a sense of belonging and solidarity. This example might be instructive for service providers in the U.S. who offer only separation as a remedy to domestic violence victims.[4] While it is possible for torture survivors to be victims of domestic violence, this practice may be harder to implement in the torture survivor's context because rarely does a victim have the opportunity to confront their perpetrator, let alone have their grievances mediated. However, recognizing the power and influence of "community", which celebrates positive cultural norms and practices, could prove to have therapeutic effects on survivors, especially when formal legal redress is not possible. This noteworthy emerging practice highlights the role of law and access to justice for torture survivors.

Multi-Disciplinary Approach

The Center for Victims of Torture in Nepal[5] assists torture survivors in prosecuting perpetrators and seeking compensation. The programme also provides mental health services. In a study the programme conducted to evaluate a broad range of symptoms, including functioning and disability,[5] the authors hypothesized that providing multidisciplinary services to survivors, which included mental health, basic medical, and an opportunity to seek legal redress for injustices suffered, would improve psychiatric symptoms, functioning and disability more than a comparison group receiving only psycho-education sessions.

Several limitations were noted by the authors: the length of the study was limited to five weeks and it is not known if legal redress was realized in any of the cases. Additionally, one individual's sense of injustice, related to a lack of redress for the trauma, appeared to be an independent factor of psychiatric problems.[5] Yet, the study concluded that a multidisciplinary approach which included legal services in a naturalistic treatment setting was moderately more effective in decreasing somatic symptoms and disability and increasing subjective well-being and functioning when compared with psycho-education sessions alone.[5] The therapeutic effect of the pursuit of justice through legal remedies did not require a positive legal outcome.

Like the Nepal study, a multidisciplinary approach (psycho-legal) to treatment of torture survivors was implemented by Jananeethi, a human rights organization in India. The approach was described as client-centered and included the following multi-disciplinary services: 1) cognitive-behavioural counseling, 2) educating clients about their legal rights, and 3) the pursuit of justice through the judicial process.[5] The overall objective of this study was to increase awareness amongst the survivors of their legal and human rights and support their individual and collective fight for legal justice. In contrast to the focus of the Nepal study, where effectiveness was specifically measured by improvements in psychiatric symptom measures, functioning

and disability, this general objective placed emphasis on the effect of access to justice in a multi-disciplinary approach.

Access to justice in the India study came in many forms including legal education, direct legal assistance, and encouragement to participate in systemic advocacy as a collective. Jananeethi staff employed the "testimony method" developed in Chile during the military dictatorship of the 1970s, which assumes that public testimony about human rights violations not only becomes a means of obtaining justice, but is a cathartic and positive reframing experience for survivors.[5]

However, this study acknowledged "grotesque delays in the justice process" in India.[6] Settlement of human rights matters in India was trapped within a cycle of delay and neglect within their legal system.[6] Additionally, and not surprisingly, some of the survivors still had problems dealing with stress and other psychological demands,[6] and impunity may have hindered the survivors' individual healing.[6]

Despite these challenges, the study found that the psycho-legal approach directly resulted in survivors' feelings of empowerment and support while self-esteem was strengthened and knowledge about the legal system increased.[6] The lesson learned from this study, which is consistent with a conclusion drawn in the Nepal study, is that the pursuit of justice through legal remedies produced a healing result for survivors, even in cases where there was no positive legal outcome.

Summary

Treatment for torture survivors typically requires a multidisciplinary approach because the sequelae of torture include physical, psychological, social, and often, particularly in the case of those survivors who are seeking refuge and adjustment of status in the U.S., legal needs. Formal legal assistance, when delivered as part of a comprehensive programme of other services, can positively impact the therapeutic process. With only six articles to review, it is clear that more rigorous study and evaluation needs to be undertaken to prove the efficacy of the many legal services being provided to survivors of torture.

Learning Points

The process of seeking redress, whether through a legal action against the torturer or indirectly by exposing the human rights violations in an asylum proceeding, can be a cathartic and therapeutic experience for the survivor. The evaluation process for an asylum claim, even though it may be a single intervention, is therapeutic to the survivor.

Highly Recommended Readings

- Allden K, Baykal T, Iacopino V, Kirschner R, Özkalipçi O, Peel M, Reyes R, Welsh W, editors. Istanbul Protocol: manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Geneva: United Nations. Office of High Commissioner for Human Rights, 2001.
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Treatment of survivors of torture: Spiritual domain

Marcus M. McKinney, D.Min., L.P.C.*

"Storytelling reveals meaning without committing the error of defining it."

Hannah Arendt

Significant human experiences seem to include the need to explore, talk about, and continually shape what gives us meaning in life through those experiences. This can be done in religious ways, formalized with worship, rituals and scripture that honour our personal experiences. But it is also done in less formalized ways, in stories we tell about the joy and pain of living and dying.

A careful review of best, promising and emerging practices involving spiritual approaches for torture survivors demonstrates a variety of support benefits and the need for further research. While the literature does not reflect approaches that meet the criteria for best practices, there are important promising and emerging approaches that merit attention. A consistent theme in the literature is the limitations of clinical language. Spiritual approaches are rarely described by average people as "techniques" to address psychological issues. The healing value of telling a trauma story remains challenging to quantify into narrow outcomes. When a trauma story is told involving an experience of torture, pain is often ushered back into life, even if it may allow for admitting the need for support. In a review of the current literature on spirituality's incorporation into interventions for survivors of torture, the following promising and emerging practices are highlighted: personal narratives and storytelling, community and social support networks, activism and advocacy. The following patient-centered practices strengthen a sense of belonging, identity and common values among survivors of torture by complementing spirituality with health to further realize their human potential.

Personal Narrative and Storytelling

When skilled care providers consider incorporation of spirituality into their practice of treating torture victims, the evidence affirms client-centered spiritual support. Despite lack of education and training in the area of spirituality and health, practitioners overwhelmingly see the importance of this area and studies of clients clearly reflect their desire to have this dimension of their lives considered in health.[1] The work here calls for careful spiritual assessment,

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something that is very difficult to do in a meaningful way. To be 'patient-centered' is to appreciate that we must honour their story. Stories can be filled with details that, in time, may invite focused interventions and spiritually relevant support. For a webinar reviewing approach to this topic with torture victims see endnote.[2] Assessment can be done in a formal or informal way. A good listener of a story can make a great assessment using personal narrative stories as well as religious activities like Bible stories, sermons, confessions, testimonials.

Larimore's work emphatically reinforces practices incorporating spirituality that is patient-centered. He notes that words and definitions may get in the way. Faith, spirituality and religion are often dissected in a western preoccupation to define and differentiate ideas. It is hard to listen to people as "whole" beings if we keep dividing the human experience. Sometimes we get to know symptoms (or diagnoses) before we know the person. It's tempting to treat the symptom. This may be a mistake from a client-centered approach. A story is good for its own sake. If a practitioner is open to being taught by clients/patients, they may hear what it is in a person's story that is spiritually important and healing as well as symptoms that need treatment. Larimore's research would call practitioners to learn about the dominant religious and spiritual traditions of the people served, as well as listen to unique expressions from clients as they share their stories. A good assessment might appreciate the small meaningful details of a trauma story, including what the person believes in, what they may no longer believe in, and where they might find hope. Storytelling emphasizes the patient centered approach with the practitioner in the role of listener, allowing the incorporation of spirituality into therapy without necessarily providing answers. Although there are substantial positive outcomes, this is currently considered an "emerging practice" as there is only qualitative descriptions lacking empirical evidence at this time.

Community Support

In communities where Buddhist associations (or Temple communities) have served refugee populations who experienced torture there is clear evidence of good outcomes from offering material, psychological, social and spiritual support.[3] What emerges in the literature, however, is how the participants in such studies speak in holistic ways about their needs. The religious community is seen as caring for the whole person: food and clothing, as well as religious encouragement and listening are spoken of together. Buddhist teachings, rituals, festivals, and structured activities intended to offer meditative options for persons seeking help are all woven together.

For skilled care providers, the compelling lesson includes working in teams, where possible, to understand a religious framing of care. For example, in settings where a large Buddhist community is being served it would be advisable to have a leader from that community describe how people seek help, how they talk about their needs, and what facilitates their care. In some instances our Western assumptions may be misinformed. In one study that focused primarily on Buddhist religious leaders, it was clear that the word "meditation" was not usually expressed by participants in conversations with investigators. Political and spiritual coping were predominant themes used to describe spiritual benefits.[4] A deeper reading of these outcomes might actually speak to the most common theme in all of the literature: the meaning found in survivors' advocating for, talking about,

and seeking belonging. This is sometimes found in one's religion, homeland, or values within a community. In this sense, a person can experience enhanced coping when the care provider hears that the "cause" they fight for is seen as core to who they are. Reminders of a sacred site, their home, or a ritual can stir resilience, touch the soul, and help a survivor cope with great pain. Community support as cited in the literature as an intervention increases belonging and purpose amongst clients, however the descriptions are anecdotal and are therefore an emerging practice. Table 1.

Social Support Network

The practices enhancing a sense of belonging in the literature include social and spiritual support, advocacy, and what might be called 'sanctuary.' In issues of legal status in the United States, the approach of appreciating the need for belonging is even more evident. A temporary legal status punctuates this point. In a study on liminal legality, Menjívar notes, "legal nonexistence can mean erasure of rights and personhood."[5] If a person flees their country of origin due to violence, but is treated as an economic immigrant, political protection might not be

Table 1. *Treatment of Torture Survivors: Spiritual Domain*

	Article	Type of Service
Personal Narrative and Storytelling		
1	Canda ER. Buddhism as a support system for southeast Asian refugees. Soc Work 1992;37(1);61-7.	Promising
2	Menjívar C. Liminal legality: Salvadoran and Guatemalan immigrants' lives in the United States. AJS 2006;111(4):999-1037.	Promising
Community and Social Support		
3	Elsass P, Phuntsok K. Tibetans' coping mechanisms following torture: an interview study of Tibetan torture survivors' use of coping mechanisms and how these were supported by western counseling. Traumatology 2008;15(1):3-10.	Promising
4	Koop II. Refugees in church asylum: intervention between political conflict and individual suffering. Peace and Conflict: J Peace Psychol 2009;11(3):355-65.	Emerging
5	Larimore W, Parker M, Crowther M. Should clinicians incorporate positive spirituality into their practices? What does the evidence say? Ann Behav Med 2002;24(1):69-73.	Emerging
6	Snajdr E. Gender, power, and the performance of justice: Muslim women's responses to domestic violence in Kazakhstan. Am Ethnol 2005;32(2):294-311.	Emerging
Activism and Advocacy		
7	McKinney MM. Community psychiatry and religion. In: Huguelet P, Koenig HG, editors. Religion and spirituality in psychiatry. New York: Cambridge University Press; 2009. p. 215-231.	Promising
Other		
8	Piwowarczyk L. Torture and Spirituality: Engaging the sacred in treatment. Torture 2005;15(1):1-8.	Emerging

awarded. Without a visa, deportation means traveling through hostile countries and possible torture. In these critical situations, linkage with religious organizations shows life-saving advantages. Many religious-based organizations fill an important gap in government protection, offering legal help, social services and a spiritual 'home' where people can feel they are welcomed. Koop notes a deep sense of this holistic support in European refugees seeking asylum.[6] Interventions Koop observed included relaxation, framing a political meaning for suffering, creating a home country cultural atmosphere, and processing trauma. Structures that invited persons seeking help to find roles in the church (for example, assisting with a church garden) deepened the identity of the person to a 'home' community. Discussions that "frame" the meaning of suffering, making connections to personal deep values and having those values affirmed may reduce the symptoms of distress. Here too, Koop noted, "displaced refugees cannot be carried within a framework of a rigid 'school' approach to psychotherapy."

To be clear, practices gleaned from the literature include very hands-on guidance for clients who feel isolated but need a safe place to talk and possibly even to live. While some communities have religious "councils" or ministerial associations, a list itself will not likely help. Care providers would do well to offer their expertise to speak to local places of worship on occasion regarding a topic of interest by the community, then assess those groups for meeting social support needs of clients. In the same way, advocacy seems to work best when the community connection is a person, rather than a general agency name and number. While there is strong evidence that the safe haven provided by church support offers identity and belonging to vulnerable populations in limbo, the intervention lacks quantitative results and is classified as an emerging practice.

Activism and Advocacy

One of the most interesting emerging practices involves activism, advocacy, mediation, assessment, and support in the frame of a "grassroots" approach truly born from a religious self-styled community aiming to serve women responding to domestic violence. The leader of this effort said it well to a group of dignitaries at a Kazakhstan conference, "Do not forget God in our pursuit to solve the problems of our society."[7] Communities, like individuals, have stories that need to be told. This may be one of the most important and basic needs traditionally met by religion. The locus of this approach lies less in clinical centers or government agencies, and more in the agency of women in a community. In this case, Muslim women joined by common values of their faith and shaped by common experience (a kind of self-assessment) felt their wounds called for the healing application of cultural and religious responses. The study is not clear about why this group sought to revitalize their connection to Islam. What is clear is that it led quickly to their desire to bring their traditions alive, teaching women "what they could do, who they could be."

The help that naturally grew out of this self-styled, religiously informed community was "informal and practical." As previously mentioned, one might consider many religious activities involve telling and listening to stories: personal stories, Bible stories, sermons, confessions, testimonials. All give sacred value to story telling and all need a caring listener. Although activism and advocacy fortify common values and give individuals a collective agency, these

approaches as cited in the literature are unable to demonstrate more than anecdotal information. Activism and advocacy are community interventions that are "emerging practices" for consideration.

Summary

The literature rarely cited sample size and leaned heavily on qualitative methodology. In many cases there was an apology for small or non-quantified samples. If the qualitative outcomes fairly indicate the effectiveness of faith–based approaches there is a need for substantial research on the nature of the care offered (interventions). While all of the merited studies, by definition, had to be evidence-based practices, a theme of collaborative approaches invites more community-based research. For example, torture centers that partner with a pastoral counseling center might find a viable cohort to evaluate clinically sound, spiritually relevant approaches to care.[8]

In light of evidence-based practices, spiritual approaches recommended for torture survivors might include: collaborating with religiously based organizations familiar with the population served, identifying the social services within religious communities (possibly create a directory), learn from clients as well as religious traditions and/or healing practices utilized locally, and discover which religious groups are best positioned to provide legal advocacy and support in the community. A simple survey seeking to discover what services are available might be used through local religious associations, or given to individual clergy you meet. The survey, to be effective, might list the commonly asked for services heard from clients. From a more individual perspective, it is beneficial to listen to the stories that highlight what gives hope and emotional support. Equally important is what has been lost (home, belonging, identity, common culture). Consider pastoral counseling collaboration through clinical[9] as well as traditional, informal groups like the ones noted above.

After several stories are shared, when trust is built and a safe place is experienced – then, maybe those things that mean the most to the torture survivor can be revealed – a place of worship, a prayer, a meal, a sanctuary, a savior, a sacred scripture, a new home, or maybe a friend he or she can trust. Piwowarczyk states, "helping people connect to communities of faith can be critical to not only decreasing the isolation that survivors may have, but also potentially helping in the process of restoring one's capacity to trust again."[10] These may be surprisingly important components found in a story that can lead to healing resources and outcomes.

Learning Points

To care for people who have experienced torture, it is good to first consider how most people ordinarily seek help: we try to find someone we trust to talk to, who won't so much 'practice' on us, as they will help us feel safe to tell our story, and identify what spiritual resources (maybe correlated to symptoms) can help us.

Invite clients to identify a "spiritual home" in their community and learn more about it. Discover how their spiritual orientation frames the experience of torture and healing.

Consider the art of collaboration: practical resources offered through religious agencies, pastoral counselors, elders from the community… virtually any psychologically-sound, spiritually-relevant resource that expands the fabric of care for the person. With permission, allow the community of care to broaden as needed.

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