

Dialogus

"A Free E-mail Newsletter – Furthering the Dialogue to Better Serve Survivors of Torture"

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Dialogus provides a forum for members of the torture treatment centers in the U.S. who serve survivors of torture to participate in a dialogue about innovative approaches in their work with survivors as well as share resource information, news, and solutions to challenges we face. We hope that you will enjoy being part of this forum and community. However, if you wish to unsubscribe to Dialogus in the body of the text, just type: Unsubscribe (your e-mail address).

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Editorial

Launching of Interactive Article Series

In the inaugural edition of this e-newsletter last August, we described the impetus behind the creation of Dialogus. The staff of PTV envisioned a forum for an on-going dialogue amongst interested staff of Torture Treatment Centers in the U.S. Our intention was to encourage people to keep in touch and to continue the dialogue started at our annual meetings. We wanted to encourage people to write about their experiences, their observations, and their quandaries while working with survivors.

We have been delighted that several people have submitted articles to Dialogus, and we look forward to more contributions from others. In addition to the types of articles that have already appeared in Dialogus, we are pleased to be launching a series of interactive articles with this edition. The first article in this edition about a training conducted for INS asylum officers is an example of this interactive style. Articles that explore observations and challenges, and pose questions to the other members of this e-newsletter forum are welcomed. We see this as an incredible opportunity for continued collaboration and progress in our field. Feedback and responses to the questions posed will be compiled and shared in the next edition or on our Web site. All responses should be sent to the editor of Dialogus at: PTVnewsletter@usa.com. We look forward to hearing from you.

This edition and all earlier editions of Dialogus will be archived by February 1, 2001 on PTV's website at: <http://www.ProgramForTortureVictims.org/Dialogus>.

Article

Training INS Asylum Officers: Reflections on Process and Questions Raised
by S. Megan Berthold, Ph.D., LCSW, Ken Louria, MFT, and Marc Sadoff, LCSW,
BCD

The Program for Torture Victims (PTV) in Los Angeles trained approximately 80 INS Asylum Officers and their supervisors last fall. Marc Sadoff was asked to conduct this training by one of the asylum officers who had found his psychological reports to be very helpful in understanding applicants' situations. In preparing to conduct the training, we invited this asylum officer and the Quality Assurance Training Officer to one of our clinical meetings to get a better grasp of their perceptions of the challenges, concerns and training needs of their team of officers. While the Quality Assurance Training Officer was not able to attend this meeting, she lent her full support through several telephonic conversations prior to the training session.

After viewing the recently released PBS documentary "Well Founded Fear" about the asylum process in the Newark Asylum Office and speaking with officers in the Los Angeles Asylum Office, we learned that there are workload differences between the Los Angeles and Newark Asylum Offices which may indicate doing an assessment and formulating different goals for training for different locations. For example, though there are a variety of immigrant populations served at both offices, Newark may experience an upsurge of Chinese applicants, while the Los Angeles Office may find itself fairly constantly working with a large number of Central Americans along with an ever shifting workload of applicants from countries all over the world. Each population brings it's own unique set of challenges to the asylum officer's task of assessing credibility in light of country conditions and understanding the applicant's presentation in the context of cultural, political and psychological differences.

As this was our first session of training, we tried to establish rapport with the officers by showing our interest in the difficulties and challenges they face. We were asked to conduct a workshop about PTSD. As we met to plan the agenda, the INS representatives and we decided it would be beneficial to also address the issue of interviewer burnout.

What we found helpful to us as therapists was being able to separate the INS as a governmental entity that seeks to enforce certain policies from the asylum

officers as individuals. As one would expect, the range of opinions that we heard at the workshop ran the gamut from cynicism, frustration and anger to caring, compassion, and empathy. Yes, a number of the officers expressed skepticism about the claims made by many applicants. However, we found great openness toward us, considerable knowledge about country conditions, and compassion and empathy on the part of the many of the officers toward asylum seekers. Based on their questions, these officers appeared to want information and tools that could help them determine the credibility of the applicant's claims.

It helped to break the ice and create an atmosphere of interest and receptiveness to have one of the trainers (Marc) perform a few magic tricks to illustrate some concepts such as the fact that we all have biases, which can lead to misperceptions. The use of small group discussions, case vignettes, and saving time for dialogue and questions appeared beneficial. We also played a few minutes of the PBS video "Well Founded Fear" which showed how a Chinese applicant initially spoke about his torture in an unemotional and matter of fact tone of voice. We asked them what impressions they had of his case. Next, we showed them the same man speaking in detail about being tortured later in the video. This time he was clearly in great emotional anguish simply trying to get through his descriptions of specifically how he was tortured. The use of this media piece seemed helpful to illustrate some of the sequels of PTSD and particularly how the processes of detachment and avoidance can affect an applicant's presentation.

One of the challenges we faced was how to address the issue of the credibility of asylum applicants as it related to PTSD. Our aim was to widen the understanding of the participants that traumatic reactions in survivors of torture can effect both the verbal and non-verbal presentation of clients in a variety of ways that could easily be misinterpreted. We hoped to be able, in some small way, to mitigate a "rush to judgment" regarding the credibility of torture survivors. We verbally acknowledged that we could not give the officers a 'cookie cutter' method of determining whether an applicant had PTSD or whether they were credible. We did not want officers to think that if certain conditions were present or absent then the applicant was definitely credible or not credible. We felt that this would be dangerous and could potentially have a very devastating impact on individual applicants. We shared some of the elements that we take into consideration when making our clinical assessment of credibility. At the same time, the group seemed hungry for any tips or cues that could help them assess if PTSD may have an impact on how the client presented in their office.

Only a handful of the participants had ever seen a medical or psychological affidavit in the files of the applicants they interviewed. We surmised that the vast majority of applicants with PTSD would be appearing before them without an accompanying psychological evaluation. This meant that the asylum officer might be the first trained person to come into contact with the applicant who might even explore the possibility of psychological distress. However, in the context of the officer's already overwhelming tasks to complete within their allotted few hours with each case, we came to appreciate their need for a set of brief questions which could alert them to the possible existence of posttraumatic stress reactions. What arose in our training then was the question: What can the officer do when he or she believes that the applicant may have PTSD? Since, we were told, the asylum officer cannot give out a referral for a psychological evaluation, their hands are somewhat tied, leaving them feeling powerless to actively recommend anything to the applicant. A number of participants indicated that this contributed to their own stress.

They shared the enormous time pressures they faced each day to quickly make a decision, often seemingly without enough facts, sometimes with little more than an hour to hear a case. Some expressed anxieties related to knowing that their decisions would have a major impact on the applicants' lives and fears of, "what if I'm wrong?" Others relayed the difficulties of hearing horrendous stories day in and day out. There were mixed reactions to our attempt to normalize these reactions and discuss the impact of secondary or vicarious traumatization on therapists, physicians, attorneys, asylum officers, and others working with survivors. The feedback that we received from participants was largely positive. The Quality Assurance Trainer in charge of the program expressed interest in having us conduct more workshops for officers on the issues of burnout and self-care.

This training raised many questions for us. We know that many other centers and individuals have had extensive contact with and have trained INS personnel in their areas. We welcome your feedback, thoughts, and responses to the following questions:

What challenges have you faced in training INS Asylum Officers?

What formats and approaches to training INS Asylum Officers have you found to be most effective, and what are the key areas to cover?

What are your thoughts on addressing the issue of credibility pertaining to PTSD with Asylum Officers?

What can we suggest the Asylum Officer do if they suspect PTSD is present, and there is no psychological report? How can we help the Asylum Officers accept or handle their sense of powerlessness in many of these cases?

Have you found opportunities to train immigration judges? If so, how did you arrange this and what subjects were the focus of your trainings?

We look forward to hearing your thoughts on these and other related issues. Feedback and responses to the questions posed will be compiled and shared in the next edition or on our Web site. All responses should be sent to the editor of Dialogus at: PTVnewsletter@usa.com.

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Article

Do Victims of Familial and Political Violence Experience Similar Barriers to Primary Health Care?

by Ernest Duff, M.Div., M.A. and Terri Pease, Ph.D.

Connections must be made between sociopolitical violence such as torture and war, and familial violence, also known as "domestic" violence. Feminist critiques of international human rights instruments regarding torture and other cruel, inhuman or degrading treatment (Copelon, 1994) point out that much work needs to be done to break down patriarchal conceptions that facilitate the idea that state-sponsored violence is more egregious than "private" forms of violence. Indeed, the existence of a "parallel state" within the family system, in which the male abuser is sanctioned by the larger society, has been postulated. The argument has been put forward that the international instruments on torture can be interpreted within a new framework to support the inclusion of familial violence as a human rights

violation and international crime of magnitude.

A convergence of experience in applied settings addressing the healthcare needs of victims of sociopolitical violence and of those victimized in the familial setting suggests a resolution of the false dichotomy, repeatedly set up by the marginalization of familial violence to the status of something "less" than torture. Our experience with these groups of survivors highlights that the similar needs and presentations of these groups is powerful evidence of an underlying parallel between two forms of extreme and illegitimate control. At the micro level, our observations suggest reforms in the provision of health care to populations so that the needs of survivors of sanctioned violence can be met. At a macro level, the implication of dissolving the division between governments sanctioning control via violence and familial control via violence can lead to broader discussions of the responsibility of the international human rights community to place gender-related violence on a level that matches the concern and focus rendered to political torture.

This paper presents the experience, thinking and scholarship of two decentralized health care related programs in a large metropolitan area of the United States to address these questions. Both programs, The Partnership to Prevent Domestic Violence and the Solace Program for Survivors of Torture and Refugee Trauma are within a larger umbrella agency known as "Safe Horizon." Safe Horizon is the United States leader in the victims' rights movement; its mission is to provide support, prevent violence and promote justice for victims of crime and abuse, their families and communities. The two aforementioned programs serve, respectively, victims of domestic violence and victims of sociopolitical torture. In our experience, people who have experienced either of these two types of victimization present similar challenges when they seek health care. Their similar responses to a generally benign system clarify that torture and domestic violence both change the subject's ability to perceive and respond to the environment encountered in countries (or situations) of refuge. Lack of knowledge in health care systems about torture survivors, for instance, also leads to primary health care providers missing the opportunity to identify them as such (Eisenman et al, 2000). Similarly, in the United States, healthcare providers correctly diagnose domestic violence in their patients in only one in thirty five cases (Physicians for a Violence Free Society, 1999). They commonly assert that domestic violence does not exist in the populations with which they are familiar (Sugg, 1992).

Gender-related violence in the family not different than political torture Copelon (1994) concludes that the process, purposes and consequences of domestic violence and torture are very similar, and she emphasizes that just because domestic violence is not officially sanctioned its atrociousness is not diminished, nor is the need for international sanction. Citing international conventions, she