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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Article

"Cultural Issues in Psychotherapies with Torture Survivors"

by Jose Quiroga, M.D., and Roger Gurr, M.D.

This article is an excerpt from a larger report entitled, "Approaches to Torture Rehabilitation: A desk-study, covering effects, cost effectiveness, participation and sustainability" prepared by Dr. Quiroga and Dr. Gurr in 1998 for DANIDA, the Ministry of Foreign Affairs of the Danish Government as part of a human rights consultancy. This excerpt originally appeared in E-Research Newsletter, Volume 8, Number 1, March 2000 (ISSN 1527-2591), Special Issue
(Part 1 of 2 editions): Torture Survivors**

Apart from dealing with positive symptoms of PTSD, which seem to be similar across cultures and which seem to respond to controlled exposure across cultures, the main issue is restoring meaning to the survivor's life and restoring social connections and status. There are major differences between cultures in their concepts about the process of torture and it's meaning, which obviously affects the type of therapy required. In English, the word torture comes from Latin roots and means to cause pain or suffering to get a confession. In Khmer, the words for torture are a combination of the Sanscrit/Pali word for savagery/cruelty and the Buddhist concept of karma. Cambodian survivors generally feel they are somehow responsible for their suffering because of their karma, and will endure amazing suffering because they believed it to be part of their destiny (Mollica, 1988). So, unlike Chilean survivors, they do not politicize their torture and its subsequent effect on their lives.

Some cultures are very reluctant to express emotions or to cry (e.g., Afghan males) or to reveal sexual torture or rape, so that the torture story has to be pieced together over a long period once trust has been established (Mollica, 1988). In refugee groups, the most meaningful snippets of information have at times been expressed during informal contact, such as while being driven to appointments. This means that pushing survivors to tell their torture story may be counterproductive and indirect supportive methods may be more useful.

Some societies have no history of psychological therapies and expect cures based on medications or religious ceremonies. There can be an expectation

that the therapist will divine what is wrong with them and decide on treatment without their active involvement, so there can be an expectation in some refugees that therapists will be directive. In cultures that value social connections rather than individualism, group activities and therapies can be more useful. Symbolic actions to assist with grieving for lost family members, where proper burial and mourning ceremonies were impossible, have also been found useful in some refugee communities.

These issues and more indicate the need for different approaches for each culture in designing interventions. Thus in both developed and developing countries, services should legitimately take on very different appearances.

Western psychology is more egocentric in orientation, where the forces of the individual psyche are the most important factors explaining psychological experiences. Individuals are considered as a bio-psychical unit. Most of the rest of the world has a socio-centric ideology that places individual experiences in a network of social relationships, which are the sources of self-esteem, self-realization and self-control. Western therapies are individualistic and seldom emphasize the social and cultural context (Elsass, 1997).

Illnesses, tension and conflicts are resolved in these societies through existing in-built cultural processes. Interventions that do not recognize these factors could be detrimental (Chakraborty, 1991). A good example is the experience of the Medical Foundation of London in Uganda. They were invited by the government to begin a center for survivors of war trauma and torture in the capital. The number of survivors was overwhelming, independent of a wide or narrow definition of survivor eligibility for the program. In spite of the fact that the prevalence of trauma and symptoms was high in the population, there was not great increase in psychiatric breakdowns: social cohesion and solidarity acted as protective forces. The most serious problem they found was the danger of undermining local individual and community responses by establishing a specialist center. It was decided that, instead of a center modeled after those in Europe, to support local efforts and establish special programs for those survivors who do not receive the social support they need, such as refugees, children exposed to violence, women survivors of rape, and ex-soldiers (Bracken et al., 1992).

Psychologists who work with torture survivors in the countries where torture is happening daily, consider that PTSD is a diagnostic category that is too limited, and does not capture the magnitude of torture as a trauma. Torture is a man-made, politically motivated, physical and psychological trauma oriented to destroy the political identity of the victims and to intimidate a sector of society. The term “post-traumatic” means that the torture was a single isolated trauma. However, most survivors have a history of previous cumulative traumas that continue after this episode, even in those who migrated to other countries with different cultures, languages, without family and local social support (Reeler, 1994; Becker, 1995).

PTSD is a subcategory of anxiety disorders which are classified as mental disorders in the DSM manual. Most psychologists do not consider torture survivors as true psychiatric patients in that they are experiencing a normal reaction to an abnormal stressor. Labeling torture symptoms as a mental disorder is seen as a medicalization of a socio-political problem (Becker, 1995; Lira, 1998).

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News:

The Torture Abolition and Survivors Support Coalition (TASSC) is holding a meeting/conference for survivors of torture in Washington, D.C. on December 8-10, 2000. The theme of the conference is, "HEALING THROUGH SOLIDARITY: SURVIVORS UNITE, SURVIVORS ORGANIZE." The main objective of the December 8-10 conference is to discuss how TASSC can move forward to become a stronger organization to serve survivors of torture. TASSC was formed three years ago by Sister Dianna Ortiz and a group of survivors and friends with the support of Guatemala Human Rights Commission/ USA. TASSC is a coalition of torture survivors from around the world and is guided by two principles: (1) Torture is an international crime against humanity, and (2) Survivors must be accorded the right to speak for themselves about torture, given that their knowledge comes from direct experience. TASSC plans to continue the work of educating people about torture and strengthening the survivors' support network. TASSC is inviting survivors to participate in the December meeting/conference and welcomes their input about TASSC and issues that the conference should address. For further information about the conference or about TASSC, contact:

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