Supporting interventions after exposure to torture

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Abstract

A wide range of reactions as panic, demoralisation, feelings of being insecure and unsafe, hopelessness and any kind of dysfunction dominate after torture. The range of PTSD and other psychiatric disorders can be explained by variations in severity, frequency and duration of traumatic events.

The advanced numbers of refugees and asylum seekers illustrate the need of people after the experience of torture to find a safe place for recovery. The various steps for immediate coping strategy after being tortured are evaluated.

Stressors after torture, as pressure on families, decline of social and economic life, threats, feelings of guilt and shame and health problems due to torture act as remainders for the torture experience.

Coping with exposure to torture starts immediately during the experience. A phase-oriented research, taking into consideration internal and external resources, risk factors and protective factors, as well as pre-trauma status, could help to understand more about the needs torture survivors have after being released from detention.

Key words: torture psychosocial reactions, refugees, coping, prevention, cultural context, resilience

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The problem

The atrocious experience of torture is widespread, but there are no global numbers available which document the extent of torture and cruel, inhuman and degrading treatments.[1] Exposure to torture, cruel, inhuman or degrading treatments, not only causes medical needs, but also a broad range of human needs, such as relief from pain, worries about the future, feelings of horror, anxiety, hopelessness, excessive feelings of dehumanization, worries about loved ones, grief, and extreme stress. Exposure activates distress, panic, demoralisation, feelings of being insecure and unsafe, hopelessness and any kind of dysfunction, mainly described in pathological classifications. There is a wide range of psychosocial long-term reactions, which can either be qualified as disorders or imply a high risk to develop disorders such as Posttraumatic Stress Disorder (PTSD), Disorder of Extreme Stress not otherwise specified (DESNOS), somatisation disorder, depression, panic disorder, suicidal ideation, alienation and persisting medical problems.[2] Being released after exposure to torture can prolong these problems, depending highly on the surroundings of a survivor. There are additional traumatizing factors (displacement, refuge, ongoing danger of being detained) and factors enhancing coping skills (supportive environment, social acknowledg-

ment of being a torture survivor, medical and psychosocial support systems …).

Psychosocial interventions could raise resilience and recovery of individuals and communities. The article tries to identify research questions and related ideas for clinical and psychosocial management of situations where treatment is not possible, because a safe and secure environment is not (yet) given.

Definition of trauma after torture

Trauma can be defined by the event itself or via criteria to assess an event as traumatic. Green[3] defines criteria like life-threat or threat of bodily integrity, injury, intentional injury, confrontation with unthinkable and unbelievable impacts on human dignity, learning about a traumatic event or the danger of being confronted with it, being guilty of a traumatic event. Events or incidents which can be characterized by one or more of these criteria are traumatic events which produce, at least in the early stage, a traumatic reaction. Each experience of torture or other cruel or inhuman treatment can be characterized by one or more of these criteria as traumatic and can lead to the above mentioned responses. What is missed in this list is loss of loved ones, missing loved ones or friends, being in close relation to primary victims or other victims of torture (secondary traumatization).

The United Nations (UN) also defines torture via criteria.[4]

The victim is exposed to a broad variety of torture methods, nowadays this is mostly to have a psychological impact while at the same time breaking a victim's will and resistance,[5] thus forcing the acceptance of the torture regime's power.

Torture is subjected fundamentally to social meaning, including to religious and/or political causations. It includes the immoral act of the perpetrators. This is the dimension which affects mostly survivors and their families and the communities where torture survivors come from.[6]

Development of reactions and description of psychosocial reactions and symptoms

Acute pain, extreme stress, fear, panic, a sense of unreality and shame and often paradox feelings of guilt dominate. The extent of desperation is high. Phenomena of dissociation occur. Sights, sounds, smells and feelings of the event persist as indelible images in the memory. As the immediate stress reaction dissipates, longer-term effects appear. Basic assumptions and beliefs are challenged by the torture acts. Individuals feel vulnerable, damaged, endangered, helpless and hopeless. Grieving for loved ones, grieving for home, for memorabilia are additional factors, which worsen the situation of the survivors, when escaping the country.

Coming back to the family and the community add reactions like alienation, keeping secret about torture and the consequences, feeling stigmatized and being stigmatized to persisting symptoms. Often survivors feel guilty or unworthy for surviving. A wide variety of emotional disturbances is experienced within the weeks following the exposure. Grief, depression, anxiety, guilt, anger, irritability and hostility prevail. Sleep disturbances, nightmares, panic attacks, depression, suicidal ideation and trials of self-medication by alcohol, nicotine and other drugs are additional reactions, which are reported to be common after torture. These reactions are not all of clinical value, but some of them are to be considered as risk-factors for chronic disorders such as PTSD.[7]

Often survivors of torture report peritraumatic dissociations, related to impair-

ment of attention, perception and changes in awareness, together with a feeling of numbness, which helps to comfort pain. Dissociative symptoms persist and can enlarge to amnesia. The massiveness of pain and loss of control provokes feelings of shame and guilt and depersonalisation.

These early reactions underlie a constant process of adoption and assimilation, therefore they are polymorph and labile, and occur in divers "pictures" and react to the ongoing situation.[8]

Psychosocial reactions and symptoms

Psychological torture and cruel, inhuman and degrading treatment mostly have an extremely negative impact on health. Effects, both short-term and long-term, include memory impairment, concentration-incapacity, somatic complaints, hyperarousal, avoidance, irritability, severe depression, nightmares, feelings of shame and humiliation and PTSD.

In epidemiological studies, consequences are complex PTSD, depression, somatisation, anxiety disorders, panic attacks, dissociative disorders, eating disorders, obsessive-compulsive disorders and personality disorders.[1, 9, 10] Prevalence rates of PTSD and other psychiatric disorders associated with torture vary significantly across refugee studies. Within clinical populations PTSD rates from 69–92% across all patient groups.[10] Hollifield et al[11] reviewed refugee mental health literature, noting rates of PTSD ranging from 4% to 86%, with similar variations for depression and anxiety. This range is explained by variations in severity, frequency and duration of traumatic events and methodological limitations. Keller et al[12] add the cultural perspective. Asian patients have the lowest rate of PTSD. Within community samples Basoglu et al[13] found a life time PTSD rate of 33% in a sample of political activists and non-activists, both groups being torture survivors.

If the consequences do not meet criteria of a disorder, there are still symptoms: unspecific somatic complaints, changing of consciousness (derealisation, depersonalisation, numbness, amnesia), affective syndromes, and impulse control order (outburst of anger, lacking of anger), changing of perception of the perpetrator (feelings of revenge, inadequate thankfulness, sharing of values one did not share before).

Self-awareness and perception is broken or changed; feelings of being stigmatized, alienated and isolated dominate. Intrusions sometimes are similar to psychotic phenomena, the loss of orientation (time and place), and sensory re-experiencing the torture can occur. This all leads to the picture of illness, but is a survivor of torture ill or mad or somebody who suffers from being betrayed?[14]

Data on refugees and asylum seekers

UNHCR defines refugee as an individual recognized under the 1951 Convention relating to the Status of Refugees; its 1967 Protocol; the OAU Convention Governing the Specific Aspects of Refugee Problems in Africa; those recognized in accordance with the UNHCR Statue; individuals granted complementary forms of protection; or those enjoying temporary protection.

Asylum-seekers are individuals whose applications for asylum or refugee status are pending a final decision.[15]

In 2007 UNHCR[15] estimates that 25.1 million people were under its care as refugees and internally displaced persons. The number of refugees was around 11.4 million people by the end of 2007. Following the 2007 UNHCR report, the estimated average time it would take for a refugee to become naturalized in Europe is 10 years. This cut-

off period of 10 years was applied to all numbers of industrialized countries.[15]

Furthermore UNHCR confirms, that most refugees flee to neighbouring countries, thus they remain within their region of origin. UNHCR estimates, that some 1.6 million refugees (14% out of a total of 11.4 million) live outside their region of origin. Europe hosts 14 per cent of the world's refugee population, and a quarter of all refugees live in North America. However, Pakistan still hosts the largest refugee population (2 million), followed by Syria (1.5 million), Iran (0.96 million) and Germany (579,000).

For 42 per cent of the 31.7 million people of concern to UNHCR, information on age is available. 44 per cent of these are children under the age of 18; 10 per cent are under age of five. Children constitute 27 per cent of the population of asylum seekers, a group which traditionally includes single men, particularly in industrialized countries.

During 2007 a total of 647,200 individuals applied for asylum in 154 countries. 99, 200 claims were submitted on appeal or with courts. With 332,400 asylum claims, Europe remained the primary destination for people applying on an individual basis, including applicants who have been unsuccessful in the first instance.

209,000 asylum-seekers were recognized as refugees or give a complementary form of protection, including an estimated 27,800 individuals who initially received a negative decision. In Europe, 44,100 asylum-seekers were recognized as refugees and 49,200 got a complementary form of protection. By the end of the year about 740,000 individuals were still awaiting a decision on their asylum claim. The largest number of undecided cases is in South Africa (171,000). In the United States this number is 84,000. Pending cases in Austria are 38,400, and 34,100 in Germany.

These numbers demonstrate the problem of becoming and being a refugee and they illustrate the need of people after the experience of torture to find a safe place for recovery, as well as the obstacles and borders an individual has to cross after the torture experience. The number of children affected by violent acts and the number of pending asylum claims cases in Europe and the long period to become naturalized as a citizen in Europe is significant. No studies reflect the number of torture survivors within the huge population of refugees all over the world.

Process of coping – recovery from trauma

The process of coping starts immediately after being tortured and can be evaluated as a constant process of adaption to the situation. There are a few steps which almost every torture survivors goes through. The first step is the trial to come back to normal life or getting prepared for refuge. Insecurity about the future still remains prominent; the fear of again becoming a victim of torture persists. When the regime keeps power, victims often chose refuge in a safe country. They then have to undergo the process of emigration as a second step, changing culture and language, missing their families, loosing their social background, their homes and incomes, their professional status. They are alo confronted with a debate about misuse of asylum which is on going in Europe. Applying for asylum or any other protective status is the third step. Applicants for asylum are confronted with a poor social status; most of them live in camps, are not allowed to work and have to undergo a procedure of investigation and after having gotten asylum, they have to build their lives. As fourth step refugees have to adapt to the new society, they integrate and get integrated. Within this process, factors of risk and protective ca-

pability are interdependent with the coping process of the torture experience.

Keilson's concept of sequential traumatization[16] could be helpful to understand this process. He analyzed the traumatizing process of Jewish children, hidden during World War II in the Netherlands.

In his model phase three comprises everything after liberation and the end of the direct impact of the atrocious experience. This concept helps to understand the importance of phase three under the light of prevention, since terror and torture do not seem to be disappearing from the world.

Following the findings of Keilson phase three comprises risk factors or protective resources and factors for the development of the psychological reaction. Risk factors are the threat of being captured and tortured again, ongoing terror e.g. visits from police, threats to the family or friends, escape to another country, asylum procedures.[17] This enhances and prolongs feelings of helplessness and incapacitation. Protective factors could be finding a safe place, disclosure, acknowledgement of being a victim of a terror regime, social support and adequate treatment. In a study about the long-term mental health effects of mandatory detention and subsequent protection on refugees, Steel et al.[18] applied a multi-level model, that revealed that past immigration detention and ongoing temporary protection each contributed independently to the risk of ongoing PTSD, depression and mental health-related disability. Longer detention was associated with more severe mental disturbances, persisting for an average of three years after release.

Risk factors and resources – the individual's context

The survivor's own context, his or her life history, current life situation are relevant contexts to assess their ability to cope.[19] Prior life events and their resolution serve as background for assessing current adversity. Life situations include both recent life events and the specific details of the traumatic exposure.

Trauma engages survivors' need for attachment. It is of high value to consider the need of social connectedness and the need for being in contact with the social network as the lack of social contact and being in touch with family and friends could do a greater harm than the torture experience itself.[13,17]

Risk and protective factors shortly after torture experience

The additional stressors after torture, like pressure on families, no contact with the family, decline of social and economic life, are to be perceived as important predictors for the outcome of mental health and psychological disturbances.[20] Ongoing threats, feelings of guilt and shame as well as keeping secret about the torture experience enhance the risk of developing psychological disorder. Persisting health problems due to torture could be triggers, they could act as daily remainders for the torture experience. Yet the relation remains unclear, when searching for the effects of torture, injuries and major depression.[21] Still the number of individuals suffering from mental health disorders and bodily disorders after torture remains significant.[22, 23] Injuries may be considered as indicators for the severity of the exposure to torture. Early medical support could be preventive mental health consequences.

Social environment contains both risk and protective factors. A main social risk factor is the ongoing danger of being detained again. Also negative effects on the family, related to the victim's position after torture is a "secondary risk factor" for pro-

longed psychological disturbances after torture. There is no doubt that societies which use torture have a strong interest in intimidation that affects the social environment of victims and does not provide any means for an individual's recovery.

A protective environment can be characterized by a safe surrounding, societal acknowledgment of torture, caring family members and friends, and support in regaining control over daily life activities. Which coping style helps to make adequate decisions about escaping to exile or staying in the country?

Risk and protective factors during escape

It is a complex process for refugees on escape, mostly combined with a lot of costs and misinformation through carriers. It is a difficult way to enter Europe; it is much more than boarding an airplane. There is no systematic research about the psychological stress factors of escape as most of them stay in the darkness of criminalization and dubious carriers. Most research on torture survivors refer also to other related trauma exposure. There are no clear results yet about the impact of trauma-exposure during the time of escape, whether within prevalent studies or within studies which reflect the etiological components of further exposure to traumatic situations or risk factors.[9]

Risk and protective factors in the host country

The non-use of qualification and abilities, the lack of income, the loss of social status, the missing of support by the community and families are strong risk factors, as our own studies on Bosnian refugees show.[24-27]

Living conditions during the application process for asylum are difficult. Most of the refugees start in camps, condemned to do nothing. They share a room with other refugees, which they did not know before, they get food, they get small pocket money and they have insurance, but they are not allowed to work and start to build up a future. Most of them are on their own, some of them do not know what is going on with their family and all of them wait for the permission to stay. The number of pending cases remains high, although they have declined by a third since 2002.[15]

Araya et al[28] investigated internally displaced Ethiopians, focussing on quality of life mediated or moderated by mental distress, social support and living conditions. Living conditions in shelters, like the availability of food and water, sleeping comfort and support from helping organisations are associated with a higher quality of life. Mental distress and trauma were significantly related to poorer quality of life, even after controlling living conditions. Araya et al[28] suggest that intervention strategies should include psychosocial help and psychiatric help as well as help to improve the material living conditions, since both were beneficial on their own. Although there were no studies found for Europe, we believe living conditions contribute to the improvement or enhancement of the mental health of tortured refugees in exile.

ECRE (European Council on Refugees and Exiles) evaluated the minimum standards for refugee protection within EU.[29] ECRE states that there are five minimum guarantees from which there should never be derogation. The Council of Europe is aware of the psychological sequalae of torture within asylum seekers and introduced a document on how to interview a detainee to document psychological trauma symptoms.[30] All asylum applicants undergo an interrogation process in which they have to prove that their lives are in danger if they were to be sent back to the country of their origin and that they followed a legitimate process when

coming to the new country. This process is full of triggers for trauma-reactualization.[31] There is some evidence that application and interview comprise risk factors; no systematic studies were conducted on the impact of PTSD or other mental health problems during the application procedure.

Applying for asylum comprises the hope of being recognized as somebody who suffers from human rights violations and exposure to torture. Most of the survivors are carriers of symptoms, which are assessed by mental health professionals. These symptoms are not because one is mad or wrong, the symptoms occur because they were overwhelming the abilities to cope with them. A mental health professional assessing the psychological needs, reactions and symptoms could serve as somebody which gives social acknowledgment, saying that symptoms, reactions and needs can be mastered, managed and understood and that they are clearly related to the atrocious experience. However the assessment procedure causes a high level of stress. This is one side of the coin.

The other side can be described as the dark one, because it comprises the perspective of being ill or mad and being acknowledged as a mad victim, which deserves treatment and asylum, and not being acknowledged as somebody who underwent inhuman and human rights violating terror. This may cause anger and sometimes a desire of revenge against the torturers, which again can be qualified as a symptom and can lead again to the recommendation for treatment due to poor mental health. Summerfield[14] delivers evidence for this. He refers to studies e.g. from the Kosovo and from South Africa. He qualifies these studies as seeking to give scientific weight to the notion that the mental health of victims is at risk, if they do not forgive those who hurt them. Vengeful victims are promoting the cycle of violence, their emotional reactions are perceived as harmful to themselves and dangerous to others. The consequence, the reaction of the victim, should be modified. They are brutalized, not only traumatized, and therefore to recover from being traumatized, treatment against brutalization is necessary. The ethos of acceptance and forgiving relates to the person, not to the society, which committed the crime of torture. More research about revenge, reconciliation and recovery is needed, especially related to cultural frames for the meaning of torture and mental health.

Social environment, social acknowledgment, and cultural context

Kienzler[32] discusses the cultural construction and conceptualization of war trauma and PTSD in diverse contexts, stressing the meaning of the social environment for the development of disorder and resilience. Fontana & Rosenheck[33] investigated three cohorts of US-veterans from World War II, Korea and Vietnam. All individuals were registered as treatment seeking veterans. In their study the factor of social acknowledgment has a clear impact on mental health status. Veterans from Word War II returned back to the United States as heroes, whereas Veterans from the war in Korea who returned home were the targets of political critiques in the media and the public and then were forgotten warriors in comparison to World War II and Vietnam. Their "poor" performance in the war was cited as evidence of the deterioration of the American spirit. Compared to veterans of Word War II and of the Vietnam War, the veterans of the Korean War had greater distress and suicidality. These differences might reflect the greater stigma of mental illnesses in earlier generations, but also might reflect

the greater unpopularity of the Korean War. Although this study investigated veterans of war, former active soldiers, the findings reflect the importance of social acknowledgment for survivors of torture. If they were tortured because of their political activity, they are mostly not acknowledged for their activities; if they were tortured, because they were in the wrong place at the wrong time, they also do not gain any social acknowledgment, as the acknowledgment of victims or political actions is contradictory towards a regime which uses torture.

Maercker & Müller[34] defined social acknowledgment as a victim's experience of positive reactions from society that show appreciations for the victim's unique state and acknowledge the victim's current difficult situation. "Social" includes significant persons (e.g. local authorites, clergy), groups (e.g. at the workplace or fellow citizens) and impersonal expression of opinions (e.g. media). They define the positive and the negative case. In the positive case, social acknowledgment includes the unconditional support to the survivor. In the negative case, survivors experience a broad range of negative feed-back including ignorance, rejection or being blamed for becoming a victim. Most survivors of torture who are refugees are rejected and perceived as suspicious objects. This is a social condition, that causes trauma survivors to feel unsupported, misunderstood, or alienated from their surrounding, when they are seeking social support, which is especially true for torture survivors in the asylum procedure. The findings of Maercker & Müller[34] on political prisoners in the GDR (German Democratic Republic) and in victims of crime, support the relation between social acknowledgment and symptoms.

Resilience

The construct of resilience derives from studies on bereaved individuals, transformed to survivors of single traumatisation. There is a growing body of evidence, that most adults are resilient towards potentially traumatizing exposure. Bonanno et al[35] examined resilience in a New York sample exposed to the attacks of 9/11, stressing the relation of resilience and sociocontextual factors. Resilience in adults is the ability to maintain relatively stable, healthy levels of psychological and physical functioning, when being exposed to an isolated and potentially highly disruptive event such as the death of a close person or a violent life-threatening situation. Recovery describes observable elevations of symptoms, returning to baseline after several months. Resilient people may experience some disregulation and irritation in their emotional and physical well-being, but the reactions remain relatively brief and do not impact the level of functioning significantly. Resilience in children and adults is related to protective factors, mostly person-centred variables, such as hardiness or self-enhancement, which predict resilience.[36] External variables such as social and material resources and additional life stress for a better understanding of resilience.[35] Resilience becomes less likely the more prior exposure to trauma was experienced and the less individuals profit from good health prior to exposure. Besides demographic variables (gender, age, race-ethnicity, education), resilience was predicted by the absence of depression and substance abuse, social support, and fewer chronic diseases and less impact of 9/11 and fewer recent life stressors, fewer past prior traumatic events and not having experienced additional traumatic events since 9/11.

Most of the torture survivors suffer from a lack of social support, have a history of pain, ongoing life stressors, feel depressive,

and experience prolonged traumatic exposure, due the situation of being an unprotected refugee. Nevertheless "survivors of torture can teach us a great deal about courage and resilience".[37]

It can be stated that variables related to resilience within the group of tortured survivors are hardly researched, although resilient survivors (maintaining an astonishing level of psychological and physical functioning in adverse living conditions) are well know in shelter camps, counselling institutions or other helping organisations.

Prevention – research questions

Reviewing the body of literature about survivors of torture under the perspective of support in order to prevent a worsening psychological development, the following topics for further research arise.

First of all, does the definition of torture as given by the UN, fulfil criteria to do psychological research? Torture itself is changing from a bodily oriented atrocity towards a more psychological act, which leaves less scares and injuries. Also the actors change – torture is more and more provided by non-state agents. Researchers should be careful to be clear about the definition of torture they are using when studying individuals who have survived torture, especially if the purpose of a study is the differentiation in the psychological sequalae of short-term, single traumas, long term trauma, and multiple traumas related to torture-experience.

Coping with exposure to torture starts immediately during the experience. What are coping strategies during and after the exposure, which help most to overcome the procedure? A phase-oriented research, taking into consideration internal and external resources, risk factors and protective factors, as well as pre-trauma status, could help to understand more about the needs torture survivors have after being released from detention.

Beginning with the immediate phase after detention, the re-integration in the family, factors which are related with the decision to escape or to stay investigate the impact of social acknowledgment, further emotions and their influence on the decision, such as fear of further danger or hope for safety and security and material resources (e.g. access to medical services, working possibilities, further conditions of living). What are good predictors for resilience in this phase? Which factors predict the onset of PTSD or other mental health problems?

The decision to leave or to escape can be considered as a starting point for the next phase within a model of coping with torture. When leaving the country little is know about the stress factors of escape, the reception in the receiving countries and the needs of the refugees. Which internal and external resources help to cope with adversity deriving from torture and escape? How relevant as predictors for mental health are reactions such as alienation, the feeling of isolation, the loss of cultural orientation, perceiving lack or presence of social acknowledgment? Which resources in the receiving countries are needed, what are helpful conditions of living (e.g. material resources, access to medical and/or psychological support) for quality of life and what could we learn for the mitigation of PTSD or other disorders? How do feelings of guilt, shame, anger, revenge influence possible PTSD and the recovery from it? Is there social suffering additionally to the suffering from torture? How could it be defined? Could it be useful as a predicting factor for mental health problems, especially PTSD? How is social support perceived, to whom individuals get connected when living as a single foreigner in exile? Do coping styles, which predict

resilience in bereaved individuals, also help survivors of torture (e.g. self-enhancement, distraction, having been in good health prior to traumatisation)?

Once asylum is obtained, research could focus on recovery. Feelings of revenge and the need to forgive the torturer are considered as main contributing factors for recovery. Summerfield[14] is questioning these findings by relating them to the western medical model of PTSD. A first step of recovery could be to accept feelings of anger and a need for revenge or for justice towards the regime of terror as the assumptions about the world are challenged deeply by the experience. Torture experience also creates a moral vulnerability, as principles such as "do no harm to others" or "my world is a safe place" are shattered. Is it the duty of the survivor to moderate these feelings? Is it the duty of the environment to moderate their feelings towards acceptance of anger and mistrust? Questioning the western tradition of perceiving victims of war and torture could lead to a culturally sensitive approach, focusing on the social meaning of atrocities within the community of survivors.

Is PTSD an adequate out-come variable for such a model and for which time-line? Is it adequate for studies with individuals seeking treatment? Do we have the right measures, when we conduct studies in refugee populations and torture survivors?

What are confounding variables in such research as torture is for the most survivors an act with large implications on further living. It starts a process in an individual's life, which never ends as symptoms and reactions reflect the broad range of human strength and weakness.

Does the PTSD category include cultural sensitivity or is too western oriented so that the psychological consequences are widely overseen in tortured populations, which arrive in Europe? Could a model include the multi-ethnic nature of torture survivors? How to get access to torture survivors when doing research?

Research has a great responsibility when deciding which variables are relevant for the study of torture and its outcome.

Prevention – some practical considerations

Shared reality

Survivors and helpers are affected by what they see, hear, understand, or have in mind on torture. They share a social context where narrative forms reality. A picture on TV may affect risk perception more than the experienced traumatic situation. Both survivors and helpers are part of that narrative and embedded in the same social context with different positions. This opens an opportunity for intuitive understanding, empathy and connectedness. It can also overwhelm helpers and reduce their efficiency when positions and possibilities to influence are not kept clear. The helper's position should reflect its influence to foster empowerment and self help capacity, but it must not share the powerless position of most torture survivors in exile. Helpers are endangered to trap into (counter) transference, when sharing reality with their subjects of help.

Elements of psychosocial support

There is always something to do in order to help distressed survivors. When little can be done to reduce the main stressor (as in the case of torture experience), reducing survivors' loneliness could be a means to mitigate the reactions. When information about the development of asylum or acknowledgment as a victim, or on processes of social justice (from reconciliation commissions) is lacking, information can be provided and the

feeling of loss of control can be reduced by this. When loss of economic resources is the problem, a possibility of work could be raised. When a lack of cultural bonding is a stressor, the bonding could be created. When the main distress is connected with having no structure for the day or having lost a private space, structure can be given and privacy could be created. When pain and injury are main stress variables, medical treatment is needed.

When the asylum procedure causes stress, torture survivors can be prepared and interviewers can learn about the behaviour of torture survivors. It is the duty of the interviewer to question the evidence for asylum. Memory disturbances of traumatized survivors[31] are challenged by the legal procedure which also includes the question: Is the applicant telling the truth? The mismatch of disturbed memories and truth searching triggers traumatic stress; inconsistent evidence is often regarded as intent to deceive.[31] Teaching interviewers about autobiographic representation with episodic features and other trauma specific memory performances could ease the stress situation for both parties in the process.

The concepts of buddy-work and peer-support for unaccompanied minors could be helpful to empower torture survivors. Well trained buddies take a parental role for minors and buffer tertiary stress by helping with homework from school, applying for work, or provide leisure activities together with their families. They also serve as experts and teachers for the new culture.[38]

Hence much can be done before, and often instead of, treatment interventions. Professionals, accordingly, may find themselves in situations where being a therapist is not the required skill, and therefore they should accept other roles.

The aims of interventions based on psychosocial stress management in the aftercare for torture survivors are: learn about new tasks and start to perform them, find interpersonal interactions, and although mistrust is high, learn to control emotion and to live with symptoms of intrusion and dissociation and regain a small extent of self-esteem.

Psychosocial stress management includes reducing the stressors, finding and optimizing resources and managing survivors' reactions. Stress management encompasses real and perceived elements of this triad. It applies to individuals and groups. Its outcome is better judged by evaluating the resulting improvement in coping.

Interventions in the aftermath of having been exposed to torture might include stress management and treatment of traumatic responses. Stress management involves all the steps to reduce the intensity of environmental demands, enrich resources and support adaptive responses. It is a generic approach, valid across traumatic situations. Trauma theory adds the extent to which the specific individuals are confronted with a broken life, loss, major change and/or traumatic challenge. Trauma therapy should specifically address the processing of incongruous experiences.

Trauma changes survivors forever. Some traumatic situations confront survivors with evil, sends them beyond the boundaries of civilization and evokes questions that have no answers. Still, it is the decision of the survivor to become a patient or to go on with life, even if symptoms are present. Providing help to encourage self-help could be a first step to find one's treatment.

Conclusion

If we consider the needs of people as symptoms, treatment and care will be delivered.

If we consider the needs as normal reactions, which are overwhelming and exhaust-

ing, where individuals do not have every day routine in coping with reactions and events, one will give support to affected people.

Psychosocial interventions (support, stress management and some treatment) thus do not aim to prevent PTSD. This could be a consequence, but is not a target. Interventions target the individual's, a family's and/or a community's skills to cope better with the consequences of torture by mitigating symptoms in order to regain self help capacities to master the situation.

Torture is a worldwide problem that demands worldwide attention from psychosocial experts, both in practice and research. Great advances have been made within the last 20 years, but a lot of questions are still raised, yet not answered. Torture does not just destroy the life of the survivor and its family; it destroys entire societies. Further research could also serve as a strong argument for more democracy and human rights.

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