Torture Survivors and Traumatised Refugees

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Contents

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25.1 Epidemiological Aspects and Types of Traumatisation

Despite international efforts to uphold human rights, organized state persecution and systematic torture are continued to be practiced in many regions of the world, as well as severe forms of human rights violations to the civilian population in (civil) wars. The majority of people who leave their countries of origin due to persecution and war are internally displaced persons or flee to neighbouring countries; only a minority of these people reach Western countries as refugees.

In international epidemiological studies, the prevalence rates for post-traumatic stress disorder (PTSD) in torture victims and refugees vary widely from 10% (Review: Fazel et al., 2005) to 31% (Meta-analysis: Steel et al., 2009). Recent representative international studies covering the population of torture victims and refugees report prevalence rates of 8–37% for PTSD (Alpak et al., 2015; Slewa-Younan et al., 2015) and 28–75% for depression (Gammouh et al., 2015; Slewa-Younan et al., 2015). In Germany, studies show PTSD prevalence rates of 7–77% in institute-based samples and 16–55% in population-based studies (Bozorgmehr et al., 2016), but no representative studies are available yet. In an older study, 40% of asylum seekers were diagnosed with PTSD shortly after their arrival in Germany (Gäbel et al., 2006), and in a study in a reception centre, the PTSD rate was 27% (Butollo & Maragkos, 2012).

25.1.1 Torture

In the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations, 1984), torture is defined as follows.

Torture

"... any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity..." (United Nations, 1984).

Among the "man-made disasters", torture is one of the most damaging forms of intentional and in most cases purposely planned systematic violations. Although 162 out of 197 countries have ratified the Convention against Torture (as of January 2018, OHCHR, 2018), torture was still being practiced in 122 countries around the world in 2015 (Amnesty International, 2016). Even some modern constitutional states do not hesitate to use torture; in the name of "war on terror", torture was practised various countries, such as in Iraq in Abu Ghraib prison or in Guantanamo, USA. Miles (2006) was able to show that the use of psychological torture methods, the "harsh interrogations", was systematically researched in the USA and refined by doctors and psychologists. Similarly, systematic measures of "psychological decomposition" were used to torture opponents of the regime in the former GDR (Behnke & Fuchs, 2010; Maercker et al., 2013).

Systematic torture generally involves a combination of physical torture (e.g. hanging, forced postures, electric torture, water-

boarding) and psychological torture (e.g. mock executions, overstimulation or stimulus deprivation, isolation). Also, forms of humiliation and violence are regularly used, that are particularly taboo and dishonouring in the respective culture of the victims, e.g. sexualised violence and torture against women from traditional and Muslim societies (Wenk-Ansohn, 2002). Female and male victims of sexualised violence can be found among survivors of torture and violence in wars and civil wars from all areas of origin, as this form of violence is the most degrading form of humiliation and dishonour in all cultures (Gurris, 1995). In a study (N = 154) by Busch et al. (2015), sexualised torture was described in 78% of the women and 25% of the men that were examined. Due to the particular tabooing, epidemiological data on this issue are generally hardly available. When tortured persons die under the torture, they are usually described to the public as "disappeared", which means that the states evade responsibility. This creates endless psychological strain for the surviving relatives (Heeke & Knaevelsrud, 2015; Preitler, 2006), as they can neither bury the loved ones nor mourn the loss.

Systematic torture has special aspects compared to other forms of traumatisation (Gurris, 2003b).

Specific Aspects of Systematic Torture

- By other people planned and intentionally
- The vital threat
- Extreme humiliation
- Prolonged and repeated exposure over long periods
- Inability to act, helplessness and dependence
- Possible betrayal of companions, existential threat to family members or political friends
- Feelings of guilt (especially when witnessing the torture of others, death of fellow prisoners, extension of persecution measures on family members)
- Deep shame (due to humiliation and loss of control, especially after sexualised torture)
- Socio-cultural uprooting and alienation
- Continuing stress due to persistent persecution, living in the underground or a situation of flight and exile
- Persistent shaking of self-confidence, trust in others and the world
- Loss of coherence
- Loss of self-efficacy

"Torture places the individual in a situation of extreme helplessness and vulnerability, which sooner or later leads to the breakdown of important emotional, cognitive or behavioural functions" (Fischer & Gurris, 2000, p. 468). The traumatising effect results not only from the traumatic situation itself and the peritraumatic reaction directly connected to it, but also from its lasting significance for the individual in his or her personal, social, historical and political context, as well as from the resulting social and material consequences (Gurris & Wenk-Ansohn, 2013).

Torture is a systematic and intentional damage to the personality of the victim and ultimately aims to damage the core of the personality (Drozdek & Wilson, 2004; Maier & Schnyder, 2007).

It means a humiliation and degradation deeply affecting the personality structure and social relationships; it influences family, society and subsequent generations (Kira, 2002; Weierstall et al., 2011). Studies on the second and third generation of Holocaust survivors (Kellermann, 2001), in Iraq (Fritzemeyer, 2017) and with refugees from Iraq and Lebanon (Daud et al., 2005), show that torture can create a transgenera-

tional problem. In addition to the individual consequences, the effects of traumatisation in the social system, especially in the family, must therefore be considered. Children can be parentified and overburdened, and parents may keep children close to themselves because of their own fears and restrict their range of movement or show aggressive outbursts.

25.1.2 War Trauma

Refugees have often experienced prolonged and repeated traumatisation caused by other persons. This "type" of traumatic events (see specification of traumatic events according to Maercker, 2009) is associated with an increased probability of developing trauma sequelae. A "dose–response effect" was found, which shows that a higher number of war traumas is associated with increased distress and a higher probability of diagnosing trauma sequelae (Steel et al., 2009). War traumas often include not only the experience of bombing and attacks with weapons, but also torture-like systematic violence – often in the form of sexualised violence.

25.1.3 Stress Due to Flight and Persistent Strains in the Host Countries

In most cases, refugees have experienced potentially traumatic situations not only in their country of origin but also during their flight and are in a persistent stress situation in the host country. These sequential traumatisations have a significant impact on the development of trauma sequelae. The model of sequential traumatisation (Keilson, 1979) continues to be helpful for understanding the development of mental disorders in torture victims and traumatised refugees. Keilson distinguishes 3 traumatic sequences:

- Sequence 1: Beginning of persecution characterised by increasing repression or a war situation;
- Sequence 2: Time of persecution until flight, i.e. a phase with a high risk of traumatic events;
- Sequence 3: Phase after the end of the persecution.

It was shown that sequence 3 is crucial for the course of mental disorders. The course of the disorder is highly dependent on contextual factors after the traumatic experiences. In the case of traumatised refugees, this is the phase in exile. In this phase, so-called post-migration stressors have a considerable influence on psychopathology (Porter & Haslam, 2005). Due to the political situation in many EU countries (e.g. Dublin procedure), refugees are confronted with increasingly long-term and serious post-migration stressors. In Germany, for example, the stricter asylum laws that have been in force since 2016 (see BAMF, 2018) have led to the increased number of residence titles with restricted rights (e.g. subsidiary protection) and higher rejection rates, resulting in longer asylum appeal processes. These legal decisions have an impact on the living situation of the refugees in terms of their social situation (e.g. restricted family reunification, longer stay in refugee shelters). The future prospects remain uncertain, and a feeling of constant dependence arises. It has been shown that post-migration stressors such as uncertainty about residence (Nickerson et al., 2011b), fear of deportation (Herlihy et al., 2002) and the hearing process itself (Schock et al., 2015) are associated with an increase in PTSD symptoms. It should be noted that there are first indications that new traumatisation and post-migration stressors in the host country have a comparable influence on the increase in psychopathology (Schock et al., 2016). Retraumatising experiences (▶ Sect. 25.4.1.7) contribute to the fact that a processing or recovery process is impeded (Brandmaier & Ahrndt, 2012; Car-

swell et al., 2011; Herlihy & Turner, 2007) and a chronification of trauma-reactive disorders is facilitated (Laban et al., 2004, 2008).

25.2 Psychological Consequences of Traumatisation and Flight

Torture victims and people who have fled war zones often suffer complex post-traumatic sequelae and high levels of comorbidity (especially depression with pronounced suicidal tendencies; anxiety and obsessive-compulsive disorders; severe dissociative disorders; impulse control disorders; substance abuse; somatoform disorders, pain disorders). Below is a brief description of the stress-related mental disorders that can arise as a result of stress or trauma, with reference to the group of torture victims and refugees.

25.2.1 Posttraumatic Stress Disorder

PTSD symptoms in torture victims and refugees are usually characterized by a high severity of symptoms (Spiller et al., 2016; Stammel et al., 2017). The described intrusions usually refer to the most threatening and emotionally stressful sequences. Triggers of these intrusions refer to these sequences (e.g. New Year's Eve firecrackers, basements, narrow corridors, uniforms).

In many cases, the full-blown picture of PTSD does not yet appear during flight, but often shows a delayed onset after arrival in the host country. One explanation for this could be that the symptoms are suppressed beforehand due to the ongoing (surviving) stress or are not yet noticed.

25.2.2 Complex Post-Traumatic Stress Disorder (CPTSD)

For people who have been exposed repeatedly or over a long period of time to man-made trauma, Herman (1992) coined the term "complex PTSD" (▶ Chap. 3). The complex and chronic psychological trauma consequences (Cloitre et al., 2011; Herman, 1992) in torture victims and refugees include disorders of regulation of the affective arousal level, disorders in relationships with other people, changes in attention and consciousness, psychosomatic disorders and changes in personality and its systems of meaning. These were listed in DSM-IV as "disorders due to extreme stress, not otherwise specified" (DESNOS, American Psychiatric Association, APA, 1996), but are no longer included in the current DSM-5. After long lasting trauma-reactive disorder processes, torture victims and refugees may show symptoms that were once classified in the ICD-10 as personality change after extreme stress (ICD-10 F 62.0; Dilling et al., 2011), but are no longer used in the ICD-11. In ICD-11, complex PTSD (CPTSD) is included as a separate diagnosis and is intended to be a sibling diagnosis to PTSD. CPTSD should, in addition to the "classic" PTSD symptoms, include symptoms from three other areas (difficulties in emotion regulation, negative self-concept, interpersonal difficulties). Data on the prevalence of CPTSD in torture victims and refugees are rare to date. Current prevalence rates according to ICD-11 diagnosis vary from 3% (Silove et al., 2017; Tay et al., 2015) to 33% (Nickerson et al., 2016).

25.2.3 Prolonged Grief Disorder (PGD)

People who have lost one or more loved ones in their country of origin or during flight often show clinically significant symptoms. Until now, coding a prolonged grief disorder has only been possible with auxiliary diagnoses (e.g. adjustment disorder F43.2 or other reaction to severe stress F43.8). In the ICD-11, however, there will probably be an independent diagnosis for this disorder,

which is characterised by a persistent mental attachment (or persistent longing) in relation to the deceased person, as well as a deep emotional suffering. The duration of this grief goes beyond the respective culturally or religiously accepted grieving phase, but extends at least over a period of 6 months. Exact prevalence rates of PGD (according to ICD-11) in refugees are still missing. Older studies, however, indicate that this disorder occurs frequently (31–54%; Craig et al., 2008; Momartin et al., 2004).

25.2.4 Adjustment Disorder

In terms of differential diagnosis, an adjustment disorder (ICD-10 F 43.2, Dilling et al., 2011) should also be considered for refugees who have experienced a stressful phase of life in their home country and during their flight and who are simultaneously in the phase of adaptation in exile (Sluzki, 1979). This diagnosis, often used as a "residual category", will be newly and more clearly defined in ICD-11 (▶ Chap. 5). Here, the dysfunctional symptomatology is triggered by the presence of a psychosocial stressor (or loss of resources). For the cohort of torture victims and refugees, this loss of resources is manifold and serious (including loss of social structure, loss of family, loss of financial and social status). For example, refugees in the host country may experience symptoms of maladaptation, with symptoms of anxiety and depression and mental preoccupation, as well as difficulties in coping with a new situation, with or without PTSD. Prevalence rates on adjustment disorder in refugees and victims of torture are scarce. An older study shows prevalence rates of 6–40% among refugees in post-conflict regions (Dobricke et al., 2010).

25.3 Need for Psychosocial and Therapeutic Care

Due to the severe psychological burden caused by traumatic experiences in the country of origin and during flight, as well as the often continuing impact of serious post-migration stressors, the earliest possible access to adequate health care at various levels (i.e. social, medical, psychological) is recommended. Therapeutic services should be adapted to the needs of the respective legal and social context and phases of the migration process. ◘ Figure 25.1 shows different levels of health care, based on the intervention pyramid for humanitarian disasters – IASC Guidelines (Inter-Agency Standing Committee, 2007), a graduated approach to mental health and psychological support recommended by the UNHCR, here adapted to the conditions in a country with a developed health care system (Wenk-Ansohn, 2017). With the model of care levels, it is important that, if necessary, an allocation can be made from one care level to the other in the sense of a "stepped care model" (NICE Guidelines, NICE, 2009); parallel, coordinated therapeutic interventions at the different levels are often also useful.

It should be emphasised that adequate material and social basic care, i.e. covering "basic needs", are the basic prerequisite for medical and psychotherapeutic measures to be effective.

> Achieving secure living conditions is a prerequisite for psychological stabilisation after traumatic experiences.

The following framework conditions are central to cope with traumatic experiences:

- Security,
- Sufficient material conditions,

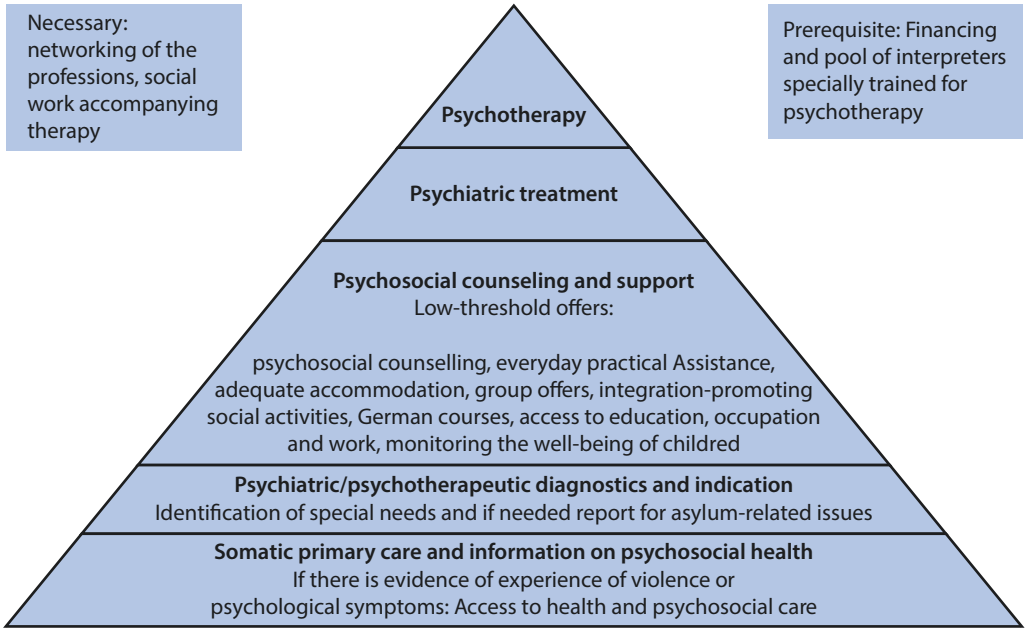

Fig. 25.1 Elements of adequate health care for refugees (see Wenk-Ansohn, 2017)

- Social recognition,
- Possibility of social contact and autonomous action,
- Hope and future prospects.

Most traumatised refugees do not have a secure residence when they are admitted for treatment, that often lasts for years. Because of their psychological symptoms, traumatised refugees are often not able to present their persecution in a "complete, consistent, detailed and vivid" manner, as demanded by the authorities in the asylum procedure (Birck, 2002). So far, the early identification of vulnerable groups by independent, specially trained health professionals has only taken place in some regions of Germany, as is actually required for the implementation of the Reception Directive of the European Union (Europäische Union, 2013). Overall, a large proportion of particularly vulnerable refugees are not identified in the initial asylum procedure or by the health system. These refugees are often for years in the middle of legal proceedings with uncertain future prospects. In view of this situation, the qualified expert assessment of trauma-related and other mental health problems in refugees or the preparation of an expert statement/psychological or medico-legal report (mlr) for refugees undergoing treatment is of great importance.

The diagnosis of trauma sequelae can, if necessary, support the statements on a political prosecution, describe the need for treatment and, if serious health risks are to be expected in the case of forced return, support the recognition of obstacles to deportation (Haenel & Wenk-Ansohn, 2004; Wenk-Ansohn et al., 2013; Scheef-Maier & Haenel, 2017). In 2003, the German Medical Association released standards for assess-

ment based on the United Nations Istanbul Protocol (United Nations, 2004; in German translation: Frewer et al., 2009) and the proposals of the working group "Standards for the Assessment of Psychologically Reactive Trauma Consequences in Residence-Related Procedures" (Gierlichs et al., 2012) together with a corresponding certified curricular training. The training and other requirements for assessors have also been adopted by the Chamber of Psychotherapists and the German-speaking Society for Psychotraumatology (see homepage DeGPT). This is a complex subject with legal questions on the one hand and professional requirements on the other. Shorter reports according to minimum standards can also be helpful. In 2007, there was a landmark decision (decision of German Federal Administrative court, September 11, 2007), which determined which minimum requirements must be met by the "substantiated presentation of an alleged PTSD" in order to initiate further obligations of the court to investigate the facts (Deutscher Anwaltsverein, 2008).

25.4 Psychotherapy with Torture Victims and Refugees

Torture victims and traumatised refugees from war zones need treatment that takes into account both the specific traumatisation and the stresses and strains of exile.

The requirements for a treatment concept for torture victims and war traumatised persons living under exile conditions are manifold. They include trauma-therapeutic expertise, a multi-professional and methodologically broad range of treatment and support, interdisciplinary cooperation, cultural sensitivity and the use of interpreters (Maier & Schnyder, 2007; Gurris & Wenk-Ansohn, 2013). The aim of such a multidimensional treatment concept is to open up individually adapted therapeutic approaches as well as rehabilitation measures, taking into account the respective disorder, limitations of everyday functions, contextual conditions and cultural imprints as well as the level of education. Ultimately, the aim of a treatment process is not only to improve the symptoms, but also to provide support in the rehabilitation process and the greatest possible participation in the host society.

Most treatment is provided in psychosocial and treatment centres for refugees, which offer an integrated multi-professional approach (for centres in Germany see: ▶ http://www.baff-zentren.org, for other countries see ▶ irct.org). In the field of regular outpatient care and in outpatient departments of institutes, it is generally not possible to offer such a comprehensive and integrated range of care that takes into account the various problem areas. Nevertheless, a meaningful approach can be achieved through networking. Close cooperation with legal and social counselling centres is necessary in order to identify residence and social issues that influence the current needs and motivation. Trauma-focused treatment is not indicated in highly unstable situations. Here, first of all, a stabilisation of the external framework is necessary and – in addition to social work – psychiatric or psychotherapeutic crisis intervention and support.

In their complementarity, different forms of therapy ensure a variable and lively setting and allow the use of forms of expression and processing at different levels and the adaptation of the procedure to different individual and cultural imprints and educational levels. In practical work, basic cognitive-behavioural or psychodynamic methods are suitable, which can be supplemented, for example, by techniques of systemic therapy (Hanswille & Kissenbeck, 2008) or imaginative methods (Reddemann, 2004). Trauma-specific techniques and modules are integrated into the therapeutic process depending on the training background of the therapist and suitability for the spe-

cific patient, such as narrative exposure therapy (NET) (Schauer et al., 2005), eye movement desensitization and reprocessing (EMDR) (Hofmann, 2009; ▶ Chap. 14) or the screen technique (described in Gurris & Wenk-Ansohn, 2013). Further useful components of multimodal trauma therapy are, according to experience, body-oriented and creative forms of therapy, such as physiotherapy, pain therapy with biofeedback (Liedl et al., 2011), concentrative movement therapy (Karcher, 2004), music therapy or art and design therapy. Research has shown that these multimodal approaches lead to significant reductions in symptoms (Stammel et al., 2017; van Wyk & Schweitzer, 2014), but there is still a lack of information on the contribution of single treatment components to the reduction of symptoms.

The efficacy of treatment approaches for refugees also seems to be influenced by the current life situation. In countries where the refugees face complications related to cultural and linguistic aspects and an increased risk of social marginalisation, these complications influence the course of treatment (Sandhu et al., 2013). Treatment studies with refugees in Europe and the US (meta-analysis, Nosè et al., 2017) showed an efficacy of NET in reducing PTSD and depressive symptoms. This supports older meta-analyses, which showed that NET is also effective in other settings in the treatment of refugees (Crumlish & O'Rourke, 2010; Gwozdziewycz & Mehl-Madrona, 2013), as well as for the treatment of torture victims (Patel et al., 2014). In worldwide studies, trauma-focused therapy approaches have generally been shown to be effective (Nickerson et al., 2011a).

While psychoeducation, skill training, resource work, sports and relaxation and mindfulness training as well as work with creative tools or focus groups, on questions such as life in exile and interpersonal skills, can take place very well in group settings, experience shows that trauma-focused work is better done in individual settings, since the experiences of torture and violence and the emotions associated with them are usually extremely full of shame.

The therapeutic procedure should be flexibly adapted to the individual development of the traumatic process and the individual process of coping with the traumatic impact, the specific constellation of symptoms (Cloitre et al., 2011), the current social life and the culturally shaped possibilities – resources and possible restrictions. The use of rigid, manualised techniques usually is limited (Ottomeyer, 2011) and does not meet the needs of those affected. A culturally sensitive approach, transparency and the consideration of the needs of control of traumatised people as well as a stable therapeutic relationship, which should be regularly reflected upon through supervision and intervision, are central.

25.4.1 Steps of Trauma-Oriented Treatment for Victims of Torture

A procedure that offers certain focal points in the course of treatment (Cloitre et al., 2011; Kruse et al., 2009) has proven suitable in the work with traumatised refugees (◘ Fig. 25.2).

The phase model is not to be applied rigidly, rather elements of other phases are also useful in each phase. In particular, due to interim crises, e.g. as a result of difficulties in the proceeding regarding the right of residence, stabilising therapeutic and social work are necessary over and over again. The therapeutic steps and modules should be adapted to the individual course of the post-traumatic process, the coping style and the requirements of coping with life in the current context (Wenk-Ansohn, 2017).

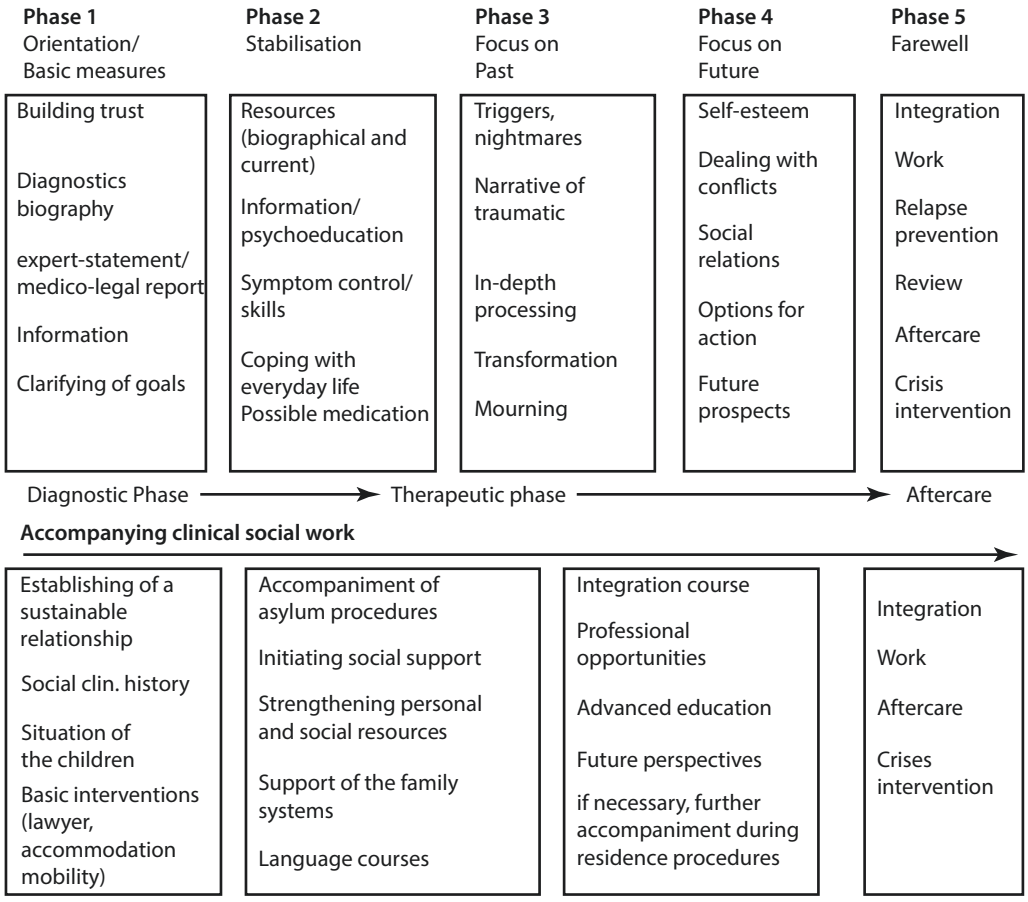

Fig. 25.2 Therapy phases – components of trauma-oriented treatment (phase model). (Modified according to Meichenbaum, 1994; Drozdek & Wilson, 2004)

25.4.1.1 Initial Interview

A detailed initial conversation in the first session with the support of an interpreter (Wenk-Ansohn, 2017) is recommended in order to decide together with the patient whether psychotherapeutic treatment is likely to be helpful for the special needs.

Initial Interview: Setting with a Professional Interpreter

Topics to ask about and for consideration of the interviewer:

- Complaints
- Key biographical data – potentially traumatic background
- Current stressors
- Social situation/residence situation; is a lawyer involved
- Motivation to contact the treatment facility; preliminary information
- Previous diagnostics/treatments
- Suspected diagnosis – no diagnosis – other problem?
- Unstable life situation or other external factors in the foreground?
- Therapy motivation?
- Treatment indication (general – current)?
- What type of action/treatment is likely to be indicated? Which mea-

sures can I offer and which not? Eventually concluding consultation and, if necessary, referral.
- In case of treatment indication: Is there a need for acute care or for long-term psychotherapeutic treatment including monitoring of the rehabilitation process?

The result of an initial psychotherapeutic interview can then be the indication of various measures by the psychotherapist himself/herself or by the network.

Indicated Measures Can Be

- Carrying out a diagnostic phase and – in case of substantial results – preparing an expert statement/psychological or medico-legal report for the proceedings regarding the right of residence
- Referral for medical diagnosis and care; if necessary, referral for documentation of injury traces by doctors trained in forensic medicine or according to the Istanbul Protocol (United Nations High Commissioner for Refugees, 2011)
- Referral to psychiatric differential diagnosis and possibly treatment; in case of suicidal tendencies, severe depression or significant dissociative or psychotic symptoms, possibly hospitalisation
- After diagnosis and preparation of a possibly required expert statement/psychological or medico-legal report: further psychosocial support through low-threshold counselling and group offers or practical support by (possibly voluntary) helpers
- Crisis interventions or predominantly stabilisation-oriented short-term psychotherapy and possibly pharmacotherapy to alleviate symptoms in a still ongoing stress situation (e.g. considerably unstable residence situation)
- In the case of severe chronic symptoms and possibly simultaneously limited ability or motivation for self-reflection: long-term (low-frequency) supportive psychotherapeutic, psychiatric or social therapeutic treatment, if necessary installation of individual case help. A day clinic treatment or close social care with integrated psychotherapy would possibly be more effective here, but such (interpreter-supported) services for migrants are hardly available to date.
- Trauma-oriented psychotherapy (usually a long-term therapy process in individual setting plus group setting if available)
- Accompanying psychotherapeutic measures, autonomy-promoting social work is generally useful for the areas: residence, accommodation and material situation, access to social activities, German and job-oriented courses; monitoring of the possible need for help of children who have arrived with the patient. It is advisable to ask adult patients who arrived with children about the welfare of the child and, if necessary, to arrange parental counselling, diagnostics with appropriate specialists or assistance from the youth welfare system.

Case Study: Mr. S., Syrian Refugee

Mr. S., a 29-year-old Syrian who has been in Germany for 1.5 years, was registered at the treatment centre for torture victims and traumatised war refugees by a social worker working in the refugee shelter.

In the first interview, he appears controlled and reserved. He reports on the history of bombings. Asked about his complaints, he reports that he can hardly concentrate during the German course, is restless, irritable, cannot fall asleep for hours and then wakes up again and again, drenched in sweat. Asked about bad dreams, he affirms and mentions that the same horrible contents occur again and again. Even during the day sometimes *"these images"* would come into his mind, *"sometimes I have the feeling that I am still in Syria"*. Asked about triggers for memories: when he hears aircraft noise or when there is a loud bang or when he sees police. Recently, when he was standing in a long corridor at the social welfare office, *"suddenly this narrowness"* (goes out of eye contact, is petrified for a minute, then comes back into contact when addressed). When asked, he confirms that he had been imprisoned and had experienced torture. Since then he would have had nightmares.

Regarding the current situation, he reports that he is in the process of re-opening his asylum procedure after having been granted only subsidiary protection. A major problem, he said, is that he has not been granted international protection and thus may not be able to bring his family together for years.

25.4.1.2 Acute Treatment Versus Long-Term Treatment

The need for treatment and thus the therapeutic procedure differ, depending on the phase of migration and the associated primary stressors. Experience in recent years has shown that it makes sense to initially offer acute or short-term therapy (duration approx. 6–9 months) to newly arrived refugees or refugees still living in a very unstable social and residence situation (Wenk-Ansohn, 2017). Taking into account emergency psychological and trauma therapy aspects, such treatment offers immediate psychotherapeutic help, which is combined with psychiatric medication and social work support if necessary. After a diagnostic phase, in which an initial narrative of the biography is also developed in an overview, psychotherapeutic interventions usually focus on dealing with current stress and trauma-associated triggers as well as dealing with symptoms with psychoeducational (Liedl et al., 2010) and skills-oriented elements (Koch et al., 2017). If necessary, after the diagnostic phase, an expert statement (also called medico-legal report) will be prepared for the proceeding regarding the right of residence, in order to support a stabilisation of the external situation as soon as possible.

Individual sessions can be combined with group sessions for acute treatment. Such acute treatment can have the effect of achieving psychosocial stabilisation and a recovery process can begin. The chronification of psychological symptoms is reduced and paths towards rehabilitation and integration into the host society are made possible. A longitudinal study with patients in an acute programme shows a significant improvement in symptoms of PTSD, anxiety and depression (Wenk-Ansohn et al., 2018). At the end of the acute treatment, it can be clarified with the patients whether further trauma-focused treatment is indicated and preferred at the current stage of the migration process or whether other steps are more important, such as participation in vocational preparation training. In the case of chronically complex traumatised persons and in the case

of already relatively stable residence conditions, a long-term psychotherapy process should rather be intended from the beginning, which also aims, after an initial phase of trust-building and stabilisation, to process the traumas as far as possible, develop coping strategies and open up new perspectives. Particularly in cases of violent loss or disappearance of close relatives, after sexualised torture or wartime violence (Wenk-Ansohn, 2002), or when dealing with perpetrators, treatment is often lengthy. Also in the case of pre-traumatic psychological problems, longer psychotherapeutic treatment is often necessary (Wenk-Ansohn, 2017).

25.4.1.3 Diagnostics and Basic Measures

Components of the Diagnostic Phase (5–10 Sessions) After Admission

- Clinical psychological and if necessary psychiatric diagnostics
- If required, general medical diagnostics and documentation of eventual physical traces of torture
- Psychological test diagnostics
- Social anamnesis
- Start with initial social work interventions
- If necessary and if there are substantial findings: Preparation of an extensive medico-legal or psychological report or a shorter expert statement for the proceeding regarding the right of residence
- Joint decision-making with the patient on treatment planning

In addition to clinical diagnostics, this first stage of treatment includes an assessment of the previous course of symptoms and psychological test diagnostics. Likewise, the reconstruction of the biography including the traumatic events should be worked out in this phase, as far as this is possible and ethically justifiable at this time – and necessary for a possible report. This procedure presupposes careful handling (Pielmaier & Maercker, 2012) as well as good skills in early recognition and in dealing with dissociative reactions and must be accompanied by initial therapeutic support and psychoeducational interventions. The pressure of having to prepare an expert statement/psychological or medico-legal report for submission to the authorities is problematic for the early phase of the interaction and the therapeutic relationship and is associated with professional and ethical problems (Gurris, 2003c). At the same time, however, this also offers the possibility of a first verbalization ("first disclosure") and thus an important step for the treatment (Gangsei & Deutsch, 2007; Gurris & Wenk-Ansohn, 2013). If the patient succeeds in overcoming his or her avoidance, traumatic experiences are often verbalized for the first time during the diagnostic phase and a process of integrating traumatic fragments in the overall biography begins. A narrative is created that is recorded in writing (see Testimonial Therapy; Cienfuegos & Monelli, 1983; Jørgensen et al., 2015). The material can then be part of the expert statement/psychological or medico-legal report in the asylum procedure and at the same time be a documentation for the patient.

Continuation of the Case Study Mr. S.

In the diagnostic phase, the suspected diagnosis of PTSD is confirmed, accompanied by depressive symptoms. During the interview, Mr. S. is limited to negative thoughts about himself and the future. Mr. S. reports to have had a happy childhood, worked as a craftsman after school, married at the age of 22, he had a 5-year-old daughter. In 2012, he had been arrested on the charge of supporting the opposition. Regarding torture he reports different forms of torture, such as beatings, electric shocks, hanging. Some of his friends had died in custody, and even today he hears the screams of the tortured people in his dreams, wakes up from them. He himself had been bought free after 3 months. In the following period, he reports to have been repeatedly detained at checkpoints and asked to collaborate with the regime.

His house had been bombed, his brother had been killed (cries, apologizes). He had fled with the hope of being able to catch up with his family as quickly as possible in a safe way. At the moment, he is very afraid for his wife and daughter, he has heard that his town is being bombed again. He currently has no telephone connection to them (cries). Sometimes he thinks about going back to Syria. Asked whether he had reported on his detention at the hearing in the asylum procedure at the Federal Office, he said that he had mentioned this, but that in the notification of decision is written that he had not been believed. At the end of the diagnostic phase, a psychological and medical expert statement documenting psychological and physical consequences of torture is written for his asylum procedure.

25.4.1.4 Psychological Test Diagnostics

The use of questionnaires and/or standardised and structured interviews to assess mental health is challenging for victims of torture and traumatised refugees, but is however possible and recommended. It should be mentioned here that the collection and acquisition of information regarding mental symptoms can have different objectives (e.g. recording of current symptoms, monitoring symptom changes over time, supporting the decision on the diagnosis). Different instruments are used to operationalise the respective objective (self-assessment questionnaire, external assessment scales, interviews, behavioural observations).

The challenges in test diagnostics for torture victims and traumatised refugees can be divided primarily into 2 categories:

- **Language**

Adequate recording and exploration of the symptoms by psychodiagnostic procedures requires the use of qualified interpreters or the use of instruments that are already translated into the patient's language. It should be pointed out that ad-hoc translations during the diagnostic process should be avoided if possible, as this can lead to inaccurate translations and specific concepts may be translated incorrectly, which leads to a loss of validity.

- **Culture**

The perception and experience of psychological symptoms are also influenced by the cultural background of the person. However, it should be noted that "culture" does not produce stereotypical symptom manifestations, but rather that these symptom manifestations are characterised by individual variances (e.g. gender, age, education). The challenge is therefore to understand diagnostics as an open exploration process. Following on from the concept of "culture", the diagnostic instruments per se represent a challenge in a transcultural set-

ting, since they were developed on the basis of Western concepts of disorders and also validated in Western samples. For adequate application in non-Western contexts, first of all a linguistic adaptation (i.e. independent back and forth translation) is required, and in a second step, validation and, if necessary, cultural adaptation. Currently, however, hardly any sufficiently validated questionnaires are available in the various languages. The development, validation and free provision of such instruments for practitioners are desirable and are currently being aimed at.

In the practical implementation of psychodiagnostics, there are specifics and challenges, which are merely listed in the following (for a more detailed overview, see Stammel & Böttche, 2017; Böttche & Stammel, 2018).

Preparation

The diagnostic session should be announced in a timely manner. This includes, on the one hand, the provision of information about the course of the session, i.e. the duration (usually 50–100 min) and the content. Since obtaining information may remind of interrogations during torture or hearings during or after flight (e.g. at borders, asylum hearings), it is also important to explain the purpose of the diagnostic session clearly and comprehensibly beforehand.

The literacy level should also be assessed. Especially when answering questions using rating scales (i.e. multi-point rating scales such as "never", "often", "sometimes", "mostly", "always"), non-literate persons often find it difficult to classify their symptoms. Visualised rating scales in the form of differently sized circles or other geometric shapes often help here.

Depending on the literacy level (and the presence of translated instruments), the presence and involvement of the interpreter is also necessary.

Test Diagnostics Session

During the diagnostic session, as with other patients, various problems may arise that require appropriate general psychotherapeutic procedures:

- Short-term severe stress until decompensation or dissociative states;
- Items are not understood;
- Rumination is classified as intrusive experiences;
- Answers too detailed, containment of the patient is necessary;
- Answers are only given in extremes (motivation, cultural linguistic customs, etc.);
- Different information for clinical anamnesis and test diagnosis.

25.4.1.5 Stabilisation and Resource Work

In the initial phase of therapy (and repeatedly in the course of therapy), it has proven to be effective to focus on emotion-regulating, control-restructuring, desensitizing and resource-activating interventions.

Proven Stabilizing Treatment Steps

- Structuring everyday life and promoting activity, encouraging self-care
- Psychoeducation in individual or group settings (Knaevelsrud & Liedl, 2007)
- Identification of symptom triggering conditions in everyday situations, dealing with triggers
- Skills training (Koch et al., 2017; Sendera & Sendera, 2007), mindfulness training
- Practice of self-soothing procedures (e.g. various forms of relaxation, stabilizing body work [Karcher, 2004]), physical activation
- Sleep hygiene and possibly sleep-promoting antidepressant medication

- Symptom-oriented methods of pain control and management (Gurris, 2003a)
- Strengthening the ego functions in dealing with current everyday conflicts, self-management
- Support of self-determined action in the social environment, "empowerment"
- Reviving and anchoring of pre-traumatic resources, e.g. through biography work, guided imaginative journeys and imaginative techniques (Gurris, 2005; Reddemann, 2004), resource work with EMDR (Korn & Leeds, 2002; Rost, 2008)
- Acknowledgment and therapeutic use of introduced metaphors, exploration of traditional rites
- Acknowledging feelings of grief, e.g. loss of home, family structures, cultural environment, property, etc.

Continuation of the Case Study Mr. S.

The psychiatrist prescribes Mr. S. a sleep-promoting antidepressant medication with mirtazapine, which he takes for several months. In addition to individual therapy, Mr. S. participates in a psychoeducational group for 12 sessions, in which progressive muscle relaxation is also practiced. In the group, he gradually overcomes his timidity. The social worker motivates Mr. S. to take part in a German course again. In the individual therapy, the first 10 sessions focus on the following contents:

- Development of a therapeutic working relationship;
- Structuring of everyday life, sleep hygiene (e.g. evening walks, no looking at pictures from home on the Internet in the evening);
- Dealing with trauma-associated triggers, reorientation exercises;
- Resource work, validation of skills, evoking and anchoring of positive childhood memories using the lifeline (manualised in Schauer et al., 2005);
- Mourning for the loss of his brother and for leaving the family.

News of bombings in his home area repeatedly leads to crises, in which he sometimes visits the centre without an appointment to share his worries, to find someone to whom he can communicate and who can give him support in all the fear.

25.4.1.6 Trauma-Focused Treatment

The necessity of integrating the extreme traumatic events into the biographical narrative of those affected is emphasised across all therapy schools. This means that avoidance and dissociation should be resolved, as far as possible in each case, in favour of the gradual empowerment to expose oneself to the traumatic images and memories in a conscious and controlled manner. The associated feelings should be admitted and verbalised in a bearable form and a new position in relation to the experience should be worked out. The trauma-confronting work is only started when patient and therapist are sure that sufficiently strong resources have been "established".

Trauma exposure in torture victims and severely traumatised war victims should only take place if there is sufficient stability of the external and internal situation and with the patient's consent and if

the therapist–patient relationship is sustainable. It should not be carried out in psychosis-near conditions or in cases of suicidal tendencies.

Depending on the therapeutic background, different forms of trauma-focused work are used. If, in the diagnostic phase, a rope symbolizing the life line was used in the reconstruction of the biography, this work can be taken up again in the later course of therapy for trauma exposure within the framework of a therapeutic procedure based on NET (Schauer et al., 2005; ▶ Chap. 16).

In addition to narrative processing, "screen work" or "screen technique" (Sachsse, 2008; Putnam, 1989) is a proven possibility for trauma-focused work. Using this technique, traumatic events are viewed as in a film and a narrative is created at the same time. The screen technique is based on Putnam (1989) and was further developed by Gurris (2003b) as a multidimensional imaginative-narrative exposure. At its core, it is a flexible imaginative form of approximation and distancing, which is carried out imaginatively and at the same time narrative-meaning-making on changing levels of experience and behaviour. While the patients are encouraged to approach the trauma scenes imaginatively (projected onto an imaginary screen) in a detailed and continuing manner, they can use various previously learned distancing techniques that enable controlled relief and prevent flooding at the same time – e.g. reducing the size of the screen, switching to a dynamic resource image.

Imaginative-narrative trauma-focused techniques, which make proximity and distance to the painful events and images controllable for the affected person, enable a careful reconstruction of memories, supported and deepened by the therapist, involving various channels of perception and gradual elimination of dissociation, as well as the processing of trauma-related emotional and cognitive schemata. This results in a composition of traumatic fragments and the expression of connected feelings through verbalisation.

Continuation of the Case Study Mr. S.

In the individual therapy of another 15 sessions, Mr. S. increasingly reports the content of his nightmares, in which the particularly traumatic moments are shown. He verbalizes details of his brother's death and the feeling of helplessness when he could not stop the heavy bleeding. His mother had not been able to get over this death and subsequently became very ill. Since the nightmares repeatedly depict scenes of imprisonment, he is willing, after initial avoidance reactions, to face the memories of his arrest and torture in detail. He can overcome his sense of shame and also share how he experienced an extremely humiliating and painful anal rape, from which a dialogue about a sense of honour and masculinity develops.

He also describes as particularly incriminating the cries of fellow prisoners who were tortured in the neighbouring cells and some of whom died in prison. The unifying element, which apparently does not allow the memories to rest, are feelings of guilt to have survived, which we then work on over several sessions – until he was able to say: *"It was out of my hands. I did what I could"*. This gives room for mourning for the lost. In the following time, the nightmares decrease significantly, Mr. S. is able to concentrate better in the German course.

With torture survivors, trauma-focused work is often not possible as a sequential working through of the entire traumatic memories. Often, however, elements ("hotspots") and different levels of the traumatic sequence and its meaning can be focused on at different points in the therapeutic process. Trauma-focussing work or trauma exposure should not be seen in isolation, but as part of a treatment process, which, as a whole, focuses on the functional impairment at the various levels of the complex trauma sequelae and on social rehabilitation (Cloitre et al., 2011).

25

25.4.1.7 Work on Symptom Stabilizing Cognitive and Emotional Schemata

The term symptom-stabilizing schemata here is used for psychodynamically effective and cognitive patterns that can impede the processing and coping with the traumatic experience. Depending on the pre-traumatic personality, cultural ties, constellation of the traumatic situation, attribution of meaning, reactions of the environment, social consequences and other influencing factors, the centrally effective symptom-stabilizing schemata are of different types (cf. psychodynamic tension points of the course of the traumatic process; Bering, 2011). In both cognitive and psychodynamic therapy, work on symptom-stabilizing schemata is an effective component that can also be applied when detailed exposure to the traumatic experiences themselves is not possible or not desired or when symptoms persist after confrontation with the traumatic memories. External symptom-stabilizing factors elude the influence of therapy, but the patient may be able to develop a new attitude towards them. Internal symptom-maintaining schemata, such as shame and guilt (see Boos, 2005; Kröger et al., 2012), can be dealt with in therapy and their symptom-stabilising effect can be reduced (Fig. 25.3).

The symptom-stabilizing inner schemata are reflected in the behaviour in the therapeu-

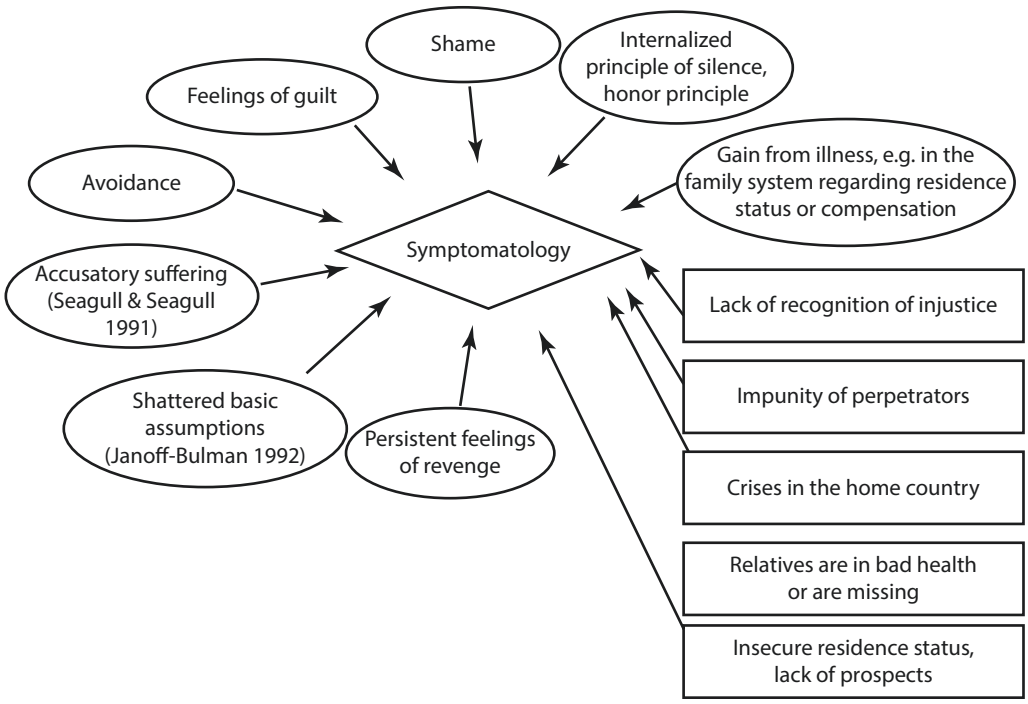

Fig. 25.3 Symptom-stabilizing factors. (*Rectangular* outer factors, *oval* inner schemata)

tic relationship or in the social environment as well as in the form of repeated scenically or symbolically trauma-connected stressful dreams. The interaction in the therapeutic relationship, everyday conflicts or dream contents brought into the therapy can be used as an occasion and access for processing. Some patterns and conflicts are difficult to change, especially if they are influenced by inner cultural imprintings and interrelationships in the current social environment. The therapist can possibly act as a bridge for the development of new interpretations, taking into account the views of the exile society, e.g. experienced sexual violence does not mean loss of honour. An in-depth dialogue on meanings, limits and possibilities for changing self-perception, patterns of interaction and options for action is required.

The work on the individual dysfunctional processing mode has a reducing effect on the persistent or recurrent PTSD symptoms and comorbid disorders. It counteracts a traumatic process that otherwise deepens in the personality.

Even in cases where avoidance behaviour dominates, clinical experience shows that stabilisation and reduction of PTSD symptoms can be achieved by processing symptom-stabilising cognitions, psychoeducational, control-focused as well as resource-oriented, activating and social integration-promoting therapeutic interventions (Kruse et al., 2009). With dominant avoidance behaviour, a tendency towards persistent distressing dreams, a persistent depressive processing mode and somatisation is noticeable (Huijts et al., 2012; Wenk-Ansohn, 2002).

25.4.1.8 Dealing with Reactualisation and Retraumatisation

During ongoing therapies, obstacles and crises must be expected, e.g. if a further deterioration occurs as a result of negative news from home or burdens in the asylum procedure, with the re-actualisation of traumatic content and/or worsening of depressive symptoms. In the case of severe deterioration or retraumatisation (Schock et al., 2010; Wenk-Ansohn & Schock, 2008), emergency psychological interventions are necessary. Relief and self-control techniques are then in the focus, possibly temporary medication may be helpful. If it is also a matter of restoring external security, social work and/or legal advice are also necessary.

25.4.1.9 Integration Phase

Based on the work on conflicts in the current reality of life and relationships, the focus is on the effects of traumatisation on the personality and self-confidence, the development of new perspectives as well as a renewed ability to act and relate. The therapeutic space of individual and group therapy can serve here as a place to gain and test new scope for action.

In the final phase of therapy, the therapeutic accompanying of the integration process in exile is a central theme with the following focal points.

Focus on Therapeutic Support

- Establishment of social relations
- Processing of relationship patterns shaped by trauma and flight experience
- Promotion of autonomy and competence development through motivating to participate in measures such as language courses or vocational preparation courses
- Support for the gradual integration into the work process, adapted to the patient's state of health (Wenk-Ansohn, 2007)
- Processing of relapse, development of strategies for new stress situations

In this phase, social work in groups is helpful. Cooperation with the network of organisations that offer integrative measures for refugees is also recommended. The end of the therapy should be well prepared so that it is not processed as a breaking off of the relationship, especially since traumatised refugees have experienced traumatic break-ups of the relationship before the flight.

Continuation of the Case Study Mr. S.

After the medico-legal report had been submitted to the judge, the Federal Office was asked to revise its decision, as there was sufficient evidence for a personal preliminary prosecution. Mr. S. is granted refugee protection under the Geneva Refugee Convention and can apply for family reunification, a process which will last months though. Mr. S. can feel hope and joy again. However, there are several relapses when he hears of bombings in his home area. Such news causes fear and the traumatic content to reappear, so that elements from the stabilization phase are rehearsed, and we put together an "emergency suitcase". In addition, a self-esteem problem is to be worked on during this therapy phase, which is based on the fact that Mr. S. puts himself under pressure to offer his family a good life here, but without sufficient knowledge of German and formal training, he cannot work in his previous job. Parallel to psychotherapeutic individual sessions, autonomy-promoting support through clinical social work is increasingly coming into the focus. The social worker arranges a vocational preparation course.

After termination of the regular therapy (with diagnostic phase a total of 50 sessions over 1.5 years), Mr. S. takes a few individual sessions as part of the aftercare programme to discuss current stresses and conflicts. Six months after end of therapy, he presents us very happy his wife and his little daughter, who is proud that she is already attending a welcome class.

The farewell process is of particular importance. The possibility of aftercare in the sense of further selective support in the event of renewed stress, e.g. conflicts in the building up of life in exile, should be granted.

25.5 Therapeutic Work in a Transcultural Setting

25.5.1 Transcultural Encounter in Psychotherapy

Perception, feeling, thinking and forms of expression are culture- and context-dependent. The cultural background of individuals is not only determined by geographical origin or ethnicity, but is also influenced by many factors (e.g. educational level, gender). Values, social norms, the position of the individual in relation to other members of the group and patterns of thought and action are handed down in the interaction of the group, change in the historical and social context over the generations and form internalized "maps of meaning" (Clarke et al., 1979).

In a traumatic situation, culture-specific systems of meaning influence the evaluation of the event and interpretations of the trauma and its consequences (Afana et al., 2010). The culturally shaped actual or anticipated reaction of the social environment has a significant impact on the course of trauma reactions and coping options. In women from traditional societies, in which

honour and shame play a central role in regulating social status and references, complex trauma-reactive disorders are particularly common after rape or other forms of sexualised violence (Wenk-Ansohn, 2002) with chronification processes maintained by collective dysfunctional cognitions (Kizilhan & Utz, 2013). The tendency to conceal the experiences has the effect that treatment is often sought out late and under great pressure, e.g. when deportation is imminent.

In diagnostic and therapeutic interventions, the systems of meaning as well as thought and behavioural patterns underlying interpretations must be explored and taken into account to allow cultural adaptations (Heim & Maercker, 2017; Kizilhan & Utz, 2013). Symptoms and accompanying behavioural patterns may also vary. Even though symptom clusters of PTSD occur across cultures, their form of expression, the interpretation of symptoms, their classification, and the understanding of disease may vary across cultures (► Chap. 18).

Psychotherapy with refugees means an encounter with people that demands openness to reflect on one's own reference systems, awareness of one's own cultural and contextual ties and flexibility for changes of perspective. On the one hand, psychological models from Western contexts should not take place without verification and adaptation (Gurris, 2012; Schnyder et al., 2016). In a systemic perspective, the societal, historical-political and current social context should also be included. On the other hand, the therapist should not lose sight of the individual patient. Here, an attitude of respectful curiosity and committed neutrality with the help of circular questions has proven to be successful (Oesterreich, 2004). Attention to non-verbal communication makes it possible to reduce misunderstandings and to enter into a direct, lively contact with each other (von Lersner & Kizilhan, 2017).

Helpful Tools in Transcultural Communication

- Openness and respect
- Observing rules of courtesy
- Mindful handling of shame and taboo subjects
- Pay attention to potentially culturally divergent communication styles/language cultures and indirect expressions
- Inquire meanings of words, phrases, metaphors
- Circular questioning, approaching from different perspectives
- Clarify misunderstandings and encourage further inquiries
- Reflect and make transparent your own culture/culture-bound behaviour
- Dialogue on potential differences in culture of origin and exile
- Make the professional role and the therapeutic approach transparent
- Repeatedly emphasize the own commitment to confidentiality (and that of the interpreter) (also towards relatives and friends of the patient)
- Resourcefulness and courage to improvise (e.g. letting patients draw, use of symbolising objects)
- Pay attention to non-verbal communication

25.5.2 Communication with Interpreters

In addition to facilitating linguistic communication between patient and therapist, interpreters play an essential role in clarifying culture- and communication-specific questions – a resource that can be used in the short follow-up discussion after the sessions.

The necessary training of interpreters for use in a therapeutic context includes the teaching of the basics of

- psychopathological symptoms and problems of traumatized persons,
- basics of therapeutic work and therapeutic relationship,
- contents of special medical/psychological terminologies
- concepts related to the everyday reality of asylum seekers
- exercises in literal translation in a therapeutic setting

Training should also include methods of preventing vicarious trauma and burnout.

Psychotherapy involving interpreters generally requires clearly structured cooperation with clearly defined activities and roles (Abdallah-Steinkopf, 2017). The therapist is responsible for the structuring of communication, the course of the conversation and the therapeutic process and has the protection of the interpreter in mind. Transference and counter-transference reactions take place in a triad (patient-interpreter-therapist; Haenel, 2001). The therapist's constant attention to these events and joint reflection on them with the interpreter is necessary. In order to have an overview of all what is happening in the triad, a seating arrangement in a triangle has proven to be effective, which also illustrates the aspect of partnership for successful communication.

Rules for Communication

- **General rules**
  - Preliminary talk before the first assignment
  - Professional and specially trained interpreters
  - No relatives/acquaintances as interpreters
  - Confidentiality (set out in writing)
  - No private contacts, no disclosure of the telephone number of the interpreter to the patients
  - Presentation of the interpreter and informating the patients about regulations for language mediation
- **Rules applicable for the interpreter**
  - Translating in first person form/direct speech
  - Translation as literal as possible
  - Everything spoken in the room will be translated (also the patient is informed that every communication between interpreter and patient outside the therapy will be communicated to the therapists)
  - Generally consecutive translation
  - Use of regular supervision and further training
- **Rules for therapists:**
  - Paying attention to the flow of speech of the patients
  - Adapt the language to the level of education and ability of abstraction of the patients
  - Short sentences and avoidance of abstract or technical terms;
  - Polite stopping when the spoken gets too long
  - Offer the interpreter to interrupt and ask back
  - Striving for direct address and eye contact with patients and paying attention to non-verbal communication
  - Follow-up conversation with the aim of relieving the interpreter by clarifying misunderstandings, peculiarities, methodical approaches, triadic aspects of the relationship

If the rules of communication are followed, therapy in a transcultural setting with the support of interpreters is not less effective

than in a native speaker setting. In a meta-analysis, in which 13 studies with refugees were evaluated, no treatment-related differences were found between studies in which interpreters were used to facilitate sessions and those in which this was not the case (Lambert & Alhassoon, 2015).

25.5.3 Therapist–Patient Relationship

Central to the therapeutic relationship is that it is based on sincere and recognisable respect, because regaining a sense of dignity is central for victims of torture and other forms of humiliating violence.

In therapy with torture victims and war traumatised people, extremely contradictory attitudes are noticeable frequently. On the one hand, too great distance of the therapist with a lack of empathy can lead to the patient closing his or her mind and even to the termination of therapy. On the other hand, a lack of distance and too much empathy with over-identification and even personal involvement are frequently observed (Haenel, 1998; Wilson & Lindy, 1994). Experience shows that in therapy with traumatised people, a controlled distancing from the usual therapeutic abstinence is recommended (Maier & Schnyder, 2007; Wenk-Ansohn, 2002). Of central importance is a high degree of transparency in therapeutic work. In additionx, however, the therapeutic attitude towards torture victims and refugees also requires partiality with regard to respect for human rights and condemnation of human rights violations.

In the case of people traumatised by torture, an attitude of overprotection can lead to those affected being perceived solely in the role of victim, with the subjective motive of sparing them and withholding unpleasant realities from them. In the end, they are thus further incapacitated and fixed in their role as victims.

In the therapeutic setting, an interaction is created in which the patient can recognize himself as an equal human being in his basic human dignity. Fischer and Riedesser (1998) describe the transference relationship in trauma therapy as a process of re-bonding. In the case of trauma caused by human hands, the overcoming of mistrust and the rediscovery of the foundations of the communicative reality principle are particularly necessary.

Torture survivors tend to transfer perpetrator aspects to the social environment (Comas-Diaz & Padilla, 1991; Wilson & Lindy, 1994). The setting in diagnostics and therapy alone can trigger violent re-actualizations of the traumas with flashbacks or dissociative states. On the part of the traumatised person, an associative link with experienced interrogation situations or psychological tortures develops. If these processes cannot be adequately processed and resolved, not only is further treatment blocked, but retraumatisation can also occur. On the other hand, the fear of perpetrator transference can lead the therapist to avoid clarification and confrontation, so that therapeutic opportunities are not used. The repeated reflection of the therapeutic relationship in supervision during the course of treatment is therefore a basic requirement (Lansen, 2002).

25.5.4 Vicarious Traumatisation

The possible psychological consequences for care givers in their work with traumatised persons have been described repeatedly (▶ Chap. 27). The particular pressures on therapists in centres for torture victims and war traumatised persons and the effects of trauma-related patterns on the interac-

tion of teams have been investigated (Pross, 2006), as have institutional factors promoting burnout (Pross, 2009). A changed world view can have a fundamental impact on the well-being of the professionals, as treatment takes place in a life context (Ghaderi & van Keuk, 2017) that is influenced by violent conflicts in the world and the often restrictive conditions also in the host country. Gurris (2005) and Deighton et al. (2007) found in a study in treatment centres for traumatised refugees on the 3 scales of ProQOL R-III ("Compassion Satisfaction", "Burnout"and "Compassion Fatigue"; Stamm, 2010) less favourable values for therapists of torture survivors compared to other helping professions. It was shown above all that the therapists were permanently burdened by the insecure residence situation of their patients. Around 50% of the sample showed strong feelings of exhaustion, powerlessness, helplessness as well as anger and rage. About one third of the therapists could be assumed to partially fulfill the criteria of PTSD.

It is therefore necessary to have a good structuring of work and cooperation between the different professions in the institution. Therapists should have well-founded psychotherapeutic training and be trained in psychotrauma therapy. Regular supervision, constant work on the therapeutic role and attitude as well as sufficient self-care (Schneck, 2017) and networking are prerequisites for positive management of the stresses and strains. At the same time, the work is enriching due to its diversity and intensive interactions with people from other cultures.

25.6 Concluding Remarks

The treatment of traumatised refugees and torture victims brings along special requirements: working mostly in a transcultural setting, involving interpreters, as well as the treatment of extremely traumatised people, most of whom suffer from complex disorders. At the same time, the patients are in a process of coping and adaptation determined by many factors due to cultural uprooting and stress in exile.

> A schematic application of trauma therapy techniques is often not appropriate in the treatment of traumatised refugees and torture victims, even though these techniques can be important components of the trauma-oriented treatment process.

It is necessary to adapt the form of treatment to the special situation of the refugees. Social work and low-threshold services as well as psychiatric- or psychosomatic-oriented medical treatment, if required, can be a useful supplement to psychotherapeutic work. Transparent cooperation and networking are necessary for this.

> Social work accompanying therapy is usually necessary for the psychotherapeutic work to be effective.

The treatment of torture victims and traumatised refugees requires a biopsychosocial approach and, in addition to trauma-oriented psychotherapy, also includes the promotion of integration into the host society and a rehabilitation process in the sense of Article 14 of the Convention against Torture (see UN-Committee against Torture, 2011).

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