

# SOCIAL WORK WITH REFUGEE SURVIVORS OF TORTURE AND TRAUMA

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## Chapter objectives

- To introduce relevant information about refugee survivors of torture and trauma necessary for understanding this field of practice
- To describe the development of the social work field of practice in New South Wales and the current issues
- To introduce some ethical issues for working as a social worker in this field

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## Introduction

The field of practice with refugee survivors of torture and trauma has been established relatively recently, both internationally and within Australia. However, the problem of human rights abuses and forced exile caused by oppressive regimes has existed since the early days of human history. In this chapter, social work with traumatised refugees—people who have suffered from state-sanctioned violence or war, and have been forced to flee their homelands—is examined. In fear of persecution if they return to their own country, refugees have sought asylum in many countries including Australia.

Related areas of practice include working with tortured or traumatised Australian-born people such as the Indigenous population and Australian war veterans. These significant topics merit attention, as they involve large populations within Australian society whose situations arise from specific historical events that shaped our nation. Social work with people of non-English-speaking backgrounds is also a broad area of practice that intersects with work with refugees. To work in this field of practice is to be confronted both with the vulnerability of people to tragedy and painful events, and with the depth of cruelty in human nature (Herman 1992). Central to the social work code of ethics is a commitment to social justice and valuing the rights of all people. Working with refugee survivors of human

rights abuses is, therefore, an important field for social workers, and relates to the core values of social work.

## **The worldwide situation for refugees**

The United Nations defines refugees as people who are outside their own country and who cannot, or do not want to, return because of a well-founded fear of being persecuted for reasons of race, religion, nationality, political opinion, or membership of a particular social group. The 1951 Convention was initially applied to refugees from Europe following World War II, and the Protocol of 1967 extended protection to people fleeing persecution from situations all around the world (Silove 2002). Most Western nations including Australia signed these conventions and prior to this last decade there was an international acceptance of these principles.

Over the last 50 years, the numbers of people in refugee-like situations have increased significantly. Silove et al. (2000) writes that during the last two decades of the twentieth century there were more than thirty-five civil wars and a larger number of lower-intensity conflicts. These included 'ethnic cleansing' and violent attacks on civilians, including women and children, by local militias and warlords or non-government paramilitary forces. These conflicts have led to large population movements, and many displaced people with 'refugee-like' experiences who do not fit the United Nations definition, and who have not been able to gain refugee status either from the United Nations or regional agreements on the status of refugees. These include the 'internally displaced persons' (IDPs)—people who have fled and are still living in a dangerous situation in their own country.

There are at least seventeen million (UNHCR 2004) 'Persons of Concern' who are within the UNHCR mandate. 'Persons of Concern' include refugees (9.7 million, January 2004), asylum seekers, internally displaced persons, returnees, and stateless people. The majority of people fleeing their country seek refuge in neighbouring areas, usually in countries in the developing world. Only a minority of these people will lodge applications to be resettled in other countries. Some will travel directly to countries in which they hope to settle and lodge applications once they have arrived. These people are 'asylum seekers'.

Pittaway (2002) writes that examining the answers to the complex problems of refugees includes analysing the root causes of refugee flow. This includes acknowledging the (at least partial) responsibility of the developed world in supporting and generating many of the circumstances that contribute to this flow of refugees. While this critical issue is beyond the scope of this chapter, it is significant that 80 per cent of the world's refugees and displaced people are women and children.

### **Recent international developments in response to the growing refugee crisis**

During the period 1980 to 1999, the majority of the five million people seeking asylum in the developed world were allowed to live in the community while awaiting the outcome of

their refugee applications (Silove et al. 2001). However, in response to the threat of larger numbers of asylum seekers and refugees, governments of developed nations have implemented policies to deter people from seeking asylum. The last 10 years have seen an erosion in the previously humane international commitment towards helping refugees. Some of these policies of deterrence include more stringent visa restrictions, rigorous border checks and document validation, and the interruption of voyages of vessels suspected of containing smuggled asylum seekers (Silove et al. 2000). The most disturbing aspect of this trend is the tendency to confine asylum seekers, including children, in detention centres, often for lengthy periods, while their cases are being assessed. For example, in 2000 the United States detained five thousand asylum seekers at any one time. However, Australia stands alone in placing in detention all individuals without valid visas irrespective of whether or not they were seeking asylum (Silove et al. 2001).

Isolated centres, such as Woomera in Australia, are surrounded by barbed-wire fences, with their remoteness making access to health, social, and legal services difficult. Detainees may be denied access to study and work, and live in continuous anxiety about the future. The length of time they must spend in detention is often unknown to them. Escapes, riots, hunger strikes, protests, and violent outbreaks have occurred in detention centres in different countries, pointing to the psychological effects of imprisoning traumatised people who have not committed any crime (Silove 2002). Independent inquiries in several countries have raised serious concerns about human rights violations in detention centres for asylum seekers. In Australia there have been numerous reports by the Human Rights and Equal Opportunity Commission (HREOC) into mandatory detention, and also by the Commonwealth Ombudsmen's Office. The National Inquiry into Children in Immigration Detention, announced in November 2001, was another significant inquiry in Australia.

Alternative systems are now in place in some countries, where rather than being detained asylum seekers live in the community but are monitored by the government. Family or friends or agencies may pay financial bonds to ensure that a person complies with the requirements of the immigration system. These systems are imperfect but do allow a degree of freedom and dignity for asylum seekers (Silove et al. 2001).

### Australia's humanitarian programme and recent developments in policy concerning asylum seekers

Since World War II, of the 5.5 million people who have migrated to Australia more than 560,000 people have arrived under humanitarian programmes, initially as displaced persons and more recently as refugees (Crock 1998). World events have influenced Australia's pattern of refugee intake. For instance, after World War II, large numbers of displaced people from Europe settled in Australia. Since that time, people have fled from totalitarian governments, and/or from ethnic or religious persecution. Countries from which refugees have fled include: Hungary (1950s); Czechoslovakia (1960s); Chile, Argentina, Uruguay, Colombia, Brazil, El Salvador, Peru, and other Latin and Central American countries (1970s and 1980s); Afghanistan, Iran, Iraq, Palestine, Vietnam, Cambodia, Laos, Burma

(Myanmar), China, Sri Lanka, Fiji, and countries of the former Soviet Union (1970s, 1980s, and 1990s); Somalia, Eritrea, Ethiopia, Sudan, Sierra Leone, other African nations, and countries of former Yugoslavia (1990s to the present). The most recent arrivals have been from situations and/or conflicts in Kosovo, East Timor, Iraq, and Afghanistan; from other Middle Eastern countries; and from African nations such as Sierra Leone, Liberia, and Sudan. Currently Australia accepts approximately 12,000 humanitarian entrants each year.

Crock (1998) describes the historical ambivalence in the Australian community towards accepting asylum seekers. On the one hand, Australia has been seen to be a generous country, accepting refugees since the end of World War II. Australians have been proud of their harmonious multicultural society, which stands in contrast to the hatred and violence of many ethnic groups living side by side in other countries. Australia's refugee resettlement programme is outstanding.

Crock describes how, on the other hand, racism and discrimination have always been part of the nation's development, too. There is a fear of invasion by 'boat people' (which is interesting given that the White civilisation in Australia began with an 'invasion' by boat people, many of whom were people who had been abused and discriminated against). This is accompanied by ignorance of the realities of the torture and trauma experiences and losses suffered by refugees, and a low level of recognition of Australia's international responsibilities towards refugees. These attitudes were born out in the 'near hysteria' in some sections of the community regarding the arrival of the Vietnamese boat people, and in 1993 opinion polls that showed that popular acceptance of Asian migration was tenuous. During the 1990s the One Nation Party advocated an end to the immigration programme.

By 2001, Australia's treatment of asylum seekers had caused much controversy and dismay both within Australia and across the world. With the world watching, Australian authorities turned away asylum seekers who had been rescued by a Norwegian ship, the *MV Tampa*, and used the navy to relocate them to the island of Nauru in the Pacific Ocean, and other destinations (the so-called 'Pacific solution'). Later, 350 boat people drowned off Indonesian shores and another boat was engulfed in flames (Silove 2002). Australia's treatment of asylum seekers became a major agenda item at various international meetings; for example, the UN World Conference Against Racism (Durban, August 2001), a meeting of the Society for International Development (Den Haag, September 2001), and at the Executive Committee Meeting of the UNHCR (Geneva, September 2001) (Pittaway 2002). Then early in 2002 over 200 detainees at the Woomera Detention Centre embarked on hunger strikes and acts of self-harm. Australia had previously been regarded as a leader in humane treatment of refugees, and now was seen as a renegade state (Silove 2002).

Sidoti described the current refugee policy as lacking any clear formulation in law or ethics, and being based on public fear and government manipulation (Sidoti 2002). He has proposed a set of basic principles and practices that are more in accordance with fundamental principles of being Australian and being human beings. While Australians may be warned that they are facing a huge influx of refugees, in fact our country is relatively inaccessible to asylum seekers. In contrast, many poor countries of Africa, Asia, and the Middle East host

millions of displaced people, and even among developed nations Australia ranked 17 out of 21 industrialised countries in the number of asylum seekers received in 1999. Recent studies have shown that asylum seekers have suffered the same types and intensity of trauma as people who have been approved as refugees, and the main difference between the two groups is that asylum seekers have used alternative measures to reach safety (Silove 2002).

## **The impact of torture and trauma on refugees**

McGorry (1995) cites several studies that show that the majority of refugees have suffered significant levels of trauma and have also experienced many losses (Westermeyer 1991; Krupinski & Burrows 1986; Krupinski et al. 1973). A significant number of refugees also have suffered torture. In the most significant finding of her research about refugee women, Pittaway (1991, pp. 68–9) notes that the extent and degree of torture and trauma experienced by refugee women before arriving in Australia has been grossly underestimated: almost three-quarters of the sample of 204 women had suffered medium to high levels of trauma. Australian torture and trauma services indicated to the New South Wales Refugee Health Policy Advisory Committee in 1997 that 80 per cent of refugees from particular countries had suffered significant levels of torture and trauma. Silove (2002) documents studies that show high levels of exposure to trauma among asylum seekers, but with some variation according to ethnicity and background. For example, exposure to murder varied between 27 and 92 per cent, to personal life threat between 44 and 88 per cent, and to torture between 26 and 72 per cent.

Torture and ill treatment of prisoners has been reported in over 100 countries (Evatt 1996). The many forms of physical and psychological maltreatment are summarised by Cunningham et al. (1990). Physical torture commonly reported includes beatings, forced standing (often while naked), bondage, suffocation, burnings, electric shocks, sexual abuse, mutilation, and submersion in or irrigation with cold water. Psychological torture can include sleep disruption causing disorientation; sensory deprivation, hallucinations, and paralysis caused by drugs; solitary confinement; denigration and insults; sham executions; false accusations; prolonged interrogations; and being forced to watch loved ones being raped, tortured, or killed (Cunningham et al. 1990). Hosking (1990) points out that torture is not limited to any one geographical region, race, or political regime; yet, there appears to be a higher rate of torture in countries with military dictatorships or regimes that do not allow individuals or groups to participate in the political decision-making process.

The purpose of torture is not only to punish individuals or to extract information but also to destroy the integrity of the individual's personality (Reid & Strong 1988). Political opponents are then broken—a useful tactic in spreading terror and forcing compliance with those in power. Writing in 1989 just before his murder in El Salvador, the Jesuit priest Martin-Baro suggested that the psychological effects of state violence on the general population included people's thinking and behaviour becoming stereotyped, polarised, and rigid; people becoming isolated and losing their confidence in themselves and each other; and a general devaluing of human life (1989). Martin-Baro outlines the societal dimensions of

state terrorism clearly:

I would like to emphasise the social dimensions of torture, disappearances, abductions, and terrorism. It is important because for every tortured Salvadoran, there are at least a thousand Salvadorans paralysed by terror. For every Salvadoran killed, there are at least 10,000 who are violently forced to abdicate from their personal options and values. For every disappeared person, there are at least 100,000 Salvadorans who are systematically denied their right to conduct their own lives and to determine their life projects. And that is why we think that even when we are speaking of very deep psychological problems, we are talking about political problems (1989, p. 5).

Most refugees come from countries in which there have been years of political, social, and economic instability. Many flee international or civil wars, and situations of military dictatorship, oppression, and violence. People suffer from ill health as a result of famine, disease, and poor medical facilities. Their economic circumstances are affected by political corruption and deprived living conditions. They fear persecution from the authorities or certain groups within society. Many lose their livelihood. Some see their close family members 'disappear' or arrested, tortured, imprisoned, or killed (Hosking 1990).

The situation in Afghanistan is one example of far-reaching destruction that has occurred over three decades, and which has continued to create enormous numbers of refugees and displaced people. These circumstances were brought about through war, and the activities of oppressive regimes, warlords, and militias, backed by powerful nations. This situation has led to the deaths of more than two million people, the disabling of hundreds of thousands of people, and has resulted in more than six million refugees. People were attacked by air and artillery bombardments, millions of landmines were placed, and there were mass killings, torture, and imprisonment. People died from poisoned water, were burnt, or were thrown from planes and there was a particularly large number of civilian casualties, mainly women and children. The result of the Soviet occupation was a group of warring factions and a people who had been divided by the occupying force as a way of controlling resistance (Bowles & Haidary 1994; Dadfar 1994). In addition, Pilger (2003) describes how US and British governments colluded with the warlords and mujahideen, helping to fund and train over 100,000 Islamic militants in Pakistan to overthrow the Soviet Union in Afghanistan thus contributing to the development of the Taliban, and other militant groups.

During the period 1992–93, millions of Afghans returned from Pakistan to Afghanistan, only to suffer from the fighting between the mujahideen warlords, and then from the severe oppression under the Taliban regime (Maley 2003). Zia-Zarifi (2004) describes how currently warlords, militias, and brigands dominate Afghanistan, with the Taliban forces also becoming more powerful again. Attacks on US troops, on the government of President Hamid Karzai, and the foreign community supporting him continue. Many women and girls have again been forced out of schools and jobs due to the insecure situation and power of local fundamentalist warlords and militias. Villagers have been kidnapped and held for ransom; there has been widespread rape of women, girls, and boys; there has been robbery and murder; girls' schools have been burnt down; and the death rate of mothers giving

birth is the highest in the world. There is very little safety or rule of law outside the main cities. Poppy cultivation and the heroin trade have blossomed again, reinstating Afghanistan again as the world's leading producer of heroin. Foreign states—for example, Pakistan, Iran, Saudi Arabia, India, Uzbekistan, and Russia—are again becoming involved in the country's affairs for their own reasons (Zia-Zarifi 2004; Pilger 2003).

Refugees escaping from their country can be exposed to danger and violence: for example, Krupinski and Burrows (in Hosking 1990) estimate that 30 per cent of Vietnamese 'boat people' were robbed by pirates, and over 10 per cent were raped or abducted. Nearly one hundred thousand Indochinese boat people died on the seas, by starvation when engines failed, or by pirate attack. Refugees who escaped from their countries by sea often are not allowed to land when they reach a new destination. For example, as described above, in 2001 Australian authorities turned away asylum seekers who had been saved by the MV *Tampa*, relocating them to Nauru. There have been more recent examples of refugees dying at sea; for example, as described above, the drowning in 2001 of 350 boat people near the Indonesian shores (Silove 2002).

Those who escape by land—for example, from Cambodia or Laos—often have been forced to hide from soldiers, cross minefields, swim across wide rivers under artillery fire, and try to avoid capture by border police. Refugees escaping the massacres of the civil war in Somalia describe having to walk for several months to the refugee camps in Kenya, experiencing attacks by militias, starvation, and exhaustion. People who manage to reach refugee camps generally live in appalling situations: the camps are overcrowded and unsanitary, and there is often insufficient food and water. There is a lack of effective law enforcement and internal security. Violence is common. Soldiers and gangs may rape, blackmail, or rob other refugees in the camp. Pittaway (2002) describes how domestic violence and sexual assault are frequent, and how women and children are the most vulnerable to violations of their fundamental rights.

People may survive in refugee camps for years with little hope of resettlement. A Khmer colleague described how, suddenly, waves of panic and terror can sweep through a refugee camp; people live in constant fear and feel helpless and angry. Mehraby describes the situation in one camp for Afghan refugees:

The houses were very small with two to three rooms and small windows with plastic coverings rather than glass. A house this size would be shared by three families ... there was one school for the 15,000 children, and it went to primary school level only. Girls were not allowed to attend ... There was one public health clinic. The main health problems were infectious diseases. Most deaths among children at the camp could have been prevented by immunisation (1999, pp. 14–15).

### The issues facing refugees in Australia

Aroche and Coello (1994) suggest that there are three main challenges faced by refugees in their country of resettlement: torture and trauma issues; migration and resettlement issues,

including grieving and the losses associated with living in exile; and normal life cycle stages, including personality and family issues. They point out that these challenges not only affect individuals but also families, social networks, and communities, and influence how these people and groups interact with the social and political systems in the country of resettlement. In addition, these challenges must be dealt with in the context of the cultural, psychological, educational, and religious dimensions of the individual, family, or community.

*Coping with experiences of torture, trauma, loss, and migration*

Many survivors of torture and trauma experience chronic symptoms that continue for many years, including hyper-arousal (causing, for example, sleep problems, irritability, poor memory, and concentration); re-experiencing the traumatic events (traumatic nightmares, intrusive memories, and flashbacks); and numbing and dissociation (avoiding thinking about the past, avoiding people or places that are a reminder of the past, being unable to remember aspects of the traumas, general social withdrawal, inability to feel certain emotions, and restricted sense of the future). Herman (1992) describes this condition as the 'dialectic of trauma' in which the survivor vacillates between a constant re-experiencing of the trauma, and trying to block out the unbearable memories. It appears that in the early period following the trauma hyper-arousal and re-experiencing the trauma predominate, whereas later numbness and dissociation seem stronger.

Herman (1992, p. 33) writes that traumatic events such as torture confront human beings with the extreme experiences of helplessness and terror, and people come face to face with violence or death. During torture a person's sense of identity, trust in others, and life-sustaining personal beliefs are deeply attacked, casting them into a state of existential crisis. Hence, the primary effects of torture are on the psychological structures of the self, and also on the systems of attachment and meaning that link individual and community (Herman 1992, p. 51).

The developmental stage of life in which the trauma started is important in understanding the effects upon a person and family. The issues faced by survivors who have been traumatised from an early age are deeply embedded in themselves and in their relationships. The severity and length of the trauma is also relevant to understanding different reactions and recoveries: some people may have survived years of imprisonment and torture; others, one night of detention and assault. While not meaning to minimise the effect in the latter example, severity of experience is an important dimension for understanding the effect of trauma upon survivors.

There is an important emphasis in this field of practice on not 'pathologising' people who have normal responses to abnormal experiences: psychiatric labels, such as chronic or complicated post-traumatic stress disorder, can deflect attention from the political situations of abuse in which the symptoms started. At the same time, these categories of symptoms can be a helpful framework for people to understand their confusing and debilitating condition.

Trauma can be 'carried' by an entire family and by groups and refugee communities. The loss, disappearance, or torture of a parent or sibling traumatises all family members,

and living with a person with a severe post-traumatic and/or grieving condition continues to be distressing. Domestic violence may be experienced in a family in which one member has been arrested and tortured, then acts out aggressively or in response to internal triggers from imprisonment. Many refugee families live in an ongoing state of crisis, re-enacting traumas and instability from the past. The psychological and social effects on the general population of living under state terrorism, as previously described by Martin-Baro, can be seen in the distrust and division that is rife in many refugee communities (Aroche & Coello 1994).

The view that refugees are traumatised people with multiple problems is only one side of the story. It is important to affirm the survival skills and strengths that these people have developed through their experiences. While avoiding stereotyping refugees as 'victims' or 'heroes', it must be recognised that these are determined people who have come through overwhelming life events to finally reach a country of resettlement. Many are, in fact, outstanding individuals who have suffered for their convictions. The challenge is to recognise the depth of suffering of refugees, together with affirming the courage needed to endure such horrible experiences and their aftermath.

In addition to suffering from reactions associated with traumatic experiences, refugees have to endure many major losses; for example, deaths and disappearances of family members, friends, and comrades. Refugee colleagues have pointed out that these losses are for many more disturbing and painful than the aftermath of trauma. In addition to the normal grieving and adjustment of moving to a new country, other issues faced by refugees in the migration process include being forced to flee (rather than choosing to leave) their homes, not being able to return home, and not having chosen to come to Australia but rather escaping here as a last resort.

Many refugees in Australia feel guilty and can agonise over relatives 'lost' in a war zone back home, or starving and sick in hopeless situations in refugee camps. Many refugees cannot properly begin their new lives in Australia as they may still be emotionally and financially focused on the situation of close relatives overseas. Some refugees may come from cultures in which the extended family lives together; therefore, the definition of 'close' relative can include a large number of people. The grieving following separation from these relatives is deep. Many refugees spend a considerable proportion of their lives trying to care for family members overseas: for example, saving money to send to relatives in camps, and enduring protracted processes to sponsor relatives to come to Australia.

Hence, in addition to suffering from severe trauma symptoms, refugee survivors of torture and trauma also have to cope with painful losses and separations. Most refugees present with a combination of symptoms of trauma and grief, and these can be expressed at the level of the individual, family, or community (Savage 1999; Bowles et al. 1995).

### *Physical health issues*

Physical health issues may be directly or indirectly related to traumatic refugee experiences, or be an outcome of living in a situation of poverty and political instability. Physical health

problems of refugees can include infectious diseases such as intestinal parasites and tuberculosis; poor dental health; torture- and war-related injuries and disabilities; low levels of immunisation; somatisation of psychological problems; delayed development of children; and urinary tract infections, incontinence, and obstetric problems as a result of female genital mutilation (FGM). Forms of FGM are practised in the Horn of Africa, the Middle East, and in parts of South-East Asia, and these practices appear to be culturally related (NSW Refugee Health & STARTTS 2004).

*Resettlement issues: practical issues; visas*

*Working with Refugees: A guide for Social Workers* (NSW Refugee Health & STARTTS 2004) summarises some significant practical factors that have an impact on the process of resettlement for refugees, including unemployment, income support, accommodation, English-language ability, and education for children and living in rural or isolated areas. Although refugees may be suffering from a combination of trauma and grief-related psychological issues and physical health issues, pressing practicalities for survival generally are what concern them upon arrival in Australia. These factors tend to exacerbate each other.

Major factors affecting resettlement have been the recent changes in Australian immigration policy, which particularly affect asylum seekers, as described above. People arriving in an 'unauthorised manner' (by plane or boat) without a visa are placed in detention centres while their applications are processed. Asylum seekers who arrive with visitor visas are permitted to remain in the community, but may spend years waiting for the processing of their applications, and approximately one third of them are not permitted to work nor have access to Medicare. Since 2001, people with a Temporary Protection Visa (TPV) have been granted a three-year protection period in Australia, and then must apply again for protection, and they may be granted another temporary or a permanent visa. These TPV holders have no right to sponsor their spouse or children, and have limited access to Centrelink and other services. They are permitted to work and have access to Medicare (NSW Refugee Health Service & STARTTS 2004).

Silove and Steel (2000) describe the growing evidence that the stress facing asylum seekers adds to effects of the previous trauma in creating the risk of ongoing symptoms. Clients on TPVs face constant anxiety about the future; one client said to me that she felt as if she was on 'death row'. Currently there are 8000 people in Australia on TPVs according to Amnesty International (May 2004). Many of these people include young men who escaped life-threatening situations, leaving behind family members in danger, and who now live in fear for the fate of their relatives. Of 9160 'unauthorised boat arrivals' between July 1999 and June 2002, 8260 had successful asylum claims—evidence that the majority of those people arriving by boat had strong reasons to board (Refugee Council of Australia 2004). Silove (2002) describes these people with a TPV, or who have been placed in detention, as the 'new underclass' in Australia, as they are living without any rights of citizenship, family reunion, or permanent resettlement.

Allegations of abuse, untreated medical and psychiatric illnesses, suicidal behaviour,

hunger strikes, and outbreaks of violence among asylum seekers in detention centres have been reported. Amnesty International is currently conducting a campaign to have the 150 children in detention centres (as at May 2004) and their families released, following the HREOC (Human Rights and Equal Opportunity Commission) National Inquiry into Children in Immigration Detention.

*Resettlement issues: children and adolescents*

In addition to visa and detention problems, there are specific issues for groups of refugees, such as children, adolescents, women, men, and the aged. For refugee children, problems include high vulnerability to disease in refugee camps, poor physical development due to lack of nutrition, arrested psychological development due to early trauma, deprivation and family breakdown, separation anxiety and low self-esteem, disrupted education, and lack of care for unaccompanied (without parents) minors.

Refugee adolescents also suffer these problems, which complicate the development of their adult identity and may lead to acting out using drugs or sexual behaviour. In addition, they may find that they are confronted with two value systems (from their home country and from Australia) when they are trying to develop their own identity. This can create family tension. In addition, teenagers and children may be used as family interpreters as they tend to learn English more quickly than their parents, and this changes the roles in the family (NSW Refugee Health & STARTTS 2004).

*Resettlement issues: women*

For refugee women, a major problem is the high rate of sexual abuse suffered as part of the refugee and war trauma. The Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) estimates that at least one third of refugee women have experienced sexual assault, and for some nationalities this proportion is much higher (Refugee Health Policy Advisory Committee 1997). Swiss et al. (1998) reported that 49 per cent of Liberian women surveyed had experienced physical or sexual violence from soldiers during the war. Refugee women suffer from many health problems—for example, cervical cancer and sexually transmitted diseases—due to lack of facilities and screening in refugee camps over long periods, and due to cultural practices such as female genital mutilation as mentioned above. Childbirth can be especially traumatic for refugee women as it may trigger memories of sexual abuse. Domestic violence is another common problem for refugee women whose partners may have been tortured and act out the abuse on their wives. The isolation and loss of extended family network of refugee women also makes them more vulnerable. They may find that their family role in Australia becomes different from their role in their home country, and this may be liberating and at the same time put pressure on their marriage.

Women with a 'women at risk' visa have permanent residence, and are likely to have recently suffered experiences of danger, as they were granted the visa because they were at special risk of sexual or physical violence. They are single women or single mothers, and

have special support needs; for example, counselling and social support.

The Australian Law Commission Report of 1994 (Crock 1998) found that female refugees were greatly disadvantaged in a number of respects. First, in 1994, there were three men admitted into the country for every one woman. As a response to this finding, the gender balance of the overseas programme has been corrected and, by 1997, the ratio was almost even. Second, female applicants were less likely than men to be able to demonstrate 'good settlement prospects', having received fewer educational and career opportunities in their homeland. Women found it harder to prove that they would be in danger of persecution at home: they often had support roles and did not have the public profile that was more common for men and that was the objective basis for their fear of attack.

A major issue is whether rape and sexual harassment is persecution: in many countries a major form of oppression is systematic or random acts of rape by military groups, yet it is often seen as a by-product of war rather than as persecution. In general, it can be argued that the definition of a refugee fits more comfortably with male experience than female experience, even though over two thirds of the world's refugees are women (Crock 1998).

#### *Resettlement issues: men*

Refugee men are more likely to have experienced longer terms of imprisonment and lengthier, extreme forms of torture. Many have been soldiers. They are more likely to have bullets or shrapnel embedded in their bodies, and to have poorly set broken bones and other injuries. Many TPV holders are young men who have left their families overseas; approximately half the men in the Refugee and Humanitarian Program in 2002–03 were under the age of 20. Often they spend long periods of isolation in Australia. If they have a permanent visa they may wait for lengthy periods for applications to sponsor their families to Australia to be processed. Some suffer from drug-, alcohol- and smoking-related problems, and from sexually transmitted diseases (other than HIV/AIDS for which there is offshore screening). Other problems include unemployment and poor self-confidence due to their loss of status in the family as the breadwinner and traditional head of the family. Men are less likely to seek support from groups or from counsellors, or to attend general health services. However, at some torture and trauma services they form a majority of clients (Refugee Health Policy Advisory Committee 1997; NSW Refugee Health & STARTTS 2004).

#### *Resettlement issues: ageing refugees*

Older refugees include those who arrived in Australia soon after World War II or who have aged in Australia, and those who have recently arrived as elderly migrants to join their refugee adult children. Their particular problems include a lack of English, particularly as memory declines; isolation, including lack of family and close friends in Australia; and loss of status and the respect paid to elderly people in their society of origin. Elderly refugees may suffer from trauma symptoms, which may develop long after the trauma occurred: experiences in old age can trigger trauma reactions; for example, situations in nursing homes with staff. Memory problems—for example, due to dementia—can trigger suppressed trauma.

matic memories also (Refugee Health Policy Advisory Committee 1997; NSW Refugee Health & STARTTS 2004).

### Refugee resettlement: provision of services

The Refugee Resettlement Working Group (1990) outlined the extensive role played by the non-government sector in refugee resettlement, complemented by limited government funding programmes largely provided by the Department of Immigration and Multicultural Affairs. The broad policy is that non-governmental organisations offer the best service for resettlement of refugees as they understand the needs of refugees, are accessible, and can provide the most appropriate support. In general, these non-governmental organisations are run by small, newly arrived refugee groups that can themselves be stressed and fragile. Devolving responsibility for service provision to them places a greater responsibility, including a financial one, upon them.

The establishment of specialised services for refugee survivors of torture and trauma is a relatively new development. Following World War II, Jewish welfare societies worldwide pioneered services offering assistance for Jewish survivors of the holocaust (Cunningham 1996). The first service specifically for refugee survivors of torture (the Rehabilitation and Research Centre for Torture Victims in Denmark) began in the mid 1970s, and others began to be set up in Europe and North America in the late 1970s and early 1980s. Corresponding services were established in countries in which human rights violations were being carried out, especially in Latin America (McGorry 1995). By 1997, it was estimated that there were at least 265 centres worldwide (Cunningham 1996). They include services within repressive countries, in which health professionals and volunteers may work at considerable risk to the safety of themselves and their families; services in countries of first asylum (for example, health workers in refugee camps), who usually work long hours with few resources; and services in countries of resettlement (Cunningham & Silove 1993). A central issue for most services is the combining of community development and individual clinical approaches in order to meet the broad needs of the client group (McGorry 1995).

In Australia, the first clinic for assisting tortured refugees was established in Brisbane in 1985 at the Mater Misericordiae Hospital Child and Family Psychiatric Service. The report by Reid and Strong (1987) to the New South Wales Government Department of Health led to the establishment of the first torture and trauma service, STARTTS, in Sydney in August 1988, and assisted the development of other services in other states, such as the Victorian Foundation for Survivors of Torture.

Related services in New South Wales include the New South Wales Refugee Health Service (established in 1999) and the New South Wales Transcultural Mental Health Service (established in 1993). The former focuses more on physical and general health issues for refugees rather than specifically torture and trauma issues, and has a broad role in provision of information and training, healthcare assessment and advice. The latter has a specialist role in promoting access to mental health services for people of non-English speaking background. Mainstream health services are also becoming more accessible for

refugees, through the bilingual counsellor programme and through training programmes run by STARTTS and New South Wales Refugee Health Service.

Recent developments in social work in this field include a community development project managed by social workers and others from New South Wales Refugee Health and STARTTS to produce a resource for social workers to use when working with refugee clients, primarily in the health field. This resource was written by a steering committee of senior social workers and others from various agencies, following a research project by a social work student who had surveyed many social workers to ask them what kind of information they would like in such a resource. This resource *Working with Refugees: A Guide for Social Workers* was launched at the International Social Work Conference in Adelaide in October 2004, and is the first of its kind for social workers in Australia.

## **Social work practice in torture and trauma services: practice issues**

Torture and trauma services in Australia operate on a diverse range of models; some following a more traditional medical model, and others combining a range of interventions within a broad community development framework. In the more traditional services, the roles of social workers tend to be more family- and welfare-oriented. In services combining community development approaches with psychological and other interventions, the roles of the social worker tend to be more flexible and diverse. Generalist social work training, which examines both the individual and society, is a good introduction to understanding this field. Training about the welfare system gives a good background for advocacy and resettlement work, which is an important aspect of most social work with refugees. The overt emphasis of practice on human rights abuses is congruent with the social work code of ethics that demands commitment to the principles of social justice.

### **Social work in the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)**

STARTTS has gradually developed within a broad framework of community development, within which are many levels of intervention for refugee survivors of torture and trauma. These include work with individuals and families; group work; community work, networking with refugee communities; influencing the mainstream health system; social policy development; and other work at a socio-political level (Aroche & Coello 1994). STARTTS provides a psychiatric service, body-work service, youth programme, and employment programme, and, more recently, has received funding to coordinate an early intervention programme for refugees. In 1999, STARTTS was responsible for the mental-health needs of refugees from Kosovo and East Timor brought to temporary 'safe havens' in New South Wales.

A feature of STARTTS is the high proportion of workers who have a refugee and/or non-English-speaking background. The development of the service and referral of clients has relied greatly upon the understanding and commitment of these workers who have formed a bridge between STARTTS and the refugee communities. In the period from 1988 to 2004, STARTTS developed from having a handful of workers to having seventy-nine staff in 2004. STARTTS's policy from the beginning was that staff should not follow defined professional roles within the medical model—that is, the social worker looks after families, the doctor manages the team and performs medical assessments, and the psychologist does testing and psychotherapy. Instead, the philosophy was to use all the skills, both professional and personal, of each worker (Cunningham & Silove 1993). Staff from a variety of professional backgrounds—social work, psychology, art therapy, community nursing, and welfare training—were employed to fill generalist counsellor and project officer or bicultural counsellor positions.

Initially there were two social workers at STARTTS: one became the first permanent manager of the service, and the other (the author) was the first counsellor and project officer. At first the team was small and tried to respond to the needs of the client group rather than fitting rigid role definitions. In the early days, both social workers were involved in a broad range of tasks; gradually, as more staff were employed, they were able to specialise in a particular area. STARTTS was set up to develop into a specialist service, providing expertise and research to the mainstream health sector about working with refugee survivors of torture and trauma.

Currently social workers are employed as managers, community development workers, clinical trainers and supervisors, and counsellors and project officers specialising in psychotherapy and clinical supervision or family therapy, or working as generalists providing both counselling and community development work. A number of social workers are also working in a newly established early intervention programme as case managers. Some social workers have refugee backgrounds and work as bicultural counsellors with a particular refugee community.

McGorry (1995) argues that there are many reasons that a community development perspective is an appropriate global framework for establishing a torture and trauma service. Torture and organised violence are outcomes of systematic power abuses. Community development helps a community of people address their own needs, confronting the use of power, and examining issues such as access, justice, and participation. It challenges processes that prevent access and equity in society. The social work literature and training has much to offer this field of community development. Important elements of community work in this field include influencing state and national policy concerning refugees, and becoming involved in international processes, such as the work of Amnesty International, which aim to prevent human rights abuses. Other activities include development of self-help groups,

consultation with refugee communities, and organising youth camps for refugee children and adolescents.

Another aspect of practice with traumatised refugees is helping them to deal with their deep psychological and physical wounds. STARTTS uses a range of helpful interventions, including various forms of psychotherapy, medical and psychiatric interventions, physiotherapy, body work, traditional medicine, and group therapy. Social workers are mainly working as clinical supervisors, psychotherapists, family therapists, and case managers. The clinical work is challenging on a number of levels. First, the professional has to consider the broader political issues and recognise the injustices inflicted upon their clients. Social workers need to understand the political conflicts that their clients have experienced. At a more immediate level, political dimensions of race, gender, and power differences in the therapeutic relationship are also important.

Second, there is no single therapeutic paradigm suitable for all clients, and research on clinical work is still at the exploratory stage. Therefore, professionals, including social workers, specialising in various approaches and orientations (for instance, cognitive, behavioural, and supportive psychoanalytic psychotherapy; Rogerian counselling; brief family-therapy interventions; and others) have to work in creative tension. Flexibility, open-mindedness, lack of dogmatism, and appreciation of the different contributions that each intervention makes are all necessary for a team to function effectively.

Third, professionals cannot only focus on individual or family dynamics, but have to recognise the broader socio-cultural and religious dimensions of the psychotherapy: a perspective that is congruent with the broad emphases in social work training. It is stimulating to examine the philosophical and cultural roots of our Western therapeutic theories and practice: Are they applicable to people from other cultures and classes? Are they connected with the healing practices of other cultures? What is the role of religious faith and political belief in psychotherapy, particularly in the context of working with people from different religions and political ideologies? While none of these are new questions, they are only beginning to be examined in refugee torture and trauma work. In the modern context of the shifting and mixing of the world's population, questions of cross-cultural psychology and understanding are becoming highly relevant. Working with interpreters in a psychotherapeutic relationship, for instance, is a complex aspect of clinical practice with this client group that is being explored.

Fourth, the practical issues facing refugees upon resettlement cannot be ignored. Most counsellors and therapists also are working as advocates for their clients in the broader society: for instance, helping them gain permanent residence, and assisting them with housing, social security, recognition of qualifications, and referral to medical, dental, and other treatments, and English classes. Becker (1991) makes the point that the inner and outer turmoil experienced by refugees is linked—both aspects must be addressed. Talking with clients about their feelings when they have nowhere to live does not address the most salient issue. At the same time, only addressing practical concerns is unlikely to be successful as the internal chaos of refugees may continue to destabilise their life (see, for example, Nguyen & Bowles 1998; Silove et al. 1991a, 1991b). McGorry (1995) notes the complex nature of

this combination of counsellor and advocate roles, and the need for skilled supervision of workers in order for it to be successful.

There is a danger of social workers becoming submerged in this field of practice as it is so complex and engrossing. It is important to maintain links with social workers in other health areas and with professionals of similar values and ideologies in other fields. This networking will also prevent workers in torture and trauma becoming too precious about their work, and can facilitate the cross-fertilisation of ideas.

### Ethical issues and conflicts in refugee torture and trauma work

Current Australian policies of deterrence—for example, mandatory detention of people without visas, ‘the Pacific Solution’, and the issuing of three-year TPVs urgently require reviewing. A number of alternative models have been placed in the public view by expert bodies. For example, the model proposed by the Refugee Council of Australia provides for three levels of security—closed detention, open detention, and community release—with the idea that closed detention is only for identity and security checking and is time-limited. The recommendations of the STARTTS and FOS Submission (2002) to the HREOC Inquiry into Children in Immigration Detention also include early release from detention provisions for torture and trauma survivors, and major changes to the temporary protection visa system, if not complete abolishment. This submission describes in detail the damaging effects of detaining children who are asylum seekers, and strongly argues against this policy (STARTTS & FOS 2002).

It is stressful working within such a system, and, as with all social work, there is a tension between being a social change worker and a social control agent. It is important to discuss ethical issues with colleagues and supervisors in order to help clients and, as far as possible, to work for a more humane immigration system in the network with others. Racism and the lack of public understanding about, or denial of, the torture and trauma backgrounds of refugees and asylum seekers are further problems in the Australian context—as in other countries that receive refugees. These attitudes provide support for harsh policies and laws towards refugees and asylum seekers. Manipulation of public opinion has been cleverly carried out. For example, asylum seekers lately have been branded as ‘queue jumpers’, are suspected of being terrorists, and have been wrongly accused of ‘throwing their children overboard’. Social workers in this field are in a position to stay aware of the facts about asylum seekers, and to play an educative role as far as possible.

The ethical issues specific to this work demand that we face the broader political conflicts and inequalities that create the refugee problem, and try to determine what response is moral and reasonable. The massive dimensions of the international refugee crisis make the work of a small refugee service in Australia seem insignificant. Vast numbers of people live in danger and poverty, and workers can feel overwhelmed. The narrow definitions of eligibility for refugee status need to be revised at both the United Nations and national levels. The problems facing refugee women and children, who make up 80 per cent of the world’s refugees, need to be taken further into account within both international and Australian law and social policy.

Workers may wish to take a stand on these issues and support lobbying and direct-action groups, yet, in their spare time, often need to restore themselves rather than stay 'at work'. They may also experience a conflict of professional interest working in public health and, at the same time, being critical of government policies. Workers may be engulfed by horror hearing the feelings and stories of the clients. The vicarious traumatisation of workers who deal with survivors of abuse is well documented (Pearlman 1996; Pearlman & Saakvitne 1995; Herman 1992; Bustos 1990). All people who work with trauma inevitably are affected by it and have continually to process the issues in order to prevent burn-out. Without regular supervision, psychotherapy, and support it is easy for workers to start acting out dynamics of trauma with each other.

A key to surviving torture and trauma is being able to reconnect with others, and to keep replenishing a core of hope inside oneself. This is true for clients, workers, and anyone else confronted with these terrible experiences of abuse and loss. These issues are overwhelming if workers try to face them on their own. Paradoxically, torture and trauma experiences can lead to people joining together to build new lives for refugee survivors.

## **Ethics in context**

You are a social worker working as a counsellor at a torture and trauma service. You have been requested to visit an asylum seeker in a detention centre. This person is suffering from nightmares and panic attacks. You have been told that this person is a survivor of torture and that his family is in danger in his country of origin. What should you do?

Issues to consider: What is your opinion of detention centres? Are you supporting this system by going? Is it possible to provide counselling at a detention centre? Is an alternative location possible? What is your agency's view of visiting the detention centre? What will happen to this person if you don't go? Is it possible for any other health worker to go? Are you the most appropriate person? What other services does his person and his family need? What country is he from and what is happening there?

## **The future for social work**

Social workers can make a valuable contribution to this field of practice. The social work code of ethics, valuing social justice and dignity of all people, is highly relevant for working with survivors of torture and trauma, many of whom have suffered for their beliefs. The broad psycho-social-political emphasis in the social work perspective is ideally suited to work with this client population. The emphasis in social work training on community development is also relevant for work not only as community workers and managers but also as clinical workers who advo-

cate extensively for their clients. Social workers have had a strong influence on the broad directions of this field of practice to date, and their contributions are respected and valued.

It must be said that this area of social work practice is rewarding. The capacity of people to rebuild a life of meaning, to hope, and to trust others again after suffering such shattering experiences is constantly surprising. The enduring sense of support and commitment between colleagues of varying cultural backgrounds overrides professional barriers. This work is personally challenging, and offers much scope for social work theory, practice, and research development.

## Review questions

- 1 What are your thoughts about asylum seekers coming in boats to Australian shores?
- 2 What contribution can social work make to working with refugee survivors of torture and trauma?
- 3 What do you think about Australia's refugee programme since World War II?

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In effect, torture as an instrument of political and social control is intended to rob its victims of their "voice" and their agency, to have them serve as abject warnings to the general populace. It is a particularly concentrated and inhumane means of subordination by which power is maintained (Fanon, 1963).<sup>27</sup> To accomplish the shift from victimhood, survivors of torture must reaffirm their integrity and reclaim their ability to act in the face of contravening hierarchical inequities. They can then reject the feelings of worthlessness and weakness instilled by their torturers.<sup>28</sup>

**Trauma Recovery Principles.** The concept of loss is at the heart of working with torture victims, given their prototypic ordeals of multiple traumatization. While refugees have many health, mental health, and social support needs, the focus here is on trauma. Consistent with current national mental health policy,<sup>29</sup> this paper is based on a public health model.<sup>30</sup> Section IV reviews major cultural issues that arise when working with refugee populations. Section V focuses on trauma interventions, including 1) the application of current trauma treatment models to refugees, and 2) new approaches to trauma healing emerging from direct experience with refugee communities.<sup>31</sup>

**Center for Survivors of Torture and War Trauma City of St. Louis Mental Health Board of Trustees St. Louis, MO <http://www.stlcenterforsurvivors.org/>. Center for Victims of Torture Minneapolis, MN <http://www.cvt.org/>.**

Refugees from conflict zones often continue to experience trauma from persecution, imprisonment, torture and resettlement for a long time. Thus, it is important to understand the challenges of refugee families and communities.<sup>32</sup> Survivors of torture have been shown to suffer intense and prolonged pain, and they have a greater risk of developing chronic pain and other health problems.<sup>28</sup> Treatment of chronic pain from injuries that damaged nerves, muscles or bones may need more than one type of therapy, starting with medical care. Complementary therapies such as psychotherapy and body work appear to help the emotional and physical healing process.<sup>28-29</sup>

**Family-centred care.** Since PTSD affects the whole family, it is important to learn its effects on all family members.