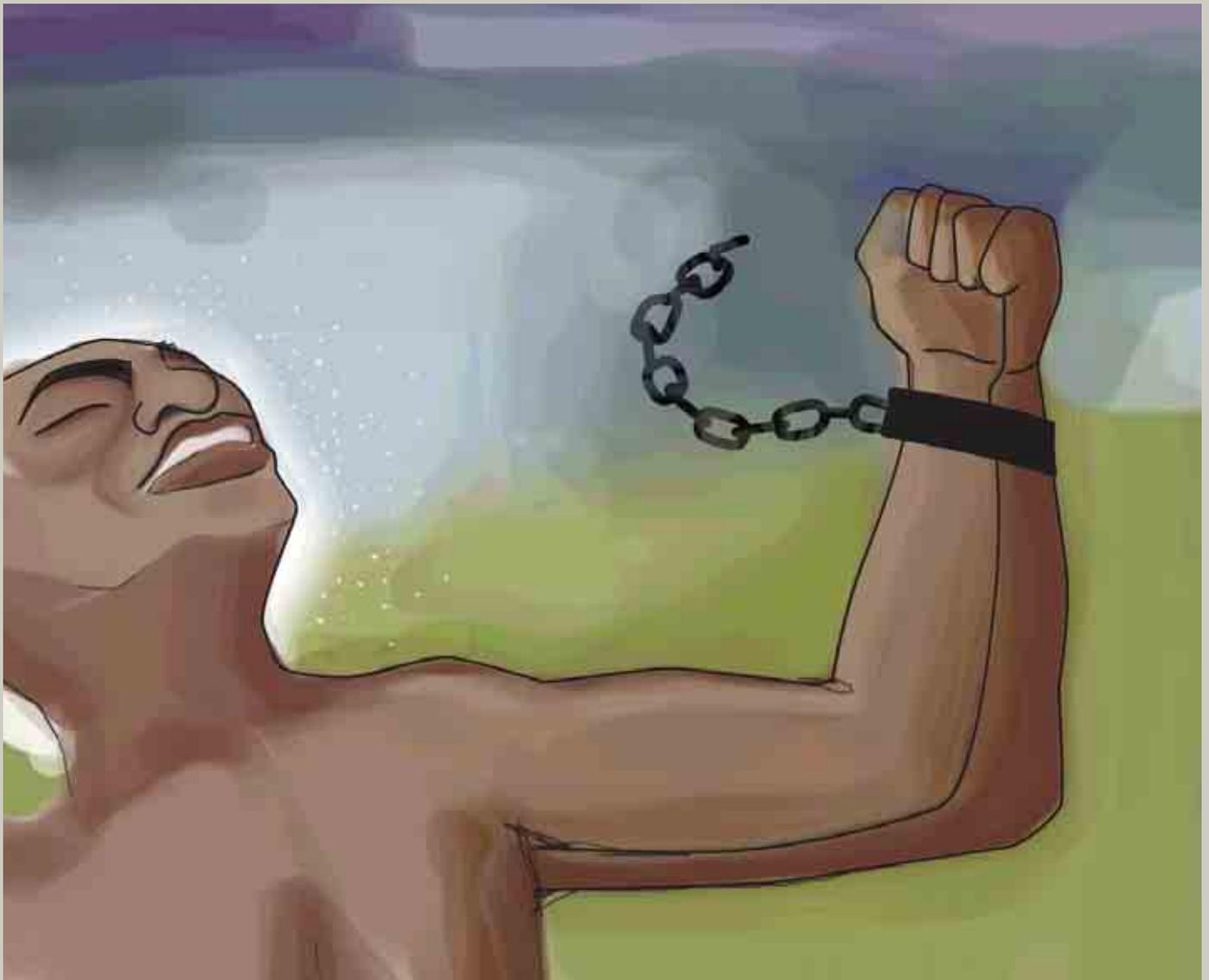




DEVELOPING AN AFRICAN TORTURE REHABILITATION MODEL:

A contextually-informed, evidence-based psychosocial model for the rehabilitation of victims of torture



PART 2

Detailing an African Torture Rehabilitation Model through engagement with the clinical team

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August 2013

A NOTE OF THANKS

This work would not have been possible without the support and contribution of several people.

Firstly, a big thank-you goes to the CSVR clinical team who participated in this intensive process tirelessly. Your ability to attend the draining sessions with so much energy, interest, and openness is highly appreciated. This report is yours, it represents the many hours of challenging thinking, debating, and finally agreement that you engaged in. The clinical team that participated in this process included: Marivic Garcia, Boitumelo Kekana, Pravilla Naicker, Gaudence Uwizeye, and Eulinda Smith. Nomfundo Mogapi and Malose Langa participated in a limited number of these meetings, but provided important inputs along the way. I hope that you find this document useful as you continue to provide support to victims of torture. Secondly, I would like to thank the victims of torture that have the courage to share their difficult stories with our clinical team; something we know is far from simple. Your experiences were ever-present as we worked to improve the ways in which we intervene. I would also like to thank Veronica Laveta who worked with me to develop and co-facilitate the process with the clinical team and became an important sounding-board along the way. Thank you to Hugo van der Merwe and Veronica Laveta for reviewing this document. I would also like to thank Stacey Leibowitz-Levy and Craig Higson-Smith for their feedback and thoughts during the process. To the broader CSVR staff who have supported this project and continue to do amazing work, thank you for your encouragement and curiosity. I would also like to express appreciation to the following organisations that support us with funding and other forms of inputs which make it possible to do this work: Dignity: Danish Institute Against Torture; the United States Agency for International Development (USAID); the Center for Victims of Torture (CVT); and the United Nations Voluntary Fund for Victims of Torture (UNVFVT). Your continued partnership with us ensures that victims are able to access rehabilitation services and contributes to the prevention of this horrific human rights violation. Finally, I would like to thank my friends and family for their on-going support, especially to my wonderful son Chimobi, you bring happiness and love.

Monica Bandeira

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INTRODUCTION

Torture remains a reality in many countries around the world. As one of the largest recipients of refugees in the world, South Africa has become home to many victims of this extreme form of human rights violation. Sadly torture continues to be perpetrated within South Africa, which has high rates of violent crime as well as one of the highest levels of economic inequality in the world. These factors continuously impact on the rehabilitation of victims of torture.

The impacts of torture are diverse and include biological, psychological, and social dimensions. In many instances, the impacts of torture are exacerbated by additional, external stressors that victims are exposed to, either directly or indirectly, related to their experience of torture. The torture rehabilitation field has been criticised for not implementing evidence-based interventions in the treatment of victims of torture. However, several important reasons exist for this. Most importantly for torture rehabilitation centres in developing countries, is the fact that evidence-based treatments have been developed in relation to the treatment of Post-Traumatic Stress Disorder (PTSD), providing a limited perspective of the impact of torture. In addition, these evidence-based treatments have not been conducted with victims of torture. So, although such treatments are important in the rehabilitation of torture victims (many of whom present with PTSD), they fall short of addressing the broader impacts of torture.

The above challenges require more creative ways of developing appropriate interventions. This project encompasses one such attempt. It incorporates research and clinical team engagement as a way of developing a contextually-based, evidence-informed intervention. The goal is to gain an understanding of what the main challenges faced by victims of torture are, and how these can be addressed effectively.

In order to do this, the Centre for the Study of Violence and Reconciliation (CSVR), a trauma counselling centre based in Johannesburg, South Africa, has embarked on a three step process. Step one involved conducting research to set the foundations of a rehabilitation model detailed in the report entitled: PART 1 – Setting the foundations of an African Torture Rehabilitation Model through research which is available at www.csvr.org.za. In the second step, upon which this report is based, the clinical team at the CSVR detailed the components of the model. Finally, the model will be implemented and tested. In addition to this, a report on gender and torture will be published. In order to contextualise this model, it is highly recommended that the Part 1 report be read first.

The three-step process allowed the CSVR to outline the way in which its clinical team could best address the main impacts that many victims of torture experience. The impacts that have emerged are varied and can be placed into three broad categories (Figure 1 below). The first centres around current stressors that clients have to deal with on a day-to-day basis, which may be directly or indirectly related to their torture experience. It includes stressors like accommodation difficulties, economic difficulties, repeated victimisation, pain, and difficulties with service providers. These stressors alone can lead to distress and coping difficulties, but when paired with experiences of torture the impacts are likely to become exacerbated. The second category of impacts includes those linked to social and/or interpersonal difficulties. Included here are isolation, family-related stressors, and family breakdown. These are primarily linked to the client's ability to function in relationships and/or challenges that they experience within their family. The final category revolves around the client's' psychological reactions to their experiences, usually the result of a complicated interplay between past-traumas, current stressors, risk, and protective factors. Included here are traumatic responses, mood disturbances, bereavement, and anger.

IMPACTS MOST COMMONLY EXPERIENCED BY VICTIMS OF TORTURE IN THIS CONTEXT WITH THE MOST SEVERE AFFECT

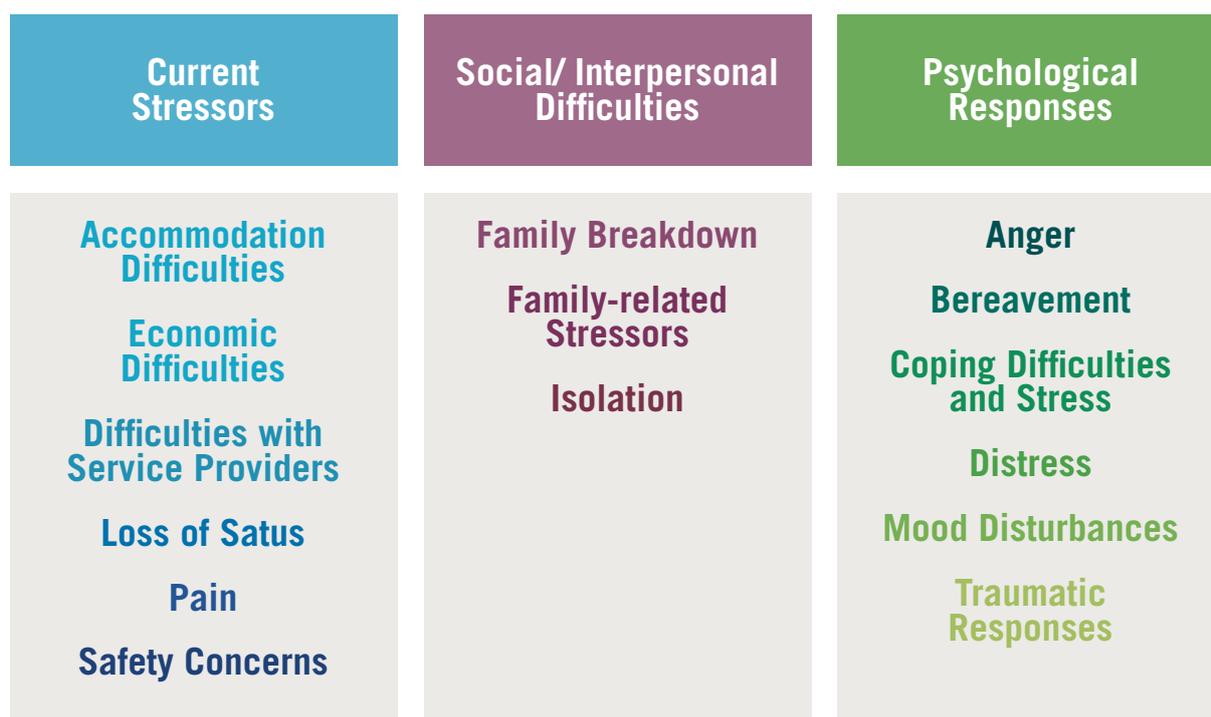


Figure 1: Categories of impacts identified through research

Given the complexity of presentation, a straight-forward, generic, staged torture rehabilitation model, is hardly possible. Rather, assessment of what impacts are present for each client followed by the development of a treatment plan becomes imperative. The detailed model presented below, offers options to clinicians for treatment of different impacts present. It does not include all possible impacts, which clinicians will need to assess for and treat appropriately. Based on the CSVr's research, however, these are the most common impacts which have the most negative effect on victims of torture within our context (that of a developing, multi-cultural urban setting).

It is clear that the treatment of victims of torture within this context requires a broader approach to clinical work to include those current stressors that have significant impacts on clients' lives. Focussing solely on trauma treatment is insufficient and problematic. At the same time, clinical work on the psychosocial impact of torture is of central importance and should not be replaced by a purely problem solving, case management approach to resolving current stressors. What is suggested here is a focus on all three categories from a clinical perspective. In other words, working clinically with clients to increase their ability to manage and/or resolve current stressors, mitigate their psychological reactions to torture that they may be experiencing, and improve their social or interpersonal functioning.

It should be kept in mind that the CSVr has developed this model for internal use and it will be evaluated over time. It is in no way meant to be a definitive method of intervention and is not seen as static or rigid. The purpose of this document is to serve as a guide for current clinicians and as a training source for incoming clinicians. The CSVr hopes, however, that it may be of use to other organisations working in similar contexts or dealing with similar impacts, and is therefore making it public. Any feedback from organisations that make use of this model will be welcomed, please direct feedback to info@csvr.org.za.

METHOD

The overall purpose of this project is to develop a contextually appropriate torture rehabilitation model. In the first step of the project, the most common impacts of torture and suitable interventions were identified. This entailed a three-stage research process involving: a review of existing literature, an analysis of individual session process notes completed by clinical staff providing psychosocial rehabilitation services to victims of torture at the CSVR, and finally a Delphi process with a panel of experienced people in the field. This initial process resulted in the identification of:

- Those impacts that are most commonly experienced by victims of torture in our context (a developing, multi-cultural urban setting) and have the most severe effect. In total, a list of 18 impacts was identified as listed in table 1 below.
- The most appropriate interventions for these.

Table 1: Final list of impacts which most victims of torture experience

IMPACTS	
1.	Accommodation difficulties
2.	Anger
3.	Bereavement
4.	Concern for employment opportunities
5.	Coping difficulties and stress
6.	Difficulties with service providers
7.	Distress
8.	Economic difficulties
9.	Family breakdown
10.	Family-related stressors
11.	Intrusions
12.	Isolation
13.	Loss of status, recognition, position in society
14.	Mood disturbances
15.	Pain
16.	Repeated victimisation
17.	Safety concerns
18.	Traumatic responses

In the second step of the project, upon which this report is based, the clinical team at the CSVR was consulted to detail the torture rehabilitation model through the following:

- Feedback was given on the results of the research process in step 1.
- Each Impact was discussed in terms of:
 - What needs to be assessed in relation to it?
 - What the theory of change is in relation to the impact (if x then y because z)?
 - What interventions emerged from the research?
 - Which of the interventions are broader than the particular impact (i.e. done with all clients across impacts)?
 - How could interventions be grouped together?
 - How each of the grouped interventions could be implemented?
- Broader assessment questions were explored.
- Discussions on the broader process of intervention were facilitated (including, for example, treatment planning and monitoring services).
- The foundations of this work were identified.
- The implications for broader clinical processes and procedures were discussed and decisions made on how these should change with regards to: assessment, structure, support for clinicians, and monitoring implementation of the model.

The methods used when facilitating this process with the CSVR’s clinical team were altered during the process in order to maximise the output. This resulted in a difference in detail between some of the impacts. The most affected impacts were: Isolation, Coping Difficulties and Stress, Distress, and Difficulty with Service Providers, which have fewer details in terms of how to proceed with clients.

By the end of the process, the original list of 18 impacts was contracted into 14 (table 2 below).

Table 2: Grouped impacts which most victims of torture experience	
GROUPED IMPACTS	
1.	Accommodation difficulties, economic difficulties, and concern for employment opportunities
2.	Anger
3.	Bereavement
4.	Coping difficulties and stress
5.	Difficulties with service providers
6.	Distress
7.	Family breakdown
8.	Family-related stressors
9.	Isolation
10.	Loss of status, recognition, position in society
11.	Mood disturbances
12.	Pain
13.	Safety concerns and Repeated victimisation
14.	Traumatic responses and Intrusion

The clinical team was able to detail interventions for each of these groups of impacts, as described below.

HOW THE MODEL WORKS

The detailed components of the model outlined in this document are understood to occur within a broader picture of intervention. For the CSVR, intervention includes the following aspects (illustrated in Figure 2 below): intake, assessment (on-going), treatment planning (on-going), intervention, termination, and monitoring and supervision. The detailed model described here focuses on what happens within the intervention process and is limited to the impacts identified as most commonly experienced by victims of torture, and those having the most severe effect. It is acknowledged that the aspects covered here may not include all the impacts experienced by victims of torture. In addition to this process, the clinical team will review their current assessment tools and systems and alter them so that they fit better with the developed model. Treatment planning, monitoring, and supervision will also be altered to better align with the model and ensure that testing is possible.

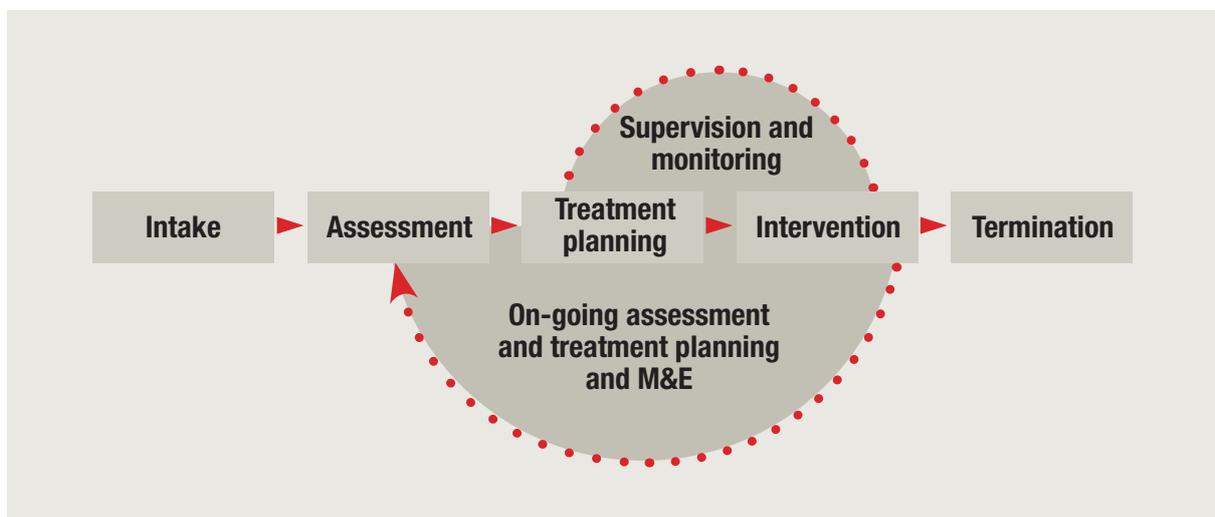


Figure 2: A broader picture of clinical intervention

Accordingly, the model is adaptable to each client depending on the results of the assessment process. This process will enable the clinician to identify which impacts currently affect the client and should be addressed through the clinical process. Some of the impacts are covered in detail below, but some may not be. Clinicians will need to take the information they obtain from the assessment process and develop a treatment plan including a prioritisation of what impacts will be dealt with, when, and how. This is not a static process and is flexible to changes that may emerge.

The detailed interventions below are largely based on work with individuals and/or families. However, during this process, the team decided to develop two group interventions, one for clients dealing with accommodation and economic difficulties, and another for clients dealing with pain. Both groups will be developed over the next few months, so could not be outlined here.

EXPLORING THE FOUNDATIONS OF WORK WITH VICTIMS OF TORTURE

The clinical team discussed a number of elements that form the foundation of work with victims of torture. These are outlined here and form part of the work done with all victims of torture. In a way, they can be understood as essential elements necessary for clinical work to take place with victims of torture.

Trust, Safety and Containment

Trust and safety within the clinical relationship are achieved when clients feel: comfortable to open up about their experiences; relaxed; that the space is confidential; that the clinician is able to cope with the situation; and respected. Within this, the client is able to: share intimate details of their experiences; give feedback to the clinician about something they have a problem with or disagree with (including the clinician or organisation); stop telling their story; and have a degree of control in the therapeutic process (e.g. input into treatment goals and control over pace). Within a trusting and safe clinical relationship, the clinician demonstrates congruency (verbal and non-verbal), is open with the client regarding their reactions but still remains “in control”, and is able to cope and contain both themselves and the client. This can be impacted over time by other factors, e.g. personality, trauma-related reactions or external stressors. A sense of predictability is present e.g. session times, therapeutic process, clinician “shows up”. Establishing boundaries (e.g. what are acceptable and unacceptable behaviours; what services we provide; and availability of the clinician) will further assist in developing trust and safety.

When working with victims of torture within challenging contexts, part of the role of the clinician is to bring calmness to the client’s situation. Containment is built when clients feel in control/have control over the process and know that when they express strong emotions (release) they can become calm again within the session (unwrapping/wrapping). Containment happens when trust and safety are present and includes the clinician’s ability to cope with the process and the client’s story.

Empathy

Empathy involves a shared understanding of the client’s experience and reality and the ways in which this affects them. It centres on the idea of “walking in someone else’s shoes”, in other words, seeing things from the client’s frame of reference, which may be more important and more difficult when dealing with victims of torture. Empathy is achieved through the clinician being open and available to listening to the client; maintaining a non-judgmental understanding; using open body language; accurately reflecting both what the client is saying and their emotions; acknowledging the client’s experiences and their reactions to these; remaining non-judgmental; admitting to the client (through asking for clarification) when the clinician does not understand; not reacting overtly to the client’s story; and not jumping to the rescue too fast when the client admits to strong emotions, such as guilt.

Being present including active listening

Being present means really being in the room with the client. It involves active listening, having appropriate reactions to the client, catching yourself when “leaving” and bringing yourself back, mindfulness, asking clarifying questions, probing, and not behaving in ways that indicate not being present, e.g. looking at the clock. It includes an awareness of self, the client, and space in terms of what is happening in the session.

Active listening involves paying close attention to what is being said (using verbal and non-verbal indicators) and reflecting back to the client. It also includes listening for cues on: torture, links, reactions, what the client is not saying (incongruity), trends, and presence of other disorders/symptoms.

Non-judgmental acceptance

When this is present clients are able to speak about their horror and “shadows”—negative thoughts of self (e.g. blame, guilt, shame) without the clinician showing strong reactions or judgment. The clinician understands that the client’s actions, thoughts, and feelings are as a result of their circumstances, which is different to condoning the client’s actions.

Empowerment approach

The clinician’s role is to help clients to help themselves. Clients are seen as agents of their own healing. It assumes that clients have the ability and capacity to heal and the process is seen as a partnership between the clinician and client. This involves challenging clients to use their resources, helping them to identify their past and present skills and abilities, reinforcing and celebrating steps or efforts that the client takes in the process, assisting the client to expand their safety area/comfort zones, and allowing the client to control the pace of the process. It is reinforced by the clinician setting boundaries when the client wants them to take control and make decisions and/or choices for them.

Self-awareness, including awareness of transference and counter transference and mindfulness

Self-awareness is about the conscious use of self by both clinicians and clients. For clinicians this may involve being aware of the power they have and using it in an empowering way, reacting to clients as a way of reinforcing their strengths and abilities, and purposeful questioning, i.e. being aware why certain questions are being asked. This can be developed with clients by discussing counter-transference reactions with them as a reflection on how their affect or behaviour could impact on others, and as a reflection of something clients are unable to articulate, such as their feelings. If clients hold the clinician in high esteem, the clinician should reflect back to the client what their role has been (deflect praise) and create awareness of the client’s own achievements.

This includes the ability for clinicians to recognise, take ownership over, and work with their own reactions to clients. Due to the vulnerability of victims of torture, clinicians need to be aware of clients’ transference (wanting the clinician to be the rescuer) and clinicians’ counter-transference - becoming the rescuer. This awareness allows clinicians to work more effectively with clients.

Mindfulness involves clinicians monitoring their thoughts, feelings, and behaviours in the session or about the client, remaining present, reflecting on their reactions and what they could mean (client/self/relationship), addressing these appropriately, and being aware of the client’s reactions to the process and adjusting appropriately.

Confidentiality

Confidentiality is especially important when working with victims of torture. It includes having sessions in private spaces, and clients knowing and providing permission for their case/information to be shared. Clients need to know who their information might be shared with, and assured that no identifying information will be revealed. Confidentiality is extended to the organisations’ systems and procedures. Clinicians may need to take additional steps to build trust in confidentiality for some clients.

Congruence/genuineness

Congruence or genuineness involves clinicians not being ambivalent, being predictable, doing what they say, not giving mixed messages, and not making promises that cannot be kept. Clinicians should: not lie to clients, remain honest about realities, not pretend that they care, be honest and open with clients about their own discomfort, and admit to their own difficulties. It is important that clinicians are aware of their own limitations while being who they are - genuine but professional. Clinicians should be honest with themselves, talk to a manager and/or supervisor when not coping, and refer clients to other professionals if necessary.

DEFINING THE CORE BUSINESS IN RELATION TO CLINICAL SERVICES TO VICTIMS OF TORTURE AND/OR CRUEL, INHUMANE, AND DEGRADING TREATMENT (CIDT)

The CSVR's clinical team had lengthy discussions regarding the services they offer and where the limits or boundaries of these are. The following was agreed upon amongst the team.

The CSVR provides psychosocial rehabilitation/therapy/counselling to victims of torture and CIDT who are in need of, willing, able, ready, and interested in engaging in the counselling processes. This could be done with individuals, couples, families and/or groups.

This is the specialist knowledge and experience that the CSVR has to offer and that is needed by clients.

Clients have a myriad of other needs (including: legal, humanitarian, and medical) that may fall outside the CSVR's scope of expertise. However, the importance and influence that these needs may have on clients' psychosocial wellbeing is acknowledged. Therefore, the CSVR's role and responsibilities in relation to clients' other needs include:

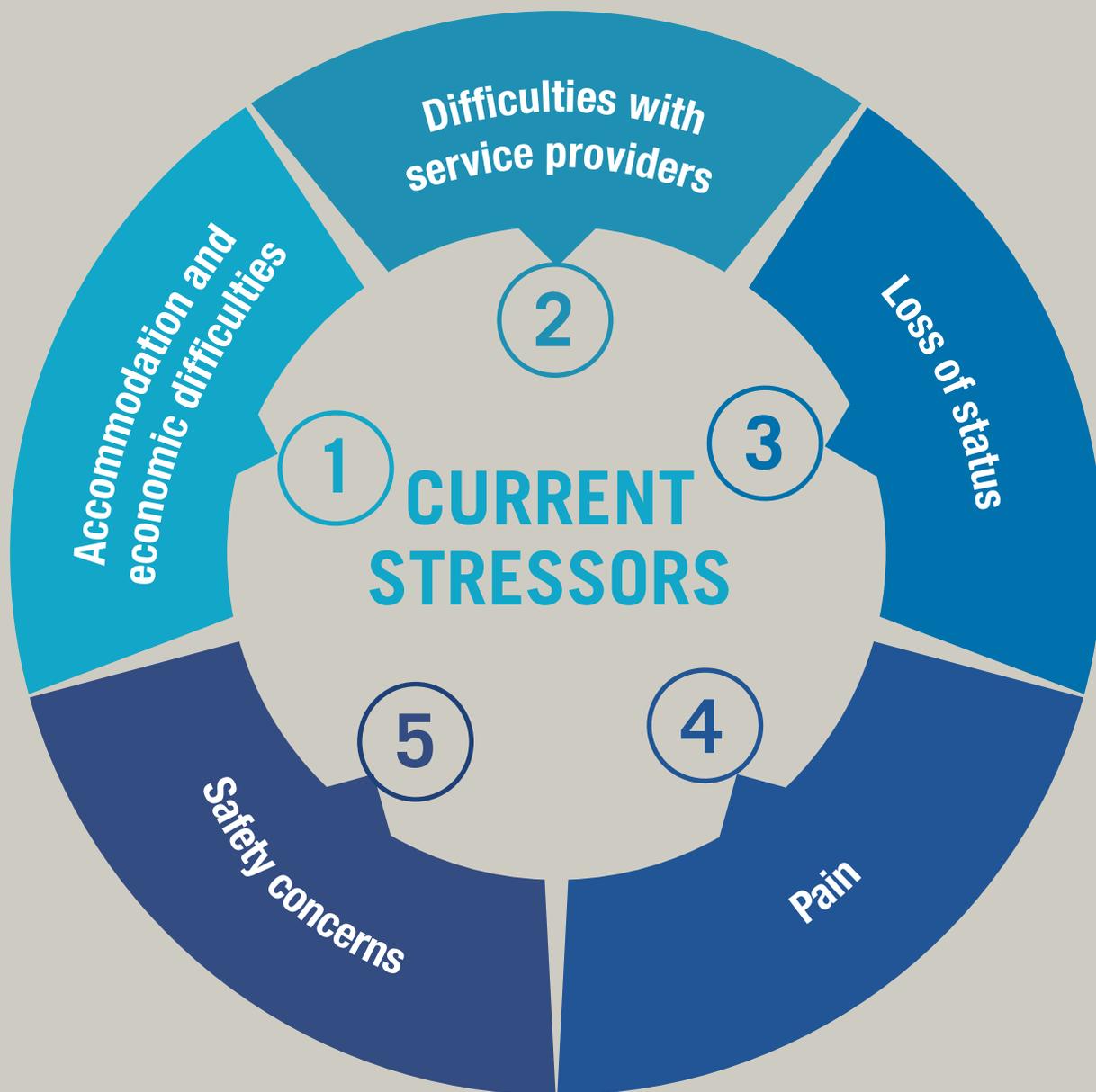
- Assisting clients to access the service providers that can best assist them in meeting their other needs. This includes (but is not limited to) providing accurate, up-to-date information, writing referral letters, and/or making calls on behalf of clients.
- Providing psycho-education to clients on how therapeutic work helps increase their ability to meet their other needs.
- Empowering clients to resolve their other needs by connecting them to their strengths and abilities in a therapeutic way.
- Working therapeutically to increase clients' functioning, which should increase their ability to meet their other needs.
- Regularly enquiring and acknowledging those needs that clients are struggling with, providing that they are, in some way, interfering with the therapeutic process. For example some people may not have secure accommodation, but feel relatively safe and are not concerned about this and, therefore, the clinician does not need to explore this situation.
- Working with patterns that may be emerging from clients' difficulties in meeting their other needs that could have psychosocial/therapeutic aspects to them.
- Creating a clear boundary between the roles of psychosocial service providers and other service providers. Clinicians should clarify that it is the clients' and other service providers' responsibility to meet the other needs.

The clinicians' focus is "on the counselling room", in other words working with clients in therapeutic ways which may build their capacity to get their other needs met. Given this, clinicians should not engage directly with clients on how to meet their other needs, e.g. problem solving about how to make money.

Given the empowerment focus, clinicians should always attempt to build the clients' ability and capacity to access service providers that may assist them in meeting their other needs. Clinicians should only get more practically involved if:

- The client or his/her children are in a situation of acute danger.
- If not getting more involved will lead to the client or their children being in a severely vulnerable position.
- The client is made to understand that it is an exception to how clinicians usually work and will be limited to this specific situation.
- All possibilities of the client or other service providers taking more responsibility for resolving the situation have been exhausted.
- The situation is discussed with a manager and/or other clinicians.

With regards to the final point, exceptions should always be discussed by the clinical team to ensure consensus regarding decisions and/or agreements over how similar situations should be dealt with in the future.



Accommodation Difficulties, Economic Difficulties, and Concern over Employment Opportunities

1



This discussion occurred slightly differently to the other impacts as it required the team to make decisions about the core business in terms of services to victims of torture (outlined above). It was a useful exercise as the team tried to gain clarity on where the line lies between the services that clinicians should provide directly and those which are best provided by others. In addition, it was necessary that the team attempted to gain clarity on what their role is in terms of clients' basic/humanitarian needs. Given the high impact of these difficulties on clients and on their ability to engage in psychosocial rehabilitation, it is insufficient to dismiss them as not part of the counselling process. These difficulties need to be addressed in some way; the question was, "how?" The team reached the following consensus regarding the core business as it relates to victims of torture.

DEFINITION:

Economic difficulties: This refers to the experience of financial difficulties which could range from poverty to an inability to afford to pay for something specific.

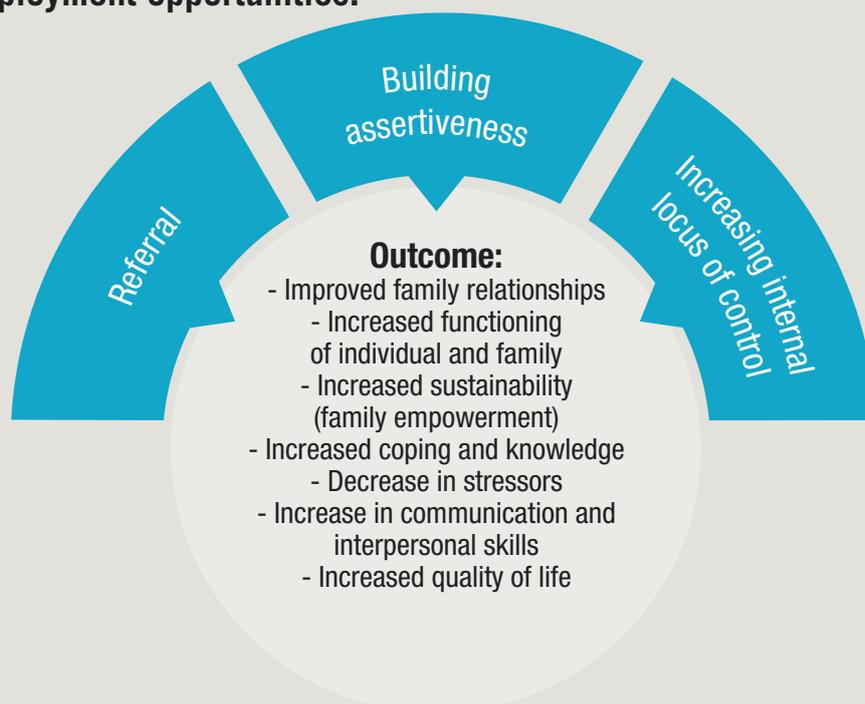
Accommodation difficulties: This refers to challenges clients experience in relation to accommodation. It includes not being able to afford accommodation, challenges in relation to current accommodation (unsafe, unstable, inappropriate), not being able to find appropriate accommodation, and homelessness.

Concern for employment opportunities: Added by panellists during Delphi process, so no definition developed.

What should be assessed in relation to this impact?

- Accommodation situation
- Concerns regarding this, with a special focus on safety
- Economic situation

Overall strategy agreed on in terms of dealing with accommodation difficulties, economic difficulties, and concern over employment opportunities:



Detailed strategy:

Once a detailed assessment is conducted, clinicians will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

REFERRAL

This is the most appropriate way to assist clients in addressing those needs that fall beyond the clinicians' core business. Information on where clients can go will be developed and updated on an on-going basis, including:

1. **Name of organisation**
2. **Address**
3. **Contact information**
4. **What services they provide**
5. **Who is their target group**
6. **Cost involved (if any)**
7. **Description of the process to access services (e.g. referral letter, appointment, phone call, etc.)**
8. **Working hours, including when clients can go**

The following sub-categories are needed:

- a. **Accommodation assistance:**
 - ▶ Shelters (for men, women, families, and women with children)
 - ▶ Non gender-based shelters for victims of violence
 - ▶ Organisations that provide financial support for accommodation
 - ▶ No fee shelters
 - ▶ Low fee shelters
- b. **Economic assistance:**
 - ▶ Organisations that assist with education-related expenses such as:
 - ➔ school uniforms
 - ➔ bursaries
 - ➔ stationery
 - ➔ fees
 - ▶ Organisations that provide support regarding employment such as:
 - ➔ assistance with developing CVs
 - ➔ small business support
 - ➔ interview skills development
 - ➔ funds for businesses
- c. **Food assistance:**
 - ▶ Soup kitchens in client-relevant areas
 - ▶ Shower and meal places
 - ▶ Government institutions such as: South African Social Security Agency (SASSA); Department of labour; the Department of Social Development
- d. **Legal assistance:**
 - ▶ Police stations in client-relevant areas
 - ▶ Where to go and the processes to obtain assistance with documentation
 - ▶ Where to go and the processes for certified translation services of documents
 - ▶ Where to go and the processes for protection orders
 - ▶ Information on home affairs and procedures there

- e. **United Nations High Commissioner for Refugees UNHCR specific brochure:**
 - ▶ What services they provide
 - ▶ What are the processes for clients
 - ▶ Who are the implementing partners
- f. **Psychosocial support for problems outside of clinicians' core business:**
 - ▶ Community mental health clinics in client-relevant areas
 - ▶ Domestic violence organisations or services
 - ▶ Bereavement focussed organisations or services
 - ▶ Substance-abuse organisations
 - ▶ Children focussed mental health organisations or services
 - ▶ Telephonic services
 - ▶ General counselling services (e.g. churches)
 - ▶ Government services
- g. **Medical assistance:**
 - ▶ Public hospitals and clinics in client-relevant areas
 - ▶ HIV/AIDS clinics
 - ▶ Where to go and the process to follow for medical documentation of torture

BUILDING ASSERTIVENESS

1. **Building assertiveness in the session:**
 - a. Create spaces for the client to give feedback and respond to these positively
 - b. Encourage the client to speak up when they are having a problem with you or the organisation. Next, ask them how it felt to be assertive with you – explore their fears with them
 - c. Allow the client a degree of control over when and what to talk about
 - d. Ask the client what they need and integrate this into the process
 - e. Model good assertive behaviours
2. **Psycho-education in relation to assertiveness:**
 - a. **Assertiveness includes:**
 - ▶ Speaking up
 - ▶ Not being passive
 - ▶ Asking for what one needs
 - ▶ Expressing one's needs in a functional, respectful, appropriate manner
 - ▶ Being firm and clear
 - ▶ Decisiveness
 - ▶ Containing emotions
 - ▶ Not being aggressive
 - ▶ Being informed
 - ▶ Using body language and non-verbals effectively
 - b. Assertiveness lies on a continuum between passiveness and aggressiveness
 - c. Different situations require people to lean more towards either side of the continuum. As we go too far towards the ends of either side, we become less likely to obtain what we need from the interaction
 - d. People communicate assertiveness with their bodies and words, by the way we speak and the way we carry ourselves
 - e. Sometimes new and different contexts require us to be more or less assertive, e.g. the way you would behave at work may be different to how you would behave in church. Similarly, the way you speak to your boss may be different to how you speak to your community elders
 - f. People who may have changed countries sometimes need to work on their assertiveness skills as the new cultures they are in might require different responses

- g. When people become more assertive, initially there may be negative reactions from others (such as family members), but these should dissipate over time
 - h. Ask clients to describe some of the consequences of being too passive and/or too aggressive
- 3. Explore client's past strengths and abilities:**
- a. Ask the client to think of a time when they were more assertive or a time when they needed something from someone and how they approached the person. Discuss what did and what did not work
 - b. Explore how they spoke, carried themselves, and what they said
 - c. Link their example to assertiveness
 - d. Explore fears they may have regarding becoming more assertive
- 4. Develop clients' assertive verbals and non-verbals:**
- a. Demonstrate passive and aggressive postures and ask the client what each communicates
 - b. Ask the client what assertive behaviour looks like and build on this. They could be assisted by asking if they know someone in their lives and/or communities who is assertive and what their behaviour looks like
 - c. Work with client on:
 - ▶ Looking up – raised head (if eye contact is uncomfortable, look at people's eyes or noses)
 - ▶ Using a clear voice
 - ▶ Using a confident tone (not whispering, not shouting, not hesitating)
 - ▶ Maintaining an upright posture and straight back.
 - ▶ Using context-appropriate eye contact (explore cultural and gender aspects here)
 - ▶ Speaking clearly (unambiguously, direct, precise, taking full advantage of their window of opportunity, need to avoid long story-telling)
 - ▶ Developing a clear, uncomplicated message
 - ▶ Showing respect for the person
 - d. Provide clients with information on Victims' Rights as a way of building their knowledge regarding their rights. Refer to: <http://www.npa.gov.za/files/Victims%20charter.pdf>
- 5. Role-play with client including repeating scripts if necessary:**
- a. Role-play problematic behaviour for the client
 - b. Role-play respectful, assertive behaviour
 - c. Provide the client with opportunities to practice and/or do homework
 - d. Agree on tasks for the client to complete and follow up on progress, exploring difficulties and gains
- 6. Build client's ability to assess other people's reactions and alter their behaviour accordingly:**
- a. Work with the client on being able to understand what the other person needs in the situation, e.g. respect for their authority or to be treated respectfully)
 - b. Ask the client to give examples of people they will need to approach for things and work through what they think the other person would need
 - c. Use role-plays to demonstrate and build the client's ability to recognise what the other person means by what they are saying and how they use their body
 - d. Ask the client to describe how they know when someone is becoming irritated, angry, or withdrawing from them, in order to build their capacity to recognise other people's reactions early and to respond accordingly
 - e. Role-play with the client as a way of practising the above
- 7. Assist client to contain their emotions by:**
- a. Linking emotional containment to being more effective in accessing services
 - b. Asking the client to identify the signs indicating that they are getting angry
 - c. Once the above signs have been identified, work with the client on how to contain these emotions/reactions by, for example:

- ▶ Developing awareness of thoughts and feelings
 - ▶ Deep breathing – with visualising exhaling tension
 - ▶ Counting to 10 slowly
 - ▶ Grounding – using an external, tactile object to feel and “play” with during highly emotional situations
 - ▶ Getting clients to remember their ultimate goal
- d. Exploring locus of control by showing that the client is in control of their emotions and how they react to these. While they cannot control what others do, they can control their own reactions to this and can influence others.

■ INCREASING INTERNAL LOCUS OF CONTROL

1. This is linked to empowerment.
2. It can be a slow process starting with small gains.
3. Link this to taking control and responsibility over one’s own life.
4. Ask the client to list the things they have control over in their lives (if they list other people, challenge them by asking if they really have control, or rather influence over them?).
5. Assist clients to differentiate between control over self and control over others.
6. Make a link between locus of control and a torture experience, which focussed on taking control away. In this a way they can reclaim what was taken away from them.
7. Ask the client what they are able and unable to stop.
8. Explore what they have control over such as:
 - a. How they behave towards others
 - b. How they react to others
 - c. What they say
 - d. What they think and feel
9. Differentiate between control and influence. Clients cannot control others, but they have influence over how others react to them, based on their behaviour. They also do not have control over their past experiences, but do have control over and influence on what happens now and going forward.
10. Highlight the client’s role in their recovery - they are the “major stakeholders” and although the clinician can assist and influence this, it is the client (not the clinician) that has the power and responsibility over their own recovery.

Difficulties with Service Providers

2



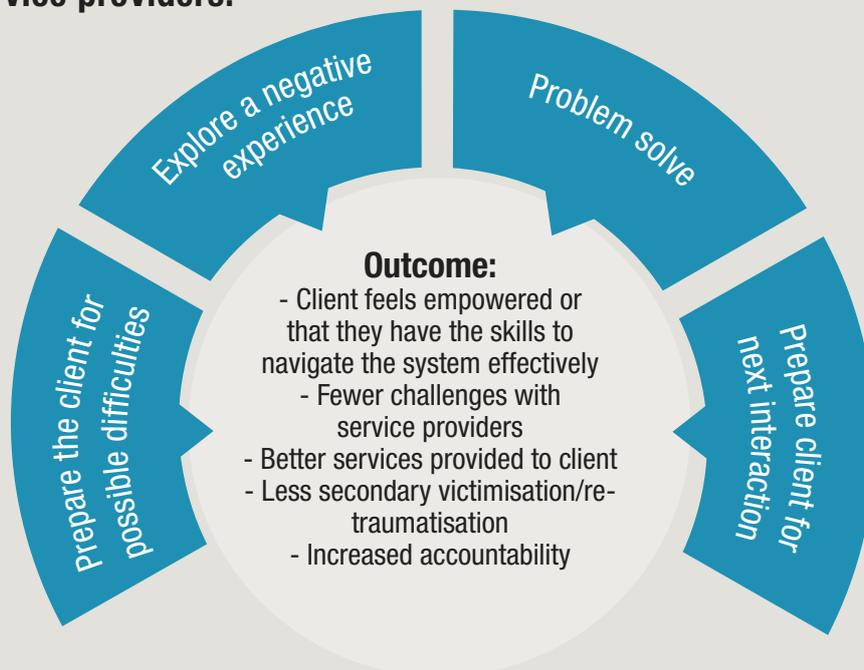
DEFINITION:

This refers to challenges the client experiences with service providers they interact with, including, among others, hospital staff, aid organisations, and the Department of Home Affairs. Challenges experienced include: difficulties with accessing services; conflicts with specific people working for service providers; and dissatisfaction with the services and/or help received.

What should be assessed in relation to this impact?

- Which service providers the client tried to access
- What happened, in terms of
 - what worked
 - what did not work
- What the impact was on the client
- Level of empowerment and/or skills in approaching service providers
- Level of assertiveness, including aggressiveness and passiveness, in interactions
- Interpersonal style, looking at cultural and gender factors
- Specific facts about what happened to explore if the difficulty lies with the client, the service provider, or both
- Fears about being assertive

Overall strategy agreed on in terms of dealing with difficulties with service providers:



Detailed strategy:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

EXPLORE A NEGATIVE EXPERIENCE

1. Allow the client to describe their experience /difficulty with the service provider(s) in detail.
2. Allow emotional expression.
3. Provide validation and containment.
4. Ask for details regarding how the client and the service provider(s) behaved in the situation.
5. Explore what worked and what did not, as well as what resulted in positive and/or negative consequences.
6. Explore what the client could have done differently. Clinicians may need to challenge or reality-test the client when doing this.
7. Identify and explore with the client the root causes of their difficulty, is it internal, external, current, and/ or historic? Also look at possible gender and cultural elements that may have played a role.
8. Ask the client what action/s they will take next? Do they need to go back to the service provider, go somewhere else, or are there other options that would mean they do not need to go back?

PROBLEM SOLVE

1. Get the client to brainstorm possible solutions to the problem.
2. Provide ideas or guidance in terms of possible solutions, after first eliciting ideas from the client.
3. Evaluate the ideas that emerge. Assist the client in selecting one or two options based on:
 - a. Practicality
 - b. Affordability
 - c. Capability
 - d. Client motivation
 - e. Most pros and least cons
 - f. Gender considerations
4. Develop a plan-of-action, which is a step-by-step process. This should be detailed and could be linked to timelines.
5. Options identified may include the clinician taking action.

PREPARE THE CLIENT FOR POSSIBLE DIFFICULTIES

This could be done with clients that have already had difficulties as well as those who will be going to the service provider(s) for the first time:

1. Ask the client what they have heard or experienced about the service provider or provide examples of other clients' difficulties.
2. Discuss the client's rights and responsibilities in terms of each service provider. Ask the client if they are aware of these and, if not, describe them.

3. Explore appropriate and inappropriate questions the client could ask.
4. Explore the client's responsibilities towards service providers, e.g. being on time, getting information about what services they provide and not asking for something beyond what the service provider can offer.
5. Build the client's assertiveness skills and feelings of empowerment. Focus on what would help the client get what they need. This could take time and may include:
 - a. Assisting the client to differentiate between what behaviour is acceptable and what is not in different situations
 - b. Challenging submissiveness by:
 - ▶ Exploring what the consequences of this are
 - ▶ Possibly confronting or challenging the client
 - ▶ Exploring gender and cultural elements that may be at play
 - ▶ Setting small, attainable goals which the client is likely to succeed in
 - ▶ Starting with close relationships and expanding from there

Focus on areas such as:

 - ▶ Dress
 - ▶ Body language
 - ▶ Tone - how the client speaks
 - ▶ When the client should be cooperative and polite and when they need to be more assertive e.g. asking for supervisors
6. Use role-plays to prepare the client.
7. Pre-empt the client's responses (emotional, cognitive, and behavioural) and build their capacity to contain these.
8. Recognise that the client may require anger management skills. **REFER TO ANGER – SECTION 9**
9. Continuously remind the client of their ultimate goal and encourage them to keep this in mind.

■ PREPARE THE CLIENT FOR POSSIBLE NEGATIVE EXPERIENCES SUCH AS

1. Long queues.
2. Long waiting times.
3. Being sent back-and-forth.
4. Safety aspects related to going in and out of areas where the service provider is situated.
5. Negative attitudes of service providers – address this by building the client's understanding of the service provider's position; they may be overworked, have limited resources, have limited understanding and/or training, may have had negative experiences with other clients, and likely have poor management.
6. Whether they are likely to be asked for money, including when this is legal or not.
7. Possible triggers that could negatively affect the client, explore what these could be and how the client could manage these using Cognitive Behavioural Techniques.

Clinicians should keep in mind that this work is about building the client's sense of control and power, which may have been removed by the torture incident. Encounters with service providers can be very testing and difficult for clients.

Loss of Status, Recognition, and Position in Society

3



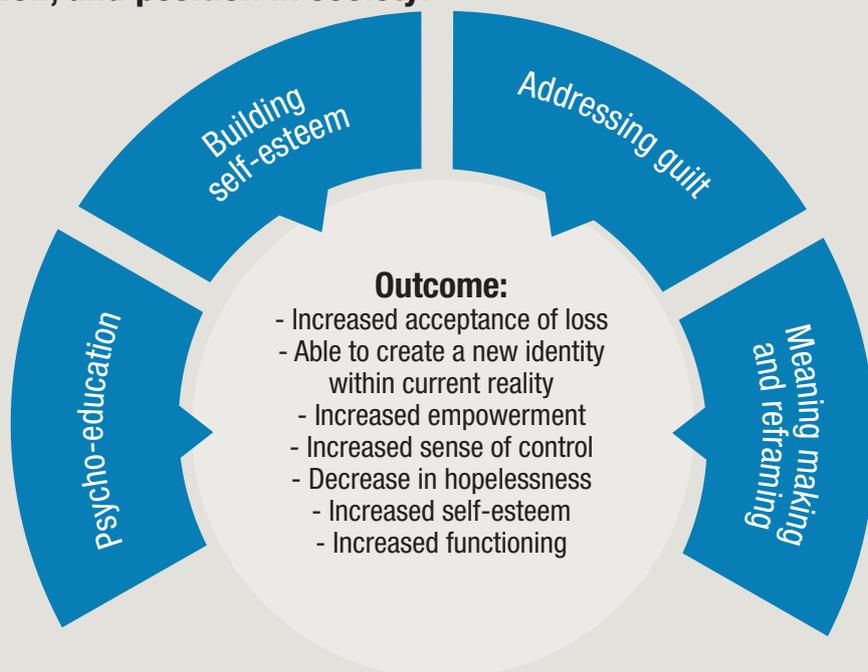
DEFINITION:

Added by panellists during Delphi process, so no definition developed.

What should be assessed in relation to this impact?

- What the client did before the torture - possibly in their home country
- The level of responsibility held by the client in their personal and professional lives
- The kind of life the client had before the incident; look at the following areas: financial, social standing, and position in society
- What the client's life looks like now

Overall strategy agreed on in terms of dealing with loss of status, recognition, and position in society:



Detailed strategy:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

PSYCHO-EDUCATION

1. These losses are often linked to our sense of identity.
2. They often result in significant role changes which are difficult to manage.
3. The losses are real and need to be mourned in some way.
4. They can lead to anger at the injustice (“unfairness”) of the situation.
5. Losing these things does not mean that everything is lost. Things that remain include:
 - a. Skills
 - b. Knowledge
 - c. Abilities
 - d. Strengths
6. Given the opportunity, many of the things that were lost can be regained.

BUILDING SELF-ESTEEM

1. Assist the client TO understand losses in terms of positives, e.g. standing up for one’s beliefs against injustice or to help others.
2. Focus on the internal strengths that allowed the client to gain the status and social position that they had before, moving from a focus on external things to internal capacities.
3. Identify and positively reinforce these strengths.
4. Reflect back to the client ways in which they are strong or able in relation to what they do or the roles that they play.
5. Work with the client to identify opportunities to use the skills that they have identified:
 - a. These skills could be paid or unpaid
 - b. Start with small gains such as: keeping their clothes clean or improving their posture
6. Explore the consequences of remaining stuck in a negative view of what has happened for:
 - a. The client’s sense of self
 - b. Other family members, especially children
 - c. The short-term
 - d. The long-term
 - e. Mood disorders
7. Explore feedback from others that the client may have experienced (e.g. asking how clients children have responded).
8. Develop a plan and monitor its implementation.

■ ADDRESSING GUILT AND SHAME

1. **Validate and acknowledge feelings of guilt. It may feel to the client like it would have been easier not to have survived.**
2. **Explore specific areas of concern such as rational and/or irrational thoughts:**
 - a. **Regarding irrational thoughts, examine realistically what the client could have done to prevent the loss:**
 - ▶ Ask the client what was within their control
 - ▶ Ask the client what they could have done differently and what the possible consequences could have been before offering additional ones to what they proposed. For example, often clients will express options that could have put them in more danger
 - ▶ Reality test their thoughts by asking if they actually could have done what they have suggested
 - b. **Regarding rational thoughts, examine where they could have done something to prevent the loss or where their actions made the situation worse:**
 - ▶ Ask the client if they would have behaved differently had they known what was going to happen
 - ▶ Link this to what their intentions were - did they intend for this outcome?
 - ▶ Link back to the fact that it would not have been possible to know the outcome. They did their best given what they knew
 - ▶ Explore what they would have done differently if they knew what was going to happen
 - ▶ Validate and acknowledge what the client says
 - ▶ Explore possible forms of reparation and/or apology, which could be symbolic
 - ▶ Explore the client's difficulty to forgive him/herself
 - c. **Explore control over:**
 - ▶ The loss
 - ▶ Other people's actions
 - ▶ The client knowledge that the incident was going to happen
 - ▶ Who is really responsible for the outcome
3. **Complete the "what ifs" of both the incident, as well as future actions they may be thinking about.**
4. **Explore risk-taking behaviour linked to guilt.**
5. **Ask the client why they think they survived, build on positive responses or challenge distorted thinking.**

Unattended guilt may lead to shame, whereby feeling bad about one's actions turns into feeling bad about one's self:

 - a. Explore if this is the case for the client
 - b. Explore negative thoughts about self, linked to the loss
 - c. Develop alternative scripts to existing ones
 - d. Addressing guilt is central

■ MEANING MAKING:

1. **This is about the client making sense of their experience, which may include post-loss growth.**
2. **This is only done with clients who initiate it during therapy, which may depend on the kind of loss or its context.**
3. **It should not be imposed on clients.**
4. **It is a slow process that takes time.**
5. **The therapist should validate and acknowledge the client's struggles in making sense of the incident.**
6. **Empathetic listening by the clinician is vital.**

7. **Respecting the client's beliefs is equally important.**
8. **Making meaning from the experience without minimising the pain can instil hope in the client.**
9. **The clinician can ask the client what keeps them going despite their difficulties, as they could have given up but have not.**
10. **Illicit what meanings the client attributes to their experiences. Do not, however, attribute meanings yourself:**
 - a. Ask the client why they think these things happened to them
 - b. Be open to different cultural and religious meanings
 - c. Ask the client how their religion/spiritual/philosophical position would explain their situation - they could speak to a religious leader or read the bible. Be cautious around negative explanations that may emerge
 - d. Ask the client how others in their community have made sense of similar experiences
 - e. Ask the client what helped them get through the trauma
11. **Explore possible meanings the client has formed about the loss, do they believe:**
 - a. It is a punishment
 - b. God caused it
 - c. It was their time
12. **Explore whether this meaning is helpful or unhelpful to them in relation to moving forward and managing pain.**
13. **Explore negative/unhelpful meanings:**
 - a. Refer to rational versus irrational thinking (above)
 - b. Link to underlying emotions, e.g. guilt, anger, and shame
 - c. Ask the client if they can think of other possible explanations or meanings for the loss
 - d. Explore cultural or religious meanings
 - e. Illicit positive or alternative reframes
 - f. Explore the issue of control and remind the client that although they do not have control over the loss, they do have control over what meaning they give to it
 - g. Explore how the client could change the meaning of loss e.g. through rituals
 - h. Challenge meanings by asking the client how this has impacted on them; explore their feelings thoughts, and behaviours
14. **If strong emotions are expressed regarding the meaning of the experience/s, the clinician should contain these, validate them, and explore why they have such strong emotions.**
15. **There may be no explanation or meaning possible. In these cases, validate and acknowledge the client and contain them. Work on acceptance that there may be no answers right now and reflect on this difficulty.**
16. **If the client is searching for meaning but is unable to think of any, suggest some possibilities but be cautious not to "rescue" the client by offering these too soon.**
17. **If meanings are positive/helpful then reinforce, encourage, and validate these.**
18. **Explore the possibility of there not being any meaning for the loss, we may never know why an incident happened.**
19. **Ask the client if they feel that the deceased could play a different role in their lives now as, for example, an angel or an ancestor.**

Pain

4



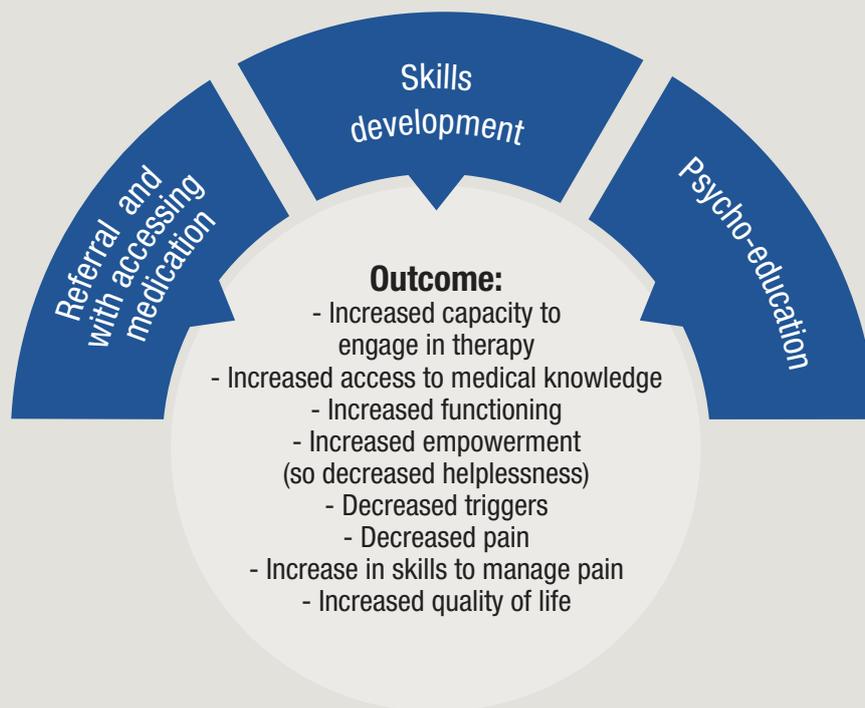
DEFINITION:

This is the experience of pain which may be related or unrelated to the torture experience. It includes pain in the back, chest, and limbs, as well as head-aches. The pain may be chronic, residual, and/or general.

What should be assessed in relation to this impact?

- Whether pain is present
- Where the pain is located in the body
- Whether the pain is due to torture
- The nature/quality of the pain, that is, what it feels like
- When and how often the client feels the pain
- Past treatment sought to identify what worked what did not
- The impact of pain on current functioning
- The clinician's observations regarding the client's physical status

Overall strategy agreed on in terms of dealing with pain:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

REFERRAL AND ASSISTANCE WITH ACCESSING MEDICATION

- 1. Always refer a client that complains about pain to a doctor on the referral network for assessment and referral to specialist(s) and/or recommendations for treatment and/or medication. The only exceptions to referring are:**
 - a. If the client is already accessing medical treatment and is satisfied with it
 - b. If the pain does not impact significantly on their functioning and they are not concerned about it
- 2. If the client is having difficulties in accessing service providers, refer to the section on "Difficulties with Service Providers".**
- 3. Refer refugees and asylum seekers to the Jesuit Refugee Services (JRS) for support for costs involved in accessing medical care through the public health system:**
 - a. The clinician must write a referral letter to the JRS (with the client's consent) which includes the following information: why it is important that the client receives assistance, what is being requested, what the counselling service has done thus far, what the doctor has recommended, reference to the doctor's letter and how addressing pain will impact on the client. The letter should mention that the client is receiving ongoing services from the counselling centre
- 4. Refer the client to a pharmacy on the referral network for discounted medication.**
- 5. Draw a clear boundary in relation to the counselling centre's ability to deal with pain.**
- 6. Emergency cases should be referred to the emergency room of the local hospital.**
- 7. If the client has financial resources to pay for care, inform them that they could ask the referral network's doctor to suggest private practitioners that they may access.**
- 8. Provide the client with support in accessing medical care but in a very limited way (not more than 10 minutes), by exploring what options they may have and making a referral.**
- 9. Do not go into a detailed problem solving exercise with the client in relation to pain as it is not the counselling centre's core responsibility or business.**
- 10. If pain is a key concern for the client, the clinician should check-in with them on an on-going basis, without going into too much detail, regarding progress made. The goal is to acknowledge the impact of pain and empathise with the client, which can be done briefly at the beginning of each session.**

SKILLS DEVELOPMENT

- 1. Explore triggers of pain with the client so that they are able to recognise these and react proactively to them.**
- 2. Relaxation techniques:**
 - a. Breathing exercises, e.g. staccato breathing, focussing on rhythm of breathing, deep abdominal breathing
 - b. Visualisation, e.g. breathing into pain then exhaling/letting go of it, a comforting surrounding ring of healing, guided imagery, tapping, etc
 - c. Illicit from client what activities are relaxing for them and encourage them to do these
- 3. Encourage the client to follow the recommendations made by medical professionals. Work with blockages if these are of a psychological nature.**
- 4. Explore what makes pain more severe and less severe and link this to the client making choices that will assist them.**

5. Explore options to resolve barriers.
6. Develop the client's ability to accept the current circumstances by reality testing, outlining what has already been done, and exploring the locus of control. Increasing internal locus of control:
 - a. This is linked to empowerment
 - b. It can be a slow process starting with small gains
 - c. Link this to taking control and responsibility over one's own life
 - d. Ask the client to list the things they have control over in their lives (if they list other people, challenge them by asking if they really have control, or rather influence over them?)
 - e. Assist clients to differentiate between control over self and control over others
 - f. Make a link between locus of control and a torture experience, which focussed on taking control away. In this way they can reclaim what was taken away from them
 - g. Ask the client what they are able and unable to stop
 - h. Explore what they have control over such as:
 - ▶ How they behave towards others
 - ▶ How they react to others
 - ▶ What they say
 - ▶ What they think and feel
 - i. Differentiate between control and influence. Clients cannot control others, but they have influence over how others react to them, based on their behaviour. They also do not have control over their past experiences, but do have control over and influence on what happens now and going forward
 - j. Highlight the client's role in their recovery - they are the "major stakeholders" and although the clinician can assist and influence this, it is the client (not the clinician) that has the power and responsibility over their own recovery
7. For clients who are resistant to seeking help for their pain or who are reluctant to implement steps that could moderate the pain, the clinician could reframe the situation by pointing out to the client that managing their pain is a way of regaining the control that the torturer(s) removed from, and are still exercising over them.
8. Externalise the pain as something the client is experiencing rather than who they are. This can be done by naming the pain (using cultural names may be appropriate here) and encouraging the client to "befriend" their pain in order to better know how to manage it.
9. Assist the client to differentiate between pain (inevitable) and suffering (optional) by working on their cognitions/thoughts.
10. Develop the client's skills to manage their life or daily functioning around the pain.
11. Identify and engage support systems that can assist the client.

■ PSYCHO-EDUCATION

1. **The relationship between stress and pain:**
 - a. Stress may lead to muscles contracting, which can increase pain
 - b. Extreme stress can increase cortisol and adrenaline levels, which break down into lactic acid, leading to a decrease in energy and an increase in pain
2. **Some pain may be chronic and may never completely disappear, requiring the client to accept and manage it.**
3. **Pain may take time to resolve and quick fixes are unlikely.**
4. **One needs to find ways to manage life with pain.**
5. **Pain reduces one's level of psychological and physical capacity. It is therefore important to manage the pain, and to be realistic about the expectations that one has of oneself given their level of pain.**
6. **It is important to do what the medical practitioners have recommended.**
7. **The impact of pain can include:**
 - a. How people think – low concentration and lack of focus
 - b. Impatience
 - c. Irritability
 - d. Relationship difficulties
 - e. Inability to do things that used to get done before the pain
 - f. Low self-esteem - feeling useless and always complaining
 - g. Questioning, “why did this happen to me?”
 - h. Anger, especially towards the perpetrator
 - i. Depression - explain the negative cycle between pain and depression
 - j. Withdrawal as the person is less mobile and may sense a lack of understanding from others
 - k. Changes in the way in which others treat the person with pain
 - l. Thoughts about the future may become more negative
 - m. A need to alter their goals as they can no longer do what they planned to

Safety Concerns and Repeated Victimisation



DEFINITION:

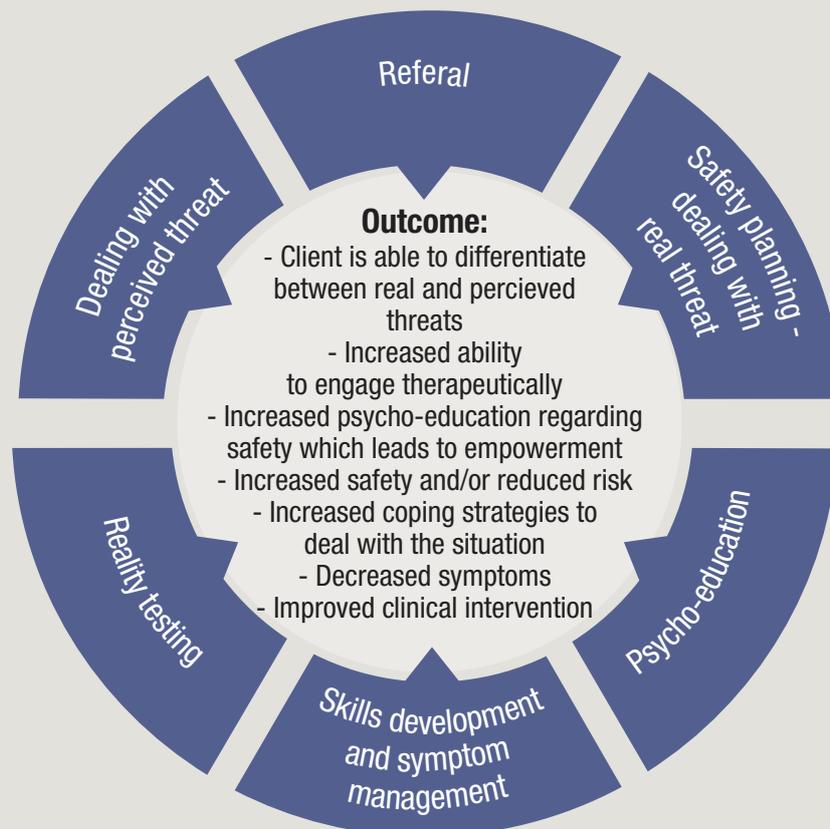
Safety concerns refer to perceived or real concerns regarding the safety of the client and/or their family.

Repeated victimisation refers to the client's repeated exposure to traumatic events.

What should be assessed in relation to these impacts?

- If the client's accommodation status raises concerns around the client's safety, ask:
 - How the client feels at their current accommodation
 - Whether they feel safe
- If the client does not feel safe, establish what makes them feel unsafe
- Does the client feel that their children are safe
- What are the ways in which the client knows that the situation is unsafe
- How the client is impacted on by feeling unsafe
- Are there particular places where the client feels safe and/or unsafe - explore the details of why they feel that way
- The degree to which the client feels unsafe

Overall strategy agreed on in terms of dealing with safety concerns and repeated victimisation:



REFERRAL

Develop a list of service providers and options that the client can refer to for help if feeling threatened, including:

1. **Local police station.**
2. **Local magistrates offices to obtain a protection order.**
3. **Safe houses.**
4. **UNHCR protection officers.**
5. **Refugee community leaders if the threat is internal to the community.**
6. **Active and respected ward councillors.**
7. **Intelligence services.**
8. **Independent Police Investigative Directorate (IPID).**
9. **Department of Community Safety.**
10. **Police hot-line 10111.**
11. **Lawyers for Human Rights for advice.**

SAFETY PLANNING – DEALING WITH REAL THREATS

1. **Validate and acknowledge the client's feelings and concerns.**
2. **Explore what resources the client has around them:**
 - a. Police stations
 - b. Security guards
 - c. Churches
 - d. Neighbours they trust
 - e. NGOs or CBOs
 - f. Community councillors
3. **Get the client to obtain information on the above resources (including contact numbers and physical address) in case they need to go for help.**
4. **Establish what the client has already tried to do. Explore what worked and what did not work and why. The clinician may need to explore and challenge the client, e.g. when they say "I can't go to the police".**
5. **Work with resistance that may emerge about asking for help. Ask the client if they or others have been helped by people before and highlight success stories.**
6. **Emphasise the importance of being very clear should the client ask for help. For example, know the name of streets so you can give the closest corner to the police.**
7. **Work with the client on how to remain calm:**
 - a. Breathing exercises, e.g. staccato breathing, focussing on rhythm of breathing, deep, abdominal breathing
 - b. Illicit from the client what activities are relaxing for them and encourage them to do these
 - c. Get them to think of a sentence they could repeat in a threatening situation to remain calm, e.g. "Stay calm, I can do this"

8. **Get the client to think about what they could do to feel safer or increase their safety. Ideas should be practical and specific. Build on the client's ideas by offering additional ones, for example:**
 - a. Wearing different clothes or using disguises
 - b. Behaving differently
 - c. Taking different routes
 - d. Using jewellery
 - e. Avoiding higher-risk places or times of day
 - f. Adding security measures in their place of accommodation, e.g. additional locks
 - g. Exploring the possibility of relocating
9. **Work with the client on a plan for if they are attacked, which spells out in detail what they will do. This should be aimed at reducing the risk of further harm, how to get help, where to go, and what to do.**
10. **Develop the client's ability to become more aware of their surroundings in order to recognise threats early. Identify what an appropriate level of vigilance should be for the client. Explore the vigilance continuum with the client and where they should be on it.**

Under-vigilant
Appropriately vigilant
Hyper-vigilant
11. **Assist the client to differentiate between the internal and external cues of a threat.**

PSYCHO-EDUCATION

1. **How traumatic experiences may increase fear. This may be generalised or very specific, e.g. if someone was tortured by police officers then they may be afraid of all police officers.**
2. **Trauma may shatter the following assumptions people hold, which may increase unsafe feelings:**
 - a. The world is a benevolent, good place
 - b. The world is meaningful - events in the world "make sense"
 - c. The self is worthy.
3. **The dangers of not dealing with safety concerns:**
 - a. The client's behaviour may become ingrained (a habit) or even develop into phobias
 - b. It may limit their psychological and physical functioning
 - c. It may obstruct their goals
 - d. It impacts the entire family
4. **Not dealing with a threat or becoming a victim to it means that the client is giving power to others over them.**
5. **How trauma affects an individual's ability for threat appraisal by causing them to move from appropriate to hyper- or under-vigilance.**
6. **Too much fear and anxiety reduces one's ability to function.**
7. **Small doses of fear can be protective.**
8. **Explore cultural and gender aspects related to safety concerns.**
 - a. The impact of repeated victimisation, such as:
 - b. The erosion of resilience
 - c. Increased vulnerability
 - d. Hopelessness and helplessness

- e. Strong victim mentality
- f. Idealisation of the client's home country, despite the fact that it is a place of risk where they were tortured
- g. Fatalistic view and foreshortened future
- h. Impact of additional traumas may be worse due to previous experiences
- i. Increased questioning - "why me?"
- j. Increased external locus of control
- k. High defensiveness, which may be appropriate in some instances
- l. Increased risk of mental collapse or of a decrease in functioning

■ SKILLS DEVELOPMENT AND SYMPTOM MANAGEMENT

1. Relaxation exercises:

- a. Breathing exercises, e.g. staccato breathing, focussing on rhythm of breathing, deep, abdominal breathing
- b. Illicit from the client what activities are relaxing for them and encourage them to do these
- c. Get them to think of a sentence they could repeat in a threatening situation to remain calm, e.g. "Stay calm, I can do this"

2. Presenting oneself in a way that could reduce the risk of victimisation:

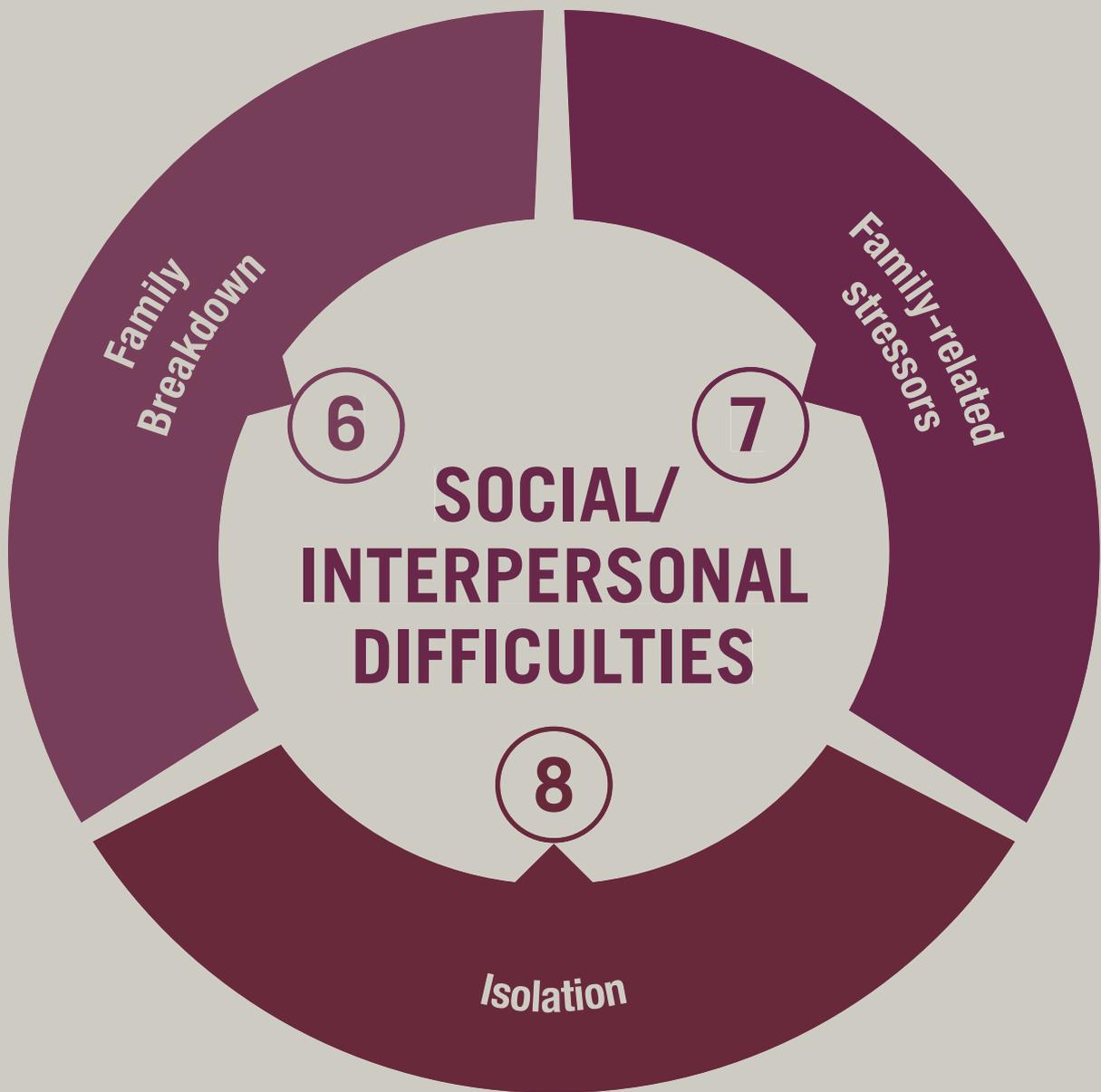
- a. Making oneself "bigger" by using the body assertively
- b. Looking up and around
- c. Keeping the shoulders back
- d. Greeting or making eye contact with people who concern the client

3. Developing appropriate threat appraisal and increasing vigilance through:

- a. Identifying higher risk areas
- b. Paying attention to how others are behaving
- c. Challenging the client's high-risk behaviour
- d. Identifying cues that may lead to a threat and learning to trust one's instincts

4. Increasing internal locus of control:

- a. This is linked to empowerment
- b. It can be a slow process starting with small gains
- c. Link this to taking control and responsibility over one's own life
- d. Ask the client to list the things they have control over in their lives (if they list other people, challenge them by asking if they really have control, or rather influence over them?)
- e. Assist clients to differentiate between control over self and control over others
- f. Make a link between locus of control and a torture experience, which focussed on taking control away. In this a way they can reclaim what was taken away from them
- g. Ask the client what they are able and unable to stop
- h. Explore what they have control over such as:
 - ▶ How they behave towards others
 - ▶ How they react to others
 - ▶ What they say
 - ▶ What they think and feel
- i. Differentiate between control and influence. Clients cannot control others, but they have influence over how others react to them, based on their behaviour. They also do not have control over their past experiences, but do have control over and influence on what happens now and going forward
- j. Highlight the client's role in their recovery - they are the "major stakeholders" and although the clinician can assist and influence this, it is the client (not the clinician) that has the power and responsibility over their own recovery





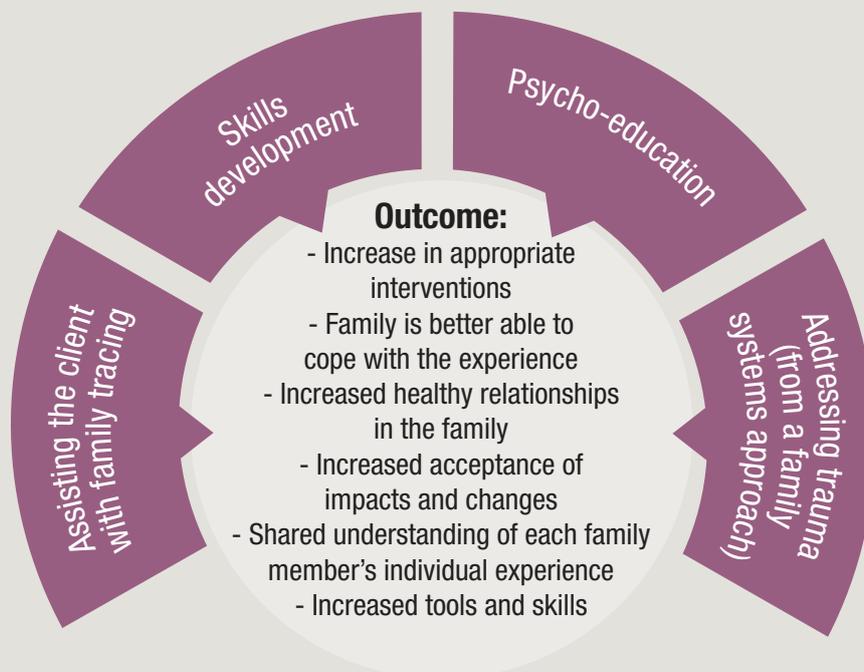
DEFINITION:

This refers to a severe problem experienced in the family. It includes loss of contact with family members, the development of unhealthy relationship patterns, and trauma which directly impacted on the entire family.

What should be assessed in relation to these impacts?

- Interpersonal dynamics i.e. how people in the family are relating to each other
- Genogram with a focus on healthy and conflictual relationships between members. Include those who are missing and/or dead
- Conflicts among family members
- Pre- and post-trauma changes in relationships
- How conflicts in the family are currently being dealt with
- Level of impact of these conflicts, including identifying which are the most significant
- Whether the client is concerned about certain members of the family
- What help has been sought and/or what has been tried, assessing what worked and/or what did not
- Explore culturally appropriate interventions for this issue
- Trauma histories of different family members. This could be part of the genogram
- Behavioural changes in family members post-trauma
- Baseline functioning of individuals and the family pre-trauma

Overall strategy agreed on in terms of dealing with family breakdown:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

■ ASSISTING THE CLIENT WITH FAMILY TRACING IF FAMILY MEMBERS ARE MISSING

1. Assess who is missing and who the client is distressed about.
2. Ask about the last contact - when, how, and what.
3. Explore what the client has already done to trace missing family members and what other options may be available to them.
4. Refer the client to the Red Cross Tracing project; the following link has information on where to refer clients and information on the project: <http://familylinks.icrc.org/en/Pages/Countries/south-africa.aspx>.

■ SKILLS DEVELOPMENT

1. Relationship building:
 - a. Clinicians may need to do work at an individual level before working with the family
 - ▶ Explore what the client could do about the situation
 - ▶ Explore the things over which they have control and those over which they do not
 - ▶ Work on how they can deal with their emotional reactions within a conflict
 - b. Explore existing relationship patterns within the family
 - c. Identify what works and does not work. If the client is stuck, offer your own insights of what works and does not
 - d. Role-play with individuals and/or families. Reverse roles then explore how this felt with the aim of clarifying intentions and building empathy
 - e. Keep the client focussed on the outcome they want to achieve
 - f. Explore what they gain from the relationship as a way of balancing negative focus
 - g. Work on increased understanding of differences and the intentions of other family members
 - h. Explore how trust has been eroded and what behaviours are needed for trust to be re-built
 - i. Build communication skills:
 - ▶ This requires a certain level of trust
 - ▶ The goal is to create safe spaces where all members of the family feel that they can speak and be heard
 - ▶ This should be modelled in the session by allowing all members of the family space to talk
 - ▶ Link this to being able to understand where different family members are at, which would allow the client(s) to be more effective parents
 - ▶ Before getting the family to try this, clinicians may need to work with parents on being open to listening to family members without interrupting or reacting negatively, both during and after the session
 - ▶ Work through what respectful communication looks like. Discuss things like active listening, importance of tone, the role of non-verbals, and respectful speaking
 - ▶ Build listening skills through the use of a talking stick, whereby the person holding the stick gets to speak without interruption, while the rest of the family actively listens. Follow this with time to reflect back what the person said. Encourage the family to practice this in the session
 - ▶ Explore the positive aspects of effective communication and the negative aspects of poor communication in families
 - ▶ Get clients to focus on their own emotions when communicating, rather than blaming others. This can be done by getting clients to use the following structure: "I feel... (own emotion), when you do ..., because ..."

■ PSYCHO-EDUCATION

1. Explore the effect of family breakdown and conflict on families as a whole and the individual, for example:
 - a. Anger
 - b. Taking sides and/or colluding
 - c. Silencing effect
 - d. Fear
 - e. Anxiety

2. Normalise the individual and family emotions and/or experiences of the event.

3. Regarding trauma/torture:

Explain that families that have been through similar experiences often react in the following ways:

- a. Self-blame about one's actions, by holding oneself responsible for the event happening or worsening or not being able to prevent it or protect their family
- b. Guilt (expressed in questioning, "why me?") and feeling that they are the reason for the incident occurring
- c. Blaming other family members for the event, or parts of it, which made things worse
- d. Confusion about:
 - ▶ Role changes - taking and/or abdicating responsibilities in the family
 - ▶ What happened to others in the incident
 - ▶ How different members have reacted to the incident
- e. Withdrawal from social interactions
- f. Feeling that the family is unable to cope and is falling apart
- g. Over-cautiousness and over-protectiveness over some family members

Other aspects to note include:

- a. The impacts parents' responses have on children; explain that parents' reactions are often what determine the reaction of children. For example, if parents are overly anxious, then children are more likely to display anxiety
- b. Different people react to trauma differently, which is normal
- c. Some people are resilient, and so can better cope
- d. Some people feel overwhelmed by the experience and/or the consequences of it; feeling like one is unable to cope
- e. Traumatic incidents affect people differently on a spiritual level i.e. questioning or turning to religion
- f. Normalising the client's reactions to the event and to the changes/stressors present since the event, including linking them to other victims' experiences
- g. Highlighting that recovery is a process that will take time and that different people work at different speeds, which is not a sign of weakness
- h. Reinforcing that this is a major event and therefore people need time to recover from it
- i. Identifying ways that family members can be supportive, including by:
 - ▶ Understanding that each individual experiences trauma differently
 - ▶ Allowing emotional expression if necessary
 - ▶ Listening to the story
 - ▶ Not expecting people to be "normal"
 - ▶ Assisting with practical chores
 - ▶ Understanding adaptive behaviours and changes

Refer to page.....for info on psycho-education and families

4. What can be expected at an individual and family level given the particular stressor(s).
5. What the process to overcome the stressor(s) (e.g. bereavement) may look like at an individual and family level.

6. How the client and/or family can relearn life skills and adjust to their new realities, including new roles, responsibilities, socio-economic status.
7. Family systems and how these impact or are impacted on by the stressor(s), including:
- a. Individuals cannot be understood in isolation from one another—families are systems of interconnected and interdependent individuals, none of whom can be understood in isolation from the system
 - b. “Movement” in any one part of the “system” will affect all parts of the system
 - c. The family systems approach suggests that sometimes our behaviour may have as much to do with the “systems” (groups) of which we are a part (the patterns that get established within these systems) as it may have to do with the personality of each person within the system
 - d. Each member is unique within the system
 - e. Each member has their own needs that they may want to get met by the system and/or individuals in the system
 - f. Each member brings something to the system
 - g. Each member can influence the whole system
 - h. Members play different roles and take on or are given different responsibilities within the system
 - i. Focus of the system should be on finding ways that benefit the best interests of the system as a whole
 - j. Change and trauma may alter the roles that different members play and how the whole system functions
 - k. Terms from Family Systems Theory include:
 - ▶ **Family Roles:**
 - ➔ What is expected of each family member
 - ➔ The most basic types of roles are “father,” “mother,” “aunt,” “daughter,” “son,” “grandmother,” etc. Explore what is expected from people in each of these roles
 - ➔ There are also roles beyond this most basic level. For example, one person may be the “clown” of the family while another may be the “responsible one”
 - ▶ **Family Rules:**

These are rules about how the family operates and are often unspoken. For example:

 - ➔ When people are angry at each other, do they express this or keep it to themselves?
 - ➔ How affectionate or emotional are family members expected or allowed to be with each other?
 - ➔ How are decisions made in the family?
 - ➔ Families tend to develop patterns about these sorts of things which become “unspoken rules.” Family members may see this as “just the way it is,” but different families develop different “unspoken rules”
 - ▶ **Homeostasis/Equilibrium:**
 - ➔ Systems develop typical ways of being, which are reliable and predictable
 - ➔ Whether these roles and rules are adaptive or not, there is a pull from the system not to change, but to continue functioning as things have always been
 - ➔ The tendency of systems to keep doing things as they’ve always been done is known as homeostasis or the system’s equilibrium
 - ▶ **Circular causality:**

This refers to the fact that in family systems, each family member’s behaviour is caused by and causes the other family members’ behaviours. They each impact the other, in a circular manner
 - ▶ **Boundaries:**

For families to function well, subsystems must maintain boundaries
 - ▶ **Adaptation:**

Despite resistance to change each family system constantly adapts to maintain itself in response to its members and the environment
8. Developmental stages and how these are linked to needs and reactions to trauma – Refer to Appendix 1 (Child development and trauma guide) and Appendix 2 (Understanding traumatic stress in Children) for additional information.

9. Parenting and role changes in terms of parenting, e.g. parentified children.
10. The role that gender, culture, and tradition can play in families and how they manifest within the family. This can be done by:
 - a. Exploring the family's gender and cultural beliefs and norms regarding how families function
 - b. Exploring which of these norms were adopted by the family
 - c. Identifying what works and what does not work
 - d. Examining how stressors can impact on relationships

■ ADDRESSING TRAUMA USING THE FAMILY SYSTEMS APPROACH:

1. Explore the impact of the trauma on the family and relationships thereafter.
2. Explore changes that have occurred in the family system since the trauma with regards to:
 - a. Behaviours
 - b. Roles, both practical and emotional ones
3. Explore how the family is interacting with the world since the trauma.
4. Refer to page 91 Section 14 for trauma treatment and families.

Family-related Stressors



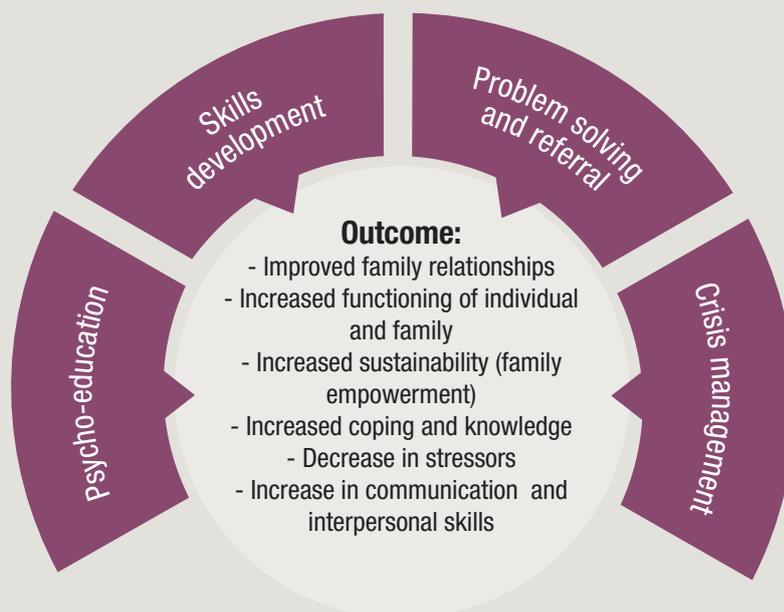
DEFINITION:

This refers to stressors clients experience in relation to their family and includes: problems experienced by family members, especially children (health problems, exposure to violence or threats, experiences of discrimination, etc.); difficulties in meeting the needs of family members; concerns about the well-being of family members; negative behaviours displayed by family members; and difficulty in managing the expectations and/or demands of family members.

What should be assessed in relation to these impacts?

- How things are going in the family right now
- What is impacting the client; includes interpersonal, economic, and security stressors
- Draw a family genogram with a focus on identifying sources of stress and support
- What resources exist within the family
- Torture of other family members, which can be explored through the genogram
- Those stressors with the greatest impact on the client
- The client's level of empowerment
- Who, within the family, could be brought in to assist

Overall strategy agreed on in terms of dealing with family-related stressors:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

■ PSYCHO-EDUCATION

1. What can be expected at an individual and family level given the particular stressor(s).
2. What the process to overcome the stressor(s) (e.g. bereavement) may look like at an individual and family level.
3. How the client and/or family can relearn life skills and adjust to their new realities, including new roles, responsibilities, socio-economic status.
4. Family systems and how these impact or are impacted on by the stressor(s), including:
 - a. Individuals cannot be understood in isolation from one another—families are systems of interconnected and interdependent individuals, none of whom can be understood in isolation from the system
 - b. “Movement” in any one part of the “system” will affect all parts of the system
 - c. The family systems approach suggests that sometimes our behaviour may have as much to do with the “systems” (groups) of which we are a part (the patterns that get established within these systems) as it may have to do with the personality of each person within the system
 - d. Each member is unique within the system
 - e. Each member has their own needs that they may want to get met by the system and/or individuals in the system
 - f. Each member brings something to the system
 - g. Each member can influence the whole system
 - h. Members play different roles and take on or are given different responsibilities within the system
 - i. Focus of the system should be on finding ways that benefit the best interests of the system as a whole
 - j. Change and trauma may alter the roles that different members play and how the whole system functions
 - k. Terms from Family Systems Theory include:
 - ▶ **Family Roles:**
 - ➔ What is expected of each family member
 - ➔ The most basic types of roles are “father,” “mother,” “aunt,” “daughter,” “son,” “grandmother,” etc. Explore what is expected from people in each of these roles
 - ➔ There are also roles beyond this most basic level. For example, one person may be the “clown” of the family while another may be the “responsible one”
 - ▶ **Family Rules:**

These are rules about how the family operates and are often unspoken. For example:

 - ➔ When people are angry at each other, do they express this or keep it to themselves?
 - ➔ How affectionate or emotional are family members expected or allowed to be with each other?
 - ➔ How are decisions made in the family?
 - ➔ Families tend to develop patterns about these sorts of things which become “unspoken rules.” Family members may see this as “just the way it is,” but different families develop different “unspoken rules”
 - ▶ **Homeostasis/Equilibrium:**
 - ➔ Systems develop typical ways of being, which are reliable and predictable
 - ➔ Whether these roles and rules are adaptive or not, there is a pull from the system not to change, but to continue functioning as things have always been
 - ➔ The tendency of systems to keep doing things as they’ve always been done is known as homeostasis or the system’s equilibrium

► **Circular causality:**

This refers to the fact that in family systems, each family member's behaviour is caused by and causes the other family members' behaviours. They each impact the other, in a circular manner

► **Boundaries:**

For families to function well, subsystems must maintain boundaries

► **Adaptation:**

Despite resistance to change each family system constantly adapts to maintain itself in response to its members and the environment

5. Developmental stages and how these are linked to needs and reactions to trauma – Refer to Appendix 1 (Child development and trauma guide) and Appendix 2 (Understanding traumatic stress in Children) for additional information.

6. Parenting and role changes in terms of parenting, e.g. parentified children.

7. The role that gender, culture, and tradition can play in families and how they manifest within the family. This can be done by:

- a. Exploring the family's gender and cultural beliefs and norms regarding how families function
- b. Exploring which of these norms were adopted by the family
- c. Identifying what works and what does not work
- d. Examining how stressors can impact on relationships

■ SKILLS DEVELOPMENT

1. Communication skills:

- a. This requires a certain level of trust
- b. The goal is to create safe spaces where all members of the family feel that they can speak and be heard
- c. This should be modelled in the session by allowing all members of the family space to talk
- d. Link this to being able to understand where different family members are at, which would allow the client(s) to be more effective parents
- e. Before getting the family to try this, clinicians may need to work with parents on being open to listening to family members without interrupting or reacting negatively, both during and after the session
- f. Work through what respectful communication looks like. Discuss things like active listening, importance of tone, the role of non-verbals, and respectful speaking
- g. Build listening skills through the use of a talking stick, whereby the person holding the stick gets to speak without interruption, while the rest of the family actively listens. Follow this with time to reflect back what the person said. Encourage the family to practice this in the session
- h. Explore the positive aspects of effective communication and the negative aspects of poor communication in families
- i. Get clients to focus on their own emotions when communicating, rather than blaming others. This can be done by getting clients to use the following structure: "I feel... (own emotion), when you do..., because..."

2. Parenting Skills:

- a. Explore what parent(s) already do to identify what works and what does not
- b. Provide practical tips on how to do specific things that the client is struggling with
- c. Provide psycho-education on relevant aspects relating to the stressors present, e.g. bonding
- d. Get the client to provide detailed descriptions of what happens with a child in relation to what is causing stress. Ensure that the actions of all are described - child, both parents, and other children
- e. Assist the client in building routines and structure for children after psycho-education on this is provided
- f. Explore possible age-appropriate activities that could be facilitated for different children
- g. Explore problematic behaviours and how these could be changed

- h. With the parents, look at their discipline style and provide inputs in terms of positive reinforcement
- i. Develop a plan with the parents regarding chores for different children as well as rewards
- j. Explore time spent with children and attention given to children by parent(s). Provide psycho-education regarding the importance of dedicated time and attention to children, linked to each child's developmental stage. Assist the client to develop a realistic plan to do this given their available resources
- K. Explore what child-specific needs may be present and how the parent could meet these socially, emotionally, cognitively, and spiritually. Identify easy gains within the client's limitations and build skills for the client in relation to this
- l. Be aware of and explore cultural and gender aspects that may be present
- m. Link building parenting skills to increasing their ability to cope and making things easier for them
- n. Develop a plan for parents to try and follow up on the implementation of this

C. Family problem-solving:

- a. This can be done once safety has been created in the session whereby family members feel free to talk and participate without fear of reprisal either during or after the session. Work may need to be done with parents beforehand to ensure that this is possible
- b. In the session ask individual family members to identify a problem the family is dealing with, which could be external or internal. Each family member could come up with a problem which will be dealt with over the sessions
- c. Get everyone in the family to brainstorm possible solutions to the chosen problem - this is an open and free-flowing process. Write all ideas down on a flipchart
- d. Discuss the pros and cons of the ideas
- e. Get the family to agree on the solution that they will try
- f. Allow time for the family to implement the chosen solution and follow-up
- g. The goal is to get the family to do this process at home on their own, possibly during weekly family meetings that you might help the family to set up

■ PROBLEM SOLVING AND REFERRAL

1. Refer to other service providers for stressors unrelated to the counselling organisation's core business.
2. Link families to resources they could access that may assist in resolving the stressor.
3. Refer to "Family Problem-solving" discussed above with an emphasis on exploring what other family members could do in the problem solving process.

■ CRISIS MANAGEMENT

1. **Contain the client and explore cause(s) of distress:**
 - a. Demonstrate control over the situation, which could include the following:
 - ▶ Take the client(s) to a quiet place
 - ▶ If necessary, offer them water and tissues
 - ▶ Ask the client(s) to take deep breaths
 - ▶ Ensure that you remain calm
 - ▶ Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room
 - ▶ Be reassuring
 - b. Once the client(s) has calmed down, ask them what happened to ascertain the cause of the distress, but continue to contain the client
 - c. Acknowledge, validate, and engage the client with empathetic responses
 - d. Link the current distress to past trauma(s) if a link is clear
 - e. Assess the situation for safety to self, to the client, to others, and from others

- f. Explore how the client has tried to cope, what they have done or are doing, and evaluate the effectiveness of these attempts
- g. Identify other ways in which they could try to cope by looking at the past or perhaps suggesting new ways

2. Skills development:

- a. Breathing exercises, e.g. staccato breathing, focussing on rhythm of breathing, deep abdominal breathing
- b. Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room
- c. Guided imagery
- d. Affect regulation, through assisting client to calm themselves down and manage their reactions
Schedule a follow-up shortly after this meeting which could be face-to-face or telephonic

Isolation

8



DEFINITION:

This refers to a lack of a support network.

What should be assessed in relation to these impacts?

- What support the client has around them including family and friends. Look at both physically close and distant supports
- Participation in social activities - both quantity and quality
- Employment status
- Frequency of contact with support structures
- Level of access to support when needed - quality and quantity
- Comfort level of close relationships in terms of discussing difficulties
- History of factors that may influence level of isolation such as trauma, personality, other events, the client's own behaviour, etc. Look at internal, external, current, and historic factors
- The client's report of isolation
- Draw a diagram reflecting the number and quality of connections, that can be updated over time
- Participation/engagement in sessions
- The client's level of trust in others
- Level of trust in the clinician

Overall strategy agreed on in terms of dealing with isolation:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

■ IDENTIFY AND EXPLORE WITH THE CLIENT THE ROOT CAUSES OF THEIR ISOLATION

1. This could include internal, external, current, and historic causes.
2. This could include linking isolation to past trauma(s) that the client may have experienced.
3. Ask the client how isolation has affected them.
4. Clinicians may need to add to what the client says.

■ SKILLS DEVELOPMENT

1. **Explore with the client what would decrease their isolation and/or increase their level of trust:**
 - a. Set specific goals for the client
 - b. Explore the client's ability to assess safety/risks in terms of reducing isolation (emotional and/or physical) and their willingness to take steps outside of their comfort zone
 - c. Look at the opportunities that already exist in the client's life to reduce isolation. This could include increasing the quality or quantity of existing relationships
 - d. Identify specific areas of interest for the client, things they enjoy or enjoyed in the past. Pay attention to possible triggers; things they are good at, or things that interest them which may be new
 - e. Ask the client to identify where they could participate in or find out about participation in what interests them. If the client struggles, provide suggestions but illicit the client's response first
 - g. Break down what the client will be trying to do into steps which could be linked to sessions, for e.g. "before the next session you will..."
 - h. Follow-up and adjust the plan according to the client's feedback and progress
2. **Trust appraisal skills – the ability to identify when it is appropriate to trust or not. Developing appropriate threat appraisal and increasing vigilance through:**
 - a. Identifying higher risk areas
 - b. Paying attention to how others are behaving
 - c. Challenging the client's high-risk behaviour
 - d. Identifying cues that may lead to a threat and learning to trust one's instincts
3. **Relationship building skills:**
 - a. Clinicians may need to do work at an individual level before working with the family
 - ▶ Explore what the client could do about the situation
 - ▶ Explore the things over which they have control and those over which they do not
 - ▶ Work on how they can deal with their emotional reactions within a conflict
 - b. Explore existing relationship patterns within the family
 - c. Identify what works and does not work. If the client is stuck, offer your own insights of what works and does not
 - d. Role-play with individuals and/or families. Reverse roles then explore how this felt with the aim of clarifying intentions and building empathy
 - e. Keep the client focussed on the outcome they want to achieve
 - f. Explore what they gain from the relationship as a way of balancing negative focus
 - g. Work on increased understanding of differences and the intentions of other family members
 - h. Explore how trust has been eroded and what behaviours are needed for trust to be re-built

4. Communication skills:

- a. This requires a certain level of trust
- b. The goal is to create safe spaces where all members of the family feel that they can speak and be heard
- c. This should be modelled in the session by allowing all members of the family space to talk
- d. Link this to being able to understand where different family members are at, which would allow the client(s) to be more effective parents
- e. Before getting the family to try this, clinicians may need to work with parents on being open to listening to family members without interrupting or reacting negatively, both during and after the session
- f. Work through what respectful communication looks like. Discuss things like active listening, importance of tone, the role of non-verbals, and respectful speaking
- g. Build listening skills through the use of a talking stick, whereby the person holding the stick gets to speak without interruption, while the rest of the family actively listens. Follow this with time to reflect back what the person said. Encourage the family to practice this in the session
- h. Explore the positive aspects of effective communication and the negative aspects of poor communication in families
- i. Get clients to focus on their own emotions when communicating, rather than blaming others. This can be done by getting clients to use the following structure: "I feel... (own emotion), when you do..., because..."

5. Strengthening/building an internal locus of control:

- a. This is linked to empowerment
- b. It can be a slow process starting with small gains
- c. Link this to taking control and responsibility over one's own life
- d. Ask the client to list the things they have control over in their lives (if they list other people, challenge them by asking if they really have control, or rather influence over them?)
- e. Assist clients to differentiate between control over self and control over others
- f. Make a link between locus of control and a torture experience, which focussed on taking control away. In this a way they can reclaim what was taken away from them
- g. Ask the client what they are able and unable to stop
- h. Explore what they have control over such as:
 - ▶ How they behave towards others
 - ▶ How they react to others
 - ▶ What they say
 - ▶ What they think and feel
- i. Differentiate between control and influence. Clients cannot control others, but they have influence over how others react to them, based on their behaviour. They also do not have control over their past experiences, but do have control over and influence on what happens now and going forward
- j. Highlight the client's role in their recovery - they are the "major stakeholders" and although the clinician can assist and influence this, it is the client (not the clinician) that has the power and responsibility over their own recovery

6. Building self-esteem and/or confidence:

- a. Assist the client understand losses in terms of positives, e.g. standing up for one's beliefs against injustice or to help others
- b. Focus on the internal strengths that allowed the client to gain the status and social position that they had before, moving from a focus on external things to internal capacities
- c. Identify and positively reinforce these strengths
- d. Reflect back to the client ways in which they are strong or able in relation to what they do or the roles that they play
- e. Work with the client to identify opportunities to use the skills that they have identified:
 - ▶ These skills could be paid or unpaid

- ▶ Start with small gains such as: keeping their clothes clean or improving their posture
- f. Explore the consequences of remaining stuck in the current position for:
 - ▶ The client's sense of self
 - ▶ Other family members, especially children
 - ▶ The short-term
 - ▶ The long-term
 - ▶ Mood disorders
- g. Explore feedback from others that the client may have experienced (e.g. asking how clients children have responded)
- h. Develop a plan and monitor its implementation

■ **PREPARE THE CLIENT FOR POSSIBLE NEGATIVE EXPERIENCES AS THEY BEGIN TO REDUCE THEIR ISOLATION**

1. **Build the client's resilience in terms of preparing them for possible negative experiences as they attempt to expand their social network.**
2. **Create realistic expectations.**
3. **Emphasise that this may take time and may require several attempts.**
4. **Role-play possible negative reactions from others to prepare the client.**



Anger

9



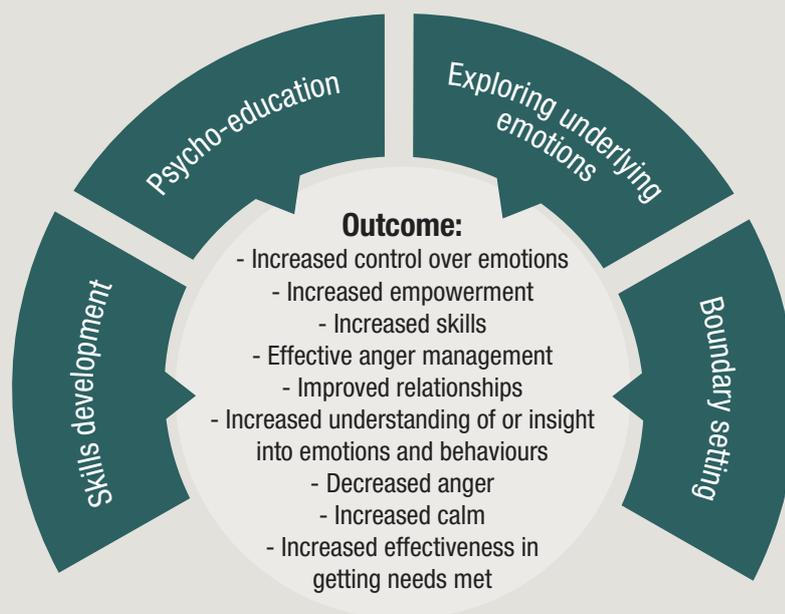
DEFINITION:

This includes both anger towards others and arising from the circumstances that the client finds themselves in. With the former it could include anger at the perpetrators, authority figures, staff of aid organisations, community members, clinicians etc., and include wishes for revenge.

What should be assessed in relation to these impacts?

- What triggers the client's anger
- What the client does when they are angry
- How they manage their anger
- How often they feel themselves getting angry
- The specific situations that lead to anger
- The impact that anger has on them (body, mind, relationships, and emotions)

Overall strategy agreed on in terms of dealing with anger:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

SKILLS DEVELOPMENT

1. Working through an experience of anger:

- a. Ask the client to describe in detail an incident when they were angry
- b. Explore and identify the cues that were present when they were getting angry. These could include thoughts they had, bodily reactions, and ways they behaved
- c. Explore what they understood the other person's intentions were during the incident
- d. Ask them if there was anything they could have done in the situation to stop it from escalating; at what point in the example could they have acted differently?
- e. If the client is having difficulty with this, the clinician could ask "what do you think would have happened if you had done...?"

2. Relaxation techniques in the moment of anger:

- a. Discuss the possibility of walking away from a situation that is escalating. Work with the client to identify when this is the most appropriate thing to do.

3. Finding ways to direct anger towards less destructive outcomes such as:

- a. Doing exercise
- b. Hitting a pillow
- c. Going to another room, such as the bathroom, and breathing deeply
- d. "Shaking it out" of the body

4. Exploring the "self-talk" present during an anger situation and interrogating it – is it true or false, or is there insufficient information to decide? Test and possibly challenge some of the assumptions made.

5. Exploring some of the consequences of anger in general and in different situations relevant to the client.

6. Building assertiveness:

- a. Building assertiveness in the session:
 - ▶ Create spaces for the client to give feedback and respond to these positively
 - ▶ Encourage the client to speak up when they are having a problem with you or the organisation. Next, ask them how it felt to be assertive with you – explore their fears with them
 - ▶ Allow the client a degree of control over when and what to talk about
 - ▶ Ask the client what they need and integrate this into the process
 - ▶ Model good assertive behaviours
- b. Psycho-education in relation to assertiveness:
 - ▶ Assertiveness includes:
 - ➔ Speaking up
 - ➔ Not being passive
 - ➔ Asking for what one needs
 - ➔ Expressing one's needs in a functional, respectful, appropriate manner
 - ➔ Being firm and clear
 - ➔ Decisiveness
 - ➔ Containing emotions
 - ➔ Not being aggressive
 - ➔ Being informed
 - ➔ Using body language and non-verbals effectively

- ▶ Assertiveness lies on a continuum between passiveness and aggressiveness
 - ▶ Different situations require people to lean more towards either side of the continuum. As we go too far towards the ends of either side, we become less likely to obtain what we need from the interaction
 - ▶ People communicate assertiveness with their bodies and words, by the way we speak and the way we carry ourselves
 - ▶ Sometimes new and different contexts require us to be more or less assertive, e.g. the way you would behave at work may be different to how you would behave in church. Similarly, the way you speak to your boss may be different to how you speak to your community elders
 - ▶ People who may have changed countries sometimes need to work on their assertiveness skills as the new cultures they are in might require different responses
 - ▶ When people become more assertive, initially there may be negative reactions from others (such as family members), but these should dissipate over time
 - ▶ Ask clients to describe some of the consequences of being too passive and/or too aggressive
- c. Explore client's past strengths and abilities:**
- ▶ Ask the client to think of a time when they were more assertive or a time when they needed something from someone and how they approached the person. Discuss what did and what did not work
 - ▶ Explore how they spoke, carried themselves, and what they said
 - ▶ Link their example to assertiveness
 - ▶ Explore fears they may have regarding becoming more assertive
- d. Develop clients' assertive verbals and non-verbals:**
- ▶ Demonstrate passive and aggressive postures and ask the client what each communicates
 - ▶ Ask the client what assertive behaviour looks like and build on this. They could be assisted by asking if they know someone in their lives and/or communities who is assertive and what their behaviour looks like
 - ▶ Work with client on:
 - ➔ Looking up – raised head (if eye contact is uncomfortable, look at people's eyes or noses)
 - ➔ Using a clear voice
 - ➔ Using a confident tone (not whispering, not shouting, not hesitating)
 - ➔ Maintaining an upright posture and straight back.
 - ➔ Using context-appropriate eye contact (explore cultural and gender aspects here)
 - ➔ Speaking clearly (unambiguously, direct, precise, taking full advantage of their window of opportunity, need to avoid long story-telling)
 - ➔ Developing a clear, uncomplicated message
 - ➔ Showing respect for the person
 - ▶ Provide clients with information on Victims' Rights as a way of building their knowledge regarding their rights. Refer to: <http://www.npa.gov.za/files/Victims%20charter.pdf>
- e. Role-play with client including repeating scripts if necessary:**
- ▶ Role-play problematic behaviour for the client
 - ▶ Role-play respectful, assertive behaviour
 - ▶ Provide the client with opportunities to practice and/or do homework
 - ▶ Agree on tasks for the client to complete and follow up on progress, exploring difficulties and gains
- f. Build client's ability to assess other people's reactions and alter their behaviour accordingly:**
- ▶ Work with the client on being able to understand what the other person needs in the situation, e.g. respect for their authority or to be treated respectfully)
 - ▶ Ask the client to give examples of people they will need to approach for things and work through what they think the other person would need
 - ▶ Use role-plays to demonstrate and build the client's ability to recognise what the other person means by what they are saying and how they use their body
 - ▶ Ask the client to describe how they know when someone is becoming irritated, angry, or withdrawing from them, in order to build their capacity to recognise other people's reactions early and to respond accordingly
 - ▶ Role-play with the client as a way of practising the above

- g. **Assist client to contain their emotions by:**
 - ▶ Linking emotional containment to being more effective in accessing services
 - ▶ Asking the client to identify the signs indicating that they are getting angry
 - ▶ Once the above signs have been identified, work with the client on how to contain these emotions/reactions by, for example:
 - ➔ Developing awareness of thoughts and feelings
 - ➔ Deep breathing – with visualising exhaling tension
 - ➔ Counting to 10 slowly
 - ➔ Grounding – using an external, tactile object to feel and “play” with during highly emotional situations
 - ➔ Getting clients to remember their ultimate goal
 - ▶ Exploring locus of control by showing that the client is in control of their emotions and how they react to these. While they cannot control what others do, they can control their own reactions to this and can influence others

7. Improving communication skills:

- a. Assist the client to calm down and think before responding, so not saying the first thing that comes to mind
- b. Build listening skills, encourage the client to really listen to what the person is saying before responding
- c. Develop the client’s ability to listen to a person’s underlying message (what is underneath their words)

8. Increasing internal locus of control:

- a. Showing the client that responsibility over anger lies with them, but they are not their anger
- b. This is linked to empowerment
- c. It can be a slow process starting with small gains
- d. Link this to taking control and responsibility over one’s own life
- e. Ask the client to list the things they have control over in their lives (if they list other people, challenge them by asking if they really have control, or rather influence over them?)
- f. Assist clients to differentiate between control over self and control over others
- g. Make a link between locus of control and a torture experience, which focussed on taking control away. In this a way they can reclaim what was taken away from them
- h. Ask the client what they are able and unable to stop
- i. Explore what they have control over such as:
 - ▶ How they behave towards others
 - ▶ How they react to others
 - ▶ What they say
 - ▶ What they think and feel
- j. Differentiate between control and influence. Clients cannot control others, but they have influence over how others react to them, based on their behaviour. They also do not have control over their past experiences, but do have control over and influence on what happens now and going forward
- k. Highlight the client’s role in their recovery - they are the “major stakeholders” and although the clinician can assist and influence this, it is the client (not the clinician) that has the power and responsibility over their own recovery

PSYCHO-EDUCATION

1. The anger curve:

- a. This starts with feeling calm followed by a trigger that escalates our emotions and we begin to feel stressed (often with bodily reactions), our thoughts escalate our angry feelings, we stop listening to what the person is saying, or only hear attacks. As our emotions increase we begin to lose control culminating in an angry reaction. The negative emotions take time to dissipate

2. Consequences of anger. Clinicians may ask the client what these could be, then add:

- a. Negative reactions from others
- b. Damaged relationships

- c. Negative residual emotions that may arise again in other settings or interactions
 - d. Leaves people feeling sad, tired, and sometimes guilty
 - e. High stress can lead to physical problems such as hypertension, cardio-vascular problems, and ulcers
 - f. Isolation - self-imposed or others avoiding you
 - g. Lowered trust - of others or by others
 - h. Lowered impulse control
 - i. Lowered ability to think rationally
 - j. Impaired/poor decision making
 - k. Increased exposure to more trauma (increased exposure to violence from others as a reaction to your anger)
 - l. Increased hopelessness
 - m. Less likely to get what you want
3. **Anger can be useful if transformed into a motivating energy, such as achieving justice. There is a need to clarify when it is useful and when it is not.**
 4. **Anger is often linked to underlying emotions that we find hard to express such as pain and powerlessness.**

■ EXPLORING UNDERLYING EMOTIONS

1. **Clinicians need to build a lot of trust with the client to be able to confront underlying emotions.**
2. **Clinicians must start by acknowledging and validating their client's experiences.**
3. **Ask the client what is causing them to get angry.**
4. **Look for trends in relation to triggers of anger as well as exceptions, e.g. no trigger if there is a woman involved.**
5. **Ask the client what other emotions they feel when they get angry.**
6. **Reflect back on other emotions the client may have felt during the described event, e.g. "that must have been hurtful".**
7. **Link the client's reactions to previous experiences they may have disclosed.**
8. **Ask the client to describe when they began to feel this way.**
9. **Ask the client if there were other times in their lives when they remember feeling so angry.**
10. **Explore with the client how their parents or primary care-givers dealt with anger.**
11. **Explore their thoughts during anger and probe them about where these thoughts come from, so link current feelings to the past.**

■ BOUNDARY SETTING IF THE CLIENT BECOMES ANGRY IN THE SESSION/TOWARDS THE CLINICIAN

1. **Acknowledge the anger, then remind the client that they need to respect you and others, which means containing their emotions and not shouting - something you can assist them with.**
2. **Inform the client that unless they are able to calm themselves, you will not be able to work with them – link to psycho-education on how anger reduces rational thinking.**
3. **Clarify expectations the client has of you or the organisation.**
4. **If anger escalates, involve someone else.**
5. **Ensure that sessions happen at a time when other people are around.**
6. **Leave the door ajar.**
7. **Sit closer to the door.**

Bereavement

10



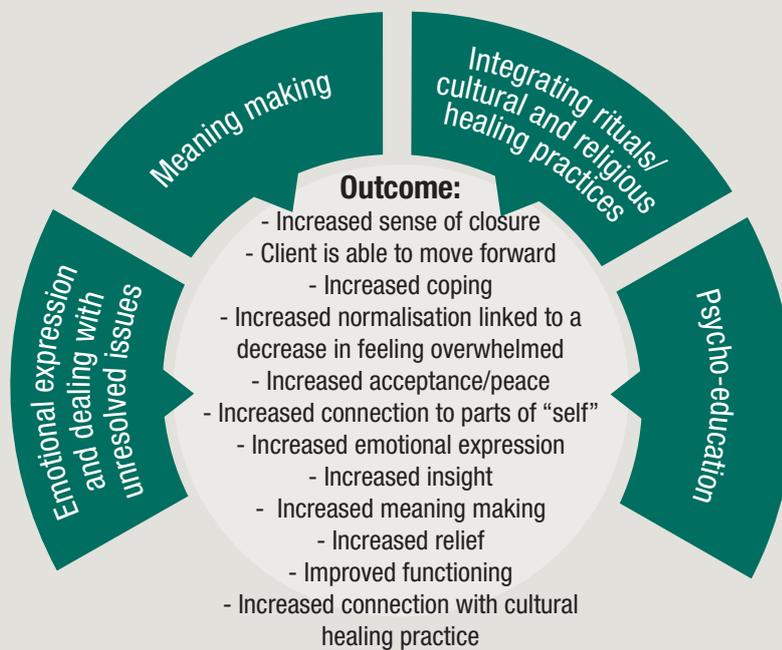
DEFINITION:

This refers to the client's reaction to the loss of someone with whom they had a bond. It may include traumatic and non-traumatic losses.

What should be assessed in relation to these impacts?

- Any significant losses the client has experienced
- The who, when, and how of the loss/es so as to assess for traumatic bereavement
- Which loss/es remain unresolved for the client - in assessing this, the clinician can ask the client which losses remain with them or bring them a lot of pain when they think about it
- This could be done as part of a genogram

Overall strategy agreed on in terms of dealing with bereavement:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

PSYCHO-EDUCATION

- 1. Anniversary reactions.**
- 2. Loss can lead to:**
 - a. Substance use/ abuse as a way of numbing the pain
 - b. Avoidance and denial
 - c. Distraction
 - d. Withdrawal or constantly going out, thereby avoiding or denying support
 - e. Not wanting to talk about the loss or to be asked about it
 - f. Avoiding reminders of the person or the loss, including smells, places, people, etc.
 - g. Sleep disturbances
 - h. Intrusions
 - i. Anger towards: self, others, God, the deceased, and/or perpetrators
 - j. Guilt
 - k. Shock or disbelief
 - l. Thoughts about what one could have done differently
 - m. Questioning why they survived and not the other person
 - n. Ideas of revenge
 - o. Loneliness
 - p. Hopelessness
 - q. Sadness and possibly depression
 - r. A change in roles and responsibilities
- 3. People's ability to cope may depend on:**
 - a. The relationship they had with the deceased, whether this was good, bad, or ambivalent
 - b. The nature or circumstances of the loss
 - c. If some things were left unsaid
 - d. Own traumas and other losses
 - e. Current vulnerabilities or stressors
- 4. How people deal with loss:**
 - a. Speaking about the event with someone they trust
 - b. Exploring the emotions linked with the loss
 - c. Having a contained space where they can talk about it
 - d. Getting additional support from others
 - e. Going at their own pace
 - f. Recognising that the process takes time and will involve some pain which should decrease over time.
Clinician could say: "this is a journey we will travel together"
 - g. Noting that usually the bigger the loss, the more time is needed to recover from it. People can take up to two years to recover from non-traumatic losses, so losses involving trauma could take longer
 - h. Recognising that family members react differently to loss, which is ok
 - i. Noting that some people take longer and sometimes people can seem fine until something happens which causes a setback
 - j. Emphasising that it is important to accept differences in reactions to loss
 - k. Accepting that moving on does not mean forgetting

EMOTIONAL EXPRESSION AND DEALING WITH UNRESOLVED ISSUES

1. Emotional expression:

- a. Do psycho-education first
- b. Build safety
- c. Assess if the client is ready and willing to talk about the loss
- d. Explore the client's fears about talking about the loss
- e. Ask the client what they need to feel supported (in the session, personally, and externally) and work on building this
- f. Reassure the client that the sessions will be conducted at a slow pace where they feel comfortable and contained, and that they can slow or stop the process at any time
- g. The process should be done "bit-by-bit", i.e. one loss at a time
- h. Build containment:
 - ▶ Linking emotional containment to being more effective in dealing with their loss
 - ▶ Asking the client to identify the signs indicating that they are getting emotional
 - ▶ Once the above signs have been identified, work with the client on how to contain these emotions/reactions by, for example:
 - ➔ Developing awareness of thoughts and feelings
 - ➔ Deep breathing – with visualising exhaling tension
 - ➔ Counting to 10 slowly
 - ➔ Grounding – using an external, tactile object to feel and "play" with during highly emotional situations
 - ➔ Getting clients to remember their ultimate goal
- i. If the client becomes uncontained, do crisis management:
 - ▶ Demonstrate control over the situation, which could include the following:
 - ➔ Take the client to a quiet place
 - ➔ If necessary, offer them water and tissues
 - ➔ Ask the client to take deep breaths
 - ➔ Ensure that you remain calm
 - ➔ Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room
 - ➔ Be reassuring
 - ▶ Acknowledge, validate, and engage the client with empathetic responses.
 - ▶ Link the current distress to past trauma(s) if a link is clear.
 - ▶ Assess the situation for safety to self, to the client, to others, and from others.
 - ▶ Explore how the client has tried to cope, what they have done or are doing, and evaluate the effectiveness of these attempts.
 - ▶ Identify other ways in which they could try to cope by looking at the past or perhaps suggesting new ways.
- j. Ensure that tissues and water are available
- k. Link back to the assessment process and ask the client to tell you about the losses they mentioned
- l. Ask the client what happened - look out for traumatic versus non-traumatic, and expected versus unexpected losses
- m. Ask the client to describe the loss in detail
- n. Ask what the worst/hardest part is for them (the clinician may also have some ideas of this) and explore this
- o. Ask about their thoughts, feelings, and behaviours related to the loss
- p. Ask how they feel about the loss now
- q. Clinicians should be listening out for:
 - ▶ Cues of "stuckness" and unresolved issues such as anger, guilt, and blame
 - ▶ Trauma
 - ▶ Any symptoms they may be dealing with
- s. Explore specific areas of concern such as rational and/or irrational thoughts

- t. **Regarding irrational thoughts, examine realistically what the client could have done to prevent the loss:**
 - ▶ Ask the client what was within their control
 - ▶ Ask the client what they could have done differently and what the possible consequences could have been before offering additional ones to what they proposed. For example, often clients will express options that could have put them in more danger
 - ▶ Reality test their thoughts by asking if they actually could have done what they have suggested
- u. **Regarding rational thoughts, examine where they could have done something to prevent the loss or where their actions made the situation worse:**
 - ▶ Ask the client if they would have behaved differently had they known what was going to happen
 - ▶ Link this to what their intentions were - did they intend for this outcome?
 - ▶ Link back to the fact that it would not have been possible to know the outcome. They did their best given what they knew
 - ▶ Explore what they would have done differently if they knew what was going to happen
 - ▶ Validate and acknowledge what the client says
 - ▶ Explore possible forms of reparation and/or apology, which could be symbolic
 - ▶ Explore the client's difficulty to forgive him/herself
- v. **Explore what the deceased person thinks about them or their actions. Clinicians could use the "empty chair" to explore what the deceased would say to the client or what the client would say to the deceased**

2. Dealing with guilt and shame:

- a. **Validate and acknowledge feelings of guilt. It may feel to the client like it would have been easier not to have survived**
- b. **Explore rational versus irrational guilt - refer to the above section dealing with rational and irrational thoughts**
- c. **For feelings of rational guilt, work on acceptance**
- d. **Challenge irrational guilt**
- e. **Explore control over:**
 - ▶ The traumatic incident
 - ▶ Other people's actions
 - ▶ The client knowledge that the incident was going to happen
 - ▶ Who is really responsible for the outcome
- f. **Assist the client accept that their reactions to the incident as automatic and beyond the clients control. They did what they could in those circumstances**
- g. **Complete the "what ifs" of both the incident, as well as future actions they may be thinking about. Add possible consequences to these scenarios e.g. examine the perpetrator's reactions**
- h. **Explore risk-taking behaviour linked to guilt**
- i. **Ask the client why they think they survived, build on positive responses or challenge distorted thinking**
- j. **Explore possible reparations if the client expresses an interest in this**

Unattended guilt may lead to shame, whereby feeling bad about one's actions turns into feeling bad about one's self

- a. **Explore if this is the case for the client**
- b. **Explore negative thoughts about self, linked to the loss**
- c. **Develop alternative scripts to existing ones**
- d. **Addressing guilt is central.**

3. Dealing with anger:

- a. **Acknowledge and validate the client's anger**
- b. **Link anger to feeling disempowered**
- c. **Explore who the anger is directed towards:**
 - ▶ Self
 - ▶ The deceased
 - ▶ The perpetrators

- ▶ The client's family
 - ▶ God
 - ▶ Others
- d. Anger may be linked to a desire for revenge, so explore this
- ▶ Explore the fantasy linked to revenge
 - ▶ If there is a plan, check for level of detail as this is an indicator of intent (the more detail, the higher the intent)
 - ▶ Link feelings of revenge to underlying emotions present e.g. pain or a need to regain control and/or power
 - ▶ Explore consequences of actions, both to the self and others, by asking questions about how they would feel, what would happen to them, and what would happen to those around them?
- e. Check for suicide tendencies
- 4. Focus on current relationships:**
- a. Ask the client about their current relationships
 - b. Question how support can be built now
 - c. Loss can impact on current relationships, explore how this may be the case for the client
 - d. Emphasise the need to find ways to work with the loss, while at the same time being present for others, especially for children. Assist the client in doing this
 - e. Acknowledge that loss can become overwhelming and have an impact on everything
 - f. Remind the client that others are still here now and this could be a reason to live

MEANING MAKING

1. This is about the client making sense of their experience, which may include post-loss growth.
2. This is only done with clients who initiate it during therapy, which may depend on the kind of loss or its context.
3. It should not be imposed on clients.
4. It is a slow process that takes time.
5. The therapist should validate and acknowledge the client's struggles in making sense of the incident.
6. Empathetic listening by the clinician is vital.
7. Respecting the client's beliefs is equally important.
8. Making meaning from the experience without minimising the pain can instil hope in the client
9. The clinician can ask the client what keeps them going despite their difficulties, as they could have given up but have not.
10. Illicit what meanings the client attributes to their experiences. Do not, however, attribute meanings yourself:
 - a. Ask the client why they think these things happened to them
 - b. Be open to different cultural and religious meanings
 - c. Ask the client how their religion/spiritual/philosophical position would explain their situation - they could speak to a religious leader or read the bible. Be cautious around negative explanations that may emerge
 - d. Ask the client how others in their community have made sense of similar experiences
 - e. Ask the client what helped them get through the trauma
11. Explore possible meanings the client has formed about the loss, do they believe:
 - a. It is a punishment
 - b. God caused it
 - c. It was their time
12. Explore whether this meaning is helpful or unhelpful to them in relation to moving forward and managing pain.

- 13. Explore negative/unhelpful meanings:**
 - a. Refer to rational versus irrational thinking (above)
 - b. Link to underlying emotions, e.g. guilt, anger, and shame
 - c. Ask the client if they can think of other possible explanations or meanings for the loss
 - d. Explore cultural or religious meanings
 - e. Illicit positive or alternative reframes
 - f. Explore the issue of control and remind the client that although they do not have control over the loss, they do have control over what meaning they give to it
 - g. Explore how the client could change the meaning of loss e.g. through rituals
 - h. Challenge meanings by asking the client how this has impacted on them; explore their feelings thoughts, and behaviours
- 14. If strong emotions are expressed regarding the meaning of the experience/s, the clinician should contain these, validate them, and explore why they have such strong emotions.**
- 15. There may be no explanation or meaning possible. In these cases, validate and acknowledge the client and contain them. Work on acceptance that there may be no answers right now and reflect on this difficulty.**
- 16. If the client is searching for meaning but is unable to think of any, suggest some possibilities but be cautious not to “rescue” the client by offering these too soon.**
- 17. If meanings are positive/helpful then reinforce, encourage, and validate these.**
- 18. Explore the possibility of there not being any meaning for the loss, we may never know why an incident happened.**
- 19. Ask the client if they feel that the deceased could play a different role in their lives now as, for example, an angel or an ancestor.**

■ **CREATING RITUALS FOR CLOSURE AND INTEGRATING CULTURAL AND RELIGIOUS PRACTICES**

- 1. Ask the client how they would deal with the loss from a cultural and/or religious perspective. Clinicians may ask refugees what they would have done back home.**
- 2. Explore what their family, religious, and/or community practices would entail.**
- 3. Ask the client if they have done any of these yet. If not, ask them how they could do them now, even if they need to be adapted to their current context. This conversation could be generic, but may entail going into detail.**
- 4. Get clients to prepare a letter to the deceased where they focus on saying goodbye.**
 - a. The client should be given the option of sharing it with the clinician if they would like to
 - b. Discuss with the client what they could do with the letter:
 - ▶ Burn it
 - ▶ Place it in a special place
 - ▶ Leave it in a church
- 5. Explore ways in which the client could keep the memory of the person alive, including:**
 - a. Through anniversary rituals
 - b. Story-telling about the deceased to the family, especially younger members

Coping Difficulties and Stress

11



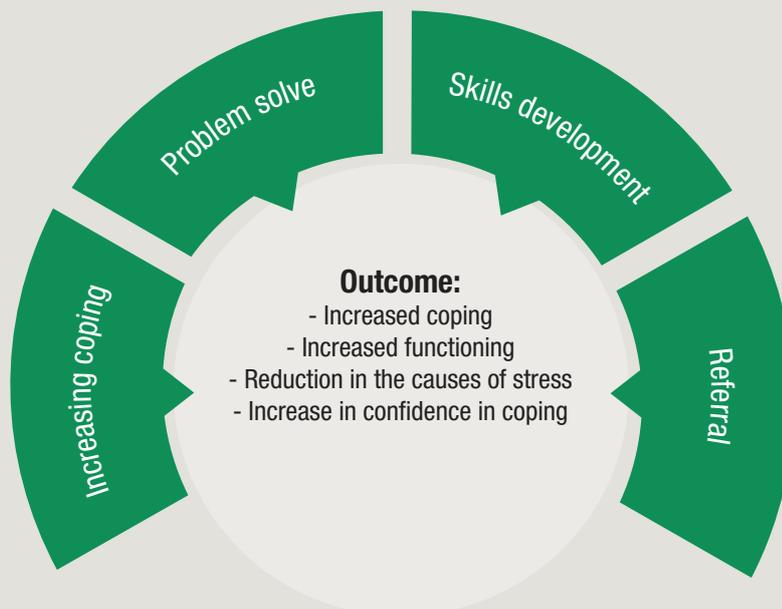
DEFINITION:

This refers to difficulties in coping with current circumstances and may include general coping difficulties, dependency issues, tiredness, feeling overwhelmed, and feeling under pressure. This is a reaction to clients feeling unable to meet all the demands in their lives.

What should be assessed in relation to these impacts?

- The client's current coping and stress level
- Coping skills or mechanisms currently being used
- How long stress and coping difficulties have been present
- Effective, positive coping strategies
- Whether the coping difficulty or stress being experienced is due to torture, current circumstances, or from the past
- Level of impairment the coping difficulty and stress is causing
- The root causes of stress: internal, external, current, and/or historic
- Level of functioning
- Confidence in ability to cope
- Number of stressors

Overall strategy agreed on in terms of dealing with coping difficulties and stress:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

INCREASING COPING

1. Identify the root cause(s) – internal, external, current, and/or historic.
2. Explore how these impact on the client and their family.
3. Explore how the client has tried to cope, what they have done or are doing. Evaluate the effectiveness of these attempts, focussing on what works.
4. Identify other ways in which the client could try to cope, looking at past strategies or perhaps suggesting new ways.
5. Encourage the client to make use of or to connect to social support systems. Ask them who is available to support them, how they could approach them, and explore what kind of support could be asked for.

PROBLEM SOLVE AROUND SPECIFIC STRESSORS

1. Get the client to brainstorm freely about possible solutions to the problem.
2. If the client is unable to, clinicians could provide ideas or guidance in terms of possible solutions, but try to avoid this if possible in order to foster empowerment.
3. Help the client evaluate the ideas that emerge through a pros and cons list.
4. Add suggestions if solutions the client comes up with are problematic.
5. Assist the client in selecting one or two options based on:
 - a. Practicality
 - b. Affordability
 - c. Capability
 - d. Client motivation
 - e. Most pros and least cons
 - f. Gender considerations
6. Develop a plan-of-action with the client. This should be a detailed step-by-step list of things to do that could be linked to a timelines e.g. before the next session. It could be written or agreed upon orally.
7. Allow the client time to implement this plan.
8. Evaluate each step on an on-going basis by:
 - a. Asking what worked
 - b. Asking what did not work and exploring why, including whether this is due to internal and/or external reasons
 - c. Addressing what did not work by building the client's skills
 - d. Alter the plan accordingly

REFERRAL TO ORGANISATIONS DEALING WITH THOSE PARTICULAR STRESSORS REFER TO ACCOMMODATION DIFFICULTIES

■ SKILLS DEVELOPMENT

1. Breathing exercises, e.g. staccato breathing, focussing on rhythm of breathing, deep abdominal breathing.
2. Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room.
3. Guided imagery.
4. Affect regulation, through assisting client to calm themselves down and manage their reactions.

Distress

12



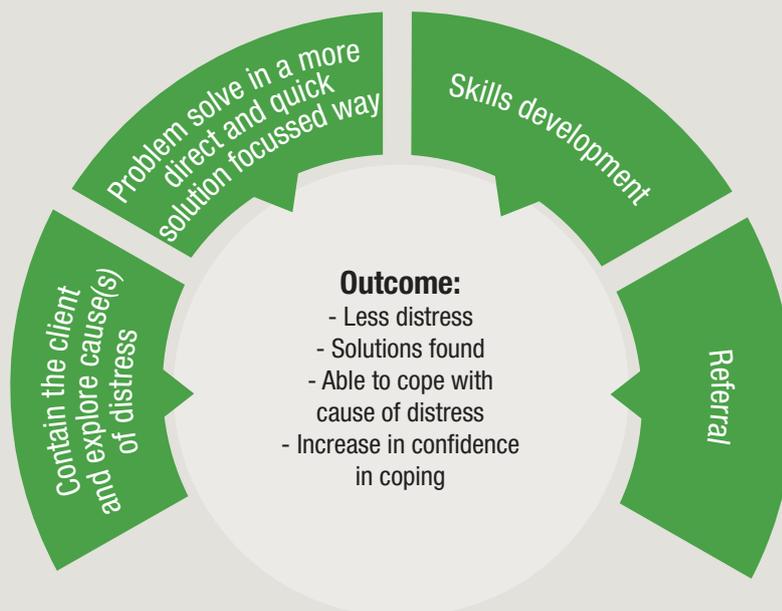
DEFINITION:

This refers to a strong reaction to a current stressor and/or crisis. The client presents as being agitated, overwhelmed, and unable to cope.

What should be assessed in relation to these impacts?

- Speed of talking
- Level of agitation
- Non-verbals such as agitated movements and crying
- Personal hygiene
- Level of calmness
- Ability to find solutions
- Ability to present needs clearly
- Perceptions of personal safety
- Level of containment
- Assessment could also include a Mental Status Exam

Overall strategy agreed on in terms of dealing with distress:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

CONTAIN THE CLIENT AND EXPLORE CAUSE(S) OF DISTRESS

- 1. Demonstrate control over the situation, which could include the following:**
 - a. Take the client to a quiet place
 - b. If necessary, offer them water and tissues
 - c. Ask the client to take deep breaths
 - d. Ensure that you remain calm
 - e. Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room
 - f. Be reassuring
- 2. Once the client has calmed down, ask them what happened to ascertain the cause of the distress, but continue to contain the client.**
- 3. Acknowledge, validate, and engage the client with empathetic responses.**
- 4. Link the current distress to past trauma(s) if a link is clear.**
- 5. Assess the situation for safety to self, to the client, to others, and from others.**
- 6. Explore how the client has tried to cope, what they have done or are doing, and evaluate the effectiveness of these attempts.**
- 7. Identify other ways in which they could try to cope by looking at the past or perhaps suggesting new ways.**

PROBLEM SOLVE

- 1. Get the client to brainstorm possible solutions to the problem, focus on fewer options.**
- 2. Provide ideas or guidance in terms of possible solutions, again, focus on fewer options.**
- 3. Evaluate the ideas that emerge, focus on those with short-term gains.**
- 4. Assist the client in selecting one or two options based on:**
 - ▶ Practicality
 - ▶ Affordability
 - ▶ Capability
 - ▶ Client motivation
 - ▶ Most pros and least cons
 - ▶ Gender considerations
- 5. Develop a plan-of-action, which is a step-by-step process. This should be detailed and could be linked to timelines. It may include clinicians taking action. Options identified may include the clinician taking action.**

REFERRAL TO ORGANISATIONS THAT COULD ADDRESS THE CAUSE OF THE DISTRESS

- 1. Identify and link the client to existing support.**

SKILLS DEVELOPMENT

1. **Breathing exercises, e.g. staccato breathing, focussing on rhythm of breathing, deep abdominal breathing.**
2. **Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room.**
3. **Guided imagery.**
4. **Affect regulation, through assisting client to calm themselves down and manage their reactions.**

Schedule a follow-up shortly after this meeting which could be face-to-face or telephonic.

Mood Disturbances

13



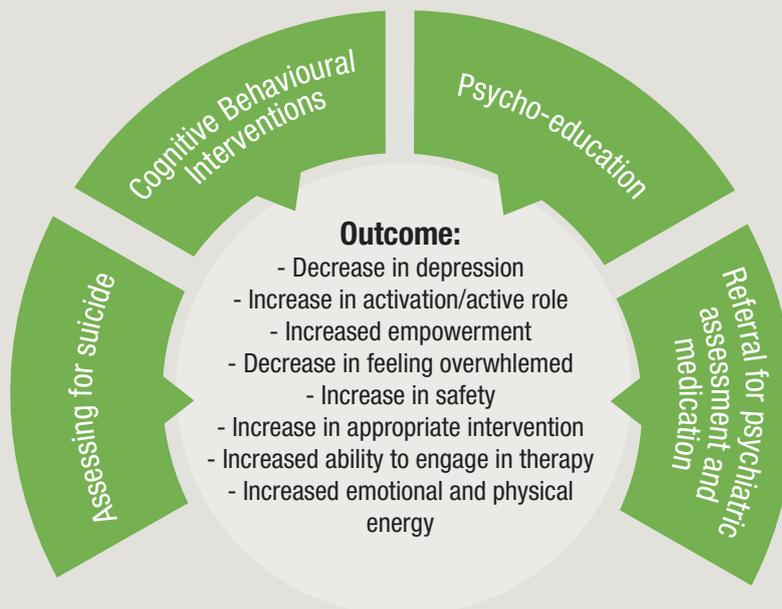
DEFINITION:

This includes any disturbances in mood such as depression, hopelessness, and emotional pain. Within depression, it includes: Major Depressive Disorder, Dysthymia, Current and/or Lifetime Depression, and Major Depressive Episodes.

What should be assessed in relation to this impact?

- Hospital Anxiety and Depression Scale (HADS)
- If depression is present then:
 - How it has impacted on the client
 - The client's energy level
 - Sleep patterns
 - Level of isolation
 - Self-destructive behaviour
 - Appetite
 - Suicide: e.g.: "sometimes when people feel very low they think about death. Have you thought about ending your life?"

Overall strategy agreed on in terms of dealing with mood disturbances:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

ASSESSING FOR SUICIDE

1. **If, either at the initial assessment or during the clinical process, there are indications that the client has had thoughts of suicide, the clinician should ask the client about these.**
2. **Ask details about the following:**
 - ▶ Level of isolation - looking at lack of support
 - ▶ Frequency of suicide thoughts
 - ▶ Previous suicide attempts
 - ▶ Intention to implement thoughts of suicide to ascertain whether these are just thoughts or whether action has been planned
 - ▶ How the client plans to commit suicide. Here the clinician is looking for the degree of detail, i.e. has the client selected a method, a place, a time of day, have they already taken some steps in the plan, e.g. buying relevant materials, etc
 - ▶ What the client plans around their children
3. **Suicide risk could fall within three levels, each with a different approach:**
 - a. **Low risk:** This is when the client has no history of attempts, is not psychotic, has some thoughts of suicide but no plan or intention
 - ▶ Do psycho-education especially on the link between depression, hopelessness, and suicide and hence the importance of dealing with depression
 - ▶ Normalise their thoughts
 - ▶ Provide skills development on thought stopping and distraction
 - ▶ Establish a contract with the client (this can be verbal) that they will not commit suicide until the next session and determine what they should do if the thoughts escalate and they begin to develop a plan e.g. letting the clinician know and/or going to a friend
 - ▶ Follow up with the client in relation to this
 - ▶ Consult with a psychiatrist to inform treatment planning and referral needs. The psychiatrist will decide whether or not they would need to see the client
 - b. **Medium risk:** This is when the client may have some history of suicide attempts, psychiatric conditions may be present, there is some idea of a plan with some intention to implement it, and they are isolated and/or alone
 - ▶ Express concern over the client's safety
 - ▶ Remind the client about the limitations to confidentiality and that you may be required to act if you feel they are in danger, even from themselves
 - ▶ Work with the client to identify a support person that they could go to if they feel overwhelmed
 - ▶ Contract with the client (preferably in writing) that they will not hurt themselves until the next session, and that if they feel overwhelmed, they will go to the agreed support person
 - ▶ The clinician may need to work with the identified support person by providing them with information on what to do if the client is suicidal
 - ▶ Do psycho-education with the client and support person on symptoms to watch out for e.g. an increase in thinking and talking about death, developing a more detailed plan, an increase in intention to complete the plan, feeling overwhelmed and hopeless, disorganised behaviour and speech, etc.
 - ▶ Provide information on where to go in such an instance, e.g. the emergency room of hospitals. Identify the closest major hospital to the client and prepare them for what to expect at the hospital e.g. queues, slow process, and procedure. Highlight the importance of the client or support person providing clear information to the hospital staff. Refer to the "Difficulty with service providers" section if this is an issue for the client. Provide a letter to the client and/or the supporter to take with them to the hospital

- ▶ Monitor the client closely through more contact and/or closer scheduling of sessions
 - ▶ Consult with a psychiatrist telephonically to help differentiate between medium and high suicide risks. For medium risk cases, refer the client to a psychiatrist, who can start medication treatment. Assist the client with access to medication and write a referral to a community clinic for continued care, including information regarding care from the counselling centre. Clinicians should keep in contact with the community mental health clinic; they should ask to speak to the head nurse, and write letters to give and ask for feedback, as well as any client specific medical factors that may influence treatment
- c. **High risk:** This is when the client is actively suicidal
- ▶ Do not allow the client to leave the session
 - ▶ Express concern over their safety
 - ▶ Remind them about the limitations to confidentiality and that you may be required to act if you feel they are in danger, even from themselves
 - ▶ Inform them that this is the case now and you feel that they need to be admitted to hospital
 - ▶ Consult with a psychiatrist telephonically to help differentiate between medium and high suicide risk. For high risk cases, the psychiatrist will help with admission to hospital and provide practical after-care management.
 - ▶ Attempt to get the client's consent to being admitted to hospital
 - ▶ Contact the client's support person to assist and to ensure that someone knows where the client will be placed
 - ▶ If the client consents and the support person is with them, provide money for them to go to hospital. This should only be done if the clinician is 100% certain that the support person will take the client to the hospital. Alternatively, call 10111 for an ambulance
 - ▶ If the client does not consent, call the police
 - ▶ A clinician could decide to not admit client to hospital if:
 - ➔ The client is able and willing to contract not to hurt themselves, even if it is only until they return the following day
 - ➔ The client has people that can watch them 24/7 and intervene if the client becomes actively suicidal
 - ➔ The clinician and client are able to schedule daily appointments until the suicide risk is contained

■ PSYCHO-EDUCATION

1. **Depression as a continuum; ranging from sadness, to depression, to major depression.**
2. **Depression is a form of extreme sadness.**
3. **Common reactions when people are depressed include:**
 - a. Withdrawal and isolation because of low energy. However, this is a vicious cycle as withdrawal and isolation lead to an increase in depressed feelings
 - b. Not wanting to take care of themselves e.g. not washing themselves
 - c. Loss of interest and/or enjoyment in things they used to enjoy
 - d. Sad and/or negative thinking, which lead to negative feelings, thereby increasing negative thinking in a downward spiral
 - e. Low energy level
 - f. Sleep disturbances
 - g. Low or no motivation
 - h. Slowed down movements
 - i. Feelings of hopelessness
 - j. Feelings of guilt
 - k. Crying
 - l. Numbness
 - m. Exhaustion
 - n. Negative self-talk, e.g. "I am worthless", "I have no purpose", or "life is not worth living"
 - o. Small tasks seem daunting
4. **There may be some gains as well (e.g. receiving sympathy) but these are usually not long-lasting.**

5. The biochemical link of depression is that it affects the chemicals in our bodies and, as such, we may need to get medication to stabilise mood and assist with coping. There are, however, things we can do to increase the chemicals that help prevent depression, such as exercising.
6. Depression can lead to substance use, abuse and dependency as a way of coping. However, some substances, such as alcohol, are depressants that can increase depression.
7. Things that can make depression worse:
 - a. Isolation
 - b. Confinement to small spaces
 - c. Having other depressed people around
 - d. Lack of support

When talking of things that can make depression worse, note that:

- ▶ The things people want to do while they are depressed are often the things that can make the depression worse
- ▶ Depression is not permanent, people don't always feel this way and it is possible to find a way out
- ▶ There may be triggers to a depressed mood, e.g. anniversaries of losses or traumatic events
- ▶ Depression, when linked to hopelessness, can lead to thoughts of suicide

8. Things that help people who are depressed include:

- a. Exercise
- b. Slowly expanding one's world
- c. Taking care of oneself
- d. Developing schedules and/or routines
- e. Changing one's thoughts
- f. Getting support from others
- g. Medication – sometimes

All the above require energy, which is often very difficult when feeling depressed. It will take time and effort, but it is possible to work through depression

REFERRAL FOR PSYCHIATRIC ASSESSMENT AND ASSISTANCE WITH ACCESS TO MEDICATION

1. If the client is unable to engage in the treatment process due to debilitating psychiatric factors (e.g. severe depression, psychosis) or risk scores remain high after a few sessions/the next assessment, the client should be referred to a psychiatrist for assessment.
2. If medication is recommended, the psychiatrist will initiate this, assist with access to medication, and write a referral to a community clinic for continued care, including information regarding continued care from the clinician. The clinician should keep in contact with the community mental health clinic, speak to the head nurse, and write letters to give and ask for feedback about any client specific medical factors that may influence the treatment. In addition, the clinician should ensure that the client has continued access to necessary medication.

COGNITIVE BEHAVIOURAL INTERVENTIONS

1. Encourage the client to exercise:
 - a. Ask the client what forms of exercise they did before
 - b. Encourage them to do the identified exercise
 - c. Work with them to identify opportunities around them for exercise
 - d. Remind the client that exercise is a way to reduce depression
 - e. Validate and acknowledge the difficulty in starting to exercise again
 - f. Identify small, attainable goals, even if this is doing some exercise at home
 - g. Obtain an agreement from the client on their exercise plan

- h Monitor the plan
 - i. Remind the client that they need to find energy in order to deal with the depression
- 2. Encourage the client to participate in external activities:**
- a. Work with the client on how they can do this, whether with an individual or a group, or even doing something in a public space, e.g. watching a community activity
 - b. Develop a plan and an agreement to implement it with the client
 - c. Monitor the plan
 - d. Identify free or low cost events that the client could attend
 - e. Establish what activities the client benefitted from previously and identify whether these activities are possible in their current situation
 - f. The clinician could suggest voluntary work to the client, but be careful that the client does not become more depressed by e.g. working with destitute children
- 3. Relaxation exercises**
- a. Deep breathing with open eyes
 - b. Guided visualisations by the clinician, which focuses on positive images
 - c. Slow movement with breathing
- 4. Cognitive work:**
- a. Ask the client to identify and discuss their thought patterns when alone
 - b. Identify their most prominent thoughts
 - c. Ask the client to describe the process of their negative thoughts, how they start and then develop
 - d. Assist the client by asking them what triggered their negative thoughts; ask what they thought after that, and so on
 - e. Make links between thoughts and feelings
 - f. Ask the client how they felt when they were having the negative thoughts
 - g. Work with the client on thought stopping; identify opportunities to stop and distract the negative thought by thinking of something else. Ask the client to think of a positive thought, image, or sentence that they can use instead
 - h. Develop new thoughts that directly contradict the client's negative thoughts. For example, "I am worthless" could be replaced by "I am worthy" or, if the client is very depressed, it could be other thoughts like "I will not always feel this way"
 - i. Practice in the session with the client using what they bring and say as examples of negative thinking and how they could stop or alter these
 - j. Work with the client to identify when they use words like "always" and "never" and how these can be stopped
- 5. Focus on the positive:**
- a. Reinforce the client's strengths by reminding them of what they have done and are doing despite the depression, e.g. getting help, taking care of others, or sorting out difficulties
 - b. Remind the client of times when they did not feel so depressed to reinforce that they can feel better
 - c. The client may have recovered from depression before, if so, remind them that they have the capacity to recover

Trauma Reactions and Intrusions

14



DEFINITION:

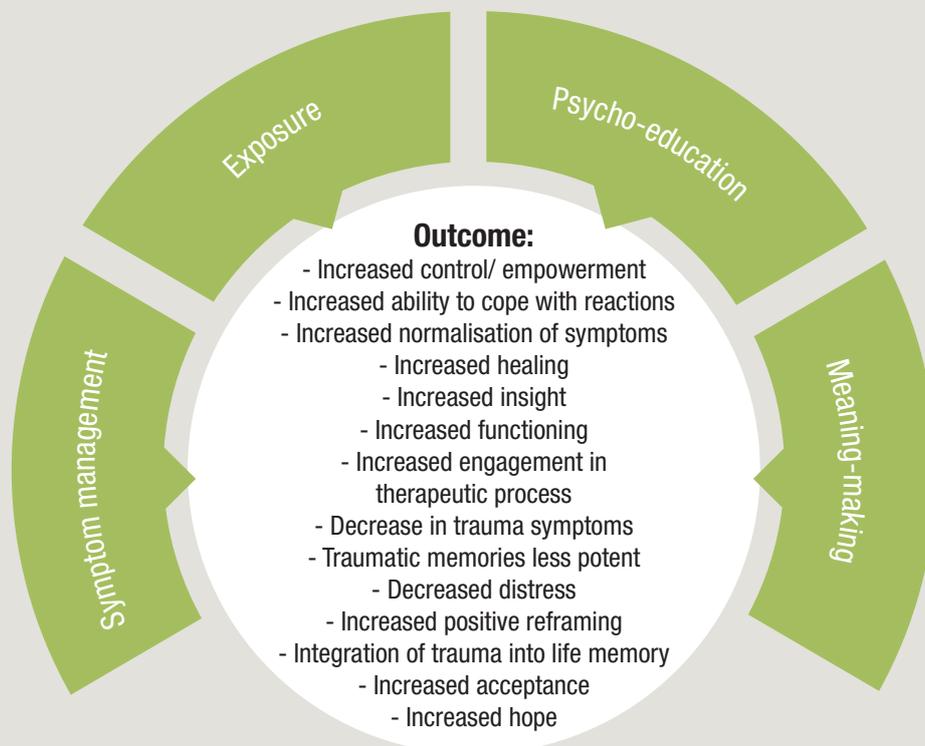
Trauma reactions include the presence of trauma-related symptoms, Post-Traumatic Stress Disorder, and Acute Stress Disorder. It may refer to current and/or lifetime prevalence.

Intrusions refer to involuntary thoughts, images or ideas that clients experience in relation to traumatic experiences. It includes flashbacks and recurrent thoughts related to the trauma.

What should be assessed in relation to this impact?

- Changes noticed by the client in themselves since the torture and other significant events
- Triggers
- Trauma symptoms, including PTSD
- How these symptoms have impacted on the client's relationships
- Trauma history
- Traumas which bother the client the most, or currently impact on them
- Effect on the client's functioning, including interpersonal relationships including at work/school, and family life

Overall strategy agreed on in terms of dealing with trauma reactions and intrusions:



DETAILED STRATEGY:

Once a detailed assessment is conducted, the clinician will be in a position to decide which intervention is the most appropriate for their client. The following options are available to clinicians:

■ PSYCHO-EDUCATION

1. Link to the client's assessment results, i.e. focus on what is more relevant to them.

2. These are some of the things that people who have been through trauma experience afterwards:

a. PTSD can cause many symptoms which can be grouped into three categories:

▶ Re-experiencing symptoms:

- ➔ Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
- ➔ Bad dreams
- ➔ Frightening thoughts
- ➔ Re-experiencing symptoms may cause problems in a person's everyday routine. They can start from the person's own thoughts and feelings or from words, objects, or situations that are reminders of the traumatic event

▶ Avoidance symptoms:

- ➔ Staying away from places, events, or objects that are reminders of the traumatic experience
- ➔ Feeling emotionally numb
- ➔ Strong feelings of guilt, depression, or anxiety
- ➔ Losing interest in activities that were enjoyable in the past
- ➔ Having trouble remembering the traumatic event
- ➔ Things that remind a person of the traumatic event can trigger avoidance symptoms and may cause them to change their personal routine. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car

▶ Hyper-arousal symptoms:

- ➔ Being easily startled
- ➔ Feeling tense or "on edge"
- ➔ Having difficulty sleeping, and/or having angry outbursts
- ➔ Hyper-arousal symptoms are usually constant, rather than being triggered by things that remind one of the traumatic event. They can cause the person feel stressed and angry and may make it hard to undertake daily tasks such as sleeping, eating, or concentrating
- ➔ It is natural to have some of these symptoms after a dangerous event. Sometimes people have very serious symptoms that disappear after a few weeks. Some people with PTSD don't show any symptoms for weeks or months

b. Guilt

c. Anger

d. Shame and humiliation

e. Loss of the sense of self, material possessions, recognition and position in society, family, community and identity

Note that some of these apply more specifically to refugees

f. Substance use/abuse as a way to deal with the pain

g. Questioning of or turning to faith/spiritual beliefs

h. Many or all of these reactions can be transferred from parents to children

i. Family members can also be affected, even if they did not directly experience the trauma

j. Certain triggers may make people feel like they are back in the event, as if it is happening again. These could be sights, sounds, and/or smells

- k. People have different reactions during trauma:
 - ▶ Freeze
 - ▶ Fight
 - ▶ Flight
 - ▶ Posturing
 - ▶ Tend and befriend
- l. Torture-specific reactions such as pain and injuries
- m. Define torture according to the United Nations Convention Against Torture (UNCAT) and ask the client why they think torture happens. Add to the client's explanations:
 - ▶ To punish someone - either directly or indirectly
 - ▶ For broader political reasons
 - ▶ To create fear and gain control of a population
 - ▶ To obtain information
 - ▶ To intimidate
 - ▶ Try to make the discussion more specific to the client and their experience
 - ▶ Link their experience to a broader torture context
- n. There are a number of risk factors that influence the impact of trauma. Some of these include:
 - ▶ Additional stressors e.g. economic difficulties
 - ▶ Isolation
 - ▶ Safety risks
 - ▶ Poverty
 - ▶ Lower education level
- o. Things that help, or protective factors include:
 - ▶ Becoming aware of the triggers, which are reminders of the trauma and can cause a strong reaction
 - ▶ Having a trusted person that the torture victim can talk to about difficulties
 - ▶ Asking for help when this is needed
 - ▶ Identifying places of support and expanding these, e.g. asking for more support from friends or engaging more in groups where one feels supported
 - ▶ Remembering strengths from before the trauma and using them now
 - ▶ Building social support networks
 - ▶ Looking after one's self, e.g. sleeping well, eating properly, and doing exercise
 - ▶ Getting help from professionals such as the counselling centres

■ PREPARING THE CLIENT FOR TRAUMA EXPOSURE

1. Note that healing takes time.
2. Emphasise that the client may have already taken the first step.
3. Time alone does not always heal, but dealing with the trauma does.
4. For some people the wound is so deep that the pain never disappears completely, but they learn to cope and feel less pain than at the beginning.
5. For others the wounds can heal in a way that they will always have a scar (the memory remains) but the trauma is not overwhelming and they can move on with their lives.
6. Part of the healing process involves talking about the difficult or traumatic experiences, but it is done at the client's pace and they can stop it at any time - the client is the driver.
7. Trauma healing is similar to healing a wound, like a cut. When it is cleaned, there can be a lot of pain, but that is necessary for the wound to heal. If the wound is covered up without treatment, it can get infected

and become a much bigger problem. Similarly, trauma counselling can be a painful process, but the pain is necessary for healing.

8. The client may have reactions to talking about the trauma, but these will be managed carefully.
9. The clinician's role is to accompany the client along the healing journey. The clinician must make sure that the client is able to cope with the therapy and may stop or slow down the process at any time.
10. The healing process may have some "ups" and "downs".
11. Therapy may include working on how the client thinks, behaves, and feels.
12. The clinician will travel with the client along the healing path until a point is reached when the client feels that they are able to walk on their own.
13. The client is the major stakeholder in their recovery, which they can influence in many ways.
14. There are no quick-fixes. Although the clinician might wish they could give the client a pill to aid recovery, that is not how the healing process works. Trauma pain is different to pain in the body and the clinician works differently to a doctor.

■ SYMPTOM MANAGEMENT AND SKILLS DEVELOPMENT

1. Managing intrusions:

a. Psycho-education:

- ▶ Intrusions are like an intruder in the mind
- ▶ People often have little or no control over these thoughts, especially over when they appear
- ▶ Sometimes it feels like the client is re-experiencing the traumatic event
- ▶ This may lead the client to avoidance behaviour, which is exhausting
- ▶ With trauma, memories can "get stuck" and keep recurring. This is because they have not been processed
- ▶ Traumatic memories are more difficult to process by the brain because they are linked to strong emotions
- ▶ Our brains try to organise memories and close any gaps
- ▶ The client may experience triggers that take them back to the event and make them feel like it is happening again. These can be something they see, hear, or smell that reminds them of the event
- ▶ Intrusions may lead to sleep disturbances
- ▶ They can also occur when the client is awake
- ▶ They are often unexpected and can lead to:
 - ➔ Anxiety
 - ➔ Heart palpitations
 - ➔ Irritability
 - ➔ Worry
 - ➔ Low concentration
 - ➔ Insomnia
 - ➔ Panic attacks
 - ➔ Mood swings
 - ➔ Tiredness
 - ➔ Frustration
 - ➔ Strained relationships
 - ➔ Isolation

b. Containing the client if intrusions happen during the session:

- ▶ The therapist must retain a calm presence
- ▶ Demonstrate control over the situation, which could include the following:
 - ➔ Take the client to a quiet place

- ➔ If necessary, offer them water and tissues
 - ➔ Ask the client to take deep breaths
 - ➔ Ensure that you remain calm
 - ➔ Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room
 - ➔ Be reassuring
 - ▶ Let the client know that therapy is a safe place where they can express their emotions. It is a container where the client can leave their emotions
 - ▶ The clinician must reassure the client of their experience, training, and support in doing their work. The client must be reassured that the clinician will be able to manage their healing process
 - ▶ The clinician should be aware of counter-transference in relation to avoiding work with difficult material
- c. Grounding techniques:**
Use grounding techniques if necessary, e.g. touch the client if appropriate e.g. put hand on their shoulder or getting them to focus on something in the room. Get the client to practise these so that they can do them on their own
- d. Relaxation exercises:**
- ▶ Breathing exercises, e.g. staccato breathing, focussing on rhythm of breathing, deep abdominal breathing
 - ▶ Guided imagery
- e. Increasing mindfulness:**
- ▶ The client needs to be guided in identifying the triggers to their intrusions and noticing what happens in their minds when the intrusions happen
 - ▶ The clinician should point out reactions the client has in the session as a way of demonstrating mindfulness. For example “see how you are...”
 - ▶ Once the client identifies their reactions and triggers, the clinician can help them work on developing a sentence that they could repeat when the intrusion happens. An example could be “I am OK. I am not back there”
 - ▶ This is about taking a step back in the situation and becoming an observer who notices what is happening
 - ▶ The clinician may ask the client to identify an object that they could focus on when intrusions occur. If the intrusions often come at home, this could be something in the house. If they occur outside, the client could find an object they keep in their pocket and feel – explain that tactile objects help people return to/ stay in the present
 - ▶ The above can be practised with the client during the session

2. Managing avoidance:

- a. Often people who have been through trauma attempt to avoid the experience. This may mean attempting to not think or talk about it and avoiding people or places that may remind them of it
- b. Although avoidance may feel better initially, it does not allow the client to process the traumatic experience and to gain control or mastery over it
- c. If the client has engaged in avoidance, the clinician could ask if it has made the trauma disappear. Explore whether avoidance has been helpful
- d. Avoidance has costs and benefits to the client. Discuss these with them
- e. In some ways the client may benefit from avoidance, especially when they don't feel that they are in a safe environment or when there is no one they trust to speak to about the trauma
- f. Some impacts of avoidance include:
 - ▶ the feeling of carrying a heavy burden alone
 - ▶ increased shame and guilt
 - ▶ impairment in relationships
 - ▶ In situations where speaking about the trauma might be to the client's benefit (e.g. at Home Affairs, UNHCR, or in court) and they cannot do so, they may become even more vulnerable as they are unable to access help

- g. Explore the ways in which the client displays avoidance. Is it places, people, and thoughts including memories?
- h. Link avoidance to the continuation of torture, where life is restricted
- i. Highlight that avoidance and its consequences can be exhausting
- j. Avoidance does not make the trauma go away. It is like a pressure cooker that could explode at a later stage in ways that the client cannot control
- k. A cycle can develop whereby avoidance leads to a bigger fear of talking about it. This, in turn, leads to more avoidance, over which more fear gets added
- l. Avoidance sometimes makes an individual think they are coping when you are not
- m. If the client has specific avoidance behaviours, the clinician can help them develop a strategy to deal with them. For example, if the client avoids men, then start breaking down the generalisations they have about men
- n. Acknowledge and validate that avoidance is there because the client does not want to expose themselves or others to what happened, as it was horrific
- o. Explore the gains of non-avoidance. Processing the trauma means that the client won't have to spend so many resources on trying to avoid dealing with it

MEANING MAKING

1. This is about the client making sense of their experience, which may include post-traumatic growth.
2. This is only done with clients who initiate it during therapy, which may depend on the kind of trauma or its context.
3. It should not be imposed on clients.
4. It is a slow process that takes time.
5. The therapist should validate and acknowledge the client's struggles in making sense of the incident.
- 6 Empathetic listening by the clinician is vital.
7. Respecting the client's beliefs is equally important.
8. Making meaning from the experience without minimising the pain can instil hope in the client.
9. The clinician can ask the client what keeps them going despite their difficulties, as they could have given up but have not.
10. Illicit what meanings the client attributes to their experiences. Do not, however, attribute meanings yourself:
 - a. Ask the client why they think these things happened to them
 - b. Be open to different cultural and religious meanings
 - c. Ask the client how their religion/spiritual/philosophical position would explain their situation - they could speak to a religious leader or read the bible. Be cautious around negative explanations that may emerge
 - d Ask the client how others in their community have made sense of similar experiences
 - e Ask the client what helped them get through the trauma
11. If strong emotions are expressed regarding the meaning of the experience/s, the clinician should contain these, validate them, and explore why they have such strong emotions.
12. There may be no explanation or meaning possible. In these cases, validate and acknowledge the client and contain them. Work on acceptance that there may be no answers right now and reflect on this difficulty.
13. If the client is searching for meaning but is unable to think of any, suggest some possibilities but be cautious not to "rescue" the client by offering these too soon.
14. Meaning making may include an interest in getting involved in the field as a volunteer - explore this with the client if it emerges.

■ TRAUMA EXPOSURE

1. Why do trauma exposure/what is its value:

- a. Going through the story, although painful, allows one to process/"digest" it, which makes it less potent.
- b. It is a way to "detoxify"
- c. It allows the negative or unhealthy neuro-pathways created by the trauma to become "un-stuck"
- d. It provides clarity about the event, which allows for reframing to occur, thereby altering the meaning given to the event
- e. It facilitates integration of memories and of the event into the client's life story, so these are not seen as separate
- f. It allows the client to make sense of the experience (providing coherence) by completing gaps and clarifying the chronological order and duration of events
- g. It allows the client to break down the event into smaller parts that they can process and cope with
- h. The experience of sharing a horrific event with a containing, empathetic, safe, and caring person frees one from having to carry the memory alone and is, in itself, a potent experience
- i. It increases one's sense of mastery
- j. It can correct distorted beliefs and/or thoughts
- k. It can confirm or validate coping and/or survival skills
- l. If the trauma is not processed, there is a danger that it will remain present and may emerge at any point and/or continue to influence the client's functioning

2. When not to do exposure:

- a. When the client is experiencing any crisis, e.g. xenophobic attack, forcible removal, uncertain and/or unsafe accommodation conditions, divorce, bereavement. The immediate crisis should be addressed or contained first
- b. When the client is psychologically unsafe:
 - ▶ Has a weak ego
 - ▶ Is uncontained
 - ▶ Dissociation or other forms of psychosis are present
 - ▶ Is suicidal
- c. When the client is extremely isolated and does not have anyone to support them
- d. When insufficient trust has been built between the client and the clinician
- e. Insufficient containment and safety exists between the client and the clinician
- f. When the clinician is not functioning in a contained, strong place
- g. When the clinician has gone through the steps in the psycho-education process highlighting the pros and cons of trauma exposure and the client still refuses

If any of these are apparent, the clinician may need to ask the client to stop telling their story, explain why it may be harmful for them to continue at this stage, and what needs to be done in order for the healing process through trauma exposure to take place.

3. What needs to be in place before exposure is done:

- a. With respect to the clinician:
 - ▶ A clear sense of the purpose of doing exposure for each client
 - ▶ Confidence in their ability to cope with and react appropriately to the client's story
 - ▶ Trust in the process, remembering that it may get worse before it gets better
 - ▶ Readiness to embark on the process
 - ▶ An awareness of possible "hooks" that may trigger counter-transference reactions
 - ▶ Mindfulness
 - ▶ A support system
 - ▶ A realistic awareness of how hard the process is

- ▶ An awareness of and preparation for possible reactions
 - ▶ An ability to be completely present without distractions or day-dreaming
 - ▶ An acceptance of one's own reactions and a willingness to deal with these proactively
 - ▶ Training in and the ability to conduct exposure
- b. With respect to the client:**
- ▶ Commitment to treatment and the process
 - ▶ Skills to contain themselves such as breathing, grounding, and boundary setting. An ability to open up and close within and between sessions
 - ▶ A capacity to cope with exposure, which includes a low risk of the client fragmenting or disintegrating in the process
 - ▶ The existence of pre-trauma functionality
 - ▶ Lack of severe psychological or psychiatric conditions e.g. depression, personality disorders, psychosis, and substance abuse
 - ▶ Other psychological or psychiatric conditions have been treated and contained
 - ▶ Understanding of the purpose and process of exposure, which is linked to the client's own objectives
 - ▶ Exposure readiness to embark on the process
 - ▶ Ability to regulate the affect which may need to be built
- c. In the relationship between the client and the clinician:**
- ▶ Confidentiality must be present and understood
 - ▶ There is trust that the clinician will be able to cope
 - ▶ The client is able to give feedback to the clinician i.e. to stop the process if necessary
 - ▶ There is a sincere connection, which includes openness and honesty
 - ▶ The clinician has been "tested" with other events and shown to have an ability to cope and contain the client
 - ▶ An empathetic acceptance exists
 - ▶ There is mutual confidence in each other's ability to manage the process
 - ▶ A non-judgemental space and relationship has been established

4. Trauma exposure:

- a. The clinician should look out for the following:**
- ▶ The sequence of events
 - ▶ Indicators of "hot-spots" where the client "gets stuck", obsesses about or avoids certain parts
 - ▶ Gaps in the story or memory
 - ▶ What the client reacts strongly to - notice emotional reactions, non-verbals, discomfort level, pauses, avoidance, and the speed of speech
 - ▶ Assess the client's ability to contain themselves, that is affect regulation
 - ▶ Assess one's own reaction and consider pausing the process if a break is need
- b. Obtain the story of the client's life. The clinician could ask "I would like to get a sense of your life before and after the torture. Can you tell me about that?"**
- c. If client is stuck, the clinician could ask: "are there any major events (both positive and negative), that happened to you before and after the torture?"**
- d. Follow the client's lead in terms of what they come up with**
- e. Once there is an overview, the clinician could say: "Now that I have a sense of what happened before and after, let us talk about what happened during the torture"**
- f. The clinician should first obtain an overview of the event from beginning to the end - it is important that the client ends the story at a point in which they no longer felt threatened. The first description does not need to be detailed, the clinician will ask for more details later**
- g. The clinician may ask clarifying questions regarding the order in which things occurred**
- h. Time can be explored, i.e. how often did events happen, when/ what happened, how long did events last?**
- i. If the client is not coping, they should be contained**

- j. The clinician may reflect back to the client when a strong reaction is noticed and indicate that further exploration of this may be beneficial in the future
- k. Check in with the client in terms of how they are feeling
- l. The clinician could develop a signal with the client to indicate when they would like to pause or stop the process
- m. Validate and acknowledge the client's experience
- n. Do active and containing listening
- o. Acknowledge the intensity of the process and the story
- p. Once the initial overview has been done, check with the client to ensure that they are willing to explore the trauma in more detail. There may be a need to do more containing training and/or symptom management with the client before proceeding
- q. Recap the initial narrative for the client, which demonstrates active listening on the part of the clinician
- r. The detailed exploration of the trauma could focus on what the client considers to be the worse part and/or other parts of the story that the clinician identified as significant
- s. Once relevant, parts from the client's story are selected for more discussion by asking the client to describe what happened in greater detail. During this process the client could be asked about sensory experiences that may have accompanied the event, e.g. sounds, smells, sights. They could also be asked to describe their thoughts, feelings, and what they did during the event
- t. The clinician should decide where in the story to start. For some clients it may be appropriate to start at less significant parts of the trauma, moving gradually towards exposure around the worse part. For others, the most significant parts may be appropriate to begin with immediately
- u. Trauma exposure could take several sessions and the clinician will need to guide the process carefully to ensure that the client is engaging in healthy affect regulation and feels contained between each session. Given the additional stressors the client may be dealing with, containment is of utmost importance
- v. Inform the client when the session's time is nearing the end so that they can calm down and slow the process accordingly
- w. Provide psycho-education regarding how the client might feel now that they have started with exposure
- x. Work with the client to develop supportive activities after the session e.g. breathing exercises, seeing particular people they feel safe with or doing certain activities they enjoy
- y. If the client struggled with containment, consider scheduling another session within the next few days
- z. During exposure work the clinician must leave time at the end of every session to contain the client

5. Trauma exposure and repeated victimisation

- a. Conduct psycho-education regarding the impact of repeated victimisation including the cycle of victimisation, i.e. that people who have been victimised are more likely to be victimised again
- b. Collaborate with the client to identify significant traumas that will be dealt with
- c. Assess which trauma is causing the most distress for the client:
 - ▶ Ask the client
 - ▶ Identify the content of their intrusions
 - ▶ Identify where the client may be avoidant
 - ▶ Identify where the client shows heightened emotions
- d. Start with the trauma that has the "least" impact on the client. This will assist with building the client's ability to cope and regulate affect
- e. The clinician may also explore the trauma that the client wants to or is comfortable dealing with
- f. Do trauma exposure as outlined above. The clinician should assess if trauma exposure is appropriate for each of the traumas or not

6. Trauma exposure and families:

Several scenarios exist in relation to torture and families. These include:

- a. One parent being the victim of torture. In this instance, trauma exposure should be done with the primary victim individually first. Next, the clinician should explore with the client if they are interested in including their spouse in the process. This should only be done if it will be helpful to the client or contribute to their relationship with their spouse. Work should be done with the client in relation to possible reactions that their spouse may have. Work should also be done beforehand with the spouse in relation to: psycho-education, symptom management, exposure and exposure readiness, and containment skills. Children should not be included in this process
- b. Both parents are victims of the same incident of torture. Here, the clinician should assess willingness and readiness of both parents to do exposure work together. There may be a need to do exposure work individually first. This is especially important in relation to feelings of blame and guilt that may emerge and could be particularly difficult to address as a couple. Children should not be included in this process
- c. Both parents are victims of different incidents of torture. In this instance, trauma exposure should be done with each spouse individually first before the clinician explore with the clients whether they are interested in including their spouse in the process. This should only be done if it will be helpful to the clients individually or to their relationship. Work should be done with each client in relation to possible reactions that their spouse may have. Work should also be done beforehand with the spouse in relation to: psycho-education, symptom management, exposure and exposure readiness, and containment skills. Children should not be included in this process

For the above three points, psycho-education, symptom management, and/or relaxation techniques may be done with the whole family. The aim of this is to increase family members' understanding of the impact of the experience and how they may be able to support their parent(s), without going into the details of what happened

- d. Children victims of torture. This could be directly or indirectly related to the parent/s' incident/s. Here psycho-education, symptom management, and/or relaxation techniques should be done with the whole family. Discuss trauma exposure and establish whether the family would like to do this together. Clinicians need to assess whether individual family members and the family as a whole are ready for trauma exposure. Factors that may influence this include: mental health status, age, children's developmental stages, and the children's ability to cope with what happened to their parents. If there is any doubt, do not proceed with trauma exposure collectively. Work may need to be done with the family beforehand in relation to exposure readiness. Prepare the family for possible reactions during the process, discuss individual differences in reaction to similar events, and discuss gender differences and how this may impact on trauma exposure reactions. This may require individual work beforehand and, therefore, additional time

Trauma exposure with a family can lead to increased family support and understanding of individual family member's experiences. It needs to be done with caution and preparatory work is essential to ensure that the family is able to cope with the process. With larger families, the clinician may consider splitting the family into smaller, age-related groups

CONCLUSION

This model represents an attempt by the CSVR to detail the way in which its clinicians can best address the needs of victims of torture that seek the CSVR's assistance. It is one component of the intervention process that includes assessment, treatment-planning, on-going review, monitoring, and supervision. The model is limited to those impacts found to be most common and with the most negative impact on victims of torture. Other impacts may also be present and should be assessed and included in the treatment-planning process.

It is clear that working within the Johannesburg context poses challenges to the recovery of victims of torture and the way in which clinicians can work to assist them. The current stressors victims experience can be overwhelming and require specific attention. Given the limitations that the CSVR has in terms of being able to address them directly, the challenge was to identify the best ways in which the CSVR could impact on the stressors while working with the client. The clinical team was able to specify ways in which the stressors could be tackled providing that all clinicians, regardless of their training or experience, work with the client in order to increase their capacity to resolve the stressors.

The psychological difficulties that victims of torture experience require in depth understanding and specific interventions. It is clear that these are not only focussed on PTSD, but cover other areas such as bereavement, anger, and mood disturbances, which expands our understanding of the ways in which victims of torture are impacted. The combination of torture and current stressors leave victims with complex symptom pictures that cannot be encapsulated solely by PTSD. It is, therefore, important that clinicians working in this field have a variety of skills, experience, and/or training.

Victims of torture also experience difficulties in interpersonal functioning. This requires that clinicians are able to work from a family-systems understanding and, if appropriate, with families. The isolation that clients feel needs to be addressed, often within a threatening, somewhat hostile environment. This poses challenges to clinicians working with victims of torture, which traditional models of intervention do not address.

The CSVR is aware that this model is a work-in-progress and changes to it are both inevitable and expected. We are proud to have been able to outline a model that attends to the CSVR's contextual realities and will assist our clinicians in working with victims of torture. It is hoped that clinicians from other organisations also find it useful.

In the final step of the project the CSVR will attempt to test the model in order to report on its strengths and its shortcomings. This will allow the CSVR to share lessons learnt from implementing the model, and further improve the ways in which victims of torture are treated.



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