Secondary Traumatisation and Counselling of Torture Victims' Family Members

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(Translated by Anika Krstic)

Abstract

The powerful traumatic experience that torture leaves behind results in the development of abundant symptomatology from the field of posttraumatic stress disorder and consequently also in the permanent personality changes not only in the victim, but also in those to whom the victim relies for help and support. Here we shall discuss the secondary victims of torture, mostly family members, as well as close friends from the victim's surroundings and the therapists who work with the traumatised person.

Through the analysis of two therapy case studies of secondary torture victims this paper will discuss the possibilities of therapeutic intervention in the family system of torture victim, focusing not only on the primary victim, but involving secondary victims into the therapeutic process and directing the interventions toward interactions within the family system. This paper stresses the necessity of a comprehensive, systematic approach to therapy both for torture victims and people in their immediate environment.

Forty year old TN, married, father of a son of fifteen and a daughter of eleven, came to the seek therapy in the Centre for Rehabilitation of Torture Victims (CRTV) after having spent seven and a half years in prison. During the first interview he complained about his primary problem being the inability to adapt to the "new life", as he saw the past two months since he had got out of prison.

> "*Everything is so new, different… I feel like a stranger wherever I go… my wife is trying to understand me, but she is also puzzled… she cries… and then I feel even worse… I see she's trying to help me, she is helping me, and than she just stops… I don't know whether she's angry or something… sometimes I think she is and than I feel lost and I withdraw… the worst thing is that the children can see all that… I'm like a stranger to them as well… as if I'm stupid for them, they say I don't understand anything…*"

After these few sentences TN closed, became withdrawn and he looked if h was trying to suppress his tears. I suggest he should come to the next session with his wife. He obviously liked the suggestion and he agreed, but said that his wife was usually very busy.

He came alone to the next session, explaining that his wife was at work and could not come at this time.

> "*She works until late afternoon… I sit, waiting for her… when she comes we sit together and keep silent… she want to ask me something and then she gives up… when I told her that she also needs to come it seemed strange to her, but she wants to…*"

I suggested they come together at a different time that would allow the wife to make it to the session.

A week later all three of us were sitting together; in her presence TN, a strong and handsome man, behaved like a confused child, as if he were constantly apologising to her for something and it was evident that his wife felt uncomfortable with this. The wife, TS seemed like a tired, incessantly worried woman. In our joint discussion both of them found it difficult to verbalise what was bothering them, as if they were both somehow ashamed. Over time they became mo re relaxed and TS began to talk.

> *"The worst is over… now when he's home I thought everything would be fine… while he was in prison I was both mother and father… I was worried*

how the children would live without their father… although my father was also away from home for years, he worked in Germany and came only during summer holidays, for a fortnight… now I don't know what I am, mother, father, wife… I'm sorry to be so confused and crying… I don't know what will happen to us…"

Both spouses were taken aback with this new life situation, TN was often in his mind still in prison with the inmates he left behind, he is unable to adapt to his new roles, TS is tired of her own adapting and apprehensive about the future, the roles she has been taking on and that she would like to abandon; she feels guilty for occasionally being angry with her husband. They both feel that they are unable to adapt to the new situation, which requires them to re-establish their relationship in a new way; they also feel guilty before one another.

TN is a torture victim with pronounced posttraumatic stress disorder (PTSD) symptomatology dominated by depression, intrusive images and memories of traumatic events (flash-back phenomena), nightmares and insomnia. What about TS, what about the children who are now 15 and 11 years old and seen by their father in the same way as seven and a half years ago?

TS and the children are victims of secondary trauma. Secondary trauma victim is any person within the social network of support around the trauma victim. These victims can be family members, partners and friends. In other words, secondary victim of trauma is anyone whose resources the trauma victim calls upon during the healing process (Remer, 2000). Given that these social support networks are much larger than the number of victims (Remer & Elliott, 1988a,1988b) the consequences of trauma greatly surpass the number of primary victims. The fact that the traumatised person is dependent on his/her surroundings for social support results in secondary traumatisation affecting a significantly larger number of people. To what extent the secondary traumatisation would manifest itself depends on various factors, mental capacities of the personality, closeness with the primary traumatised person, intensity and duration of contact, as well as the level of personality damage in the primary trauma victim.

It was obvious from TS's physical aspect, as well as from her verbalisations that her resources to help the other have been exhausted, that she herself was in need of help she was afraid or unable to ask for. As a secondary victim of trauma she remained unrecognised, which is most often the case.

Despite the attention paid as of recently to the process of healing primary victims (van der Kolk, Mc Farlane & Weisaeth, 1996) an insight into therapeutic practice of professionals working with PTSD patients shows that very little has been done to respond to the needs of secondary victims. Even when the secondary victims of trauma and their needs are mentioned, they are discussed as someone who assists in the process of primary victim's rehabilitation and not as someone who also suffers the consequences of trauma.

The complexity of mutual relations between TN and TS, which include their children, has resulted in a vicious circle of seeking help, exhausting oneself in giving help, guilt feelings and the deepening of suffering and sense of shame in both of them.

In order for therapy to be efficient it is often necessary to involve both participants (the children were involved indirectly, because the change in one segment of the system results in change in the overall system). Therapy of the primary victim does not exclude the treatment of the secondary victim of trauma, and vice versa. These two processes are parallel and have their similarities, as well as specific rules and laws.

The process of traumatisation and rehabilitation of a trauma survivor, in this case a person who has survived torture in prison together with yearlong incarceration, has 6 stages:

1. Pre-trauma
2. Traumatic event
3. Crisis and disorientation
4. External adaptation
5. Revival
6. Integration and resolution

The process that the secondary victim of trauma and his/her rehabilitation go through also involves 6 stages (Remer, 1984,1990a, 1990b,1999):

1. Pre-trauma
2. Awareness about trauma
3. Crisis and disorientation
4. External adaptation
5. Reorganisation
6. Integration and resolution

These two processes are inevitably linear in their first two stages, but in the following four they inevitably overlap, so that the linear understanding of the process becomes insufficient because the family system is a set of elements that are constantly in mutual interaction. The family is an open system consisting of constantly interacting sub-systems. Stress affecting one family member requires adaptation of the entire family. A symptom arising in an individual prompts a reaction of other members, their reaction in return influences the individual with the symptom and leads to their reaction and the circle goes on. Here we lose the classic relation of cause and effect, the problem could not be

understood through linear causality (A cause - B effect) but becomes a sequence, an interaction by which the dysfunctional behaviour is maintained (Milojkovic, 2001). Laws of circular causality govern these processes.

Pre-trauma is the early life experience that is evoked by the traumatic event in the traumatised person and by the awareness about trauma in the secondary victim. These two processes are unpredictable and completely out of control for both primary and secondary victim. In the given case study, the wife's pre-trauma was the absence of her father who spent most of his daughter's childhood working in Germany. Crisis and loss of orientation in mutual relations are reinforced in both victims by way of feedback, thereby developing an internal chaos in the system, where the two participants who are trying to adapt externally in fact only increase the chaotic nature of their life together. Partners are aware that they are unconsciously exhausting, even hurting one another with their attempts to resolve their individual inner chaos. Term chaos denotes a completely disorganised, unpredictable, twisted situation (Remer, 1999) corresponding to the mental state of the traumatised person, as well as the family system in which he/she resides. Therapeutic processes that are not harmonised could enhance the situation of mutual chaos instead of resolving it.

Specific characteristic of the healing process for secondary trauma victim is its dependence on information about the healing process of the primary trauma victim, as well as the reaction to this process. Unlike the primary trauma victim, the secondary one awaits signals from the primary victim to which he/she should react. Secondary victims of trauma, besides being concentrated on their own healing, have to dedicate their attention to changes in primary victim's healing process, as well as to the influence that these fluctuations have on their relationship (Remer 2001). This specificity requires the acceptance of the said circular model in understanding the dynamics of the disorder in primary and secondary victims of trauma, as well as its application in the therapeutic process.

The dominant feeling of guilt in TN and TS created an atmosphere of depression and a sense that they were sinking deeper and deeper. They both recognise their own confusion of roles in marital and parental field of functioning. In an attempt to support one another, the spouses begin to drift apart increasingly. Having recognised this they become more insecure and distrustful to each other. Each new attempt to improve the situation is followed by an increased fear of deepening the chaos that is already becoming unbearable. Therapy involves clarifying of this causality for the partners though examples they express in the following sessions. They begin to recognise how they hurt each other by their expectations from their own self and from the other, which makes them feel increasingly weaker and impotent before the requirements of the "new life" that becomes a continuation of captivity in a mental sense.

Reorganisation and integration as the last two stages in rehabilitation through joint work represent the coming out from a specific mental prison in which the partners had been stuck.

The following case study is about secondary traumatisation of a torture victim's child. At the outset of armed conflicts in spring and summer of 1991, the 44-year-old man

was arrested on several occasions by Croatian police and each time he was beaten up in prison, subjected to mock executions and threatened that his entire family would be killed. He came in for therapy with already developed long-term consequences of torture he had been exposed to (frequent nightmares, flash-backs, patterns of phobic avoidance behaviour, inclination to withdrawal and loneliness). He accepted therapy with a clear idea of what the root causes are for changes in his functioning, which he recognised in his fear for his own life and the survival of his family during captivity, as well as the later worries about their existence in exile. It was at the third session that he spoke about changes he noticed in his ten-year old son who was born in exile. He says his son has become withdrawn, avoids the company of others, that he is doing worse in school, that he's afraid to stay alone in the house and is scared of loud noises.

As agreed, he brought his son to the following session; the child was referred to a child psychologist with whom he began individual therapy. Son's therapy was conducted separately in another institution, specialised for child therapy, but the therapists worked closely together. During sessions the boy described his frightening fantasies in which he and his family were being killed, kept in darkness in a basement of a surrounded house. He often perceived other children in school as violent and dangerous. Numerous descriptions of son's fantasies were reminiscent of his father's real experiences from prison, although the father avoided talking about them openly at home, while the boy only had a vague idea that his father had been held captive during the war.

Unlike the previous case study of secondary traumatisation of torture victim's wife, which occurred during the wife's attempt to help her husband who was released from prison, here we have the case of secondary traumatisation that occurred due to constant listening about a traumatic experience, learning the details related to torture and indirectly through changes in torture victim's behaviour. In the second case the experience of torture itself was covered by veil of mystery, leaving open space for fantasies about what the victim might have experienced and maintaining the anxiety. The changed behaviour of the father and his relationship with family members, which became branded with constant anxiety, insecurity and often clearly expressed irrational fears represent the root causes of change in the child's behaviour.

Working experience has shown that children of torture victims develop an impression they are "branded" and less worthy, similarly to the experience of immediate torture victims. Therapeutic work with children is directed towards developing self-respect and self-confidence and is done independently from the therapy of the torture victim, the primary traumatised, in order to avoid contamination by contents related to the experience of torture.

The necessity to understand a wider systemic significance of torture experienced in prison represents an unavoidable condition for a complete rehabilitation not only of the primary but also of the secondary victim of torture. Circular development of the dysfunction requires an approach in therapy that would include a wide network of interactions and overlap. Respecting the circular model of causality within the family system implies therapeutic intervention in one point, on one sub-system, in order to induce

change in other sub-systems. Therapeutic change within secondary victim of trauma, which is not necessarily linked with trauma itself, produces a change in the primary victim of trauma and consequently, based on feedback, also induces a new line of changes in the secondary victim. When the therapist gives concrete tasks it de-focuses, family system members from the closed loop of circular re-traumatisation and leads them into an inverse cycle of therapeutic changes.

Researching all levels of systemic inter-dependence and developing an intervention methodology on the level of circular causality model remains as an outstanding task in working with torture victims. It is also necessary to adapt each therapy to the concrete family situation, take into account specific characteristics of each family, age and maturity of each participant in therapy, as well as the cultural communication patterns relevant for the given family system. No rigid model of therapeutic work has so far proven effective enough, nor could it be, which renders more complex the tasks set before therapists and researchers in this field.

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