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“GETTING BETTER” AFTER TORTURE

FROM THE PERSPECTIVE OF THE SURVIVOR

by

BRIAN LOUIS ISAKSON

Under the Direction of Gregory Jurkovic

ABSTRACT

The traditional model of Western mental health treatment for survivors of torture has focused mainly on posttraumatic stress disorder and related conditions. This model is symptoms-focused in which the goal is to reduce pathology. In this model, the mental health professional is the expert and the survivors learn from the professionals. Using grounded theory methodology, the current study seeks to expand the understanding for treatment of torture survivors by investigating, from the perspective of the torture survivors, the process of “getting better” after torture. By asking the survivors to explain this process, this study broadens the focus of areas of healing and intervention to include social, psychological, political, and biological aspects of their lives that need to be impacted in order for them to get better. Eleven adult torture survivors (9 men and 2 women) from various African and Asian countries described their process of getting better through qualitative interviews. A model of getting better was

developed to describe this process. The central phenomenon of this process is moving on from difficult past experiences. Participants described a multi-dimensional process that includes various environmental factors and intrapersonal beliefs and coping strategies that promoted moving on and getting better. These multi-dimensional themes include using belief and value systems, establishing safety and stability, and establishing social support in order to move on. Once the survivors felt a sense of safety and support, they felt empowered to take action to move on from their past. These action strategies include disclosing torture experiences, controlling memories, supporting others, and utilizing available supports. Moving on led to improved relationships, more adaptive functioning, improved health, and release from emotional pain. Findings of this study were consistent with current literature documenting recovery after torture and other traumatic experiences. Implications for both theory and practice are discussed and directions for future research are delineated.

INDEX WORDS: Refugees, Torture, Trauma, Social Support, Spirituality, Empowerment, Resilience, Safety and Stability

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by

BRIAN LOUIS ISAKSON

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2008

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2008

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August 2008

ACKNOWLEDGEMENTS

I would like to thank my wife Kelli for her encouragement, love, and support in life, school, and research. She was a gracious and patient as a coder and my chief editor. To my son Miles, who helped me keep my sanity by being ready to play at any breaks in writing. To my son Otis, whose upcoming birth urged me to work hard everyday to finish before he joined us. To my parents, for their encouragement and example to make a difference in the world while being part of a family and community.

To my advisor, Greg Jurkovic, who brought excitement and passion to clinical work and research. He encouraged me to think big and take the lead in my interests throughout graduate school. To Julia Perilla, for encouraging me to focus on strengths, give back to the community, and for her joy in seeing graduate students succeed. To Rod Watts, who introduced me to grounded theory methodology and never let up in helping me take my analysis to the next level. To Greg Brack, who taught a wonderful, mind-opening course on traumatology and whose passion for helping trauma survivors was contagious. I would like to thank Suzanne Merlis, who filled many roles in my training: supervisor, confidant, coder, and editor. To Kelly Maltese and Mayowa Obasaju, for taking time out of their own research to help code my data.

I would like to thank the staff at the Center for Torture and Trauma Survivors, Kitty Kelly, Bereket Beraki, and Asha Ahmed. They opened up their program for my research and gave of their time and energy to make this possible. Finally, I would like to thank the participants in this study who shared their deep, private stories and feelings in an effort to help others who have been through torture and to prevent it from happening in the future. Their stories of resilience and a willingness to share and open up gave me inspiration that made this dissertation research a joy to be part of.

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Chapter 1: Introduction

The traditional model of Western mental health treatment for survivors of torture has focused mainly on posttraumatic stress disorder (PTSD) and related conditions (depression and anxiety). This model is symptom focused, where the goal is to reduce symptoms of pathology. In addition, the treatment has often been modeled after treatment for Western clients of traditional mental health services. In this system, the mental health professionals are the experts, and the clients learn from the professionals. In essence, the idea of healing or recovery in the traditional model is the reduction of symptoms as determined by experts.

This study seeks to expand the understanding of the treatment of torture survivors by investigating, from the perspective of the torture survivors, the process of "getting better" after torture and what aspects of survivors' lives need to be impacted in order to get better for this healing to take place. Theorists have yet to consistently agree on definitions for the concepts of healing and recovery following traumatic events such as torture. For the purposes of this study I use the phrase "getting better" to keep the concept broad and open for the participants to make meaning within their own contexts and according to their understanding. The terms "healing" and "recovery" may have specific connotations in some cultures that may limit the focus of their description of the process.

It is probable that the idea of getting better from the perspective of the torture survivor reaches beyond reducing symptoms of posttraumatic stress disorder, depression, and anxiety. Issues identified in the literature on survivors of torture such as social support and reconnection, trust, physical health, traditional and indigenous healers and rituals, belief and values systems, forgiveness, witnessing truth, justice, getting life back into a routine, and empowerment may be more important than is traditionally assumed in treatment for survivors of torture. By asking

survivors what aspects of their lives need to be addressed and improved to get better, providers will have a better understanding of where to begin treatment and how to develop culturally-sensitive, holistic treatment models.

Defining Torture

Torture has long been used in military, political, and ethnic conflict to humiliate, demoralize, and extract information. According the United Nations (1984), torture is defined as

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.

Types of Torture

Hooberman, Rosenfeld, Lhewa, Rasmussen, and Keller (2007) conducted a factor analysis of types of torture experienced in a large sample of torture survivors receiving treatment at a torture treatment program. The analysis revealed a five factor solution for types of torture: 1) witnessing torture, 2) family torture, 3) beating, 4) rape/sexual assault, and 5) deprivation. According to Mollica (2004), the most common forms of torture include being beaten with various objects, threatened, humiliated, restrained, deprived of essentials such as food, water, sleep, and medication, and exposed to the elements. Also common are isolation, rape, sexual humiliation, suspension, suffocation, witnessing torture of others, and electric shock.

Purposes of Torture

Yawar (2004) described the various purposes of torture as a tool for reform, as punishment for opposing the torturers, and as a means of conquest. Torture is often used as a tool for reform to reshape a person's views and convert a person to different ideals. Psychological torture is often a part of this process. For example, a victim may be disoriented by being blindfolded and isolated. He or she may not know what is expected from his or her captors and how to obtain release. Degradation of the torture victim is another psychological tool used in reform. Sexual torture and assaults are common, as well as random beatings and insulting comments. The use of fear is a very powerful tool in psychological torture. The victim often hears screams of other victims and receives ongoing threats to self and family. Torture is also used as punishment of those who oppose the torturers. The victim may be burned, beaten to death, or kept in horrible living conditions. Torture is also used as a means of conquest. This form of torture is seen in ethnic cleansing where whole groups are regarded as less than human in an effort to brutalize and evict the groups.

Prevalence of Torture

The prevalence rates of torture are often difficult to determine due to the secrecy of the victimization. Recently, the Amnesty International Internal Secretariat (2007) reported that 102 countries had cases of torture and "ill treatment" by security forces, police, and other government authorities. Several studies have examined prevalence rates of torture. de Jong et al. (2001) found 8% of the population in Algeria, 15% in Gaza, Palestine, 9% in Cambodia, and 26% in Ethiopia experienced torture in random selection studies from national samples in these countries. Modvig et. al. (2000) found that 39% of the population in a random sample of representative households in East Timor had experienced torture. Mollica et al. (1993) found

that 8% of randomly selected adult Cambodians in a refugee camp along the Thailand-Cambodia border reported being tortured. And Tang and Fox (2001) found that 16% of randomly selected Senegalese adults in two refugee camps in The Gambia had been tortured. Using data from torture treatment centers, Baker (1992) estimated that between 5% and 35% of refugees had experienced torture. According to these estimates, as of the year 2000, about 600,000 to 3.4 million refugees worldwide had been tortured (Engstrom & Okamura, 2004). According to recent reports, there are between 400,000 and 500,000 survivors of torture living in the U.S.A. (Department of Health and Human Resources, 2000). Eisenman, Keller, and Kim (2000) investigated torture rates in a convenience sample of 121 people born outside of the United States attending an ambulatory care clinic in a New York City medical care center. They found that eight (6.6%) of the participants reported a history of torture. In a study of 638 adult Latino immigrants using one of three primary care clinics in Los Angeles, Eisenmen, Gelberg, Liu, and Shapiro (2003) found that 8% of the participants reported a history of torture.

Common Effects of Torture

Many studies have examined the physical and psychological effects of torture. While much of the research on the psychological effects of torture focus on PTSD, depression, and anxiety, some investigators have take a more holistic approach to examining the psychological effects of torture.

Physical Effects of Torture

Due to the many techniques used, the physical effects of torture are broad. Some of the common physical effects are damage to the head, including the skull, ears, eyes, nose, teeth, and jaw, and damage to the central nervous system, the spinal chord and motor coordination. The chest, abdomen, vertebrae, fingers, toes, and feet are often injured, along with the reproductive

systems and genitalia. Scarring of the skin due to electrical burns, beatings, ropes, and corrosive liquids is also common. The most frequently reported physical symptoms are headaches, hearing impairments, gastrointestinal distress, and joint pain (Goldfield, Mollica, Pesavento, & Faraone, 1988; Piwowarczyk, Moreno, & Grodin, 2000). These physical effects can last many years. In a study of 124 Holocaust survivors 50 years after the Holocaust, Kuch, and Cox (1992) found that 89.5% reported severe headaches, 33.1% reported gastrointestinal distress, and 50.8% reported persistent dizziness. Kahana, Harel, and Kahana (1989) found that Holocaust survivors reported significantly greater levels of physical symptoms, such as headaches and abdominal cramps, than the comparison group.

Psychological Effects of Torture

Individual psychological responses to torture and trauma vary and are determined by many factors including social context, spiritual meaning, political beliefs, genetic variability, resilience, and individual psychology (Quiroga & Jaranson, 2005). According to Ortiz (2001), the mental health of torture survivors is changed dramatically by the experience; every part of their lives is affected. Stripped of dignity, humanity, and control, they often feel less than human. Many lose hope and trust in other people and God. Survivors may blame themselves for what they have been through and what they may have put others through. They may feel humiliated for letting the torture happen to them. They may feel contaminated--no longer clean and acceptable to other people.

The psychopathological effects of torture have been studied recently. The most common psychological disorders discovered have been PTSD, depression, and anxiety (Basoglu, Jaranson, Mollica, & Kastrup, 2001). In a review of uncontrolled studies, Basoglu, et al. (2001) found that the prevalence of one or more of these disorders ranged from 15% to 85%. According

to Mollica (2004), while PTSD is often the primary focus of treatment and research, depression is the most common diagnosis given to survivors of torture. Other common psychiatric disorders and problems diagnosed in torture survivors are sleep disturbances, neurocognitive disorders related to traumatic brain injury, substance abuse (Mollica, 2004), confusion, disorientation, impaired memory, sexual dysfunction, and personality change (Basoglu, Jaranson, Mollica, & Kastrup, 2001).

Several studies compared psychological symptoms in tortured refugees and nontortured refugees. These studies controlled for trauma and difficult life experiences encountered as a refugee. In a study of 418 tortured and 392 nonturtured refugees from Bhutan living in Nepal in refugee camps, Van Ommeren et al. (2001) found that tortured refugees were more likely than nontortured refugees to experience PTSD, dissociative, affective, persistent somatoform pain, and generalized anxiety disorders. While 74% of torture victims reported experiencing PTSD at some point in their lives, only 15% of nontortured refugees experienced PTSD. PTSD was the most common mental disorder reported by the tortured refugees.

Mollica et al. (1998) investigated the effects of torture in 62 Vietnamese ex-political prisoners. These political prisoners were compared to 22 Vietnamese men who were of a similar age group and background but were not ex-political detainees. The political prisoners experienced significantly higher levels of PTSD (88% compared to 77%) and depression (57% compared to 36%) than the nontortured refugees.

A study by Holtz (1998) investigated the effects of torture in 35 Tibetan nuns and students exiled and living in India who were tortured and 35 controls who were not tortured. The tortured participants reported significantly higher levels of anxiety symptoms on the Hopkins Symptoms Checklist-25 (HSCL-25) than the nontortured participants, although the difference

was small. The mean anxiety level of the torture survivors was above the clinical cutoff score. Mean depression and somatic scores did not differ significantly between groups and were not above the clinical cutoff score.

Shrestha et al. (1998) examined psychopathology in 526 tortured Bhutanese refugees and 526 nontortured Bhutanese refugees living in Nepal. Tortured refugees showed significantly higher rates of PTSD than the nontortured refugees (14% vs. 3%). They also displayed significantly higher levels of anxiety. Forty-three percent of the tortured refugees versus 34% of nontortured refugees reached clinically significant levels on the HSCL-25. The tortured refugees also displayed significantly higher levels of depression with 25% reaching clinically significant levels on the HSCL-25. The authors commented on the surprisingly low levels of traumatization in the population studied. They stated that high social support, safe refugee camps, and religious beliefs and practices accounted for this finding.

In a study of nonrefugees, Basoglu et al. (1994) investigated 55 Turkish politically active adults who were tortured. They were compared to a group of 55 Turkish people who were politically active, but not tortured. The authors were surprised by the low prevalence rates of depression and PTSD in the torture victims, considering the severity of the torture. Lifetime prevalence rates of PTSD in the torture survivors were 33% versus 11% in the nontortured population. Current rates of PTSD were 18% in the torture survivors and 4% in the nontortured population. The torture survivors reported moderate levels of PTSD symptoms. Both these differences were statistically significant. Only two torture survivors endorsed current major depression. The authors conjectured that the low level of reported PTSD in the torture survivors may have been due to the immunizing effects of repeated exposure to stress. They also stated that the survivors reported strong emotional and social support from family and friends that may

have acted as a protective factor in the development of PTSD symptoms. The authors concluded that the low prevalence rates of psychopathology were "not consistent with the view that torture survivors are 'victims' with 'destroyed personalities'" (Basoglu et al., 1994, p. 81). In another study that investigated PTSD, depression, and anxiety in nonrefugee Nepali torture survivors, Tol et al. (2007) found that 60% of the sample qualified for a PTSD diagnosis, 86% qualified for an anxiety disorder diagnosis, and 81% qualified for a depressive disorder diagnosis.

Silove, Steel, McGorry, Miles, and Drobny (2002) investigated the effects of torture in a population of 107 Tamil refugees and immigrants living in Australia. While the number of torture survivors was small in the sample (21), they showed significantly higher levels of posttraumatic symptomatology on the Harvard Trauma Questionnaire with a large effect size ($d = .91$) when compared to the nontortured population. When the number of trauma categories reported was added as a covariate, the effect size was still moderate ($d = .53$) and statistically significant. This finding indicates that torture has a strong impact on PTSD scores beyond the impact of simply experiencing a wider array of traumatic experiences related to war.

Research findings indicate that pathology due to torture has long-term impact. In a study of Mau Mau concentration camp survivors from Kenya, many of whom were tortured, Atwoli, Kathuku, and Ndetei (2006) found that 73% of participants reported experiencing PTSD during their lifetime, and 66% had current PTSD over four decades after imprisonment. In a longitudinal study of torture survivors of various ethnicities, many of whom did not receive any psychological treatment, Carlsson, Olsen, Mortensen, and Kastrup (2006) found that between the initial assessment and the 10-year follow-up, PTSD, anxiety, and depression rates decreased significantly, with about 30% of the sample's scores dropping out of the clinical range for PTSD,

depression, and anxiety. Although this is a promising change in prevalence rates, the high scores at follow up indicate long term emotional distress.

Criticisms of the Western Focus on PTSD

Although the Western understanding of reactions to trauma and symptoms of PTSD are commonly accepted in traditional mental health research and intervention, several researchers have criticized this focus on PTSD and the culturally biased understanding of symptoms and treatments after traumatic events.

Culture Bias and PTSD

Although the studies discussed above show that common effects of torture are PTSD, depression, and anxiety, several researchers (de Jong, 2004; Pupavac, 2002; Silove, 2004; Summerfield, 1999; Zarowsky, 2004) argue that PTSD is a culturally constructed disorder that limits our understanding of the experiences of torture survivors from non-Western cultures. They criticize the focus of Western psychology on PTSD and encourage researchers and clinicians to broaden their view of the effects of war and torture. The social context of the trauma is often overlooked and leads to a misunderstanding of the social, environmental, physical and mental health consequences of torture. Researchers often try to fit their findings into culturally bound categories that are not derived from the studied population. In the process they overlook effects of trauma that do not fit into the category but may be better descriptions of the concept in that culture. For example, in a study of trauma reactions in refugees from West and Central Africa, Rasmussen, Smith, and Keller (2007) found that the traditional DSM-IV diagnosis of PTSD did not adequately describe the effortful avoidance and involuntary emotional numbing. In addition, the participants reported symptoms not included in the traditional Western model of PTSD, including the sensation of something “crawling” beneath or on the scalp,

perceived sudden movements of the heart and intense heat in the head or body. Summerfield (1999) argued that even if PTSD is regularly found in different cultures, it is a mistake to assume that the related phenomena mean the same thing across cultures.

PTSD Bias in Research and Treatment

de Jong (2004) argued that the PTSD paradigm is amplified in research and intervention in post-conflict settings. He stated that the Western construct of a PTSD diagnosis is reified in non-Western cultures and is established as the focus of intervention when there is yet to be strong empirical support to show that the category is the most relevant diagnosis and description of the mental health in these populations. This focus of trauma intervention often comes at the expense of other issues and concerns that may be more urgent and relevant to the local populations. In a review of research conducted with Bosnian refugees, Witmer and Culver (2001) found that results of adaptive functioning and resilience were minimized, with the stress being on PTSD and pathology.

PTSD and Asylum Seekers

Summerfield (1999) argued that a narrow focus on PTSD may be particularly detrimental to asylum seekers who experienced torture. Summerfield stated that there is no clear cut relationship between torture and PTSD. But this focus on PTSD may lead mental health professionals to believe that the way to prove that a person has been tortured is through the display symptoms of PTSD. In other words, if the torture survivor does not display symptoms of PTSD, then his or her story may not be credible, and thus asylum may be denied.

Medicalization of a Sociopolitical Problem

Summerfield (1999) criticized the PTSD diagnosis by arguing that researchers and clinicians are medicalizing a sociopolitical problem. He stated that in the last 50 years medicine

has replaced religion as the source of explaining stress and difficult life experiences. Summerfield argued that by shifting the phenomena from the sociopolitical to the biopsychomedical realm, the real costs of war and torture are distorted. The suffering becomes a technical problem that lies within the individual. The individual must be fixed through counseling, and the social and political effects are ignored. In a way, this absolves the mental health profession from facing sociopolitical issues, such as social justice, poverty, and causes of war and torture. It has been argued that reactions from trauma are normal psychological reactions to abnormal events and, therefore, do not qualify as disorders (Martin-Baro, 1994; Summerfield, 1999). Because of the more common focus on collectivism, people from non-Western cultures explain their difficult life experiences in terms of how the events have impacted them socially and politically, not psychologically or emotionally. These trauma survivors are often more concerned with how their cultures have been destroyed, and how life is difficult economically. They do not see themselves as victims that are broken, but as survivors who are active and resilient (Summerfield, 1999).

Western Mental Health Professionals as Experts

Summerfield (1999) further criticized the Western focus on PTSD in non-Western cultures by arguing that Western mental health professionals see themselves as the experts who can fix the PTSD problem. Local healers and mental health professionals are marginalized because they do not have the expertise and are often seen as too traumatized to be effective. Their experiences, training, and knowledge are often ignored. These local help providers may learn to focus on PTSD and downplay local healing efforts as well in order to receive the funding from and approval of western professionals. The survivor of trauma becomes a passive consumer instead of actively participating in and culturally informing the recovery process. In

many ways it is a form of mental health colonialism. In addition, according to Summerfield (1999), when the "experts" do not find high rates of PTSD in a particular population, they claim that the locals are denying the symptoms.

Narrow Focus on Single Traumatic Event

The emphasis on PTSD has been criticized further because of its simple focus on a broad range of single traumatic events that lead to similar symptoms (Summerfield 1999). The definition of a traumatic event has been broadened to the point that not just experiencing, but also witnessing or hearing about an event qualifies as a traumatic event. In addition, natural disasters, vehicle accidents, and human-to-human atrocities have been included together as possible traumatic events (American Psychiatric Association, 2000). It has been argued that this broad range of possible single episode traumatic events does not fully capture the experiences of survivors of ongoing, repeated traumatic events and torture. The diagnostic concepts of complex PTSD and torture syndrome have been developed to explain the experiences of these groups.

Alternative Trauma-Related Diagnoses

Several investigators proposed constellations of symptoms referred to by different names such as complex PTSD, disorders of extreme stress, and complicated PTSD that were not addressed by the initial PTSD diagnosis (Herman, 1992a; Spitzer, Kaplan, and Pelcovitz, 1989). Risk factors for this disorder include early onset, exposure to interpersonal stress, and prolonged duration of the stress. This constellation of symptoms is most often seen in people who were held captive, such as child and sexual abuse survivors, women exposed to interpersonal violence, and concentration camp victims (Herman, 1992b; Van der Kolk, Roth, Pelcovitz, Sunday, and Spinazzola, 2005). The symptoms of complex PTSD are arranged in seven categories: 1) alterations in regulation of affect and impulses (e.g., excessive risktaking), 2) alterations in

attention and consciousness (e.g., dissociative episodes), 3) somatization (e.g., chronic pain), 4) alterations in self-perception (e.g., guilt and responsibility), 5) alterations in perception of the perpetrator (idealization of the perpetrator), 6) alterations in relations with others (e.g., inability to trust), and 7) alterations in systems of meaning (e.g., despair and hopelessness) (Herman, 1992a). According to Quiroga and Jaranson (2005), this disorder is particularly relevant to survivors of torture because of the interpersonal and sociopolitical nature of torture. It also accounts for the often ongoing, long-term nature of torture.

Several clinicians and researchers have proposed torture syndrome as a unique syndrome that includes symptoms of PTSD but also with other features (Elsass, 1997, 1998; Genefke & Vesti, 1998). They argue that torture is qualitatively different than other traumatic experiences because it affects a person physically, mentally, and sociopolitically. Genefke and Vesti (1998) proposed that four themes unique to torture survivors are "1) incomplete emotional processing, 2) depressive reactions, 3) somatoform reactions, and 4) existential dilemmas" (p. 36). While some clinicians use this model to guide treatment, it has not been validated with empirical studies as a unique syndrome.

Models of "Getting Better"

Getting better, healing, and recovery are difficult to define. Many interventions claim to add to the healing of torture survivors, but they do not define healing. Perhaps being healthy after a torture experience could be a definition of healing. This general concept of health is defined by the World Health Organization (1946) as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The following section reviews several models of factors that promote getting better.

Silove's Five Adaptive Systems of Health

Silove (1999) developed an ecological framework that describes five adaptive systems of health that help individuals and communities maintain psychosocial stability. These five adaptive systems are 1) safety and security, 2) attachment, 3) justice, 4) existential-meaning, and 5) identity/role. Silove hypothesizes that these systems are often threatened or disrupted by war and mass trauma. First of all, the system of safety and security is threatened in torture and mass trauma through loss of physical safety and economic and material stability. Components of the attachment system, namely social support, a sense of belonging, and social cohesion, are threatened in torture and mass trauma through separation from and loss of loved ones and community. The justice system is greatly destabilized by torture, an extreme example of a human rights violation. Individuals and cultures are dehumanized, humiliated, and degraded. Sometimes victims of torture are forced to betray loved ones and perform atrocities themselves. Also threatened is the existential-meaning system. Being exposed to torture can often lead a person to question his or her faith in God and humankind and in the goodness of life. Torture survivors often search to find a meaningful reason for the atrocities experienced. The fifth is the identity/role system. One of the goals of torture is to destroy a person's individual and cultural identity, which is often additionally threatened by the loss of his or her land, possessions, and profession. If a torture survivor must resettle to a new culture, the person must develop a new identity within the bounds of that culture. Because of cultural and language differences, torture survivors are often second-class citizens in the new setting (Ekblad & Jaranson, 2004; Silove, 1999; Silove, 2004).

Historical and cultural factors in a society determine how adaptive systems of health are expressed, how threats to these systems are perceived, and how the community will react in

rebuilding these systems. Silove (2004) argues that after a major upheaval, most individuals and their communities are proactive in reestablishing these systems. The collective act of rebuilding will, in itself, promotes mental well-being. If these systems are repaired, then fewer people will suffer chronic psychosocial consequences of trauma.

Herman's Three Stage Recovery Model

Herman (1992a) developed a commonly used stage model of the trauma rehabilitation process. The three stages of this process are 1) the establishment of safety, 2) remembrance and mourning, and 3) reconnection. The model provides a useful set of goals for treatment providers, regardless of theoretical orientation. This process is not typically linear; there are often advances, regressions, and impasses. Many people do not complete all three stages.

Establishing safety. Herman (1992a) identified establishing safety as the first step in the treatment of trauma because no intervention can succeed without the survivor feeling safe. Safety includes protection from violence and maltreatment by other people, basic needs being met such as medical care, financial security, safe living quarters, adequate food and sleep, legal protection, and a supportive social network. The establishment of safety helps the survivor to interpret emotional stimuli in a grounded, present manner instead of interpreting the stimuli as a return of the trauma (Van der Kolk, 1996). The establishment of safety has been identified as an important aspect of getting better from a traumatic event, such as torture. Torture and other forms of trauma can shatter a person's sense of security and safety. The disruption caused by torture and war can lead to additional safety issues such as displacement (van der Veer & van Waning, 2004). In addition, Silove (1999) suggests that the life-threatening situation of trauma may trigger psychobiological mechanisms associated with the preservation of safety. The torture survivors may not feel safe because they may be experiencing flashbacks, dreams, and memories

which remind them of the torture (Fabri, 2001). The reestablishment of safety is important in the development of relationships that can be beneficial in the process of getting better (Fabri, 2001). Several studies examined safety and stability in refugees. For example, refugees who received asylum in their new countries displayed higher levels of mental health and quality of life compared to refugees with similar traumatic experiences and premigratory stress who did not receive asylum (Davis & Davis, 2006; Keller et al., 2006; Momartin et al., 2006). In addition, length of time in a new country predicted quality of life (Carlsson, Olsen et al. 2006), steady employment predicted quality of life (Carlsson, Mortensen, & Kastrup, 2006) and higher levels of mental health (Beiser & Hou, 2001; Hermansson, Timpka, & Thyberg, 2002), and new language fluency was a significant predictor of depression and employment (Beiser & Hou, 2001).

Remembrance and mourning. In the remembrance and mourning stage of Herman's model (1992a), the survivor constructs a narrative of his or her experiences in a therapeutic relationship. One of the major clusters of symptoms of PTSD is the avoidance of thoughts and behaviors that remind a person of the traumatic experiences. The memories are stress inducing and the person has difficulty functioning in various aspects of life because he or she avoids thoughts, people, and activities that remind the person of the traumatic event. Avoidance is a coping strategy that survivors use to maintain psychological stability when faced with destabilizing traumatic memories and hyperarousal symptoms. When memories and emotions related to the trauma are constantly avoided, the survivor is unable to extinguish the related anxiety and process and integrate the memories and emotions. Thus, the survivor is most likely to continue reexperiencing the trauma without recovery (Briere & Scott, 2006). Several studies have examined the impact of avoidance. In a study of college age trauma surviviors, avoidance

was found to mediate the relationship between trauma exposure and PTSD (Orcutt, Pickett, & Pope, 2005). Avoidance was also found to be positively related to physical health problems in a sample of adult female trauma survivors (Woods & Wineman, 2004). Andrews, Troop, Joseph, Hiskey, & Coyne (2002) found that attempted avoidance was related to PTSD and to mental control strategies of punishment and worry. However, in this same study, survivors who were able to successfully reduce arousal symptoms through avoidance displayed significantly less PTSD symptoms and more mental control strategies related to positive well being.

According to Herman (1992a), to overcome the stress of remembering, the survivor relates his or her experiences in depth with great detail. The goal is to modify the traumatic memories so they become more meaningful in the person's life and less anxiety provoking. In addition, the survivor is encouraged to examine the social and political context of the trauma. As the narrative develops, the memories become less disjointed and depersonalized and more coherent. With this emotional reworking and cognitive restructuring, the memories become more manageable and the significance of the trauma changes from a story of victimization to one of dignity and agency. Once the survivor is able to emotionally and cognitively process the traumatic experiences, the survivor is then able to mourn the losses experienced. They face the reality that they may never regain what they lost. Herman argues that with the new story, the intrusive and hyperarousal symptoms subside.

The basic concept of this stage of recovery, the reconstructive disclosure of traumatic experiences, has been examined widely in theory and research. Cognitive-behavioral therapy that focuses on exposure to memories and emotions has been found to be a powerful method of treating PTSD with survivors of sexual assault (Foa et al., 1999: Foa, Rothbaum, Riggs, & Murdock, 1991) and physical assaults or accidents (Marks, Lovell, Noshirvani, Livanou, &

Thrasher, 1998; Tarrier et al., 1999). Much of the controlled research on disclosure has been done through writing about traumatic experiences. The benefits of writing about highly stressful and traumatic experiences may include decreased inhibition, facilitating the assimilation of traumatic experiences (Pennebaker, 1997) and emotional processing (Murray & Segal, 1994). Multiple controlled studies have found improvements in physical health including reduction in physician visits (Francis & Pennebaker, 1992), clinically relevant improvements in moderate to severe asthma and rheumatoid arthritis (Smyth, Stone, Hurewitz, & Kaell, 1999), improved immune system functioning (Pennebaker, Kiecolt-Glaser & Glaser, 1988; Smyth, 1998), lowered levels of tension and fatigue and improved upper respiratory levels (Greenberg & Lepore, 1999) and improved general health (Park & Blumberg, 2002; Sheffield, Duncan, & Thomson, 2002; Sloan & Marx, 2006; Sloan, Marx, & Epstein, 2005; Smyth, Hockenmeyer, & Anderson, 2002). Improvements in mental health due to disclosure through writing include significant reduction in negative affect and depression (Sloan & Marx, 2006; Sloan et al., 2005; Smyth et al., 2002), PTSD (Sloan & Marx, 2006; Sloan et al., 2005), avoidance and intrusion (Park & Blumberg, 2002; Smyth et al., 2002), and anxiety (Sheffield et al., 2001).

Reconnection. In the reconnection stage of Herman's (1992a) model of recovery, the focus is on building a future and empowerment. Once the past has been assimilated, the survivor can focus on developing a more resilient and complete identity. He or she may work to develop personality characteristics and skills that were underdeveloped due to the trauma. The trauma survivor strives to make a meaningful life through trust and hope. The survivor may have a desire to help others who have been victimized similarly and to prevent future victimization by raising public awareness through educational, legal, and political activism. In a qualitative study of adult African American survivors of childhood abuse, Bryant-Davis (2005) found that

activism through helping others with similar experiences to gain a sense of empowerment was a helpful coping strategy for the participants in the study to deal with their own trauma history. The survivor may seek to bring the perpetrators to justice (Herman, 1992a).

Salutogenesis

While most theories focus on the negative consequences of trauma, several theories have been developed to describe the positive effects of experiencing trauma. These theories examine possible positive transformations following trauma. When only the negative aspects of trauma are examined, a biased understanding of posttraumatic reactions occurs (Linley & Joseph, 2004). These alternative theories recognize the possibility of "remaining unscathed" following trauma (Almedon, 2005). Antonovsky (1979, 1987) developed the broader concept of salutogenesis (origins of health) in response to the negative concept of pathogenesis (etiology of disease). In this model, individuals mobilize their "generalized resistance resources" to manage stress and deal with the negative effects of the environment. Included in these resources are sense of control, intelligence, genetic predisposition, individual identity, material assets, stable values and beliefs, social ties, cultural stability, and sense of coherence (SOC). Antonovsky (1987) defines SOC as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured and predictable, and explicable; (2) the resources are available to one to meet the demands posed by the stimuli; and (3) these demands are challenges worthy of engagement" (p. 19). In this sense, when a person defines his or her stress as comprehensible, manageable and meaningful, he or she can apply available resources to confront and manage the stress (Walsh, 1998).

Posttraumatic Growth

Tedeschi and Calhoun (1995, 1996, 2004) developed the concept of posttraumatic growth. Posttraumatic growth is the positive psychological change experienced after the struggle with a traumatic or very difficult life experience. The growth is not due to experiencing a traumatic event, but struggling with the new reality after the event. People who experience such growth experience improvement in some areas that exceeds what was present prior to the traumatic experience. They go beyond the status quo. The trajectory for trauma is not either growth or pathology, but growth and distress are often found together (Tedeschi & Calhoun, 2004). Tedeschi and Calhoun (2004) point out research that shows the reports of growth following traumatic experiences far outnumber the reports of psychiatric disorders. They identify five domains of posttraumatic growth: (1) warmer, more intimate relationships; (2) a greater sense of personal strength; (3) greater appreciation for life and changed sense of priorities; (4) spiritual development; and (5) recognition of new possibilities or paths for one's life. In a controlled study of Israeli ex-prisoners of war, Solomon and Dekel (2007) found that severity of PTSD was related to posttraumatic growth. They argued that despite the distress and negative affect, people can still continue to function and grow and that the presence of PTSD does not indicate an absence of maturation and growth. In addition, posttraumatic growth was related to severity of the traumatic event. The ex-prisoners of war displayed significantly higher levels of posttraumatic growth compared to the control group of combat veterans.

Resilience

Resilience after traumatic events has also been examined recently. Resilience refers to "strengths under stress, in response to crisis, and forged through dealing with adversity" (Walsh, 2003, p. 52). It is the ability to cope and adapt successfully despite significantly threatening

situations (Agaibi & Wilson, 2005). Resilience is not simply passing through a crisis unscathed or bouncing right back but it means to "struggle well" through the pain and suffering (Higgins, 1994). Resiliency is related to self-esteem, self-confidence, and the ability to adapt and problem solve (Watters, 2001). There has been a shift from studying pathology exclusively to examining how "normal" people deal with their life challenges and what key processes are used in healthy functioning. It is a shift from a focus on failure to a focus on success. This understanding can facilitate repair and growth in troubled people (Walsh, 2003). Although many people experience acute reactions after a traumatic event, most are able to cope, adapt, and rebound; most do not develop long-term disturbances (Litz, 2004; McFarlane & Yahuda, 1996; Smyth et al., 2002). The concept of resilience is similar to posttraumatic growth in that through the struggling and suffering, survivors reach down more deeply and tap into resources they didn't know they possessed or had not developed (Walsh, 2003).

Resilience may be enhanced by an internal locus of control, a supportive social network, optimism, the use of problem-oriented coping strategies (Ayalon, 2005), recognition of what can and cannot be changed leading to efforts made toward areas that can be changed (Walsh, 2003), stability, building on ones strengths, and making meaning of traumatic experiences (Walsh, 2007). In a review of literature examining Holocaust survivors, Lomranz (1995) concluded that survivors displayed levels of well-being and adaptation that were equal to or greater than non-Holocaust survivors. In one study, when compared to a control group, Holocaust survivors were more favorable to family, friends, and work and reported more stability and satisfaction with their current life situation (Shanan & Shahar, 1983).

Seeking help. Another form of resilience is seeking help for mental health problems. Survivors strive to bounce back through help from others. This help can come through family

support, religious beliefs, native healers, and formal Western treatments. Much of the help-seeking research has focused on the use of Western mental health treatments. In a sample of Asian immigrants resettled in Australia, participants reported that the process of seeking help through Western treatments was so difficult, the immigrants sought help only after the mental health problems became so bad the families could not manage them anymore (Wynaden et al., 2005). Research has been conducted on help-seeking behaviors in refugee and immigrant populations. Perceived availability of culturally sensitive services (Fung & Wong, 2007), fluency in English, assimilation (Barry & Grilo, 2002), use of traditional and alternative medicines (Berthold et al., 2007), and higher education level (Sheikh & Furnham, 2000) are related to help-seeking behaviors through Western treatments for mental health problems.

Pharmacotherapy

Traditional Western treatment after trauma often includes pharmacotherapy for severe or persistent symptoms (Piwowarczyk et al., 2000). Various medications such as anti-depressants and benzodiazepines can be helpful in reducing symptoms of chronic pain, anxiety, depression, intrusive thoughts, and hyperarousal as a result of war trauma and torture (Kinzie & Friedman, 2004; Quiroga & Jaranson, 2005). Bouwer and Stein (1998) found that antidepressants were effective in reducing symptoms of depression and anxiety in South African torture survivors.

Alternative Factors in the Process of Getting Better

Many non-Western cultures have a holistic approach to wellness and treatment. The idea of focusing on reducing symptoms of pathology is a foreign concept in these cultures. Getting better has a much broader meaning, particularly beyond fixing the individual. This section reviews concepts that have been identified as important in the process of getting better beyond

traditional Western mental health treatment. Some of these concepts are integrated into Western treatment models but are cutting edge or on the periphery of treatment.

Social Support and Reconnection.

The social network of torture survivors is often shattered. They may be separated from and lose loved ones or even witness the death of loved ones. Support systems can also be damaged by fear and mistrust of others after the torture experience. Pressures of displacement and psychological symptoms can disrupt family life (Behnia, 2003). Marriage, education, and careers may be put on hold due to the torture experience and time waiting for resettlement (Quiroga & Jaranson, 2005). The reconstruction of social networks and cultural institutions is vital in the healing process (Holtz, 1998). Social support is particularly important in collectivist cultures that place high value on relationships in families and communities. Families are often the main source for social support and mental health care for torture survivors and refugees (de Jong, 2004).

Social support as a protective factor. Several studies have found that social support before or after a torture experience acts as a protective factor from psychological distress. Lee (1988) found that strong family support before the traumatic experiences of the Holocaust acted as a protective factor in Holocaust survivors. Several authors explained that the surprising finding of low rates of psychological symptoms in torture survivors were possibly due to high levels of social support after the torture experience (Basoglu et al., 1994; Holtz, 1998). In a longitudinal study of torture survivors from various ethnicities, Carlsson, Olsen et al. (2006) found that strong social relations was related to both mental and physical health quality of life. In a study of Sudanese refugees resettled in Australia, Schweitzer, Melville, Steel, and Lacherez (2006) found that perceived social support from one’s own ethnic community significantly

predicted PTSD symptomatology, anxiety, and somatization symptoms. Gerritsen et al. (2006) found that less social support was significantly related to PTSD, depression, and anxiety in a study of Iraqi, Afghani, and Somali refugees and asylum seekers resettled in the Netherlands.

Advice. Advice is a form of social support identified as important factors in the well-being of torture and trauma survivors. Eyber and Ager (2002) conducted an ethnographic study of coping with loss and suffering in a sample of Angolan refugees and torture survivors. The participants identified "Conselho", advice or consolation, as a helpful coping mechanism. Conselho was given by family members, friends, elders, and church groups. Eyber and Ager (2002) found three main themes of Conselho. "First, death is natural and inevitable for all people…second, everyone suffers, and thus strength can be drawn from the fact that suffering is a shared experience…third, practical help must be given to people who are distressed" (pp. 871). These themes display how a collectivist culture views shared suffering.

Informal support networks. Informal support networks can be very beneficial to torture survivors. In a large study of Somali and Oromo refugee women resettled in the United States, many of whom were torture survivors, Robertson et al. (2006) found that while only 10% of the women received formal counseling services, 46% reported that they talked to friends to cope. Members of an informal social network often include family members, friends, religious leaders, neighbors, and coworkers who are supportive (Behnia, 2001). One form of informal connection with others is found in peer support groups. Behnia (2004) investigated the benefits of peer support groups. These groups allow survivors to meet other survivors who have experienced similar atrocities. Some of the other benefits include advice on new cultures and systems, finding friends, being understood, learning and talking about their problems, and learning about community services. Community gardens have also been used as settings for connecting

survivors with other survivors, community members, and caring professionals. The gardens allow survivors to reconnect with the land and provide a safe setting for survivors to express their challenges and hopes for the future (Grut, 2003).

Formal support networks. Besides relying on informal support, torture survivors may benefit from making meaningful connections with formal support networks. These people are turned to because of their training, credentials, and supposed expertise (Behnia, 2001). These professionals include medical doctors, nurses, psychologists, social workers, lawyers, case managers, etc. Behnia (2001) found that these relationships were particularly valuable when the survivors felt that the professionals spent quality time with them, really listened, and were truly trying to be helpful. These professionals are most effective when they are culturally competent. To make a strong connection, it is helpful for professionals to understand common torture and refugee experiences and the mistrust of professionals by refugees as well as the cultures the survivors come from. The survivors need to feel that their culture and beliefs are respected and they aren't going to be forced to change in order to receive help (Fong, 2004; Whaley & Davis, 2007). It is helpful for professionals to evaluate and understand their own cultural perspective and how they interact with the cultural perspectives of the survivors with whom they are working (Whaley & King, 2007).

Trust

Reestablishing trust in the social and natural environment has been identified as an important factor in getting better after torture. Because torture is deliberate, extreme harm from another person, trust in others is often shattered after a torture experience (Fabri, 2001; Piwowarczyk, 2005). Victims may also develop mistrust from others not believing their stories (Behnia, 1997). Tortures survivors particularly have a mistrust of authority which may prevent

them from seeking medical, legal, and mental health services. Once trust is re-established, survivors are much more likely to seek support from friends and service providers (Behnia, 1997; Yawar, 2004). Regaining the ability to trust allows the survivors to establish meaningful relationships and reduce fear of new people and situations (Behnia, 1997). Lemaire and Despret (2001) reported that their family therapy intervention in the former Yugoslavia was only successful once trust had been established. The families knew that the therapists cared for them and were trustworthy, so the families were willing to participate in services.

Physical Health

Improvement in physical health has been identified as an important factor in getting better after torture. Many non-Western cultures have a more holistic view of health and do not necessarily differentiate between physical and mental health (Vontress, 2001). Therefore, the whole person needs to get better. According to Wenk-Ansohn (2001), torture survivors often seek treatment first for their physical health concerns before seeking to address mental health needs. Treating physical health concerns is an important entry point in providing services. In addition, physical pain after torture experiences can serve as a reminder of the torture, which survivors may be trying leave in the past. In a study of Punjabi Sikh torture survivors, Rasmussen, Rosenfeld, Reeves, and Keller (2007) found that chronic injuries mediated the path between torture exposure and PTSD. In addition, although torture was not associated with depression, injuries were, indicating that the lingering effects of the injuries had more impact on current mood than just torture alone. In a longitudinal study of refugees from various countries resettled in Sweden, Hermansson et al. (2002) found that chronic pain as a result of war injuries was positively associated with depression and anxiety. Physical complaints were a stronger predictor of health-related quality of life and mental health than mental complaints in a

longitudinal study of refugees from various countries resettled in Denmark (Carlsson, Olsen et al., 2006). These studies indicate that mental and physical well-being are linked.

Traditional and Indigenous Healers and Rituals

A concept identified as important in the process of getting better is the use of traditional and indigenous healers, treatments, and rituals. These are treatments and rituals that occur naturally and are generated within the everyday environment of a person (Eagle, 1998). Traditional healers are important in the process of getting better because they are socially and culturally accepted in their communities (de Jong, 2004). People seek healing based on their cultural categories of causality and treatment, and therefore, they seek the experts in their culture (Pickwell, 1999). Traditional healers often view the individual in a more holistic manner than Western mental health providers in that they often consider the psychological, social, spiritual, and physical aspects of a person in diagnosing and treatment (Vontress, 2001). Since Western treatment models tend to disregard spiritual suffering traditional healers are sought (Vontress, 1991). These healers are experts in culturally based resiliency and coping strategies related to mourning, purification, healing, and reconciliation (de Jong, 2004). Treatments may include massage, acupuncture, herbal medicines, screaming, advice giving, drumming, dancing, and exorcism (Macgruder, Mollica, & Friedman, 2001; Vontress, 2001). Western models of treatment are often quite different from traditional treatments and, therefore, are not understood and often underused by torture and trauma survivors. Traditional healers provide culturally appropriate treatments and rituals that allow survivors to progress in getting better. They may engage in rituals that allow child soldiers and rape victims to be reintegrated into the community without stigma. Their services may be used for mourning rituals that allow families to mourn the dead and let the spirits of the dead move on to the next world (de Jong, 2004). In addition, use of

traditional healing is related to use of Western treatments. In a non-clinical study of Cambodian refugees, Berthold et al., (2007) found that seeking alternative medicine was significantly positively correlated to seeking Western treatments. Only a small percentage of the participants used alternative medicine without receiving Western mental health services.

Belief and Values Systems

Various aspects of belief and values systems have been identified as important factors in the process of getting better after torture and trauma, particularly in non-Western cultures.

Making meaning. In many cultures, religion and spirituality help shape how people understand difficulties and what is normal and abnormal functioning (Fallot, 2001). Making moral and spiritual meaning of experiences has been identified as an important aspect of the healing process after trauma (Frankl, 1962; Herman, 1992a; Hernandez, 2002; Solomon, 2004; Tedeschi, Park, & Calhoun, 1998). According to Vanista-Kosuta and Kosuta (1998), giving place to painful events in a person's story is a central component in the recovery of trauma. During and after torture and other traumatic experiences, it is common for survivors to try to make meaning of the experience. They may question their faith in God or the existence of God, wondering how God could allow such things to take place. A lifetime of faith may be extremely challenged and devastated. Some people may face similar experiences with their faith strengthened. They may also wonder how a person could intentionally hurt another person in such a manner (Ortiz, 2001; Piwowarczyk, 2005).

Religious and spiritual beliefs often influence the presentation and understanding of the torture experience. It is important to understand a person's spirituality before the torture to understand how the torture may have impacted their beliefs and to understand their worldview. In a study of recently traumatized adults, Overcash, Calhoun, Cann, and Tedeschi (1996) found

that experiencing a traumatic event did not challenge a person's spiritual beliefs, but provided a framework for understanding and coping. Spirituality and meaning making may promote healing in torture survivors by transforming alienation and isolation into connections with themselves, others, and communities. Spirituality may also promote health related behaviors and provide hope (Piwowarczyk, 2005).

Religious coping. Multiple studies have been conducted examining the role of religious and spiritual beliefs in the healing process. In a literature review of religious coping and posttraumatic growth, Shaw, Joseph, and Linley (2005) found that religious and spiritual beliefs and behaviors may develop through traumatic experiences and that they promote psychological recovery, personal development, and posttraumatic growth. In addition, they argue that religious beliefs can provide a systematic framework that may help victims accept difficulties and reassess their situations as less of a threat and more of a challenge to be overcome. Calhoun, Cann, Tedeschi, and McMillan (2000) found that ruminating about religious questions was associated with positive outcomes after traumatic events. Religiousness and spirituality have been found to be helpful in coping after trauma for Muslim-American women who experienced interpersonal violence (Hassouneh-Phillips, 2003), Somali and Oromo refugee young adults resettled in the United States (Halcon et al., 2004), Kosovar and Bosnian refugees resettled in the United States (Ai, Tice, Huang, & Ishisaka, 2005), Jewish teenagers in Israel facing threats of missile attacks during the 1992 Persian Gulf War (Zeidner, 1993), survivors of devastating effects of a flood (Smith, 2000) and a community sample of trauma survivors (Falsetti, Resick, & Davis, 2003). Particularly salient for refugee torture survivors, religious coping offers solutions to life's problems for people who have less access to mainstream social and economic resources (Pargament, 1997). Brune et al. (2002) investigated religious and political belief systems in 141

refugees from various countries who were tortured or experienced other war trauma. They found that a firm belief system, regardless of type, predicted lower levels of depression and higher levels of overall functioning. Jaranson et al. (2004) investigated religious commitment and mental health in tortured Somali and Oromo refugees resettled in the United States. They found that higher levels of social and psychological problems were associated with a decrease in religious practices, and any change in religious practices was associated with increased PTSD scores.

Religion can be a source of solutions or distress, depending on what aspects of religion are used to cope with stress. Through research with survivors of trauma, medical illness, and other serious negative events, Pargament, Smith, Koenig, and Perez (1998) identified two types of religious coping. The positive patterns of religious coping include religious purification, spiritual connection, seeking spiritual support, religious forgiveness, collaborative religious coping, religious focus and benevolent religious reappraisal. The negative patterns of religious coping include reappraisal of God's powers, spiritual discontent, interpersonal religious discontent, demonic reappraisal, and punishing God reappraisals. They found that people used positive coping strategies more consistently than negative coping strategies. The use of positive religious coping patterns was related to fewer symptoms of psychological distress and higher levels of spiritual and psychological growth as a result of the stressor. Negative religious coping was related to depression, poorer quality of life, and callousness towards others. Positive religious coping was used significantly more than negative religious coping by physically and/or sexually abused women (Fallot & Heckman, 2005) and Bosnian and Kosovar Muslims resettled in the United States (Ai, Peterson, & Huang, 2003; Ai, Tice, Huang, & Ishisaka, 2005). Fallot and Heckman (2005) also found that negative religious coping was related to higher levels of

emotional distress. In addition, in the studies of Bosnian and Kosovar refugees, positive religious coping was related to optimism (Ai et al., 2003), and higher levels of trauma was related to higher levels of negative religious coping (Ai et al., 2005).

Several studies have examined the role of spirituality and religious commitment in Buddhist torture survivors. Shrethsa et al. (1998) found that Buddhist religion predicted lower depression scores in a sample of tortured and non-tortured Bhutanese refugees in Nepal. Holtz (1998) found that Buddhist spirituality fostered resiliency in a sample of tortured Tibetan nuns and laypeople compared to a non-tortured matched group. These positive outcomes may be related to the Tibetan Buddhist beliefs and practices. Suffering in life is reflective of bad deeds done in a previous life or in the present life and must be dealt with as one's destiny. The person is accountable for the bad deeds. It is seen as empowering because a person can increase their karma for the next life with good deeds in this life. Also, there is a Tibetan belief that one's own suffering is small compared to the suffering of others. A person's own suffering may benefit someone else (Holtz, 1998; Shrestha et al., 1998).

Forgiveness. Related to use of religious beliefs in the process of getting better, forgiveness has been identified as a part of healing for some torture and trauma survivors. Although forgiveness may have different meanings from person to person, generally, "forgiveness consists of giving up one's right to retribution and releasing or letting go of negative affect directed toward the offender" (Toussaint, Williams, Musick, & Everson, 2001, pg. 250). Forgiveness can assist in lessening the pain of victimization and moving away from the identity as the victim (Staub, Pearlman, Gubin, & Hagengimana, 2005). In a study of military veterans, Witvliet, Phipps, Feldman, and Beckham (2004) found that lower levels of forgiveness were related to higher levels of PTSD and depression. Kaminer, Stein, Mbanga, and

Zungu-Dirwayi (2001) found that South African victims of human rights violations who were more forgiving had significantly lower PTSD scores than those who were less forgiving. In a study of New Yorkers one year following the September 11, 2001 terrorist attacks, being able to forgive was related to lower levels of stress, but was unrelated to posttraumatic stress symptoms (Friedberg, Adonis, Von Bergan, & Suchday, 2005). In a sample of college students who experienced interpersonal trauma, Orcutt et al. (2005) found that forgiveness mediated the relationship between trauma exposure and posttraumatic symptoms. In addition, studies have found that those who have received forgiveness interventions for incest survivors (Al-Mabuk, Enright, & Cardis, 1995) and perceived love deprivation (Freedman & Enright, 1996) displayed significant reductions in anger, anxiety, and depression when compared to control groups.

Another aspect of forgiveness that has been studied little is self-forgiveness, which includes "release of negative affect and self-blame associated with past wrongdoings, mistakes or regrets" (Toussaint et al., 2001, pg. 250). Toussaint et al. (2001) examined forgiveness across the age span in a random sample of adults interviewed by telephone. They found that self-forgiveness was negatively related to psychological stress across the age span, positively related to life satisfaction in young adults, and positively related to self-rated health in young and middle aged adults. Maltby, Macaskill, and Day (2001) found that both failure to forgive self and forgive others was related to anxiety and depression.

Understanding circumstances of perpetrators. Related to forgiveness is being able to understand the circumstances and take the perspective of the perpetrators promotes well-being. This involves seeking to understand why the perpetrators behaved the way they did in order to make meaning of the experiences. In a sample of Catholics and Protestants in Northern Ireland, Hewstone, Cairns, Voci, Hamberger, and Niens (2006) found that outgroup perspective taking

was significantly positively correlated to outgroup forgiveness, contact with outgroup friends, and outgroup attitude. Several studies of non-traumatized participants found that perspective taking of a wrong-doer promoted forgiveness (Hodgson & Wertheim, 2007; Takaku, 2001).

Witnessing Truth

Being able to witness the truth of what one survived as a torture victim has been identified as an aspect of getting better. Witnessing of truth can be a private or public act and can address individual or community suffering. Often, torture survivors' stories are denied or ignored because they are too painful to hear. By acknowledging the torture, people are drawn to action, which is often a difficult undertaking. In a sense, the perpetrators are continuing to exert power over the victim because the story is not believed (Ortiz, 2001). According to van der Kloot Mejiburg (2004), it is beneficial for survivors to have the individual and collective trauma acknowledged and believed by governments, caregivers, and others survivors come into contact with. When the individual or collective trauma is not acknowledged, survivors may spend their efforts proving the truth of their experiences instead of grieving and coping with their experiences.

Testimonial and narrative therapy. One form of witnessing is testimonial or narrative therapy. This method was first discussed by Cienfuegos and Monelli (1983) as treatment for survivors of political violence in Chile. In this treatment the survivor and interviewer work together to tell the survivor's story. Often the story is made in to a formal document, and together they look for ways to share the story with others. Testimony serves as a means for individual recovery from trauma through catharsis and exposure. Testimony is also an opportunity to bear witness to the historical and social effects of political violence, which is often overlooked in traditional Western treatment models (Agger & Jensen, 1990; Cienfuagos &

Monelli, 1983; Weine, Kulenovic, Pavkovic, & Gibbons, 1998). Testimony is an individual's narration of collective trauma put into a new context in which the survivor is able to develop new understandings of individual and collective history and community identity that supports social trust and peace (Weine et al., 1998). It is a constructive opportunity to integrate the individual's experience and history with the social and political context that lead to the torture (Cienfuagos & Monelli, 1983). Weine et al. (1998) explained that testimonial psychotherapy is beneficial to survivors of political violence, particularly with non-Western populations, because of the relational aspect of the survivor and therapist working together to develop the story. Also, it is similar to the oral traditions of the cultures that many survivors come from.

Weine et al. (1998) found that testimonial psychotherapy reduced symptoms of PTSD and depression in a group of 20 Bosnian refugees resettled in the United States. Cienfuegos and Monelli (1983) found that testimonial therapy was particularly beneficial for torture survivors. Twelve of 15 Chilean torture survivors reported that the use of testimony led to the alleviation of anxiety and acute symptoms such as depression, sleeplessness, and bouts of weeping. In a controlled study of Somali refugees resettled in Uganda, Neuner, Schauer, Klaschik, Karunakara, and Elbert (2004) found that brief narrative therapy significantly reduced PTSD symptoms at one year follow up compared to supportive therapy and psychoeducation.

Truth and reconciliation commissions. Another form of witnessing that has been identified as beneficial is participation in truth commissions such as the Truth and Reconciliation Commission (TRC) of South Africa. The task of the Commission was to expose and document human rights abuses committed during the government system of apartheid. It provided the opportunity for survivors of abuses to publicly or privately provide testimony of their experiences. Some perpetrators also gave testimony of the crimes they committed. One of the

goals of the Commission was to foster forgiveness and restoration through the testimonies and to grant amnesty to the perpetrators instead of seeking retribution by victims or the state. Amnesty was granted if the atrocities were politically motivated and if the perpetrator told the whole and complete truth. Plans for restitution were established as well (Truth and Reconciliation Commission of South Africa, 1998). It was believed that uncovering the truth would lead to social and psychological healing (Asmal, Asmal, & Roberts, 1994). In a study of a group intervention to promote forgiveness in Rwanda following the 1994 genocide, Staub et al. (2005) found that survivors of human rights violations were more willing to forgive if others acknowledged their wrongdoings in the group.

In several ways, TRC did not achieve their intended goals. According to Lykes, Blanche, and Hamber (2003), collective healing was given precedence at the expense of individual healing. People were encouraged to testify, but they did so for many different reasons and expectations. Some testified to receive restitution, share pain, instigate investigation into their case, set the facts straight, or ensure justice (Lykes et al., 2003). Because of the diverse reasons for testifying and the focus on collective healing, many survivors felt let down with the results of the Commission (Hamber, Nageng, & O'Malley, 2000; Lykes et al., 2003). In the final TRC report it was acknowledged that while there were collective benefits of the Commission, individual healing is very complex and bearing witness was just one part of the process (Truth and Reconciliation Commission of South Africa, 1998). In a similar vein, Kaminer et al. (2001) studied South African survivors of human rights violations, some of which testified in the TRC. They found that participating in the TRC was not related to forgiveness attitudes or current psychiatric status. The authors concluded that TRC should only be part of, rather than a substitute for, therapeutic interventions following human rights violations.

Justice

One of the criticisms of truth commissions is that survivors do not feel that justice has been served. Civil and restorative justice has been identified as important components of getting better. In addition to the threat of safety and life, torture is a human rights violation. The perpetrator seeks to humiliate, degrade, and dehumanize. Survivors of torture most often want justice to be served for the crimes committed. They may want the perpetrator punished and amends made. Life after torture may be dominated with anger towards the perpetrators and the survivor may be obsessed with seeking justice (Silove, 1999). Impunity for perpetrators of human rights violations may contribute to social and psychological problems and slow down the healing in torture survivors (Carmichael, McKay, & Dishington, 1996; Gordon, 1994; Lagos, 1994; Lagos & Kordon, 1996). Impunity of perpetrators may lead to feelings of insecurity, fear, and helplessness in a society. It implies an acceptance of violent behavior in a society. It may also enhance posttraumatic stress responses, self-blame, and guilt. It may also impede the bereavement process (Lagos, 1994). Many survivors of human rights violations feel that healing can only begin after justice has been served (Allan & Allan, 2000).

Civil or retributive justice. The first form of justice applied in human rights violations is civil or retributive justice. In this case, crimes are against the state and the focus is on punishing the perpetrator. International criminal tribunals are established to convict and punish perpetrators (Kilpatrick & Ross, 2001). In a study of Iraqi survivors of human rights violations resettled in the United States, Kira et al. (2006) found that a strong belief that justice was served with the fall of the Saddam Hussein regime significantly predicted an increase in futuristic orientation, socio-cultural adjustment, and posttraumatic growth. This form of justice has received criticisms in that it is difficult in a setting such as South Africa where many crimes were

committed over the course of many years and new leaders want to move forward and not look back. It has also been criticized because it can be difficult to prove beyond reasonable doubt that the perpetrator committed the crimes, it is often very expensive, and survivors may feel that what they have lost has not been restored (Allan & Allan, 2000).

Restorative justice. The second form of justice applied in human rights violations is restorative justice. The focus of restorative justice is to hold perpetrators accountable for the crimes committed by requiring apologies for the crime and repayment to the survivors for their losses. The focus is on the well-being of the survivor instead of punishing the perpetrator (Kilpatrick & Ross, 2001). The theory is that the apology and reparations lead to individual and community healing. As previously noted, a major facet of truth commissions is to promote restorative justice. Regehr and Gutheil (2002) state that the apology is often very important for victims of crimes even if the perpetrator is jailed or the victims receive compensation. There are three key components to an apology: 1) acknowledgement of the offense, 2) taking responsibility of fault, and 3) a pledge that the act will not be committed again (Regeher & Gutheil, 2002). Another important aspect of restorative justice is reparation or repairing the damage. This may come in the form of monetary compensation, recognition, medical and educational services, pension rights, and/or rehabilitation (such as providing counseling services) (Allan & Allan, 2000; Carmichael et al., 1996). Success in receiving reparations may help survivors gain trust in others, self-esteem, and hope in regaining control over their lives and the possibility of moving on with life (Carmichael et al., 1996).

As mentioned previously, the restorative justice model has received criticisms. Survivors may feel that the perpetrators are receiving a punishment that is not proportionate to the crime committed. Survivors may feel that the perpetrators are receiving more support than they are.

The survivor may feel their safety is still threatened. Survivors are again at the mercy of the perpetrators in that they must rely on the perpetrator to be engaged in the process in a fair and meaningful way (Regher & Gutheil, 2002).

Getting Life Back Into a Routine

Getting life back into a routine and focusing on the present has been identified as an important aspect of getting better after torture and trauma (Almedon & Summerfield, 2004). According to Turkovic, Hovens, and Gregurek (2004), taking part in normal routines such as work, sports, and social activities is helpful in regaining self-respect and self-confidence. It allows survivors to regain control of their lives. Cienfuegos and Monelli (1983) stated that getting life back into a routine "involves making [one's] previous history—political commitment, personal relationships, work, and social connections—meaningful in the present and future" (p. 44). Silove (2005) argued that the best treatment for immediate care after a crisis is social interventions that provide opportunities for work and study, reunite families, provide safety, establish effective systems of justice, and re-establish religious, social cultural and cultural systems. Summerfield (2003) found that Kosovar refugees did not feel they had mental health issues and did not want counseling. They were concerned with finding adequate employment, family reunification, and education.

Not dwelling on the past. Another aspect of getting life back into a routine is not dwelling on the past. In contrast to research supporting disclosure, narrative, and other exposure therapies, several researchers argued that working through the past and telling one's story are not necessary (McKinney, 2007; Summerfield, 1999). They argued that sociopolitical factors and interventions that help people get their lives back into a routine and establish stability may be overlooked by focusing on intrapersonal factors. Angolan survivors of civil war gave advice of

"don't think too much" in order to heal. They recommended not dwelling on the past but focusing on the present and taking responsibility for themselves and their families. They encouraged widows and widowers to remarry soon and women of childbearing age who had lost children to become pregnant soon (Eyber & Ager, 2002). In a study of New Yorkers one year after the September 11, 2001 terrorist attacks, Friedberg et al. (2005) found that higher levels of rumination about the events was related to elevated stress and trauma levels.

Empowerment

Empowerment is another concept that has been identified as important in the process of getting better after torture. According to Jaranson et al. (2001), empowerment is regaining a sense of control that was lost during the torture experience. The torture survivor had control taken away during the torture experience and imprisonment as well as after the experience when the survivor may have been dependent and anonymous in a refugee camp or detainment center. There may also be a lack of recognition of previous roles, status, and qualifications in the resettlement environment (Silove, 1999). Empowerment is important in the process of getting better because it is vital for survivors to regain the control and power that was stolen from them. Survivors need to feel in control of the getting better process in order to move forward because they may reject opportunities for getting better if they feel they are being forced. It is empowering for the survivor to be able to create a space of his or her own where difficult issues can be discussed and dealt with (Fabri, 2001). When survivors feel empowered in their lives they gain self-esteem, act with more confidence, and take responsibility for their growth and healing (Curling, 2005; Herman, 1992a).

Empowerment can be promoted through witnessing the truth of the experiences and being believed as well as reintegrating back into the political process (Jaranson et al., 2001). In

addition, empowered torture and war trauma survivors can then assist others who need help. This makes them less dependent on mental health programs and eliminates the stigma of seeking services from mental health institutions (van der Veer, 2000).

According to Ortiz (2001), even the use of the terms “victim” and “survivor” imply different levels of empowerment. The term “victim” implies that the experience has made the person weak, defenseless, in need of sympathy and in need of someone to control his or her life. The term defines the person as the torturer tried to leave them: weak and helpless. On the other hand, the term “survivor” implies that even though the person has been through atrocities, he or she has survived and can greet each new day with strength that helps him or her reclaim dignity, hope, and trust.

Summary of Literature

Traditional Western mental health treatment for torture survivors has focused on reducing symptoms of psychopathology, particularly PTSD, depression, and anxiety. In this system mental health professionals are the experts who teach the survivors how to reduce symptoms to get better. The process of getting better after torture experiences may be broader than the traditional Western model. A number of issues have been identified in the literature as being important in this process: social support and reconnection, trust, physical health, indigenous healers and rituals, belief and values systems, forgiveness, witnessing truth, justice, getting life back in to a routine, and empowerment.

Little research has been done seeking to understand the meaning and process of getting better after torture and war trauma from the survivors’ perspective (Fuertes, 2004; Hamber et al., 2000). Factors identified are most often identified by the experts, who are usually Western researchers and mental health professionals. The experts, rather than the survivors themselves,

have identified aspects in the lives of survivors of torture that need to be improved in order to get better. The result has been the spread of Western cultural trends toward medicalizing distress and an expansion of traditional psychotherapy, which often ignores local meaning systems, traditions, coping mechanisms, and priorities of the communities (Fuertes, 2004; Summerfield, 1999). In addition, theories have been developed (Silove, 1999) that describe the aspects of torture and trauma survivors' lives that are impacted and need to be improved, but do not describe how this should be done. This study sought to expand our understanding of the meaning and process of getting better from the torture survivor's perspective.

Rationale for the Present Study

The present study aims to understand the process of "getting better" from the torture survivor's perspective and what aspects of the survivor's life needs to be impacted in order to get better. A secondary aim is to understand what getting better means to survivors of torture because it will lay a foundation for understanding what they are working toward. Little research has been conducted seeking to understand the healing process from the perspective of the torture survivor. Watters (2001) argued that having refugees identify their own needs and goals in recovery and healing is crucial in order to develop services that appropriately address those needs and goals.

Broad focus on strategies used and identified traumatic experiences. In an attempt to describe how getting better takes place, it may be difficult to differentiate what strategies in getting better were already in place before the torture experience and what were developed after the torture experience. For the purposes of this study, I did not focus on the chronology of the development of the strategies; I simply analyzed strategies used after the torture experience, regardless of when the strategies were developed. In addition, I acknowledge that for many of

my participants, the torture experience was just one of several traumatic or extremely difficult experiences that occurred before or after the torture. I focused on getting better after torture with the understanding that they may have been striving to get better from other difficult experiences as well.

Emphasis on perspective and understanding of survivor. A review of the literature reveals that aspects of getting better after torture (social support and reconnection, trust, physical health, the use of traditional and indigenous healers and rituals, use of religious and spiritual belief systems, forgiveness, witnessing truth, justice, getting life back into a routine, and empowerment) have been investigated, some in great detail, but have rarely been studied from the survivor's perspective. It is essential to understand the survivor's perspective as governments, communities, and health professionals work to integrate survivors back into society. This understanding will allow communities and service providers to know where to begin to help survivors of torture because the survivors have identified how the process works, what aspects of their lives need to be impacted, and how these aspects are prioritized. This allows for more culturally sensitive interventions that may not correspond with typical Western treatment models.

Personal interest in research topic and experiences with torture survivors. I became interested in this topic through my clinical work and research in graduate school. I worked with refugee adolescents in mentoring programs that we designed with the help of local service agencies. We realized that unless we sought input from the adolescents, our well-intentioned plans would fail. We had to meet them at their level of interest in order to engage them. In addition, I began working at the Center for Torture and Trauma Survivors and saw the devastating effects of torture in the lives of the survivors. I was a co-leader of a

psychoeducational group for survivors. We developed topics for the group that covered PTSD symptoms, coping strategies, tips for better sleeping and nutrition, and acculturation issues. The clients quickly bonded in the group and felt that the topics were helpful. But the greatest impact of the group, as identified by the group members, was the social support they received from each other. Without discussing their torture experiences directly, they understood what each other had been through. The group quickly moved from a psychoeducational group to a support and process group. We discussed issues impacting their lives currently: applying for Medicaid, difficulties with children, family reunification, traditions and rituals from their cultures. They were reconnecting with people. I realized that the traditional Western methods of treatment were not being applied in this group but the members seemed to be getting better. They were smiling more, making eye contact, sitting relaxed, listening, and finding jobs. I wanted to know from their perspectives how they viewed the process of recovery, healing, or getting better.

Theoretical Basis for Qualitative Methodology

A qualitative approach was chosen because it allows for the richness of human experience to be explored, for meanings to surface, and for new areas to be explored (Miles & Huberman, 1994). Several factors led me to choose qualitative methodology over quantitative methodology. Quantitative research does not capture the individual's point of view because of the focus on the numerical properties of the data and the strategies for comparison that permit tests of significance and statistical inferences (Denzin & Lincoln, 2000). Qualitative research allows for the informant's voice and interpretation of experience to be expressed (Creswell, 1998). The emphasis is on the range and the qualities of these experiences and the constructions of themes across multiple respondents. I did not feel that a quantitative study would be appropriate because that would require me to choose what aspects of getting better *I* thought

would be important to them. As reported above, professionals too often assume they know what is best for survivors of torture and trauma. This keeps them from fully understanding the torture experience and the process of getting better. I also recognized from administering mental health questionnaires with the survivors from non-Western cultures that responses did not seem very valid because of language and cultural barriers (Summerfield, 2003). It was clear that it was not enough to communicate symptoms of pathology experienced in the past month on a Likert scale; clients wanted to talk about how they were feeling right then, and they wanted to tell me a story of their experiences that went beyond predetermined symptoms of psychopathology. Qualitative research promotes a holistic perspective in which a rich narrative can be developed that helps the researcher understand multiple dimensions and complexities of a phenomenon (Creswell, 1998). In addition, the *process* of getting better is the key component of my study. Quantitative studies emphasize the analysis of causal relationships between variables, not processes, which can be examined through qualitative methodology (Denzin & Lincoln, 2000).

Assumptions and Justification for Grounded Theory

After reviewing traditions of inquiry and the philosophical assumptions of qualitative research, I decided to use a grounded theory methodology to analyze the data, which allows for the emergence of themes and categories (Strauss & Corbin, 1990). The purpose of grounded theory is to "generate or discover a theory, an abstract analytical schema of a phenomenon, that relates to a particular situation. This situation is one in which individuals interact, take actions, or engage in a process in response to a phenomenon" (Creswell, 1998, p. 56). This provides a framework for systematically collecting and interpreting data and allows ideas about the phenomenon to be shaped by the data (Strauss & Corbin, 1990). The goal of grounded theory is to study how people act and react to a phenomenon and to connect those actions and reactions

into categories of information that form cohesive theoretical propositions or hypotheses. The theories should be "grounded" in the data from the field, with an emphasis on the actions, interactions, and social processes of people (Creswell, 1998). Because of my interest in the process of getting better after torture, a grounded theory approach is appropriate because it allowed me to build a theory about the *process* of getting better and not simply *describe* the phenomenon of getting better after torture. A grounded theory approach enabled me to learn about the process of getting better after torture directly from the survivors, in a manner that is much more natural for them than typical quantitative methods.

Research Questions

To address the process of getting better after torture, the following research questions guided the investigation:

1. What does "getting better" after the experience of torture mean to survivors?
2. What are the recurrent themes in getting better?
3. What signs of getting better do torture survivors identify so that those who provide service and support can recognize when torture survivors are getting better?
4. What aspects of the lives of torture survivors should be part of an intervention if they are to get better?

Chapter 2: Methodology

Through the qualitative methodology of grounded theory, this study aims to understand what "getting better" means to torture survivors, how they understand the process of getting better, and what aspects of their lives need to be impacted for this to take place.

Sampling Procedures

My sampling strategies were purposeful and criterion-based to ensure that each individual was uniquely qualified to answer my research question (Creswell, 1998). Participants in the study were clients at the Center for Torture and Trauma Survivors (CTTS) affiliated with the Dekalb County Board of Health in Decatur, Georgia. Participants were invited to participate if they met the following criteria:

1. Participants met criteria for experiencing torture as defined by the United Nations (1984), as described above.
2. They were targeted for torture due to political intentions of perpetrators.
3. They must not have been suicidal and in acute crisis and must have been in a stable living environment (i.e. permanent residence), as determined by the participants themselves and CTTS staff.
4. All participants must have been at least 18 years old.
5. They must have already received legal status in the United States. People who are seeking asylum are often in a state of limbo and anxiety, and they may feel that their healing journey has yet to begin.
6. A year must have passed since they arrived in the United States, allowing them to settle into their environment and begin the acculturation process.

7. One year must have passed since the torture experience. This allowed participants to process their experiences somewhat and to begin the healing process.
8. Participants must have been receiving services at CTTS for at least six months to ensure a level of comfort with the setting and allow staff to make informed recommendations for potential participants. This assured familiarity with and likely willingness to accept services from the center's staff, which was crucial if participants became emotionally overwhelmed (dissociating, experiencing flashbacks and panic symptoms, etc.) during the study.

A list of potential participants was developed as CTTS staff reviewed individual files to determine which clients meet criteria for the study. During clinical staff team meetings, staff at CTTS reviewed the list of potential participants to discuss the emotional and environmental stability of the clients (as defined above). This was done independently of the researchers in order to preserve the confidentiality of the participants and to allow staff to select participants without influence from the researchers. The staff decided which clients to approach to invite to participate. As vital members of the research team, case managers helped shape the questions to make them culturally appropriate, select participants, and ensure that the procedures and gifts were culturally appropriate. In person or by telephone, case managers recruited the potential participants by reading a brief description of the study (see Appendix A for the description read to potential participants). Before each interview, prospective participants were questioned briefly by me with case mangers present at CTTS to determine whether or not they qualified for the requirements of the study and to explain in more detail the nature and import of the study.

Participants

In the present study, 11 people were interviewed, nine men and two women. Participants came from various countries including four from Vietnam, three from Somalia, and one each from Eritrea, Ethiopia, Liberia, and the Democratic Republic of Congo. The participant age range was 39-80, and time since the torture experience ranged from 10 years to 32 years. The length of time living in the United States ranged from 3 years to 22 years, with an average of 10 years. One additional person began but did not complete the interview because she apparently moved from Atlanta. And only one person refused to participate after having read the consent form.

Interview Procedures

At the beginning of each interview the participants read and signed a consent form that described the nature of the study and were then assigned an identification number. Confidentiality and the emotional nature of the study were discussed. All participants were informed that they could stop the interview or take a break at any time. They were also informed that they could refuse to answer any questions. This allowed participants to remain in control and maintain personal boundaries during the interview. Consent forms were translated into Vietnamese and Somali. The text of the informed consent document is provided in Appendix B.

Use of Interpreters

Interpreters were available to all participants whose first language was not English. Participants were encouraged to have the interpreter present and to use the interpreter during the interviews. This allowed participants to speak in the language they felt comfortable using, particularly when emotional topics were discussed (Murray & Wynne, 2001). The interpreters were case managers at CTTS as well as one trained interpreter independent of CTTS. All of the

interpreters were certified, professional interpreters. CTTS interpreters use the metaphor model of interpreting, which means they do not do a literal, word for word interpretation, but they interpret for connotation and the overall meaning intended by the participant. Using case managers as interpreters was beneficial because they already had established friendly, working relationships with the clients. The interpreters were trained in the nature and procedures of the study and the potential questions that participants might be ask. It was important to clarify the role of the case manager as an interpreter in this situation (Murray & Wynne, 2001). They were no longer playing a role in providing services and support. They were encouraged to interpret the words of the participants as closely to the intended meaning as possible. I discussed with each interpreter his or her viewpoints on the various topics to be discussed so I could understand the lens through which he or she interpreted (Temple, 2002; Murray and Wynne, 2001). Although I encouraged them to be as objective as possible, I acknowledge that the interpreters worked from their own perspective. Although the results do not seem to reflect interpreter bias, using case managers from CTTS as interpreters may have influenced the responses in the interviews.

Interview Guide Development

Two pilot interviews were conducted to help me gain experience with the interviewing process, the specific questions being asked, and the likely topics of discussion. These interviews helped me to develop the interview so that the concepts discussed and questions asked made sense to the participants. Several questions were added to the interview guide as a result of the pilot interviews (questions #12 and #13). I determined at a later point in the analysis process that the data gathered in these interviews were valid and thus were used in the data analyses. The themes in these interviews were similar to the other interviews, and the interview process was consistent with later interviews. The following interview guide was used during the interviews:

1. What experiences did you have that led you to this program (CTTS)?
2. How long did they last?
3. Have there been other big challenges for you since_____ (use their words)?
4. What is different about you since then? What remains the same?
5. What were some of the most memorable experiences and challenges you had after _____ (use their words to name the experience)?
6. As you began moving on with your life, what were your goals or aims? Was "healing" or "getting better" one of your goals? What does "getting better" mean to you? How do people think about this in_____ (name of person's home country)?
7. Were your goals for getting better different or similar to the traditional ones in your country?
8. Could you share an experience that helped you get better?
9. How would I know you are getting better?
10. What has been the most helpful in the process of getting better?
11. How have other people helped in the process of getting better?
12. Have there been any setbacks in the process of getting better?
13. What would you recommend to people who have recently been through similar experiences?
14. What can CTTS do to help you get better?

Initial Interviews

I conducted all of the interviews with the exception of one which was conducted by an advanced graduate student in clinical psychology. Both of us had been working at CTTS for over a year and were familiar with the setting, staff, and client population. Each interview took

place in a private office at CTTS. A basic demographic questionnaire was administered at the beginning of each interview (See Appendix C for questionnaire). The initial interview lasted approximately 1-1.5 hours. These semi-structured, formal field interviews allowed the participants to discuss freely the topic with minimal direction from the researchers and allowed for adjustments in questions as themes and categories emerged (Fontana & Frey, 2000). Our responses focused on active listening and clarification.

Follow-up Interviews

Follow-up interviews were conducted for about one hour with the participants. In accordance with grounded theory methodology, theoretical sampling was used to extend the interviews. As themes emerged, gaps and holes in the theory also surfaced, so I sampled specific issues that helped fill gaps and made the categories more definitive and useful (Charmaz, 2000). These issues were topics identified in the literature (as described previously) as important in the process of getting better but which the participants did not discuss in the first interview, as well as topics that previous participants discussed. Participants were also given the opportunity to add comments to any themes from the previous interview or to bring up additional themes.

Following the interviewing, member checks were performed in which we orally presented to each participant a summary of the information gathered during his or her interview (Lincoln & Guba, 1985). The participants were asked if the information was accurate and what, if any, changes should be made to the summary. This was done to determine the credibility of the interpretation of the interview (Janesick, 2000). All participants received a gift for their participation equivalent to about ten dollars. These gifts included gift certificates to a local grocery store, nutrition drinks, and vitamins.

Data Recording

During the interviews, we took brief notes on themes and impressions that arose (Miles & Huberman, 1994). These notes allowed us to refer back to our thoughts as they were occurring, instead of trying to recreate the situation later on. They also permitted us to begin to analyze the data as it was gathered. As recommended by Miles and Huberman (1994), after each interview, the interviewer completed a contact summary sheet that included a brief review of the main issues and themes, information related to specific questions, initial thoughts and reactions related to the interview, and recommendations for the follow up interview. This way, the interviewer could immediately write down impressions and thoughts about the interview, including themes that emerged. The majority of the interviews were audio-recorded and transcribed later to allow the researchers to give full attention during the interviews. The Somali participants refused to be tape-recorded, and, therefore, the researchers hand-wrote the interviews.

Data Collection and Analysis

Data consisted of more than 21 hours of interview time. Interviews that were audio-taped were transcribed by me. Another research assistant reviewed sections of interviews that were difficult for me to understand because of the accents of the participants and interpreters. The data were collected over a five-month period and subsequently analyzed using NVivo, one of the leading qualitative data analysis software packages. Transcripts and notes were imported directly into the program. The program provides functions for categorizing, defining, editing, searching and merging codes and categories and is also equipped for the development of matrixes. The program allows memos and codes to be tagged directly in the text and linked to other sections of text and memos. All data were strictly confidential and used only for this proposed project. Confidentiality was maintained by using project identification numbers only on all identifying

documents, audiotapes, and transcripts. All tapes, transcripts, field notes, and memos were stored in a locked and secure area, accessible only to the research team.

Data were examined after each interview to allow for adjustments in the interview guide and to begin exploring potential themes and categories of getting better after torture. As recommended by Miles and Huberman (1994), I held case analysis meetings with my research associates periodically to summarize the status of the study. Interpretations, emerging concepts and categories, and future directions were discussed.

Description of Coding

Coding is the basic form of data analysis in grounded theory. Strauss and Corbin (1990) define coding as the "operations by which data are broken down, conceptualized, and put back together in new ways" (p. 57). Codes are labels used for assigning meaning to chunks of descriptive or inferential data gathered in the interviews (Miles & Huberman, 1994).

Throughout the coding process, the coders and I wrote self-reflective and analytic memos. As notes related to the formulation of hypotheses and theory, memos allowed us to immediately keep track of operational procedures and thoughts and impressions about emerging themes and processes of getting better after torture throughout data analysis (Strauss & Corbin, 1990).

There are three types of coding that serve different analytic purposes: open coding, axial coding, and selective coding. Once a provisional coding scheme was developed, it was typical for us to alternate between forms of coding and use them simultaneously as data were analyzed. The first phase of data analysis is open coding. According to Strauss and Corbin (1990), open coding "fractures the data and allows one to identify some categories, their properties and dimensional locations" (pp. 97). In open coding, concepts are identified first. Strauss and

Corbin (1990) define concepts as “conceptual labels placed on discrete happenings, events, and other instances of phenomena” (pp. 61). As concepts are identified, themes and patterns emerge. Similar concepts are grouped together into categories and subcategories (properties within categories). This reduces the amount of pieces of data to be analyzed. The categories are analyzed according to their dimensions to show the extreme possibilities along a continuum.

Preliminary Open Coding

After each interview was transcribed, I read the interviews searching for patterns and themes of the meaning and process of getting better after torture. I created an a priori coding scheme based on the research questions, review of literature, and my conceptual framework (Miles & Huberman, 1994). The start list was modified as codes and themes emerged. The specific words and phrasings of the participants assisted us in the development of codes and categories. As the interviews progressed, I had several colleagues read the interviews to examine themes and to help determine which concepts and themes needed to be examined further in subsequent interviews. As data collection came to a close I began refining my “start list” into a formal coding scheme or code book. I defined the codes and reviewed the code names and definitions with both experts and non-experts to ensure that the intended meaning of the codes was easily understood.

Training of Coders

At this point, I verified the revised coding scheme and categories with the research assistants. The research assistants were a licensed psychologist at CTTS, two graduate students in clinical psychology, and a graduate student in applied linguistics. Verifying the coding scheme and categories entailed training them to locate and code themes in a transcript interview. After reviewing the coding scheme developed by the process described above, I gave the

research assistants a copy of a transcript with highlighted text that represents codes. Some segments of highlighted text did not fit into any categories. These were ringers that were put in for coders to detect segments of text that were inappropriate to code, and, thus, should not receive a code. Once the coders chose the codes they thought were appropriate, we examined how well our codes matched. Codes were discussed to clarify definitions. After this initial training, I sent them away with a transcript to open code on their own to test out the coding scheme. After this coding, we met together to decide if the themes represented the content of the data and to decide if the names of the categories were appropriate. They also recommended an additional theme that they noticed which I had not taken into account: self-forgiveness of the atrocities. The codebook was then adjusted following the recommendations of the coders.

Intercoder Agreement

Intercoder agreement was initially assessed examining agreement on the transcript given to the coders at the end of training. The transcripts were not pre-structured into codable sections prior to the open coding, and, thus, transcripts were treated as continuous data by the coders. In addition, passages were coded into multiple categories or no categories at all. Because of this open coding method, chance agreement was low. Agreement was calculated by dividing the number of agreements by the number of instances the categories were used by either judge. Agreement was calculated for all 11 major categories separately. Agreement between each individual coder and me was calculated and then a total agreement of all four coders compared to myself was calculated. According to Lombard, Snyder-Duch, and Bracken (2005), a minimal level of agreement of 70% is acceptable for exploratory studies such as the present study. After calculating agreement for the first transcript, an acceptable level of agreement was attained for several categories (faith/spirituality/religion, received social support, sharing experiences, and

U.S. social/cultural environment), while other categories did not reach the acceptable levels of agreement (see Table 1). Because of the lack of adequate agreement, adjustments were made to the definitions of codes and further training was conducted with coders to enhance understanding of codes and categories. Agreement was calculated again from the first transcripts that the judges coded during the focused open coding phase of analysis for the categories that did meet an adequate level of agreement (see Table 2). Several more categories reached adequate agreement (seeking to understand another person's circumstances/beliefs, helping others, challenges in getting better, and signs of healing/definitions of getting better) as a result of the adjustments to the codebook and training. Possible reasons for inadequate agreement for the remaining categories (controlling/improving ill health and future oriented) are addressed in the discussion section. The theme of justice was used so little that it was not coded in any of the interviews included in the intercoder agreement analysis.

Focused Open Coding

Once the data were collected, the revised coding scheme was further refined into a codebook, and it was used to complete the training of coders for the focused open-coding phase. Due to the small number of interviews, I decided to code each interview myself along with one other coder. The final version of the codebook was used to code each interview. Data were usually analyzed sentence by sentence with some segments receiving more than one code. Because of the resulting lack of sufficient intercoder agreement for several major categories, I decided to discuss these discrepancies individually with the coders for all the interviews. For each interview, once the coder and I finished coding the interview independently I would examine both coded versions of the interviews for disagreements in coding. We then discussed each disagreement discrepancy to decide which code was most appropriate. With the changes

Table 1

Original Intercoder Percentage Agreements

Category	**Intercoder Agreement #1**			**Intercoder Agreement #2**		
	# Agree	# Disagree	% Agreement	# Agree	# Disagree	% Agreement
Faith/Religion Spirituality	30	5	86	31	4	89
Seeking to Understand	4	0	100	3	2	60
Justice	0	0	n/a	0	0	n/a
Received Social Support	17	1	94	14	6	70
Helping Others	3	4	43	4	2	67
Sharing Experiences	5	0	100	4	2	67
U.S. Social Environment	8	0	100	2	1	67
Controlling/ Improving Ill Health	2	1	67	2	1	67
Future Oriented	3	4	43	3	3	50
Challenges in Getting Better	5	2	71	5	3	63
Signs of Getting Better	3	0	100	1	2	33

Table 1 (continued)

Original Intercoder Percentage Agreements

Category	**Intercoder Agreement #3**			**Intercoder Agreement #4**			
	# Agree	# Disagree	% Agreement	# Agree	# Disagree	% Agreement	**Average Agreement**
Faith/Religion Spirituality	31	7	82	28	6	82	85
Seeking to Understand	1	4	20	3	2	60	58
Justice	0	0	n/a	0	0	n/a	n/a
Received Social Support	12	5	17	13	6	68	76
Helping Others	2	3	40	2	2	50	50
Sharing Experiences	5	0	100	4	1	80	86
U.S. Social Environment	8	1	89	6	1	86	89
Controlling/ Improving Ill Health	1	3	25	3	6	33	42
Future Oriented	1	6	14	4	4	50	39
Challenges in Getting Better	1	4	20	6	1	86	63
Signs of Getting Better	1	0	100	4	3	57	64

Table 2

Intercoder Percentage Agreements after Revisions to Codebook

Category	**Intercoder Agreement #1**			**Intercoder Agreement #2**		
	# Agree	# Disagree	% Agreement	# Agree	# Disagree	% Agreement
Faith/Religion Spirituality	n/a	n/a	n/a	n/a	n/a	n/a
Seeking to Understand	1	0	100	4	1	80
Justice	0	0	n/a	0	0	n/a
Received Social Support	n/a	n/a	n/a	n/a	n/a	n/a
Helping Others	2	0	100	4	2	67
Sharing Experiences	n/a	n/a	n/a	n/a	n/a	n/a
U.S. Social Environment	n/a	n/a	n/a	n/a	n/a	n/a
Controlling/ Improving Ill Health	0	0	n/a	9	5	64
Future Oriented	0	4	0	4	4	50
Challenges in Getting Better	5	2	71	10	4	71
Signs of Getting Better	4	0	100	6	2	75

Table 2 (continued)

Intercoder Percentage Agreements after Revisions to Codebook

Category	**Intercoder Agreement #3**			**Intercoder Agreement #4**			
	# Agree	# Disagree	% Agreement	# Agree	# Disagree	% Agreement	**Average Agreement**
Faith/Religion Spirituality	n/a	n/a	n/a	n/a	n/a	n/a	85
Seeking to Understand	0	0	n/a	1	0	100	86
Justice	0	0	n/a	0	0	n/a	n/a
Received Social Support	n/a	n/a	n/a	n/a	n/a	n/a	76
Helping Others	3	1	75	1	1	50	71
Sharing Experiences	n/a	n/a	n/a	n/a	n/a	n/a	86
U.S. Social Environment	n/a	n/a	n/a	n/a	n/a	n/a	89
Controlling/ Improving Ill Health	0	2	0	4	4	50	54
Future Oriented	4	1	80	4	1	80	55
Challenges in Getting Better	2	2	50	3	0	100	71
Signs of Getting Better	2	2	50	1	1	50	72

made to the code book recommended by my coding team and the resolution of disagreements, I decided that saturation had occurred—the point at which new data fit into existing categories established during the refinement of the coding scheme (Morse, 1995). See appendices D and E for the final versions of the codebook and code definitions, respectively.

Axial Coding

The next phase of data analysis in grounded theory is axial coding. While open coding is breaking down the data to search for themes, categories, and dimensional locations, according to Strauss and Corbin (1990), "axial coding puts those data back together in new ways by making connections between a category and its subcategories" (pp. 97). By adapting the paradigm model put forth by Strauss and Corbin (1990) in the axial coding phase of data analysis, I examined the data systematically, looking specifically at context and conditions that enabled getting better.

Strauss and Corbin's paradigm model. Before my adaptation of the Strauss and Corbin (1990) paradigm model is explained, it is important to describe the Strauss and Corbin model (see Table 3). Strauss and Corbin (1990) begin by describing the phenomenon. Next is examination of the causal conditions, events that lead to the occurrence of the phenomenon. The context of the phenomenon is examined. The context is the specific set of properties and conditions related to the phenomenon under which the action strategies are handled. Once this general context is defined, the intervening conditions--broad and general conditions in the context that facilitate or constrain the action strategies--are considered. These intervening conditions may include culture, time, socioeconomic status, and personal and group history. Action/interactional strategies the participants adopted are then examined. Strauss and Corbin (1990) stress that grounded theory focuses on the actions/interactions of people in handling,

managing, and responding to a phenomenon. Finally, by analyzing the consequences of the action/interaction strategies, the successfulness of these strategies may be determined and they may be examined and categorize accordingly.

Table 3

Comparison of Paradigm Models

Strauss & Corbin Paradigm Model	**Connections Between Corresponding Categories**	**Adapted Paradigm Model**
Causal Conditions		Enabling Conditions
Phenomena		Coping Strategies
Context		Barriers
Intervening Conditions		Central Phenomenon
Action/Interactional Strategies		Indicators and Consequences of Getting Better
Consequences		

My adaptation of the paradigm model. I adapted the Strauss and Corbin (1990) model to fit my research questions and the process of getting better after torture (see Table 3). For the purposes of this study, the term “enabling conditions” refers to specific events, context, available resources, and broad conditions that promote getting better after torture. The term “enabling conditions” combines the terms causal conditions, context, and intervening conditions from the Strauss and Corbin (1990) model. For the purposes of this study, action strategies will be referred to as coping strategies since this is a term often used in psychology literature to describe

how people handle and respond to a phenomenon. My intent was to develop a causal model to describe the beliefs, supports, and coping strategies used in the process of getting better. By focusing on environmental, psychological, and belief systems, the model becomes complicated as it examines complex and reciprocal relationships between these factors. The standard of evidence for causation in grounded theory methodology requires that the researcher demonstrates that model fits with reality, gives understanding, is useful, and is supported by existing literature (Strauss & Corbin, 1990).

Themes were often best described through an understanding of their enabling conditions and coping strategies. The process of getting better begins as survivors utilize their beliefs and available environmental and psychological resources to get better after torture. Along with successful coping strategies and helpful conditions there were impeding conditions or barriers that inhibited getting better. Although for some torture survivors the process of getting better may never be completed, the participants identified some indicators and consequences of getting better after torture that they use to evaluate their progress in the process.

Selective Coding

The final type of coding for my analysis was selective coding. Strauss and Corbin (1990) define selective coding as "the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement" (pp. 116). Selective coding resembles axial coding, but it is more abstract. In order to achieve integration, I constructed a story line that would provide a descriptive overview of the data. This story line of getting better after torture became the core category, "the central phenomenon around which all the other categories are integrated" (Strauss & Corbin, 1990, p.116). The revised paradigm model I created, described above, was used once more in selective

coding to connect subsidiary categories of getting better to the core category. This allowed the story to unfold sequentially. At this point in data analysis, conditional propositions (or hypotheses) of getting better after torture were presented. I compared the hypotheses to the data to determine how well the hypotheses of getting better were supported by the data. In such a model, if the data fits the hypotheses, the theory is validated or grounded. In addition, specific subgroups which had unique experiences compared to the rest of the participants were described separately.

Conditional Matrix.

A visual portrayal of concepts was developed in the form of a conditional matrix. Strauss and Corbin (1990) recommend developing a conditional matrix, a diagram that allowed me to illuminate the contextual conditions and consequences related to the process of getting better after torture.

Comparing Theory with Research.

In the final step of data analysis, the emergent theory of getting better after torture was compared to existing literature to examine how the theory is similar to and different from existing theory. Connecting the emerged theory to existing literature enhances internal and external validity (Eisenhardt, 1989).

Chapter 3: Results

Because of the detailed nature of the data collected in this study, the results section is divided into several subsections to illuminate the most significant of these details. The first part explains the torture and imprisonment experienced by the participants and is followed by a description of the physical, psychological, and social consequences. The second section describes major themes and patterns in the process of getting better after torture that were common among participants (see Table 4). In the third section, themes and processes unique to certain subgroups of the participants are discussed. In the final section, a causal model is presented that describes the process of getting better after torture. The data analysis software package NVivo, was used to categorize, sort, and merge the various categories described in the results section.

Description of Torture Experiences

To understand the process of healing after torture, it is imperative to have a picture of the torture experienced by each participant in the study. All of the participants experienced some form of torture, but they were not required to discuss their torture experiences as part of the study. At the time of intake for services at the Center for Torture and Trauma Survivors (CTTS), clients had to discuss their torture experiences to qualify for services. Therefore, all participants in this study met criteria of having experienced torture. Not only was the specific torture event extremely difficult to endure but participants also discussed the difficulty of experiences that followed the torture, such as refugee camps, probation, resettlement, and other war experiences. Although for participants the torture events were the most traumatic, they often did not distinguish them from subsequent experiences when describing the impact of torture and the

Table 4

Matrix of Themes of Getting Better After Torture

Central Phenomenon	**Themes of Central Phenomenon**		
Moving On	▪ Not dwelling on past events ▪ Being present and future focused ▪ Establishing and reaching goals		
Major Categories in Process of Moving On	**Enabling Conditions**	**Coping Strategies**	**Barriers**
Safety and Stability	Macro Level Supports ▪ Education and economic opportunities ▪ Increased freedoms ▪ Receiving institutional support Individual Support ▪ Help escaping ▪ Physical and economic support until health regained	▪ Restoring and maintaining health ▪ Taking medication ▪ Enduring with patience ▪ Avoiding people and memories that remind them of painful events ▪ Using relaxation techniques	▪ Economic instability ▪ Acculturative stress ▪ Psychological distress
Belief and Values Systems	▪ Faith in a higher power ▪ Belief that a higher power is in control ▪ A fair judgment by a higher power	▪ Spiritual rituals and activities, ▪ Forgiveness ▪ Understanding of the roles and circumstances of the perpetrators	▪ Anger toward perpetrators ▪ Questioning the higher power's judgment
Emotional Support and Reconnection	▪ Being understood ▪ Receiving helpful advice ▪ Encouragement ▪ Being inspired by others ▪ Regaining trust	▪ Sharing experiences ▪ Helping others ▪ Not focusing on self ▪ Activism	▪ Difficulties acculturating ▪ Some cultural norms in native cultures ▪ Unhelpful experiences with individuals
Outcome of Process	**Themes**		
Indicators and consequences of getting better	▪ Emotional wellbeing ▪ A happy, bright demeanor ▪ More adaptive functioning ▪ Getting life back to normal ▪ Improved relationships ▪ Establishment of a better life		

process of getting better. For this reason, all these experiences collectively constitute the participants' stories.

The extent to which participants discussed their torture during the interviews varied greatly. Some of the participants recounted in detail what they experienced, while others chose not to discuss actual experiences. Participants were targeted for torture for various reasons including ethnicity, active political involvement, political involvement of family members, religion, occupation, and military involvement. The length of torture and imprisonment varied from 24 hours to seven years. Various forms of torture while held against will included beatings, rape and witnessing rape of loved ones, being blindfolded and tied up, threats of death, witnessing the murders of others including family members, being exposed to the opposite sex while naked, starvation, and forced labor.

Effects of Torture

It is essential to understand the physical, psychological, and social effects of torture and imprisonment in order to understand the challenges participants were trying to overcome. Some of the physical effects of torture and imprisonment they identified were irritable bowel syndrome, a "popping" in the brain, chronic pain, blindness, loss of use of limbs, and chronic headaches. One participant simply stated, "I have so many wounds that my body can bear witness." Numerous psychological effects of torture and imprisonment were also described, including loss of self-esteem and self-value, humiliation, diminished personality, flashbacks, anxiety, depression, suicidality, nightmares, anger, "darkness in the mind," negativity, captivity to the memories, and difficulty in attention and concentration. Some of the social effects of torture and imprisonment include emotional disconnection with loved ones, isolation, loss of social status, and loss of employment.

Moving On as the Central Phenomenon

Because the process of getting better after torture occurs over a long time period, deciding how to describe it as a phenomenon proved to be difficult at first. Participants did not describe singular moments of getting better that could be described; rather, there were many factors over years that helped in this process. In this study, getting better was not a step by step process but a series of complex and reciprocal relationships. As I struggled to find a core phenomenon of the process of getting better to which all other themes related, I realized that all participants described a process of trying to "move on" after their experiences. Although each participant described his or her own way of getting better, it became apparent that the enabling conditions (conditions and resources in participants' lives that promote getting better) and coping strategies (actions taken by participants to promote getting better) pointed toward helping participants to move on with their lives (see Table 4 for matrix of categories of getting better). The term "moving on" is often used in this study because it is the language most used by the participants to describe the process of getting better. One participant described what moving on meant to him: "Don't dwell on the things you can't control. You must go forward with life and move on. It's like a tornado that's coming. It's going to come and you must deal with it and move on."

The central phenomenon of moving on that emerged from the interviews involves four themes: 1) not dwelling on past events and pain, 2) being present and future focused, and 3) establishing and reaching goals.

Not Dwelling on Past Events and Pain

An important theme of moving on identified by participants is to not dwell on past events and pain. One participant stated, "I'm not going to think about my problem now. Forget that

now, it die and buried. I will bury it like that." Another participant reported that for her, moving on was a victory over the perpetrators:

> It is in the past and you have already past that and you are showing you win. Because their aim was to have you not be successful but you are successful and have life. Because if you grieve they will get what they wanted and you will damage your health.

By not dwelling on their torture and war experiences, participants were able to focus more on starting a new life.

Being Present and Future Focused

Being present and future focused was another aspect of moving on identified by participants. Several participants explained that they know they cannot actually forget the events that happened, but they can forget or move on from the pain. When asked about this particular strategy, one participant reported, "Yes, I can't forget what I went through, that's normal. It became like part of my life. But it is not good to concentrate on that, so I concentrate on my future." Participants recognized that they could not have their old lives back and it helped them to move on by focusing on the present and future. A participant described a desire to move on from the past:

> My life is here now. I don't think I will ever go to [country of origin] and live there. I might go for visit like if I retire. Maybe if I retire it will be fine by then but right now I don't think about it. Because I think that my children will have better education and better life here. I can't go back home.

Another responded, "Life is having a future." Most participants reported being excited about the future, one elaborating with the following:

> Up to now I'm only excited about what happened to me and to move on. I don't know if it will happen in the future, but up to the time I started this program up to today I'm only excited with the way things are going. So I don't know, perhaps in the future that can happen to me.

Being present and future focused helped participants move on because they were not caught in the past but could deal with current challenges.

Establishing and Reaching Goals

A final theme of moving on is the importance of establishing and reaching goals. Some participants set goals for their children, such as helping them come to the United States, achieve in school, learn peace and tolerance, and see them get married. The importance of personal goals was also communicated in many interviews. One participant described how having a plan helped him get out of depression:

> For a time it was like someone was living day by day—no plans, no work because life is meaningless. But you are living day by day and I believe that as a human you can't live like that. You need to plan; you need to have hope that I can improve my life in the future. To start again having that kind of thought to plan, to do this, this is, I believe, is a part of healing in someone.

Another participant expressed the importance of setting goals and compared how he was currently functioning versus how he was functioning in the past:

> You have to design special thing that you want to do. See the only way you can get better is to think back and compare your past to the present. And you can be all over the place and be able to tell difference. So you have to set a goal that you want to obtain after sometime. I believe that if you do that you can count on that in the future and see if you are there or not.

Participants recognized that to get better they had to have purpose in living and be determined to make a better life by setting goals for what they wanted to achieve.

With moving on being the central phenomenon of getting better, there are three major categories in the process of getting better after torture that promote moving on: Use of Belief and Values Systems, Safety and Stability, and Emotional Support and Reconnection. Within each of these categories, enabling conditions, coping strategies, and barriers to getting better are addressed. Finally, the outcomes of moving on and getting better are addressed.

Belief and Values Systems

Using their belief and values systems to overcome challenges and to understand their torture and prison experiences was identified by all participants as playing a major role in getting better and moving on. Participants identified various aspects of their belief systems and values that helped them move on, including 1) faith in a higher power, 2) belief that a higher power is in control, 3) a fair judgment by a higher power, 4) spiritual rituals and activities, 5) forgiveness, and 6) understanding of the roles and circumstances of the perpetrators.

Faith in a Higher Power

Most of the participants expressed that their faith in a higher power was the most important part of the process of moving on. One participant said, "The assistance of that belief can help me to forget the hardship and the bad experience in the past." Another participant described how her beliefs helped make meaning of her experiences. She remarked,

> Thank God that I have my faith. I'm not asking why, when, or how. Never do I think I take revenge. So if I have no faith maybe I would go crazy, because I would ask why, when, how, and why me because I have faith that everything can happen and forgiveness is the power.

Several participants mentioned how their faith enabled them to survive their experiences. For example, one man said,

> Yes, I went through a lot. They took everything—my money, house, wives, and I even thought I would be killed. What saved me is my faith in Allah and that is what is in my heart. Without it, I can't survive.

Many participants described how their faith helped them carry on during their difficult experiences. One stated,

> Because for many went through this, there are many options. Some, to forget, they start to drink. Some, to forget, they went for drugs so they can hide the reality to themselves and things like that. But my faith was strong. That's the only thing that I kept in my life.

Another participant echoed the sentiments of several participants whose beliefs taught them to carry on through patience when he explained, "Allah commanded to have patience. If we fulfill that command to have patience, it is the big healing." Faith in a higher power helped participants move on by providing strength to carry on, to survive, and to make meaning of their experiences.

Belief that a Higher Power is in Control

The next theme of getting better by using belief and values systems is the belief that a higher power was in control of participants' lives. Several participants reported how they believe it was a higher power's will for them to survive their experiences. One responded,

> I thank God and I believe that God will guide me. I have surrendered to God. I have no other plans. The person who shot me meant to shoot me in the head. It helped me to heal to recognize that by God's grace I survived. Whenever I feel sorry for myself I realize I could be dead. My faith in God has been the most important part of the healing process. I can think. Some people have been injured and they can't think, but I can. And that's a gift from God.

In addition, several participants expressed a belief that a higher power brought people into their lives who helped them. One participant, a Christian pastor tortured by Muslims because of his religious beliefs, described meeting a Muslim psychiatrist who was very helpful to him. He remarked, "So God brought to me again a Muslim [the psychiatrist], but a good one; a wonderful one, this one." Several participants reported that their belief that a higher power has a plan for them that they need to accept helped them to move on. A participant said,

> It is God who decides—people are just tools. I need to learn more the ways of God because it is all under God's control. What I didn't get, it's not mine; what I did get, it's mine. What I feel is now that it was yesterday and the past is not mine and it doesn't bother me. It was written in the future before I was born.

Not only did some participants find strength in the belief that a higher power helped them to survive, but some participants made meaning of their experiences through a belief that the experiences were trials from a higher power given to help them grow spiritually. One reported,

> Never I asked myself "why and how it happened?" Already the holy book gave me the answers. I never asked "why me?" The book gave me the answer that Allah is testing me. What I read from it is that every person is going through the testing.

Belief that a higher power was in control helped participants to move on because they believed that they had assistance in surviving, bringing helpful people into their lives, and that trials were given to strengthen them spiritually.

A Fair Judgment by a Higher Power

In order to move on through the use of belief and values systems, many participants explained that their belief that a higher power will judge them and their perpetrators in a fair manner was helpful. Several participants mentioned that their belief that some future judgment would come from a higher power kept them from anger and seeking revenge. One commented,

> I have big faith that those who did this will get no benefit in this world. The only benefit is that they will feel guilty. They are living in guilt. They had no right to do this. I don't want revenge. God will punish them.

For other participants, it was helpful for them to not worry about what will happen to the perpetrators, but to leave the judgment up to God. When one participant was asked how she felt about the perpetrators currently, she responded, "This is not for me. God will judge them. We are not together so I don't think about them. It is not my job. It's God's job." Several participants reported that they strive to live a peaceful, purposeful life in order to be rewarded after they die. One participant commented, "I'm working hard right now to get a better life in heaven. It's a belief." A belief that a higher power will judge fairly allowed participants to not worry about their perpetrators but to focus on the future and the rewards they will receive for living good lives.

Spiritual Rituals and Activities

Participating in spiritual rituals and activities—intricate components of their belief and values systems—was very important to participants as enablers to moving on. Many participants mentioned the importance of prayer, several explaining that prayer helped them survive and escape torture and prison. One participant described how prayer helped him in prison:

> People would tell me, "Haili or Solomon or Kidani be killed." A lot of my friends be killed, shot dead. Me, I don't know, I believe that my prayer and prayer of my family, because I am innocent they didn't kill me.

Participants also mentioned that prayer gave them strength after their torture experiences. When one participant was asked what the most helpful thing in getting better was, she described the importance of prayer:

> To pray and have faith in Allah. That is the best and get some group who are good people and share with them your problems. Because people are not in the same level of faith. Some don't have patience. They are dying and want revenge, because if you're sick like that no one can help you. And the only person that can help you is Allah. So share your problems with Allah because some people talk too much and talk about you. So it is better to talk to God.

Besides praying, participants described other rituals and activities that promoted getting better. Participants expressed that washing in holy water, meditating, fasting, and using prayer beads and herbal remedies helped in the process of getting better. When asked to describe a healing experience, a participant remarked,

> First of all, when I feel difficulties if I do the ablution (wash), do two prayers, then read the Qaran, the holy book, I feel relaxed and get strength, patience, and I forget every difficulties…when I wash every thoughts and memories become erased.

Participants commented that reading scripture was very important in the process of getting better. They explained that reading scriptures helps them to have patience, forget the past and prepare for the future. When one participant was asked how he got stronger after his torture experiences, he stated, "Reading the word of God and trusting God. I read a lot. I was reading

the word of God to find strength and courage, my value in the word of God." Another participant described the effects of reading scripture: "Because whenever I read Qur'an I have patience. Life is difficult. I can forget the past." A more communal spiritual ritual involving scripture was described by one participant as a powerful aid in healing:

> Yes, difficulties have affect, but we have a healing process called read the Qur'an. Not only I was reading but others would read too. In the camps we didn't have doctors or counseling like here. But people came together to read the Qur'an. People gathered around my body as I was lying down and I calmed down and relaxed. It would last 2 or 3 hours. It was part of healing.

Finally, participants reported that going to religious services was an activity that furthered the healing process. One participant commented, "I have religious beliefs; I go to the church. So this religious belief help me to release my mind, to relax, to lead a better life." Spiritual rituals and activities helped participants to survive their experiences, gave comfort and meaning to their lives, and gave them opportunities to show their faith and take an active role in their spiritual healing.

Forgiveness

A coping strategy of belief and values systems that had a major impact on getting better and moving on for participants was forgiveness. Many described how important it was for them to be able to forgive the people who hurt them. Forgiveness, they explained, taught them patience, kept them from going crazy, and kept them from seeking revenge. When asked who he forgave, one participant said:

> I forgive everybody. If you don't forgive you broke the process of feeling the spirit in your heart. Which means you become bound by these people every time you see them; these are changes in your heart. You need to be released of this and move on. So I forgive everybody.

His description conveys a clear connection between his decision to forgive and ability to move on. Another participant expressed that forgiveness kept the emotional pain of his experiences

from continuing. He commented, "Forgiveness will help me to be strong…I choose to forgive because I don't want to be hurt again and again." Several participants remarked that their religious beliefs have been the catalyst of their ability to forgive and move on. When asked how he feels about the people who tortured him, a participant responded,

> I don't remember those people in [country of origin] that tortured me because first of all my belief say to forgive them. Because I don't remember them it brings me happiness… Jesus teaches us to forgive everyone and you will be forgiven. So, just forgive everyone to make life easier because the war [in country of origin] is so complicated. So let the past go.

In addition to forgiveness of the perpetrators, participants found it helpful to absolve themselves of any blame for their torture and harm to their families. Some participants commented that it was helpful for them to understand that torture happened to other people, not just themselves. One participant said, "I'm not the first one to be betrayed. Which means this is life. When I understood that, I forgive." Several participants reported that they realized they were not to blame for what happened. One participant's children were killed by the torturers. He explained that "God decided to take the children" and that it wasn't his fault. His recognition that he was not in control in the situation helped in his process of getting better. Knowing that he had always tried to be a good person kept another man from blaming himself. He said,

> I said to myself, "May God guide them in the right way." I was able to say that to myself because my whole life I never did bad to anyone. I never had hatred in my heart. I know there are bad people who like to hurt others. I know that I did nothing against the person who attacked me.

Forgiveness of perpetrators and self was an important coping strategy in moving on because participants were able to be released from emotional pain, be happy, and refrain from seeking revenge.

Understanding of the Roles and Circumstances of the Perpetrators

Related to forgiveness, understanding the circumstances in which the perpetrators of the torture were acting helped the participants make meaning of their experiences. Several participants commented that they realized the perpetrators were often young people simply following orders from someone in authority. When one participant was asked how he felt about the perpetrators, he remarked,

> They don't know what they were doing because you can't do that to a human being like that. I think it is because most of soldiers they use drugs. That's why, because a normal person can't do what they were doing to us. A normal person, you can't because somewhere somehow your spirit will refuse that, "no, I can't do this to a human being." And most of them they were very young children, 16 years, 17 years, 14 years. These are the soldiers. So after they give them drugs they are not themselves. So how can I continue to blame for such? Because even now there is a program of rehabilitation for these kinds of children as child soldiers. So how can I blame them?

Others commented on how it was important that the torture was an impersonal act, not done by people they knew. One participant said, "Part of the healing was thinking that I didn't know them and they didn't know me. They were misguided by others with instructions to kill." These are poignant examples of how, for some participants, understanding the circumstances and roles of the perpetrators of the torture proved to be an aid in moving on.

Barriers in the Use of Belief and Values Systems

Participants described only a few barriers related to the themes of using their belief and values systems in order to move on after torture. These barriers include 1) anger toward perpetrators and 2) questioning the higher power's judgment.

Anger toward perpetrators. While many of the participants stated they still feel emotional pain from the torture, only two participants expressed that they are still angry at the people who caused their pain. One participant stated that he got angry whenever he heard the

language of his perpetrators. When asked if forgiveness has ever been part of his healing, another participant remarked,

> We cannot forgive them. They are the robber. We consider them the robber. I want to struggle against them, but due to my aging, I'm very weak now. Condition doesn't permit me to struggle with them. My children now still young and still working. If there is fighting again against communist regime, my family will participate in that fighting.

Questioning the higher power's judgment. Several participants reported that they questioned the judgment of the higher power during and after their torture experiences, which challenged their faith. One described how he questioned God during a period of depression:

> You only ask the question, "why me?" For me it was difficult because as a pastor I say, "So God, you rejected me? Why have you allowed these people to touch me like that? I was serving you. Why have you allowed these people to touch me?" So, that was the hard part time for me. So all that silence from God, "why have you allowed these people to touch me and humiliate me like that?" So that was also something.

While participants reported that their belief and values systems were very important in moving on, they also identified anger toward perpetrators and questioning the higher power's judgment as barriers in this category.

Safety and Stability

Establishing safety and stability is a major category of getting better that emerged as a means to moving on. Many participants commented that they were not able to start the process of getting better until they were in an environment in which they felt safe. One participant stated, "When you find a good environment it helps completely the person." This section focuses on three factors that promote safety and stability: 1) macro level values and support, 2) individual support, and 3) coping strategies that promote health.

Macro Level Values and Support

Macro level values and supports refer to values and supports established by cultures, societies, and governments that participants identified as being helpful in establishing safety and

stability. Moving to a country away from torture, war, and other social turmoil was a major step in establishing that safe environment. Because the participants in this study resettled to the United States, they described the specific benefits of the safety and stability provided by living in the United States. Living in the U.S. was less stressful than living in their home countries, and participants were able to relax, particularly once a person received citizenship. The impact of this geographic change is communicated poignantly by one of the participants: "I came here not hearing bullets; there is no conflict here like between [two countries at war in homeland]. I came back to who I was. It gave me peace of mind." Throughout the interviews, participants identified several macro level enabling conditions of life in the U.S. that promoted safety and stability, including 1) education and economic opportunities, 2) increased freedoms, and 3) receiving institutional support.

Education and economic opportunities. Part of moving on through safety and stability identified by participants was the opportunity to obtain an education, as described by one participant below:

> I just want to have something I can do and take care of myself and take care of my children. I just want to make sure I have something that I can do I will live by. That is why I'm in school. I always vowed that I'm going to continue that, regardless of difficulty. Right now it's not easy but what can you do, you know? You just have to continue doing what you have to do. So my goal is to have my children educated and myself. Because I believe that is the only thing that can make a difference.

Non-English speaking participants mentioned how important it is for themselves and their families to learn English in order to establish safety and stability in the United States. One participant commented about living with Americans: "I'm learning the system, laws, enforcement. That's why I am learning English. Everything I learn because I am living with them." Related to education in this way is the ability to establish economic stability. One participant conveyed this hope in describing his dream of "the good life":

> To get good job, work hard, raise my child and maybe to buy a truck. That's my plan; to buy a truck, second hand truck. To post myself in the good life. Have 30, 40 grand for a second hand truck. To be my own boss. To lead the good life. I have one child, but to have two or three more childs.

When asked how he has healed mentally, another reported, "The economic life is better here, so it's let my mental life improve, big difference. We feel relaxed a lot." Obtaining a formal education, learning English, if needed, and establishing economic stability enabled the participants to feel safe and stable because they were able to support their families and learn their new culture.

Increased freedoms. Another important healing aspect of living in a stable country such as the U.S. for those interviewed was having more freedoms than they had in their native countries. Because participants were able to speak freely and practice their cultures and religions as they chose, they were able to relax, experience less fear, and feel peace. One participant reported,

> Here everyone is free for what he believes and for his culture. That's why it's important to keep it. I like it here because there are rights you share with others and you have privacy too—religion and culture. In this country you must respect the rights of others. That's why I like it here.

Some participants also reported that they felt that mixing the best of their native culture with U.S. culture was helpful, as exemplified by the following interview excerpt:

> American culture is open, more freedom, more open than Asian culture, because Asian culture is so strict. And you know living in the Asian culture in our homeland we have to follow a lot of law, verbal law. But, now here in the States, this is mixed both cultures help each other to open our mind. So this is a very good support.

These new freedoms allowed participants to feel safe and stable because they were able to live as they chose without worry of being harmed for their beliefs and cultural practices.

Receiving institutional support. Receiving institutional support from various agencies and organizations was another enabling condition that promoted the establishment of safety and

stability. Several participants mentioned how grateful they were to the United Nations and refugee resettlement agencies for helping them escape dangerous environments and resettle in the United States. In one case, the U.N. helped release a participant from prison just before he was to be deported back to his home country to be put on trial. The U.N. then helped him and his family to resettle in the United States. Participants also reported that receiving support from the state and federal agencies helped stabilize their lives. They mentioned the importance of receiving Medicaid, social security, and housing support. When asked about how the government has helped her, one participant stated, "They take care of me. They have a good system which I never had in my country which is to help the elderly. Now I'm in public housing so if I was in my country never would I get help like this."

As a specific example of the benefits of receiving institutional help, participants reported that the support they received from CTTS was very important in establishing stability and an environment for healing to take place. In this regard, a participant stated, "But luckily enough when I came through this program and I met these people and they created the right environment for me so the process of healing can get started." Services provided by CTTS helped restore physical health through dental work, physical therapy, massage therapy, vision check ups and medications for various physical challenges. CTTS also provided mental health services such as psychotropic medications, and individual and group therapy. Group therapy was especially important for several clients because they came to realize they were not isolated and they had a place to discuss their feelings. Specific benefits of relationships established through services at CTTS are described in a later section. Another aspect of services at CTTS that was very important was that members of the staff were from similar, if not the same, cultures as the

participants. The experience of one participant reveals the importance of culturally competent services:

> After one week I come and they called for my case manager. The introduce me. I get happy when they get my one country person that speak the language of my nation. It make me happy when I see his face. It make me very happy.

Several participants mentioned the quality of the work of the staff at CTTS. One participant expressed the connection this has to trust when he reported,

> Why I trust is because there were a lot of people claimed to provide services but these people [CTTS] follow through and I gain trust. They provide confidentiality and services with action, not only saying. Because of this action I can trust and with trust comes hope.

This institutional support was vital in helping participants establish themselves in their new communities and receive help in restoring health, all of which promoted safety and stability.

Individual Support

In addition to macro level support that helped establish safety and stability, participants mentioned help from individual people as facilitating this process. These topics include 1) help escaping from dangerous situations and 2) help restoring health and economic stability. Emotional support received is discussed in a later section.

Help escaping from dangerous situations. Participants mentioned the importance of receiving help from soldiers, friends, and even people from warring tribes in escaping from dangerous situations. In recounting his release from prison, one participant, who had been a minister for a church, received the advocacy of an American missionary. He stated,

> When the missionary learned about what happened, he took his courage and he came back. It was very, very dangerous for him. But he came back and he stay out of the prison for almost one week. He said, “it is better for you to kill me instead of killing this man.” So he stayed there.

Help restoring health and economic stability. Participants mentioned how helpful it was when their families nursed them back to health after their torture experiences and provided

economic support until they were healthy. One participant related, “For one year and a half I sleep at home, because they hit me too much inside of my feet. It was wounded you know. Everyday, everyday my dad gave me injection. I get healed by my father.” This instrumental support continued after resettlement. Family members of the participants were helpful in raising their children, encouraging them to stay in school and helping to monitor medication.

Actions Taken to Promote Health and Wellbeing

The interviews revealed that the third and final factor in participants’ ability to become safe and stable is the specific coping strategies they implemented to improve their health. These coping strategies include 1) restoring and maintaining physical health, 2) taking medication, 3) enduring with patience, 4) avoiding people and memories that remind them of painful events, and 5) using relaxation techniques.

Restoring and maintaining physical health. Participants expressed the importance of restoring and maintaining physical health in an effort to establish stability. Several mentioned how physical health may be overlooked in some programs focused on helping people recover from torture. One participant stated,

> If you see the program at CTTS, it is psychological health, your soul. But they don’t concentrate on the physical healing. If they can also think about the whole person, it will be a great job.

Numerous and varied treatments were received to restore health, including physical therapy, gall stone surgery, and repairing wounds inflicted during torture. This factor proved imperative for several participants who mentioned that until they were able to be physically healthy they could not begin the process of getting better.

Taking medication. Medication was also reported as important in participants’ efforts to establish both physical and mental stability, as it was often the impetus in helping them sleep,

eat, and concentrate. And it has helped participants calm down and feel less pain. One explained, "By taking the medication I'm getting better and better. Even I have a feeling here *[points to top of his head]*, a kind of tingling. It doesn't bother, I don't concentrate on that." While participants reported they were reluctant to take medication, they remarked that it was very important in establishing stability.

Enduring with patience. Several participants mentioned that enduring with patience was important in improving health. When asked how he deals with his flashbacks, one reported, "I tried to bear it. It means I tried to handle it. We can't do anything else. We can't overturn the situation. That's why we tried to handle with my patience." By recognizing that the process of getting better takes time, participants were able to endure their hardships with patience and, thereby, feel secure that they would get better. In recognizing the time needed for mental and physical health to be restored, some participants were able to feel stable.

Avoiding people and memories. Avoiding activities and people that remind them of their past experiences helped participants establish and maintain stability. One participant expressed his need to "mostly have to do away with things that threaten [his] survival." Participants mentioned they avoid people who remind them of atrocities or are negative or ignorant in general. They reported being paranoid that they might get hurt again and being defensive when they felt they were being pressured to talk about their past. In describing why he avoided contact with others, a participant explained,

> You don't want to share because they are ashamed things, they are strange things. And when someone comes to talk to you, you become angry and upset about that. And they push you to stay alone. You don't want someone to know what you've been through.

In addition to avoiding people and activities, avoiding painful memories of torture and war experiences was also mentioned as a coping strategy to maintain stability. Participants

described being with others, listening to music, watching television (while avoiding violent programming), avoiding news of current wars and news from their home countries, and staying busy as strategies to avoid painful memories. A participant commented on how forgetting the past helped him to move on:

> You have to forget it, like dead man and bury it. Forget it, that's it. Just think what the future hold. The past is past. We have to think for the future what will happen to us. I think only now of the future, what I have to do for those left of my age. The past is gone and it can't return. The future is come. What I have to do for next day, what I have to do for tomorrow. That is what I have to think now.

When asked about how they currently felt about the people who hurt them, several participants explained it is better to just forget those people. One participant stated, "The important thing is I try to forget it, so I can overcome. I know that this is in the past. So let things gone be gone." This avoidance of reminders of the traumatic events allowed the participants to not feel emotional pain, and thus promoted safety and stability.

Relaxation techniques. Finding ways to relax was important to participants in their efforts to establish safety and stability. Relaxation helped ease physical and mental challenges. One participant explained,

> I used to have backache. I had fracture of my spine. I had that in 2000 and, in fact, it was just recently that I had back therapy with through CTTS. But I realized that that was not the best solution. The best solution was for me to continue to calm myself down.

Listening to music, participating in spiritual rituals, and spending time with family and friends were relaxation techniques used by participants. Another participant stated that he learned self relaxation techniques in counseling and that massage therapy helped relax him as well. By relaxing, participants were able to focus and not let their emotions overtake their ability to function effectively.

Barriers to Safety and Stability

While participants reported many enabling conditions and activities that promoted safety and stability, they also described various barriers that inhibited establishing safety and stability. These barriers include 1) economic instability, 2) acculturative stress, and 3) psychological distress.

Economic instability. Participants stated that economic instability in their native countries and in the U.S. was a barrier to safety and stability. A major obstacle in participants' lives that made moving on difficult was the political instability of their native countries, which resulted in their own economic struggles. The Vietnamese participants in particular experienced economic instability after being released from prison. They were on probation for as much as 6 years, during which time they were unable to hold steady jobs that would have allowed them to support their families financially. One participant recounted,

> I recall about the time I was just released from the camp. At the time I was still in [country of origin]. At the time I had a very hard situation, especially about the hard financial situation at the time. We must do very heavy labor job to make money for survival.

Several participants mentioned the difficulty of shifting from high to low socioeconomic status as a result of political instability. One responded,

> My life have a big challenge after the probation because I must work harder and I must find out how to make my money to survive. The life changes totally. In the past I'm upper level and I go down to the very bottom of the social. Before, you know, I'm the landowner. I have a prospered life; a rich life, for rich people, in the past. But after I stayed in the prison camp and I is released I become the poorest people. I have to work for another. No land at all. So my mental life and physical life totally change. And I feel very disastered.

In addition to economic instability in their native countries, the different economic system of the U.S. and entering the U.S. at a low socioeconomic status made it difficult for participants to establish safety and stability, as explained by one of the participants:

> In Africa you can live with one dollar and people are used to it. I don't know how, but people live with something like that. But here it is not the case. The standard, you need to reach that standard so that they are sure you paid your rent, you pay your bills and you pay everything. That's why I was talking about the pressure because here everything is on you but there back in my country there are things for the community, which mean that they know is not easy for everybody to have them so they are something like that. But it is not the case here.

Several of the participants described how difficult it was to be economically stable in the U.S. because they arrived when they were already elderly. This is portrayed in the following interview excerpt:

> My main concern at this time is my wife right now she don't have citizenship right now. My income right now is my social security, SSI, about $600 per month. And my wife doesn't have this benefit. So this is my concern at this time. My wife just have a history of working in the States just 4 years so she don't qualify for her benefit for retirement. At this time we just have money coming from benefit food stamps. It's not enough for my daily life.

These participants reported how they may have to move back to their native countries because they are unable to make ends meet financially. Economic instability in their native countries and in the U.S. hindered establishing safety and stability because they weren't able to support their families and feel productive.

Acculturative stress. Besides economic issues, struggles with acculturation—learning the language, culture, way of life, etc.—proved to be a hindrance for many participants in terms of becoming stable and securely settled in the U.S. When asked about challenges in moving to the U.S., one participant responded,

> I don't remember. Even coming here is not easy because you don't know the system—what is right, what is wrong. And even when we came here we faced different problems and back home men don't do chores like sweeping and cleaning. I have sons here so they do these things even for a job but back home it was impossible for men to do these things. All that difficulties even to understand system of USA. My son helped me with that because he came first but when he is not with me I don't remember.

Another woman described feeling culturally isolated. She said, “Because I can’t communicate with anyone. I’m isolated sitting at home alone.” Another participant reported that his wife cannot obtain citizenship because she doesn’t speak English well enough to pass the citizenship test. Difficulties adapting to a new culture hindered participants from establishing safety and stability because they did not feel they were able to navigate and feel comfortable in the new culture.

Psychological distress. Additionally, psychological distress has kept participants from establishing safety and stability. Several participants expressed difficulties with memory and concentration that prevent them from reaching their goals such as obtaining an education, learning English, and gaining citizenship. One participant reported that he has failed several times to pass the English test needed for citizenship. He said, “I applied again but I can’t read and I can’t remember and concentrate.” Several participants mentioned that their symptoms of depression are keeping them from getting better. The depression has hurt their relationships with family and hindered them from working and studying effectively. In describing how his depression affected his education, a participant responded,

> And with the grade I was having those who were not putting in the hours were almost getting the same grade. And that is so because in nursing school is slow learning compared to other groups. And that is because of my level of concentration and I know that it is all due to the depression.

Many participants described how thinking of events and unwanted reoccurring memories of the torture and prison experiences still bothers them, makes them afraid, and keeps them from happiness and getting better. One participant explained, “When I sit and talk about my past it’s easy for me to cry.” They reported that it is difficult to forget the memories, which often distract them from what they are doing. A participant said that thinking of how he will never go back to his old life makes him sad. He stated,

> I can't go back home. This is just sometimes sad. It's not a bother to other people. But ones that think too much and think what had happened. And sometimes it do bother you. That is how some people become big target for this war diseases like depression and other things. That's how other people can get entrap in it. They will be there forever or for a long time because they think too much. And I'm like that. I think too much. I don't let things go easy.

In addition to not wanting to think about the memories, many participants reported experiencing flashbacks and nightmares that keep them from being stable emotionally. One participant described the effects of his reoccurring memories:

> I saw many friends of mine, they tried to escape from the camp and they got arrested and they got beat in front of me. So that's why when I released I still remember the horrible image of those people's heads being treated horribly in front of my eyes. So sometimes I have a lot of nightmare at nighttime. Sometimes I cry; I shout at the nighttime and my wife must shake me up and tell me this is horrible dream.

In describing flashbacks, a participant commented, "You can't be normal with flashbacks…My brain can't resist what happened." Various forms of psychological distress hindered participants from functioning as well as they wanted, which kept them from feeling safe and secure.

Emotional Support and Reconnection

The third and final major category of getting better is emotional support from and reconnection with people, which participants generally described as being very important in the process of getting better. One remarked,

> There are three aspects of the life: the social, family, and community. Those elements can support me to survive, to improve the quality of life. Thanks to the elements, the community, the social and the family can help me to improve a lot.

This section examines various groups important in the reconnection process, enabling conditions of emotional support, and activity strategies that promote reconnection.

Providers of Social Support

Participants were able to more easily move on from their experiences through support from different groups of people in their lives, including 1) friends and family, 2) fellow torture survivors, and 3) service providers.

Friends and family. Several participants expressed how important it is to have friends to relax, play, and laugh with. One participant described why he enjoys meeting friends at a café:

> Yeah. I love talk, I love to talk. If I go out, for example, in our area is a waffle house. A lot of people they will come there. I don't go sit alone. I will go in my own interest. I will play. Nobody knows that it is for myself. I took this like medication to go and talk and relax. It's just like medication for myself. I will feel good.

Connecting with family members was important to participants. They described themes of feeling united, taking care of grandchildren, and relaxing with family.

Fellow torture survivors. For those participants who were members of support groups, fellow torture survivors and service providers at CTTS proved to be important in the reconnection process. One participant described why her support group was helpful:

> Like today every week we come here together and we talk about problems, difficulties. I sit at home but here I share with people, get advice, some people who say be patient, I get energy from them, get happiness.

Another participant expressed how her support group helped her to relax, be happy, and lead a normal life. The realization that others were dealing with similar emotional and psychological effects of their experiences helped her learn and become stronger:

> It's great to have the group because it makes you feel calm and relaxed. You share with people different ideas and you learn more. When we come we are depressed and when we go we're happy and lead a normal life.

Participants reported that being involved in the support group helped them move on from their experiences and "relieve the burden of mental stress."

Service providers. Having a connection with service providers, particularly at CTTS, has been helpful in reconnection. Many participants expressed how important it was to be greeted warmly by staff, and one even described how it is helpful for medication providers to be friendly:

> Medication doesn't just do it alone. Medication with human, important you know. When you show me your face smiling, that stupid devil disease it will go immediately. It will scare and go. Let's say I was sick today. If I have an appointment for tomorrow and tomorrow I will go to doctor, my memory will be just fine, for if you just smile, it will just go.

Another important aspect of the relationship with CTTS is that the staff did not push participants to talk about their histories or into treatments they did not approve of. One participant commented on how the staff helped him feel valued as a human being: "I feel very thankful to these people. I think the most important, I feel valued. I'm a person; I'm a human being. Despite what I went through I'm still a human being." Reconnecting with these various groups was important in moving on because participants received emotional support and they were not as isolated.

Emotional Support

Participants mentioned various themes of emotional support that enabled them to reconnect with others and help them move on after their torture experiences. These themes include, 1) being understood, 2) receiving helpful advice, 3) encouragement, 4) being inspired by others, and 5) regaining trust.

Being understood. Participants explained how important it was to be understood by someone. Several participants expressed how important it was that doctors listen to their wishes about medication. For others, being able to relate to people who have been through similar

experiences has helped them move on. One participant described how the support group at CTTS helps her:

> When time of group comes it gives us courage to talk about the past and forget the past and see not only your suffering but many people suffering. And you see easily that the world has ups and downs and you will learn through all that how to go and get further steps to build your life. I like it because it gives me hope because trust each other and because it makes life easy.

Another participant recounted how relating to someone who had been through similar experiences was helpful:

> Because she started by explaining to me what she went through in Uganda. She was also held there as a hostage. So it is like I found a companion; someone who went through the same thing like me. Only talked to me about how she was held also in a stage in Uganda. I think that also perhaps bring something in me so that I can be open…So it is something like you see that you are not the only one. She has made it; you can make it also.

Feeling understood by others was supportive because participants felt like someone cared about them and they did not feel as isolated.

Receiving helpful advice. Receiving advice from other people was identified as being helpful in getting better and moving on. Several participants mentioned receiving advice from friends was helpful. Several participants were introduced to CTTS by friends and others mentioned exchanging information about resources and ideas with friends. One participant reported how it is helpful to spend time with other people: “Mostly when you’re in contact with people they tell you how things are and get information and they give me hope. That helps to make goals and it’s part of healing.”

Several participants received helpful advice through services at CTTS, advice that helped them see their experiences were in the past and that equipped them with useful relaxation techniques and skills for reconnecting with others. One participant described how her support group gave helpful advice: “At that moment I’m happy because when you cry they say to forget

it and it is supporting. They say 'wake up, you are safe.' Sometimes I wish everyday I had group." Receiving advice helped participants reconnect with others as well as gain helpful information.

Encouragement. Besides advice, encouragement participants received from others also strengthened them and enabled them to move on. Several mentioned how helpful it was to have family and friends encouraging them to stay in school and treatment. One participant recounted how a woman from his church encouraged him when he was feeling suicidal:

> Yes, she's among the people, you know, who value you. Who put you up. They are there. They come in your home. They stay with you for 2 hours, 3 hours, they spend their time with you. These are things, small things but very important for someone who went through these things. She was not there questioning about, but she was there and you feel that someone is there for you. You could call her at any time; she will be there for you. She will talk to you even if it is day or night.

This kind of encouragement helped participants move on, particularly when they were depressed or under great stress.

Being inspired by others. Participants commented that they have been able to keep going through difficult trials because of the inspiration to make a better life for their families. They expressed being willing to work long hours and stay in school despite difficulties in order to make a better future for their families. Several participants reported that if it weren't for their desire to support their families they would not have hope and may hurt themselves. A participant recounted how his family kept him from committing suicide:

> And one other thing I kept also was the love for my family. Every time I went through depression, I think about them. I think about all that my children went through to walk through that bush. I remember one of my daughters was playing when that happened so they make her run naked because she only pants and she went like that. And that day it was raining. So when I thought about all these things I was not the only one that suffered. They suffered also with me. If I did something wrong, what would happen to them? Their presence at that time encouraged me to go ahead and see that they went through a lot and if they lose me again it will be very sorrow. If I was single perhaps it

> would be easy to say "let me finish with this." But when you have responsibilities with your family it helps.

Inspiration from family to make a better life gave participants strength to endure difficult challenges and move forward to reach their goals.

Regaining trust. Regaining trust in others was an important theme in emotional support and reconnection. Several participants mentioned that healing is impossible without trust. Participants described qualities of trustworthy people: commitment to work, humility, kindness, and sacrificing for others. A participant described the importance of tolerance and helping others:

> Right when I see people, if they don't confuse me, I may be able to trust them. If they offer to help me without knowing me and they help from the bottom of their hearts, I may trust them. I like it when people don't ask about tribes and what tribes people are from. This implies that the people aren't suspicious and judging people by their tribes. I like people who help from the bottom of their hearts.

Participants commented on how CTTS helped them regain trust, specifically noting the importance of staff keeping their information confidential and following through on promises. One participant stressed how it was helpful in regaining trust that CTTS asked about his challenges and showed they cared:

> I have relatives, children, a wife, and friends, but the decisions in the process of healing only CTTS knows because they asked and showed care. I trust them and it helped me to heal. It's not easy when someone gives you help and trust and CTTS gave me that.

In fact, several participants expressed willingness to take part in the study and talk about their pasts because of this trust in CTTS. Regaining trust appeared to be one of the first and key themes of reconnection in order to move on.

Reconnection with Others

Several coping strategies were identified by participants in the reconnection process: 1) sharing experiences, 2) helping others, 3) not focusing on self, and 4) activism.

Sharing experiences. A coping strategy that led to moving on and getting better mentioned by participants was sharing their experiences with other people. Three types of sharing experiences with others emerged from the interviews: 1) general sharing of difficult life experiences, 2) self-disclosure for self benefit, and 3) self-disclosure to support others. Many of the participants remarked that sharing their past experiences has led to healing and stress reduction in their own lives and has also benefited others. One participant commented, "I want to share my experiences with you and my friends so we can help each other to heal the wounds we have in the past."

Disclosing specific details of their torture experiences, often for the first time, to another person was a very powerful healing experience for participants. This was most often done to receive support from others. Participants explained that opening up for the first time about their experiences lifted a burden and helped them feel normal, less isolated, and relaxed. Several participants mentioned they were then able to start to find a resolution to problems. For one participant, disclosing kept him from hurting himself. He recounted the first time he disclosed:

> For me, it was like, if I didn't do that, to share with someone, something could happen to me at that time. So for me to talk to that lady that day, it was like a day of salvation for me if not I could do something to myself wrong…I didn't feel peace but it [kept] me not to do the wrong thing.

After having first disclosed at CTTS, a participant described how opening up to his wife about his experiences improved their relationship. When asked how it was for him to share with his wife, he remarked:

> I was not ashamed to say what I went through. Because the hard part at the beginning was that you feel ashamed. I was not ashamed. Because if I didn't talk to my wife it means that I didn't trust her also. As I said, I couldn't trust anybody. So it bring to start to trust people to know that there are people in this life and they are there for you and I shared with my wife for the first time. And that brought also something great in me to share with my wife that. I think it brought healing, because my heart was broken through

> all. So it is like something which was inside of me every burden was gone, to share with her. And that was the first time after all these years to share with her.

Since disclosing was such a powerful experience, participants described specific conditions that enabled opening up. This section describes the enabling conditions of disclosure identified by participants: 1) having someone else disclose to them first, 2) feeling understood and unconditionally supported by another person, and 3) being empowered to disclose and not disclose as they choose. Several participants had friends or support group members who were also tortured who opened up first, enabling the participants to disclose as well. The participants remarked that they felt they were alone and no one had similar experiences or challenges after the torture and prison experiences. So, they needed another person to disclose first in order to understand that others had similar experiences.

Another factor that promoted disclosure was feeling understood and unconditionally supported by another person. Participants were very deliberate in deciding who to disclose to. Several participants commented that they did not feel comfortable sharing specific experiences with family and other clients at CTTS. And several stated they would only open up to staff at CTTS because the staff was trustworthy. One participant described how he will only disclose with staff at CTTS: "They were the first ones to ask. Even other people have asked about my past but I won't tell them. I tell them the chapter is closed. But I will be open to CTTS." Some participants did feel comfortable disclosing to support group members at CTTS. One woman expressed how important it was to have a setting like CTTS with supportive staff and group members which enabled her to open up:

> I have a place I can trust. I need a place for people to listen to me, not only asking questions but listening and believing me. Because I don't think people will believe me that I was looted and tortured. They may think that I'm crazy. But here I can tell in their eyes they believe and that it can happen to someone else. And that's why you're doing this study.

A participant commented that it was helpful to have a person who was trying to understand him and give him unconditional support. He described how a female volunteer from his church (who referred him to treatment) supported him before he ever disclosed his torture history to anyone:

> That lady, she loves me. I believe that helped me a lot. She was there for me, silent, quiet. It is to love a person, to be there for a person. I believe that one day the person [the torture survivor] will open himself or herself. These people [torture survivors], they don't talk even to agency, which bring us here. Because the agency stand only on material things. They give you house, they give you bed, that's all, a job. But when you find someone who come near by you, it is not about material things but about you as a person. To be there. And you feel that this person is understanding what I went through, even if the person [the volunteer] doesn't talk to me and doesn't ask. But I feel she understands or he understands me that I went through a lot. I believe that one day that person [torture survivor] will open himself or herself. It can help. I don't say that it will work but this is what I was continuing to get help with.

Participants needed to have someone who they trusted and they felt would be able to emotionally handle hearing about their difficult experiences.

An important enabling condition that promoted disclosure was that participants needed to be in control of how and when they shared their torture and prison experiences. Several commented on the importance of being empowered to open up at a pace that was comfortable to them. A participant expressed this clearly in his recollection of disclosing to his wife for the first time:

> I believe that at the first she did not want to know all the details. And that's very important for someone: don't push me. The details I give you myself when I want to. That way she didn't ask the details to say, "What happened?" She was there listening. I don't know for others, but for me, someone who went through these things, when you listen it is bringing more healing than when you want to push the person. So she listened to me most of the time. And I went through the details myself. Myself without her asking. And I remember it was the same with with Dr. X [program director at CTTS]. They never asked me questions. It came out from myself.

Another participant reported that it is important for him to be in control of when he thinks and talks about his torture experiences:

> You see, sometimes when I discuss these things and when I leave I like to just move on. You know, with what I'm doing, because you see, I don't like to think about it too much. Mostly when I think about what has passed it distracts me from what I'm doing. I mean I like to talk about it. I don't have a problem talking about because, what can you do? I mean, it already happened. And when I leave, I just forget it.

The importance of being empowered to remember and disclose when wanted and avoiding memories when wanted was described by another participant. When asked why she said it was both helpful to talk about her past and to forget her past, she stated,

> Sometimes when you have peace now it is better to remember and when comparing to situation you have now it is better to remember. It is good to forget when you remember bad memories and have flashbacks and you are going down.

Once in control of when and how they disclosed, participants could share their experiences at a pace that was comfortable to them. They stated that need to avoid memories of events at times in order to function adaptively.

Besides disclosing to receive support and relieve their own burden, sharing torture and difficult life experiences with others was also done to support, strengthen, and educate others, which in turn, helped participants to move on. Several remarked that helping others by sharing their experiences in their support and senior groups was a healing process for them. One participant described why she was willing to participate in the study:

> I trusted you because you [the interviewer] said you would help others with the [study]. I thought it was my duty to talk to you. That it will help others and that is what I need—if you're helping others like me, it means you are helping me.

Another participant expressed his reluctance to return for the follow up visit, but that he decided to continue because he felt it would help other people:

> To tell you the truth I didn't even want to come today. I was asking to myself "why am I talking to Brian, why? What kind of help can he be to the situation I went through so in the future I don't want someone else to go through?" So I was going through all these things. I say "for me, I would like someone who can help later on in this situation so people can't suffer the way I suffer." Perhaps by talking to someone else it can help in

> the process of healing even if the person is already here because you already have an idea of what is going through the mind of someone who went through stuff like that.

Helping others by sharing experiences promoted reconnection because participants were trying to stop atrocities from occurring to others and were helping others in the healing process after torture.

Helping others. In addition to helping others by sharing their experiences, helping people in different ways enabled participants to reconnect with others and move on. One participant stated, "I'm already healed but I need to teach others to heal." Participants mentioned referring friends to treatment, giving advice and information in support and senior groups, helping the poor, and driving senior citizens to doctor's appointments as ways of helping others. Several participants commented that they often learn from their own advice, particularly when they see people benefit from their advice. For example, one learned that "when you help others and give advice it helps you. And with that advice they make a decision it shows you can do something and you get a reward." A retired participant who has dedicated his life to helping others exemplifies the powerful healing effects of serving:

> And now my existence helps the community and that is part of the healing. In the community we are like a tree: different parts can help each other. When I'm healthy I give wisdom, share experiences, and educate people. Sometimes I share things from the past. But sometimes I share about current problems—like telling kids to learn English. The old things, I don't like to talk about it. If I see someone doing bad things I will tell him he is not only hurting himself but others as well.

Since he feels that he has healed, another participant described how he now focuses on finding solutions to the problems that cause war and torture:

> If you have noticed…I have even noticed myself that since the time I am talking most about solution than about what happened. Yes, it happened; we need to share. But we are seeking solution, how we can have solution. I believe solution is more important than to hold on these things, to grieve on these things. No, when someone is healed, your heart aspire really to say, "don't let these things happen again to another person because they are not good."

Not focusing on self. Not focusing on oneself was an important aspect of helping others and, therefore, moving on. "Instead of sitting and thinking about the past," explained one participant, "I go help the community. It's part of my healing." Another expressed one of the reasons he is excited about life now:

> That excitement I believe also come in this way: you don't concentrate too much on yourself; you start to concentrate also on others. When you are hit with these things you normally concentrate on yourself. "They did this to me. I went through this. It is me, me, me." But I believe that when the process of healing comes you start to think about others. That's why I was talking about my family, my children, my wife. It can't be only about myself. I have people around me. So to think about all these things, to help my son, to achieve that goal, I believe that it is also in the process of healing.

Helping others by giving advice, performing acts of service, finding solutions to problems that cause war and torture and not focusing on themselves promoted reconnection with others and participants were able to move on.

Activism. Participants described experiences of activism to help others and promote a cause that did not necessarily involve disclosing their torture history. One participant stated that fighting in the rebel army after his torture experiences was important in the process of getting better. When asked why it was helpful to be in the army, he remarked:

> Well, freedom, yes sir, freedom. I believed I would have freedom of my soul and get the doctors and the young people, everything. I understand that they fight for freedom, for their own country, for their nation. I understand that. Before that, I just go not thinking about this; only thinking about work, get money, help my family, changing clothes, keep alive. It make me proud, you know. We get our answer at the last. We get our freedom.

For others, it was important to share with others the atrocities that happened in their home countries in order to prevent it from happening in the future. A participant described why he talks to others about the problems in his country:

> Someone who went through these things like me, one day in future, if we can find the solution so that another one can't go through the same thing. So when the information the people have are wrong, which mean the solution will always be difficult. So they

> need to know exactly, exactly what is going on. If people can know the atrocities, I think that perhaps they can do something; they can do something.

Teaching people to forgive and forget was identified as a way to help others after war experiences. A participant said, "Like I said before, the person who killed isn't strong—the victim is strong if he forgives and forgets. That's what I want to teach others—to forgive and forget. I want to teach others how easy it is." Activism was not only a means to reconnection for the participants but was a way to promote the well-being of others.

Barriers in Receiving Emotional Support and Reconnecting with Others

While participants described many conditions and coping strategies that promoted receiving support and reconnecting with others, they also reported several barriers in receiving emotional support and in the reconnection process. These barriers include 1) difficulty acculturating, 2) cultural norms from their native countries, and 3) unhelpful experiences with individuals.

Difficulty acculturating. Many of the participants expressed that moving to a new country and culture has made them feel isolated. Difficulty learning English, new cultural norms, and conflict with neighbors and coworkers because of cultural differences were reasons for not connecting with people. A participant explained why he is careful about connecting with others:

> You have to work with people as a human being. But, especially in this kind of society we live in, almost 90% of the people you run into daily, they are not people that you knew before. And people from different cultures think differently. I don't trust nobody. That's how I live. This is a very complex society that we live in, very, very complex. And you don't know what other people are capable of doing. So it's difficult. You can always work with people with your mind open but you must always have to be careful.

The long, difficult process of acculturation has been a barrier to receiving emotional support and reconnecting with others.

Cultural norms of native country. In addition to adapting to a new culture, in some cases, norms of their native cultures hindered people from getting better. Many participants explained that it was shameful in their country to have mental health problems. Therefore, they were reluctant to talk to people about their problems and seek help. They felt that people would think they were crazy and they would be ostracized. One participant described how the cultural norms in his native culture keep people from seeking help:

> I have a lot of friends that are sick, I know that. They don't know anything and they can't do anything for themselves. If you don't talk to them and know their viewpoint, you will not know that they have problems. But I know with the way I have talked to people and I have read, I have been able to analyze, a lot of them have problems. But coming to people to seek help is taboo. We not used to that and you have to learn that. I mean, sitting down and talking about depression, they wouldn't understand. They just ignore it. That's how we look at it. And they don't care.

Cultural norms from native countries often kept participants from acknowledging their problems and seeking help.

Unhelpful experiences with individual people. The third barrier of reconnecting with others identified by participants was unhelpful experiences with individual people. One participant expressed his frustration from receiving treatments from doctors who he felt didn't care about his treatment:

> I used to argue with them when I go to hospital. But you see, sometimes people just don't care. They don't care. You will talk to them and they will say, "Oh, we know what is happening." Sometimes they will look at my results, my laboratory results and if they didn't see anything they say, "Oh, you're fine, you're fine."

Participants also described relationships that were damaged because they felt the person was not tolerant of their challenges. Not only did some participants feel unsupported in work and education efforts, several even felt other people were happy to see them suffer. For example, one participant recounted why it was difficult for him to trust others when people he served as a pastor seemed happy for his experiences:

> On this point of trust, perhaps for you to understand very well because when these things happen you can see people who you are very close to are happy, because you are caught, you are in prison. So when you see people you are very close to are very glad; they are happy because you are caught. You can't trust again someone. People you are ministering to, giving them the word of God, helping them, but some start to rejoice because you are caught. So it makes you to prevent to trust people again.

Indicators and Consequences of Getting Better

Participants expressed a variety of indicators and consequences of moving on and getting better, including 1) emotional wellbeing, 2) a happy, bright demeanor, 3) more adaptive functioning, 4) getting life back to normal, 5) improved relationships, and 6) establishing a better life. The indicators and consequences represent both psychological and emotional changes in the person as well as interpersonal and lifestyle changes in the person's environment. It is important to note these indicators and consequences were not simply manifested once a person "got better"; rather, they developed as the process of getting better progressed.

Emotional Wellbeing

One of the consequences of moving on and getting better identified is emotional wellbeing. Some participants recalled that they did not feel the emotional pain when thinking of the difficult events they experienced; in essence, they were released from the pain. One participant stated,

> Everything was connected to what I went through. But when I went through this program, I felt that it is like my inside was disconnected from that event. That's the way I'm talking about healing. It was disconnected to that event. Because that event kept my inside prisoner. For many years everything was connected to that event. And now I feel that I'm disconnected. My spirit is disconnected, my heart is disconnected, my thoughts. Yes, I can think about that but it is not like it was at that time.

Some participants reported that a burden had been lifted. When one participant was asked what sharing his experiences with his wife brought him he stated, "I think healing, because my heart was broken through all. So it is like something which was inside of me every burden was gone,

to share with her." Some participants were not ashamed anymore of what happened to them, as indicated by one who stated, "I was not ashamed to say what I went through. Because the hard part at the beginning was that you feel ashamed. I was not ashamed."

A Happy, Brightened Demeanor

Another consequence of moving on and getting better that surfaced during the interviews with participants is that they have a happy, brightened demeanor. Many of them reported that happiness was a result of getting better. When one participant was asked to describe what getting better meant to him, he stated,

> It is bright. When I was sick it was dark. My eyes could see but it was covered by dark. A kind of problem, you know. But now it's just bright. Everything, I just see bright things now, not just negative things.

Another participant when asked to give a sign of healing said, "You can read in my face if you like. I don't look like a person who has sadness and aloneness."

More Adaptive Functioning

Getting better was also indicated by a replacement of psychological and physical problems with more adaptive functioning by participants. They indicated improvement in concentration, memory, sleep, and mood. When asked what getting better looks like, one participant stated,

> And some bad thing that happening to me right now is being forgetful. Be able to sit and concentrate. Have nice sleeps. And those are 3 parameters that I always use know my level of improvement. So I use these three areas to evaluate myself sometimes. And I think it is getting better, little by little, it's getting better.

Participants reported being less stressed and more relaxed than they were early in the process of getting better. Several participants mentioned that although they still have symptoms, they are not bothered by them and generally feel more satisfied with life. An improvement in physical

health was an indicator of healing identified by some participants, and one participant connected this with mental health:

> The people we have two part, one physical and one mental part. When the mental opens this means can help our physical situation better. When the mental is in a good situation it helps the physical situation a lot.

Moving on and getting better was indicated by participants being able to function more adaptively as a result of improved physical and mental health.

Getting Life Back to Normal

Besides these psychological and emotional indicators of getting better, participants also reported interpersonal and lifestyle changes as indicators and consequences of getting better. Generally getting life back to normal, for example, was identified as an indicator of getting better. When describing the process, one participant stated,

> What I mean is that I wasn't who was in the past. I had flashbacks; I couldn't sleep. Now I'm functioning; I'm getting money. I became normal as I was. I was not hearing bad things. I had hope.

Several participants reported that a consequence of getting better is regaining pre-trauma health. For example, one participant stated, "Well, my goal in this whole thing is to, if not come closer to my prewar health, if not be more than my prewar health then come closer to my prewar health." Additionally, being able to function without medication was also identified as an indicator of returning to normal life.

Improved Relationships

Improvement in relationships was an indicator of getting better. Regaining trust in other people was a consequence of healing for some participants, as indicated by one who said:

> I couldn't trust anybody. So it bring to start to trust people to know that there are people in this life and they are there for you and I shared with my wife for the first time. And that brought also something great in me to share with my wife that. It brought healing.

Another important indication of healing is being more open with others and having positive interactions with other people, particularly with family. A major shift from being isolated and avoiding such contact to becoming more and more involved and comfortable with family and others occurred for one participant:

> One of the thing I know people have noticed in my life, I was avoiding contact with people. I never liked many people around me. I have noticed myself that I am in contact with different people now. I can call people very easily. Now people have noticed that I can call people very easily and talk to them and share with them conversation. I have become more open. My children have noticed that daddy has become more open. Yesterday I called off to my job because I wanted to have time with them. All day we were out.

Another example of this deeper level of interaction with others that was mentioned by participants as a result of getting better is willingness to help other people in need. One participant stated, "when I'm healthy I give wisdom, share experiences, and educate people." Participants were able to have more meaningful relationships with others, particularly with loved ones as a result of moving on and getting better.

Establishment of a Better Life

A final indicator of success in the process of getting better was the establishment of a better life for themselves and their families. For older participants in particular, it was very important for them that their children became established financially in the United States. One of them related:

> But since the time my family moved to the United States there is a lot improve and now my children grown up and they have job and our life is improving a lot. So that's why we feel better life here can help us a lot.

Safety for her family was a major concern for one woman, who remarked, "My first and last goal was for me and my kids to be safe. That's why it becomes part of my healing that they are safe. The hope that they are safe gives me strength." Some participants reported that having less

stress in the United States was very helpful. For one in particular, this was coupled with a relief of feeling removed from his difficult experiences. He explained,

> The freedom of the United States gives my family a stable life. No fear at all. No fear…Because the life here in the United States gives me less worry. Less thinking about the hardships, so we feel better.

Overall, establishing a better life indicated that the participants were getting better because they were able to relax and support their families.

Unique Subgroups of Getting Better

Several subgroups of participants had unique experiences in the process of getting better that are important to analyze. These groups include 1) seekers of help and 2) focus on stability in Vietnamese men.

Seekers of Help

One was a group of people who were unusually active in seeking help for their challenges. These participants were unique in that they analyzed what was wrong with them and tried to understand their challenges at a deeper level. One participant started to recognize his problems when he took college classes. When asked about his problems, he reported,

> Serious, serious problems. You see I had the problem before, but I didn't know. And when I came here now and I started school I began reading about depression. In fact, when we started talking, because I had a psychology class and sociology. It was at the time that I realized that I do have problem.

He was able to self-diagnose after receiving treatment that ignored psychological causes. After realizing that his concentration and sleep problems were keeping him from performing as well in his classes as he expected, he was able to find appropriate treatment.

Another participant felt that his severe depression brought him to the realization that he may hurt himself and he needed help. He stated,

> I went through depression. I believe that it was the way to the solution because that depression pushed me to start to fear about my life. It challenged me that something is wrong. Because in the past you were taking these things as part of your life but they are wrong things. They are destroying you. But you were taking them as part of your life. So I believe that that stage of depression helped me, to challenge me that you know you can hurt yourself.

Once these participants recognized that they had problems they could not solve on their own, they actively sought treatment. One participant traveled back to his native country to wash in holy water, which he found helpful for his back pain. Another participant sought help by opening up to a friend from church. She referred him to CTTS. He described his thought process of deciding to take her advice:

> I believe that that's when that sister talked to me. I opened my heart. I said, "no, let me do what she's saying. Perhaps it can help." I believe that was also something good to me so that I can start the process.

One of the participants described the importance of taking personal responsibility in seeking and taking advantage of treatment. He reported,

> The whole healing process depends on the patient himself. Because no one is going to tell you to come and see people. I mean, you have to be determined in the whole process. I mean you can do your part; the health worker can do the part. I think 90% of the rest of it you have to see that I have to help myself because I want to do something for myself. And I don't want to continue like this. Nobody is going to force you to come and seek treatment. You have to do it yourself. So I think the whole thing rests on the patient.

That seeking and receiving help is a continuous process that has been helpful was reported by another man:

> You always have to seek help. Because the human being is a social being, you have to be among people to be able to evaluate yourself. Because if I sit and talk to you and I'm somebody that can evaluate I can tell the difference. I'm able to learn something from you and you can learn something from me too.

In addition, these participants reported that disclosing their experiences to family, friends, and staff at CTTS was a very important aspect of the process of getting better. The subgroup of participants who displayed this deeper level of introspection coupled with action proved to be the

most comfortable in sharing their experiences during the interview for this study. These participants expressed that they were further along in the process of getting better than they would have been if they did not seek help. Thus, recognizing problems and seeking help appear to move the process along more quickly.

Vietnamese Participants' Focus on Stability and Providing for Their Families

In addition to the unique subgroup of participants who sought help, another subgroup of participants with a unique perspective was the elderly Vietnamese men who were more focused on the importance of stability in the process of getting better. These men described how difficult life was for them as a result of being in prison for 5-7 years and then being on probation for another period of years because they fought for the South Vietnamese army. They were unable to support their families financially and their children were not able to obtain an education. Because of this, their description of the process of getting better focused on financial stability for themselves and their children, helping their children obtain educations and successful careers, and freedom of speech and religion. They remarked that they were not able to begin to move on until they moved to the United States. One Vietnamese participant described the importance of gaining freedoms by moving to the United States after being in a prison camp and on probation for many years:

> I feel free when I came here because this is a freedom country. I have my rights but compared with in my country of Vietnam I didn't have any rights even [after] I was released from camp. I didn't have any rights to go to work until [the mid1990's] when I came here.

These Vietnamese men also described themes of religious beliefs and social support but their main focus was on stability.

Process Model of Getting Better

Torture, war, and relocation experiences left the participants in this study isolated and in much physical and emotional pain. Participants were very descriptive of supports, beliefs, and coping strategies they used in the process of getting better after torture. The three major categories in this study, 1) Belief and Values Systems, 2) Safety and Stability, and 3) Emotional Support and Reconnection, were used to develop a multi-dimensional model of the process of moving on and getting better. The model that emerged from the interviews is a model that describes the process participants underwent as they moved through phases of isolation, reconnection and support, empowerment, moving on, and finally getting better (see Figure 2).

Belief and Values Systems

Participants used their belief and values systems before, during, and after their torture and war experiences for comfort and direction. These belief and values systems can be distinguished from other factors in the process of moving on. Therefore, it is useful to include their direct impact on moving on (see Figure 2). The themes identified in the use of belief and values systems include 1) faith in a higher power, 2) belief that a higher power is in control, 3) a fair judgment by a higher power, 4) spiritual rituals and activities, 5) forgiveness, and 6) understanding of the roles and circumstances of the perpetrators.

Participants described only a few barriers related to using their belief and values systems in order to move on after torture. These barriers include 1) anger toward perpetrators and 2) questioning the higher power's judgment.

Available Environmental Supports for Safety and Stability

The other enabling conditions and coping strategies involved in the process were more interrelated and reciprocal in comparison to the direct impact of belief and values systems on

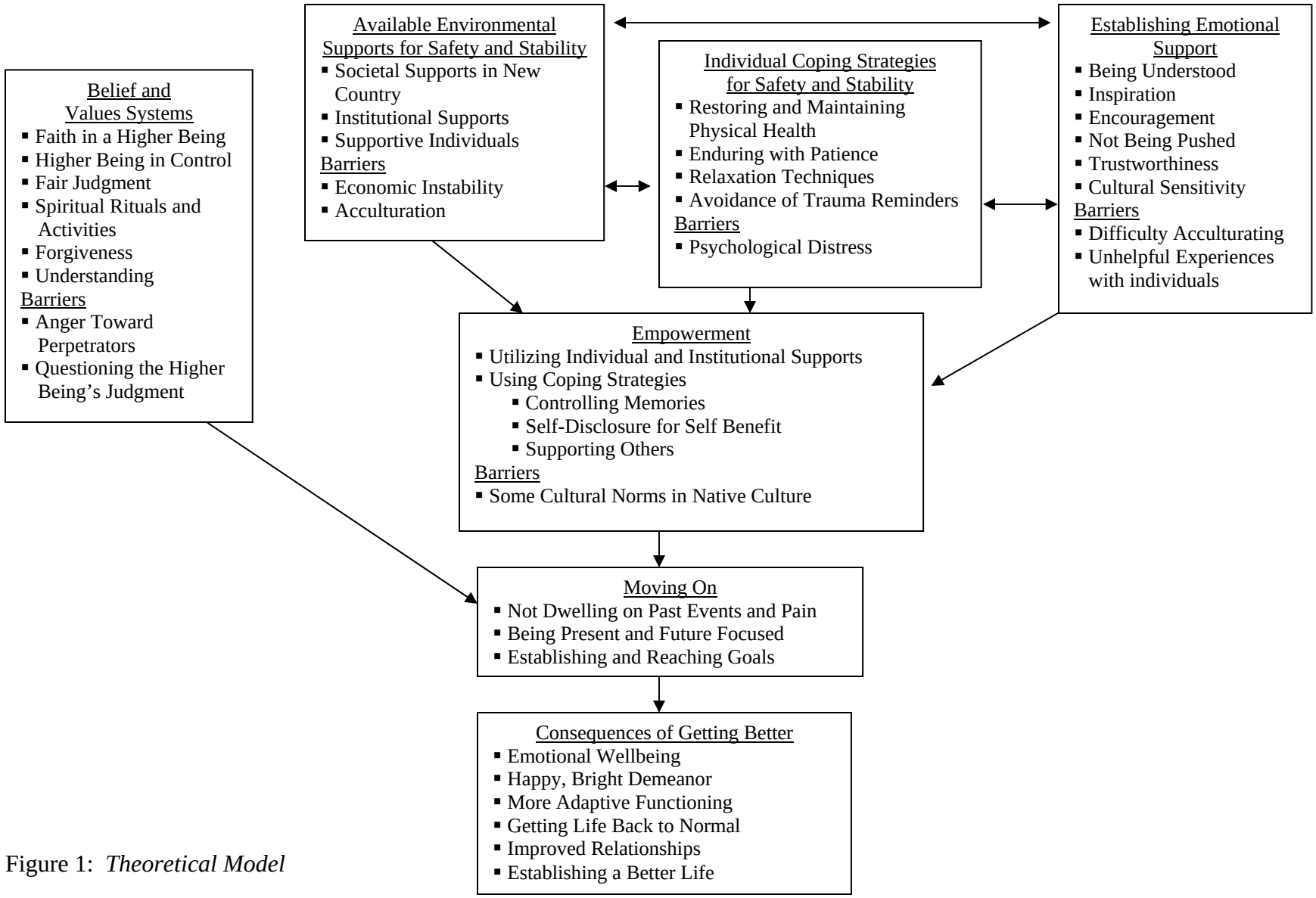

Figure 1: *Theoretical Model*

moving on after torture. One of the enabling conditions that promoted moving on described by participants was the establishment of safety and stability through the various available environmental supports. These supports include societal supports such as freedom of religion and speech, and education and economic opportunities were other environmental supports identified. Institutional supports such as refugee resettlement programs, Medicaid, housing aid, social security, and a program such as CTTS enabled moving on. Finally, supportive individuals who may have helped participants escape dangerous situations or who provided physical and economic support until the participants were able to support themselves promoted moving on. Economic instability and difficulty acculturating were identified as barriers to using available supports in order to establish safety and stability.

Individual Coping Strategies for Safety and Stability

Participants identified various coping strategies used to promote safety and stability. These strategies include 1) restoring and maintaining physical health, 2) enduring with patience, 3) relaxation techniques, and 4) avoidance of trauma reminders. These techniques were used throughout the process but were first used to establish stability and were not necessarily as adaptive as the process of getting better progressed.

While participants reported many enabling conditions and activities that promoted safety and stability, they also described psychological distress as a barrier to using coping strategies to establish safety and stability.

Establishing Emotional Support

Participants described enabling conditions that promoted establishing emotional support. These are conditions that were found in people and institutions who gave emotional and social support to the survivors at various points in their healing process. These conditions include 1)

being understood by someone, 2) inspiration, 3) encouragement, 4) not being pushed, 5) trustworthiness, and 6) cultural sensitivity.

Not only did participants describe conditions that promoted receiving emotional support and reconnecting with others, they also reported several barriers in receiving emotional support and in the reconnection process. These barriers include 1) difficulty acculturating, and 2) unhelpful experiences with individuals.

Empowerment

A greater sense of safety and stability and social support enabled the survivors to feel comfortable enough to regain a sense of control to make their lives better. They felt a sense of responsibility for their growth and healing and they were able to utilize available supports and coping strategies to promote this.

Utilizing supports. With various supports in place, participants were able to choose to utilize these supports in order to move on from their torture and war experiences. It was not enough to simply have the supports available; the survivors had to feel empowered to know that if they used these supports their lives would improve. Participants stated that they used supports such as advice from family and friends, education and economic opportunities, support groups medication, use of traditional healers and rituals.

Using coping strategies. Although coping strategies (described previously) used to establish safety and stability were more for survival and maintaining normalcy, other coping strategies were geared toward empowering them to be proactive in the process of moving on from their experiences and getting better. These coping strategies include 1) controlling memories, 2) self-disclosure for self benefit, and 3) supporting others. Participants described

various forms of supporting others including 1) sharing experiences to benefit others, 2) activism, 3) not focusing on self, and 4) helping others.

Barriers to empowerment. Participants described cultural norms from their native cultures that kept them from seeking help and accepting support. This includes stigma of mental illness and different understandings of physical and mental illness.

Moving On

Use of belief and values systems and being empowered to take control of their healing process allowed participants to move on from their torture and war experiences. The central phenomenon of this model of getting better after torture is moving on. All of the participants described a desire to move on from their experiences. They described moving on as 1) not dwelling on past events and pain, 2) being present and future focused, and 3) establishing and reaching goals.

Indicators and Consequences of Getting Better

Finally, participants described a broad range of indicators and consequences of moving on and getting better. These were themes that participants used to know that they were getting better, although every participant did not necessarily identify with every consequence. These indicators and consequences of getting better include 1) emotional wellbeing, 2) a happy, bright demeanor, 3) more adaptive functioning, 4) getting life back into a routine, 5) improved relationships and 6) establishment of a better life.

Case Composite of Theoretical Model

In order to illustrate the theoretical model, a case composite is given. Experiences of various participants were combined in order to protect confidentiality.

Philip

Philip lived with his family in Liberia. He was a wealthy businessman who was persecuted by a rebel group because of he was a wealthy member of the ruling tribe. The rebels stormed Philip's home and held him and his family hostage for five days. During that time his family was severely beaten, and one of his sons was killed while trying to escape. While held hostage, Philip and his family prayed and read the Qur'an for comfort but he felt rejected by Allah, and he asked "why me?" in his prayers. Although he questioned Allah's judgment, he never lost his faith. Philip's business partner, who was from the tribe of the rebels, paid the rebels money to let Philip and his family escape. Philip believes that being able to escape was a gift from Allah. Philip's business partner helped Philip and Philip's family escape to a refugee camp in Ivory Coast.

Philip lived with his family for six years in the refugee camp at which time he immigrated alone to the United States with the assistance of the United Nations. His refugee resettlement agency, Catholic Charities, provided financial, medical, and housing support for his first eight months in the United States. Through assistance from Catholic Charities, Philip was able to obtain employment at a food processing factory. For the first year in the United States, Philip reported being very happy although he was struggling to learn the customs and way of life in the United States. It was difficult for him to understand why life was so busy in the United States. He reported missing the slower pace in Africa.

Even though he was working long hours at work, Philip began taking classes at the community college. He was hoping to become a registered nurse. He became frustrated with his studies because he was unable to concentrate for long periods of time and he had difficulty sleeping. He felt very alone without his family and he felt that he could not trust anyone,

particularly people from his own country. Work and school became too much to handle so Philip decided to quit school. He couldn't afford to cut back at work because he was saving up as much money as possible to bring his family to the United States. At this time he became more depressed. He thought he was a failure for quitting school. He became upset whenever he thought about his son who was killed, and he tried his best not to think about him because he would often have nightmares about his death. He began having suicidal thoughts, and he missed work for days at a time. He said that the only thing that kept him going was remembering his family struggling to escape and make it to the refugee camp. He knew he could not leave his children without a father.

Moses, a coworker from Nigeria, worried about Philip, and he visited him on occasion. Philip had once told him that he lost a son while being held by rebels. On one visit when Philip was quite depressed, Moses told Philip about his experiences of being imprisoned in Nigeria for political activity. Moses described his own problems with sleep, nightmares, and constant worry. At this point, Moses told Philip that he was going to a program that helped torture survivors and he was benefiting from it greatly. Philip told how much he was suffering, and he was shocked to find out that Moses had similar problems. He told Moses some of his family's experiences of being held hostage. Moses invited him to visit the center to meet with the director, but Philip was reluctant to talk about his past.

After a few weeks of visiting with Moses, Philip decided to visit CTTS. Seeing Moses working to improve his own health inspired Philip to take control of his own health. Philip was very pleased to find out that his case manager was from an African country that had experienced years of civil war. Philip felt that this case manager could relate to his own experiences. He first met with the director for an intake interview, but he did not talk about his history. He only spoke

about his job and how the United States is different from Liberia. He returned another time to continue the interview but he did not talk much at all. He said he was able to trust the director because she did not push him to talk about his past. She just sat with him and let him take the lead. Finally, at the third visit, Philip told the director his story in detail. He stated that he just couldn't help but cry at the end because he felt a burden had been lifted. That was the only time he told his story in full detail. He said he is willing to talk about his experiences with the right people but when he goes to work, he leaves it behind him. Because the past was painful to talk about, Philip expressed mixed feelings about participating in my current study and he almost didn't return for the follow up interview. However, he decided to return because he felt he was helping others by telling his story of healing.

Once Philip felt comfortable sharing his experiences with the director, he felt he was ready to participate in other programs at CTTS. He met with a therapist individually for several months but he felt it wasn't really helpful. What really helped, according to Philip, was participating in a support group. He said it helped him to move on by discussing current problems with work, health, and relocating his family. His focus was now on reuniting with his family by finding a better job and getting back into school. In addition, medication proved helpful in reducing his anxiety and he was able to sleep better. He feels that he was able to complete three courses at the college because the medication helped him to concentrate. In order to restore his physical health, Philip was able to receive physical therapy for chronic back pain through CTTS.

Philip no longer feels as much pain when he thinks of his son who died. He is able to smile more and he enjoys spending time with friends at the Waffle House. He feels like he can joke like he used to. When asked about how he feels about his perpetrators now, he said that he

was able to forgive them. He knew that the perpetrators were young boys who were just following orders. His religion teaches that it is important to leave judgment to Allah and he expects to be rewarded after this life for following Allah's teachings. He believes that forgiving made him less angry and it allowed him to be more trustful and reach out to help others.

Analysis of Case Composite

The experiences of Philip illustrate the multi-dimensional process model of getting better after torture and the bold and italicized text indicate categories and themes in the model. Philip used his **Belief and Values Systems** through participating in *spiritual rituals and activities* by praying for strength and comfort and he read the Qur'an while being held hostage. As an expression of his belief that a *higher power was in control*, Philip believed that he was able to escape because of help from Allah. In addition, he was able to *forgive* his perpetrators and he *understood* they were just following orders. As an example of the interaction between domains, being able to forgive his perpetrators allowed Philip to be able to trust and help others. He believes in leaving *judgment* to Allah and he feels he will be rewarded for following Allah's teachings. The only barrier to using his belief and values system he mentioned was *questioning Allah's judgment* at the time of the torture.

Philip's story describes available **Environmental Supports for Safety and Stability**. As an example of *supportive individuals*, Philip and his family were able to escape with the help of Philip's business partner. They were able to live in the refugee camp and Philip was able to relocate to the United States through the *institutional support* of the United Nations. Catholic Charities enabled safety and stability by providing *institutional support* through financial, medical, and housing aid. Learning new customs and the busy lifestyle of the United States were *acculturative* barriers to establishing safety and stability. In addition, due to *economic*

instability, he chose to work to support his family rather than continue his education when he felt he could no longer manage both school and work.

Various aspects of **Individual Coping Strategies for Establishing Safety and Stability** were described in Philip's story. He *avoided* thinking about his son's death in order to prevent nightmares. In an effort to *restore physical health*, Philip took advantage of physical therapy services through CTTS. On the other hand, difficulty concentrating and sleeping, lack of trust, depression, and suicidal thoughts were examples of *psychological distress* that were barriers to Philip establishing safety and stability. In fact, Philip had to quit school for a while because of this psychological distress.

Philip's story illustrates the **Establishment of Emotional Support**. The memory of his family struggling to escape and survive *inspired* him to struggle through his depression and not commit suicide. He felt that his friend, Moses, *understood* his challenges because Moses had been through similar experiences. The *trust* Philip felt in Moses enabled him to seek services at CTTS. In terms of *cultural sensitivity*, he felt supported by having a case manager from Africa with similar experiences. Philip did *not feel that he was being pushed* to tell his story by the director of CTTS; she allowed him to open up at his own pace.

Once Philip felt that he was safe and emotionally supported, he felt **Empowered** to take action to move on from his past. He was able to *self-disclose* his experiences. Because of his *trust* in his friend Moses, Philip felt comfortable sharing some of his own experiences of torture and his psychological distress. He also shared his story with the director of CTTS and he felt that a burden had been lifted. Philip's story illustrated the importance of *being in control of his memories*. He described how helpful it was to share his experiences in certain situations but he also expressed the importance of being able to forget about the past when he was working and

studying. He *utilized various supports* available such as medication and group and individual therapy at CTTS. He also expressed a willingness to participate in the current research study in order to *support others* by telling his story of healing.

The various supports and empowerment strategies enabled Philip to **Move On** from his experiences. He described *not wanting to focus on the past* but to *focus on the present and future* in his support group. He was focused on *reaching goals* of being reunited with his family and obtaining an education and a job that could support his family.

As a result of moving on and getting better, Philip described various **Consequences of Getting Better**. Philip felt less anger and that a burden had been lifted, and he did not feel the *emotional pain* when remembering his son who died. His *relationships have improved* as evidenced by being able to spend time with friends. That he smiles and jokes more than in the past indicates a *happy and bright demeanor* and he is *functioning better* at school and work by being able to concentrate better.

Chapter 4: Discussion

The traditional model of Western mental health treatment for survivors of torture has focused mainly on posttraumatic stress disorder (PTSD) and related conditions (depression and anxiety). The literature in this area generally focuses on these symptoms, and limited research has been conducted on alternative ways of understanding and factors that promote the recovery or healing process after torture. Many of these alternative factors have yet to be integrated into treatment. In contrast, this study examines the process of "getting better" by broadening the scope of analysis using the perspectives and personal experiences of torture survivors themselves. Participants were able to identify key factors that promoted getting better as well as define what getting better meant to them. Based on the grounded theory method developed by Strauss and Corbin (1990) and the procedure of qualitative data analysis, a theoretical model was constructed of the phenomenon "moving on" which emerged as the central theme pertaining to getting better after torture. This study used descriptive, qualitative information to highlight the *process* of getting better after torture. Characteristic of qualitative research, the results of this analysis are unique to this investigator, the participants, and the context of this study.

Interpretation of Results

Eleven torture survivors from various African and Asian countries described their process of getting better after torture. The process of getting better, as described at the end of the results section, is a recursive process with many interconnected relationships. This model presents interactions between environmental and psychological factors that both promote and hinder moving on and getting better after torture. Participants described various supports, beliefs and coping mechanisms that empowered them to gain a sense of control of their lives in order to move on after torture.

The present research is congruent in noteworthy ways with existing research on the process of getting better after torture and other traumatic experiences. Participants' rich descriptions of the process of getting better help to clarify and define the concepts more fully. This section connects the results of this study with existing theory and research and explores themes that have not been examined much in the research.

Comparison of the Model of Getting Better to Other Models

The model of the process of getting better after torture (see Figure 1, pg. 111) that emerged in this study is similar to existing models developed to understand recovery from trauma. In general, participants in the current study described a broad range of areas of their lives that were impacted by torture and factors that promoted getting better that were similar to Silove's (1999) ecological model of systems of health impacted by torture and mass trauma, including 1) attachment, 2) security, 3) identity/role, 4) human rights, and 5) existential meaning. This broad focus supports arguments that a narrow focus on reducing symptoms of pathology limits our understanding of the recovery process and overlooks important areas of intervention to promote health and well-being (de Jong, 2004, Pupavac, 2002; Silove, 2004; Summerfield, 1999; Watters, 2001; Zarowsky, 2004).

In addition, similar to Herman's (1992a) model of recovery, results of this study suggest that the process of getting better has a number of complex and reciprocal relationships. Herman (1992a) suggests that trauma survivors proceed through three stages in the recovery process: 1) the establishment of safety, 2) remembrance and mourning, and 3) reconnection. In the same manner as Herman's model, the course of getting better does not necessarily follow stages in a straightforward, linear process. In contrast to Herman's (1992a) model, however, my model (see Figure 1, pg. 111) is not a stage model that describes stages that must be *passed through* for

recovery. It is a multi-dimensional model of the process of *utilizing personal beliefs and available environmental and intrapersonal resources* to move on and get better after torture. Conditions that enabled the process and coping strategies used were unique to each individual within the various dimensions of the model depending on strengths and available resources of the individual and his or her environment.

Belief and Values Systems

Participants identified using belief and values systems as a major factor that promoted moving on after torture. Participants used their belief and values systems with or without other supports and coping strategies; it did not appear to be dependent on other factors being present. Using belief systems to make meaning after torture has been identified by many researchers as an important component in the healing process after traumatic experiences (Frankl, 1962; Herman, 1992a; Silove, 1999; Solomon, 2004; Tedeschi et al., 1998; Vanista-Kosuta & Kosuta, 1998). Participants' belief systems informed their understanding of why they were tortured and imprisoned, with several mentioning that the experiences were trials from a higher power given to make them stronger. Although some people who experience traumatic events report questioning or losing their faith in a higher power (Ortiz, 2001; Piwowarczyk, 2005), the participants in this study said that they did not lose or question their faith or religious commitment (Shrethsa et al., 1998); for some, their faith got stronger as a result of their experiences (Overcash et al. 1996; Shaw et al., 2005). In fact, many of the participants stated that their belief in a higher power was the most important factor in getting better after their experiences and felt they were only able to survive because a higher power allowed them to live. Faith and religious beliefs were so important in the process of getting better after torture that the participants reported very few barriers to using their beliefs systems in the healing process.

Not only were belief systems used to make meaning of experiences, participants used their belief systems to gain strength and courage to endure hardships and to understand how they can heal (Shaw et al., 2005). The participants described, almost exclusively, positive patterns of religious coping (Pargament et al., 1998). For example, they described coping through seeking spiritual support, religious practices (e.g., prayer, fasting, washings, and reading holy writings), forgiveness, and spiritual connection.

Forgiveness and understanding. Forgiveness is another key component of moving on through the use of belief and values systems identified by participants. As with other theories (Herman, 1992a; Staub et al., 2005; Toussaint et al., 2001), although not a requirement for healing, being able to forgive perpetrators promoted moving on, gave peace, and released anger and emotional pain. In this study, only several participants remarked that they felt they were able to truly forgive their perpetrators. For these participants, being able to forgive was a very powerful experience. From my perspective, they seemed to be furthest along in the process of getting better, as indicated by the self identified lack of emotional pain and anger towards their perpetrators and their dedication to helping others who had been through difficult life experiences. Other participants described being in the process of trying to fully forgive their perpetrators, but did report that forgiveness was helpful for them. Because participants were able to let go of their anger towards others, it was easier for them to connect with others. Not only was forgiveness of perpetrators important in moving on, being able to absolve themselves of any blame for the causes of their torture or harm to their families helped participants (Toussaint et al., 2001). While several described what they could have done to avoid the torture and harm to their families, they recognized that they were not to blame.

When asked how they currently felt about their perpetrators, many of the participants stated that they did not blame the perpetrators for what they did. The participants were understanding of the circumstances of the perpetrators in that they recognized that their perpetrators were acting under orders from someone in authority (Hewstone et al., 2006; Hodgson & Wertheim, 2007; Takaku, 2001). Most likely, because of forgiveness and understanding of circumstances of the perpetrators, most participants did not discuss wanting revenge or justice to be served. Contrary to some research findings, most of the participants were not obsessed with seeking revenge (Silove, 1999), and they did not report that justice had to be served before they could begin healing (Allan & Allan, 2000). Only one participant expressed getting better through justice being served. He fought in the liberation army in his country and reported that he gained peace from fighting for the freedom of his country. In addition to forgiveness and understanding, another reason for this lack of desire for revenge and justice could be the geographic distance participants now have from where the human rights violations occurred. The participants were far enough removed from their perpetrators that they did not fear having the atrocities repeated (Lagos, 1994), and they felt secure in their new country. In their new country, there was no option to seek revenge or justice. Perhaps, if they were in their home countries they would have gained a sense of peace from seeing justice served (Kira et al., 2006), receiving reparations (Carmichael et al., 1996) or participating in a Truth and Reconciliation Commission (Asmal et al., 1994; Staub et al., 2005). But since this was not available, they may have decided to move on from their experiences and not seek justice.

Most participants reported that there were no barriers related to using belief and values systems in the process of moving on. Several participants reported that they felt forgiveness was important but they were unable to forgive and move on because of their anger towards those

responsible for their sufferings. Others mentioned that during their torture experiences they questioned God's judgment and asked "why me?" but still retained their faith. Because many of the participants reported their spiritual beliefs were the most helpful part of the getting better, this limited number and impact of barriers signifies how powerful these beliefs are.

Available Environmental Supports for Safety and Stability

Establishing safety and stability was a major factor in promoting moving on after torture and is in fact a major category in leading theories of recovery from torture and trauma (Herman, 1992a; Silove, 1999). Participants were struggling to establish safety and stability in two different ways: in order to get better physically and psychologically after torture and to acculturate to life in their new country. Participants described various factors that promoted overall safety and stability, including 1) societal supports in new country, 2) institutional supports, and 3) supportive individuals

Societal supports in new country. Much of the discussion of safety and stability in this study focused on the social and political impact of torture and imprisonment and on social and political factors that promoted safety and stability upon resettlement (Silove, 2005; Summerfiled, 1999). Moving to a country away from torture, war, and other social turmoil was a major step in establishing that safe environment. They may have had similar experiences relocating to other stable countries, but because the participants in this study resettled to the United States, they described the specific benefits of the safety and stability provided by living in the United States. Participants, particularly the Vietnamese participants, stressed the stability that comes from moving to a country such as the United States, and the stability provided for themselves and their families through employment (Beiser & Hou, 2001; Hermansson et al., 2002; Carlsson, Mortensen et al., 2006), education, and freedom of speech and religion (Silove, 1999).

Although the Vietnamese participants described other factors that promoted getting better, much of their discussion was about establishing stability for themselves and their families through societal supports upon resettlement. They were very focused on their role as providers for their families. There are several possible explanations for this. First, for much of their adult lives, they struggled to provide economic stability and physical safety for their families. The civil war in Vietnam began in the 1950's and military involvement kept these men from being able to support their families. After the war, the men spent up to eight years in prison, again unable to provide for or be with their families. Upon release, they were on strict probation for many years and were denied secure employment. They had to rely on their families for support. Resettling in a country such as the United States with their children meant a safe and stable environment for the first time in decades. In addition, the Vietnamese participants had been in the United States longer with their families and they saw these benefits while other participants were still struggling to find that stability.

Institutional support. Institutional support was very important in establishing safety and stability. Participants mentioned support in resettling to the United States as being helpful. Once they were resettled, supports such as refugee resettlement programs, Medicaid, social security, and housing aid were crucial in establishing safety and stability (Herman, 1992a). The cultural and systemic differences between their native countries and the United States were so great that the participants needed the stability that those services provided to be able to establish themselves in their new country (Colic-Peisker, & Walker, 2003; Kovacev & Shute, 2004; Williams & Berry, 1991). They specifically reported how helpful the broad range of services provided by CTTS was in creating a secure environment. Each participant used the various services according to their needs. Some participants used only medical and physical health

services, while others stressed the importance of psychotherapy services. The broad range and flexibility of services empowered them to focus on their most pressing health and well-being concerns (Curling, 2005).

Supportive individuals. Participants described having individuals in their lives who helped establish safety and stability. These individuals may have helped participants escape dangerous situations or provided physical and economic support until the participants were able to support themselves. This support was often given by friends and family before other resources were available or before participants would consider receiving institutional or societal supports.

Barriers to establishing safety and stability. Participants reported that economic instability was a barrier to establishing safety and stability. Many of the participants were more focused on making ends meet financially than they were on taking advantage of available supports and they would neglect their own health in order to support their families (Beiser & Hou, 2001; Hermansson et al., 2002; Carlsson, Mortensen et al., 2006). In addition, participants also reported that difficulty acculturating kept them from taking advantage of opportunities for establishing safety and stability (Colic-Peisker, & Walker, 2003; Kovacev & Shute, 2004; Williams & Berry, 1991). For example, if they did not speak English, they were unable to obtain an education or get citizenship.

Individual Coping Strategies for Establishing Safety and Stability

Participant described coping strategies they used to establish safety and stability. These coping strategies include 1) restoring and maintaining physical health (Vontress, 2001), 2) enduring with patience, 3) using relaxation techniques (Hinton, Pich, Chhean, Safren, & Pollack, 2006), and 4) avoiding reminders of trauma. These coping strategies were used throughout the

healing process but participants described using them to establish stability. They did not identify them as coping strategies that were empowering once they decided to actively work on moving on. As described later, it was beneficial for participants to be in control of their memories, and early on in the process of getting better, avoidance of memories and reminders of trauma appeared to be an adaptive strategy that helped establish safety and stability. This may have been adaptive because the participants needed to lower their anxiety in order to have temporary stability (Andrews et al., 2002). They reported that psychological distress, such as flashbacks, memory problems, depression, and nightmares (Basoglu et al., 2001) were major barriers in establishing and maintaining stability.

Establishing Emotional Support

Because torture and trauma survivors often isolate themselves emotionally from others, emotional support and reconnection is very important in moving on, as identified in the models of Herman (1992a) and Silove (1999). When survivors reconnect with others, they are able to receive emotional support (Herman, 1992a; Silove, 1999; Tedeschi & Calhoun, 2004). Many of the participants stated that they first connected with someone informally (e.g., church member, friend) with whom they developed a relationship and who later helped them take advantage of additional support and services that promoted getting better.

One of the qualities of this study is richness of the descriptions given by participants of emotional support they received. They described establishing support and connection through encouragement from others, inspiration through witnessing others endure trials, and relating to others who have had similar experiences. Participants stressed the importance of having someone take time to listen and seek to understand their situations and problems. Supportive people did not try to solve the problems right away. A related factor in establishing social

support identified by participants was that supportive people did not push them into treatment (Fabri, 2001). Participants were able to take their time in establishing relationships and making decisions.

Trustworthiness. Participants identified rebuilding of trust as a first step in seeking and receiving help from others, particularly institutional support (Behnia, 1997; Yawar, 2004). By believing their stories, particularly during the intake interview, staff at CTTS was able to gain the trust of the participants (Behnia, 1997; van der Kloot Mjiburg, 2004). Trust was also gained through participants being empowered to share their stories at their own pace and guiding their own treatment (Fabri, 2001). Once trust was established, participants felt comfortable participating in other services at CTTS. Trust was also gained through support providers following through on their commitments and giving good advice.

Cultural sensitivity. As identified by the participants, culturally sensitive services and providers were key components in the quality of healthcare services received (Fong, 2004; Whaley & Davis, 2007). Participants described how difficult it was for them to seek help, but having service providers who spoke their language and were understanding of their circumstances was very important in the process of getting better. In addition, the service options at CTTS were flexible to fit a person's cultural norms. For example, support groups with same gender and ethnicity participants, as opposed to individual therapy, were very beneficial to some participants.

Barriers to emotional support and reconnection. Participants described several important barriers in receiving emotional support and reconnecting with others. Difficulty acculturating due to language barriers and cultural differences slowed down the process of receiving support from people outside of their cultures (Colic-Peisker, & Walker, 2003; Kovacev & Shute, 2004;

Williams & Berry, 1991). Participants also described various unhelpful people including family, friends, and service providers. Experiences such as torture experiences not being believed and not understanding mental and physical problems kept participants from receiving emotional support and reconnecting.

Empowerment

Because having control of their lives and bodies taken away during their torture and prison experiences was so traumatic and humiliating, being able to regain the power to control their lives is important in the process of getting better (Curling, 2005; Herman, 1992a; Jaranson et al., 2001). Empowerment is important in my model because survivors had to feel that they could make their lives better in order to take advantage of available supports and beliefs. The survivors had to feel that they were responsible for their growth and healing; if not, they rejected possible opportunities for support (Curling, 2005; Herman, 1992a). Being empowered to control their health and wellbeing allowed survivors to move on from their torture and war experiences. Participants described utilizing individual and institutional supports and using various coping strategies to gain a sense of empowerment.

Utilizing individual and institutional supports. Once factors that promote safety, stability and emotional support were made available, participants had to make the decision to utilize the supports. They felt the pieces were in place to give support in taking control of their wellbeing and health. Participants described various individual, institutional (formal support groups, education opportunities, and medication) and cultural supports (informal support groups and traditional healers and rituals) they felt empowered them to move on.

Many of the participants had individuals in their lives that were supportive and gave good advice. Several mentioned that they were able to reconnect with these individuals and they

trusted these individuals as they introduced them to other supports and services. In addition, many of the participants reported taking advantage of education opportunities such as college, vocational training, and learning English as a means to move on with their lives.

Because many of the participants came from collectivist cultures where relationships are highly valued (de Jong, 2004), formal (e.g., CTTS support group) and informal support groups (e.g., activities at the senior center) were very helpful in the process of getting better (Behnia, 2004). Participants remarked how important it was to meet with people who have had similar experiences to learn from each other about how to move on and establish a new life (Eyber & Ager, 2002). In addition, they reported learning of new supports and techniques for establishing safety and stability in their support groups. The women in this study reported that the support groups at CTTS were particularly helpful in moving on after torture.

Although reluctant at first to consider medication, many participants stated that medication was very helpful in overcoming psychological distress (Bouwer & Stein, 1998; Quiroga & Jaranson, 2005). And interestingly enough, this was often due in part to the bed side manner of their physicians. If the participants were able to be part of the decision-making about medication and if their physician was friendly, they were more willing to take medication and they found the medication to be more helpful (Behina, 2001; Curling, 2005).

It is important to note that participants reported using traditional healers and traditional healing rituals—such as washing in holy water and chanting—only back in their home countries (Magruder et al., 2001; Vontress, 2001). They did not report using traditional healers or rituals in the United States. This could be due to the disruption of traditions, routines, and communities related to the acculturative stress of living in a new country, as well as simple inaccessibility of necessary resources (Williams & Berry, 1991). In addition, if they actually were using

traditional healers and rituals, they may not felt comfortable disclosing this to a mental health professional.

Using Coping Strategies. While coping strategies used to establish safety and stability were more for survival and maintaining normalcy, participants described coping strategies that were geared toward empowering them to be proactive in the process of moving on from their experiences and getting better. These coping strategies include 1) being in control of memories, 2) self-disclosure for self benefit, and 3) supporting others.

One of the more interesting aspects of moving on identified by the participants was how they dealt with memories of the past. They described a desire to focus on the present and the future, not on the past, because thinking about the past was not helpful because they could not change it. They stressed the importance of focusing on the establishment of a better life now. They also mentioned that it was more helpful to focus on helping others than thinking about past experiences. It would appear, from a traditional Western perspective, that they were avoiding memories (Briere & Scott, 2006; Herman, 1992a). Traditional Western interventions would focus on helping the participants to process their experiences so the experiences were not so anxiety provoking (Herman, 1992a). Although participants did describe avoiding memories to relieve anxiety, there seemed to be a qualitative difference between avoidance of memories to relieve anxiety and the use of not dwelling on the past in order to move on. Participants who were focused on moving on were not scared of the past; they simply did not see the value of dwelling on the past. Other participants reported that they avoided people, activities, and painful memories in order to establish safety and stability. Participants may have successfully reduced arousal symptoms through avoidance, which may have promoted wellbeing, at least temporarily (Andrews et al., 2002). Perhaps, even if the memories were distressing, it may be adaptive to

forget the past and not seek to process the trauma (McKinney, 2007; Summerfield, 1999). It may be culturally appropriate and adaptive to not dwell on the past (Eyber & Ager, 2002) but the traditional Western approach of pushing the processing of trauma in order to heal seems to often be accepted as universally beneficial (Summerfield, 1999).

To complicate the understanding of how memories are dealt with further, as addressed later, many of the participants who reported wanting to not dwell on the past also stated that sharing their experiences with another person was beneficial. Perhaps empowerment is the key to understanding how both not dwelling on the past and sharing experiences can be adaptive. Participants expressed the desire to be able to remember and discuss their past when *they* wanted to and to be able to avoid and forget the past when needed. They wanted to remember and discuss their past when it would benefit them or someone else and then avoid thinking about the past when they needed to concentrate on something else (Fabri, 2001).

Participants were very descriptive of how helpful it was to share their traumatic experiences with others (Cienfuagos & Monelli, 1983; Herman, 1992a; Weine et al., 1998). They reported experiencing a burden being lifted and feeling more normal, less isolated, more relaxed and less likely to hurt themselves when they disclosed their torture experiences, particularly for the first time (Greenberg & Lepore, 1999; Herman, 1992a; Park & Blumberg, 2002; Sloan & Marx, 2006). Important conditions for disclosure were also discussed by participants. For some, having someone with similar experiences disclose to them first helped them to open up later. They stated that they had to feel understood and unconditionally supported by the person they were opening up to (Herman, 1992a). Participants expressed the need to be in control of when they shared, how much they shared, and to whom they shared (Fabri, 2001). While participants reported that it was helpful to disclose their experiences

(Greenberg & Lepore, 1999; Herman, 1992a; Park & Blumberg, 2002; Sloan & Marx, 2006), they remarked that they did not feel the need to discuss their experiences regularly or extensively. They stated that although it was helpful to share those experiences, they are ready to move on from them. It appears that for these torture survivors, telling the torture and trauma story was helpful, but pressing for the reworking the experiences through catharsis or exposure therapy may not be beneficial and could even be harmful (Jaranson et al., 2001; McKinney, 2007; Summerfield, 1999). The participants expressed being more concerned with establishing their new lives instead of dwelling on the past (Silove, 2005).

Supporting others through various activities was a coping mechanism used by participants for empowering themselves to gain control of their health and wellbeing in order to move on. All of the participants came from cultures that were collectivist in nature. They described the importance of supporting each other through difficult experiences. Examples of supporting others include 1) sharing experiences to benefit others, 2) activism, 3) not focusing on self, and 4) helping others.

Not only did participants share experiences with others to benefit *themselves* emotionally, they expressed the importance of sharing their difficult life experiences to benefit others (Herman, 1992a). Similar to the purposes of testimonial therapy (Agger & Jensen, 1990; Cienfuagos & Monelli, 1983; Weine et al., 1998), participants in this study expressed a willingness to share their experiences with others to give emotional support to those who have been through similar experiences, to prevent future torture, and to help in the development of effective treatments (Bryant-Davis, 2005). Although activism may be beneficial to some survivors, Jaranson et al. (2001) warn against encouraging political activities until the survivor, if ever, is willing and ready. In addition to helping others through disclosing experiences, another

form of reconnection that promoted moving on was helping other people through acts of service and giving advice (Bryant-Davis, 2005; Herman, 1992a). They reported benefiting from not focusing on themselves.

Barriers to empowerment. For some participants, social norms in their native cultures hindered the process of getting better. The shame and stigma of mental illness kept people from acknowledging their problems and seeking help (Gary, 2005; Regmi, Pokharel, Ojha, Padhan, & Chapagain, 2004). In addition, participants stated that mental illness was often not recognized as a disorder in their cultures and they did not seek help until they were in danger of harming themselves or even committing suicide.

Moving On

The central phenomenon of this model of getting better after torture is moving on. All of the participants described a desire to put the past behind them and focus on the future. Many expressed they were focused on making a better life for themselves and their families through setting and reaching goals (Summerfield, 2003; Turkovic et al., 2004). A theme of moving on described by the participants was not focusing on the past but on the present and future (Eyber & Ager, 2002; McKinney, 2007; Summerfield, 1999). The importance of focusing on the present and future was supported by the therapy group I conducted at CTTS, as described previously. In developing a purpose for the group, we felt the group members would most benefit from learning about depression, anxiety, and PTSD and how to cope with these disorders. Although the participants appreciated learning this information, the group quickly evolved from a psychoeducation group to a support group that focused on pressing concerns with which the group members were currently dealing, such as finding stable employment, working with

healthcare providers, helping their children do well in school, and understanding the legal system in the United States.

Influence of torture treatment program. An understanding of and desire to move on may have been influenced by being clients in a torture treatment program. The program promotes a model in which healing and getting better are goals and expectations of treatment. Although participants may have been influenced by this model, it appears that most if not all of the participants in this study displayed patterns of seeking to get better and move on prior to and independent of participation at CTTS. For example, several of the participants described the importance of identifying their problems and seeking help, which led them to CTTS for treatment.

Indicators and Consequences of Getting Better

Although only one participant reported being healed, all of the participants described various areas of posttraumatic growth and healing as a result of the process of moving on and getting better (Tedeschi & Calhoun, 2004). The indicators and consequences of getting better identified by participants were much broader than simply reducing symptoms of pathology (de Jong, 2004; Silove, 2004; Summerfield, 1999). Even while experiencing symptoms of pathology, participants reported that their functioning was improving as they were getting better (Silove, 1999; Tedeschi & Calhoun, 2004). This finding stresses the importance of focusing on adaptive functioning as an outcome for clinical improvement and research studies. While participants did report experiencing symptoms of PTSD, anxiety, and depression (Basoglu et al., 2001; Mollica et al., 1998; Shrestha et al., 1998; Van Ommeren et al., 2001) and stressed the importance of reducing these symptoms, many of the indicators of getting better that they identified involved being able to move on and live a “normal” life again (Almedon &

Summerfield, 2004; Turkovic et al., 2004; Cienfuegos & Monelli, 1983). For example, they stressed the importance of improved relationships (Tedeschi & Calhoun, 2004), restored physical health (Carlsson, Olsen et al., 2006; Rasmussen et al., 2007), reaching goals (Curling, 2005; Fabri, 2001), and living a stable, safe life in their new country (Fabri, 2001; Herman, 1992a) as signs of getting better. Getting better was also indicated by emotional markers. For example, participants reported that they knew they were getting better because they did not feel emotional pain anymore when they thought about their experiences; they felt that a burden had been lifted and they were not ashamed. Because of moving on, participants reported being happy and having a brightened demeanor; they were able to smile again (Herman, 1992a).

Resilience

This study is rich in its description of resilience following traumatic events. Participants described how they coped and adapted after their difficult experiences. As the description of my model shows, participants used their strengths and available resources to “struggle well” through their pain and suffering (Higgins, 1994). None of the participants made it through the torture unscathed, but they all worked hard to move on and bounce back after their experiences and were healthier than they were in the past (Agaibi & Wilson, 2005). A subgroup of participants exemplified the resilience in torture survivors. These participants stressed the importance of recognizing their problems and seeking help to improve their functioning. They did not wait for help to come to them; they sought help because they saw their problems as fixable and worthy of engagement (Antonovsky, 1987). They recognized that they had problems, tried to figure out what was wrong, and took initiative in seeking help (Wynaden et al., 2005). They felt responsible for their own health (Curling, 2005; Herman, 1992a). These participants reported that being proactive in this process helped expedite the process of getting better. In addition, the

collective nature of these cultures stressed the importance of supporting one's family and this led many participants to carry on through their difficult experiences.

Strengths of the Study

The model presented in this study provides a description of environmental and psychological factors that interact to provide an opportunity for growth and healing. The model presented can be examined further qualitatively and quantitatively. This study has a variety of strengths that promoted gathering rich data and interpreting it in a meaningful way. I intentionally attempted to limit influence of the interviewer by keeping the interview questions asked and the flow of the interviews open ended. Participants were able to tell their experiences in their own manner and at their own pace. In addition, the participants were from many different cultures and there was a broad age range. This was helpful in developing the model of getting better because the participants' torture and war experiences were unique from each other, but there were many common experiences in the process of getting better.

Holistic Description of Experiences and Getting Better Process

What is often considered a weakness in quantitative research, a strength of this study is that participants described their whole experience of torture and war, the effects torture and war, and getting better afterwards (Watters, 2001). I purposely allowed participants to describe their whole experience and all that promoted getting better in order to understand all that was important in this process. I did not want to force preconceived ideas onto the participants because this may have limited their description of this process.

Collaboration

Another strength of the study is the broad range of collaboration in developing the study and in data interpretation. I worked for over one year at CTTS before I began developing the study, during which time I became familiar with the setting and the clients. I did individual and group therapy with clients to become familiar with their experiences and challenges. By working closely with staff for an extended period, I was able to gain their trust, and thus, they were excited to have me do a research study. They were very supportive throughout the whole process. I met with the program director to get her input about what research would be the most helpful in improving their services. Case managers were recruited for my research team to develop culturally competent research questions and procedures. For all but one interview, case managers served as interpreters for non-fluent English speakers. Participants already knew and trusted the case managers and this allowed them to be more comfortable in sharing their experiences. All of the interpreters shared a native language with the participants for whom they interpreted. I consulted with participants through member checks to get their feedback on the themes they described. They were able to confirm my conclusions and clarify any misinterpretations.

In terms of data analysis, I had advisors and coders with broad ranges of experience from experts in torture treatment to trauma treatment experts to graduate students in clinical psychology and applied linguistics. I purposely sought feedback from non-experts in the development of the codebook and in coding to avoid group think. Thus, through the collaboration of people with varied expertise, I was able to develop and carry out a study that allowed meaningful data to be gathered and interpreted in a culturally sensitive manner.

Positive Experience from Participation in the Study

In addition, being in the study seemed to be a very relevant and positive experience for the participants, interpreters, and the interviewers. Participants expressed gratitude for being able to tell their stories and to be listened to. One participant stated, "In my heart we very much appreciate today. You give me the chance to express my thinking inside my mind I keep for a long time. Today I have the time to open it, to record it." It appears that for some participants, being part of the study was therapeutic. A participant described being angry and depressed at the beginning of the first interview but he expressed being happy and excited about the future as he told his story and told about his family. He reported being very grateful for the opportunity to share his experiences. When asked how it was for him to share his difficult experiences with a stranger, another participant declared, "You are an American and I am [from country of origin]. When I tell to you my story when I opened my heart I told to you all of story when I get experience in the prison camp. I feel this is a healing process, can help me a lot." In a sense, participating in this study is similar to testimonial therapy. Participants were able to examine their experiences in a new context and perhaps develop new understandings of their histories (Weine et al., 1998). They were able to bear witness to the historical and social effects of political violence (Agger & Jensen, 1990; Cienfuagos & Monelli, 1983; Weine, Kulenovic, Pavkovic, & Gibbons, 1998). The case managers and staff at CTTS were very eager to help arrange the interviews because they felt being part of the study was therapeutic for the participants. Interpreters, who were mostly case managers at CTTS, also reported that the experience was very rewarding. After the interviews, the interpreters would often talk to the researchers about the interviews and what they learned from the participants. As for me, the interviews were very rewarding both as a researcher and a clinician. I was excited to do each

interview because of the energy and strength of the participants. They were very inspirational and I gained much insight into how to work clinically with torture survivors.

Limitations of the Study

There are multiple limitations to the study that must be addressed. These limitations include 1) potential bias of the researcher, 2) language and cultural barriers, 3) brief nature of interviews, 4) intercoder reliability, and 5) generalizability.

Potential Bias of Researcher

Research is rarely conducted without bias. One limitation of this study is the potential theoretical bias of the researcher. My previous training in Western clinical psychology theory and research may have biased what domains I focused on and those I may have overlooked. While I used research to guide my choice in themes to investigate, I inductively developed the coding scheme and categories derived from the data. In addition, interpreters were influenced by their own experiences, which may have influenced how words were interpreted. In order to reduce researcher bias, my research team consisted of people from a wide variety of backgrounds and expertise. As a member of setting, I may have influenced who was chosen to participate. I tried to limit this by removing myself from the selection process. I excluded any potential participants with whom I worked directly with clinically. In addition, I gave the criteria for participation to the staff and allowed them to select and approach potential participants. I did not meet with participants until after they stated they were interested in participating. Because I was a member of the setting, I may have been influenced by the strengths and limitations of the program in my questions and interpretations. I tried to limit this by using my research to evaluate the objectivity of my interview questions and interpretation of findings.

Language and Cultural Barriers

A second limitation to the study is language and cultural barriers. Working with participants whose native languages were not English invariably led to misunderstandings. Several of the interviews were conducted in English with participants who were quite fluent in English. In spite of this, these participants were not native English speakers and there may have been difficulty communicating important points. When interpreters were used, participants were able to speak freely in their own languages, but information may have been lost in translation from the native language to English by the interpreter. Cultural differences may have influenced the accuracy of information shared between researchers and participants. Even if information was understood by both parties, the subtle meanings of words and phrases are not the same across languages and cultures. To limit potential language and cultural barriers to communication, member checks were conducted to ensure that information was understood by the researchers and participants were able to verify information or make corrections. In addition, several participants who used interpreters understood English well enough to make corrections to the translation during the interviews.

Brief Nature of Interviews

A third limitation to the study is the brief nature of the interviews. Although interviewers tried to quickly develop relationships with the participants, the participants may not have felt comfortable describing their experiences in full detail. Compared to other disciplines such as anthropology, qualitative research in psychology is brief in nature. If relationships between interviewers and participants were able to develop over a longer period of time and participants were interviewed longer, more in-depth, richer data may have been gathered.

Intercoder Reliability

Another limitation in the study is the lack of agreement in coding for two major categories. The major categories of Controlling/Improving Ill Health (54%) and Future Oriented (55%) did not reach the recommended 70% agreement in coding (see Table 2). There are several possible explanations for this lack of agreement. Because I calculated agreement between myself and three coders, the chance for error increased. In addition, the large number of codes increased the chance for error. Two subcategories specifically were often confused by the coders, which seems to have limited the agreement in these two categories. Participants described how they dealt with memories of their experiences by expressing a desire to not focus on the past. In the Future Oriented major category, the subcategory of "Moving On" captured the concept of not focusing on past experiences in order to actively move forward in the new life. In the major category of Controlling/Improving Ill Health, the subcategory of "Avoidance" captured the concept of not focusing on past experiences in order to control stress. In discussing the disagreements in the coding, the coders often disagreed on whether a participant was describing moving on from the past or avoiding memories to control stress when they described why they did not focus on the past. This lack of agreement led me to try to understand how participants deal with their memories, which was discussed previously. As described in the methodology section, in order to reach agreement, I reviewed each interview with the coders to discuss disagreements. On any given disagreement in coding, we made arguments for our reasons for a particular code and reached an agreement for the best code. After this was done, there were a very small number of disagreements for all the interviews.

Generalizability

Due to the qualitative methodology of the study and the small sample size, generalizing the model of getting better to other populations, as is done in quantitative research, should be done with caution. The purpose of the study was to generalize the experiences of this sample to a theory, not to a population. The goal was to understand the breadth and characteristics of the healing experiences of the participants, not to determine frequencies or differences between subgroups. Sampling for this study was purposeful as the participants were selected based on their ability to be uniquely informative in the process of getting better after torture.

The participants in this study were clients in a torture treatment program and may have different experiences in getting better than those torture survivors who were not in treatment. For example, because of participating in a treatment program based on Western concepts of mental health, their understanding of the process of getting better and moving on may be influenced by their treatment. The participants were selected based on the clinical judgment of the staff at CTTS. They chose participants who were more stable mentally, and therefore, the sample may be healthier mentally than a typical torture survivor. In addition, the participants immigrated to the United States, and thus, have different experiences than torture survivors who remained in their native countries or immigrated to other countries.

Future Research

Although this study illuminated the process of getting better after torture, the results of this study suggest additional research topics that, if examined, would further enhance our understanding of this process. Due to the exploratory nature of this study, confirmation of these findings through qualitative and quantitative research within the same population is indicated.

Moving Beyond Pathology

Future research with torture survivors should continue to move beyond examining pathology following torture (de Jong, 2004; Silove, 2004; Summerfield, 1999). It has been well established that there are negative effects following torture (Basoglu et al., 2001; Mollica, 2004), but researchers continue to investigate PTSD, anxiety, and depression rates following torture. In addition to psychological impact, the social, political, and biological effects of torture should be examined systematically. Longitudinal research examining the effects of torture and outcome studies of torture treatment programs should examine not only reduction in symptoms of psychopathology, but also adaptive functioning and growth. For example, all of the participants in the current study displayed resiliency. Future research could examine whether most, if not all, survivors of torture display resiliency and how it is developed, as opposed to analyzing it as a unique experience for a small percentage of survivors.

Program Evaluation

In many ways, this study was a qualitative, non-systematic program evaluation of a torture treatment program. The participants identified multiple aspects of the program that promoted moving on and getting better. Future researchers might conduct a systematic, qualitative and quantitative program evaluation of torture treatment programs. Research may focus on impact of relationships developed with treatment providers, how being part of a treatment program alters expectations of getting better and healing, and what factors influence clients “buying in” to the program. Research could focus on the positive aspects of survivors taking an active role in treatment planning and decision making. Studies could examine how getting better differs among survivors who are participants in a torture treatment program and those who are not.

Safety and Stability

Aspects of safety and stability could be examined further. Research could focus on various governmental resettlement policies to understand which policies are the most beneficial in promoting stability. Also, research could examine how torture survivors who stay in their native countries or refugee camps differ from survivors who are resettled in other countries.

Reconnection

Various findings in support and reconnection should be examined further. Future research may examine the impact of disclosing torture experiences to another person, particularly for the first time. Research could also focus on therapeutic impact of various forms of interventions such as narrative therapy and exposure therapy with torture survivors. Conversely, research may focus on how to promote moving on without disclosing at all. The role of activism and helping others is an area that is under studied. Research could examine how these help others move on and promote wellness.

Dealing with Memories

Another area of study for exploration is how torture survivors deal with their memories. For example, is avoidance harmful or can moving on from torture by not directly processing experiences be beneficial? Research could examine how and when avoidance and remembering are adaptive at various points in the process of getting better. The role of empowerment in dealing with memories could be examined further as well. For example, how do survivors choose when and to whom they disclose?

Belief and Values Systems

Future research may examine how participants use their belief systems to cope and heal after torture. Studies could focus on the use of positive and negative religious coping following torture. Research could focus further on the impact of religious and spiritual devotion after torture. In the present study, use of belief and values systems had a direct effect on moving on; studies could focus further on the relationships between belief and values systems and emotional support and safety and stability. In addition, examining the role of forgiveness in the healing process could be studied further. Research could also examine how perspective taking and understanding the circumstances of the perpetrators promotes well-being.

Examining Model with other Trauma Survivors

The basic process of healing described in this study is applicable to survivors of other types of trauma. The model as a whole could be examined further in other trauma survivors. For example, studying the healing after domestic violence could be examined by seeking to understand beliefs, enabling conditions, and coping strategies that promoted healing. In addition, the finding of this study that being in control of memories and disclosing could be examined and applied to other trauma survivors. It is likely that feeling empowered to remember and share experiences is an important part of healing for other trauma survivors. Finally, the concept of moving on could be examined to determine whether other trauma survivors feel the need to "move on" from their experiences. The specific themes of moving on--not dwelling on past events and pain, being present and future focused, and establishing and reaching goals--could be examined to ascertain whether they are salient to other trauma survivors.

Practical Implications

This study's findings have a number of important implications for clinical, programmatic, and policy practice. One of the original purposes of the study was to investigate a topic that would be meaningful to treatment providers working with torture survivors.

Holistic Approach to Treatment

A combination of interventions that promote holistic well-being seems to be the most beneficial approach to helping torture survivors move on. This study demonstrates that social, political, psychological, and biological aspects of a survivor's life should be addressed in clinical and policy interventions. Participants had a holistic view of their health and did not always distinguish between physical and mental health (Vontress, 2001). Several described how their mental health is linked to how healthy they are physically (Carlsson, Olsen et al., 2006; Hermansson et al., 2002; Rasmussen et al., 2007). Many of the participants sought treatment first for physical health concerns and not mental health issues. This indicates that addressing physical health may be essential in recruiting treatment participants and in selling the value of a program to a torture survivor (Wenk-Ansohn, 2001).

In addition, torture survivors should be empowered to determine what it means to move on and get their lives back to normal. Interventions should emphasize resiliency, useful coping strategies that maintain health, and health promoting factors to promote wellness (de Jong, 2004). Service providers will then be able to tailor interventions that fit the needs of the survivors.

Trustworthiness

It is clear that developing trusting relationships with others is an essential first step in moving on after torture. Clinicians and programs should focus on developing trusting relationships with survivors before introducing them to further interventions. Once trust is established, survivors are more likely to accept other treatment options. For example, participants expressed a willingness to participate in this study because they trusted the staff at CTTS. Clinicians and programs should seek to empower clients by following the survivors' lead in what areas of treatment to focus on. Survivors should be part of the treatment team in making treatment decisions. They will often focus on a safe area of treatment before jumping into something new in order to see that they can trust the program. With trust established and the ability to make decisions about their treatment, participants in this study were doing well despite the turnover of staff and changes in treatment policies. Trust between treatment providers and survivors is even more important due to the disruptions of traditional healing methods as evidence by limited availability and use of traditional healers and rituals by survivors. Survivors may need support from new healers who can be found in treatment programs. Treatment could also focus on establishing trusting relationships outside of the treatment setting. Reconnecting with family, friends, community members, and traditional healers will help clients establish stability and have emotional support for long after treatment is done.

Sharing Experiences

From the findings of this study, it appears that torture survivors should take the lead in disclosing their experiences. Some survivors are ready to disclose at the beginning of treatment and others may never disclose their experiences in detail. Clinicians and programs should have patience in allowing participants to open up at their own pace and professionals should seek

permission for stories to be shared, not forced to be shared. While participants in this study expressed how helpful it was to disclose their experiences with another person, it does not appear that exposure therapy would be the best fit for many torture survivors. They benefited from disclosing their past torture and war experiences but then they wanted to focus on current functioning and problems. Results of this study show that culturally sensitive services are essential in connecting with survivors and helping them "buy into" treatment. Programs should develop strategies to allow clients to share their experiences in a culturally appropriate manner.

Interventions should be flexible to fit cultural and religious beliefs and practices. Whenever possible, case managers and other service providers should be from similar cultural backgrounds.

Resiliency

Clinicians and programs should take a strengths-based, resiliency approach and should recognize that even with the turmoil in the survivors' lives, they still display success and growth. Clinicians should focus on what strengths the survivors have in order to use those strengths to enhance areas in their lives that are not as strong. In addition, clinicians and programs should look for areas where survivors have accomplished growth in order to understand how the growth occurred in order to apply it to areas in need.

Belief and Values Systems

Clinicians and treatment programs should be respectful of religious and spiritual beliefs. Spirituality is such a major part of many survivors' lives that it should not be denigrated or ignored. It should be incorporated into treatment. Survivors should be allowed to share their beliefs in treatment and to discuss how their beliefs are beneficial. They may benefit from including spiritual leaders in their treatment.

Safety and Stability

Policy makers and program directors should focus on establishing safety and stability. The support received right at the time of resettlement is crucial in establishing stability. Participants in this study expressed how grateful they were to governments for providing financial, healthcare, and housing support. It appears that for many participants, the transition from government support to self-sustainability was very challenging. Policy makers and program directors could focus on making this transition less difficult through easy access to language and job training and job placement programs (Quiroga & Jaranson, 2005). Extension of financial and housing support would be helpful in cases where survivors are not self-sufficient in the allotted time, usually eight months after resettlement. In addition, for many refugees who are employed, the work is so low paying that they cannot afford healthcare. Programs to extend healthcare benefits to working survivors would help promote stability among this population. Programs could focus more on establishing connections within refugee communities to establish safety and stability. Programs with volunteers from communities who help survivors acculturate seem to be beneficial in the resettlement process. In addition, helping refugee communities develop organizations for support and advocacy can help refugees feel united and empower them to take on their challenges as a community.

Closing Comments

The 11 torture survivors who participated in this study opened their lives to share their experiences of the process of getting better after torture. Participants described a holistic process that affected social, political, psychological, and biological aspects of their lives that needed to be addressed in order to get better after torture. Their rich descriptions paint a picture of a complex, reciprocal process of utilizing beliefs, available supports, and coping mechanisms to

attain this ultimate goal. Each person described unique experiences in which they used their strengths to take advantage of these factors, as well as barriers that inhibited this process. The central theme of the process of getting better was being able to move on after torture. Participants stated that they wanted to establish a new life for themselves and their families and get their lives back to normal. Participants reported that spiritual beliefs and values gave them strength to endure hardships and were helpful in giving meaning to their experiences. In particular, they described that being able to forgive and understand the circumstances of their perpetrators was very helpful in moving on after torture. They described the importance of using societal and institutional supports and individual strategies for establishing safety and stability in order to move on with their new lives. Various qualities of individuals and institutions promoted a sense of emotional support that enabled participants to reconnect with others and promote healing. Once participants felt a sense of safety, stability, and emotional support, they were empowered to utilize environmental resources and personal coping skills such as controlling memories and disclosing of experiences in order to move on. Moving on led to more meaningful relationships, reestablishment of health, more adaptive functioning, and emotional wellbeing for these participants.

Participants displayed great strength and resilience during this process. Their lives were damaged greatly due to torture and war trauma but they are working hard to return to health and wellness. As quoted previously, one participant eloquently summed up the process of moving on:

> Don’t dwell on the things you can’t control. You must go forward with life and move on. [Life] is like a tornado that’s coming. It’s going to come and you must deal with it and move on.

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Appendix A: Recruitment Statement

Description of Study for Case Managers

Please read the following to potential participants:

You are invited to be part of a research study at CTTS. This study will involve 2 discussions about getting better after torture. The researchers are interested in your perspective on this matter. This will help shape future treatment for torture survivors. Your participation is completely voluntary. You will not lose any privileges at CTTS if you do not participate. Your participation will take about 2-3 hours of your time. The discussions will take place at CTTS. MARTA tokens will be provided for your travel. An interpreter will be available to interpret for you. You will receive a gift for your participation equivalent to about $10. If you are interested, I can set up a time for you to meet with the researcher and he will explain the study further.

Appendix B: Informed Consent Document

Georgia State University
Department of Psychology
Informed Consent

Title: Getting Better After Torture Experiences

Principal Investigator (P.I.): Gregory Jurkovic, Ph.D.
Student P.I. Brian Isakson, M.A.

I. Purpose:

You are being asked to take part in a research study. The purpose of this study is to understand how people get better after having survived torture. A total of 20 people will take part. Everyone in the study is a torture survivor. The study will take about 2.5 hours of your time during two meetings over the next few months.

II. Procedures:

The meetings will be audio taped. You will discuss your experiences with a graduate student in clinical psychology from Georgia State University (GSU). An interpreter will be available to interpret during the interview, if needed. The meetings will take place at The Center for Torture and Trauma Survivors (CTTS). The first meeting will last about 1.5 hours. A follow up meeting several weeks later will last about 1 hour. You will receive tokens for MARTA to help you to travel to and from the meetings. You will also receive a a gift for your participation equivalent to about $10 even if you decide to quit during or after the first interview.

III. Risks:

There is a chance that taking part may cause you to get upset because of the discussion of torture experiences. We will try to prevent this by allowing you to discuss only topics you want to discuss. If you do get upset, we will arrange for you to meet with a counselor at CTTS, if you desire.

IV. Benefits:

Taking part in this study may not benefit you directly. The knowledge gained from this study may help shape future treatment for clients who have experienced torture.

V. Voluntary Participation and Withdrawal:

Participation in research is voluntary. You have the right not to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or stop participating at any time. If you decided that you do not want to be audio taped, you will not be able to participate in the study. Whatever you decide, you will not lose any of your benefits at CTTS.

VI. Confidentiality:

We will keep your personal information private. We will remove all information that can identify you. We will use a participant number rather than your name on study records. If you decide you want to be in this study, it means that you agree to let us use and share your personal health information for the reasons we have listed in this Consent Form.

While we are doing this research the research team may use only the personal health information that you have given us: your experiences of getting better after torture. The people who will be able to look at your personal health information are the P.I., student P.I., and their research team. They will look at it so they can work on this research study. We may also share your health information with the GSU Institutional Review Board (IRB). This information may be shared by the people or places we have listed, but it will be shared in a way that does not fall under the protection of federal regulations that apply to the privacy of health information. This research may be shown to other researchers. Your name and other facts that might point to you will not appear when we present this study or publish its results. The findings will be summarized and reported in group form. You will not be identified personally.

If you sign this form you are letting us use your personal health information until the end of the study. You may say that you do not want us to use your personal health information after we have collected it. If you decide you don't want us to use your information anymore please let the researcher or your case manager at CTTS know. They will help you to put your request into writing. If you don't want us to use your information anymore, we will stop using it. We want to let you know that because the interviews do not have your name on them, we might not know which interview is yours.

You may not be able to look at or get a copy of your health information that you gave us while we are doing the research; however, you will be able to look at or get a copy at the end of the study.

Audio tapes and discussion texts will be stored in a locked cabinet in a secure office at GSU. Audio tapes and participant number codes will be destroyed at the end of the study. Computers used to store and analyze data will be secured with password and firewall-protection. Information that identifies you will be stored apart from other data to keep your privacy. Only the P.I., student P.I., and their research team will have access to the audio tapes and discussion texts.

VII. Contact Persons:

Call Brian Isakson M.A. at 404-651-3679 or Gregory Jurkovic Ph.D. at 404-651-3271 if you have questions about this study. If you have questions or concerns about your rights as a participant in this research study, you may contact Susan Vogtner in the GSU Office of Research Integrity at 404-463-0674 or svogtner1@gsu.edu.

VIII. Copy of Consent Form to Subject:
We will give you a copy of this consent form to keep.
If you are willing to volunteer for this research, please sign below.

_____ _____
Participant Date

_____ _____
Researcher Date

Appendix C: Demographics Questionnaire

Please answer the following questions:

1. How old are you? _____
2. What country were you born in? _____
3. What level of education did you receive? _____
4. What was your occupation in your home country? _____
5. What is your current occupation? _____
6. How many children do you have? _____
7. What is your marital status? _____
8. What year did you experience torture? _____
9. How old were you when this happened? _____

Appendix D: Final Version of Codebook

Code #	Coding Category
1	**1) Faith/Spirituality/Religion**
2	a) Belief that God is in control
3	b) Trials are from God
4	c) God will judge fairly
5	d) Spiritual Rituals
6	e) Forgiveness
	i) Forgiving Others
	ii) Forgiving Self
7	**2) Seeking to understand another person's circumstances/beliefs**
8	a) Appreciation of diversity
9	b) Understanding circumstances of perpetrators
10	**3) Justice**
11	a) People will get what they deserve
12	b) Revenge
13	**4) Received Social Support**
14	a) Physical
	i) Helping to escape/resettle
	ii) Daily living
15	b) Emotional-Relational-Reconnection
	i) Feeling understood by someone
	ii) Encouragement
	iii) Inspiration
	iv) Advice
	v) Cultural identification/practices
	vi) Regaining trust in other people
	vii) Relating to a person who experienced similar difficulties
16	**5) Helping Others**
17	a) To survive
18	b) Value of activism
19	c) Not focusing on self
20	**6) Sharing Experiences**
21	a) Bearing witness/Testimonial
22	b) Disclosure
	i) Characteristics that facilitate disclosure
	ii) Sharing experiences with a person
	iii) A person sharing experiences

Code #	Code Category
	iv) with participant
23	**7) US Social/Cultural Environment**
24	a) Economic Stability
25	b) Freedoms
26	c) Organizational assistance
27	**8) Controlling/Improving Ill Health**
28	a) Relaxation techniques
29	b) Medication
30	c) Avoidance
31	d) Restoring Physical Health
32	e) Recognizing problems/symptoms
33	**9) Future Oriented**
34	a) Moving on
	i) Plans/Goals
	ii) Adjusting to new culture
35	b) Hope
36	c) Seeking Help
37	**10) Challenges in getting better**
38	a) Acculturation
39	b) Economic challenges
40	c) Unhelpful people
	i) Not understanding
	ii) Lack of cultural understanding
41	d) Thinking of events
42	e) Distress/Symptoms of pathology
43	**11) Signs of Healing/Health, Definition of getting better**
44	a) Improved Health
	i) Prewar health
	ii) Improvement in mental health
	iii) Improvement in physical health
45	b) Improved relationships with others
	i) Trusting others
46	c) Emotional
	i) Emotional pain of memories is gone
	ii) Not ashamed
	iii) Self satisfaction
	iv) Brightness in the person
47	d) Able to reach goals

Appendix E: Code Book Definitions

1 Faith/Spirituality/Religion

They use their faith/spirituality/religion as a means to get better

1a Belief that God is in control

God is in control of the person's destiny (e.g., escaping, finding peace), not to be used when rewards are mentioned

1b Trials are from God

God gives trials as a means for growth

1c God will judge fairly

Belief that person and/or perpetrator will be rewarded and punished by God for actions

1d Spiritual Rituals

Person uses rituals for coping (prayer, spiritual healers, holy water, scripture—person describes gaining strength from scriptures, not using scripture to make a point)

1e Forgiveness

Person describes forgiveness of perpetrators as a part of getting better

2 Seeking to understand another person's circumstances/beliefs

Being tolerant of differences in people promoting getting better

2a Appreciation of diversity

Seeking to understand another person's beliefs/differences promotes peace and healing

2b Understanding circumstances of perpetrators

Understand the circumstances of perpetrators (e.g., perpetrators were following orders from higher up)

3 Justice

Belief that perpetrators will be punished for their actions leads to getting better

3a People will get what they deserve

Non religious belief that people will be punished for actions

3b Revenge

Person has sought revenge or would like to seek revenge for what has been done to them (e.g., Military involvement)

4 Received Social Support

Receiving social support from family, friends, and/or professionals plays a role in getting better

4a Physical

Person receives physical social support (at micro level)

4b Emotional-Relational-Reconnection

Person receives emotional social support/reconnects with another person

5 Helping others

The act of helping another person promotes healing

5a To survive

Participant helps another person to survive difficult experiences

5b Value of activism

Participant is active in promoting social justice issues (Finding solutions to problems in home country, being politically active)

5c Not focusing on self

Healing affects of focusing on helping others helps participant forget own problems

6 Sharing Experiences

6a Bearing witness/Testimonial

Participant shares experiences with others in order to educate people about injustices

6b Disclosure

Disclosing torture/war experiences to another person facilitates the process of getting better. [Disclosing is for support and for being understood, not for bearing witness]

7 US Social/Cultural Environment

The macro level environment a person is in promotes healing

7a Economic Stability

Living in the U.S. has provided the participant economic stability

7b Freedoms

Living in the U.S. allows freedoms that the participant didn't in home country (freedom of speech, religion)

7c Organizational assistance

Organizations (e.g., U.S. government, church, U.N.) has provided assistance that stabilizes/improves a person's environment (e.g., Medicaid, education, economic). This does not include emotional-relational-reconnection support from those programs.

8 Controlling/Improving Ill Health

Strategies are used to control/improve mental health symptoms (e.g., flashbacks, depression, sleep problems) and/or improve physical health problems that promote getting better

8a Relaxation techniques

Person uses relaxation techniques to reduces stress (e.g., deep breathing, listening to music)

8b Medication

Person uses medication to promote getting better (e.g., psychotropic, blood pressure meds)

8c Avoidance

Person uses avoidance to control stress/cope (e.g., avoids memories, people, news programs; avoids trusting others; uses distractions to avoid)

8d Restoring physical health

Restoring physical health is identified as part of the process of getting better

8e Recognizing problems/symptoms

Recognizing problems/symptoms as part of the process of getting better

9 Future Oriented

Person focuses on future in order to cope—only use this category if it is an explicit focus on the future that doesn't fit in a subcategory, not just a hint like "forgive and forget"

9a Moving on
Person actively seeks to move forward with new life (e.g., finding work, buys house)
9b Hope
Person describes having hope for the future
9c Seeking Help
Person actively seeks help in order to overcome challenges

10 Challenges in getting better
Participant identifies roadblocks that slow down the process of getting better
10a Acculturation
Difficulties adapting to life in the U.S. slows down the process of getting better
10b Economic challenges
Unstable economic situation slows down the process of getting better
10c Unhelpful people
People in the participants life behave in a way that hinders the process of getting better
10d Thinking of events
Spending too much time thinking about difficult past experiences hinders the process of getting better—this is not used for intrusive thoughts, flashbacks, and nightmares of PTSD symptoms
10e Distress/Symptoms of Pathology
Distress and symptoms of pathology hinders the process of getting better (e.g., sleep problems, flashbacks, headaches)

11 Signs of Healing/Health, Definition of getting better
Participant identifies signs that they are getting better
11a Improved Health
A sign of getter better is improved health
11b Improved relationships with others
Participant identifies improved interpersonal relationships as a sign of getting better (e.g., more talkative, spending more time with family/friends)
11c Emotional
Emotional signs that the person is getting better
11d Able to reach goals
A sign of getting better is the person is able to reach goals that were set

Additional definitions for subcategories not being coded

1ei Forgiving Others
Person describes forgiving others as part of the healing process
1eii Forgiving Self
Person describes forgiving self for what happened to them or not taking blame as part of the healing process
4ai Helping to escape/resettle
Person receives help from another to escape from torture or prison/resettle to new country
4aii Daily living
Person receives help in daily living to survive (e.g., family helping after release from prison, food, economic support)
4bi Feeling understood by someone
Feeling another person understands challenges and past experiences facilitates the process of getting better
4bii Encouragement
Another person goes out of their way to give encouragement to the participant
4biii Inspiration
Person receives inspiration from someone else (e.g., family bonds give strength to not give up, seeing others healing)
4biv Advice
Person receives advice from another person/agency
4bv Cultural identification/practices
Person receives support through cultural identity and practices (e.g., participating in Vietnamese senior club)
4bvi Regaining trust in other people
Regaining trust in another person facilitates the process of getting better
4bvii Relating to a person who experienced similar difficulties

6bi Characteristics that facilitate disclosure
Certain characteristics in the other person facilitate disclosure (e.g., not pushy, understanding, instill hope, feeling valued)
6bii Sharing experiences with a person
Person describes disclosing for support and being understood
6biii A person sharing experiences with participant
Another person discloses difficult experiences with the participant

9ai Plans/Goals
Person develops plans/goals for future (e.g., establishing new life, receiving an education, healing) and is determined to follow through (e.g., self-evaluation)
9aii Adjusting to new culture
Adjusting to new culture promotes healing (learning language, customs)

10ci Not understanding
People do not understand the challenges faced by the participant which hinders the process of getting better

10cii Lack of cultural understanding

Participant identifies beliefs/behaviors in native culture that have hindered the process of getting better

11ai Prewar health

A sign of healing is getting back to prewar/pre torture health

11aii Improvement in mental health

Improvement in mental health is a sign of getting better (e.g., mood, sleep, anxiety)

11aiii Improvement in physical health

Improvement in physical health is a sign of getting better

11bi Trusting others

Improved trust in others is a sign of getting better

11ci Emotional pain of memories is gone (e.g., burden has been lifted)

11cii Not ashamed

The person is not ashamed of what happened to them

11ciii Self satisfaction

Person feels a self satisfaction and a sense of peace in life now

11civ Brightness in the person

Person shows a brightness in characteristics (e.g., smiling, face more open)