

# Healing the wounds - personal reflections on the evolution of therapeutic methods for survivors of torture

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## Abstract

With the arrival in Denmark of torture survivors from Latin America in the nineteen seventies and eighties, therapists faced the challenge of how best to accompany the survivors in their healing processes. The New Left and Feminism were important political movements which influenced the therapeutic approaches discussed at that time. In the author's meeting with Latin American colleagues a dialogue about therapeutic methods was further developed with emphasis on the connection between "Human Rights and Mental Health". The civil war in the Balkans in the nineties brought new challenges: the development of psychosocial community interventions as well as an intensification of the debate between the "medical" and psychosocial approaches to trauma healing. Cooperation during the last decade with NGOs in e.g., India, Cambodia, and Honduras brought new and more holistic perspectives on therapy represented by a brief version of Testimonial Therapy that sought to integrate cultural and spiritual traditions as well as "third wave" cognitive methods.

## From European feminism to Latin America reality

For me, a reflection on the past should take its point of departure in 1984, when I started working at the RCT as a clinical psycholo-

gist with Latin American political refugees who had arrived in Denmark and had been exposed to torture and persecution in their homelands. At that time, I was active in the New Left Movement, which assembled activists who campaigned for social issues such as women's rights and political rights. I wanted to use my psychology degree politically, primarily through a feminist perspective. I was a member of a Consciousness-Raising Group (CR-G). CR groups were a central and revolutionary part of the Women's Liberation Movement and I wrote my master's thesis on the healing dimensions of CR groups with the purpose of analysing how they supported women in understanding the relationship between the "private and the political spheres". One of the main subjects in these groups concerned female sexual oppression and how a patriarchal society dominated women's sexuality. In the CR-groups, women gave testimony about their private lives, seeking to see their personal experiences from a political perspective.

When I met the Latin American refugees and torture victims, I found resonance and political discourse that was familiar. They talked about their "life project", how it had been disrupted and how they longed to return to their homelands and continue the struggle for human rights and freedom. Many of them were activists. That was why they had

been imprisoned and tortured. During the Eighties, I also met with Elizabeth Lira and other Latin American colleagues at conferences who brought their books and articles to Denmark. They connected, following Martín-Baró, “mental health and human rights” with political oppression and torture. The healing processes we created in the dialectical connection between the private and the political spheres. The victims suffering from a repressive political system. Furthermore, refugee women from the Middle East and Latin American women also gave testimonies about how patriarchal oppression of women was abused worldwide during sexual torture (Agger, 1989; 1994).

Colleagues in the South were sending us, in Europe, a clear message: paternalistic and medicalising attitudes were not acceptable when torture and violence are rooted in politics. Evidence of this was the heated debate among professionals working with survivors of torture and state violence in the Nineties. On one side of the battle were the “medicalising” people who viewed the distress of torture survivors as an “illness” (Post-Traumatic Stress Disorder), which in principle should be cured as other types of medical conditions. On the other side were the professionals from the psychosocial community, which I belonged to. Part of this debate was reflected in the pages of *Torture Journal*, among other places. We accused the medical side of neo-colonialist approaches and were critical of the widespread use of the PTSD diagnosis. Many of us did not feel that the symptoms of PTSD could adequately describe the stressful experiences of torture and war. As Chilean colleagues emphasized: giving medical diagnoses to survivors of state terrorism can be viewed as double victimisation: “blaming the victims” by stigmatising them as “mentally ill” (Agger & Jensen, 1996).

### **Psychosocial and community work: the debate in the Balkans**

From 1993 to 1997, during the war in the former Yugoslavia, as the European Union (EU) Coordinator of Psychosocial Programs for war-affected people, we searched for practical and valuable methods to accompany the suffering population. National and international mental health professionals were feeling overwhelmed and helpless as the first war in Europe since the Second World War developed and the refugee crisis intensified. Likewise, did the battle between the “medical” and “psychosocial” professionals. How should one approach trauma and healing in this new war context? The war necessitated other interventions on a mass scale than what was common under peaceful circumstances.

Eventually, it was recognised that little healing could be done during the war. The best approach was to focus on survival or prevention of the deterioration of the survivors’ psychological and social status through community mental health. Eventually, we arrived at the following definition of psychosocial emergency assistance: *The aim of psychosocial emergency assistance under war conditions is to promote mental health and human rights by strategies that support the already existing protective social and psychological factors and diminish the stressor factors at different levels of intervention* (Agger et al., 1995)<sup>1</sup>. That definition was an official EU position and, thus, a commitment beyond the biomedical approach.

The war rapes and sexual torture of both men and women in ex-Yugoslavia ignited further discussions and reflections. Were there

<sup>1</sup> The research also concluded that psychosocial work needs to be accountable, despite the large difficulties it might entail to do assessments of efficacy of projects implemented in war-torn communities.

national or international interests in constructing a rape victim identity of ex-Yugoslav women or a trauma victim identity of the ex-Yugoslav people? It would seem like the war rape and trauma survivors were exploited for various political purposes.

In an evaluation carried out by the EU in Bosnia and Croatia in 1995 during the last months of the war, we distributed questionnaires to 2,291 participants and 165 national staff members of psychosocial projects funded by the European community (Agger & Mimica, 1996). The results indicated that the participants were most often exposed to life-threatening events (85%), loss of home and property (85%), hunger and thirst (60%), torture or extremely bad treatment (30%), and illness (30%). 80% reported that participation in the project was of considerable help to them. Our study illustrated that war trauma is much more than exposure to a single stressful event. It is a long and enduring state of severe stress and uncertainty about the future (Agger & Mimica, 1996). Maybe the true war trauma symptoms should have been identified as nationalism, lack of tolerance for differences, and withdrawal into ethnic groups – symptoms of the terror and mistrust that the horror of civil war had caused in the population. However, the psychosocial projects, viewed as crisis intervention, seemed to have attained their goal: to keep people going even under complicated circumstances.

### **Integrating new ideas towards a holistic approach to therapy**

Over the last years, interesting new developments have been the “third wave” cognitive methods, which are inspired by Asian religious practices and combine elements of meditation and mindfulness with cognitive-behavioural therapy (CBT). In an action

research project from 2008-2010, we<sup>2</sup> developed a particular brief version of Testimonial Therapy (TT)<sup>3</sup> that sought to integrate Asian cultural and spiritual traditions (Agger et al., 2012, Jørgensen et al., 2015). This new version included a public ceremony at the end of the testimony process. This ceremony came to play an essential role because it connected the survivor to his or her community through public acknowledgement and mobilisation based on the narrative about the human rights violations suffered by the survivor.

Sadly, Testimonial Therapy has in some instances been used to justify the expansion of Narrative Exposure Therapy (NET) – a therapy allegedly based on TT with little emphasis on the political context of the traumatic experience. The emphasis of NET is rather on narrating in as much detail as possible the survivors’ painful experiences without reference to the ideological and cultural meaning or frame within which the torture was perpetrated. The lack of a meaningful frame might hinder the process of integrating the traumatic experience and in some cases lead to re-traumatisation by repeating the painful experience without facilitating an understand-

- 2 In a cooperation between the RCT and Asian NGO partners, in particular with People’s Vigilance Committee for Human Rights (PVCHR), led by Dr. Lenin Raghuvanshi, Varanasi, India. I was in the role of an external consultant.
- 3 Testimonial Therapy is an individual “human rights” psychotherapy for survivors of torture and other types of violence that has the narration of the survivors’ traumatic experiences and a public ceremony as its central components. The trauma stories are recorded, jointly edited by the therapist and survivor, compiled into a document, and read out in a public ceremony. The document may be used by the survivor to raise public and international awareness about human rights violations (Agger et al., 2012; Puvimanasinghe & Price, 2016).

ing of “why this horror happened to me”. NET can basically be viewed as one more exposure technique with another label, and not much different from the medical model which the RCT advocated in the Eighties (Mundt, Wünsche, Heinz & Pross, 2014).

“Third wave” cognitive methods, which have emerged recently, focus on holistic processes of well-being in contrast to symptom alleviation, and they often incorporate “Eastern” methods of meditation and spirituality, e.g., Compassion Focused Therapy (CFT), and Culturally-Adapted Cognitive Behavioural Therapy (CA-CBT). My research in Buddhist Cambodia from 2010 to 2012 indicated that Third Wave methods are becoming more readily transposable to work not only with Buddhist torture survivors but also with victims of persecution in other cultural or religious contexts. As “Western” practitioners of psychotherapy we have much to learn from Eastern traditions, e.g., Cambodian notions of the importance of “cooling the body” and “thinking too much” correspond well with Western notions of core “emotion regulation and distress tolerance skills” and how to “restore self-regulation” (Agger, 2015).

### **Integrating indigenous practice**

In Honduras in 2017, during training with thirteen Indigenous leaders of the Lenca people who were also survivors of state violence, we<sup>4</sup> explored and integrated Indigenous cultural practices of the Lenca into a local design of a psychological trauma healing process which

included Testimonial Therapy. The leadership of MILPAH emphasized their determination to preserve the culture and religion of the Lenca, and during the training the participants designed a Cosmic Circle Ceremony which consisted of a circle on the earth made with plants, flowers, water, incense, and four colored candles. Standing within this altar, which they had built themselves, the survivors read their testimonies aloud and the Circle, thus, became an essential healing element of the modified Testimonial Therapy ceremony. The Cosmic Circle incorporated elements of nature: earth, air, fire, water, by which the participants could invoke their ancestors, and the guardians of the rivers and the forest. The ceremony also allowed the survivors to invite their relatives and neighbours of the community whereby their struggle for human rights could be reaffirmed and legitimised.

As an effect of the COVID pandemic, the Cambodian mental health NGO Transcultural Psychosocial Organization (TPO)<sup>5</sup> has recently explored the possibilities of including online testimonial therapy in its toolbox. An online ceremony might include up to one hundred people who could witness the ceremony at a time when only a few people are allowed to attend a ceremony at the local pagoda.

### **Final remarks**

When I look back at the reflections on the evolution of therapeutic methods described here, there seems to be a direction going

4 The Honduran Psychologist Arely Alvarado and I cooperated in the framework of the Danish NGO “Nunca Más – International Network for Human Rights and Psychosocial Response” and in collaboration with “MILPAH” (Movimiento Independiente Indígena Lenca de la Paz-Honduras), an indigenous Honduran human rights group.

5 Especially through the Cambodian Psychologist Phaneth Sok. Testimonial Therapy carried out by TPO was adopted by the UN-supported Khmer Rouge Tribunal in 2014 as one of the reparations made available to survivors (Lesley, 2021; Esala & Taing, 2017). The tribunal was established in 2006 to bring to trial senior leaders and those most responsible for crimes committed during the Khmer Rouge regime from 1975-1979.

from a rather radical one-sided view in the early Eighties towards a broader spectrum of approaches that includes diverse aspects of human existence in the political, social, physical, spiritual and cultural spheres. A long journey shared with people and communities in many different contexts and positions.

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