Shrink Rap Radio #59, November 7, 2006. Working with the Victims of Torture

Dr. David Van Nuys, aka "Dr. Dave" interviews Dr. Uwe Jacobs
(transcribed from www.ShrinkRapRadio.com by Jo Kelly)

Excerpt: "*So people are very depressed, they can't sleep, they have nightmares, they are hyper vigilant, people are simply afraid. There is a persistent fear that they experience, and if you think about it, really what torture is about – torture is about instilling fear, and it is usually successful. Torture really is a political instrument, it is an instrument of oppression; and what it's designed to do is to shut people up, to have them get in line, to lie low, to flee the country, to no longer be a problem to those who are in power*."

Introduction: That was the voice of my guest, Dr. Uwe Jacobs.

Dr. Uwe Jacobs, Ph.D. is a psychologist and Director of Survivors International a non-profit organization located in San Francisco, dedicated to providing essential psychological and medical services to survivors of torture who have fled from around the world to the San Francisco Bay Area. Survivors International aims to help survivors put the pieces back together by providing the support they need to re-establish healthy and productive lives after their experiences of torture. Since 1990, Survivors International has provided treatment to over 2000 survivors from 96 countries, treating an average of 25 to 35 patients a week through a growing network of providers which include physicians, psychiatrists, psychologists, social workers, and volunteers.

Website: www.survivorsintl.org

Dr. Dave: Dr. Uwe Jacobs, thank you for agreeing to be my guest today on Shrink Rap Radio.

Jacobs: You're welcome.

Dr. Dave: You are currently the Director of Survivors International. What is Survivors International?

Jacobs: Survivors International is a non-profit organization, non-governmental organization, that is dedicated to the care of survivors of torture and gender based persecution. We do direct service, information and

referral, and advocacy for people who have survived torture and gender based violence from around the world.

Dr. Dave: When was the organization founded?

Jacobs: It all started in about 1986, 20 years ago, and there was a group of clinicians in the East Bay primarily, and around a man by the name of Jerry Gray, and they were interested in this issue and wanted to create just such an organization to help survivors of torture. It took a few years to really get it going, and then the first clients came and it started slowly to gain momentum; and then increasing numbers of survivors came for help. And at this point this year we have just passed the threshold of 2000 clients; so we have at this point seen 2000 clients from 96 different countries.

Dr. Dave: Wow. When and how did you get involved?

Jacobs: I got involved in I think 1994 it was. Simply because I was at the time in an internship and I was supervised by Dr. Laura Dansky and she was the Clinical Director at the time. She knew my work, and we got along well and she asked me whether I had an interest in this – and I said yes of course. It struck me as really a great thing and I had been an Amnesty member as a young adult, like a lot of other people, and for human rights and so on. I had no idea really what this would mean: what does it mean to encounter somebody who survives torture, and how or why could I help them, and so on. But at that point in time I was referred my first client – and I just looked it up because we had this anniversary as it were, about client number 2000 – and the person that I saw was client number 300 for the organization, which gave me an appreciation just of how much has happened since then.

Dr. Dave: Yes. Now you were a psychologist intern, right? When you say internship?

Jacobs: Yes, at the time that I was taking this on, I was a psychological assistant. In terms of the clinicians working with Survivors International, these were all licensed health and mental health professionals: MDs Ph.D.s, LCSWs mostly; and I was the only one who was pre licensure at the time. But some of that had to do with the fact that I had a lot of prior experience, and previous graduate psychology work in Germany and so forth.

Dr. Dave: Thinking back to that first case, I would have thought that would be a little scary, kind of daunting – torture is such a heavy thing to contemplate. Do you recall what your feelings were when confronting this

first client that you knew you were going to be seeing who was a victim of torture?

Jacobs: Well what I do recall was just this sense of uncertainty, and a bit of fear I suppose about perhaps not knowing enough; or who am I to get into this. At the same time I also had some confidence in my abilities generally to hopefully be smart enough to ask for help if there was something that wasn't going well; and in any case I had the benefit of supervision at the time that was formalized in several ways. There were monthly clinical meetings that were held at the headquarters of Survivors International, and so naturally because I was a new clinician and this was my first case, I then was asked to present the case to the clinical committee. These were all senior clinicians really, and so I had the benefit of being able to discuss it, and get everybody's ideas and support, and I knew that. I think that is one of the things that is really crucial in doing this type of work – really any clinical work – especially with something that is so loaded, that you feel like you have contact with colleagues who are encountering similar problems.

Dr. Dave: Yes. What are the symptoms that you typically see in survivors of torture?

Jacobs: Well, a lot of survivors of torture have really post traumatic stress disorder, as well as major depressive disorder, to be really technical for a moment. If you look at it strictly from a medical diagnosis standpoint, much more often than not those are the two diagnoses that apply at the same time.

So people are very depressed, they can't sleep, they have nightmares, they are hyper vigilant, people are simply afraid. There is a persistent fear that they experience, and if you think about it – really what torture is about – torture is about instilling fear, and it is usually successful in the sense that someone who has experienced torture becomes a fearful person. Torture really is a political instrument, it is an instrument of oppression; and what it's designed to do is to shut people up, to have them get in line, to lie low, to flee the country, to no longer be a problem to those who are in power.

That's what torture is about, and it works – in the sense that people then have these kinds of problems, usually life long. So in some sense the medical I just talked about, the political, and interpersonally it really is mostly about the shattering of trust, you can say. What happens is that people learn at a very deep level that other people cannot be trusted: because if a human being is capable of being that sadistic to you over a period of time, and putting you through such agony time and time again, that means

that people are bad – it of course generalizes to a certain degree – and so trust is shattered.

But there are many sort of mediating variables: torture happens in different contexts and in different ways, and I have talked about it now as if it were this monolithic entity, which it isn't at all. Torture can mean a decade of detention in a dungeon, and daily specialized methods of inflicting pain and suffering that we typically associate with the word torture. We have people who experience that type of thing, on the other hand torture can mean in the context of genocide your neighbour begins to turn on you and takes your house away from you; somebody forces you – as somebody said to me yesterday, to rape his daughter, and get herded into a concentration camp and starved, and people beat you. It's a very different context – and it's not solitary confinement, it's not about being a political prisoner – it's about being part of a group of people and a genocide is being perpetrated. So a lot of people we saw from Bosnia went through those kinds of experiences, whereas other people we see come from these various places around the world where political dissidents get locked up and tortured. So there is a really wide spectrum of the meaning of what torture is and what people experience.

Dr. Dave: How do you sit with their stories? Just hearing you allude to some of these things I find myself taking some deep breaths. I would think it would be hard for you and other clinicians to kind of sit with these painful stories. How do you cope?

Jacobs: It's really a common question, and everybody's question, it's of course a good question. I'm not sure how possible it is to answer something like this. We are often in so many different ways drawn to things that we usually want to avoid, because they are painful or they make us feel helpless. Some of what we as clinicians have in general I think is a bit of the sense of trying to do the impossible.

Dr. Dave: Yes.

Jacobs: Freud talked about "the impossible profession", and there is something to that about being stimulated by trying to prevail for good; trying to preserve something that is essentially good within ourselves, and within relationships that bring healing, that we want to insist upon in the face of this adversity or this evil and pain. So time and again we are all drawn to doing this sort of thing; and in some ways it's not so much exactly what we do in technical detail, but more the idea of communicating to the other that we are there and we are trying. Much more so that we are trying rather than

that we have the answer. That in itself is really a gesture that has healing built into it in some way.

Dr. Dave: So do you find that in fact it makes a difference, because I heard you say that it leads to life long problems? Are both true, it helps and at the same time there are maybe residual pieces that just aren't healing?

Jacobs: Yes, I think that if you asked a number of different survivors of torture about that, you would get different answers. Because it is very difficult to predict how somebody over the course of a lifetime copes with or heals from this kind of an experience. You can hear anything from very dark descriptions or experiences of "nobody and nothing can change this", this has marked a person forever and there is no such thing as trust anymore in the world, in other people and so on, and people commit suicide. Or you can get an experience of having healed and restored meaningful relationships in terms of going on to having families, finding partners, having children, starting fresh. Still feeling pain or having certain symptoms but being able to gradually build a life never the less.

In terms of the symptoms themselves, to the degree that they are chronic, they fluctuate. They ebb and flow. If you put a person under stress, that exacerbates them. If a person is given a peaceful environment and a way to flourish, then they get better. One of the things that we see all the time is that their symptomatology is exacerbated by the stress they are under in their political asylum proceedings. Because that creates a lot of stress and fear – what if they deny my asylum claim, and say that I can go back to where I was tortured?

Dr. Dave: Yes.

Jacobs: To have that hang over your head, that's very very bad.

Dr. Dave: Sure.

Jacobs: So then what we see is that if we provide the immigration court with some documentation that supports the person's testimony about what was done to them, and they then are successful in their asylum claim, then there is an enormous relief that occurs. People feel a lot better, and they get a sense of energy about them – I'm looking for a job, a place to live; things are looking up now, I'm now safe. It may be that in some cases as things stabilize, as they realize that there is still a lot of pain, they may come back for therapy later. Yesterday I had a situation where somebody had got political asylum assistance from us several years ago, and is now coming

back with an explicit request for treatment – that happens. It has these kind of cycles too that one goes through in life as well.

Dr. Dave: Yes. Have you and your colleagues found any therapeutic approaches that seem particularly effective in working with these victims.

Jacobs: My sense has been in talking to other people over all this time, that this is like everything else in the sense that folks who do very different kinds of things clinically, in terms of technical methods do have success in making feel better, in alleviating symptoms and so on. It doesn't seem to matter so much exactly what the methodology is, as it does whether first of all the two people who are working together can work together in some ways.

There isn't really a lot of studies out there – you have to do research studies – and those that are out there that I have seen, they are pretty minimal. In some cases they don't show any improvement and it's a very mixed bag. What I have found is simply that amazing things happen clinically with people doing different things: we have some people who work very behaviourally, other people who are very analytical in their approach – so that is really all I can tell you.

Dr. Dave: I remember years ago there was research that showed outcome studies of therapy that indicated that years of experience were more important than school of thought.

Jacobs: Yes, but there are also studies that showed years of experience had nothing to do with it, and that in fact beginners were as effective as people with a lot of experience – if I remember correctly (laughing).

Dr. Dave: Oh I don't remember that one, I had better go back to my text books (laughing).

Jacobs: I seem to remember that. But one of the problems we have, if we are trying to use statistically based methodology on this type of thing, very often we are not really able to study this well enough because what we are dealing with is too complex for that kind of an approach, and that is how I have always felt about it. To the degree that we do research I have always trusted process research more than the traditional outcome study that is more modelled after medical drug studies and so on, because it is just not subject to that kind of study if you ask me. That is kind of a theoretical psychology discussion and I may or may not be right about that.

Dr. Dave: Yes. What countries are most of your clients coming from these days?

Jacobs: Let me say first, in any given year we may take in 120 or 150 new clients, and you look at where do they all come from, and it turns out that it's 50 different countries or more.

Dr. Dave: Oh really? OK.

Jacobs: So there are many countries where we have "an n of 1" so to speak, and over time it varies quite a bit where people come from, of course depending on what happens in the world. We still have for example, a lot of people coming from Central America: from Guatemala, El Salvador. We also have a lot of people coming from various places in Africa – whether it is Kenya, or yesterday I met with somebody from Sudan. There is always people from the Middle East, North Africa, there is always some people coming from places like Tibet or China, or Seiks coming from Punjab India – not so much anymore now of course – so it is very diverse.

But now also I should add that because for the last couple of years we have expanded our mission to include people who have experienced gender based persecution, including severe domestic violence against women. Women will flee from places like Mexico to the US; or Central America, or Indonesia or places where they couldn't get away and could get no protection from their husbands, boyfriends or abusers who would persecute them. So now you have to think about it not just in terms of political oppression but also in terms of culturally based oppression of women on the one hand, and sexual minorities: gays, lesbians, transgender folks who get persecuted for who they are rather than in terms of what their political or ethnic affiliation may be.

Dr. Dave: OK. On your website I saw that you wrote an editorial that appeared last year in the San Francisco Chronicle, in which you were critical of both US government policy and the American Psychological Association. Perhaps you can give us a recap of your concerns.

Jacobs: Well right now what's happening is that the US government is using torture increasingly openly, and defending the use of torture. Although at the same time denying that what is being done is torture – giving it different names, by saying that something like water boarding is an effective interrogation technique and doesn't fit the definition of torture. That of course is very bad.

In the past we had a situation where the US government through the School of the Americas exported torture into different countries, clandestinely, so that even though we knew that some of the survivors of torture who came to us essentially had the marks of the CIA on them, it wasn't at the point where it is now. There is a really important difference between doing things secretly for geopolitical purposes on the one hand, and on the other hand saying we need to torture people in order to get information from them, and to create a whole culture of cruelty within the military and to advance that kind of an agenda.

What that does, it really messes up the image of the US as the most important power in the world, that even though it does things wrong periodically, will on the whole enforce human rights standards. We have lost that status now. That has a ripple effect throughout the world, so that everybody else can do whatever they want and US is not in a position to say what we all have to do is to come to a standard of not torturing people systematically.

I'm not sure if that is the answer you wanted, but this is where we are now.

Dr. Dave: Yes, you are definitely touching on the issues that I was interested in. And the American Psychological Association developed an ethical position in regard to Guantanamo. Maybe you could quickly characterize that.

Jacobs: Yes. The position of the American Psychological Association is from my point of view not settled at this point, because there are some contradictions. On the one hand the APA has had clear statements on the books against torture on the one hand, with specific resolutions; but also of course has its general ethical principles, and psychologists are traditionally very clear that they do not condone or use any kind of abuse, much less torture. So, in some ways you could say that given the code of conduct that psychologists are held to, you wouldn't even have to talk about something like torture because it is so far beyond what we commit ourselves not to do, that it shouldn't be an issue.

Dr. Dave: Yes.

Jacobs: So then the question arises, why is it that one has to have specific resolutions that make a statement about "we don't participate in something like torture". The reason is, there are psychologists (and there is quite a few of them) who work within the armed forces, and other agencies of the government, that do among other things interrogations of enemy combatants

of various kinds. Then the question becomes what can the role of a psychologist be when we interrogate in order to get information?

So the position that the APA leadership took was from the beginning very strong in the direction of preserving the helping role of psychologists to the military or any other government agency that seeks to obtain information. And that psychologists will do things that are on the one hand ethical, and on the other hand helpful to interrogators, in terms of helping them get information out of people, in other words.

Dr. Dave: And you feel there is a conflict of interest there?

Jacobs: Right. So the other position that the APA could have taken would be to say that in principle psychologists should not get involved with interrogating people in context in which: on the face of it people's human rights are violated, due process is not given, it is not clear; and in general they should not directly assist in any kind of coercive interrogation technique, whatever exactly is being done. The APA failed to take that position.

The other APA, the American Psychiatric Association did take that position. They took the position that psychiatrists should not get involved in this kind of interrogation business, period. And because the principle "first do no harm" really dictates that we shouldn't get into that sort of thing.

And it was my feeling, and it is still the feeling of a lot of us who work in this field, that really in spite of having these strongly worded resolutions against torture and abusive treatment by the APA what really counts hasn't been addressed. It is really questionable whether the assertion that psychologists actually will do good if they get involved in these things because they can prevent abuse, they can prevent what we call behavioural drift and so forth, which was one of the arguments advanced by Gerald Koocher. So that's a debate that's still going on at various levels within APA, although my sense is that really the APA leadership at this point would like the debate to be over, and say: we have said everything there is to say about it, we don't torture people, we have a very strongly worded resolution, and that is really the end of it.

Dr. Dave: Yes. And as a matter of fact, I have thought that I would like to do a special show just on this topic alone. Maybe I will get back to you if you are interested, because I would like to have somebody who represents both sides of this debate, and have a little bit of a discussion between two people.

Jacobs: Yes, such discussions were certainly had. I had a couple of meetings with Stephen Behnke who is ethics director for APA, and there were some things that we just disagreed on. For example he took the position that it would be too difficult to enforce certain things; because it would mean that psychologists could say that any kind of involuntary mental health treatment for example is a coercive or abusive situation, so therefore I cannot participate in it, and so on. And I just did not feel that was a valid objection; I thought that was apples and oranges and I thought that anybody who wants to be clear about them can be clear about them.

Dr. Dave: Yes, well I hope maybe we can come back to this in a future session. Before we tie things up here – some proportion of our listeners are psychology students and others may be thinking of mid life career changes in that direction. What was your academic path like?

Jacobs: My academic path was that I studied psychology at the University of Tubingen for several years in Germany; and I had a bit of a double life because I was outside of university very interested and pursued all kinds of depth psychology: everything between psychoanalysis, and bioenergetics, and primal therapy and so forth. I got involved in all kinds of different things experientially, and was really much more interested in all kinds of depth psychology. But at the university, of course had to study very mainstream academic psychology and so I got a kind of very mixed education and experience from the beginning. Then I came to US on a scholarship and went to Antioch West in San Francisco which had a program of somatic psychology, and completed that program.

Dr. Dave: Was that for a bachelors degree or a masters degree?

Jacobs: No that was for a Masters in Clinical Psychology that I got there from Antioch University.

Dr. Dave: OK

Jacobs: That program now is at CIIS, it moved around a bit.

Dr. Dave: For my listeners, CIIS is California Institute of Integral Studies in San Francisco.

Jacobs: Yes. It is a very interesting program, it is really built on the premise that learning should be primarily experiential, and it should be embodied, and so it's very powerful and I really liked going through that.

Then after I was done there, I went to The Wright Institute in Berkley and that is where I got my Ph.D. So I had three graduate psychology courses in a row essentially, and they were all very different.

Dr. Dave: Well I really want to thank you for being my guest today on Shrink Rap Radio and hopefully I will have you back again.

Jacobs: You are welcome; thanks a lot.