

HUMAN TRAFFICKING

Trauma and Psychotherapy A Collection of Papers

Human Trafficking Trauma and Psychotherapy

Collection of paper

Editor
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Trauma and Human Trafficking Collection of Papers

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Introduction

About the collected papers and the project

These collected papers were created as one of the activities within the project ***Not for Sale! Building towards consensus on combating human trafficking in Serbia***, which was realized by the organization ASTRA with financial support by The European Union, through the program *European Instrument for Democracy and Human Rights* (EIDHR). The project which encompasses the formation of a psychotherapist network and training of therapists for treatment of human trafficking victims was created as a response to the needs and problems recognized while working with human trafficking victims for over ten years in local communities across Serbia. Namely, providing direct help to the victims of human trafficking, which is a big social problem, we noticed the necessity of systemic provision of psychological support to victims so that the trauma they had been exposed to could be worked through and incorporated into the person's overall experience and so that she could go on with life, making productive and functional choices for herself. Furthermore, experience in working with trafficking victims also taught us that the best long-term effects are attained by regular psychotherapeutic work over a longer period. We conceived the project in accord with present-day principles for better care of mental health, which underscore the significance of availability of psychological services in communities populated by those in need of such help. Today ASTRA's network of psychotherapists comprises fifty psychotherapists from thirty towns in Serbia, who are professionals in the area of psychotherapy, while as part of the project

they have also been trained to recognize potential victims and carry out field crisis interventions, as well as to provide long-term psychotherapy to human trafficking victims.

The collected papers can be used as a basic theoretical overview of concepts and psychological approaches to complex trauma and as a set of recommendations for working with victims. It is good reading not only for psychotherapists but also for other professionals working in the field of mental health and disorders as well as for employees of institutions which task is to recognize potential trafficking victims and understand the process that underlies reactions of people who had been exposed to the phenomenon that is frequently called modern slavery.

This publication consists of two sections:

- » The first section contains conclusions and recommendations written on the basis of content expounded at the international conference “Contemporary Psycho-Social Challenges in Combating Human Trafficking” and discussions initiated by the presentations. The objective of the conference was to highlight current challenges in combating human trafficking which are seldom addressed by professionals and decision makers, as well as to open up dialogue on significant issues, above all on approaches offered and models recommended for providing direct psychological support to human trafficking victims. Recommendations contain information about trafficking as a phenomenon, followed by the definition of trauma and complex trauma, discussion on posttraumatic stress disorder (PTSD) and complex PTSD, as well as recommendations for working with victims and understanding complex processes they are going through.
- » The second section consists of papers written after training entitled “Human Trafficking and Psychotherapy” organized for psychotherapists, and international conference “Contemporary Psycho-Social Challenges in Combating Human Trafficking”. They were written by international and local experts in the field of psychology and psychotherapy, as well as practitioners with rich experience in providing psychological support to traumatized persons. In this section of the handbook, we look at complex trauma and the psychological process that occurs as a response to traumatic experiences the victim had been exposed to. The authors do so by presenting their perspective, offering

explanations and recommending techniques which they have tested in their psychotherapeutic practice. Authors whose papers are featured in this collection belong to different psychotherapeutic modalities as part of humanistic and depth orientations.

This project represents a pioneering endeavor in the field of providing psychological support to human trafficking victims and will have long-term positive effects on the wellbeing of people who had been exposed to very severe forms of abuse, violence and maltreatment.

Ultimately, we wish to thank our donors who have recognized the significance of this endeavor, without which the realization of the Collected Papers and entire project would not have been possible, above all The European Union and program *European Instrument for Democracy and Human Rights* (EIDHR) on their desire to meet the needs that were coming from the fieldwork. Realization of part of the activities was financially supported by the company VIP (Belgrade), the cooperation and contribution of which hold an important place in the accomplishment of our goals.

About ASTRA NGO and human trafficking problem

ASTRA is a non-governmental organization devoted to eradicating all forms of human trafficking, especially trafficking in women and children. During more than ten years of work, ASTRA has been simultaneously active in the areas of providing direct help to victims, training, prevention, raising awareness, research and reporting. As part of its program of direct help for victims, ASTRA provides its clients with psychological, medical, legal assistance and other forms of help in the long-term process of recovery and social reintegration. Part of ASTRA's activities are geared towards prevention, which means that, in addition to trafficking survivors, ASTRA SOS Hotline may be called by citizens who wish to obtain information about this problem, available mechanisms of protection and conditions of safe stay abroad.

According to the United Nations Convention against Transnational Organized Crime, article 3. of the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, human

trafficking is defined as: „the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.” Human trafficking has been similarly defined in the Council of Europe Convention on Action against Trafficking in Human Beings: „a) »Trafficking in human beings« shall mean the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.”

According to data available to ASTRA, the most frequent form of human trafficking in Serbia is sexual exploitation, i.e. coerced prostitution, where in the majority of cases women and children are exploited, as follows: in the period from 2002 until 2012 – 70%, whereas in the year 2012 sexual exploitation has a 76% share. In the year 2012, all newly identified victims were female (29 persons). During the 2002–2012 period, 87% of the victims were female. According to data provided by Center for Protection of Human Trafficking Victims, among the identified victims of human trafficking during 2012 in Serbia, 77% were persons of female gender. Women are forced to render sexual services without financial compensation, specifically, the traffickers take away the money they had earned. Their exploitation frequently lasts for years, since traffickers have well developed mechanisms of threats and intimidation, physical violence and injuring the victim herself or her loved ones so as to elicit fear in her, which is why trafficking victims seldom decide to try and escape from such a situation. Frequent target of traffickers are children, i.e. persons under the age of 18, who are then exploited in this manner. According to data of Center for Protection of Human Trafficking Victims, in the year 2012, among the identified victims there were 41% minors,

whereas, according to ASTRA's data, in 2012 among the identified victims there were 31% minors. In the period from 2002 until 2012, 37% of the victims were children.

In our country today, there is also widespread labor exploitation, whereby persons are offered jobs with a good wage and seemingly satisfactory conditions. Once the workers have accepted the offer they had received from the human trafficker and they have reached the destination, they are subjected to exploitation and taken advantage of. What happens is that, at the target destination, their freedom of movement is restricted, they are left without food and water, as well as without compensation for their work. Moreover, traffickers threaten their safety and the safety of their family members, which is why they are compelled to finish the job or remain on location as long as it suits the trafficker. During the previous several years in Serbia, a trend has been noticed whereby the number of labor exploited persons is on the rise. Data provided by International Labor Organization allocate labor exploitation to the most frequent form of human trafficking on the global level, the estimate being that around 14.2 million people are the subject of labor exploitation¹.

Other forms of human trafficking are: forced begging, forced marriage, coercion into criminal activity, illegal adoption and human organ trafficking.

From the presented facts we can see that human trafficking is a very complex social phenomenon, where fundamental human rights are severely encroached upon. It belongs to a form of criminal activity that leaves long-term consequences on the individual, her/his close surroundings, but also society at large. As is the case with every other social problem, so human trafficking, i.e. solving that problem, requires encompassing, coordinated work by all the significant segments of society, not only on assuaging the effects and providing all necessary forms of help to victims, but also on problem prevention and creating a social climate where human trafficking does not happen.

Irena Korićanac

Psychologist and Psychotherapist


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¹ ILO 2012 Global Estimate of Forced Labour.

Human Trafficking, Trauma and Psychotherapy

**Conclusions and Recommendations
from the International Conference
Contemporary Psycho-Social Challenges
in Combating Human Trafficking**

Irena Korićanac



"The victims are society members whose problems represent memories of suffering, violence and pain in a world that society strives to forget."

Dr Michael Korzinski

Introduction

ASTRA – Anti trafficking action organized, on 15th March 2013, in Belgrade, the international conference "Contemporary Psycho-Social Challenges in Combating Human Trafficking". The conference objective was to highlight current challenges in combating human trafficking which are seldom discussed among professionals and decision makers. The conference brought together over a hundred local and foreign experts, who addressed, in two separate panels, the issue of providing psychological support to human trafficking victims, as well as the issue of adequate approach to psychotherapeutic work with persons who had exited the trafficking chain. The conference was organized with the support of The European Union via program *European Instrument for Democracy and Human Rights* (EIDHR).

We are presenting the conclusions pertaining to the most salient issues and challenges regarding the provision of psychological support and psychotherapy to human trafficking victims, defining of trauma and complex trauma, PTSD and complex PTSD, as well as recommendations

for working with victims, significant areas that need to be paid attention to by persons helping the victims, as well as the best models for work. Speakers at the conference were international experts from countries in which the system in this area is well regulated, Doctors of Science whose specialization is the field of providing psychological support to victims of torture and other forms of trauma, besides being thoroughly knowledgeable about the problem of human trafficking in their countries. ASTRA was host to experts with years of experience working with trafficking victims, while also being experts in the field of psychological sciences. The speakers were Dr Michael Korzinski, expert on trauma and social issues from Great Britain, Dr Mary Burke, holding a doctorate in psychological sciences, Professor at Carlow University in Pittsburgh, USA and creator of PhD program in Counseling Psychology and Psychotherapy at the university where she teaches, as well as Mariana Matei, psychologist and expert on the problem of human trafficking, director of shelter for women who are trafficking victims in Romania. In the afternoon session, local practitioners spoke, being psychotherapists with substantial experience in work with victims of diverse forms of violence, including human trafficking, such as Danijela Budiša, PhD in psychological sciences and transactional analyst, Dr Marija Vezmar, psychiatrist, psychoanalyst and group analyst, followed by Jelena Radosavljev Kirčanski, MA in psychological sciences and family therapist, Vukašin Čobeljić, Master of Clinical Psychology, psychologist and constructivist psychotherapist as well as Biljana Slavković, psychodrama therapist.

A conference in this area represents a pioneering endeavor by ASTRA, the objective of which is setting into motion systemic and practical changes and opening up as many issues as possible that are significant for this field. It should be kept in mind that we are talking about substantial differences that exist in our country compared to western countries. Although experts from abroad, who presented their papers at the conference, pointed out that they are dissatisfied with the number and quality of research studies in this field in their countries, education as part of doctoral studies in the West enables orientation towards the specificities of this phenomenon, whereas in Serbia the formal education system doesn't offer an opportunity to obtain an education in the field of human trafficking, which leads to a situation where we lack scientific research studies and papers that would encompass the specificity of the phenomenon and recommend procedures for crisis interventions, as well as best practices, techniques and modalities available in Serbia

which are efficient in work with human trafficking victims.

Human trafficking as a traumatic event – definition and overview of scope of the problem

Human trafficking is a big social problem which has far-reaching negative consequences, not only for those persons who have survived trafficking, their families and closest environment, but also for society at large. Human trafficking is called modern slavery, and it represents a criminal act and dramatic form of breaching fundamental human rights. During the course of over ten years of experience in providing direct help to human trafficking victims at ASTRA, psychological support has been recognized as one of the priorities in an attempt for the person who had undergone trafficking to reintegrate herself and continue a productive and functional life. The definition of human trafficking and forms in which it appears, makes it clear that this is a remarkably traumatic experience that belongs to the order of experiences that did not have to happen, i.e. aren't "destiny", but are accidental, which makes them harder to process psychologically. A person who has undergone trafficking, in her desperation often asks herself: *Why did it happen to me of all people?* In the United Nations Convention against Transnational Organized Crime, article 3. of the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, human trafficking is defined as: „the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs .” Human trafficking has been similarly defined in the Council of Europe Convention on Action against Trafficking in Human Beings: „a) » Trafficking in human beings« shall mean the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or

benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.”

The above definitions present insight into the scope of the problem and indication of dramatic experiences which people lured into trafficking had been exposed to. It doesn't stem from the definition, but practice has shown that human traffickers were mostly not only known by the victims before the abuse, but these had primarily been trusted people and often very close to the persons they subsequently exploited and whose trust they took advantage of. They are often family members, partners or friends. Human trafficking represents a severe blow to basic trust and faith in people and their benevolence, a breach of dignity and fundamental human rights of the individual. The person is treated as a commodity and in the period while she is being exploited, she is not treated like a human being who has consciousness and emotions. It is clear that persons who had been trafficking victims experienced situations and events that lie outside of ordinary human experiences, frequently being hard to understand for the very reason that such atrocities and abuse of people are very distant from the experiences an average person is capable of thinking about and empathizing with. When it comes to psychotherapy with human trafficking victims, issues of trust and establishing good rapport, which are very significant for every psychotherapeutic dyad or group, become even more significant. Trust as a social construct is a very interesting topic treated in philosophy and sociology. From the psychological standpoint, trust is necessary so that we can establish a close relationship with other people, to rely on others and depend on them, their advice and love in some moments. According to Erikson, the building of trust is one of the goals in the first phase of child development, which is called basic trust acquisition phase (Vlajković, 2005), during which an experience of self is acquired as well as base for identity formation. Thus the capacity for trusting other people is a predictor of a person's wellbeing. When trust is abused in a way that human traffickers abuse the trust of their victims, the therapeutic task to regain trust in people is often very complicated and may seem unattainable. An individual who has experienced such betrayal understandably approaches further relationships very cautiously and without much faith in people, also having considerably reduced

capacity for good and healthy human relationships. What is more, when we consider, in the context of psychotherapy, the relationship of trust between client and therapist as a curative factor and necessary basis for good rapport, it is clear to what extent this necessary objective is a difficult task for the psychotherapist and client who has undergone trafficking. At the conference, experts underscored the building of trust in the therapeutic relationship as the prerequisite and groundwork without which it is not possible to embark on processing the experienced trauma.

Social context of human trafficking – social and economic problems of victims

A well organized and just society in which people find employment and realize their potential, as well as a society which reacts in a timely manner to the demand for services sought by victims of various exploitation forms, is not fertile ground for human trafficking to take root. The number of trafficking victims grows in situations of crisis and transition, in countries that have high corruption rates and lack a free labor force market and healthy competition. Regarding social relations, it is important for a person to be brought up in an environment free of domestic violence, where close relationships are nourished, as well as love and respect among family members. Patriarchal society ruled by gender inequality, gender based violence and bad position of and discrimination against women and minorities, creates an environment which fosters the development of this social problem. The above mentioned social factors define the wider context in which psychotherapy with the victim occurs and make the psychotherapeutic process and recovery more difficult, making the victim's treatment unpredictable. We will list and explain concisely the mentioned factors and their indications for treatment.

Poverty, unemployment and social exclusion

Poverty, unemployment and social exclusion belong to main causes of human trafficking. In countries with high unemployment rate and high poverty risk rate, people are in constant search for employment and better life, often having undergone years of frustration because of bad living conditions and impossibility of providing for the basic needs. Such a state leads to decreased caution and acceptance of various job offers,

without additional background checks and analysis of offered conditions. This implies that trafficking victims are in a very harsh material situation that they lack the money to pay for psychotherapy, whereas on the other hand, even when treatment is provided as part of a free-of-charge system of social protection or via NGOs, it is questionable how the work should proceed and whether or not it is at all possible to work with a client so poor that she lacks the finances for regular meals, perhaps coming to therapy hungry.

Discrimination on the labor force market and corruption

As a country in transition at the time of world economic crisis, Serbia has a very high unemployment rate and numerous problems in the field of employment. Add to that the fact about the connection between corruption and disregard of human rights, as well as that corruption is often mentioned as one of the biggest problems of Serbian society, it is clear that the situation is very bad and that Serbian citizens have difficulties providing for basic living conditions and realizing their potential. In such circumstances, women, as well as various socially marginalized groups, are the last to be hired and first to be fired, which exposes them to an array of risks. When women are refused access to a regulated labor force market, they are compelled to seek work on the black market, where they are completely unprotected, subjected to the most diverse forms of abuse and are easy prey for human traffickers. Similar risk is faced by jobless men, especially socially marginalized groups. This factor, like the previous one, tells about the dire poverty of victims and objectively bad life perspective which the individual is capable of influencing little, if at all.

Discrimination based on gender

In transitional societies, especially during crisis periods, there is often retraditionalization and repatriarchization of society, with the strengthening of gender stereotypes. The man is seen as the breadwinner and supporter of the family, whereas the woman ought to devote herself to the household. The role of woman as weaker and requiring support creates a climate whereby bad living conditions develop as well as

dependence on the partner. Patriarchal society opens up possibilities for various forms of violence against women, also meaning for human trafficking. Discrimination and clients' experiences related to this issue must be included in the therapeutic process and adequately worked through. It is significant for therapists to work on reconsidering their own prejudices so as to be open and able to recognize them when they emerge, preventing the prejudices from impacting on the therapeutic process.

Violence against women and children

Violence against women and children, especially domestic violence, also makes women and children more often exposed to human trafficking. Domestic violence is a salient factor because of which many girls and young women, little girls and boys want to leave their families and their country, since protection is lacking which must be provided by the system in such cases. Accordingly, for women who are faced with unemployment, sexual harassment and domestic violence, offers for a well-paid job abroad represent an escape to a better world, while for children they represent an escape from violence. Although during its provision of direct help to trafficking victims for over a decade ASTRA has encountered victims who had come from stable environments and had had family support, but nonetheless became victims of human trafficking, still there are much greater numbers of victims, primarily women, whose histories contain experience of emotional, physical and sexual violence in the family and partner relationship. This serves as evidence of the client's insecure attachment, as well as of likelihood that the client had been a violence victim even before human trafficking, which must be taken into consideration in therapy, i.e. explored and treated.

Why didn't the victim run away?

The question arises as to why the victim didn't try to run away or didn't escape the situation in which she had found herself, especially keeping in mind that trafficking victims often have contact with the outside world and there are occurrences when it seems that they could have found a way out of the trafficking chain. Experts at the conference attempted to explain the complicated mechanisms of perfidious manipulations which

traffickers use so as to keep the victim under control and retain power over her actions, which enables them to exert years of exploitation and gain substantial income from that exploitation. In fact, mechanisms for establishing power and control which traffickers use to manipulate their victims are carefully selected for each victim individually. These are physical violence or threat of violence, followed by very “refined” manipulations which exclude physical violence, but which objective is to intimidate the person and strike where she is weakest. Namely, traffickers first become thoroughly acquainted with all the characteristics, above all weaknesses of the person, before taking steps which lead her into the human trafficking chain. The supposition is that everyone has a part of the self which is vulnerable and could become the target of abuse. For someone it’s personal dignity and image of self in the family and community, while for someone else it’s love and close relationships, family and friends; yet for another person it might be a threat that he will hurt her child, so it’s enough for her to be shown a photo of the park next to the house where her child plays every day to make it clear that she must not put up a fight since she is potentially risking the safety and life of her child. For some individuals, the possibility of being publicly disgraced in front of family and idea about lost dignity is a line that must not be crossed. Threats of physical violence or watching the trafficker while he physically and/or sexually abuses one victim often serve as a clear signal for others what will happen to them if they try to run away. These “violence treatments” which can take the most diverse forms may, when they last a longer period, be considered torture. After a certain time, as the result of such threats and violence, what emerges is that the victim stops feeling and loses the experience that she is a person at all, that she has needs and wishes. She carries out orders just like the human trafficker demands. Numbness then becomes the sole manner to survive physically and psychologically the horror in which she has found herself. Fear is a very powerful weapon in the hands of human traffickers, whose personality profiles often manifest psychopathic traits and severe disturbances in social functioning. Horror, torture and threats of identity loss that the victims undergo is also known in the literature as *experience of mental death* (Ebert and Dyck, 2004).

On trauma and complex trauma

Trauma is defined as a life event which sets a task in front of a person and her coping mechanisms that she had developed up until then, which at that moment in life she is incapable of cognitively and emotionally processing in the usual way i.e. using existing mechanisms. Hence, psychological structure faces a challenge and must adapt to the new circumstances. A traumatic event can be an isolated, one-off situation, but also continuous exposure to threatening stimuli and events that the person perceives as difficult and menacing. When it comes to human trafficking, we are talking about complex trauma, which may be discussed from two important perspectives. Firstly, it is rarer to find cases of trafficking victims who had not had severe traumas in childhood or earlier period of adulthood (e.g. victims of sexual violence and incest, victims of domestic violence etc.). In cases when they had had early trauma, the trafficking experience represents a trauma which cumulatively builds on the trauma which the person had endured in earlier life phases, most often in childhood. Therefore, we are talking about complex trauma when the person had had severe traumatic experiences that were not psychologically processed before she became a trafficking victim. The other view of complex trauma relates to the fact that human trafficking experiences are especially dramatic human experiences. In that case the concept of trauma and its psychological consequences, the way trauma is defined in psychology, cannot fully encompass and describe such experience and psychological effects it leaves. Consequently, we are talking about complex trauma when the traumatic experiences built on one another and/or when traumatic events were particularly dramatic and unexpected, so much so that they can be equated with torture.

Nonetheless, it is significant to point out Judith Herman's standpoint that it is wrong to refer to traumatic experiences as those foreign to everyday experience, for the very fact that it is very rare to find a person today who has not had some kind of traumatic experience (Herman, 2001). On the other hand, the intensity of psychological reaction to trauma is proportional to the severity of experience that the person underwent (Vlajković, 2005; Herman, 2001). The fact that trauma is close to each human being poses great potential for change and empathy. Even so, unprocessed personal trauma in the therapist or some other person who ought to help the victim can be a significant obstacle in work (Kast, 1998). Thus it is necessary to introduce the concept of complex

trauma so as to additionally stress the specificity of this experience, as well as psychological consequences that are to be expected. The above discussion speaks in favor of universality of human experience as such (Jalom, 1980, 2005), so it is important for each traumatic experience to be viewed through the prism of identical consequences which can potentially be left on the person, although many factors, such as personality, previous experiences and objective and subjective assessment of traumatic event severity, will greatly affect the intensity and duration of consequences.

Psychological consequences of human trafficking

The list of psychological problems faced by human trafficking victims is very long and psychotherapists and research studies attest to the fact that the following problems and challenges occur as a reaction to the experiences and situations the victims had been exposed to:

- » posttraumatic stress disorder (PTSD)
- » complex PTSD or Disorder of Extreme Stress not Otherwise Specified
- » depression
- » absence of emotional reactions
- » anxiety disorder
- » self-blame
- » helplessness and meaninglessness
- » nightmares
- » anger and rage control problem
- » suicidal ideas and attempts
- » paranoia
- » Stockholm syndrome
- » fatalism and temper tantrums
- » psychoactive substance abuse problems, alcohol abuse
- » problems in everyday grooming
- » sleeping problems
- » dissociative disorders etc.

At the conference it was underscored that it is necessary for professionals who come into contact with trafficking victims (police officers, attorneys, judges, social work center employees, doctors, psychologists etc.) to understand thoroughly the consequences such experiences leave on a

person's psyche. This is important so that they could develop their own potential for empathy and have patience for the person who can have frequent mood swings, be very withdrawn and closed, or may be rather brazen and offend the interlocutor. Helpers should have understanding for the fact that the victim's every reaction, no matter how socially unsuitable for the particular situation, is justified and psychologically rooted in the context of trauma the person had undergone. Doctors tend to tell the family and friends of persons who are in terminal phases of organic illness that they shouldn't be angry at their loved ones because of arrogant behavior and profound fear, rather to be angry at the illness which has left psychological consequences on their loved ones and changed them to unrecognizability. The same can be applied and the same understanding is necessary when it comes to victims of psychological trauma. A good recommendation would be "to get angry" at the trauma, not the person.

Furthermore, victims are frequently unable to remember all the events precisely. This is mostly due to the fact that the cognitive apparatus, primarily thinking and remembering, doesn't function in the usual manner. Thus it often happens that the person makes contradictory statements, of which some parts make sense, while others are illogical and completely useless. In the greatest number of cases, the victim isn't trying to lie, rather it's a mechanism she is using to defend herself from intensive emergence of memories so as to protect herself since she can't stand exposure to trauma and emotions that such exposure might stir up. While working with these people, it is not unusual to have a whole range of different feelings – from exceptional empathy and wish to do for them even more than what our professional role entails, to strong negative emotions and wish to find an exit from such a situation as soon as possible. If we succeed in accepting and understanding our emotional reactions to the victim's story and behavior, as well as in differentiating, as psychotherapists, which of those feelings and experiences are part of transference and countertransference between therapist and client, we can help the person sitting across from us. This issue also opens up the question of boundaries and maintaining the setting. Experts pointed out that it is exceptionally important to have inner boundaries which are strengthened by personal psychotherapy and other forms of work on oneself, while the usual, strictly required setting will be rather difficult to uphold and will probably be tested by clients and situations more than is customary. As long as the psychotherapist is aware of her decisions and

obtains the clients' informed consent, boundaries can be maintained so as to help the client and retain the profession's ethical minimum.

At the conference there was also discussion about the fact that every conversation about traumatic experiences can stir up emotions and thoughts that are hard for the victim to cope with and represents a threat of retraumatization. When faced with difficult content, each person uses a wide range of defense mechanisms, of which the most frequent is dissociation. It is a mental process that leads to a breach of links between thoughts, memories, emotions, actions and sense of identity. When a person dissociates, pieces of information aren't interlinked in the usual way, while there is processing of content by connecting emotions with events and a preserved continuity and stream of consciousness. For instance, during the traumatic experience, when there is no possibility to physically leave the difficult and threatening situation, the person may split off memories of the place and conditions in which trauma unfolded, avoiding painful feelings. The outcome of this process is lack of information in memory about the entire traumatic experience. Dissociation produces changes in recollection of events, so the dissociating person may have problems with sense of identity and continuity of personal past. Dissociation is regarded as a continuum. One pole of the continuum contains mild forms of dissociation which crop up while daydreaming or when a person „loses herself“ in a good book or film. This is a brief event that entails momentary loss along with preserved awareness of the surroundings. The other pole of the continuum contains complex forms of chronic clinical dissociations which lead to serious deteriorations of psychological functions and loss of contact with reality. Thus dissociation enables the person to either not remember the events and have fragmented recollections of them or, on the other hand, to not link emotion with the events, being capable of speaking without affect about atrocities she has endured, as if it had happened to someone else or as if it were a newspaper article she had read. It is often that in the literature concepts of dissociation in this first sense are equated with splitting. Nonetheless, for the purposes of this text, we will define splitting as a tendency to see things as either good or bad. Alongside projective identification, it is considered to be the most primitive defense mechanism. For instance, a child who is the victim of sexual violence inflicted by parents uses splitting and separates the experience of parents s/he depends on and loves from that of parents who are sexually abusing her/him. In that case the child retains the image of parents as good, while

identifying with the bad, believing that s/he is bad and that's why such things are happening. The splitting mechanism may be used to explain body-related feelings attested to by trafficking victims. The body, the experience thereof, and consequences of trafficking induced trauma on the body of the survivor are issues that have been discussed thoroughly at the conference. Namely, the topic of splitting mechanism was covered, since it is a way in which victims separate their consciousness from the body, abandoning the experience that the body is part of them or that it is theirs at all. The relevance of the body was accentuated for therapy of this type of trauma and the standpoint voiced that first and foremost "the body must be cleansed", i.e. the symbolism understood which the body has for the person who has survived such brutalities that human trafficking inflicts. Only then can trauma be worked through and psychological recovery brought on. So that the therapist can adequately address the client's experience, her bodily scheme and role of the body in the trauma, she must resolve the relationship with her own body and related issues. It is significant for therapists to understand that trafficking is not an intellectual construct, but rather a somatic experience and the point lies exactly in the body which had endured abuse. One of the most salient aspects of mental health is the experience of one's body as a safe place. This aspect is destroyed by human trafficking and the victim no longer experiences her body as a safe place. The body ceases to belong to the person, she cannot control her body, its needs, movement etc. Accordingly, in human trafficking, the body has been taken from the victim, it no longer belongs to her. That is why it's important to understand the body and messages it brings to treatment. In addition to regaining trust in people, regaining the experience of own body as a safe place is set as the most significant aim of psychotherapy. For victims, words often don't have meaning, while the body is cut off and it's impossible for them to feel as long as they are cut off from their bodies. It's the dissociation process: when the person dissociates, there is no link with words and no meaning, what often happens to those who aren't psychotherapists, but unfortunately to therapists as well, is that they fail to recognize the moment when the person is dissociating, when content becomes so difficult as to prevent her from going further. When the person in treatment becomes unsettled, it is our priority to calm her down. We can frequently obtain this information by watching the client's body, the position of the body, trembling etc. It is important to keep in mind that when the calming process begins and signs of being unsettled disappear, it is crucial to stay awhile longer with the client in the state she

is in so as to stabilize that state. Experts quoted Winnicott and his concept of “good enough mother”, which speaks about the fact that when the mother takes her unsettled baby into her arms, the baby gradually calms down, then her body slowly relaxes and that first moment of relaxation indicates she is on a good path towards calming the baby down; so as to fully calm the baby, it’s necessary for the mother to continue to be present the same way for a while. It is then that the psychological state is stabilized, while the body completely relaxes. This very concept is necessary to keep in mind when working with unsettled clients: first signs of client’s relaxation should be interpreted as an indicator that our interventions are successful, and that we should continue in the same direction for some time so as to stabilize that state.

It is essential to understand that creating a safe environment is the first task not only of psychotherapists but also all other persons who come into contact with the victims. Process in which we are stable and sincere in what we can objectively offer, our capacity to contain feelings, so giving the client wholeness and perseverance, represents the key for forming an environment where the mistrusting person starts to rebuild trust. It should be kept in mind that victims experienced betrayal by someone they had trusted, that they were in a situation where the sole person who could help them at the moment, i.e. the only person they were able to address for help was none other than the trafficker exploiting them. It is solely in a safe environment that it is possible to build a relationship of trust, address the body, build a complete life story of the client, link dissociated thoughts and feelings, integrate traumatic experience into the entire life experience of the person and support the client during change and defining of new life goals.

PTSD or complex PTSD

Posttraumatic stress disorder (PTSD) is frequently the individual’s response to traumatic events. PTSD is defined in DSM IV² as development of a group of symptoms after being exposed to extreme traumatic stressors, including threat of death or injuries, or peril to physical integrity of the person and exposure to events where other persons are exposed to danger jeopardizing their life or threatening to inflict severe injuries. The person’s response to such events can be fear, helplessness and terror. It is then that the person fears the events will be repeated and

² *Diagnostic and Statistical Manual of Mental Disorders*

avoids everything linked to the trauma. PTSD is a diagnostic category well known to experts in the area of mental health and disorders, especially taking into account the fact that as a country we are in a postwar period, whereas this diagnosis was created so as to explain a group of symptoms with which soldiers were returning from the battlefield. This very fact is one of the arguments used by those who, like Judith Herman, deal with complex traumas which above all pertain to problems in interpersonal relationships and experience of being trapped, similar to those that emerge when the person has been exposed for years to domestic violence or human trafficking.

Hence, in a situation of prolonged, repeated traumatic experience, we are talking about complex trauma. Human trafficking is considered an event that can elicit complex trauma since by its definition it entails that the person is locked up and prevented from leaving the traumatic situation of her volition and without severe consequences, as well as that the trafficker controls what the person is doing, if she is moving, if she has eaten and what she has eaten etc. Complex trauma can occur as the outcome of bad object relations in childhood or consequence of exposure to extreme stimuli later in life. If failures in object relations occur in the formative period during childhood, the person won't build a capacity for relationships and will have an attachment model that prevents her from establishing a close relationship with another person. On the other hand, long-term exposure to traumatic events in adult age, especially when it comes to traumas stemming from interpersonal relationships, particularly if they last long and are repeated, may lead to complex trauma. When it comes to human trafficking, the case is often that both of these prerequisites for formation of complex trauma are present, i.e. that the person had been exposed to bad experiences as a child and has bad experiences with primary objects, whereas during the trafficking experience she was exposed to extreme traumatic events, that built on the previous trauma. This complicates the problem and makes treatment prognoses even more uncertain. According to detailed research conducted by Melissa Farlin, as much as 68–97% of women who were victims of trafficking for the purpose of sexual exploitation had had the experience of sexual violence in life prior to entry into the trafficking chain. In such situations, the existing classification of mental disorders and PTSD don't define completely the consequences of such events. Professionals who worked with domestic violence victims during the 70s of the past century depict a clinical picture which is not possible to fully

describe utilizing the existing classification. So as to explain the effects of complex trauma, the concept of complex PTSD was introduced, or Complex Posttraumatic Self Dysregulation or Disorder Of Extreme Stress Not Otherwise Specified, the characteristics of which are – pathological dissociation, emotional dysregulation (e.g. rapid changes from rage to emptiness and melancholy), dysregulation in behavior and control of own behavior, problem in bodily functioning (somatization), negative self-perception, changes in relationships (from boundary crossing and connection to devaluing others and distance) and loss of a sense of life purpose. During the 90s, lobbying commenced by professionals who work with victims of domestic violence, equated in certain cases with imprisonment, because of duration and abuser’s mechanisms, that this disorder be introduced into DSM IV revisions; nonetheless, it didn’t happen. Polemics arose as to whether or not complex PTSD would find its place as part of DSM V. Still, for those who work with victims, it is important to understand the distinction which professionals draw between these two diagnostic categories. They underscore that the difference between PTSD and complex PTSD is the fact that exposure to complex trauma causes changes of personality, such as deformation of attachment model and identity, which do not characterize PTSD, so there is risk for persons suffering from it to be misdiagnosed e.g. to be allocated to the category of personality disorders, implying that they may be subjected to inadequate therapy. Complex PTSD is brought into relation with prolonged exposure to traumatic events, like in cases of imprisonment, i.e. deprivation of fundamental human right to freedom of movement. Although experts link complex PTSD with the experience of domestic violence which the person has endured for a long time, this can be directly applied to human trafficking victims, since their right to choice and freedom of movement has been taken away, and they are living in conditions of imprisonment.

Complex PTSD symptoms that are the outcome of long exposure to traumatic events in which the person had been imprisoned or had felt that way (Herman, 1992) are as follows:

- » Problems in regulation of affective impulses
People suffering from complex PTSD have a problem regulating their emotions. They can feel intense depressive feelings and harbor suicidal thoughts or have a problem controlling rage and anger.

- » Changes in cognition (attention and consciousness)
They imply repressing memories, experiencing repeated memories (*flashbacks*) or dissociating. This symptom implies a sense of depersonalization. Dissociation in this case, unlike PTSD, is linked to the person's exposure to long and severe violence in close relationships that went on in childhood or in the case of coerced keeping in conditions of imprisonment.
- » Changes in self-perception
The person feels hopeless, feels chronic shame and guilt. She thinks she is different than others and feels outcast.
- » Changes in how the person views the perpetrator (abuser, trafficker)
There are often instances when the person internalizes her system of beliefs. She feels she has no power over the situation and that power is in the hands of the perpetrator. Victims are often completely occupied with their relationship with the perpetrator (e.g. constantly thinking about revenge).
- » Changes in close relationships
The person experiences changes in relationships, isolates herself or feels strong mistrust.
- » Somatic and/or medical problems
Body-related problems appear, which can sometimes be directly linked with the abuse the person had been subjected to.
- » Change of life philosophy and worldview
Persons suffering from complex PTSD can lose faith in people and humanity, having a sense of hopelessness and meaninglessness regarding their future. There is an especially strong sense of being alone in their suffering and that there will never be anyone who could understand them and their desperation.

Psychological support for human trafficking victims

Experts agree that, when it comes to psychological support for victims, it should not be confined to psychologists, psychiatrists and

psychotherapists only, but also include professionals in the system who come into contact with victims so that they too can provide support to the victims and approach them with patience. Trauma and its consequences should be understood by doctors, attorneys, prosecutors, social work center employees etc. Each link in the system which has a role in providing diverse types of help also has its role in psychological support for the victim. When the system is functioning well, the victim receives a message that the support she has is stronger than traffickers and she regains the power she had lost by becoming a trafficking victim. Therefore professionals need to master the skills of active listening, to perform their job responsibly, give adequate information and not promise the impossible, not judge and not stigmatize. When professionals behave in such a manner, they provide a safe space in which the victim recovers and gathers strength to reintegrate into society, but also to process the emotions and thoughts related to events she has survived.

When it comes to psychotherapists, it has been pointed out that personal psychotherapeutic work of the therapist is very important for this process as well as understanding oneself and one's own processes as proportional to the understanding that therapists have for their clients. Furthermore, it has been underscored that it is necessary for all, as part of their schools and orientations, to acquire theoretical knowledge on development of psychological functions and psychological processes, as well as on trauma and its consequences so as to be capable of understanding the processes the client is going through. In addition, the salience has been highlighted of supervision and intervision, exchange of knowledge and experience among colleagues. The first task for therapists is to create a safe space for all clients, and it is important to invest a lot of time into that process due to the specificity of clients who have been trafficking victims. Work on the body and understanding the link between body, psychological attitude of the person towards the body and terror of trafficking are firmly intertwined and it is necessary to treat them as such in psychotherapy. Transference and countertransference were also addressed. It was pointed out that how a person symbolizes her relationships and other personality traits develops through the relationship with parents. The very manner in which parents had responded to expectations is the manner in which expectations from other people appear later in life. Securely attached persons have a firm base to absorb the experience of trauma. A secure attachment model raises the client's capacity to become attached to the therapist and work

with her productively. It is important to keep in mind that trauma may have reduced the person's capacity for attachment. Clients expect from the therapist to respond in treatment the same way that parents had responded to their needs, e.g. to be either unavailable or emotionally open. This is especially noteworthy when the therapist is working with those who had had early traumas, their primary figures having failed to provide good care, so they expect us to do the same. The greatest number of clients who are trafficking victims belong to this category.

It is the psychotherapist's capacity to be a secure base which represents the greatest hope that the therapist can provide a corrective experience to her clients. In order to attain that, it should be understood that persons who lack a secure base don't value themselves, nor are we as therapists worthy of respect in the eyes of such persons. Thus it is important to consider what kind of base the client has and whether she has had earlier traumas or is entering treatment solely with the existing trafficking induced trauma.

At the conference, for work with trafficking victims, it was recommended that use be made of the phase model of integrative psychotherapeutic work on trauma as one of the models which proved successful in practice. This model was offered by Julian Ford, who described the problem scope and all aspects the psychotherapist must monitor when working with the traumatized. The model has three phases, which aren't strictly linear but unfold in a spiral and often replace one another. It is important for therapy to unfold in a rhythm most suitable for each client, with the aim of integrating personality aspects which are unacceptable to the client, renewing or building secure attachment, for the client to become aware of existing strengths, build new skills and join all fragments of her personal life story. The model entails a phase of stabilization and security, followed by the phase of working through traumatic experiences and phase of supporting changes, as part of which various therapeutic interventions exist, as well as different behaviors of the therapist and different therapeutic goals:

» Phase of stabilization and security

The goal of this phase is to develop good rapport with the client, stabilize the client and teach her how to become stabilized on her own. Trust is a significant issue in this phase. The therapist gathers information so as to obtain a clear view of the client's clinical

picture in order to select the best possible treatment. In this phase, the focus is on psycho-education, in which we educate the client on psychotherapy and psychological processes that therapy brings on, but also on trauma, so that she could understand the situation and feel supported, grasping that the therapist can understand and accompany her through the recovery process. In this phase it is important to let the client know that what she is feeling is normal and expected, taking into account the circumstances. The client must also be informed that treatment increases anxiety and will be unpleasant and difficult in some parts. For this process it is important to provide full informed consent on whether or not the client wants to enter the following phase.

The motto of this phase is: *Victims were alone in trauma, while now they can be with someone during the recovery process.*

» Phase of working through traumatic experiences

In this phase the goal is to work through the trauma by making the story more complete and modulating and organizing autobiographic memory. The client focuses and is oriented towards current life, while in this phase the therapeutic relation is strong and stable. Emotions are worked on and the client is allowed to feel them in therapy to the extent which is functional for her recovery. When emotions are intense, the therapy situation is used so that the client can practice what she learned about regulating emotions during psycho-education in the first phase of therapy and come to terms with such an experience. This corrective experience brings back power to the client and stirs up positive processes. It is possible solely if the client–therapist relationship is good, if the client feels safe and if she has mastered the skills of coping with symptoms. The objective is to avoid retraumatization until memory of trauma is integrated as part of that person’s trauma narrative.

The motto of this phase is: *Trauma is part of the client’s life, not her whole life. A person has a trauma, not the trauma the person.*

» Supporting change in life

The client is supported in this phase to lead a functional life and make responsible choices for herself, which had often been stifled by trauma. In this phase the client should get support and evaluate and reconsider her perspective, as well as understand her role in relationships. The goal is for the client to leave the position of victim

and enter that of survivor, starting to believe she has power over her life. Development in the following aspects is supported: relationships, work, leisure and enjoyment, meaning of life through spirituality, or defined life purpose and aim.

Conclusion

Conference participants opened up a substantial number of issues, but they also provided answers to a considerable number of dilemmas, especially when it comes to the most effective techniques in providing psychological support to human trafficking victims. When working with victims, the ultimate goal is for the trauma to become an integrated part of the client's experience so that she is capable of replacing the role of victim with life roles that will help her regain power and lead a productive life. The path towards this goal is very long and demanding, requiring much patience above all from clients, but also from psychotherapists. When it comes to the role of psychologist, psychiatrist and psychotherapist and improvement of the situation in the sphere of combating human trafficking, it is necessary to work on all aspects of the personality and obtain continuous education so that the therapist could best respond to challenges that such work presents. Furthermore, it is significant to take responsibility for the profession's progress; conducting research, writing papers and presentations for conferences, within modalities and theories they belong to, as well as case studies from psychotherapeutic practice. Establishing a safe space in private practice, institutions and organizations where psychological support is provided directly helps clients who were victims, while publishing professional papers and research studies indirectly helps all victims. Both ways are equally important for those who strive to be socially responsible professionals.

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Identifying and Treating Trauma in Victims of Trafficking and Exploitation

Dr Michael Korzinski

I didn't know I was a slave until I found out I couldn't do the things I wanted.'

Frederick Douglass³

Introduction

Human trafficking is not a new phenomenon, and the traumatic impact that the experience has upon the lives of the survivors are not unique.

This paper is an attempt to share some of what I have learned about trafficking and complex trauma with colleagues who encounter it in the practice of their different disciplines. None of us, as professionals, operates in a vacuum, though our professional disciplines tend to disconnect us from one another. As fellow professionals we seek to appreciate the similarities and differences in our approaches. We are for more effective working together than we are separately.

I have used the voices of victims to articulate their hurt, as Frederick Douglass did. And their voices identify the psychological truth of the victims' experience.

³ *Narrative of the Life of Frederick Douglass, an American Slave, Written by Himself* in June 1845. Frederick Douglass (1818–1895) rebelled against his enslavement in the South of the United States of America and became a leader of the abolitionist movement. When many Northerners refused to believe that this eloquent orator could have been a slave, he responded by writing an autobiography (the first of three), the *Narrative of the Life of Frederick Douglass, an American Slave, Written by Himself* in June 1845 which identified the men who once had owned him, by name.

I hope my thoughts, from my experience of treating victims and helping them to rebuild their lives, will find a resonance with your own work and experiences.

From Slavery to Trafficking: Voices Past and Present

Human trafficking is the modern day criminal manifestation of a problem that has vexed humanity from the beginning of recorded history. Slavery was as fundamental to the way of life of the Egyptian Pharaoh, as it was to the Plantation owner of the American South. The suffering of their slaves is captured in works of literature as diverse as Homer's Iliad and Odyssey and Mark Twain's Huckleberry Finn. Slaves had no 'rights' other than those accorded to slaves. One such 'right' was the right to be tortured. Torture was defined in Roman Law as a 'certain kind of inquisition made for the purposes of tearing out the truth by torments and bodily pain.' (Peters, 1985). The pernicious cruelty of the act relegated its use solely to slaves until 2 AD. Confessions extracted under torture were considered the highest form of 'truth'. A confession of a slave was only valid if it was extracted under torture on the assumption that slaves could not be trusted to reveal the truth voluntarily (Peters, 1985). In more modern times science also played a part in reinforcing and perpetuating the rationale for slavery. Samuel G Morton, an anthropologist who collected and measured hundreds of human skulls, used his influence to make the case for black inferiority and in doing so 'scientifically' rationalise the enslavement of Africans⁴. The 20th century saw the emergence of new forms of 'slavery' in which millions of people were reduced to 'worthless prisoners' in the Nazis' concentration camps or in Stalin's Gulags.

It has taken thousands of years for the world to recognise that slavery, like torture, is wrong and in doing so create the moral and legal framework for it to be abolished. Today's victims have a sophisticated network of professionals supported by national and international laws designed to protect the victim and punish the perpetrators. The modern day survivor has true rights, a concept unknown to our ancestors⁴. Each generation confronts new forms of these ancient practices that remain extremely

⁴ However it was only a short time after the bombing of the World Trade Centre and the tragic loss of 2,996 innocent lives on 11 September 2001 that the Bush administration began to rationalise the use of torture as key weapon in the new 'war on terror'.

difficult to eradicate. What has not changed is our capacity to dehumanise and exploit vulnerable groups of people and in the process perpetrate extreme acts of cruelty that in many cases is tantamount to torture. Fredrick Douglass over 160 years ago recounted his experiences at the hands of Mr Covey, a 'slave breaker' whose job it was to 'tame' slaves:

I was broken in body soul and spirit. My natural elasticity was crushed, my intellect languished, the disposition to read departed, the cheerful spark that lingered about my eye died; the dark night of slavery closed in upon me; and behold a man transformed into a brute.⁴⁵

Over a century later his voice is indistinguishable from the young men and women (I refer to the victim in this paper as 'she' simply for convenience) who visit my consulting room today.

The Impact: 'Why should I tell the truth?'

I read Fredrick Douglass' words to a young woman whose experiences at the hands of her trafficker left her feeling broken, alone and unable to 'trust anybody'. Tatiana straightened up listening intently to every word. She asked the meaning of a few words. 'What is a "brute"?', she asked. I replied, 'It is like an animal.' She replied, 'He understands how I feel. I think they even treat animals better than I was treated. What happened to him? Where is he from?' I said it was written over a century ago by an American slave. She burst into tears. I asked if her tears had any words. She said, 'When I listened, I thought he expresses himself so well. I wish I could speak like that. It is how I feel. But when you said it was written over a 100 years ago it hit me this has been going on a long time. Long before I was born. It is so sad.' I said, 'It is interesting, he is a 200 year African American man but he seems to understand you better than the police.' She burst out laughing. 'Yes, that is exactly right.' In between the tears and laughter she managed to blurt out, 'It is painful but I am not alone.' She slowly gathered herself. Her breathing became more regular; she paused, smiled and said, 'Do you think he had someone who listened to him?' She burst out laughing again. I joined her. She said, 'I feel better. Thank-you' She responded to genuine concern for her pain.

Trafficking victims feel degraded, isolated and unreachable. They often

report feeling unlovable. This is of course exactly what the trafficker wants the victim to feel. As a therapist it is one's job to listen but also demonstrate to the victim in the here and now that she is not alone.

Frederick Douglass' accounts of his ill-treatment at the hands of Mr Covey were considered unbelievable because he was 'an unlearned and rather an ordinary Negro.' Here shares an experience that is not dissimilar to the modern day victim who often finds his or her account being questioned by the authorities and judged 'not credible'. Mr Douglass responded to his doubters in the following way:

'Well, I have to admit I was rather an ordinary Negro when you knew me, and I do not claim to be a very extraordinary one now... It was when I lived with Mr. Covey, the Negro-breaker, and member of the Methodist Church. I had just been living with master Thomas Auld, where I had been reduced by hunger. Master Thomas did not allow me enough to eat. Well, when I lived with Mr. Covey, I was driven so hard, and whipt so often, that my soul was crushed and my spirits broken. I was a mere wreck. The degradation to which he subjected me, as I now look back to it, seems more like a dream than a horrible reality. I can scarcely realize how I ever passed through it, without quite losing all my moral and intellectual energies. I can easily understand that you sincerely doubt if I wrote the narrative; for if any one had told me, seven years ago, I should ever be able to write such a one, I should.'

Modern day trafficking victims fear they will not be believed. Many do not have the capacity to formulate their response in the composed and lucid manner of Mr Douglass. The fear of having their experience denied, the requirement to tell the story over and over again to different people simply confirms the victim's worst nightmare. The trafficker reinforces a fear of authority that often already exists within the victim. Whether it is the fear of a parent, husband, boyfriend, relative, police force, or a Government the victim will have had many experiences of the abuse of power by some authority. They meet 'new' people with the same scripts running in their heads: that authorities are not to be trusted. One young woman after a year of treatment put it in the following way:

'Why should I tell the truth? It is the biggest mistake in my life. If you want to get help you have to lie. I will do something bad.'

"We believe you but why did you not tell the immigration person you were trafficked?" What is wrong with these...people? If they could know what it's like to be in my skin, they would not ask these stupid questions. Why do they write one thing in my refusal letter – and in my file something different? I want to kill somebody. I want to destroy everything. Why do I have to prove myself? Let's humiliate her again again and again.

*When I see the court building I cannot go in I feel so claustrophobic. All of them are my destroyers. I will lose control. I am going to smash people. The judge must have a beautiful life. How [can a Judge] judge me if he has never tasted my life? Nothing is going to help. Speak with the barrister again. Speak with the solicitor again. I am not a person with a good reputation. I am a piece of ****. Two years have destroyed me. I just need to feel safe. A place to recover and help myself.'*

This was her truth. Her experience needed to be acknowledged. She needed someone to hear it unconditionally without 'judgment'. The abusive process produces in the mind of the abused a sense of the herself as rubbish. After two years of being sexually violated, held captive, physically and morally degraded she needed to take out what had been put into her without being humiliated again. Her anger sounded big, but as a person she felt so small. She was fighting with what little she had to even remember. She had the right to say that what happened to her was wrong, First and foremost to herself. Then to me as her therapist. She was not ready to say it aloud.

Protection, Self Blame, Shame: 'At least I could keep the money'

A young woman is battered by her boyfriend in Moldova. She goes to the police. The officer responds, 'What did you do to deserve it?' As a woman in her country she felt as if she were a subclass of humanity not worthy of protection. When she was trafficked to the UK she was arrested and the Home Office removed her back to Moldova. It was the final betrayal.

She described her experience in the following way:

'I had a very loving supportive family and a wonderful childhood. My father died when I was only 13, which made life very difficult financially and being the oldest of five children I felt that I had the responsibility to go and get a job and help to support my family, as there was no other help from the local authority.

At the age of 14 I got a job as market trader and continued to support my mother and my other siblings. At the time I had a boyfriend who was very violent and abusive; every day I was beaten up and went to work with black eyes. I have approached the police on several occasions but they did nothing to help me and only told me that I must have done something to deserve it. This did nothing for my confidence and made me feel vulnerable.

One day one of my trusted regular customers who always bought products from my stall over the years offered me the opportunity to come to England. At that time it sounded a very good idea to escape the abuse and to start a new beginning.

I took the opportunity but when I got to England I found my whole situation worse than the situation I left behind me. I had to have sex with 40 men a day - these men were as old as my uncle and as young as my brother - for as little as £20 pounds and when I refuse to have sex with them the traffickers told me that I had to pay back £20,000 and I was not allowed to leave the country until the debt was cleared or my family would be killed.

After three months of sex slavery I was arrested and deported back to my home country with no money at all. I felt dirty, ashamed and helpless. I could not look in my mother's eyes; I felt that she and everyone around me knew that I have been used as a prostitute. I could not approach anyone to tell my sorrow, which made it difficult, and I felt like I did not belong there any longer. What else could I do with my life? Next time I would sell myself. At least I could keep the money!'

She was later re-trafficked to the UK.

Many years later she questioned whether anyone could ever love her. 'Michael', she said, 'I have [been forced to have sex with] so many men. How could anybody love me?' She reckoned it had been in the thousands. She hated the prostituted part of herself. It became the split off, disowned part of her personality that needed to be welcomed home. The question was not how could anyone else love her but could she ever love herself again.

Duty – the Power of Culture, Family and Personal Beliefs: 'Why weren't my parents like you?'

Not long ago I was working with a young woman from China who was sold to a snakehead gang by her stepmother and her father. At first she had no words to express how she felt. Her responses were monosyllabic. As a girl she had learned early in her life that what she felt was of no consequence. It was alien to her that someone should be interested in how she felt. She felt angry that her brother was treated differently. She listened to the conversations her stepmother had with others in her village about selling her. She eventually found the words, 'I felt that I owed my father a debt for bringing me into this world. I hated my stepmother but I loved my father. I thought that after I paid this debt I would be free. My life would be my own.' Her eyes filled with tears, 'You are a stranger but you have shown me more kindness than my own parents. Why? Why do you do this? It is not right. Why did all these terrible things have to happen to me? Why do I have to come all this way to find kindness? Why weren't my parents like you?' It is a good question. We take compassion for granted but it is something as precious as the air we breathe.

Exploitation of Trust by the Trafficker

The trauma the victim experiences has its origins in human relationships. Human trafficking is different from the trafficking of arms or drugs because human beings make choices. One does not need to build a relationship with narcotics to control it and transport it from place to place. But one needs to build a relationship with 'human cargo' to transport it. The trafficker must identify and understand the victim's needs in order to exploit those needs, drive the victim's decisions and ensure

that the victim complies. Establishing trust and then betraying that trust is central to the relationship between the victim and perpetrator. Once the victim's mind is moved - she is prepared to take the decisions that will set her journey in motion - the transportation of the 'body' from one place to another becomes a simple matter of logistics.

Traffickers are adept at targeting the very basic things that people are conditioned to want and need: trust, love, attention, positive feedback, affection, dreams, protection, safety and rewards. The wanton exploitation and violation of these needs is an assault on basic humanity. The victim feels less than human. The fact that so many victims describe themselves as feeling less than an animal is testimony to the brutal success of the process. The perpetrator takes the decision in which his or her own self interests are more important than propriety, rules, regulations and common morality.

Victim Control: 'I had a hand in my enslavement'

The *control* of the victim is of paramount importance. Stripping the person of their humanity is the way that slaves have been broken and controlled for centuries. The fact that the modern day victim has choices that slaves in the past did not have only adds to the psychological complexity of the situation. However, these 'choices' are as much conscious as they are unconscious, often rooted in a person's attachment system, developmental history and basic survival needs. The notion internalised by the victim that 'I had a hand in my own enslavement' through choices they have is as fundamental to 'breaking' the person as is whatever additional brutality is meted out against the victim once the true intention of the perpetrator reveals itself. Even though the choices are based on deception, the exploitation of one's hope and desperation he or she carries the humiliation of having arrived in such tragic circumstances.

The victim's own self-loathing and shame breaks her from the inside. The seeds of the victim's undoing are sown in the decision to trust in the intentions of her fellow human being. The betrayal of all that is good and decent in human relationships is fundamental to breaking the trafficking victim. She becomes convinced of her own 'sub-humanity'. That is not to say that trafficking victims do not demonstrate extraordinary resilience and capacity to survive in the most harrowing of circumstances. Survivors experience many complex feelings. Survival may be a matter of luck or

circumstance, or the consequence of resilience and ingenuity. It may come at a terrible cost, and experienced with profound feelings of guilt and shame. I have never met a victim where this issue did not dominate her inner world. It is *her* part in making the 'choices' that represents rock against which she is shattered.

This was the case of the Chinese woman mentioned earlier in this paper. From the time that she was born she had no choices. She was conditioned as a girl within her culture to obey, respect her elders and honour the 'traditions' of her village, even if one of those traditions is the selling of their sons and daughters abroad by parents who may want to believe they are sending their children to a better life but whose goal is to raise money. The State too can betray, by to meet its international obligations to protect vulnerable groups such as women and children. Cultural attitudes towards women within certain societies represent a betrayal within that culture of a woman's right to be treated equally. The betrayal is perpetrated by an individual who flourishes in such conditions and targets the vulnerable. The betrayal may come all at once or take a long time but when it hits, it is the psychological equivalent of a tsunami in which the emotional and relational foundations upon which we have built our lives is, in some cases irredeemably, destroyed.

One victim I worked with put in the following way:

'The traffickers and the pimps are very good at controlling. You don't even realise it at the beginning. He has a simple conversation with you, but he's learning all about you. Then it starts to become more heavy. He controls when you wake up, who you see, who you talk to, calling on your mobile 24/7.

In the beginning he asked me if I wanted to use his mobile phone to call my family. I was really happy thinking he was generous and kind. I didn't have much money at the time so I was really grateful. Afterwards he would ask me questions about my family and other stuff. But once he had all my numbers everything changed. He said he'd talked to my sister and my mother. He said he'd told them that I was working as a prostitute⁵. I was horrified. Then he laughed. Did he call my sister and my mother? I didn't know. He had beaten me with his mind. I felt it physically

⁵ She wasn't. This was before she was trafficked.

even though he didn't touch me. My body collapsed. If my family knew I would kill myself. I did everything he wanted after that but the pressure never ended. Bad people always win. What is the point of goodness? Spend one week with these shit people who play with your mind and I guarantee, you Dr. Michael, you will go down.'

Understanding and Misunderstanding Personal Choices: 'Why didn't she just run away?'

The 'needs' that the trafficker exploits in the victim may be socio-economic, cultural or rooted in our earliest stages of development such as the need to feel safe, loved and secure. Here there are similarities between the trafficker and torturer. The torturer is also seeking to identify and exploit the victim's vulnerabilities. However, whereas the objective of the torturer, namely to inflict torture, is clear to the victim, the aim of the trafficker remains hidden until it is too late for the victim to respond effectively. The fact that the victim *has* made choices, albeit in hindsight poor ones, or does not even believe that she even has a choice intensifies the feelings of self hatred. 'How could I have been so stupid? Looking back I can see now it was all a big setup.' The victim's own sense of incredulity is mirrored by officials who often find that she was a 'willing victim' because it is simply not believable that the victim did not reach out to ask for help.

The same culture of disbelief which victims of domestic violence suffered 30 years ago is not dissimilar to what is faced by modern day trafficking victims. Why remain trapped in a violent and abusive relationship? Why doesn't she simply leave? Over the 20 years that I have been working with victims who have suffered egregious violations of their human rights and dignity these two questions consistently come up in relation to human trafficking. After all victims of human trafficking often come into contact with members of the public and the authorities - but they do not necessarily identify themselves as victims, may fear to seek assistance, or don't even see themselves as having the capacity to ask 'please help me' to a stranger.

'She was not "imprisoned". She was "walking around". Why didn't she just ask for help?' It is counter-intuitive, for those who commence an

assessment with personal disbelief, to accept that a victim would remain in an exploitative relationship when there appear to have been many avenues through which the victim could have escaped if she had really wanted to. I was once presenting a case study of a victim of human trafficking. A member of the audience raised his hand and asked, 'How could she [the victim] be so stupid?' I replied, 'She was young, naive and fell victim to a predator. But not stupid. Their trauma is rooted in betrayal and a desperation that blinds them to the risks of their journey in the hope that whatever happens it cannot be worse than the life they are leading at moment.'

Destruction by Design: Somewhere over the rainbow

Trafficking and torture share the same aim of breaking down the victim's defences. The victim of trafficking, however, is *made to feel safe* by design. Human cargo requires one to relate to it, encourage it, to get it to believe that the choices are good ones. The victim in essence must feel safe and trust the perpetrator to begin the journey. The idea is nurtured that 'somewhere over the rainbow' there is safe world where, 'dreams come true'. The myth is created and then destroyed. One is reminded of Dorothy in 'The Wizard of the Oz' the 1939 American film in which Dorothy, an orphan raised on a bleak farm in Kansas, dreams of a place somewhere over the rainbow where dreams come true. But over the rainbow, in a magical technicoloured land of new possibilities, she is confronted by the Wicked Witch of the West. Her new world comes crashing down (I'll save the ending to the end of this paper.) In the real world when the betrayal is played out by the trafficker and the victim is faced with the 'Wicked Witch of the West', whether it is in the form of brutal physical torture and or psychological coercion, the destruction of the belief in one's self and the loss of faith one holds in others is profound and in many cases complete. Self hatred, toxic self blame and shame are the outcomes.

Trafficking is designed to force the victim into a position of isolated helplessness, in which the victim's own decision-making process is used against her. The only person to whom the victim can turn for relief from her suffering is the perpetrator who is implacable, hostile or even gratified by the victim's experience. Trafficking is the total abuse of power.

Trafficking is the abolition of love. The trafficker must strip the other's humanity. He or she must not see in the eyes of the victim the eyes of a daughter, son, sister, mother, or brother. How could they do what they do if they did? It is the annihilation of empathy. Why was it that the Nazis didn't find it that difficult to get people to run their death camps? What was it that allowed the camp guard to go home and tuck his own children into bed while committing genocide against the children of his neighbours? It seems that throughout history there have been and will be the Mr Coveys of this world, a God-fearing member of the Methodist Church capable of whipping a man until the poor soul's humanity is flayed away along with his skin. I met a young trafficking victim who had screamed at her trafficker as she was being raped by him, 'Think of your sister. How can you do this? Please stop.' It only intensified and fuelled the man's rage. The rape was a way of destroying the very thing that she was asking him to remember, that she, like his sister, was a human being. She never said it again.

The trafficker creates scenarios in which the victim eventually learns that ultimately there is no possibility of influencing the outcome. Even compliance leads only to more manipulation. A victim might be strong and resolute yet the psychological pain can destroy the integrity of a person's mind and body, and their loyalty to friends and ideals. It is a dehumanising. Core to the experience is the victim's terrifying and all-consuming sense of helplessness, and the devastating recognition that the harm done to her is intentional. The most basic adult decision-making processes are systematically undermined. Deprived of her liberty she is deprived of all that is natural about her bodily functions, for example she may not even be able to decide when or where to go to the toilet. This may seem trivial, until the victim is forced to soil herself. She will be told by her trafficker to insert a sponge during her menstrual cycle so she can continue to service the customers. A young Vietnamese boy will be locked up in a house 24/7 to tend cannabis plants. He has no access to the outside world until the house is raided by the police.

Trafficking represents the total loss of the control of one's world. It is designed to take the person back to her earliest stages of development in a process of enforced psychological regression. The objective is to break down the victim by making her childlike and dependent so that mature defences crumble. The only escape is into the most primitive defensive survival mechanisms. The victim becomes completely reliant

on the trafficker for her survival, analogous to the extreme cases of child abuse and domestic violence. Trafficking robs the victim of the most basic modes of relating to reality. The sense of time is warped by sleep deprivation. The victims have nothing familiar to hold on to: family, home, personal belongings, loved ones, language, name. Gradually, they lose their mental resilience and sense of freedom. They feel alien – unable to communicate, relate, attach, or empathise with others (Bowlby, 1969).

The aim is not only to break the person in a conventional sense, but to reformulate the personality by an assault on connections between one's mind and body and on the victim's relationships to other human beings. The victim's sense of attachment (relationship) to other human beings, developed over years from infancy is destroyed. The damage to a person's capacity to form and maintain relationships, together with enduring personality change, helps to explain the profound problems faced by trafficking victims in rebuilding their lives after release⁶. The loss of safety, direction, and the ability to detect or respond to cues of danger can set off a chain of events leading to subsequent or repeated trauma exposure throughout adult life.

The release from the exploitative trafficking scenario may of course arise from accident or design.

Clinical Classifications of Traum-based Harm: From Soldier's Heart to Complex Trauma

Our greatest writers have described the-after effects of traumatic events: William Shakespeare in 'Coriolanus' and Charles Dickens in 'A Tale of Two Cities', and a variety of attempts to formulate the ways in which human beings respond to images and experiences of catastrophic violence and loss. A classification of these responses has evolved over time and reflects the historical, social and cultural contexts in which the observations were made.

Palpitations suffered by soldiers under combat conditions during the American Civil war were known as 'Soldier's Heart', generally classified as a physical manifestation of an anxiety disorder, or a somatoform autonomic dysfunction. It was first observed in Union Soldiers in hospitals away from the field. Da Costa believed that the symptoms developed

⁶ Throughout history other terms have been used such as 'battle fatigue', 'concentration camp syndrome' and 'war neurosis'.

due to the level of stress that was maintained during a Civil War soldier's active duty. These symptoms were primarily cardiac in nature, including: chest pains, palpitations, breathlessness, and extreme fatigue with or without physical exertion.

The term 'shell shock' was used by psychiatrists to describe the presenting symptoms of soldiers who had been subjected to the relentless bombing and intense hand to hand combat in the trenches in World War I. The British psychiatrist CS Meyers, who in 1915 coined the term, described soldiers' reactions to trauma as follows: 'The normal personality [is] replaced by an "emotional" personality. Gradually or suddenly an "apparently normal" personality returns - normal, save for the lack of all memory of the [traumatic] events; normal, save for the manifestation of somatic, hysteric disorders indicative of mental dissociation.'⁷. Doctors argued that a bursting shell creates a vacuum, and when the air rushes into this vacuum it disturbs the cerebro-spinal fluid and this can upset the working of the brain. The reality was that the horrors of watching comrades being blown to bits, maimed and the killing of another human being at close quarters had more to do with complete psychological and physical break down than 'bursting shells'. When Abram Kardiner recorded his observations of World War I veterans, noting that on return to civilian life 'the subject continues to behave as if the original traumatic situation was still in existence,' the foundation was set for the inclusion of Post Traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders, Versions III (DSM-III) and IV(DSM-IV) (Kardiner, 1941).

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder [PTSD] emerged in relation to the symptoms that were exhibited by young men returning to the United States from the Vietnam war¹. As much as it was a medical diagnosis it also allowed people to inhabit the sick role with dignity². Now psychologists are applying their understanding to the experiences of the 'victims' of the modern day slave trade³. Though the examples may appear to be profoundly different, I am reminded how betrayal featured in the experiences of those young. What they believed they were fighting for and what they found on the ground were two different things. Their world view imploded along with the napalm that maimed and killed thousands of innocent Vietnamese

⁷ Psychiatric Times Vol 14 No 3 (1 March, 1997).

men, women and children. Is this what it meant to fight for freedom and democracy? Post Traumatic Stress Disorder was in my view as much a response to the helplessness these men felt and the horror that they witnessed, and were indeed part of, as it was to the betrayal of values that they had been taught about freedom, democracy and the 'American Way'. Their trauma was compounded by the same society that turned their back on them, labelling them baby killers and losers⁴.

According to the DSM-IV⁵, a traumatic event has occurred if "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and "the person's response involved intense fear, helplessness, or horror." Originally published in 1994 by the American Psychiatric Association, it was released in 2000 as a text revision. Earlier versions of the DSM date back to 1952. The Handbook is used by mental health professionals for diagnosing mental illness. The current diagnostic formulation of PTSD derives primarily from observations of survivors of relatively circumscribed traumatic events: combat, disaster, and rape. In contrast to the circumscribed traumatic event, prolonged, repeated trauma can occur only where the victim is in a state of captivity, unable to flee, and under the control of the perpetrator. Examples of such conditions include prisons, concentration camps, and slave labour camps. According to Judith Herman:

*'Such conditions also exist in some religious cults, in brothels and other institutions of organized sexual exploitation, and in some families. Captivity, which brings the victim into prolonged contact with the perpetrator, creates a special type of relationship, one of coercive control. This is equally true whether the victim is rendered captive primarily by physical force (as in the case of prisoners and hostages), or by a combination of physical, economic, social, and psychological means (as in the case of religious cult members, battered women, and abused children).'*⁶

Experienced clinicians have observed that victims of car accidents and natural disasters often have quite different clinical presentations to those who experienced abuse, deprivation, and/or neglect at the hands of their caregivers. The age at which the trauma occurred also shapes subsequent adaptation patterns. While the symptomatology of victims of single-incident traumas are fairly well captured in the DSM-IV

diagnosis of PTSD, victims of interpersonal trauma present with a more complex picture' as the nature of the traumatic experience is profoundly different⁷. For example it is not unusual for victims of trafficking to have experienced other forms of inter-personal violence before and/or after being trafficked.⁸⁹ Some have suffered domestic violence, forced labour or sexual exploitation in their country of origin, or have fled and been trafficked after suffering torture or persecution at the hands of the state. Others have suffered (and/or are at risk of suffering) further harm after escaping the control of their traffickers because of their specific vulnerability to being re-trafficked, exploited or subjected to domestic violence or forms of forced labour within dangerous relationships. Yet other victims have been deceived by apparently friendly associates, including 'boyfriends' as well as 'punters' (clients of prostitutes) who have offered to 'rescue' them from their exploitation situation and have then harmed, re-trafficked or exploited them further.

The term 'inter-personal violence'¹⁰ is used to refer to intentional and repeated acts of physical and/or psychological cruelty inflicted by a person or persons against individuals who are physically and/or psychologically entrapped. Psychological entrapment may involve the use of debt bondage - in some cases people who have been trafficked have never agreed to the repayment of any debt prior to their arrival in the destination country and it is suddenly imposed upon them; in others there has been the understanding of a debt, but they have not realised or agreed to the amount that they are eventually expected to pay.

Other forms of psychological entrapment may involve the use of the victim's own belief systems as a means of control. Beliefs about gender, family love, culture and religion are targeted and manipulated. Victims of trafficking from West Africa may have been subjected to 'Juju' rituals by the traffickers.¹¹ The perpetrators co-opt centuries of African belief systems and perform ritualised, often violent ceremonies in order to subjugate and silence victims through the threat of their destruction or the destruction

⁸ Banwell, S., Phillips, R. Schmiechen, M. (2002). Trafficking in Women: Moldova and Ukraine. USA: Minnesota Advocates for human Rights.

⁹ International Organization for Migration. (2002). Return and reintegration-counter-trafficking: Situation report in Kosovo. [On-line report]. http://www.iom.int//DOCUMENTS/PUBLICATION/EN/Kosovo_sit_report.pdf.

¹⁰ "Torture: The Bioethics Perspective," in *From Birth to Death and Bench to Clinic*: Steven H. Miles, The HastingsCenter Bioethics Briefing Book for Journalists, Policymakers, and Campaigns, ed. Mary Crowley (Garrison, NY: The HastingsCenter, 2008), 169-172.

¹¹ Juju is the use of charms, potions and amulets and is a Creole corruption of the French word *jou-jou* meaning plaything.

of their loved ones by malign spirits. They are entrapped by their own overwhelming fears and beliefs. In Syria there are reports of woman and girls being subjected to rape and other forms of violent sexual assaults. It has also been reported that the women and girls are then being trafficked for the purposes of sexual exploitation. The laws of Islam are said to elevate and designed to protect the women's honour and modesty. Islam - according to certain scholars - forbids women to wear clothes that are not modest and to travel without a mahram; it forbids a woman to shake hands with a non-mahram man. These messages may have been part of a young Muslim woman's culture, family upbringing and religious faith. Rape is heinous crime in any context. However, in certain cultures the mechanisms of dealing with crimes of sexual violence both in war and in peace come up against one's beliefs about what it means to be a woman or girl within that society. The woman's own sense of her honour and her place in the community has been damaged permanently. She internalizes the shame and stigma that objectively lies solely with the perpetrator and state actors who are not doing enough to prevent these atrocities. In certain cases the rapes are so violent that that they result in permanent physical damage. She may have suffered internal or other injuries as a result of the rape. However, it is the damage to the idea and belief about herself, as a wife, a mother a daughter and the sanctity of one's own body that makes her feel as if she has been permanently destroyed. These beliefs are built up over a lifetime, in the case of culture and religion over millennia. Once she has lost her faith and belief in herself the woman becomes highly vulnerable to future exploitation, which is what seems to be happening in Syria today.

As opposed to overt acts of physical violence, inter-relational aggression makes use of the victim's relationship with the perpetrator, as a means of inflicting social and psychological harm. Such acts include purposefully excluding a person from normal social activities, restricting her contact with other people, threatening to withdraw one's 'love', threatening the use of force of violence, violation of trust, threatening to expose shameful secrets, restricting access to the necessary financial resources to survive, creating and maintaining a state of absolute dependency etc. It forms the basis of a toxic bond between the victim and the perpetrator.

The cumulative impact of repeated acts of inter-relational aggression is as potentially damaging psychologically, physically, socially and morally as overt acts of interpersonal violence. The impact of inter-relational aggression is more difficult to document as the behavioural indicators

may only become apparent in the context of the victim's relationship with someone who is trying to help rather than exploit.

Trauma that specifically targets one's connection or attachment to other human beings and is repeated through one's daily contact with the perpetrator is damaging on every level. The trauma is compounded when the origin of the threat is someone with whom the victim has a connection. Whether the trauma happens early in one's developmental history or later in life, it is the system of attachment that is assaulted. The impact upon the child and the adult are remarkably similar. A child is literally dependent on the perpetrator because the child does not have the physical, psychological or other resources to liberate herself from the situation. In case of an adult the aim is ultimately to reduce the victim to a state of dependency and helplessness. The result is a form of psychological regression, where the victim is taken back to the early stages of development and violated. A perpetrator exerts total control over a victim who is psychologically and/or physically entrapped; the victim as stated earlier in this paper is forced into a position of isolated helplessness where the only person to whom she can turn to for 'help' is the perpetrator who is often implacable or even gratified by the victim's suffering. The CIA, "Human Resource Exploitation Training Manual – 1983"¹², on the theory of coercion is useful in understanding this process: the purpose of all coercive techniques is to induce psychological regression in the subject by bringing a superior outside force to bear on his will to resist. Regression is basically a loss of autonomy, a reversion to an earlier behavioural level. As the subject regresses, his learned personality traits fall away in reverse chronological order. He begins to lose the capacity to carry out the highest creative activities, to deal with complex situations, or to cope with stressful inter-personal relationships or repeated frustration.

The complexity of trafficking requires clinical assessment of individual, long term histories, not only those aspects which relate directly to the trafficking experience. Psychological and physical injuries can frequently span much or all of the lifetime of a trafficked person. Some of these injuries may be immediately apparent, but others can only be fully understood and documented over multiple sessions with a trusted clinician¹³.

¹² <http://www.gwu.edu/~nsarchiv/NSAEBB/NSAEBB122/CIA%20Human%20Res%20Exploit%20H0-L17.pdf>

¹³ This level of investigation invariably goes beyond that conducted by a 'competent authority' and allows for consideration of all the victims 'personal circumstances' (Paragraph 183 of the Explanatory Report – Action against Trafficking in Human Beings, 16.V.2005 Article 14 "... the victim's personal circumstances must be such that it would be unreasonable to compel them to leave the national territory."

Complex Post Traumatic Stress Disorder

The concept of Complex Post Traumatic Stress Disorder – Disorders of Extreme Stress Not Otherwise Specified (DESNOS)- was first introduced by Judith Lewis Herman and BA Van der Kolk (Herman, 1992) (Kolk, 1993) . Both are leaders in the field of treating survivors of extreme forms of traumatic experience rooted in interpersonal violence and relational trauma. It has been argued that experiences of prolonged totalitarian control such as where the victim is in state of captivity, unable to flee and under the control of the perpetrator, causes a disorder that is more severe, more complex and more enduring than what is defined in the current DSM classification. Symptoms associated with Complex Post Traumatic Stress Disorder include:

- » Difficulties regulating emotions, including symptoms such as persistent sadness, suicidal thoughts, explosive anger, or inhibited anger;
- » Variations in consciousness, such as forgetting traumatic events, reliving traumatic events, or having episodes of dissociation (during which one feels detached from one's mental processes or body);
- » Changes in self-perception, such as a sense of helplessness, shame, guilt, stigma, and a sense of being completely different than other human beings;
- » Varied changes in the perception of the perpetrator, such as attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge;
- » Alterations in relations with others, including isolation, distrust, or a repeated search for a rescuer;
- » Loss of, or changes in, one's system of meanings, which may include a loss of sustaining faith or a sense of hopelessness and despair.

Much of the existing research on CPTSD has emerged from studies that are looking at interpersonal trauma that occurred during key developmental stages in childhood and adolescence. However, clinical experience has born out that adult survivors who have been exposed to prolonged and severe interpersonal trauma can also manifest symptoms associated with CPTSD. This move beyond simple psychiatric diagnoses into the realms of complex trauma reactions is helpful because it moves the survivor away from a sense of being reduced simply to a naïve categorisation of symptoms and allows the individuality of the experience and, importantly, its social, political, economic and cultural context to be considered. However, in taking this step, it is also important

that the advances which have been made in the understanding of some of the simple trauma reactions and their treatment are not ignored. It is important to find the right balance, acknowledging that these conditions (especially PTSD and depression) are common in victims of trafficking and that they may be treatable, whilst at the same time recognising the complex and human nature of the experience and of the response and the limits of existing treatment paradigms.

DESNOS¹⁴ is not a coded diagnosis in the DSM-IV, although its symptom constellation has been identified in numerous research studies and its explanatory power is recognised by clinicians throughout the world (Bessel, 2005). One needs to look to ICD 10, for a formerly coded diagnosis that covers similar clinical ground to what is being addressed by DESNOS. Enduring personality change after catastrophic experience (EPCACE) is a diagnostic category included in the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10), as one of the adult personality disorders. Preliminary investigation suggests there is considerable endorsement in principle for this new category amongst experts. 'Enduring personality change is present for at least two years, following the exposure to catastrophic stress. The stress must be so extreme that it is not necessary to consider personal vulnerability in order to explain the profound effect on the personality. The disorder is characterised by a hostile or distrustful attitude toward the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of being on edge and estrangement. Post Traumatic Stress Disorder (F43.1) may precede this type of personality change.'¹⁵ Examples of the types of events that can cause the personality change include: Concentration camp experiences, disasters, prolonged captivity with an imminent threat or possibility of being killed, exposure to life-threatening situations such as being a victim of terrorism, and torture. Trafficking would also fall within this category.

Memory Recall: The ramifications of trafficking-led trauma

It is not surprising that victims' accounts are often filled with, distortions and contradictions, or omit a great deal.

¹⁴ As stated earlier: Complex Post Traumatic Stress Disorder – Disorders of Extreme Stress Not Otherwise Specified (DESNOS).

¹⁵ The ICD-10 Classification of Mental and Behavioural Disorders. F 62.0 Enduring personality change after catastrophic experience.

The experience at the time can be so unbearable that the person cannot encounter it directly; she can either actively forget, or the memory is subject to a process of delay (deferred action) and only activated at a later date, or most commonly there is a fundamental disturbance in the laying down of memory itself.

The affective-neurobiological effects on memory and body are well. The flooding of stress hormones released in a state of shock knocks declarative memory (chronological recall of events) situated at the hippocampus, out of action, whereas the amygdala is intensely activated, which elicits a fear response, without a memory of the event. Dissociation is frequent, coupled with high levels of arousal, a fight–flight state, rendering the trauma unassimilated; it thus remains ‘a speechless terror’. An amnesiac lack of recall is the result. The experience can be so overwhelming that all one is left with is chaotic fragmented images, somatic affects, and bodily enactments (Yovell, 2000) (Schore, 1994, 2000). Experientially, the person does not quite witness what has happened because the moment as such, in some important sense, is missed and only later relived.

The Relationship between Victim and Perpetrator: Attachment and the trauma that bonds

It is clear that the attachment the victim forms with the perpetrator is complex and powerful. It has been discussed throughout the medical literature on trauma¹⁶. The question of why victims seem to choose to remain in abusive relationships – a response that appears illogical – has been posed by many researchers. One of the most difficult behaviours to comprehend is when the victim seems to have formed an emotional attachment to the perpetrator. Those of us who have worked in the field all have come across cases of women who remain loyal and continue to ‘commit’ to the men who trafficked and sexually exploited them through prostitution. In domestic violence cases the victim continues to love the man who batters her. Such women may not even relate to the idea that they are victims.

A young woman from central Africa who was trafficked to the UK for the purposes of labour exploitation called her mother on a regular basis to

¹⁶ Prax Kinderpsychol Kinderpsychiatr. 1996, Jul–Aug; 45(6):198–205.

tell her of the abuse that she was being subjected to at the hands of her 'employer'. She was desperate to go home but her mother told her to remain and that she 'would talk to the woman'. The victim made it clear that she was being subjected to physical and psychological abuse, that the working conditions were brutal, and that she was made to sleep in the closet under the stairs like a dog. The promise of attending school was broken. She wanted to come home. However, she obediently complied with her mother's wishes and remained in a position of enforced servitude. She was in fact referred for treatment because the police were puzzled as to why she kept on saying that she was 'guilty' even though they had all the evidence required to prosecute her trafficker. It took this young woman several months of treatment before she began to comprehend that there was anything strange or wrong with her mother's behaviour. Later it was discovered that her 'guilt' was born out of a sense that she must have done something to displease her mother. Otherwise why would her mother have sent her to this terrible place? In her mind, she must *deserve* to be punished.

As far back as 1936, Anna Freud in her book *The Ego and the Mechanisms of Defence* attempted to understand the identification of victim with the aggressor. When threatened with repeated violence, whether it is within a family or concentration camp, Freud postulated that the victim will emotionally identify with the aggressors rather than resist them. It is a form of psychological defence designed to preserve the victim's sanity. Ferenczi (1933) considered that when we feel overwhelmed by an inescapable threat, we 'identify with the aggressor'. Hoping to survive, we sense and 'become' precisely what the attacker expects of us – in our behaviour, perceptions, emotions, and thoughts. Other theories such as Traumatic Bonding, Stockholm Syndrome and Learned Helplessness have more recently tried to explain the bond formed between the victim and perpetrator.

Donald Dutton and Susan Painter's paper 'Emotional Attachments in Abusive Relationships: A Test of Traumatic Bonding Theory' published in 1993 was the seminal work on traumatic bonding theory. They postulated that, 'traumatic bonding, [is where] powerful emotional attachments are seen to develop from two specific features of abusive relationships: power imbalances and intermittent good/bad treatment'. Dutton and Painter (1981) liken this attachment process to an elastic band which stretches away from the abuser with time and subsequently 'snaps' the

woman back. These behaviours have a neurological basis as sustained and overwhelming states of helplessness and fear produce actual changes in the brain that make it extremely difficult for the victim to free him or herself from the state psychological bondage that has been created with the perpetrator (Post, 1992) (Yehuda, 1999). Attachment deepens with terror. Furthermore the idea that attachment is strengthened by intermittent good/bad treatment is counterintuitive and still 'beyond the ken' of most people (Ewing, 1987). The theory of learned helplessness was based on research initially conducted with dogs. Martin Seligman, a psychologist, placed dogs in cages and administered random shocks to them. Like most domestic violence and trafficking situations, the 'shocks' were not based on the dogs' behaviour in any way. The dogs tried to escape from cages and tried to avoid the shocks, but nothing worked. Eventually they stopped trying since their attempts were repeatedly unsuccessful. Even when researchers tried to teach the dogs to escape the dogs were hesitant. It wasn't until repeated efforts were made by researchers (eg dragging the dogs to their escape) that the dogs finally learned to escape and avoid the shocks. One important aspect of the theory is that even when it was apparent that the dogs could escape they did not do so because of learned helplessness. They had reached a point where they had been conditioned that nothing they did would help them to prevent the shocks (Peterson, 1987). The trafficked woman's perception of her own control over her own situation has a great deal to do with it. Even if she were able to escape, if she believes that she cannot leave or survive on her own, she will not leave. Walker (1979) theorised that some women remained in physically and psychologically abusive relationships because of extreme fear and the belief that there is no escape. The victim also feels as though she has no choice but to remain in an abusive situation. This syndrome develops over time, as the cycle of violence occurs and the person loses hope and feels unable to deal with the situation. The victim may continue to try and attempt, within the abusive situation, to minimise the abuse but the actual thought of leaving recedes as a possibility. Core to the helplessness includes both the lack of control and failure. Learned helplessness response is a consequence of (a) repeated exposure to traumatic events and stimuli that were as unpredictable as they were dangerous; (b) in which there was zero possibility of the victim influencing the outcome of the events. It is essentially the experience of uncontrollable failure to solve a problem originally perceived as solvable. Crucial to understanding human learned helplessness one should analyse the meaning a person attaches to the uncontrollable failure.

The significance of the Five Fs - freeze fight flight fright faint - response is becoming increasingly important in our understanding of the human adaptation to stress. Maggie Schauer and Thomas Elbert postulate that the cascade “Freeze-Flight-Fight-Fright-Flag-Faint”... “is a coherent sequence of six fear responses that escalate as a function of defense possibilities and proximity to danger during life-threat. The actual sequence of trauma-related response dispositions acted out in an extremely dangerous situation therefore depends on the appraisal of the threat by the organism in relation to her/his own power to act (e.g., age and gender) as well as the perceived characteristics of threat and perpetrator. Repeated exposure to traumatic events forms a fear network that can become pathologically detached from contextual cues such as time and location of the danger... Thus, survivors of life-threatening events with PTSD become “stuck” in the trauma.”

The past as it were hijacks the present. This has enormous implications for our work with victims of trafficking as many will have gone through each one of the five stages multiple times in response to the trauma to which she has been exposed. It has been hypothesized that individuals who go through each one of the stages is prone to higher levels of dissociation and problems with affect regulation subsequent to the traumatic experiences. Trauma fundamentally becomes a problem of affect regulation and robs the person of his or her capacity to live in the present. Treatment therefore must engage with that part of the trauma that resides in the subcortical non declarative systems of the brain.

Reflections

In writing this paper I realise that its readers will reflect the diversity of people who have an interest in this subject. You may be an experienced professional or just starting to explore this work. It is important to remember that we bring our own values, born out of our upbringing, culture, and professionalism. We may find it incomprehensible that children should be bought and sold by their parents or turned into child soldiers. In our culture JuJu or witchcraft is a simple superstition but for the young victim from Nigeria the power it holds over her is real and trying to convince her otherwise can make things worse. Whether one is a police officer, immigration official, lawyer, judge, feminist, psychologist, NGO specialist or social worker we bring who we are to the problem including our own problems.

The psychologist is typically concerned about the victim's trauma. He or she will be asked to prepare a report and provide a diagnosis. There are models of good practice in preparing reports such as the Istanbul Protocol the Manual for Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1999 (Istanbul Protocol). An important tool in the prevention of torture and the fight against impunity is the effective investigation of torture. The same should apply in trafficking cases. Are the physical and psychological findings consistent with the alleged report of trafficking? What physical conditions contribute to the clinical picture? Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual? Why was she late in disclosing crucial details related to her immigration claim? What clinical reasons could there be for inconsistencies? What kind of treatment will she require? These are just a few questions that a mental health professional might be expected to answer with respect to a victim's allegation that he or she has been trafficked. Simply cutting and pasting the Istanbul Protocol and applying it the case of to victims of trafficking would be a grave mistake, but it does serve as model for good practice and a solid starting point on which to build a more specific protocol related to human trafficking.

The police investigating will rightly be concerned about the evidence trail, the testimony and prosecuting the trafficker. They will have been building a case that seeks not to rely completely on the victim's testimony. Officers recognise they have big hurdles to overcome if they are to demonstrate to a victim whose experience of the police in her own country has been less than positive that they are.

The immigration authorities in every country are tasked with protecting the nation's borders. However, the skills necessary to identify victims of trafficking are highly specialised and one must seriously question whether identification should be left to them. Their primary concern is the authenticity of the claim. 'Is this person a genuine trafficking victim?', or, 'If she is a victim is it safe to send her back?'. They do not aim to build a relationship of trust with the 'applicant'. They will want to know whether or not the victim is co-operating with the police. Is the victim's story consistent? They will measure the case against existing case law and, hopefully, their obligations under the law. Why was the victim late in disclosing crucial details about their trafficking? A case worker may raise doubts about the victim's credibility that are often at odds with facts that

have already been confirmed by the police or expertly commented upon by trafficking specialists from NGOs. The legal representative wants to ensure the client is properly represented but may find it difficult to get a coherent story, and will refer the client to the psychologist or other mental health professional for an opinion. The victim is having to tell her story multiple times to different people all of whom have different agendas. Universally a victim finds this profoundly difficult as more and more people get to know about their shameful and degrading secrets. Often the retelling reproduces harm and pain.

In Conclusion

Trafficking is an abuse of power. It is a betrayal of all of that is good and decent in human relationships. As Fredrick Douglass put it over 160 years ago, 'behold a man transformed into a brute.' Trafficking strips the victim of his or her humanity. It is an experience that teaches people harsh lessons about the innate cruelty of their fellow human beings. Many of these lessons are first learned in the family. The family is where we learn to be a person. Many of the victims I have seen have had difficult beginnings in their own families. Time and time again I hear how the family of origin story is marred by neglect, poverty, abuse and cruelty. Others are not. These lessons are often repeated with different people and in different forms. The family analogy extends to us as ; there are many different and at times competing interests when it comes to our responses to victims of human trafficking. We must not mirror the dysfunctions that have blighted the victim's life. If we do, we compound their trauma and confirm that they are living in a dangerous and unpredictable world, and one where she should expect no decent and fair treatment from their fellow human beings. When we work well together we have the power to transform the victim's experience of authority into something that is positive and compassionate.¹⁷

Dorothy survived her ordeal in Oz because she met in others the qualities of the heart, courage and mind as embodied in the tin-man, the lion and the scarecrow. The Good Witch of the North brought her own special skills to the situation, including wisdom, kindness and understanding. We would do well to remember these qualities as we go about our work with those who have been trafficked.

¹⁷ Martin Luther King's speech 'I Have a Dream', delivered 28 August 1963, at the Lincoln Memorial, Washington D.C.

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**Complex trauma
and severe forms of
human trafficking:
Implications for
practice**

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The impact of traumatic experience on an individual's psychology is essential for mental health professionals to understand. It is important because the way that our clients think and feel about themselves and the relative safety of the world around them has meaningful implications for recovery from trauma and subsequent quality of life. Human trafficking or modern slavery is a violation of basic human rights in which one person benefits from the exploitation of another, through forced labor or commercial sex. Trauma, to varying extents, is often a part of this exploitation. This article will provide an overview of human trafficking and complex trauma, with an emphasis on trauma associated with sex trafficking of women and girls. Given the research regarding the experiences of women and girls, in particular those involved in the commercial sex industry through sex trafficking or prostitution (Farley, Baral, Kiremire & Sezgin, 1998) the clinical focus will pertain to clients whose histories are characterized by early relational abuse and neglect and sexual trauma. Treatment will primarily be addressed from an Attachment Theory and Object Relations, trauma informed approach.

Human Trafficking

"Human trafficking" or "trafficking in persons" and "modern slavery" are terms often used interchangeably to refer to a variety of crimes associated with the economic exploitation of people. The United Nations Convention against Transnational Organized Crime, which

was adopted by U.N. General Assembly resolution 55/25, is the primary legal instrument used to combat transnational organized crime (<http://www.unodc.org/unodc/en/treaties/CTOC/index.html>). It was signed by member states of the U.N. at a conference in Palermo, Italy on December 15, 2000 and was entered into force in 2003 on the 29th of September (<http://www.unodc.org/unodc/en/treaties/CTOC/index.html>). The Convention is supplemented by three Protocols, each of which focuses on specific types of organized crime. Of relevance is the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children and Article 3 of this protocol defines human trafficking as follows:

“Trafficking in persons shall mean the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs” (Europol, 2005, p. 10).

While there have been disagreements about and variations on the definition of human trafficking among practitioners, scholars, activists and politicians (Laczko & Gramegna, 2003; Richard, 1999), this definition is commonly used by those working to address the issue. The definition comprises three essential parts: recruitment, movement, and exploitation, all of which point to critical aspects of the trafficking process. It is important to note that it is not necessary for “movement” to include crossing from one country into another; an individual can be trafficked within the borders of her or his own country, town and can even be trafficked from the home in which she or he lives.

Also critical to understanding human trafficking is understanding what is meant by coercion. The term “coercion” in this context specifically refers to (a) threats of harm to or physical restraint against any person; (b) any scheme intended to cause a person to believe that failure to perform an act will result in harm or physical restraint against any person; or (c) the

abuse or threatened abuse of the legal process. However, it is essential to take other factors into consideration with regard to coercion, in particular when working with victims of sex trafficking and prostitution, such as whether the individual had any legitimate alternatives to support her basic needs (Hernandez, 2001) when approached by the pimp (trafficker). If not, then the thinking is that desperation to perform responsibilities such as support a child and feed and keep one's self safe, can be a form of coercion.

Who is at Risk for being Trafficked?

In popular stereotypes victims of human trafficking are often portrayed as innocent young girls who are lured or kidnapped from their home countries and forced into the commercial sex industry (Bruckert & Parent, 2002). While this is not necessarily an erroneous depiction, women, men, and children of all ages can be trafficked for sex and labor. Those at risk of trafficking most often come from vulnerable populations including undocumented migrants, runaways and at-risk youth, females and members of other oppressed or marginalized groups, and the poor. Traffickers target individuals in these populations because they have few resources and work options.

Traffickers manipulate and control victims and are known to make use of a combination of violence and affection in an effort to cultivate compliance and sometimes loyalty in the victim. This can sometimes result in *Stockholm syndrome*, a psychological phenomenon wherein hostages experience and express empathy and positive feelings for their captors. This psychological manipulation reduces the victim's likelihood of acting out against the trafficker and may lay the groundwork for a more complex trauma reaction in victims.

Regions impacted by political instability and war create an environment that fosters trafficking. In particular, long-term military occupation as well as the presence of "peace keepers" feed the commercial sex industry in these areas and facilitate the sex trafficking of women and girls (United Nations Development Fund for Women/UNIFEM, 2002). Another situation that promotes trafficking is that of natural disaster. Natural disasters can destroy communities in a matter of minutes and create physical and economic insecurity. Children can be separated from their caregivers making them prime targets for traffickers. Natural disasters do not only impact children however, they increase adult vulnerability to trafficking

as well. The kind of devastation imposed by disasters of this type can create extreme poverty and make it very difficult to meet basic needs. This for example, may lead to immigration during which the likelihood of victimization at the hands of a trafficker is increased.

Worst Forms of Human Trafficking

Categorization of trafficking by the nature of the work performed is a common although misleading practice. Categories of labor and sex trafficking are most often used, though concerns have been raised that this separation may serve to make invisible, the sexual exploitation that occurs for most women in this situation, even if they are involved in what might be described as a labor trafficking situation. In other words, a woman may be trafficked primarily for domestic servitude, however it is likely that she will be forced to engage in sex acts as well. This speaks to the unique vulnerabilities of women and girls when it comes to trafficking.

Sex trafficking is an extremely traumatic form of human trafficking in which a commercial sex act is induced by force, fraud, or coercion; or a commercial sex act in which the person induced to perform is under 18 years of age. Victims of sex trafficking can be girls, boys, women, or men -- although the majority are girls and women. Sex traffickers use a variety of methods to control and “break-in” victims including confinement, physical abuse, rape, threats of violence to the victim’s family, forced drug use and more. Victims of this form of trafficking face numerous psychological and physical health risks.

Child trafficking involves displacing a child for the purpose of economic exploitation. In the case of children, force, fraud and coercion do not need to be demonstrated. It is estimated that 1.2 million children are trafficked each year (UNICEF, 2009). Like adults, children are trafficked for the purpose of labor and sexual exploitation.

Worst forms of child labor is a term that refers to child work that is seen as harmful to the physical and psychological health and welfare of the child. The International Labour Conference in 1999, adopted Convention No. 182 concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour. The sale and trafficking of children is noted in this convention as one of the “unconditional” worst forms of

child labor. Other unconditional worst forms noted in the Convention include “the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances” and “the use, procuring or offering of a child for illicit activities...”

Child soldiering is a form of human trafficking that involves the use of children as combatants; it may also involve children forced into labor or sexual exploitation by armed forces. In this case, traffickers may be government military forces, paramilitary organizations, or rebel groups. In addition to being used directly in armed conflict, children may be used for sexual purposes or forced to work as servants, cooks, guards, messengers or spies.

Trauma and Sex Trafficking

Trauma is defined as an experience that threatens one’s sense of safety and security and may or may not involve physical harm. Generally, trauma is experienced as either a single or a repeating event that overwhelms an individual’s coping mechanisms and interferes with one’s ability to integrate and make sense of emotions and thoughts related to the experience. According to the Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association, 2000), a traumatic event is one that involves “actual or threatened death or serious injury, or a threat to the physical integrity of self or others” and one in which “the person’s response involved intense fear, helplessness, or horror” (pp. 218-219). A wide variety of events can be characterized as traumatic. For example, naturally occurring or human made catastrophic events such as dangerous storms and war or interpersonal violence such as intimate partner violence, rape and emotional or physical abuse. Human trafficking, whether for labor or for sexual exploitation, may be experienced as traumatic by the victim. The extent to which the victim is traumatized depends on the specifics of the situation and on the perspective and previous trauma history of the victim.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is the name used by the American Psychiatric Association for the symptom clusters that sometimes

develops in those who have experienced a trauma (APA, 2000). The three symptom clusters are characterized by a reliving of the event in ways that are disruptive to daily functioning. The symptom clusters include “intrusive recollections” (e.g., flashbacks, recurrent distressing memories), “avoidant/numbing symptoms” (e.g., feelings of numbing or detachment, avoidance of places, people, etc. that remind the victim about the event) and “hyperarousal symptoms” (e.g., difficulty concentrating, hypervigilance, exaggerated startle response). Responses to trauma may be acute and/or chronic and it is important to keep in mind that different people respond to trauma in different ways, and not all develop PTSD. There are some indicators however, as to who may be more likely to develop PTSD following a traumatic event (Halligan & Yehuda, 2000).

The indicators include:

- » Magnitude of the traumatic stressor
 - › Individuals for whom the traumatic stressor is characterized by stronger magnitude and intensity are more likely to develop PTSD.
- » Individuals whose traumatic experience was sexual victimization
- » Sense of control
 - › Those who feel a higher lack of control over the trauma are more likely to develop PTSD. This speaks to the notion of recovery as at least partly related to restabilizing and feeling more in control of one’s safety. For those who are unable to notice ways in which things may have been different with regard to prevention of the trauma, the ability to feel safe and in control are compromised.
- » Sense of responsibility
 - › Conversely, those who have a real or perceived sense of responsibility over the occurrence of the traumatic experience are at increased risk for developing PTSD symptoms.
- » Intrapersonal variables
 - › Trauma experiences where the victim feels betrayed by a loved one or by some other meaningful person who the victim trusted puts the victim at increase risk for PTSD. This also pertains to rebuilding a sense of safety to enhance recovery, and this becomes more difficult when the victim’s sense of connection and support is compromised by not knowing whether s/he can trust the love of important people in her/his life.
 - › Similarly, those with limited social support are more likely to develop PTSD symptoms.
- » Concurrent stressful life events

- » Age of onset
 - › Victimization at earlier life stages increases the likelihood that PTSD symptoms become a part of the post-trauma experience.

Finally, when thinking about PTSD, it is important to keep in mind that the cessation of symptoms may not be permanent. As initially described in 1960 by Parod and Caplan, it is possible for the reemergence of symptoms after the initial crisis period following a trauma has passed. This may occur following exposure to a “trigger” or the occurrence of another trauma and is more likely to emerge as problematic for those who have not fully processed the initial trauma (Hiley-Young, 1992). However, even for those who have adjusted to a prior trauma, exposure to a new traumatic event may reactivate the emotions associated with the earlier event thereby complicating the current experience.

Complex Trauma

Much early research regarding the impact of traumatic experiences focused primarily on extraordinary events such as natural disaster and violent, unexpected trauma such as car accidents or shootings (Pynoos et al., 1987). Today however, there is more research focusing on interpersonal trauma (e.g., rape) and the most common form of trauma experienced during childhood (i.e., interfamilial abuse and neglect) and the long lasting impact that such trauma can have on subsequent development and psychological functioning (Callahan & Hilsenroth, 2005; Chapman, Dube, & Anda, 2007; Massie & Szajnberg, 2006; Putnam, 2003; Putnam & Trickett, 1997; Rich, Gidycz, Warkentin, Loh, & Weiland, 2005).

As a result of this research and based on the experiences of clinicians, there was recognition of the failure of the PTSD diagnosis to fully account for the full range of experiences following trauma and a number of authors proposed a specific diagnostic category called *complex PTSD* (Herman, 1992) or *disorders of extreme stress not otherwise specified* (DESNOS; Pelcovitz et al., 1997; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). This alternative more completely accounts for the experience of patients suffering from a wider range of persistent symptom clusters that are considered more complicated than those in PTSD.

Another way to think about a more complete picture with regard to trauma reactions, is to think about reactions as existing on a continuum based in part on characteristics of the victim and the nature of the trauma (Briere & Spinazzola, 2005). The end of the continuum characterized by less complex reactions are predominantly single-occurrence, adult-onset traumatic events. These would be one-time trauma events in which the victim is an adult with a “normal” developmental history, a secure base for attachment and no other psychological disorders. More complex trauma reactions exist on the other end of the continuum and typically include victims who are more vulnerable at the time of the trauma. This may mean earlier age of onset, multiple incident, and protracted trauma experience. The nature of the traumatic event in these situations is often interpersonal and invasive in nature, such as with child abuse or rape, as is the case with sex trafficking. Those whose psychological trauma sequel most often fits into this category are those whose trauma experience interrupts formative (i.e., earlier) developmental periods. Such individuals are at increased risk for dysregulation in various interpersonal and intrapersonal domains. Specifically, disorders of extreme stress involve lasting personality changes that are characterized by dysregulation in emotion/affect, behavior, bodily functioning (e.g., somatoform disorders), interpersonal functioning in relationships/attachment, consciousness (e.g., disassociation), self-perception/self-concept and systems of meaning (Herman, 1992; Pelcovitz et al., 1997; Roth et al., 1997; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Disassociative responses to trauma are not specific to any particular type of trauma. However, they are generally thought to be more common in situations of childhood sexual abuse (Freyd 1996) and they are a key diagnostic feature of complex trauma in children. Disassociation can be defined as the “failure to integrate or associate information and experience in a normally expectable fashion” (Putnam, 1997, p.7). In other words, disassociation interrupts “contact” across domains of functioning (e.g., thinking, feeling, emoting, etc.) Much like the way we think about trauma reactions as existing on a continuum, so too can we think about disassociation on a continuum with one end characterized by normal daydreaming and the other by disassociative disorder. Disassociation begins as a protective factor against feelings and thoughts that seem utterly unbearable. Like other protective defense mechanisms, disassociation can become problematic with regard to the extent to which it inhibits intimacy in relationships.

While more information is needed regarding the experiences of women and girls victimized through sex trafficking and prostitution, what research has been done highlights that most have a history of relational abuse and neglect or sexual trauma that predates the current situation (Farley, Baral, Kiremire & Sezgin, 1998). This means that they are more likely to be suffering from complex trauma symptoms and from a psychodynamic perspective, this calls for consideration of the impact of a possible rupture in attachment and ego development earlier in life that may influence recovery from the current trauma. Object Relations and Attachment theories are briefly outlined below and treatment recommendations are offered.

Conceptualizing the Impact of Trauma

Psychodynamically oriented and attachment theories offer a framework that can be helpful in understanding the implications of and treatment issues related to trauma. From the vantage point of these dynamic theories in which relationship with others form the basis for personality development, chaotic and abusive familial environments and other forms of early trauma can have deleterious ramifications. Trauma expert Judith Herman (1997) aptly captures the significance of early trauma when she says, "Repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms personality" (Herman, 1997, p.98).

Attachment Theory

Attachment theory was originally conceived by John Bowlby and gives primacy to the nature of affectional bonds in early life and their impact on human development (Bowlby, 1988). According to Bowlby's attachment theory, it is critical that parents fulfill their obligation to protect and provide security for children. A parent-child relationship characterized by consistent parental sensitivity and emotional availability promotes the child's development of a secure attachment orientation, one that is marked by the internalization of a positive working model of self and others. The secure attachment orientation provides the foundation or "secure base" for future relationships. Specifically, through this positive and integrated sense of self and other, securely attached individuals

are comfortably able to experience both closeness and separateness in intimate relationships (Lieberman & Knoll, 2007). Conversely according to attachment theory, when early parental caregiving is characterized by rejection or more overt abuse (trauma), the individual is more likely to struggle in relationships with others. To take this a step further, the person may develop an “insecure” attachment orientation and internalize a negative or problematic working model of self and other. This may look like a negative self model (e.g., self as not lovable) or a negative other model (e.g., other as not trustworthy or reliable).

The absence of trust and subsequent limitations with regard to attachment, preclude the child from developing a sense of control over physical skills and independence, adversely affecting initial formations of competence and self-esteem. This disrupts the later development of autonomy, and leads instead to shame and doubt (Erikson as cited in Kraus, 2008). The disruption in the development of initiative is confounded by failure to experience a sense of power and control in the child’s environment. A sense of purpose successive to initiative is compromised, and the child instead develops feelings of guilt. The quality of a child’s attachment is the primary indicator of whether she will develop the skills necessary to successfully navigate through these stages of psychosocial development, achievement of which forms the initial groundwork for feelings of competence and accomplishment related to self-esteem and trust in others.

Object Relations Theories

Similarly, object relations theories also give primacy to the nature of early relationships and their impact on human development. Within object relations theories (and most psychodynamically oriented theories of personality) the “self” refers to the unique combination of dynamics of the ego and the internal objects that comprise an individual’s character and create a sense of identity that is enduring and relatively stable throughout the lifetime (Scharff & Scharff, 2005). When we look at object relations theories, the self is believed to result from growth in the context of personal relations, or relationships with other people. In other words, connection with others is the primary means through which personality development (or one’s sense of self) occurs. Objects can be people (e.g., mother, father, grandparent) or things with which we form attachments

(e.g., stuffed animal, a child's blanket). These need-fulfilling objects and the developing child's relationship with them are incorporated into a self, and become the foundational blocks of the self-structure, or personality. The critical developmental "issue" is the child's movement from fusion with and dependence on the mother (or other primary caregiver) to a state characterized by increased independence and differentiation (Eagle, 1984). The very emergence of the "self" is characterized by increasing maturity or sophistication of the infant's relationships with primary objects (e.g., parents, older siblings, other caregivers). The self is capable of qualitatively different relationships with others, at specific stages of development.

Thus the foundation for the self-structure is thought to be formed early in life and is borne out of our relationships with primary objects (significant others). Once formed, the foundation for the self-structure (or personality) can be modified, however, one's basic tendency is to seek connection with others (friends, romantic partners) who will reaffirm these early self-object relationships. Modifying or otherwise altering the self-structure does not typically happen easily, although it can be done. However, the more traumatic one's early self-object relations, the more rigid and resistant to change the self-structure (personality) becomes.

An underlying tenet of object relations theory is the critical nature of the connection between the mother (or other primary caregiver) and the infant during the earliest (preverbal) level of development. The caregiver must have an intimate emotional connection with the child during this important period in order for subsequent development to proceed in an ideal manner. In particular, the relationship must be characterized by the mother's emotional identification with her baby; identification to the extent that the mother anticipates the infant's needs before s/he is even aware of them. During this period, the infant is believed to only have self-knowledge through identification with the mother (i.e., inability to differentiate between self and other) and it is this relationship that is thought to provide the foundation for the infant's secure movement to knowledge of self as separate. If the quality of the preverbal relationship with the mother is not characterized by close emotional identification, then the infant's experience of self as separate may be characterized by fear and anxiety.

In the context of intrafamilial trauma in which the attachment relationship is marred by abuse and neglect, an infant internalizes representations

of others as dangerous, self-seeking, and deceitful (Bailey, Moran, & Pederson, 2007). Over time, these representations lead the child to interpret the intentions and actions of others through a lens of distrust and anticipated rejection. This disrupts the development of interpersonal skills and, consequently, peer relationships in which the child would normally experience a sense of belonging and identification. Failure to achieve this developmental task further compromises the child's sense of agency and relational confidence, which in turn negates feelings of competence and accomplishment necessary for the development of positive self-esteem and, like with attachment theory, trust in others.

For children, emotional abuse and physical or sexual trauma perpetrated by a primary caregiver or other adult figure is characterized by invasion and control of the child rather than the provision of security and the facilitation of optimal growth. So rather than being present and available for the child's use in building internal objects, the adult actually plays a destructive role that slows or stops the process of building mental structure, sometimes causing the child to split her or his self into parts that are not able to grow together. The intrapsychic mechanisms that evolve in such an environment are defined by a child's inability to conceptualize herself as separate from external experiences. From the perspective of a child, all events are inextricably tied to her thoughts, feelings, and behaviors, including the experience of abuse (Lieberman & Knoll, 2007). On a fundamental level, the child associates her "bad" behavior with the abuse, an association motivated by her need to maintain some semblance of attachment to needed caregivers. It is not the outside world on which I am dependent that is bad, the child interprets, it is me. This process of self-blame, eroding a child's self-worth, disrupting the development of positive self-esteem and an integrated personality structure, is referred to as "splitting". Splitting is a psychic mechanism that includes both normal developmental processes and defensive strategies (St. Clair, 2000). Self-blame is mollified when the child's fears and anxieties are met with a caregiver's protective response (Lieberman & Knoll, 2007). When a child cannot rely on her caretaker to alleviate such anxieties, and when the caregiver is actually the source of danger the child's use of splitting, while serving an immediate self-protective purpose, results in a fragmented self-structure and can lead to the development of mental health problems (Chapman, Dube, & Anda, 2007). Through the internalization of bad objects, splitting enables the child to experience a temporary sense of control over the "badness" outside and sense of safety in her

environment. The attachment motivation is primary to the child's survival strategy, and splitting serves to defend against fears of attachment figures, fears which threaten annihilation of a child's underdeveloped self system.

Children in unsafe environments may make other psychological adaptations in order to preserve a semblance of attachment to their caregiver. Beyond the splitting described above, adaptations may take the shape of denial in which case the abuse and associated feelings are submerged into the child's unconscious or the adaptation may include rationalization or some other form of minimization (Herman, 1997). Either of these defensive strategies serves to protect the child by allowing her to maintain a sense of connection to the abusive caregiver and a sense of safety and hope for change.

Extension of these theories to work with sex trafficking victims, whose earlier life experiences are characterized by inadequacy in the areas of attachment and object relations, allows for an understanding of deficiencies in development and the more complex trauma reactions s/he may experience. This should also highlight areas of need with regard to treatment.

Treating the Adult Victim of Sex Trafficking

The point in presenting an outline of these theoretical approaches is to attempt to provide insight into the potential experiences of some clients whose victimization through sex trafficking, may be predated by other relational or physical trauma. In other words, it is possible that the clients with whom we struggle the most, are suffering with more complex trauma reactions grounded in earlier life experiences, onto which the current trauma is layered.

Adults who experienced relational trauma as children or who are otherwise exposed to violence may exhibit maladaptive functioning in multiple domains (i.e., affective, cognitive, behavioral, physiological and social). Such maladaptive functioning will be observable in the various systems in which they exist (i.e., work settings, family system, friend and romantic relationships). Clinician assessment of sex trafficking victims should include information gathering of prior relational and/

or sexual trauma history, including the nature of the relationship of the perpetrator(s) to the client, the duration of the victimization and understanding of the developmental stage of the victim when the trauma or relational failures were perpetrated. Initially questions should be open-ended and more general and then move toward more specific, closed questions.

Despite variation with regard to specific treatment recommendations, core themes exist across treatment stratagem. Concepts which seem to be integral to the provision of effective treatment to traumatized individuals include the establishment of safety, connectedness with others, identification of internal states and affect regulation, cognitive restructuring, improved self-concept, and mastery over developmental tasks (especially in relation to children) (Amaya-Jackson & DeRosa, 2007; Cook, Spinazzola, Ford, Lanktree, Blaustein, et al., 2005; Crenshaw & Mordock, 2004; Ford, 2005; Kinniburgh, Blaustein, & Spinazzola, 2005; van Der Kolk, 2005; Vickerman & Margolin, 2007;).

Self, esteem and attachment problems that have been associated with ongoing childhood neglect and abuse must be understood and treated in the context of the therapeutic relationship in order for repair beyond symptom reduction to occur (Pearlman & Courtois, 2005). Treatment implications as informed specifically by attachment and object relations theories (as described above) call for a unique approach to the relationship between the client and the therapist. In particular, these theories require us to think about the ways in which the injuries perpetrated in the context of what should have been nurturing, growth promoting relationships, can begin to heal within the context of the relationship between client and therapist. The counseling room can become a place where problematic behaviors and feelings are experienced, "heard", explored and hopefully resolved to the extent possible at the client's developmental stage. Fundamental to treatment with traumatized individuals, is the corrective interpersonal experience, the mechanism through which negative models of self and other and insecure attachment orientation can hopefully be re-worked. In 1988 Bowlby suggested that in order to alter the client's inner working models, that there needs to be significant attention to the client's relational expectations of the therapist and of others. This calls for a "re-parenting" of sorts and is not a simple endeavor, as noted by Dozier and Tyrrell (1998):

"From an attachment theory perspective, the therapist's work with a client is similar to, yet more difficult than, the mother's with her infant . . . The mother's task is easier than the therapist's because she need not compensate for the failures of other attachment figures . . . exploration of prior working models cannot wait until after a secure base is established; rather, the processes occur in tandem (p.222)."

The treatment frame and related boundaries are of particular importance when working with survivors of abuse, neglect and sexual trauma. Boundary violations are a primary characteristic of the trauma experience and a corrective experience necessitates a consistent "holding of the treatment boundaries" by the therapist, accompanied by a collaborative effort to understand the meaning for the client when s/he pushes against them.

Similarly, when working with clients with traumatic histories reenactments of the trauma are not uncommon. This has been conceptualized as a representation of the unprocessed trauma in an attempt to gain mastery (Messman & Long, 1996; Van der Kolk, 1989). Such reenactments can be expressed in a variety of ways including relationally, somatically and psychologically. Much like with boundary violations, the therapist and the client ideally work collaboratively to understand their meaning in the context of the present situation as well as the past.

Treating the Child Victim of Sex Trafficking

Fundamental to treatment with traumatized children, much like with adults, is the corrective interpersonal experience, the mechanism through which negative models of self and other and insecure attachment orientation can be re-worked. Treatment models such as Dyadic Developmental Psychotherapy (DDT), an evidence-based treatment with its conceptual origins in attachment theory, (Becker-Weidman & Hughes, 2008) emphasize the relationships between therapist and client, caregiver and child (when the client is a child), and therapist and caregiver (when the client is a child) as central components to the effective provision of therapy. A core concept of DDT is "intersubjectivity", or the reciprocal experience between child and therapist (and child and parent) that emerges from affective attunement, joint attention and awareness,

and congruent intentions (Becker-Weidman & Hughes, 2008). This relationship provides adequate mirroring through which the child's fragmented self-system can begin to take cohesive form.

The importance of directly addressing and attempting to re-work the child's attachment orientation relates to the acquisition of competencies delayed or otherwise impacted by traumatic experience. Domains of competence marred by trauma include interpersonal, intrapersonal, cognitive, and emotional (Kinniburgh, Blaustein, & Spinazzola, 2005). The Attachment, Self-Regulation, and Competency (ARC) (Kinniburgh, Blaustein, & Spinazzola, 2005) is a comprehensive intervention framework which emphasizes that secure attachment provides the basic safety and security necessary to achieve all other competencies, including those mentioned above. When working with children a central component to child's response to trauma is deterioration in the ability to regulate internal states (van der Kolk, 2005). As a result of failure (or traumatic interruption) in the attachment relationship to provide the secure base from which a child's normative anxieties are assuaged and affective regulation skills develop, traumatized children are overwhelmed with feelings of fear, anger, and a desperate need to be nurtured. It follows that treatment with this population provides a nurturing environment in which a child can practice and acquire affect regulation skills (Kinniburgh, Blaustein, & Spinazzola, 2005; Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005; van der Kolk, 2005; Vickerman & Margolin, 2007,).

The ARC framework identifies three primary regulation skills to be addressed in treatment, which are affect knowledge, expression and modulation (Kinniburgh, Blaustein, & Spinazzola, 2005). Affect knowledge refers to the ability to be aware of one's own feelings, to understand the relationship between experience and emotional response, and to be able to accurately identify emotional expression in others. Affect expression skills are achieved when a client feels safe enough to communicate feelings. It has been observed that securely attached children learn a broad vocabulary through which to communicate affective and physiological needs and experiences and spend more time doing so than children who lack such attachments (van der Kolk, 2005). Skills related to affect modulation include the ability to both identify changes in internal emotional states and return to a comfortable state of arousal. Development of skills related to affective regulation promotes adjustment to negative working models of self and other which evolved

originally in the traumatic environment. Such models are defined by the internalization of negative emotions (e.g., anger, fear, apathy) and responsibility for one’s own trauma (self-blame).

The ARC framework is built around the following ten building blocks:

Attachment	Self-Regulation	Competency
Caregiver Affect Management	Affect Identification	Developmental Tasks
Attunement	Affect Modulation	Executive Functions
Consistent Response	Affect Expression	Self-Development
Routines and Rituals		

Since early trauma derails normative development, hindering achievement of age appropriate tasks and consequently, a sense mastery over one’s environment, treatment should provide opportunities to successfully achieve developmental tasks (Amaya-Jackson & DeRosa, 2007; Crenshaw & Mordock, 2004; Ford, 2005; Kinniburgh, Blaustein, & Spinazzola, 2005; van Der Kolk, 2005). Treatment strategies designed to address the needs of young children often incorporate the use of play therapy, whereas approaches to adolescents utilize adult-oriented interventions while addressing the specific challenges faced during this stage of development, such as high risk behaviors and peer pressure (Vickerman & Margolin, 2007).

Use of play in therapy gives the child opportunities to work through and integrate traumatic events, but it also provides opportunities for fun and relaxation, and supports the child in developing a sense of physical mastery (van der Kolk, 2005). Trauma leads to isolation and impaired abilities to engage in meaningful connections with others. Treatment, then, should also provide opportunities for relationship building with peers, adults and the community (Kinniburgh, Blaustein, & Spinazzola, 2005). The development of intrapersonal competencies, including positive self-esteem and feelings of self-efficacy, should also be a goal of treatment when working with traumatized children (Crenshaw & Mordock, 2004). A strengths-based perspective is fundamental to effective treatment. Through positive feedback and affirmation, therapists can help children to identify and refine strengths, which contribute to ego development and positive self-esteem.

Similar to the experience of PTSD among adults, re-traumatization is a feature of traumatic stress response in children. This relates to compromised abilities to integrate traumatic memories. Failure to integrate these memories results in a state of extended hypervigilance, in which the child responds with fear and anticipated danger to most stimuli, including that which does not actually pose a threat to the child's safety. Essential to the therapeutic process is the facilitation of opportunities for the child to develop a narrative around the trauma in order for it to be assimilated into past memory (Crenshaw & Hardy, 2007). This enables the child to be free from the grip of triggers which replicate feelings associated with traumatic experience.

As a result of failure of the environment to provide opportunities for children to process and understand traumatic experience, many children engage in trauma reenactment in an effort to gain a sense of mastery over this experience (Crenshaw & Mordock, 2004). On an unconscious level, the child is making efforts to assimilate overwhelming experiences into a tangible reality over which s/he has control. Behavioral manifestations of reenactment, such as seductive actions and aggression toward caretakers or other children, must be understood as attempts on the part of the child to work through overwhelming experiences. Play therapy provides an outlet through which children can reenact experiences safely and, with the help of the counselor, process fragmented memories. There is a growing body of evidence which suggests that trauma memories are stored in the right hemisphere of the brain (Gil as cited in Crenshaw & Hardy, 2007). This indicates that traditional talk therapy alone may not be as effective with regard to working through traumatic experience for children, as the right hemisphere is more responsive to nonverbal strategies, such as the use of play.

During the initial stage of play therapy, therapists can explain the purpose of therapy and set reasonable boundaries, such as rules against hitting the therapist, that create a secure frame without interfering with the child's ability to experience necessary feelings of personal control and mastery (Crenshaw & Mordock, 2004). The child should understand that the therapeutic context is one in which s/he can express scary thoughts and feelings in order to make them go away, and choices about play materials and other aspects of how the session is spent are reserved for the child, not the therapist (Crenshaw & Mordock, 2004). Furthermore, the pace of therapy should be dictated by the child's process and creative expressions. Play therapy is a modality through which the child can

maintain a safe distance from traumatic experience, and gradually act out scenarios more specific to the actual trauma (Crenshaw & Hardy, 2007). The importance of allowing the child determine the pace of therapy cannot be overemphasized. It is as crucial to give the child space to maintain relative distance from painful feelings associated with traumatic experience, as it is to be available and present when the child is ready to address such emotions (Crenshaw & Hardy, 2007). Failure on the part of the therapist to embody such responsiveness would replicate feelings of abandonment experienced by the child. This speaks to significance of the intersubjective experience between therapist and child as noted above. Through the process of play therapy, the therapist should pay attention to the emergence of posttraumatic play, or scenes in which the child appears to be stuck in her/his reenactment of events over which s/he has no control (Crenshaw & Hardy, 2007). In this scenario, the therapist can facilitate working through of traumatic experiences by introducing protective characters such as firefighters or police officers into the play sequence (Gil as cited in Crenshaw & Hardy, 2007).

Increasingly over the past decade, attention has been given to the role of cultural and individual diversity in the fields of counseling and psychology. As was pointed out by Mascolo, (2004), people present themselves in dimensions characterized by both personal and “communal” representations. Cultural and individual differences may influence the manner in which the trauma is experienced, the type of support received from the child’s family and larger community, and the nature of the counseling relationship.

Summary

Exposure to traumatic events that predate sexual exploitation through trafficking, especially within the familial context, presents a grave concern for mental health professionals working with survivors. Attachment and object relations theories were used as the backdrop against which the impact of trauma was considered. Assessment and treatment should take into consideration familial and cultural contexts, developmental stage, nature and degree of the early trauma, as well as features of the current situation. All domains of the functioning should be assessed and treatment should include both empirically validated approaches as well as interventions that acknowledge the interpersonal and intrapersonal nature of the trauma.

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Trauma - psychoanalytic perspective

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Introduction

In the field of psychoanalysis, trauma and its consequences, political and social violence, did not receive enough attention for a long time. Specific ambivalence often characterized its clinical and theoretical assessments. One of the important reasons for that was the fact that psychoanalytic clinical theories increasingly concentrated on the "here-and-now" relationship of transference and counter-transference, therefore on meanings that develop in the psychoanalytic encounter within the therapeutic situation. Nonetheless, over the past decades, trauma and its consequences have been drawing an increasing extent of scientific interest in psychoanalysis. Psychoanalytic literature on trauma has become so abundant in the meantime, that I cannot even begin my attempt to present here a comprehensive overview of papers pertaining to trauma theory. On several occasions I have heard the opinion that psychoanalysts do not deal with trauma, which is just one of the misconceptions linked to psychoanalysis. After all, psychoanalysis did arrive to Serbia in the midst of bad times, the year 1995.

The increase of violence in society and raising awareness of domestic violence, of all forms of abuse including sexual abuse of children, have led to human traumatization and its consequences becoming an integral issue for the development of theory and technique in psychoanalysis.

The concept of trauma with various terms that are present in the literature

(stress, shock, cumulative, retrospective, transgenerational etc.) is very modern today. At one point, trendiness of the term led to its dilution so that each event or experience could be traumatic.

In medical literature the term implies a hit inflicted upon bodily tissue, so the meaning of trauma was extended to include a hit to "mental tissue". The metaphor "mental tissue" partly relates to ideas that the mind functions by way of associated links between feelings and ideas, which are severed as the outcome of trauma. In one way or another, the metaphor »mental tissue« pertains to formation of symbols in a wider sense (Bion, 1967).

The concept of trauma should relate to intrapsychological consequences, but it often also encompasses an external event. Events caused by human behavior have a far more malign effect than those caused by acts of nature. The former could have been avoided, while the latter is somehow fate.

Is there a separate trauma memory where recollections are stored differently than in explicit autobiographical memory? Some are of the opinion that due to extreme stimulation, the traumatic events are specifically coded and integration and interpretation with the aid of semantic memory are interrupted. Remembering the traumatic events, on the other hand, happens as an affect state, as a response to somatic stimuli, such as smells, sounds and visuals. The result is non-symbolic, inflexible and unchangeable content of trauma memory. To what extent are these trauma recollections "engraved" in memory and can they change by way of later experiences?

One should admit that there is a battlefield of arguments among scientists, of which one group claims that traumas are "eternal scars" that will always, in one way or another, impact the mind of the hurt person, while the second group claims that the metaphor of "scars" distorts discussion about what is implied in psychoanalysis by "development" and "treatment". Psychoanalytic work with persons who have been exposed to traumas is based on ideas that traumas are symbolized and worked through, or, to put it differently, that effects of such "encapsulated" experiences can be "opened up" through the psychoanalytic treatment.

But let us start from the beginning.

Development of Trauma Theory in Psychoanalysis

Freud initially formulated traumatic experience as something that overwhelms the Ego (psychoeconomic perspective). Initially this was related to female patients' recollections of sexual seduction in their childhood. Freud's conclusion was that it had been prepubescent sexual trauma, genital stimulation by an adult of a child who had not been able to experience it as sexual. It is only on the occasion of second seduction after puberty and due to sexual maturity that occurred in the meantime, that the early experience acquired meaning in a delayed action (*nachträglich*). Through associative linkage with acute experience, because of overstimulation, this first experience develops its traumatic effect. This compels the person to defend herself from recollections of it and make it unconscious. If such a defense mechanism fails, hysteria symptoms appear.

Both psychoanalysis and cognitive psychology alike were showing, over and over, reservations when viewing memories just as accumulations of appropriate events in life regarding the extent to which fantasy and desires influence perception and to which memories are constantly re-processed, depending on the context in which they emerge into consciousness. Furthermore, discovery of Oedipal complex and knowledge that it is possible for fantasy to be experienced as reality and that fantasies can impact us the same way as actual events, influenced Freud to give up the seduction theory.

World War I compelled Freud and his students to address, once again, traumatic neuroses and pathogenic effects of factors from the outside world. The psychoeconomic aspect came to the forefront, through the concept of shield against stimuli, or stimulus barrier – hypothetical barrier as protection from psychological hurting by stimuli from the outer or inner world.

During a traumatic experience, there is a breakthrough through this protection, the intensity of penetrating excitement is too great to allow to be overcome and psychologically linked. The psychological apparatus regresses to primitive modalities of reaction. Repetition compulsion brings the traumatic event up to the present moment in the hope that excitement will be acted out or psychologically linked. Thus the pleasure principle will be reinstated. Ego is absolutely helpless in front of unbearable excitement in the traumatic

situation. The Ego, which in the case of danger normally generates an anxiety signal, now becomes overwhelmed with automatic anxiety. The decisive factor was “too much”, excess of excitement and paralyzed Ego which was not capable of discharging pent up psychological tension or link it psychologically. These are psychologically indigestible experiences that can not be metabolized and detoxified by working through them and towards achieving recovery. Trauma breaks through the protective shell and is indelibly registered in the body, directly impacting the organic base of psychological functioning. The specificity of trauma lies in the process structure of perception and affects, as well as in the experience that psychological space has been broken into and symbolization destroyed. Traumatic experience is essentially the experience of something that is “too much”.

An indicator that the traumatic event occurred is momentary reaction: the paralysis of all action, the numbing of feelings, whereas among children temper tantrums are frequent as well as vegetative instead of psychological reactions. A description of traumatic shock clearly indicates that ego functions are at peril which had been acquired last: among adults they are synthetic and integrative functions, whereas among children – speech and control of excretory functions.

The person experiences helplessness since the mental apparatus is not capable of overcoming the experience “the usual way”. According to this model, the Ego has been given excessive abundance of stimuli and impressions. The outcome is that psychological apparatus processes are pushed towards a state of disaster. As a result, various apperceptions, which are usually organized and interrelated via links and associations, become unstable and fused. Instead of being the basis for creating thoughts, apperceptions are filled with a limitless quantity of anxiety, fear and pain, which is why cognitive functions are less capable of working through the emotional meaning of experiences.

In other words, something foreign, “a traumatic event”, descends on the individual, penetrates all barriers that the mind sets up as a line of defense. It takes over the mind and becomes the dominant facet of inner landscape of the mind (Erikson, 1995; Rey, 1994). It takes over the person in major aspects of his/her life; the latter can be called “a traumatic state”. It was not until 1950s that research began on early phases of child development, bringing new insights into the concept of trauma.

From the object relations perspective, trauma represents a loss of internal protection that relates to the inner other – primarily the loss of necessary feelings of basic trust, but also impacts infantile omnipotence and self-idealization. This can be experienced as a loss of protective and empathetic other, or as damage to the relationship with internalized others who normally give meaning to thoughts and actions. When these internal links are severed, damaged or destroyed, connection to others can be perceived as dangerous. Establishing relations (external or internal) with the other is under threat of turning into poisonous food for thought. What commences is a process of distorting the symbolization process. Traumatized person often sees the therapeutic encounter as frightening because of his fear of reliving and retraumatization and because he has experienced atrocities inflicted by people, which damages the capacity for trust. For him it represents a risk of repeated onset of helplessness and feeling of abandonment in utter desperation, which can even lead to the pattern of withdrawal that, in return, creates a negative spiral, vicious circle of isolation, since withdrawal also means loss of potential support.

What ensues is a defect in coping with the emotional experience so, for instance, the body is utilized, through somatization, as an arena for increased tension due to non-metabolized affects, or agitation can offer some solution for aggression etc.

Contemporary psychoanalytical concepts of trauma underscore that the inner loss of one or all objects that give empathic meaning in a traumatic situation leads to projection of the need for empathy onto the perpetrator and his evil internalization. The evil persecutory object takes the place of inner objects and determines the inner dialogue. Furthermore, the traumatic situation and its consequences destroy the possibility of its symbolization and understanding of its meaning (Grubrich-Simitis, 1984). Trauma becomes “the black hole” in psychological structure. Non-integrated fragments of trauma later reemerge into consciousness and overwhelm the Ego which, however, cannot structure and integrate those fragments. Without assistance, they cannot be incorporated into a meaningful story and the experience cannot be “stored”. So as to describe this psychologically, it is necessary to resort to metaphors. Most frequently used are: foreign body, hole (Cohen, 1985; Kinston and Cohen, 1986), emptiness in the psychological texture (Caruth, 1995), crypt (Abraham and Torok, 1979) or empty circle (Laub, 1998).

Since the 1950s, psychoanalysts have been researching deficient early mother-child interactions and their traumatic effects on the infant, for which various terms were introduced such as “strain trauma” (E. Kris, 1956), “silent trauma theory” (Hoffer, 1952), “cumulative trauma” (M. Khan, 1963), “deprivation trauma” (Bowlby, 1973). However, the concept of trauma is thus in danger of becoming overly expanded and applied to every possible deficit in the mother-child relationship, thereby tainting its specificity.

With the development of object relations theory, the object relation becomes the basis for trauma theory. Whether or not an event or a situation will seem traumatic depends on whether or not there had been an intensive relationship between the child and traumatogenic object. That way the object relation itself possesses traumatic character. Abuse and maltreatment come from the person whom the child needs for protection and nurturing, so that in the case of severe traumatization what is damaged is not solely the internal object relation but also inner communication between representations of self and object which has a protective function and provides security. This is how islands of traumatic experiences form which are isolated i.e. split from inner communication.

I would like to underscore insights which pertain to incest and Holocaust, for several reasons: many parallels can be drawn between victims of incest with its psychological consequences and trafficking victims. Trafficking, the contemporary slavery, is essentially the breach of fundamental human rights to freedom and dignity, most often implying the exploitation of the vulnerable. Emotional immaturity and dependency either among children as incest victims or in trafficking – as the outcome of early age, illness, socio-economic deprivation, are taken advantage of by the perpetrators. I suppose this often involves youths with history of trauma. All the factors are at play: heredity, physical health and mental balance at a particular moment, extent of self-confidence, developmental phase, developmental disorders linked to either the impaired parent-child relationship or to external factors, individual life history before and after the trauma. Based on descriptions, Holocaust and fascism have dealt the fourth narcissistic blow to humankind. The first was Copernicus with his heliocentric theory challenging the idea about Earth as center of the Universe, the second was Darwin with his Theory of Evolution, challenging the idea of special origin, whereas the third was Freud with his idea about man as conscious being with unconscious determinism.

The ultimate blow was dealt by World War II, where the notion about human goodness was questioned by the atrocities perpetrated. Work with Holocaust survivors contributed to the development of massive traumatization theory in psychoanalysis, also applicable when working with contemporary world violence fatalities such as terrorism victims, political exiles, refugees, trafficking victims.

Incest/Breakdown and Attempt to Maintain the Relationship with Abuser-Parent

In the eighties, a shift occurred within the psychoanalytic community in thinking about sexual abuse and treatment of incest victims.

It must be noted that, as early as 1932, Ferenczi expounded his revolutionary theory of trauma in his last lecture "The Confusion of Tongues between Adults and Children".

In "The Confusion of Tongues" Ferenczi offered new ways of solving the issue of "reality" or "fantasy". He proposed the analysis of the situation on various levels. In my opinion, one level pertains to interpersonal dynamic between adult and child, while the other pertains to intrapsychological consequences. In keeping with Ferenczi's train of thought on intersubjective process, we can say that it is important not only for sexual abuse but also for other traumatic situations. He recognized the mechanism of object loss or love loss, placing the whole mechanism of trauma in a wider context, i.e. the context of object relations theory. He abandoned the distanced analytical standpoint because he grasped that with traumatized patients, in certain situations, it is necessary to be unconditionally sincere, admitting mistakes and even disclosing own feelings. Ferenczi recognized the effects of lies and deception as a traumatizing facet and threat of their repetition in the therapeutic situation. Trust that is gained by way of this sincerity represents a difference in relation to the traumatogenic past and enables its therapeutic working through. Because of that, Ferenczi holds, it is not only the object relation that has a traumatogenic effect, but also and especially, communication that is built into it: disappointment, loss of trust and denial or refutation of the event generate insecurity in own perception.

Ferenczi wrote about the traumatization process: "A typical way in which

incestuous seductions may occur is this: an adult and a child love each other, the child nursing the playful fantasy of taking the role of mother to the adult. This play may assume erotic forms but remains, nevertheless, on the level of tenderness". Unfortunately, it often happens that the adult "mistakes the play of children for the desires of a sexually mature person". The child becomes helpless, receiving, instead of tenderness, a passionate love saturated with aggression.

The child speaks the language of tenderness and devotion, while adults speak that of passion and sexuality. Confusion becomes the primary subjective state, the child cannot attribute psychological meaning, s/he senses that something is not right, even when the child responds to abuse. No child who has been sexually molested will ever celebrate such a form of affection and love. Confusion becomes the primary intrapsychological state since the adult conveys to the child that s/he is loved due to sexuality, yet the child's need is for care, love, tenderness, which is a fundamentally empathic and tender experience. The narcissistic and non-empathic parent expresses love as passion, responding to the child's need for tenderness with power, domination, sadism. Sexuality is not love, but rather aggression.

Sense of reality is impaired since the child receives the message that molestation is tenderness. Through identification with the aggressor, semblance of tenderness is maintained. The most salient change that occurs in the child's mind is that, because of identification with the adult partner, saturated with anxiety-fear, there is an introjection of the adult's feeling of guilt which turns what had been innocent play up until then, into punishable transgression. Children, due to their need for parental attention, feedback and care, are "emotionally programmed" to yield and submit to the adult, to provide what is asked of them. "I will give you the sex you demand since I need the love you say you're giving me." The child keeps quiet, speech is suppressed and "the tongue is tied", and even when s/he does speak, s/he is accused of being a hysterical liar.

How many times have we heard from our patients that they could not speak because "no one would believe them". A patient molested by her father says that she kept silent for years out of guilt that she had done something bad, out of shame that something is wrong with her, and out of fear that she would lose her beloved father. Very typical story.

Holocaust / Massive Traumatization / Complex Trauma

In working with Holocaust victims, it quickly surfaced that the trauma theory which had been in place up until then proved unsuitable for encompassing the specific symptoms and experiences of survivors. This kind of traumatization with its immense human suffering was something new and could not be adequately described by way of diagnostic categories in force at the time. It was not just a one-off instance of breaking through the barrier against stimuli, as is the case with some trauma caused by shock, rather it was extreme, massive and long-lasting stress. The terror that lasted for months and years, physical cruelty, horrible hunger, helplessness and dehumanization, loss of family, witnessing torture and killings, all of it far surpassed that which can be psychically withstood.

Massive aggression, considered by numerous scientists to be the central point of survivor syndrome, had been turned inwards against oneself and led to somatization and to frequently described chronic reactive depression. Severe loss of self-esteem accompanied withdrawal from the outside world, affective numbness with intermittent episodic temper tantrums, with nightmares in which the past is relived and incapability of verbalizing traumatic experiences.

Pre-traumatic personality often had no role whatsoever in Holocaust survivors. Much more important were the length of captivity in the camp and horror to which they had been exposed or had survived. Traumatization had been so massive, that there was no regression to an earlier psychosexual level, but rather the mental structure itself was destroyed.

The capacity for metaphorical language and action was lost. Those persons live in a twofold reality. Such psychologically indigestible experiences, in a situation when external help is lacking, lead, within the self, to identification with the aggressor – either complete, or split off and encapsulated, so that the alternative self manifests itself when recognizing threat, be it internal or external.

In everyday life they behave in accord with reality. However, occasionally

the psychological reality of the Holocaust surfaces and undermines their life. In some areas of the psyche, trauma has destroyed the capacity to differentiate reality from fantasy.

The experienced traumatization surpasses the psychological capacities of the survivors to mentally process it, which is why it also pervades the life of the next generation – transgenerational trauma.

Massiveness of this trauma could not be adequately described by the economic model of protective barrier penetrated by the stimulus. The center of Holocaust survival contains the breakdown of empathic process. Communicational dyad between self and its good inner objects breaks down, leading to absolute internal loneliness and utter hopelessness. Traumatic reality destroys the empathic protective barrier which the internalized primary object had built, as well as trust in continuous presence of good objects and extent to which human empathy can be expected, namely that others will recognize basic needs and will react accordingly. In the case of trauma, the good inner object, as an empathic mediator between self and environment, remains mute (Cohen, 1985; Kirshner 1993). The loss of empathic inner Other destroys the possibility for trauma to be told. It cannot be included in the story. When it comes to traumas caused by human hand, violence, it is necessary for a social discourse to exist, in addition to the empathic listener, about historical truth of traumatic events and their denial and defense. If defensive tendencies dominate over the manner in which society faces calamity, the victims often feel left out, blocked or left aside with their experience, which undermines their sense of security anew, making them vulnerable to retraumatization or condemning them to silence, since they can't expect understanding.

Complex, repeated, cumulative trauma, which grows in time, affects the deep strata of personality, so that, in the posttraumatic period as well, they continue to be a threat to themselves and have difficulty staying in treatment.

At the moment of being overwhelmed by danger, we revert to the earliest form of object relation – desire for omnipotent parents who will save us, take us into their arms and rescue us from danger. Yet if the parent does not arrive, if there is no help, we feel the abyss of despair. After shock, the abandoned child goes through tantrums, attempts to regain the parent

through attracting attention, then gradually loses hope and, in extreme cases, becomes biologically closed, as witnessed among orphans. Traumatic response is described as bimodal. The person feels stiffness, numbness and represses representations of traumatic experience which return episodically, while the feeling of abandonment and loss of connection with the object is in the background. Archaic attempt at a solution is the quest for a parent, a group, the need for magic protection. A split ensues between instruments from a higher level of functioning during efforts to establish control and security and archaic levels of magic thinking and early object relations. The opposition between control and loss of control, surrender, is underscored, the dependency on the object is revealed – that is where shame begins because of the undesired regression. The metaphor of the fall is precise and illustrative. It depicts the infant's primary fear of dropping from parents' arms, reflecting abandonment on the most primary, instinctive, animalistic level.

The ego's helplessness and being overwhelmed ultimately imply the cessation of ego functions and loss of capacity for resistance and survival. There is frequent occurrence of placing one's own existence into the hands of fate – like the American soldier's game of Russian roulette in the movie "The Deer Hunter".

The outcome of this pathology of primary object relations which are severely impaired is that increasing closeness of dangerous traumatizing object and violence easily become an integral part of life cycle.

Repetition compulsion has been called Samson's complex by some authors – he kept making the same mistake and choosing Philistines for wives even though they always ended up betraying him. The essence is that it exists as addiction to extreme emotions. Through trauma, perpetrators and victims become dependent on each other. Alongside the old explanation about acting out and tension release processes, today there is more and more talk concerning neutralization of increased level of excitation by way of addictive behaviors including re-exposure to situations that resemble the trauma. Revictimization produces analgesia.

The paradox of traumatic state is that numbing and blocking of affects is experienced as unburdening from painful affects of apprehension. The subject gives up and surrenders to the traumatic state that is determined by altered state of consciousness, "catatoid state" that acts as an affective

and cognitive filter. In it, various authors recognize adjustment to an unbearable situation. Catatoid state leads to a “robotic state”. Submission implies some form of surrender and splitting of the self into an observing part and another part, the body, which the Ego will sacrifice. Even after the traumatizing situation has ended, the traumatic reactions live on.

Countertransference, Function of the Therapist and Therapy

Countertransference feelings have led to the division of therapists who deal primarily with trauma into two extreme groups, so-called traumatophilic group of therapists who are, as a rule, always searching for contained trauma, and so-called traumatophobic group of therapists who rationalize their feelings of aversion and disgust by ignoring the existence of trauma.

Therapists who deal with trauma often reveal how they are constantly under stress and overwhelmed, with a wide range of reactions irrespective of unsolved personal conflicts. That insight has led to formation of the concept of secondary traumatization or delegated traumatization. It's impossible to sit calmly and listen to recounts of atrocities. We're open to listening, which also implies that we are vulnerable. Even when we are aware of the cause, we aren't prepared for listening outside the normal scope of experience, none of us expects that such events will befall her/him or dear ones in life.

Classic definition of countertransference relates to the therapist's unconscious reactions to the patient's transference. Originally used with a narrow meaning of reciprocal response to transferential love, it was later expanded to include situations in which a breakdown occurs in receptive and empathic responses, when own unconscious needs and conflicts impact our understanding or technique. The therapist experiences subjective unease, with thoughts and feelings that are unexpected and unwelcome, such as anger, fear, shame, voyeuristic excitement, sadism. Problems arise with defining boundaries, a stable setting, keeping the secret, relative activity and inactivity, passive repetition of interpretations that had already been rejected, forgetting timeslots, double booking of appointments, cancellation, fear of losing control when working with the traumatized person or narcissistic conviction that one possesses a special

talent for working with the traumatized. Thus depending on therapist's personality type, there may arise avoidant or hyperidentification countertransference.

Unlike classic theories of countertransference as an impediment, a pathological response due to own unresolved conflicts, a more contemporary approach to countertransference is the so-called totalistic one – it relates to all emotional reactions the therapist has. It is self-understood that transference cannot go without touching the person it pertains to. Unlike the classic standpoint, in this case the therapist's experience is seen as valuable and informative, not negative and interfering. Countertransference is the main instrument for understanding the patient's conflicts, affects and object relations. Each instance of transference evokes countertransference and the process can unfold in both directions, it can be bidirectional. There is mutual impact of participants in the dyad. Therapist's thoughts, feelings and fantasies can reflect and illuminate the patient's experiences which are communicated unconsciously, so countertransference can be said to be a form of unconscious communication. Objectivity of the therapist does not lie in freedom from affective involvement but rather in the capacity to become conscious of such involvement and take it into consideration when working with patients so as to better understand them.

Do these dilemmas sound familiar: Which role am I playing for the patient now, how should I react? What she needs is real action, help, not words of interpretation? Is a therapist needed here or the right person, where that right person means a parental or a new figure, can we choose or do we have to fulfill the patient's wishes, or if I am doing that, am I not playing out according to the patient's dictate? Work with traumatized persons draws enormous amounts of energy, what is needed are time and inner space, but our reaction, countertransference, is not an impediment, it is the core of the treatment.

Victim, perpetrator, omnipotent rescuer – these are the most frequent manifestations of the introjective–projective cycle.

There is a description of countertransference reactions of concordant identification – the therapist feels s/he is with the patient. Reactions to trauma are synonymous with the patient's, through identification with the patient's unconscious self and object experience. We feel like the

victim. For instance, the feeling of patient's passive dependency is felt as incompetence and therapeutic feebleness. Typical countertransference feeling of "walking on eggshells" can be the experience of fragility and unconscious need the patient has for control and fear of losing control, projected feeling of helplessness. We have to be willing to accept the role of victim, in order to feel what the patient feels through trauma.

Complementary identification is a different type – it is identification with transference objects. The therapist feels the emotion which the patient places in the transference object. Via projective identification and counteridentification, various roles are induced in us. We somehow manage with the role of rescuer. But it gets harder to be in the role of abuser. Still, at one moment we are compelled to accept that each time we leave the patient, we identify with the aggressor. What is part of normal daily activities for us, means abuse, maltreatment, aggression for the patient. Strong internal boundaries are needed in order to maintain differentiation and identity, not to be drawn into acting out – when, for instance, we are pressing for integration of trauma, whilst actually attacking defense structures, when we are confronting denial and avoidance – whilst patients experience assault from our side. Hard as it may be to recognize oneself in that role and discover such countertransference feelings, they hide substantial opportunity to discover some specific experiences that the patient had had in the perpetrator's hands. For example, in therapy we are addressing feelings of helplessness and horror when exposed to sadism and callousness of the aggressor. However, it is only when we catch the disdain in our own countertransference that accompanies identification with the aggressor, that we can understand this significant aspect of the patient's experience that he was not able to express and which, if properly utilized, leads to discovering suppressed and hidden feeling of shame in the patient.

The therapist's role can be educational, cognitive and affective. It is educational when we are helping someone understand what had happened to him, what is normal and natural, as well as what is uncommon and outside of normal life experience. It is cognitive when certain wrong or immature attitudes such as "bad things don't happen to good people" are redefined. Ultimately, affective integration of what had been excessive, affects of which there had been too many, so that they are unbearable and not subject to self-regulation, or affects which are unacceptable because of their kind. I would like to draw attention to

the importance of reintegration of aggressiveness, anger and rage, which often represents a problem for us therapists too, when we overstress the positive transference in defense of aggressive impulses. Therapists often foster rage towards perpetrators, social neglect and indifference, the state and the victim's living conditions. Maybe it is that very rage which the patient is incapable of feeling and reintegrating as the essential component of recovery.

The way how a patient copes with trauma is individualized, in transference we come across personalized version of the original trauma, the way that a foreign body is treated.

Resilience or depletion (flexibility–recovery or exhaustion) reflect different courses of posttraumatic development which underscore the vulnerability of a traumatized person. Resilience is capacity to use sources in the environment, relations with others and internal resources, unlike depletion – the state of mental exhaustion. Numerous research studies have proven that attachment is a possible mediator for development of resilience, so that psychotherapy is capable of providing an opportunity for addressing the inner world and emotional sources. The point is that therapy of a person and not that of trauma is embarked upon, which is why it has to last long, not only because of difficulty in maintaining the therapeutic alliance.

Exposing these patients to their trauma histories without the possibility of providing security in their lives and self-regulation leads to retraumatization and decompensation. They are sensitive to subsequent victimizations and there have been instances of secondary and institutional traumatization.

Therefore the therapist's first task is to enable regaining of trust, i.e. holding. It is solely the secure holding, not only in therapy, but also in the environment, within which the victim can develop greater sense of self. In the situation of loss of relations, trust in others and oneself, invasion of horrifying objects, secrecy, silence, being voiceless, impaired containing function and symbolization, unspeakable pain and gap within oneself – they can regain resilience. Stability plays a key role in rebuilding of trust. The therapist must be capable of withstanding negative transference and acting out and to be there when the patient returns. Painful disappointment is unavoidable due to persistence of symptoms and when

the analyst proves insufficient and incompetent – which leads to strong negative transference reactions. Winnicott described the breakdown of object idealization by hatred – because of a fault, failure of the object to perform its function, when sudden, unpredictable intrusion causes hatred which breaks the idealized object. Our patients had experienced a breakdown in the area of stability, support of good enough environment, with the dispersal of capacity to believe in someone or something. Thus, ours is the therapeutic role of a witness, if the phase of early security and building of therapeutic alliance is undergone, when stabilization is reached, as well as in the phase of processing and resolution of trauma, the phase of pain and sadness. The third one must exist. Boundaries of the personality are breached, torn, fragmented, internal and external reality intertwine, run parallel, undifferentiated, fantasy has replaced reality, while reality has a hallucinatory taste. Believing in the importance of subjective truth of someone's experience, we accept the credibility of the patient's experience and later, when the fragmented parts begin to organize themselves into a narrative, into a more coherent material, a chance appears for the correction of self-regulation and processing of traumatic material towards which a new relation is developed. If social marginalization, isolation, discrimination, not knowing the language, sometimes lack of basic facts from personal history such as date of birth or origin are added to the trauma which overwhelms the ego and creates attacks on linking, we reach the necessity of rebuilding of meaning which is possible solely through psychological reality. What is psychological reality? Arlow's answer is a metaphor about two film projects from opposite sides of a transparent screen, where one projector represents external reality, whereas the other unconscious fantasy, and the screen reflects a blended, integrated picture.

Without psychological reality, which entails, alongside that which is objective, also acknowledging and linking of fantasy, memory and reality, they would resemble the protagonist of Antonioni's film "Blow-Up". He witnessed and photographed a traumatic event, a murder, sadistic conceptualization of the primary scene, after which his life changes, but from his storage, his memories, he can't find the one which contains the recorded trauma. Lacking a photo is analogous to the impossibility of recalling a traumatic event, he remains solely with a fragment of experience, a fragment out of context, to the limit of the unreal and in the closing scene he is playing tennis on a court without a racquet, ball and opponent...

Can the bridge be bridged – internalized good object reinstated, the unspeakable given words? We believe in the strength and power of the human relationship to heal wounds.

Bystanders

Ultimately, a few words about bystanders. Straub points out that there is actually no such thing as a neutral bystander, let alone an innocent one, since the person standing and watching atrocities in fact contributes to those atrocities. People who dissociate dependency and tend to find this quality solely among the victims, as well as those who dissociate aggression and tend to find it only among potential perpetrators upset the balance in the aggressor's favor. Despite their power, bystanders often feel powerless. They are sensitive to delegated and anticipatory trauma. This can include strong identification not only with the victim but also with the aggressor. Both of these responses are problematic, including guilt which increases blaming of the victim, due to siding with the aggressor. Bystanders are actually incredibly powerful to influence the course of events. Consequently, active, helping bystanders such as individuals, therapists, organizations, congresses and conferences provide a new definition of reality. They challenge the uniform view and draw attention to the loss of respect for values among aggressors and passive bystanders. They affirm humanity of the victims.

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Case Study – Psychotherapy with a Human Trafficking Victim

Dr Danijela Budisa

Note

Information related to the identity of human trafficking victim and other participants in the event, as well as all other data about the case which could disclose the identity of persons mentioned in the text have been altered to protect the victim's privacy.

General information

Nina P. requested help from me in mid-2010, when she was 29 years old. I was contacted by colleagues from ASTRA who announced her visit, because during that period she did not communicate with anyone outside her family.

She cohabits with her husband in the same household with his parents, in a rented apartment at the outskirts of a town in Serbia. At the moment when she requested help, she was 7 months pregnant.

She has parents and a sister, who is two years older than her, and they all still live in the countryside. Her mother is unemployed, while her father and sister occasionally have temporary jobs.

Nina P. is unemployed; she has graduated from junior college, but never worked in the field she had been educated for. She had temporary jobs.

She has no social contacts outside her family, whereas before the traumatization she liked to socialize with one to two female friends.

She has had two romantic relationships, before and after the traumatization. The first relationship she had had during college, and it lasted several months. The current relationship has been going on for two years. She met her husband after the traumatization, in the company where they both worked. Soon, they started living together.

Nina P. came to psychotherapy at the suggestion of ASTRA's employees, but also due to her husband's pressure, since he insisted that she needed psychological help. She herself recognized that she could use some professional support, but on the other hand, she avoided new contacts – afraid that she might be recognized by someone who knew what had happened.

Therapy dynamics

We made an agreement about the frequency and place where the sessions will be held. Initially we saw each other once or twice a week, depending on how often she felt the need to come in for therapy. After several months of work, we had weekly sessions lasting one hour each.

We had several hiatuses in our work. When she gave birth, we took a break that lasted two months. Afterwards, whenever the baby was ill, she avoided coming for several weeks, afraid that the child's state "might get complicated". Taking into account that psychotherapy indeed did her good, this pattern of absence primarily tells about her willingness to disregard her own wishes and needs.

She never came alone, always accompanied by her husband, and after giving birth, bringing the baby too. The husband was mostly with the baby in the other room, while very rarely, if the baby cried, Nina would hold her baby during the session. She was often late for sessions after having given birth – either the husband was late from work or they could not find a parking space in front of the building, whereas Nina was afraid to walk alone from the building entrance to the apartment within the counseling center.

Developmental history

Nina P. grew up in a small town, in an impoverished region in central Serbia. She had lived with parents and sister in the family house.

Although in the beginning Nina P. talked about her primary (birth) family members in an idyllic tone, she later described her mother as unstable, inconsistent, someone who is more in tune with her own wishes and needs. In her relationship towards Nina, her mother had a varying attitude – at times she was devoted, other times not, depending “on her own mood”. Mother sometimes showed that her primary family was more important than her secondary one. She was treated at the psychiatric ward several times because of attempted suicide, which mainly occurred in situations of family conflict. Mother never had stable employment, she held temporary jobs from time to time. Nina mentions that she has recently become uneasy when in contact with her mother because she is afraid her mother might take poison „when something unsettles her”, but also that she will spread information about everything that had happened. The impression is that Nina P. cares more about mother’s needs and wishes than vice versa.

Her father she describes as withdrawn, silent and distanced. Their communication was seldom and limited. In relation to her father, Nina P. feels the most shame „because of everything that happened”. From time to time he works at the local factory.

Nina P. speaks about her sister with pride. She says that they have a good relationship and that contact with sister does her good. Her sister also holds temporary jobs.

Nina P. states that there had been no experiences of abuse or previous traumatization whatsoever.

Traumatization and psychological complaints

Before I start describing the traumatization that Nina P. was subjected to, it is important to point out that regarding some parts I still do not have precise data. I did not ask questions on issues which the client did not bring up herself, with the aim of respecting her wishes and needs, which

I considered much more important for an efficient psychotherapeutic process than precise data as to when and which exact events happened. During her junior college Nina stayed with close relatives, married couple Jelena and Milan. Milan first raped Nina when she was 21 years old. It lasted for some time, then Nina P. returned to live with parents, whom she told nothing, nor did they notice that something was going on. Since Jelena was diagnosed with cancer, Nina's relatives and mother insisted that Nina stays with the relatives, to help with house chores, "to return the favor they had done her by providing accommodation while she was at college". The sexual abuse then continued, whereas Nina blames herself the most for having agreed to return. After a while, Nina P. became pregnant, because of which Milan started acting as pimp, so that she could "earn money for an abortion". Jelena took clients' phone calls and scheduled time slots, while their son, Nina's cousin, also sexually abused Nina on several occasions. Milan and his son beat her and intimidated her "that they will expose her". All the while, her parents did not notice anything, although they were in contact. All the money she earned by way of prostitution was taken by her relatives.

Nina P. was the victim of human trafficking for about five years. She never said a word to anyone until the moment she started living with her husband, who insisted she take legal action. It was then that she told her parents, who supported her, whereas certain relatives exerted pressure so that she would drop charges. The abusers threatened they would harm her and her nuclear family members because she had taken legal action, but all three were arrested as soon as the charges were pressed. During the court proceedings Jelena was released from custody due to health problems, in order to continue cancer treatment, while her husband and son stayed in prison.

At the moment when Nina P. sought psychotherapeutic help, her psychological complaints at the time boiled down to lowered mood, apathy, irritability, anxiety, preoccupation with endured trauma, dread of possible spreading of information about her being prostituted and raped, sense of inadequacy and self-contempt because of endured experience, feeling of helplessness and "flashbacks" of rape scenes. She never had disassociative phenomena, and remembered the entire experience clearly. She attempted suicide after her husband discovered her traumatic experience (he read her letters), and had suicidal ideas several more times, from which she was distanced at the moment when she came to me. She

claimed that she gave up on the idea of suicide „because of the child“. We considered the option of including a psychiatrist in the treatment, although Nina declined it. Taking into account that the mentioned complaints were not persistent, I did not insist on the necessity of seeing a psychiatrist. She was functional all the while.

When it comes to personality structure, Nina P. manifests several passive-dependent elements, tends to neglect her own wishes and needs in order to please others, has low self-confidence, low level of initiative, tends to efface her own capabilities and overestimate the capabilities of other people and extent of life's hardships, she is pronouncedly self-critical, with pessimistic cognitive style. Most of the above traits existed even before the traumatization experience.

Psychotherapeutic process

First contact and establishing the therapeutic relation

During the first contact, Nina P. was terrified and overwhelmed with shame, she could hardly speak, being silent for long stretches of time and avoiding eye contact. Regardless of her reticence in contact, she seemed warm. She is very tidy, adequately dressed for her social status. She mentioned that she sought help because she is terrified, most of all from news spreading about her "relative having raped her". In addition, she is constantly alert lest someone might recognize her, which is why she avoids contact with new people.

During the first session I assessed that it is very important not to interfere with her manner and tempo of speaking, so that she would not feel pressured and so that I would avoid deepening her feeling of shame by mistimed interventions. My active listening along with expressing empathy for her feelings were very important for creating a relation in which Nina felt safe and accepted, to the extent possible at the very outset, keeping in mind that she was very reserved and partly mistrustful. For the purpose of establishing a good therapeutic relation, I used a set of interventions such as open-ended questions, active listening, reflecting and summarizing, so that Nina P. would feel I understand and accept her. Generally, in the several initial sessions, my approach was nondirective, so that Nina P. dictated the tempo and content of work. I chose such a non-

intrusive approach with the aim of avoiding the risk of Nina experiencing being pressured and threatened in the therapeutic relation.

Challenges of work

Negative attitude towards herself was Nina's major psychological problem. It manifested itself through feeling of shame, self-contempt, disregard for her own wishes and needs, passive approach to problem solving and obtaining of pleasure. In my opinion, Nina had had the same problem in a lower intensity even before the traumatization experience, which significantly contributed to the mentioned problems deepening.

When it comes to feelings of shame, guilt and self-contempt, my interventions boiled down to expressing empathy, pointing out that those feelings are an expected reaction to the endured traumatic experience and inviting her to check how realistic the logic is that is at the background of the mentioned feelings.

Furthermore, the problem of *accumulated rage* constituted salient content of the psychotherapeutic process. Occasionally she had an "acting out", in situations which reminded her of the traumatic experience by way of her sense of being unjustly threatened. Strategy of solving the above problem consisted of several aspects. The first objective we set was for her to allow herself to feel anger, always, anywhere and any place, after we achieved that she stopped believing how every feeling of anger must turn into action and that expressing anger leads to loss of control over one's behavior. Then, it was important to allow herself to express anger and dissatisfaction immediately after each situation in which she feels threatened, instead of accumulating rage, which results in harmful uncontrolled release (by hitting things and self-inflicting physical injuries). This was a very difficult task for Nina P. considering that such a pattern of functioning had been completely unfamiliar to her, even before the traumatization. The third aspect of resolving pent up rage pertained to devising a plan for subsequent expression of rage towards the abusers. Towards that purpose, Nina would imagine the abusers and tell them everything she thinks about them, their actions and way they had treated her. I encouraged her to verbalize openly and harshly, because her experience was equally brutal and inhuman. I insisted on calling the abusers that instead of "relatives" with the aim of creating a more realistic experience of their responsibility. It was easier for her to first address the

abusers by way of writing letters. She did the same in the case of her parents, because of severe neglect.

After she began occasionally expressing anger and dissatisfaction toward members of the family she lives with, she learned the principles of *assertive expression* of the mentioned feelings.

One of the challenges encountered during the course of work was for Nina to put her own *needs and wishes* before those of other people (except for her small child). Nina P. succeeded in refusing to speak in detail about her traumatic experience even though her husband had pressured her to do so, instead asking him to hug her in that situation. She also learned to ask for a hug from her husband in situations when she is tense and irritable, without asking questions. She made an agreement with him to tell him when she was feeling uneasy, instead of covering it up, but also not to go into conversations on topics Nina did not want to talk about.

Keeping in mind that communication with parents additionally upset her (she always got some information about the abusers) I supported her in reducing these contacts to the intensity she finds comfortable. Nina was relieved due to this permission. She reacted rather well to expressed protection and the fact that her wishes and needs were put first. However, what occasionally presented a challenge for me was *maintaining boundaries between therapeutic and rescue interventions*. My countertransference reaction manifested itself through the experience of excess responsibility for the course of psychotherapeutic process. Knowing that if Nina's part of responsibility were written off, it would contribute to deepening her victim position, I took great care throughout my work with her that we be equally engaged in the psychotherapeutic process.

Nina's *transference reaction* in the psychotherapeutic process manifested itself through very subtle signs of feelings of shame and inadequacy, in the situation when she spoke about the traumatic experience. While working through those feelings, Nina P. reached the insight that she was projecting onto me the signs of disapproval and judging. Work on transference was very useful in strengthening the working alliance, but also in attaining the objective of Nina separating the traumatic experience from her human value.

In later phases of work, obtaining pleasure and finding a hobby were an important segment of work so as to attain the objective of acknowledging own needs and wishes. The result of this work is that Nina indulges herself occasionally, which considerably contributed to the improvement of her life quality.

Nina's *attitude toward members of her primary family* was protective and rescuing, her wishes and needs being second place, because of which Nina felt frustrated and dissatisfied. With the aim of commencing the process of solving this problem, we made an agreement that Nina would talk more about how she felt and what she needed when she talked with her mother or father. Their willingness to hear her out and respect her wishes very favorably influenced her to respect her own needs and wishes to a greater extent as well.

However, a big challenge of work was for Nina to accept the fact that *life can be quality*. In this phase of psychotherapeutic work (after 18 months) she found it strange that nothing bad was happening to her. It became clear that, when there are no negative events in reality, Nina provides them in various ways – through recalling undergone traumas, self-reproach because she does not feel bad yet she should, having in mind the experience she has had, feeling of shame if she is enjoying, since she thinks that she does not deserve enjoyment after all she has lived through, that enjoyment leads to problems etc. The process of working on this problem is still not finished.

Traumatization and capacity building

One of the consequences of traumatization is Nina's experience of being endangered, at the same time attributing unrealistic powers to abusers. The objective of this part of psychotherapeutic work was to create a realistic perception of current powers of abusers, but also of her own current powers. It was important that Nina separate the past from the present, that she had been a victim of human trafficking, but that she is now safe.

The client's traumatic experience led to her *losing faith in the possibility of sincere and benevolent interpersonal relationships*. She avoided social contacts because of fear that someone might maliciously "provoke her with questions about her past", as well as shame because of endured experience. Expressing empathy in connection with this experience, I

requested that we reconsider how realistic the above conviction is, also continuing the commenced work on separating the traumatic experience from her human value.

I helped Nina devise *strategies for efficient self-protection* in a situation when faced with someone who is familiar with the fact that she has endured this type of trauma. Consideration of the fact that she can *now* protect herself, unlike the previous experience, was very useful in attaining the therapeutic objective of creating a realistic perception of own powers and capacities.

Nina was *groundlessly blaming herself* for many things and undertaking responsibility for abusers' actions. She accused herself for not having protected herself from the traffickers. We reexamined her actual possibilities of efficient self-protection in a situation of threats, physical punishment and experience of being humiliated. In addition, we indicated many of her constructive trauma survival strategies (e.g. she wrote down the positive things clients had said about her).

Nina commenced the *process of grieving* because of five-year loss of freedom, which I normalized and connoted as a necessary step in processing the traumatic experience.

Preparation for the trial

The trial itself and going to court was a significant issue in psychotherapeutic work. She was preoccupied with the court proceedings, while feelings of fear and shame were intensified. Her fears concerned her capacity for telling everything that had happened during the traumatization, that those present in the courtroom would not understand her, that the entire procedure is futile. She was afraid that fear would make her speechless, that there would be malicious questions, as well as that she might have a tantrum. She expressed a multitude of unrealistic expectations from herself – that she must look the judge in the eye, speak fluently and seem self-assured.

I assessed that, for efficient testimony, it is important that Nina not undertake responsibility for abusers' actions, as well as that she have realistic expectations from herself, that it is okay to be scared, ashamed, speak interruptedly, look at the floor etc.

During psychotherapeutic work, Nina reached the insight that manifestations of her shame, insecurity and fear are an expected reaction of any socialized person, a fact that can be an advantage in court. Furthermore, she realized that she is capable of thinking even when scared, meaning that she can protect herself in a situation of malicious questions. We considered how realistic the expectation is that the judge would be biased toward the abusers, as well as that abusers would be able to influence the court proceedings.

As the experience of personal power became more realistic, she frightened herself less and less with the trial. Upon second hearing, where she faced the abusers, she was satisfied with how she testified.

The abusers were sentenced to penalties which Nina experienced as adequate and deserved (Milan: nine years; Jelena: eight years; and cousin: three years). This considerably helped Nina to acquire a more realistic perception of their responsibility, but also her own human value.

Work with Nina was a very useful experience for improving my psychotherapeutic skill – all the while I was monitoring the described countertransference, which helped me to perceive her capacities and powers more realistically despite the fact that she had been the victim of human trafficking. My opinion is that this experience will facilitate my future work with traumatized persons.

Psychotherapy with Human Trafficking Survivors – Psychodramatic Approach

Biljana Slavković

Notes on terminology

In the present article the author most often uses the term *survivor*, instead of *victim*. The term *survivor* provides a realistic picture of a person who has preserved a certain level of capacity for recovery and continuing life, since he managed to survive complex trauma. The term *victim* can label a person and affect the perception of that person by the people from her/his environment. However, in certain cases, in direct work with clients it is convenient to use the term *victim* since in such a manner the character of the experience they endured is clearly named (which they do not see clearly because of guilt and shame). For the same reason, it is recommended to utilize the terms *violence*, *abuse*, *torture*.

In the text, the terms *survivor* and *client* are primarily used having the female gender in mind, mainly because of statistics indicating that, in the greatest percentage, women are the ones who had been subjected to human trafficking trauma. Of course, the suitable term (*survivor*, *client*) also relates to men and children of both sexes who have experienced trafficking.

Terms *perpetrator*, *trafficker* and *human trafficker* are used as synonyms in this article.

In the Serbian language, the word *trauma* is most frequently used twofold: to signify "a traumatic event", but also meaning "the consequences of

such an event (trauma)". Clarification of these terms is important so as to normalize, in treating survivors, "psychological trauma as a normal response of the victim to an event which is not normal (violence)" (Autonomous Women's Centre, 2009). This distinction is significant because it is very useful for survivors to understand and accept their state as something that was the only possible response, a strategy by way of which they survived violence. In their mechanisms of power and control, the perpetrators always normalize their violent behavior and interests, transferring the responsibility for their own violence to the victims. Victims are ashamed of their position, feeling guilt because of their situation and believing that they themselves are to blame for what is happening to them.

Traffickers are very manipulative persons, with psychopathic personality characteristics, exceptionally organized, with plenty of resources (money, corruption, weapons). In their big so-called "work", they successfully make goods for sale out of people (women, children, men). They undermine victims' identity, humanity, spontaneity, resilience, health, hope, trust in people, life joy – all that makes them human. With the help of similar mechanisms used by Nazis to dehumanize holocaust victim, turning millions of people into numbers, so as to steal their property, while burning the victims in furnaces.

Proper usage of language and adequate terminology in itself represents a significant healing agent and ensures that the threat of survivor revictimization is lessened in psychotherapeutic work, counseling, representing the clients.

Psychotherapy with clients in NGO ASTRA (Belgrade, Serbia) – Concepts, experiences, challenges, recommendations

Since human trafficking is a complex phenomenon, I will offer basic information about the destructive effects on survivors first. I will present the main characteristics of violence against the victims, mechanisms of psychological trauma as the outcome, i.e. psycho-physical response to prolonged traumatic situation of human trafficking. The present paper will provide a concise overview of trauma consequences, symptoms,

survival strategies. More details on symptoms can be found in the text by B. Slavković, "Human Trafficking– Experience of Complex Trauma – Necessity of Protecting Survivors from Retraumatization by Institutions, Professionals and Procedures" (in: *Combatting Trafficking: Good Practice – Handbook for Institutions*, Belgrade, 2010). Furthermore, details on psychodrama (PD) as a modality recommended by the author for working with survivors can be found in a series of professional articles and books.¹⁸

In this paper, the author uses personal professional experience in working with ASTRA's clients who had been involved in various forms of psychotherapy during the period of six years. It should be noted that there are significant differences between crisis intervention, short-term and long-term psychotherapy in working with trafficking survivors.

Psychological trauma

"Psychological trauma is usually defined as an event outside common human experience which represents a life threat. A traumatic event disables customary response systems which provide persons with a sense of control, connection and meaning. Traumatic events cause a breakdown in habitual systems of adaptation to life conditions. The common denominators for psychological trauma are: intense fear, helplessness, loss of control, fear of annihilation."¹⁹

Individual traumatic event may occur in the life of anyone (natural disaster, death of a loved one, street mugging etc.). Prolonged, repeated trauma appears in situations of subjugation, when the person cannot run away because she is under constant control of the perpetrator (as in the situation of domestic violence). Thus a special relationship is created between perpetrator and survivor based on a specific relation and coercion. Such a situation certainly also pertains to persons in the human trafficking chain. It is obvious that the perpetrator, in this case trafficker, becomes the most powerful person in the survivor's life, whereas the psychology of the survivor stems from actions and beliefs of the trafficker.

¹⁸ A list of recommended texts on the usage of psychodrama in work on overcoming trauma can be found in the section *References*, at the end of this article.

¹⁹ Džudit L. Herman, *Trauma i oporavak*, Serbian edition: Psihopolis, 2012. p. 68

Trauma caused by human trafficking – complex trauma

The term *survivor* relates to each person who is compelled, against her will, to perform certain jobs. “Isolation and exclusion are also trafficking terms, covering the forms of control exercised over a trafficking victim to keep them from the outside world”.²⁰ Each person who is a trafficking survivor has experienced complex psychological trauma. Psychological trauma, as the survivor’s response to a traumatic event, will differ in each person, whereas the factors which impact on these differences I will address further in this paper. At present, it is important to note that, because of different reactions to trafficking-induced trauma, institutional professionals should provide an individualized approach for each person, especially when it comes to crisis interventions and processes of long-term psychotherapy. That way, the threat of generalizations can be avoided, as well as personal projections of the therapist about needs, difficulties and capacities of the survivor. Accordingly, processes of helping survivors are strengthened by realistic, not idealized expectations which other professionals have about ongoing psychotherapeutic treatment results (e.g. unrealistic expectation of prosecutors or representing attorney that treatment will quickly build the survivor’s capacity to successfully participate in court proceedings).

Human trafficking as a form of the most intense violence (torture)

Trafficking as a complex psychological trauma encompasses all existing forms of violence that the perpetrator inflicts, and that fact later represents exceptional challenges in recovery of survivors. It includes physical violence, psychological violence, sexual violence, economic violence. It should be pointed out that trafficking is mostly considered to be a form of gender-based violence, since the majority of victims are women (girls and children). The role of women in patriarchal society is in accord with inflicting violence on women; the woman’s role as passive–submissive is generally accepted, whereas the expectation is that the woman will withstand domestic violence (from where trafficking victims are often “recruited”). Furthermore, idealization of “romantic love” is present, as well as the concept of saving the marriage at any cost, arranged marriages,

²⁰ Jenny Bjork, Ketië Chalk (eds.), *10 things you need to know about human trafficking*, World Vision Asia Pacific, 2009, p 4.

sexualization (woman as sex object), presence of incest occurrences in the family, frequent lack of social (as well as legal) condemnation of rape, crises of postwar and transitional environment, which aggravate violence against women, economic pressure on women to ensure survival of the family during economic crisis etc.

The following characteristics describe, from the aspect of psychological experience, the typical situations faced by survivors in the trafficking chain:

- » Unpredictability of events
- » Uncontrollability of events²¹.

Strategies of human traffickers

In this section, a concise list of mechanisms of control which traffickers use during torture of survivors is provided.

Limiting movement – Present in all forms of human trafficking. In the majority of cases all aspects of the survivor's life are under trafficker's control (food intake, sleep, hygiene, medical treatment, contacts etc.). According to United Nations' data, among sexually exploited survivors, "just 3% stated that they are always free", although a subsequent interview showed that it meant the following: "I was always (free), I could go out when I wanted to, but only with someone".²²

Violence (threats, intimidation, attacks, exposure to dangers) –According to United Nations' statements, around 60% of survivors who have been in a sexual exploitation chain had experienced violence in the period prior to being drawn into the trafficking chain, while 90% of them confirmed that they were subjected to physical and sexual violence or exposure to another person being violated in the trafficking process.

Abuse in these cases ought to be interpreted in the most general sense: as psychological (which is contained in other forms of abuse),

²¹ Metin Basoglu, Susan Mineka (eds.) *The role of uncontrollable and unpredictable stress in post-traumatic stress responses in torture survivors*, in *Torture and its Consequences: Current treatment approaches*, M. Basoglu (ed.), Cambridge, 1992, Internet http://www.unodc.org/documents/human-trafficking/TIP_module3_Ebook.pdf, 10/04/2013, p.4

²² "Anti-human trafficking manual for criminal justice practitioners, Module 3: Psychological reactions of victims of trafficking in persons", UN Office on Drugs and Crime, Vienna, 2009, Internet, http://www.unodc.org/documents/human-trafficking/TIP_module3_Ebook.pdf, 10/04/2013/, p.5

physical, sexual, economic. A situation whereby one's needs are neglected regarding food intake, hygiene, health protection (e.g. obtaining necessary medications, not treating wounds, coercion to have intercourse without prophylactics or while pregnant) is also considered to be abuse. Threats that family members or other loved ones will be hurt additionally endanger the survivors in the psychological sense. Abuse (e.g. threats) from traffickers' criminal groups is experienced by survivors even after exiting the human trafficking chain. The situation is aggravated by slow investigation and court proceedings, in which survivors are often retraumatized because of inefficient protection by the police and because of their economic dependency (lack of employment, housing, bad psychological and health situation, stigmatization by the environment, often family itself).

Such situations make it much harder to engage in profound psychotherapy, as the clients are in a continuous crisis situation.

Symptoms which appear as the outcome of exposure to trafficking

Emotional reaction after surviving violence is defined as violence induced trauma syndrome. All that the survivor experiences at the time is a normal response to an event that is not normal. It is possible to recognize three phases of responding to a traumatic situation: immediate response, reorganization/adaptation and recovery phase.²³ Phases of responding to a traumatic situation and symptoms that characterize them help us to adequately recognize the state in which the client is, as well as to plan interventions in the recovery process.

Due to the significance of understanding how much a traumatic experience endangers the survivors, we will quote the following: "Dr Bessel Van der Kolk says that 'from the very outset the body is involved in the traumatic process. Changes in the nervous system have been demonstrated, as well as information processing in the brain, hormonal balance and regulation of vegetative functions. Some of them appear as structural changes (...), which is also a reason to believe that long-term changes elicited by imbalance in regulatory functions and increased

²³ Ivana Slavković (ur.) *Program razvoja dobrih praksi u oblasti nasilja u porodici. Rad sa ženama žrtvama nasilja u porodici*, Autonomni ženski centar, Beograd, 2009, str.3

tension can cause irreparable changes and be the basis for increased proneness to illness and fatality of traumatized persons.”²⁴

Taking into account that human trafficking is a complex trauma which includes long-term and intensive abuse, the following clusters of negative consequences among survivors should always be observed:

- » physical injuries
- » acute and chronic somatic illnesses
- » long-term impaired mental health (emotional problems, psychosomatic problems, bad social functioning, emergence of severe mental illnesses). According to UN statistics, 52% of women, after 90 days from exiting the human trafficking chain, continue to have at least 10 symptoms of impaired mental health. According to research on survivors’ experiences, the symptoms matched the intensity of torture symptoms.²⁵

When it comes to physical symptoms, there is certainly presence of exhaustion, weight loss, sleep disturbances (insomnia or extended sleep), gastrointestinal problems, immune system disorders, dermatological, genital and venereal, neurological, sensory problems of hearing and sight etc.²⁶ Presence of a series of physical symptoms further conditions and exacerbates the emotional state of survivors. More will be presented further in this text, especially because professionals in institutions will primarily be faced with this symptom cluster in contact with survivors.

Symptoms of mental health disorders as the outcome of trauma

Symptoms and states that emerge among survivors as consequences of traumatic experience during trafficking are numerous: depression, pronounced anxiety, psychosomatic disorders, PTSD²⁷ characterized by intrusive recollections – *flashback* episodes, brought on by the most varied triggers, withdrawal and avoidance, nightmares, intensive fears, feeling that one is losing one’s mind, incapability of rebuilding or

²⁴ Tamara Štajner-Popović, Sverre Varvin, Kovitlac: *psihoanalitički osvrti na traumu*, (ur.), IAN, 2002, str. 175.

²⁵ *Anti-human trafficking manual for criminal justice practitioners, Module 3: Psychological reactions of victims of trafficking in persons*, UN Office on Drugs and Crime, Vienna, 2009, Internet http://www.unodc.org/documents/human-trafficking/TIP_module3_Ebook.pdf, 09/04/2013, p.7

²⁶ Cathy Zimmerman, Mazedra Hossain, Kate Yun, Brenda Roche, Linda Morison, and Charlotte Watts,(urs.)*Stolen Smiles*, Internet, <http://www.lshtm.ac.uk/php/ghd/docs/stolensmiles.pdf>, 08/04/2013, p. 55.

²⁷ post traumatic stress disorder

maintaining relationships etc.), self-destructive behavior (impulsiveness, self-harm, suicidal impulses), animosity towards the environment, altered sleep patterns, eating disorders, addictions, psychotic episodes.

Role of the psychotherapist when working with human trafficking-induced trauma survivors

Context of psychotherapy with clients when service providers are NGOs

Prior to commencing work with human trafficking survivors, it was important to define the role of the psychotherapist in this context, in which she is hired by ASTRA to carry out psychotherapy with clients within the organization which the clients visit in order to obtain other forms of support as well. The fact that ASTRA finances the majority of its activities by way of donor programs, including psychotherapy, influences to a certain extent the psychotherapy dynamic: alongside the client and psychotherapist as parties in the treatment setting, there is also “a third” in this relationship, mostly because of impossibility to function otherwise in practice. This primarily means that certain funds are limited (time and resources) and that the donor has particular requirements regarding submitting reports on clients’ progress. These requirements are often opposed to maintaining the inviolability of confidentiality principle in the therapist–client relationship. The confidentiality principle is a basis for building and keeping trust between client and psychotherapist. Accordingly, control in this relationship must be held by the parties themselves, without interference by “the third party”. However, the context of donor funding of survivors’ psychotherapy programs has the unavoidable complicating effect on uncertainty of support duration (especially in long-term treatment). Therefore it is important to inform the client and therapist in due time about temporal limitations of therapeutic work, as well as other changes that can be imposed from outside that may disturb the therapeutic *setting*. The recommendation is that sufficient time must be provided for working through separation and adequate closure of phase attained in the therapeutic process.

When it comes to addressing trauma and crisis intervention, in working with clients at ASTRA, I leaned on earlier experiences from that field, which I had been acquiring since the year 2000 (NGO Susret). They include teamwork

in psychodrama with children and youths from a social welfare center, as well as treating internally displaced persons and refugees (children, youths, single mothers) in a collective center (long after the specific traumatic event), individual work with women victims of domestic violence who had been beneficiaries of specialized NGO services, teamwork (group work) with children in crisis interventions after placement in shelters, psychodramatic experience and individual psychodramatic experience in work with clients who had frequently been victims of family violence and other forms of violence, as part of "Psychodrama Institute". In addition, my long-term involvement in the area of *the right to a life without violence*, i.e. preventive work with young people and training or supervision of experts in social welfare centers as well as other professionals (police, prosecutors, educational institutions, NGOs, politicians, local self-government representatives, media representatives etc.) in relation to the phenomena of violence in general, gender-based violence, family violence, peer violence, violence against minorities, transgenerational violence, institutional violence, have helped me immensely to understand better the clients who were entering the psychotherapeutic process as trafficking victims. Why was the experience I mentioned important? Because human trafficking victims have survived a big part of the listed forms of violence, i.e. they had been exposed to long-term, multilayered, cyclical violence even before they were drawn into the trafficking chain.

Personal capacities of the psychotherapist for working with trafficking survivors

"Studying psychological trauma means facing human vulnerability in the natural world as well as the capacity for evil in human nature. Studying psychological trauma means being witness to horrifying events. When these events are natural disasters or 'God's will', those who have witnessed them immediately empathize with the victim. But when traumatic events are purposeful acts, the witnesses are drawn into a conflict between victim and abuser. It is impossible to remain morally neutral in this conflict. The witness is compelled to choose a side. It is very challenging to be on the abuser's side. The sole thing that the abuser asks the witnesses to do is to not do anything. He is invoking the universal wish to see no evil, hear no evil and speak no evil. Contrary to that, the victim asks the witness to share with her the burden of suffering. The victim demands that some action be taken, demands participation, remembering."²⁸

²⁸ Herman L. Džudit, *Trauma i oporavak*, op.cit., p. 28

According to Dr Eva Roine²⁹, “Trauma dwells in the body as a character pattern. It must be worked through. We must find the language of the body and follow it without pressure. But, if therapists have not understood and experienced traumas of their own lives, they will not dare descend into their patients’ depths of being. When treating such patients, it is more dangerous to stop halfway than go all the way. Accordingly, retraumatization and victimization may occur when the therapist is too afraid of facing her own anxiety.”

In some situations, as a therapist, I have come across tough challenges when I found myself in the role of *witness* to survivors’ experience. Clients had been subjected to brutalities that we are almost incapable of comprehending in our *average lives*. I was attuned to my inner responses as I listened to their experiences, or directed psychodramas, or intuited what was not uttered yet, while “in the presence of pain”. My internal responses ranged from a strong feeling of empathy to feeling of rage towards abusers, helplessness, sadness, desire to protect each of my clients completely and forever, to be directive and “solve it all quickly”, to become involved in the greatest possible extent. Or else I would feel that I could no longer listen, that I was occasionally sleepy, that time is passing slowly, that I feel physical nausea, heaviness or some other unpleasant symptom. Part of the strategies I apply in working with survivors lies in paying attention to what is going on within me, in understanding my own inner response, resonance – as a part transferred from clients or part of my countertransference. As a psychodrama therapist, I understood that I bring my specificities into the process, that something is related solely to me and my other roles. I realized that efficient work with clients requires that I take care of myself, a request not always easy to fulfill.

How not to be “the omnipotent psychotherapist”?

I would like to add that it is also useful to give up the already mentioned role in which psychotherapists and other counselors often find themselves – “the rescuer’s” role, based on excessive expectation from ourselves when it comes to helping clients. This often happens because clients unconsciously convey intense expectations to the psychotherapist, but also because of pronounced actual powerlessness, which is a reflection of the lack of overall social, long-term and systemic support to survivors.

²⁹ Roine, E., PhD, *Upotreba psihodrame sa žrtvama traume, Psihodrama i trauma – odigravanje sopstvenog bola*, Kelerman, Peter Felix; Hadgens, K. (urs), IAN – Međunarodna mreža pomoći, 2001, p.73

Becoming conscious of one's own limitations and reminding oneself that clients have the right to their own limitations (despite our effort) is of great benefit for the therapist-client relationship, as well as the therapy process efficiency. That way we additionally strengthen the survivors' right to their own decisions and building long lost autonomy, in which their resilience plays a significant role.

Teamwork with colleagues in ASTRA teams represents, in my personal experience, a model for safer and more efficient work with clients, especially when it is necessary to plan broad measures of support for clients, particularly on the level of safety, cooperation with colleagues from other institutions and organizations (psychiatrists, psychologists, representatives of other psychotherapeutic modalities). Constant personal supervision/intravision helps in the prevention of secondary victimization of those of us working with trafficking-induced trauma survivors and I consider it compulsory.

Recommendations for those in the helping professions working with persons who have survived human trafficking-induced trauma

When speaking about the role of support for survivors, I would like to point out the significance of certain principles for working with violence survivors³⁰(diverse forms of violence towards women, domestic violence, trafficking) which are to be recommended to each helper, regardless of whether s/he is a professional in counseling, psychotherapeutic work, providing various forms of psycho-social assistance (hotline services, volunteering, providing humanitarian aid, assistance in employment etc.), or intervening as medical doctor, school psychologist, social worker, legal advisor, teacher, or providing any other support service to survivors.

- » Believing, not judging, accepting and validating experiences of the victim of violence (survivor) – The woman who is a victim of violence mainly feels guilty and ashamed, at least for part of the violence she

³⁰ Cited in: Autonomni ženski centar (adapted and amended edition) *Work For Care; Sexual and Domestic Violence During and After War, A Trainers Manual*, Admira Foundation, Utrecht, 2005.

Note by B. Slavković: The listed principles relate originally, in the quoted text, to work with women who have undergone various forms of violence against women, but I recommend them as completely applicable and indispensable principles for ethical and efficient work with human trafficking survivors (who are mostly women, girls, children, and a smaller number of men).

suffers. Women will find it hard to retell their entire experience if not approached with complete belief, acceptance and basic assumption that they are not the ones who provoked violence.

- » Providing immediate assistance in the extent possible, followed by building a support network – A wider support network provides more efficient protection and recovery, lower dependency on just one person or group for support.
- » Planning safety and providing protection– At every moment, the woman’s safety must be a priority. In some cases, the survivor will underestimate the degree of danger. In such situations, a professional has the obligation to insist on planning the woman’s safety, even though we acknowledge the victim’s wish to make her own choices.
- » Confidentiality – It is of significance to respect the victim’s wish for confidentiality of facts she has spoken about, as well as to understand the need for confidentiality because of her increased experience of safety. The woman who addresses us for help usually has an emotional history filled with mistrust and disappointment, so the confidentiality principle is crucial and fundamental for creating a relationship of trust.
- » Interpreting survival mechanisms as strength, not as pathology – These survival mechanisms should be recognized and acknowledged as something that has helped the victim at a certain moment to survive and cope with her situation at the time, but should not be regarded as an indicator of psychopathology or “cause” of violence. Consequently, it is important to recognize that, after a certain time, some of these strategies do not have any effects or may even prove to be counterproductive for the victim.
- » Significance of educating the victims about violence– about mechanisms of violence, consequences, survival strategies and symptoms.
- » Respecting the woman’s volition – Although it sometimes does not match our attitude, it is our obligation to respect the survivors’ right to make independent decisions about their life.
- » Believing that there is a way out of every situation of violence– Continuous support and faith in the woman’s strengths that she would succeed in escaping violence.
- » Voicing a clear opinion on violence– We condemn violence and the abuser as the sole responsible person for the violence he is inflicting.
- » Striving for equality in our relationship with the woman – Survivors always have less power than helpers and it is important that we refrain from abusing the power we have at our disposal in our own roles.

Psychotherapy with persons who have survived human trafficking – Experiences at ASTRA in the period 2007–2012

“Trauma strips the victim of power and control; therefore the guiding notion for recovery is renewal of the survivor’s power. This task has the advantage over all other tasks, since no other therapeutic work can succeed if security is not provided in an adequate manner.”³¹

ASTRA has timely realized, unlike many state institutions, the destructive effects which human trafficking leaves on survivors. Therefore the decision crystallized itself about providing psychotherapeutic treatment to clients, as part of the overall psycho-social, legal and other support which survivors receive in the organization. In addition to hiring several psychotherapists in private and state-owned institutions for work with clients, in 2007 psychotherapeutic activities were initiated at the ASTRA Day Center, which have lived on to the present day, in various forms.

Experience which I will share in this text comes from several different roles that I had as an associate at ASTRA Day Center: on assignments of crisis intervention, individual and group psychotherapy of clients (psychodrama) who have survived human trafficking, as well as clients rescued immediately before they were supposed to enter the trafficking chain (after having gone through the phase of being recruited by traffickers); from the role of leader of periodic activities on prevention in working with vulnerable youths, using group work techniques, art-techniques and psychodrama and, ultimately, from the role of supervisor to the organization’s hotline team, which I held at one period.

A text of such scope certainly requires a summary of diverse experiences, with an attempt to systematize, based on mentioned practice, the major useful insights and skills in working with survivors. The author will respect the secrecy of survivors’ identities and in cases when supplying examples, they will be carefully expounded so as not to endanger the interest and protection of survivors.

³¹ Džudit L. Herman, *Trauma i oporavak*, op.cit. p. 258

Statistics and timeframe, indications for psychotherapy

As a partaker in these activities in the period from 2007 until today (September 2012), I will share the experience I acquired working with trafficking survivors, who were ASTRA's clients at that time. In addition to a psychodrama group, individual psychotherapy involved eighteen clients during the five-year period, of which three clients had been in treatment as part of the psychodrama group, switching to individual therapy after the group had terminated. Individual work was based on psychoanalytic psychotherapy and application of individual psychodrama. Group work with youths from child care institutions, with the aim of prevention, involved nine clients of both genders and was conducted periodically during the years 2010/2011.

In the present text, the focus is on psychotherapeutic work with clients and perceiving difficulties in mental functioning which prevailed among trafficking victims, the survival strategy these persons used, resistance we encountered in the therapy process, major challenges for the therapist and method and interventions which proved to be useful or less successful. Since this article does not contain complete case studies, insights will be presented as overall observation of what was the most striking and widespread in working with human trafficking victims, whereas the author has taken care so as not to induce generalizations in readers. What was salient for the therapist was certainly constant concern about individualized approach to each client, regardless of similarity of problems faced by persons who have exited the trafficking chain.

Indications for commencing psychotherapy

This is an important issue whenever we encounter clients, so categories we use for assessing capacity for psychotherapy also hold true for trafficking survivors. In the selection process, I used, among other things, valuable insights about the application of psychoanalytic psychotherapy in working with torture survivors from wars on the territory of former Yugoslavia, especially because trauma brought on by human trafficking is defined, to a great extent, as torture. "In initial encounters there is a need for the therapist to acquire a notion about the client's mental functioning, degree to which her capacity for relating has been preserved, as well as

ego functions, sensitization to psychological processes – possibility of introspection, capacity for symbolization and verbalization, motivation... This is necessary because we must keep in mind that the clinical features and behavior of tortured clients, especially in initial contacts, present themselves as borderline functioning with prominent usage of primitive defense mechanisms organized around splitting and projective identification. But, such features are most often the outcome of torture itself, since in subsequent work it would emerge that the majority of our clients had had, before the torture experience, a behavior that indicated average distribution of psychological structure and maturity that characterizes general population. As early as the outset of treatment, one should understand, as far as possible, in what way and to what extent the interaction of premorbid structure and torture experience influenced the development of current state, which often means recognizing space and capacities for recovery itself.”³²

The question of motivation is recognized and defined as one of the main bases for successful psychotherapy. “Sufficiently pronounced motivation for change enables both the therapist and patient to begin and develop the psychotherapy process, to overcome expected difficulties and hiatuses during its course as well as to successfully bring it to closure. Motivation for psychotherapy is most often based on the intensity of psychological suffering and certain degree of recognition that impact may be exerted on that suffering by way of psychological means. It is also built on the basic assumption and trust that the other person can help with that. Other traits as well, such as socio-cultural ones, intelligence, educational level, environmental support, sometimes influence decisively the success of psychotherapy.”³³

According to my experiences, those who have survived human trafficking do not express pronounced need for psychotherapy, i.e. they rarely recognize psychotherapy as a way to reduce their psychological suffering. Alongside basic mistrust towards people in the period after exiting the trafficking chain, prejudices against doctors are activated, as well as against psychiatrists, psychologists, psychotherapists even in the context of a non-governmental organization which serves to offer support. For that reason, it proved that periodic talks with ASTRA’s clients

³² Slavko Mačkić, Jovanka Cvetković (urs) *Tortura u ratu, posledice, rehabilitacija, Psihoanalitička psihoterapija žrtava torture*, 2004, IAN, p. 229

³³ *Ibid.*, p. 231.

were useful, as their objective was to provide information on what psychotherapeutic treatment is and what purpose it serves. Thus in many cases resistance towards entering treatment was reduced. Furthermore, some clients would exchange experiences at the Day Center with those already in treatment, which would incite their motivation too. Additionally, the phase in which the clients were at the time influenced motivation: in certain cases intensive symptoms motivated the client to enter crisis intervention treatment; on the contrary, clients who had survived trauma much earlier, with the presence of survival strategies that were partly still functioning, had great fear from “opening up old wounds”, simultaneously feeling that perhaps they would also want “to get rid of the horror that is still in them”. In the case of entering therapy, that ambivalence considerably affected the building of a relationship with the therapist, as well as dynamic, continuity and outcome of treatment. For instance, some clients of the psychodrama group dropped out after several sessions – fearing that contact with experiences they had tried to “forget” might impact negatively on their “new life, relationship with new partner or newborn children”. Certain clients had been receiving psycho-social support at ASTRA for years, but whenever offered to enter psychotherapy, they refused to consider joining any of the offered treatments (“it’s too late now”, “as if that could change anything”, “I have more pressing concerns in life”, “my health is imperiled”). It seems that these clients could not bring into relation the experience of past trauma with how they are feeling and living in the present, which would then motivate them for psychotherapeutic work on experienced trauma. Very often they suffered from psychosomatic difficulties and truly impaired physical health. They had difficulties in interpersonal relationships (fears, distance, ambivalence, mistrust, lack of self-confidence etc.), partnerships (impossibility of being in an emotional relationship, choosing partners who neglect them or are violent etc.), difficulties in parental roles. They showed signs of high anxiety or depression symptoms. Moreover, the usual life challenges were additional overly heavy burden for some of these women; they felt tired and spent, without vitality. Still, resistance was sometimes so intensive as to make them react with anger towards counselors who were suggesting at least the initial talk with a psychotherapist. In these cases, when there is no inner motivation, the policy of the organization is to always respect the clients’ autonomy in making the decision as to whether or not to enter treatment, this decision in no way conditioning other forms of assistance provided.

Applying psychodrama in work with persons who have survived human trafficking-induced trauma

Indications – motivation, group structure and dynamic of relations and psychodrama process

From fear to changes – concise overview of psychodrama process in the group

The psychodrama group was formed at ASTRA in February 2007 and lasted fifteen months. The setting meant two monthly sessions in the duration of two and a half hours. After initial substantial turnout (ten women), the group was reduced to five female clients, of which three were the actual group core, i.e. came more regularly and the life of group process unfolded around them.

Such a situation regarding presence of clients in the group was partly the outcome of external circumstances – availability of work space and funding, but primarily of limited possibility of clients to be present in Belgrade more often, as well as in the organization itself. All psychodrama group members were women (which was in fact a requirement, taking into account the type of trauma), the age varied from adolescence (18–19 y.o.) up to 32 y.o., which also represented a challenge in work.

All members had been severely neglected and abused in their families (all of them stated that they had been abused in the primary family), and some of them had spent part of their childhood in social welfare institutions, where they also experienced aggression, in various forms of peer violence. In some cases, domestic violence included sexual violence, which aggravated their position, and was mostly the trigger for entry into the trafficking chain. These girls mainly had a history of extreme poverty; some of them had behavior disorders (earlier they had been included in psychological and psychiatric treatments in adolescent centers). Human traffickers were most frequently neighbors, acquaintances, romantic partners or extended family.

During work in the group, clients reported diverse health impairments: epilepsy, depression, self-harm, asthma, alopecia, eating and sleeping disorders, various gynecological or endocrine complaints, a set of psychosomatic symptoms. Certain clients were pronouncedly closed

and withdrawn in the group, or else extremely open, with a need to utterly expose themselves. Mistrust prevailed, as well as occasional animosity and aggression toward others in the group, including the therapist. They strongly voiced their doubt that “anyone can accept them and understand their pain.”

For months, the majority of clients did not open up the field of experienced trauma; memories had been repressed or split off, and sometimes they would say that “they actually forgot what really happened, that they can’t stand thinking about it”. I noticed temporal disorientation – relating to when and what went on, not just in connection with the exploitation period but earlier periods too, especially for those clients who had been displaced from family and lived in social welfare institutions. A strong experience of discontinuity existed that had been created by various intensive traumatic events (from domestic violence and later trafficking-induced trauma).

In group life, there was presence of dynamics of frequent reconsideration of trust and safety: fear from other group members or therapist, clients’ experience “that they are different and forever marred”, “as if I were *alien*”. All clients had a profound feeling of emptiness and “damage, revulsion towards self and others”, elements of depersonalization and derealization emerged. On the cognitive plane, there was presence of passivity, concentration problems, impossibility of following what another person is saying or what is unfolding in group work. When it comes to value principles, lack of hope for the future was evident, and opposite to that, presence of idealized fantasy that something could “suddenly save them” (“unexpected force that appears out of nowhere and solves things”).

Period of changes

After several successful sessions based on clear rules (benevolence, “I participate as much as I want”, “I don’t hurt myself or others”) and when the number of present members became constant (around four months since the start of group work), thanks to establishing a minimum of cohesion and trust in the group, there appeared a need to speak about and to enact feelings of powerlessness, anger, sadness. There was a pronounced need for mutual support and tenderness, and there emerged elements of empathy and tele-phenomenon³⁴, the need for a “a

³⁴ Tele—the concept phenomenon taken from psychodrama of J. L. Moreno signifying “mutual empathy”.

safe place", for "mom who cares about me and bakes cookies that smell good", "for the image of a stronger me from the future", for an encounter with "ruined parts of myself". The appearance and order of these issues in group dynamic or in individual psychodramas could be understood as working through the trauma in phases, of which more will be said later. Psychodrama method made it possible, "by way of enactment, for events to unfold *here-and-now* for the protagonists and thus provide a frame in which we can truly change something [...] In psychodramatic enactment, the person participates with her whole being [...] Psychodrama group work aimed at a breakdown of projections and transference in relationships incites authenticity and enables clients to practice and build relationships based on mutual compassion (tele-feelings)."³⁵

As a psychodrama therapist, in my work with survivors in the abovementioned group, I applied psychodrama based on the following concepts.

"Psychodrama is an action method since the majority of its techniques are action-based. Furthermore, it can also be considered interpersonal therapy as it is realized in a group that becomes the place where quality interpersonal relationships are established. In its essence, it is existential, humanistic therapy which regards the person as a whole and cherishes faith in her/his healthy potential. The view of a person in psychodrama is exceptionally holistic and humanistic. In psychodrama, a person is always regarded in entirety, s/he is a unique, inimitable and authentic being, viewed not only in her/his wholeness but also in relation to the world around her/him. Therefore, in psychodrama, non-verbal language is also important for complete understanding of a person. All psychodrama variants, from existential to psychoanalytic, are based on role theory, developed and original theory of psychodrama."³⁶

Psychodrama is used in work with diverse clients who have different psychological disorder diagnoses. As a treatment principle, it is utilized with neurotic, psychotic and borderline clients. Psychodrama can be used to facilitate development and growth of the personality and its potential. Since it is based on universal human features, psychodrama does not set overly limiting conditions for inclusion of clients in the therapeutic

³⁵ Gabriele Muller, Edita Ostojić (ed.) *Vratiti svoju delotvornost i samopoštovanje: Terapija traume metodom psihodrame*, Kuća SEKA, Goražde, 2011, str.75.

³⁶ Ivana Slavković, *Osnovi psihodrame*, Institut za psihodramu, 2006, www.ip.org.rs. (09/04/2013)

process. In addition, psychodrama is a flexible form in its attitude towards the client, open to integration with other modalities during treatment.

Since it is based on action and includes verbal and non-verbal levels of functioning, psychodrama represents a powerful therapeutic agent, especially because verbalization is impaired as the effect of traumatic experiences. Experiences of repeated sexual abuse, injury and self-harm, with a complex relationship that the survivors have with their own body after such experiences (shame, guilt, repulsion, incapability of accepting "this ruined, gross body", "pining for the lost innocent body", lack of capacity to imagine and carry out future romantic and sexual life, exceptional fear and repulsion towards men, questions regarding one's own sexual identity, actual severe health problems as the outcome of sexual exploitation and physical violence, coercive abortions or giving birth etc.) are successfully treated in a psychodrama group. In that context, group homogeneity where the members shared similar experiences enabled sufficient trust to recall the trauma and exchange related feelings. In addition, psychodrama offered clients in the group an opportunity to discover their capacities and abilities they weren't using or weren't using to a sufficient extent.

Psychodrama and trauma

If we take into account the mentioned psychological, somatic, value-related and spiritual symptoms of survived trauma, we can conclude that psychodrama is a successfully applicable method for working with persons who have survived trafficking-induced trauma, when directed by trained psychodrama therapists and trainers, with certain caution, which will be addressed later in this text. There are numerous examples of psychodramatic clinical practice in the activities of international psychodrama therapists in the fields of torture, sexual abuse, transgenerational trauma of holocaust, PTSD induced by diverse causes.³⁷

"In my experience, when the client brings to life her trauma in a psychodramatic crisis intervention, accepting and integrating it as an event from the past, dissociative and psychosomatic reactions will

³⁷ Examples of successful usage in clinical practice have been described by: F. Kellerman (Israel), A. Blattner (USA), M. Karp (GB), F. M. Bousa – A. E.- Bario (Spain), E. Roine (Norway), A. Bannister (GB), S. Taylor (GB), O. Nave (Israel), Sue Daniel (Australia), G. Leutz (Germany), K. H. Hudgins (USA), A. Schucenberger etc.

disappear equally rapidly as they had appeared. I attribute this effect mostly to the change in adaptive responses to acute trauma, so that traumatic limitations are actively re-entered instead of run away from, traumatic memories are actively relived instead of being kept outside of normal awareness, and there is catharsis and experience of *self* again instead of analgesia and trauma unfolding in the depersonalized *self*.”³⁸

Psychodrama as safe work with human trafficking survivors

“Spontaneity as a self-regulating process is the intermediary between outer and inner world and is responsible for a person’s emotional balance. Starting from such theoretical base, psychodrama strives to provide an opportunity for the protagonist (client) who is fixated on the trauma resolving process to remember, repeat and work through painful events from the past. That process of re-enactment is therapeutic to the extent in which it helps the protagonist to emotionally reintegrate and cognitively process (recognize) loss which has beset him/her, thus enabling the development of spontaneity which could alleviate effects of trauma.”³⁹

It is important to point out the application of psychodrama in work with dissociative disorders – treatment by way of psychodramatic “crisis intervention” through theatrical enactment (physical, emotional, mental expression), with parallel verbalization and processing of affective memories on a symbolic level. The outcome of such approach is fusion/integration⁴⁰. As observed by Karp⁴¹ “the psychodrama method enables new visualizations and verbalizations which replace trauma-related states.”

During the fifteen months of working with ASTRA clients in a psychodrama group, the following therapeutic aspects of psychodrama were applied in work with trauma, in a safe group environment (according to Kellerman):

³⁸ Leutz, G.A., “Über den psychodramatherapeutischen Umgang mit dissoziativen Störungen”, in Peters, H., Schifferdecker, M. und Krahl, A., *150 Jahre Psychiatric Band 1*, Koln: Martini, 1996.

³⁹ Piter Feliks Kelerman, M.K. Hadžins (eds.), *Psihodrama i trauma – odigravanje sopstvenog bola. Terapijski aspekti psihodrame u radu sa traumatizovanim ljudima*, IAN, 2001, p. 21.

⁴⁰ Frank Putnam, *Multiple Personality Disorders*, New York Nad London: The Guilford Press (cited from *Psihodrama i trauma – odigravanje sopstvenog bola. Terapijski aspekti psihodrame u radu sa traumatizovanim ljudima*, Leutz, G.A., *Pojava i tretman disocijativnih stanja svesti u psihodrami*, IAN, 2001, p.158)

⁴¹ Marcia Karp. *Psihodrama u slučajevima silovanja i torture*, Piter Feliks Kelerman, M.K. Hadžins, *Psihodrama i trauma - odigravanje sopstvenog bola*, (ed.) IAN, 2001, p.60

1. re-enactment (*acting out*);
2. Cognitive reprocessing (action insight);
3. Discharge of surplus energy (emotional catharsis);
4. Surplus reality (*as if*);
5. Interpersonal support (*tele* phenomenon);
6. Therapeutic rituals (*magic*).

Outcomes of working in a psychodrama group

Positive experiences in such a group were primarily due to the group being considered a safe place (often the only one) for clients. They experienced the group as a place where they can be present, to the extent they need at that moment. The dynamic in this group was remarkably complex, because of the fact that the group was homogenous regarding the central traumatic experience (human trafficking and domestic violence), whereas heterogeneous according to other characteristics (clients' age, education, social context, psychological functioning, psychopathology). Group dynamic, action or sociodrama work in the group, including a series of personal psychodramas, enabled the building of trust, possibility to open up (enact) part of the traumatic experience in a controlled situation, to experience emotional corrective experience, to connect the suffering body with memories, experiences and feelings, to start with enactment and reach verbalization of feelings (which is difficult because of trauma). It was significant for the clients to work on disintegration of the feelings of guilt and shame, especially if they understood they are not the only one it had happened to. Group as a healing entity and therapist offered the containing of difficult emotions, in relation to which clients usually have the experience that "if they express them, it will destroy other people", which is why they withdraw into isolation. Feelings of intensive fear, horror and hatred, the need to hurt someone or oneself (desire for revenge or compensation, which is one of the phases of trauma elaboration) were made conscious and enacted. Furthermore, they were able to find alternatives, to develop those roles that are constructive, what provide support, that are from the future (surplus reality which proved to be a very useful technique in this group).

Since this text is not intended solely for psychodrama therapists, I will not dwell on all theoretical concepts and techniques of psychodrama applied during sessions themselves. I will conclude this chapter on usage

of psychodrama as group therapy with ASTRA's clients talking about challenges I encountered as group leader, as well as recommendations I would like to share with those who will apply psychodrama in their work with persons who have survived trafficking-induced trauma or some other complex traumatic experience.

Challenges and recommendations for applying psychodrama when working with trafficking survivors

- » Even when the group is semi-open, it is not possible to introduce new clients often, because of their relationships outside the group in the organization where they receive support, as well as lower motivation for work in the group. It is important to carefully assess the introduction of new members so as to ensure group life, to avoid undermining the feeling of security among already present clients. Therefore a small (up to eight members) psychodrama group is formed more often, which is why complications may arise early on in maintaining the optimal number of clients, with always expected *dropouts*.⁴²
- » Clients' attendance, i.e. absence was sometimes affected by issues of their safety (court proceedings and other legal concerns, threats by the trafficker etc.), family problems, pregnancy and giving birth or abortion, refusal by current partner to let them go to the group since he controls them or physical illnesses.
- » Because of mentioned difficulties in maintaining continuity of members' attendance, difficulties appear in creating and keeping cohesion and trust in the group.
- » In the stabilization phase, it is necessary to organize groups once a week, with clear rules, especially those related to session duration, cigarette break, physical contact during sessions between clients and therapist, rules of equality, benevolence and, above all, confidentiality.
- » Clients' contacts outside the group, as part of other activities of the support providing organization, reflect on relations within the group, whereas the therapist's interventions in this aspect are limited. The recommendation is that everything significant in relationships outside the group be brought to the group as "grist for the mill" when working on interpersonal relations.

⁴² *Drop out (verb)* – to leave the therapy process; *dropout (noun)*

- » Homogeneous group structure regarding type of endured trauma is mentioned as an advantage in work on traumatic events, but may turn out to be an obstacle: psychodrama is a therapy which includes optimism and hope as therapeutic dimensions. I therefore believe that inclusion of trafficking survivors in a heterogeneous group, in which certain members are less traumatized and with more preserved resources, would be beneficial. The significance must be underscored of high capacity for empathy of all clients in such a group and clear gender structure: when it comes to survivors of human trafficking, which almost always includes sexual violence, the ultimatum is to create an entirely female group led by a woman therapist.
- » Difficulty when working in a classic PD setting is the problem of clients' reduced concentration because psychodrama lasts two (or two and a half) hours.
- » Clients being overwhelmed with their own content slow down the commencement of group dynamic and working through of relations in the group.
- » There is a threat from emergence of anti-group elements.
- » Sometimes external circumstances linked to legal issues (testimony etc.), judicial system, deportation etc. will cause sudden dropouts, which is, as a rule, difficult for the client, the group, as well as the therapist.
- » Psychodrama may intensively and quickly stir up repressed or dissociated traumatic content and requires clarity of boundaries, setting and careful monitoring of resistance in clients.
- » It is necessary for each client to work on her relationship with the therapist even though it is demanding. The role of therapist is important – she is support, continuity in the interpersonal, security, she does not judge or evaluate, she offers healthy boundaries, is not in the role of “rescuer”, does not have overly high expectations from herself, clients and the group or from psychodrama modality itself. She supports healthy capacities that exist in clients, offers emotional corrective experience. She ensures space for openness, development of spontaneity and creativity as capacities for recovery and development. If there is a need, she proposes inclusion of other forms of support (cooperation with a psychiatrist, clinical psychologist).
- » When it comes to addressing “the central” trauma, the therapist should not impose a central issue (“human trafficking”), around which the group is *technically* gathered. The group and individuals open up these issues when ready, sometimes at the outset, sometimes much later or never directly.

- » The technique of *sharing* feelings at the end of a session serves to help other group members to resonate with the protagonist's work, inciting themselves to work through more actively the issues that are important to them, thus reducing resistance.
- » A psychodrama group offers a concept, understanding and working through of underlying transgenerational, domestic violence which precedes trafficking violence. Healing in this area indirectly helps to strengthen self-confidence of clients, as well as to break down feelings of guilt and shame and open up new areas for desired change.
- » Recommendations for treatment of profound trauma and PTSD are based on empirical research and neurophysiological results obtained via PET scanners. "Psychodrama can activate frightening memories, but must not retraumatize. It can strengthen the person by enabling new states of consciousness when enacting traumatic scenes and incite new visualizations and verbalizations which would replace trauma-related states."⁴³
- » "Treatment of PTSD in psychodrama has the following tasks after fear reduction: activation of memory of that fear and providing new pieces of information, including those that are incompatible with existing pathological elements in that structure, so as to form new memory."⁴⁴
- » Psychodrama incites the participants' imagination, contact with archetypes, forgotten or undiscovered rituals, human potential for creation, building new roles, that way enabling future life and eliminating the experience that "trauma has cut everything short" (which actually does happen in the lives of survivors).
- » When working with trafficking-induced trauma survivors, we keep in mind that man had inflicted upon them indescribable pain, suffering and humiliation, using them as goods. Psychodrama as interpersonal therapy can return the faith in relationships with people who are not abusers, from which there is no threat. Reconstruction of the relationship with others based on benevolence helps survivors to come out of isolation.

Individual psychodrama was conducted at ASTRA in working with various clients of different scope, in accord with needs, assessment, sensitization or resistance to enter roles etc. What individual psychodrama is missing is certainly the group as catalyst and healing entity ("group as good mother").

⁴³ Marcia Karp., *Psihodrama u slučajevima silovanja i torture*, Piter Feliks Kelerman, M.K. Hadžins, *Psihodrama i trauma - odigravanje sopstvenog bola*, (eds), *ibid*, p.60

⁴⁴ *Ibid.*, p. 60 (cited in Van der Kolk, B. A., (ed.), Alexander C. MacFarlane, Lars Weisaeth, *Traumatic Stress: The effects of Overwhelming Experience on Mind, Body and Society*, 2006, The Guilford Press)

Tangible support from the group is missing as well as *sharing* and deeper working through in role reversal. Also missing are interpersonal learning and therapeutic effect of universality. In individual psychodrama, function of the group is reduced to a relationship with the therapist, which represents the central relationship. Sessions last between 50 and 60 minutes, depending on the dynamic, i.e. level of psychodrama work. Individual psychodrama contains the usual phases: warm up, enactment, integration.

At times, work with clients at ASTRA was organized so that the whole session is an individual psychodrama. In another situation, the action technique would be combined with previous conversation of analytical orientation, which can serve as a kind of warm up for further psychodrama work. Instead of the client speaking during the entire session, she would enact a vignette (short psychodrama in one scene) in the second part of the session. It is especially useful to apply individual psychodrama in cases when the client has the need to prepare for court testimony and facing the traffickers–perpetrators, thereby preventing retraumatization from loss of control in repeated testimonies to the police or in court or social work center.

In individual psychodrama, various objects (dolls, pillows or anything from the room that the client protagonist chooses) are used as auxiliary egos. Other techniques are used the same as in group psychodrama (*here-and-now*, roles, role reversal, mirroring, surplus reality, *as if*, doubling etc.), except that reversing roles with the therapist is not recommended, since it can be confusing in such context. It is possible to enact the entire psychodrama in a safe environment – where the protagonist utilizes objects only, does not enter roles, stays aside, in a limited space, as a “puppet play director”, speaking through objects about herself, especially if that is an expression and working through of memories related to the traumatic experience. In such a position the protagonist has control over the situation and, while the therapist is guiding her, she can influence the scene, change the outcome, protect herself, ask for help..., the way it was not possible at the moment when she was enduring violence.

Individual work without usage of psychodrama

A number of clients of both genders showed pronounced resistance towards the psychodrama technique in individual setting. These were mostly persons with a very low level of spontaneity or those who entered

therapy during the phase of initial mortification or shock. Sometimes psychodrama technique stirred the protagonist more intensively than expected, so she felt overwhelmed and withdrew. Adolescents sometimes refused “to play because it’s stupid and it’s what kids do”. In the mentioned situations, I kept track of how the relationship of trust with the client is unfolding, to what extent clients are opening up and then I would cautiously proffer the psychodrama technique again (sometimes after several months had passed, even a year). In a certain number of cases, psychodrama was then completely accepted as a natural part of the process. Possibility of participating in psychodrama – of entering other roles – I understood as progress of those clients, as liberation from roles of submissive “good victims” and emergence of spontaneity and other inner capacities for change and recovery.

Other useful techniques

All the forms of my work with clients at ASTRA encompassed my usage of additional techniques with the aim of enabling clients to come into contact with intrapsychological facets and expression when verbalization was impaired, as well as in the function of building trust in the group. Utilizing, in my work with trauma, the training experience I acquired primarily from Israeli psychodrama and biosynthesis therapists, I applied art-therapy and other techniques: individual drawing and painting, group drawing, drawing in pairs, actual size body pictures and elaboration of painted thoughts, feelings, energies, listening to selected musical pieces in the function of warm up, elements of yoga breathing and lighter exercises – in the function of relaxation from stress and focus on bodily manifestations of trauma (especially in psychosomatic symptoms, with the aim of becoming conscious of bodily functions and accompanying feelings); I used guided fantasy and visualizations, dolls (already described in the section on individual psychodrama), storytelling in a circle, enactment of favorite or made up fairy tales, the games “Magic Shop” or “Time Travel” etc.

The techniques and methods which were used enabled me to customize as much as possible the approach to each client or group. Occasionally relying on so-called eclectic approach, I fulfilled the holistic principles I believe in. Elements which are children’s play or remind us of it return our potential or strengthen our “inner child”, which trauma greatly imperils. Feedback from clients confirmed that such an approach was justified.

“What was the most important in these five years of therapy is that I started trusting people a little bit, not everyone, but at least some of them.”⁴⁵

Factors of recovery from endured trauma

The course and outcome of recovery among trafficking-induced trauma survivors is influenced by three significant factors:

- » Characteristics of traumatic event itself (long term, intensive trauma which man inflicts),
- » Pretraumatic personality features (earlier resources of the person which can be regained or built upon with support),
- » Environmental factors (reactions of survivors’ environment, timeliness and quality of support or lack thereof, repeated victimization – institutional violence during various processes).

At ASTRA, clients of both genders embarked upon therapy in very different periods and moments in relation to traumatic experience events: some had exited the trafficking chain several years prior to therapy, others shortly before (several months), whereas there were cases when only several weeks or as little as days had passed. This fact required identification of the phase in which the client is with regard to application of accepted phase model of recovery process: “stabilization; confrontation with traumatic experience, grieving; integration”⁴⁶. Timely recognition of phases was key in offering clients adequate support, especially in the stabilization phase, which is the most exacting and takes up the longest part of process. Even when clients embarked on therapy many years after torture and trafficking had stopped – many of them were still in this first phase of stabilization. Lack of support after trafficking chain exit most often prevented timely working through of the trauma and shift towards remaining phases, which could lead to lasting recovery. Furthermore, deep repression of trauma experience, as a survival strategy, additionally aggravated opening up of these experiences in therapeutic processes and prompted frequent dropping out from therapy.

As I already mentioned, the greatest number of clients were involved in crisis intervention. “Crisis intervenors need to help clients to identify

⁴⁵ Stated by client during reflection on the process of her five-year individual psychotherapy at ASTRA.

⁴⁶ Gabriele Muller, Edita OstojčVratiti svoju delotvornost i samopoštovanje, *ibid.*, p. 175

protective factors, inner strengths, psychological hardiness, and resiliency factors that can be utilized for ego bolstering. Crisis intervention should culminate with a restoration of cognitive functioning, crisis resolution, and cognitive mastery."⁴⁷

Negative external circumstances during crisis intervention made it additionally harder to establish stabilization, as follows:

- » safety reasons, when clients and their families are still being threatened by traffickers;
- » institutional violence: slow, unpredictable investigations and court proceedings, required repeated testimony; various requests by representatives of institutions that survivors take active participation in processes when the systems expect them to (not when they are psychologically ready); lack of sensitization of system representatives to the needs and protection requirements of survivors;
- » general social stigmatization of survivors (institutions, organizations, family, media);
- » clients frequently moving due to economic and/or safety reasons;
- » difficulties in obtaining health services, lack of institutional support (health insurance, social security);
- » pronounced existential difficulties of clients – housing, employment, dire poverty, impossibility or difficulty of finding a job or continuing schooling;
- » intrusive expectations from system representatives and environment regarding “therapy process”;
- » lack of ethics among system representatives when working with survivors;
- » an array of inadequate interventions or violence by family members or current partners (who had in some cases been part of the human trafficking chain);
- » difficulties in parental roles or unplanned pregnancy problems;
- » placement in a shelter or maternal shelter, which in some cases led to a request to terminate treatment already started in another organization.

Stabilization phase in clients’ psychological makeup would be characterized by intense fears, impaired feeling of security, self-isolation, loss of power and control over one’s own life, strong feeling of shame

⁴⁷ Albert R. Roberts, Ph.D., *Crisis Intervention Handbook: Assessment, Treatment and Research*, Oxford University Press, 2005, p.39

and sense of inferiority, tainted trust in people, altered values (e.g. “all people are bad”, or “I’m myself to blame for what happened to me because I didn’t run away from the trafficker”).

Other characteristics in the stabilization phase which were noticed among a number of clients are as follows:

- » presence of posttraumatic stress disorder symptoms,
- » dissociation,
- » presence of psychosomatic complaints,
- » addictions (which was the case when traffickers had used drugs as a method of additional submission of survivors),
- » pronounced mistrust and animosity towards people, as well as towards the therapist – difficulties in making the basic therapeutic alliance,
- » impulsive behavior, self-injury,
- » depressive symptoms; suicidal impulses.

“In this phase the traumatic experience endangers clients’ biological, psychological and social functioning, occasionally eliciting profound regression in relation to the bases upon which the person’s integrity had been built.”⁴⁸

Process in the phase of stabilization and intervention

Speaking about the process in the psychodrama group and models of working with clients in an individual setting, I partly provided information on the state and symptoms of clients, survival mechanisms they had utilized, resistance in therapy and changes that had been observed.

When it comes to interventions, what I would like to underscore as the greatest challenge is building the client’s trust in the therapist and therapy process itself. Sometimes making a contract (verbally or by using the psychodrama method) would additionally help in attaining this aim. Talking about severe symptoms that the client feels and normalization of these symptoms, i.e. bringing the symptoms into a relation with traumatic experience, were beneficial for the majority of clients. They would start comprehending that they are not “abnormal, crazy, damaged, derelict,

⁴⁸ Gabriele Muller, Edita Ostojčić, *Vratiti svoju delotvornost i samopoštovanje, ibid.*, p.176.

ruined etc.”, but that they are suffering because of the violence that other people had inflicted upon them.

Because of the presence of intense shame and experience of responsibility for their position, which traffickers strategically “instill in the victims”, those feelings are strongly activated in contact with the therapist. Normalization of these feelings and verbalization that “she isn’t guilty or responsible” is something that helped in the long run for survivors to start establishing a feeling of security in the therapeutic relationship, then self-confidence, as well as to start understanding differently the symptoms they feel because of traumatic experience and to begin mastering them. Psycho-education has proven useful when surmounting PTSD symptoms, so that the client’s competence increases in understanding what is happening to her as a natural outcome of an unnatural event – violence she had been subjected to, but which does not mean complete lack of a future for her. “Interventions linked to PTSD symptoms enable the survivors to:

- » regulate intensive accompanying emotions,
- » cope with intrusions: recurring images and thoughts [...]
- » distance themselves and increase the share of the cognitive when a symptom appears.”⁴⁹

I would like to point out that there were situations in which the act of the traumatic event itself was not mentioned for a long time in therapy. Patience for the client to begin talking about it proved to be very useful. Long after establishing a trusting relationship with the therapist (sometimes as late as the second year of therapy), memories would emerge and willingness be shown to share the experience of abuse; repressed content would appear and it was then very important not to insist on cathartic works (in psychodrama), which might overwhelm the client by their intensity. I also underscore the significance of cautious confrontations in this phase and timeliness of interpretations.

Resistance in the stabilization phase

Clients of both genders would often be absent, forget the sessions (which could be understood, in addition to resistance, as a symptom of trauma – difficulties concentrating and remembering); they would

⁴⁹ Ibid, p. 182.

have a profound sense of futility and devaluation, unpleasant feelings in relation to therapy and therapist (“As if you or this could help me at all...”) or they would be frightened by stirred up feelings and disruption of survival strategies used up until then (especially if a lot of time had elapsed since the traumatic events). The fact is that 100% of clients who were in treatment had also had the experience of domestic violence, which is why we are talking about clients with a long history of abuse. This made change considerably more difficult as well as integration of corrective emotional experience and acceptance of oneself. A number of clients dropped out or went through a phase of instability, presence and absence.

The therapist’s experiences in this phase ranged from apprehension that clients will drop out of therapy hastily, through feeling “powerlessness and anger”, to constructive division of responsibility for this relationship with the client. In a considerable number of cases, the client’s taking of responsibility to be in treatment made further work possible and prevented interruption of therapy. Deidealization of the therapist role sometimes speeded up working through of anger and sadness that the clients had been repressing.

Salience of teamwork

In certain situations, with the clients’ agreement, psychiatric support was included. The team and the therapist evaluated whether cooperation with a psychiatrist was necessary in cases when clients had intense PTSD symptoms, depressive symptoms that were deepened (meaninglessness of life, energy drop, impossibility of focusing, intense sleep and eating disorders, difficulties in maintaining hygiene, suicidal thoughts etc.), difficulties in social functioning, pronounced anxiety and panic attacks, addiction symptoms. Such a concept of cooperation brought relief to clients, reduced symptom intensity, increased their safety and enabled the continuation of psychotherapy. Still, an adequate selection of psychiatrists willing to cooperate was of crucial significance for success of teamwork. In addition, ASTRA team for psycho-social support has an important role in helping clients to make timely visits to their chosen psychiatrist, to go to regular checkups, obtain and adequately use the prescribed therapy. Pharmacotherapy was not a prerequisite, except in cases when the clients’ lives were imperiled because of suicidal impulses

and in case of hospitalization. Generally, this type of teamwork proved to be the most efficient help to clients in the stabilization phase.

Stabilization and difficulties when proceeding to other phases of working through trauma and recovery

Positive results of stabilization phase

As already mentioned earlier in this text, the greatest number of clients of both genders embarks on psychotherapy in the first phase of recovery – phase of stabilization. This phase has a different duration in each client, depending on internal and external conditions.

Among a number of clients, better functioning in the social surroundings has been achieved (after successfully satisfying primary needs, establishing safety and a certain level of self-confidence, regaining sense of competence, work on finding resources – in psychodrama it is certainly also an optimistic outlook on life and return of hope, gaining corrective emotional experience – through relationship with the therapist, group members, counselors at the organization etc.). That way the survivors learned how to establish control over bothersome symptoms, which additionally strengthened them and rose the level of their trust in own strengths and willingness to accept themselves, despite the difficulties they feel. More successful functioning was made possible in various existing roles, as well as building new roles.

In this phase, special significance and challenge lies in work on emotions, which is often difficult because of strong intensity of feelings and impossibility of control, or splitting off emotions (with the aim of self-protection – avoidance). Work on emotions, in an individual, as well as group setting, contained recognition of situations that stir up emotions, monitoring bodily manifestations linked to emotions, differentiating, naming and discerning emotions, linking them with earlier, older experiences. Part of the work focused on seeking new creative and constructive mechanisms of coping with emotions. Work also encompassed a change in values, denouncing inner “persecutors”, messages that most often originated from inadequate parental figures,

society and, ultimately, traffickers. Work on deconstruction of these messages enabled creating a distance from “destructive ego states” and building an authentic experience of self as an individual. Such a liberated personality is not compelled to play out towards herself those destructive patterns she had been conditioned to and which date back to her painful psychological history.

Phase of confronting trauma, grieving phase, integration phase

Firstly I will provide concise definitions and objectives of other phases of working through trauma in the recovery process. Namely, taking into account the scope of these topics, we cannot present in detail all the information that characterizes work with clients in recovery phases.⁵⁰ By way of brief illustrations from my practice I will clarify what made possible the working through of traumatic experience in all four phases of recovery.

Confrontation with trauma – enables survivors to integrate repressed, split off parts of traumatic experience and own personality. This phase is feasible solely if results have been attained in the stabilization phase, which has already been discussed.

This phase is painful for survivors and a challenge for psychotherapists. The process of accepting repressed and/or split off traumatic experiences and parts of self during the confrontation phase is a pathway towards healing, when the “survivor starts thinking that the trauma may not be the most important, not even the most interesting part of her life story”.⁵¹

Grieving phase – Psychological traumas always have various losses, i.e. experience of loss, at their core. Grieving is present in all phases of trauma, but specifically focused work on this aspect is done after confrontation with traumatic experiences. It is in human nature to face an array of losses and grieving during their lifetime. In the case of being subjected to intensive trauma, support in this process is necessary when external hindrances exist (e.g. the fact that the survivor’s loved partner became

⁵⁰ Note by B. Slavković: I recommend, as an exceptionally useful publication that addresses in detail the theory, practice and examples (case studies) of psychological trauma therapy, the work by Gabriele Muller and Edita Ostojčić *Vratiti djelotvornost i samopoštovanje: Terapija traume metodom psihodrame*

⁵¹ Džudit L. Herman, *Trauma i oporavak*, ibid., p.310

her trafficker) or internal resistances (e.g. fear of overwhelming pain). It is then that obstacles crop up, thwarting the natural grieving process and it is when we encounter the phenomenon of prolonged grieving.

When dealing with the grieving process is impaired, “grief denial can manifest itself in many ways. Most often it emerges as fantasizing about a magic resolution through retribution, forgiveness or compensation.”⁵² Such fantasies inhibit survivors from truly allowing themselves insight into the scope of personal losses, to grieve for what has been taken away from them and for it to lead to definitive recovery. Traditional and religious patterns of grieving sometimes help in allowing the right to this phase (religious rituals, wearing specific clothes or insignia that the person is in mourning etc.). In the case of human trafficking survivors, because of intense feeling of guilt and shame for what they have lived through and because of the environment’s lack of understanding, the grieving process is often not supported the right way. Statements such as: “Be thankful for being alive at all...”, “Why are you grieving for him when he had sold you...”, “Let bygones be bygones – life is ahead of you...” are just part of inadequate messages when it comes to grieving process support. Unfortunately, such unfitting messages sometimes come from professionals/helpers as well.

I would therefore like to mention examples of what survivors are grieving for, since I have the impression it is important for opening up space without prejudices for our clients. This includes pining for oneself from before, pining for innocence and ideal of love and partnership (especially among young girls), pining for a romantic relationship or specific partner who had actually been the source of violence undergone, pining for some part of oneself – “which is either destroyed or has disappeared”, “pining for wishes and plans that I had had” and pining for the future – “which I don’t see and which doesn’t exist for me”, “pining for what I actually lost: an unborn child, body part, health...”, pining for the loss of trust in people (“I will never be able to trust anyone again, yet it’s hard for me being alone”), pining for lost relationships (social atom of the person she used to be) and especially pining for anonymity “because those who had abused me or used me as consumers could meet and recognize me”. Psychodrama work in an individual or group setting I especially recommend as a creative way of working through the experience of loss. The protagonist can safely study his/her losses, feel them, limit the

⁵² Ibid., p. 301

overwhelming effects of these confrontations. S/he can finish unfinished business. Additionally, in ritual scenes, those objects and symbols that have been lost yet are pined after can be “buried or stored”, or else – they can be brought back to life. Furthermore, if the victim gives up revenge against perpetrators (“to inflict them with what they had done to me”) or forgiveness (“I will rise above them and forgive them...or God will forgive them”) or compensation (“that perpetrators will realize they had made a mistake, that they will beg forgiveness and apologize”) – space truly opens up for integrating loss, for new life experiences, also meaning the return of the right to a future for the survivors.

Integration phase is the closing phase in the process of recovery from trauma. This is a phase when the survivor takes initiative in planning her life. The therapist supports the client’s autonomy, not only in the therapeutic relationship but other relationships as well. Tasks in this phase include summarizing (self-evaluation) of previous phases, providing stability of desired changes that have happened and applying these changes in further life.

In my work up until now with clients of both genders at ASTRA, a total of three persons continued recovery through psychotherapy, after (more or less) successful stabilization phase, passing through phases of confrontation with traumatic experience, grieving and integration. Two clients spent five and a half and five years respectively in individual psychotherapy, whereas the third person, during a total of 15 months’ work, passed through phases of confrontation and grieving, but we were not able to ensure further work and complete follow-through of the integration phase because of external circumstances (moving to a different city) and partly psychological resistance.

Phase of integration and outcomes – Processes I led with clients at ASTRA included work on closure of the therapy process through several spontaneous cycles of the client’s evaluation of the therapy process. It brought brief regressive patterns in clients, which were interpreted as resistance against termination of therapy and separation from the therapist. Parallel with these insights, clients felt the benefit of having attained changes, built new roles, that they have ended the action of threatening introjections, that they have renewed the capacity for relationships, reduced or eliminated many symptoms which were the consequence of trauma.

They also reported that they can think about the traumatic experience as “true past”, which still contains difficult feelings and losses, but is no longer the central place in their current lives. Hope and faith in the future returned, especially if external circumstances helped (e.g. adequate court decision punishing the trafficker or providing at least partial material security, conditions for continuing schooling etc.). Trust in oneself, building self-respect, possibility of forming meaningful relationships, wish for intimate relationships based on emotions, return of a desire for quality sex life – all are indicators that recovery has been successful.

“It’s good that I can now talk about what happened to me, without it overwhelming me and without becoming petrified; I won’t forget it and I can’t change it, but I want to go on living, I want to have a family if I meet someone I will start loving and who will start loving me. I’m not asking too much, just that much.”

Conclusion:

What are the current possibilities for psychotherapy with human trafficking victims in Serbia?

I have already mentioned that psychotherapy with survivors and counseling of those who had been subjected to trafficking are organized just within some non-governmental organizations. These programs are realized primarily thanks to international aid, through wider projects of support to survivors. Such projects always require evaluation of the realization of program activities, which in many cases represents an obstacle to the manner in which survivor psychotherapy activities are monitored. Adhering to the confidentiality code in psychotherapy, specificities of the relationship between therapist and client are in direct opposition with writing reports, albeit generalized ones, on the psychotherapy work process. Moreover, measuring progress in psychotherapy is not simple, especially if no research is included, which of course entails testing clients. At ASTRA we did not apply these types of research, especially due to sensitivity of clients to these acts in light of their loss of trust in people and specificities of human trafficking-induced trauma. For all those reasons, there is a permanent problem in providing sufficiently predictable, long term funds for psychotherapy of survivors.

The second complicating factor is frequent mobility of clients, because of safety and economic reasons and investigations as well as court and legal proceedings, which they are mostly involved in after exiting the trafficking chain. This certainly obstructs continuity and amplifies already existing resistance, which has already been discussed. In those conditions, it is difficult to provide long term psychotherapy which is uninterrupted by external factors. Thus, unfortunately, it is not possible for the therapist to follow therapy of many clients after the stabilization phase.

Despite the growing number of psychotherapists in Serbia in the recent years, the majority of resources are in bigger cities. The need has presented itself for expanding the network of psychotherapists who are motivated to acquire additional training on violence as a phenomenon and work with specific trauma, so as to be able to conduct psychotherapy with human trafficking survivors.

A special challenge lies in the fact that various state institutions are not sensitized, even though they are legally bound to care about those who have survived trafficking-induced trauma. If there existed true determination to respect domestic and international laws, protocols and conventions, it would be possible to sustain programs of survivor recovery by investing from existing state funds (e.g. fund for indemnification of victims, by confiscated goods from organized crime, from budget allocations through the system of healthcare and social welfare or on the local level).

A disquieting factor which obstructs the recovery of victims is poverty. Sometimes the poverty is so extreme that I ask myself, as therapist, whether or not it is possible to do psychotherapy with a client who has often not even met the basic needs (food, housing, healthcare). One systemic solution by the state and social welfare system could solve these problems the victims have, without relying on NGO projects, which are very limited when it comes to material assistance to victims. The dilemma certainly remains as to the extent in which psychotherapy treatment is effective in such living conditions.

I would also like to point out the significance of cooperation between all sectors which are in charge of health in general and mental health in particular, supporting survivors of human trafficking-induced trauma. It is also important that the following organizations and institutions

start networking towards the aim of creating conditions for recovery of survivors, based on a multidisciplinary and holistic approach, adhering to already recommended principles of working with the victims – survivors.

- » psychotherapy associations which apply work on psychological trauma in their activities
- » healthcare centers with primary healthcare protection, which is the basis for all further treatment of survivors
- » specialized institutions – mental health hospitals and institutes, especially institutions for combating addictions.

Additionally, I would like to underscore the salience of continuous training of all experts and those in the helping professions, related to phenomena of violence, trauma as a response to violence, gender-based violence, specificities of sexual violence, domestic violence, survival mechanisms, symptoms, techniques applicable in work with survivors, value principles of victims/survivors, prejudices that hinder our work, importance of retraumatization prevention, necessity of supervision or intravision for experts working with survivors (so as to preserve their capacities and remain efficient in working with clients of both genders).

Ultimately I would say that psychotherapy work with those who have survived human trafficking is very challenging, not only on the professional, but also on the personal level. My inner helper is the motto “never to draw conclusions too quickly and to primarily experience each client separately, not focusing the therapeutic relationship on trafficking-induced trauma as the central and only issue in working with her”.

Time, hope and commitment – those can be key factors for recovery of our clients.

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Violence and Trauma Influence and Consequences of Domestic Violence on Children

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When a story appears in the media about human trafficking, the public divides into those who think that responsibility is solely the traffickers' and those who tend to ascribe the responsibility to trafficking victims themselves. The former pose questions like how can someone end up in a situation to be deceived, terrified, tricked... they are also convinced they themselves are smart and resourceful enough as to avoid ever ending up in such a situation.

Are the victims of human trafficking truly naïve? What makes them susceptible to manipulations by others? Can any one of us become a victim?

Maybe it would be good to start from the last question. The answer is very clear – yes, becoming a human trafficking victim can happen to any of us. Have you ever gone to a job interview and been willing to be hired, even though some of the terms were unclear? Today it is very difficult to find a job, let alone a well-paid one, while you just got lucky and saw such an ad. Have you ever reserved a room in a privately-owned house just based on an ad in the paper or on the internet? Even stable, self-confident persons will probably give an affirmative answer to the above questions.

Nonetheless, certain factors increase the risk of entering such and similar relations. In the present text we will deal with those (early) developmental factors which could increase our vulnerability and prompt a dark circle of abuse.

We are all someone's children

The human newborn is dependent on others, above all on parents. S/he needs their protection, guidance and training, so as to be able to stay alive. S/he lacks biological and psychological independence, besides food and physical protection, s/he also needs support and solace from parents. The child expects not only love, tenderness and security from parents, but also assistance in organizing all external and internal stimuli in a systematic manner. Thus the fear of abandonment and loss of parental love is one of the strongest fears each of us experiences and represents a normal developmental phenomenon.

All children have these developmental experiences. In the majority of cases, parents help in overcoming these fears by enabling children to acquire the experience of security. Still, some children are subjected to amplification of these fears by their own parents, who expose them to extreme forms of physical and/or psychological peril. For the child, one of the most terrible experiences is exposure to violence, either the child being a direct victim of violence, if we are talking about abuse and neglect of children, or being a witness of violence between parents or against one parent. Although in both of these situations there are similar responses, certain differences exist in the manner how the child grapples with traumatic experience, so we will take both situations into thorough consideration.

Abuse and neglect of children

"Abuse or neglect of a child encompasses all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment, as well as commercial or other type of exploitation, resulting in actual or potential harm/impairment of the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power."

Most frequently there is talk about the following forms of abuse:

1. Physical
2. Emotional
3. Sexual
4. Neglect
5. Child exploitation

- 1.** Physical abuse of a child results in actual or potential physical injury, and includes hitting, burning, strangling, shaking the child or any other action aimed at harming the child. In our environment it is often justified as a measure intended to educate and discipline, a way for the parent to “train” a disobedient child and “talk some sense into him/her”. Well-known sayings such as “The beating stick came straight from heaven” and “I was brought up that way too and look at me now” reflect what kind of attitude is still present when we’re talking about physical punishment.

What its supporters forget is that violence always leads to violence, albeit delayed or masked, which is why it is not recognized easily. A child learns from parents how a conflict ought to be resolved, so if an aggressive model is offered as the solution, the child will adopt it. The key thing in this type of abuse, which also appears in all other forms, is (ab)use of power by an adult, with the aim of “subjugating” the child to carry out the abuser’s will. This form of violence also occurs in the case of adults, in couples, and also accompanies human trafficking, since it enables abusers to keep the victim in a state of fear.

- 2.** Emotional abuse (synonyms are psychological violence, mental abuse) of a child represents interaction (activities or absence thereof) that inflicts psychological injury upon the child, by persons s/he depends on, making the child vulnerable. It signifies an inadequate relation that has been established between adult and child, which is why it can’t be regarded as an individual event, but rather a series of events or relation. The most frequent forms of emotional abuse are verbal degradation, insults, cursing, derision, ignoring or not showing love towards the child. This also includes all forms of psychological manipulation, which refers to the relationship the child has with the abuser. Namely, a child is not only physically, but also psychologically dependent on adults, which a violent adult takes advantage of so as to keep the child in a situation of psychological subjugation.
- 3.** Sexual abuse of a child is any sexual act between an adult and a child (relations with contact or without, penetration and non-penetrative forms of relations, oral or anal sex, forceful exposure of naked child in the presence of an adult, as well as using children for pornographic purposes), which is in discord with legal regulations or social norms, which the child does not understand and is not mature enough for, therefore not being able to consent to it.

In this form of abuse there is clear gender domination – out of every four sexually abused children three are girls while one is a boy. Gender distinction exists in the case of abusers too – out of every five perpetrators of sexual abuse of children, 4 are men, while 1 is a woman. Out of the total number of child sexual molestation cases, in over 98% the perpetrator was a person the child knew, most often from the circle of closest family.

- 4.** Neglect (negligent treatment) is a so-called passive form, since the abuse does not entail an act of doing, but rather absence of doing – the adult does not take adequate care of the child and her/his needs, not only on the physical level (providing food, clothes and grooming), but also on the emotional (lack of love) and educational level (preventing the child from attending school).

This form of abuse is becoming more frequent in our community, sometimes because of the bad socio-economic situation, when the parents have objective difficulties caring for the child in an adequate manner, whereas other times in completely opposite situations, when parents do not devote sufficient attention to the child because they are busy providing socio-economic security.

- 5.** Child exploitation means using the child for labor or other activities for the benefit of other persons, which impairs the child's physical or mental health, education, moral or socio-economic development. It is most often manifested through usage of children for or during begging, for stealing, including children in jobs that are not suitable for their age, physical and mental capacities, as well as child trafficking.

In all of these situations, the child is directly exposed to violence. While it is happening, the child is focused on him/herself, on the pain s/he feels and how to survive the violence physically and psychologically. Faced with life threat, s/he defends him/herself with shock, disbelief, often even amnesia, which can then or later cause dissociative disorders.

The public is not sufficiently sensitized to the phenomenon of child abuse, while the conclusion that "we don't have that here" can still be heard (albeit rarer and rarer) even in professional circles. Therefore it is necessary to point out that Serbia has adopted a series of legal regulations for controlling this phenomenon and punishing the perpetrators: the

National Strategy for Children (2004), the General Protocol for Protecting Children from Abuse and Neglect (2005), the Family Law (2005), the Constitution of the Republic of Serbia (2006), the Criminal Code (2006), the Law on Juvenile Perpetrators and Criminal Justice Protection of Juveniles (2006), the National Strategy for Prevention and Protection of Children from Violence (2007).

Domestic violence

In addition to direct exposure, when the child is an immediate victim of violence, s/he can be a witness of domestic violence. Although it took a long time to recognize this type of exposure as significant, the Children's Rights Law draft includes this category of children.

Depending on the theoretical and practical framework, there are different definitions of violence. One of the most frequently utilized is that violence is: "intentional usage of physical force or power against oneself, other persons, groups of people or communities, which can lead to or leads to injuries, death, psychological damage, inadequate development or deprivation."

Domestic violence is behavior by which one family member imperils the bodily integrity, mental health or peace of another family member. This term is used to describe all modes of violence that occur in the family context – be it violence between spouses, cohabiting couples, or people living together. Accordingly, it encompasses violence to which children are directly exposed or are its witnesses.

Domestic violence is a phenomenon present in all countries of the world and all cultures; people of all races, ethnicities, religious, political and sexual orientations, social and cultural levels and both genders can be the perpetrators of domestic violence. Nonetheless, in a substantial number of cases, those who commit violence are male, not only because of physical strength but also because of the power society ascribes to them.

For centuries, patriarchal culture considered this mode of violence to be common law, people justified it and it was customary. It was only with the strengthening of women's movement, especially feminism and women's

rights movement of the 1970s that domestic violence was recognized as a phenomenon which, by way of its harmful effect, leads to a series of negative consequences for the individual, the family and society at large.

Even though it is now recognized more frequently and reacted to, there is still strong pressure by the public to turn a blind eye to this phenomenon. Thus, according to some estimates, in the USA and the UK, just one third of domestic violence cases are reported to the police.⁶ According to the data of the Victimology Society of Serbia, in the Balkans one out of every four women is subjected to domestic violence. Domestic violence is just part of the global problem of violence against women, its scope illustrated by a piece of data by the World Health Organization from year 2002 claiming that 40-70% of murdered women were killed by their husbands or fiancés. Unfortunately, "milder" forms of violence often remain unrecognized – since they are considered part of the folklore of a nation or women do not report them due to various reasons (fear, threat, economic dependency), which is why they do not make it into statistical overviews. Hence it is rightly thought that the number of women who are domestic violence victims far surpasses the number shown by statistics and is difficult to estimate.

Domestic violence has different faces, most often (as in the case of abuse and neglect of children) includes one or more forms: physical, emotional (alternative terms: mental, psychological), sexual and economic.

Although violence can happen continuously or "just" occasionally, the frequency does not reduce its seriousness or harmfulness.

Domestic violence and violence against women represent a serious problem in all societies since they are forms of breaching fundamental human rights and freedoms. Numerous documents have been adopted which regulate the protection of women's rights from domestic violence: the UN Convention on the Elimination of All Forms of Discrimination against Women (year 1981), the Beijing Declaration and Platform for Action (1995), whereas in our country the Criminal Code, the Family Law and the Law on Public Peace and Order.

Consequences that violence leaves on children

Children's exposure to or witnessing of domestic violence results in a series of immediate, but also long-term consequences on physical and mental health of children. Traumatic experience in childhood can be an individual, very intense, sudden and brief event, such as accident, disaster, sudden death, physical assault or rape. Domestic violence and abuse/neglect of children belong to cumulative events, which means that the child must develop an organized system of psychological defense so as to survive long-term exposure to trauma.

Unlike the situation when the child is a direct victim and focuses on immediate survival, when s/he is the witness of domestic violence, s/he perceives the event from outside, but is emotionally still highly involved. Frequently, the sense of responsibility appears for not having prevented violence, as well as "survivor" guilt, but also complex issues of loyalty to the victim and/or abuser. Alongside these direct ones, violence also leads to indirect consequences not only to the child, but also her/his future family, social environment and community at large. Children were present in 90% of domestic violence incidents, even in those situations which ended fatally.

The child is, let us recall, dependent on parents. S/he fears they might abandon or stop taking care of him/her. S/he is attached to parents, loves them and identifies with them. In the situation of violence, the child watches her/his parent (most often father) attack, humiliate and hurt the other parent. Research has shown that between 40% and 60% of men and women who abuse adults also abuse their children. Girls whose fathers abuse their mothers are 6.5 times more likely the victims of their fathers than those who have non-violent fathers.

Though most people think the child's age is inversely proportional to the degree of trauma that violence leaves on children, this opinion belongs to the domain of prejudices. Children are not resistant to traumatic experiences, because of which they change permanently. The younger the child, the greater the degree of stress, as well as consequences that violence leaves. Violence is inapprehensible for the child, who does not understand someone's motives to be violent, or the circumstances that lead to violence and in which it occurs. Since they have the need to understand and organize things, children start fantasizing, so as to

attribute sense to something that is inconceivable to them. By nature egocentric, focused on themselves and convinced that everything that happens is directly connected to them, children think that violence is the outcome of something bad they have done, taking on the blame for the violence occurring, or for not having done anything to prevent it and protect the victims.

Just before the end of the school year, an eight-year-old boy was brought in for treatment because of aggressive behavior in school. Physical aggression (hitting, poking, pushing) was mainly directed toward younger boys, although he was occasionally verbally aggressive towards his teacher as well. He was brought in by his mother, who claimed that father did not recognize that the boy had a problem and that he considered this to be usual children's mischief. Already in the first session, the boy clearly verbalized depression and feelings of guilt: "...I'm a bad boy, I'm to blame for everything, I can't get on with others...", very quickly linking that content with events at home and powerlessness to prevent constant verbal conflict between parents. Over the course of therapy, there was increasing frequency of aggressive fantasies and anger directed at parents, who put him in the position of having to choose between the two.


Feeling of guilt is especially pronounced when the child is a witness of violence against his/her parents, since s/he has a strong need to protect them. On the other hand, when that very parent is violent, the child is confused by the fact that the person who ought to provide security and stability is actually hurting the other parent. So as to protect themselves from these intrusive thoughts and to overcome confusion, children use various coping mechanisms.

Children who had been victims of domestic violence represent an especially vulnerable group, which is why they are more susceptible to further abuse or maltreatment, meaning also manipulation that human traffickers resort to. These children, later young adults, view the world from a different standpoint. Although aware that violence is not a way to solve a problem, they have this mode of behavior "recorded", often considering it a legitimate mechanism. How come this is so?

Most of these children never succeeded in developing secure attachment – relationship with a primary object, i.e. person responsible for providing

the child with love and stability. Consequently, the child did not have a person who would continuously encourage and reassure him/her to proceed through life challenges. The mother, who is also endangered, focuses on how to protect herself, her life or the sense of integrity and identity, often not succeeding in adequately devoting herself to the child. Thus children who are victims of domestic violence often have insecure attachments, leading to low self-esteem, emotional difficulties and altered perception of self. The child sees him/herself as less worthy and desirable, often develops the feeling of guilt for not having prevented violence and abuse. In some children such feelings lead to increased anxiety, depression, withdrawal, social isolation, even suicidal ideas.

Among other children it can incite anger, strong sense of animosity towards the perpetrator of violence, and lead to aggression and revenge fantasies or actions or to self-destructive behavior. Self-injury represents one of the ways for the victim to regain control over own body, mind and feelings:



“Don’t prevent me from hurting myself. I have the experience as if I’ve died, that I can’t feel anything anymore. When I cut myself I feel pain, and it’s a way for me to feel alive again.” (17-year-old girl, who had been raped several times by her older brother since the age of 11)

The repertoire of self-destructive acts also includes abuse of alcohol and/or substances, with the aim of “shutting off” overly strong stimulation.

Depending on the age when violence started, how long it lasted and how intensive it was, the child can have a whole series of difficulties. At preschool age, withdrawal usually appears, as well as regression to earlier developmental phases, separation anxiety, but also tantrums and violent or traumatic play, the objective of which is to retrospectively establish control over the event the child hadn’t been able to control. At school age, children more often manifest cognitive difficulties, concentration problems, increased irritability and revenge fantasies. Other children tend to resort to somatizations, self-accusation and feeling of guilt. The manner in which adolescents react to violence is similar to adult reactions – from “acting out”, manifested in the form of self- or heterodestructive behavior, to withdrawal, depression and altered perception of the future.

Hence, the most frequent consequences of traumatic experiences in childhood are: chronic posttraumatic stress disorder, depression, cognitive narrowing/inhibition, increased aggressiveness, but also permanent personality disorders such as borderline personality disorder.

Why do these disorders occur? After severe or chronic traumatic experiences, the brain is continuously in a state of prolonged alarm (hyperarousal), which considerably affects the capacity to process information. The younger the child, the greater the degree of trauma and the probability that s/he will react with dissociation. Older children, especially those who are witnesses, not direct (physical) victims of violence, will more likely develop increased sensitivity and "hyperarousal" for events around them.

Repeated cycles of violence

In situations of repeated and prolonged abuse, a specific relation forms between the abuser and victim, based on control and dominance of the abuser. Threatening that he will endanger her life or that of a close person, or that he will expose some of her secrets (in sexual abuse of children, the abuser often threatens that he will disclose to the child's community that s/he has had sexual relations but that s/he had also initiated them), the abuser instills fear in the victim as well as sense of helplessness and social isolation. It is astounding that even persons who are professionally in charge of children expect that the child ("when big enough") should muster up the strength and hide/protect him/herself from the abuser, reporting the violence. Such expectations are also put in front of women cohabiting with violent partners, whereas they are additionally accused because they are not leaving the violence, but rather "keeping" themselves and their child in that situation.

Years of experience in working with women who had endured and were enduring domestic violence I encountered numerous difficulties they had in ending it. The most frequently mentioned ones (economic dependency on the partner, lack of support, social stigma, fear that the abuser might get custody of the children) are just some of the numerous obstacles the woman actually faces. Beneath and behind them are those even more complex ones, which relate to psychological difficulties in escaping the vicious circle. So as to be able to understand them, it

is necessary to understand the complex mechanism which is at the background of violence and enables its upholding.

The feeling of helplessness and isolation is a key for upholding of violence, also making the person who has survived violence especially vulnerable to reoccurrence of a violent experience. How come someone becomes a victim of violence again, even in some new circumstances, by other abusers? How come she “doesn’t recognize and run away” from the new situation of violence on time?

Imagine a child who has been watching or directly undergoing domestic abuse. How does the world look to her/him, which messages does s/he get about people? From the position of a child compelled, because of dependency, to remain in that situation where no adult is capable of protecting her, the child gains an experience that violence is unavoidable and cannot be forestalled, regardless of what s/he does. S/he anticipates that violence will certainly occur, sometimes even consciously entering a violent relation (e.g. when the father comes home drunk) so that the act will finish as soon as possible or so as to protect someone else (mother, younger child) from expected aggression. The child’s way of thinking is: “since I can’t avoid this, I might as well grit my teeth and get it over with soon as possible”.

This model takes root and, in the long run, firmly establishes the victim’s model of behavior and conviction that violence, even though not quite legitimate, is in fact a socially acceptable mode of solving problems and conflicts. Thus violence acquires the quality of “infection” and is “passed down” to the following generation, so we refer to it as “transgenerational transmission of violence”.

A 60-year-old woman, who had decided to get out of a marriage with a violent husband, spent a year in an intensive therapeutic process. The path from decision to realization was long and often painful. Before this marriage with the abuser, the woman had been married in youth to a man who had frequently been absent, kept parallel relationships, gambled. After several years of marriage, he left her and moved to a different town, while the woman remained in her small community. “I married the first one who wanted me. As second-hand goods, was I even allowed to choose? Who would want ‘used goods’ discarded by another man?”

Undermined self-respect and social stigma paved the way for new violence. An abused child often does not know that a different life is possible, a woman who lives with violence tries to convince herself it is normal, getting themselves anew into that which is familiar, even though painful. This provides the sense of being able to control the situation. Adults with a history of dysfunctional behavior in childhood are three times more likely than peers to be severely physically violent with their partner. This may sound paradoxical, but the feeling of “familiar misery” is sometimes easier for a child to bear than complete uncertainty of a new relationship. Due to this mechanism, the victim stays in the position of subjugation, isolated from others and from new experiences that could be reparatory.

That very mechanism of power, physical and psychological control and isolation is used by abusers, be they in the family or outside it. That mechanism is also used by human traffickers for keeping their victims separated from the outside world and increasing the gap between freedom and slavery. Besides coercion human traffickers use another, even more perfidious mechanism for attaching the victim to themselves. Young girls, especially those who had been abused/neglected in their families and rejected by the community, yearn to be important to and loved by someone. Some abusers take advantage of this need, seducing their victims, showering them with “love”, attention and gifts, making them exclusive, and asking for “small favors” in return for their “goodness”. Using this behavior, they increase dependency, underscoring that the victim ought to be thankful, since she is special and chosen.

Is there hope? The role of psychotherapist in the process of overcoming traumatic experience

However, not all children who had been victims or witnesses of domestic violence will themselves develop violent behavior. Influence will be exerted by the following mediating factors: nature, frequency and severity of violence, witnessing violence and/or direct victimization, personality dimensions (gender, age, degree of emotional maturity), child’s cognitive style, as well as environmental dimensions (strength and coherence of the family, social network support, psychosocial interventions). In that segment, the psychotherapist’s help is of great significance.

Key feeling of the abused person is disempowerment and isolation from others, a sense that she is branded because of her experience, unacceptable to others, though she sometimes isolates herself, convinced that other people can't understand her experience. Hence recovery is based on reestablishing connections, while the therapist is often the first person this reparation happens with.

Children who are victims of domestic violence, especially sexual abuse, have such a strong experience of social stigma, that they sometimes cannot even utter what had happened to them. They want to talk about the traumatic event, but do not find words to describe it, or are too ashamed to say the words. This situation occasionally, though considerably rarer, occurs when we are working with women victims of violence, especially if the violent act had been particularly degrading for the victim. In such situations it is convenient to use material which is less demanding verbally, while closer to children – toys (dolls, puppets...), drawing, writing letters or stories about what had happened to them. This is especially important if we are working with a child who underwent trauma at a younger age, when words were not yet the dominant mode of communication. Every trauma “reduces” our defenses to a lower developmental level, which is why it is good to start the recovery process from it.

Since talk about traumatic experiences usually elicits unease among people, as well as tendency to avoid finding out, while for the person exposed to violence it represents a stressful and potentially retraumatizing situation, we will provide concise guidelines for working with children and youths who survived this type of trauma.

The first thing in psychotherapy with victims of violence is establishing a relationship between therapist and client, i.e. person we are talking with. Although it is important in all forms of counseling and psychotherapy, when we are working with persons who had been exposed to violence, this relationship is key, since their trust in relationships is impaired, whereas persons who ought to have been in the protective position were the main perpetrators of violence. Sometimes the greater part of a therapy session goes by in exploring trust in relationships – clients “test” the endurance and stability of the therapist, at times with very harsh psychological manoeuvres (degrading the therapist's competence, questioning the very meaning of psychotherapy, hinting that the therapist

lacks strength to grapple with client's feelings). Such behavior tests our professional integrity, but it is necessary to be aware that it is a way for the person who had been subjected to violence to try and regain control over events, albeit in such a paradoxical manner. Many of them find it embarrassing to tell about their experiences, thus using such behavior as defense against frightening and unpleasant content. The therapist's task is to show that s/he is a person of trust and that s/he wants to listen and help. S/he should help the client regain security and sense of wholeness, to understand that her reactions are often "a normal response to abnormal circumstances", to regain faith and hope in other people and life itself.

When it comes to domestic violence, as a rule, therapy should not commence before the violence has been ended. Anyone who has the information that a child is exposed to abuse and/or neglect or domestic violence, must report it to the social work center in charge, and if necessary (depending on how endangered the child is) to the police as well. This is not only a civic duty, but also professional duty of anyone working with children.

It is only when the child has been provided with adequate care that the rehabilitation process i.e. psychotherapy can start. Unfortunately, despite increasing sensitization of professionals working with children in all sectors, the number of reported children remains very low, while interventions are slow and inadequate. Therefore psychotherapists are often in a situation to work with a child even though s/he returns to living space s/he shares with the abuser. In such situations it is necessary to include the non-abusive parent and other adults in work, since they could become involved in the system of providing protection and support for the child.

Therapeutic interventions themselves as well as techniques for working with children who are victims of domestic violence depend on the therapist's theoretical frame of reference. When working with victims of violence, all modes of psychotherapy can be applied, including group work. Therefore we will not deal with specific techniques used, but will once again underscore the significance of a supportive relationship, which is necessary so that the person who had undergone violence can feel safe and embark on the recovery process.

Traps for the therapist

Among most people, stories about violence elicit a twofold reaction – shock and dismay over the fact that a person can inflict so much pain upon another person, followed by the need to avoid any further knowledge, but also an almost morbid curiosity to find out the details. Accordingly, crime pages and articles about violence against children sell the newspapers and keep viewers riveted to TV screens.

Psychotherapists are also human beings, meaning that such need also occurs among them. Long years of training, personal work and supervision teach us to overcome these feelings.

When you are working with a person who is suffering, especially if she is a child, a need appears to save her immediately from the situation, especially if the violence is still going on. As already mentioned, it is one of the rules in work with domestic violence not to commence therapy until the violence has been stopped. This rule is adhered to when it comes to children who are violence victims – the absolute imperative being to first provide for the child's safety, only afterwards conducting psychotherapy. On the other hand, in the case of women victims of violence, they often come to counseling or therapy so as to gather strength to exit the pattern of violence. In those situations, the therapist might be tempted to impose on the client his/her own pace, but s/he must follow the needs and capacities of client herself. Omnipotence is hard to control, but it is important for us to be aware that what is important for me might not be important for my client. She has her own needs, strengths, but also obstacles (internal or external) that she must overcome. Most importantly – she needs to regain her power and capacity to control her life, whereas the supposition that she ought to keep up with our pace of decision-making and recovery is exactly what takes away that power from her. Her power is often invisible to them as well as us, while our task is to make it easier for her, not to teach her how to breathe.

Not only do omnipotence and need to control confine us in our work, but also helplessness and sense that we do not influence anything may impair our therapeutic work and render it futile. Questions impose themselves as to how competent we are to help, whether or not we have enough strength, knowledge, information? Is what we are doing sufficient?

Alongside these two measuring scale pans that we often balance upon, the issue of trust also presents itself. In therapy we are always guided by the client's best interest. What happens when it goes against the obligations we have as professionals? We know we must report violence (especially against children). The abuser should be punished, thus prevented from continuing with the violence, and so that the victim's suffering acquire legitimacy. In practice, there are cases when the child/parent/ young woman does not want to report the abuser, since she is afraid of social stigma and isolation.

A fifteen-year-old girl, after a year of being raped by the grandfather her family shares the house with, told parents what had been going on. The family cut off all contact with him, but they still live in the same house, since they lack the finances to move away. Neither she, nor her parents, want the case reported to the police, since they live in a small community where "public disgrace" would immediately ensue.

Such situations provoke our professional, moral, human responsibility. There is no universal solution for them. They require that we grapple, again and again, with the demons of violence experienced by our clients as well as with our personal demons. Conversations with colleagues help as do supervisions, but we must be open to constant self-examination.

Even though violence inevitably leaves traces that can't be erased, their impact on the person's further life can be alleviated. Persons who had been exposed to violence in childhood are, in fact, more vulnerable to new instances of violence in life, but are not necessarily predisposed to put up with it later. The younger the person, the greater the risk of her being drawn into a chain of abuse, maltreatment, as well as human trafficking, one of the most extreme forms. On the other hand, to return to the beginning of the story – each one of us is under a certain extent of risk. Accordingly, the prevention programs of organizations such as ASTRA, which are intended for young people, can provide considerable contribution towards sensitization of youths to the issue of violence and raise awareness about the need for intervention and treatment of persons who have had these dramatic life experiences.

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Biographies

Irena Korićanac, Psychology BA, Clinical Psychology MA, Psychotherapist

Graduated in Psychology at the Faculty of Philosophy in Belgrade, currently completing her Master studies in Clinical Psychology with the thesis entitled: Death, Trauma and Mourning – Interpretative Phenomenological Analysis of the Experience of Loss. She is a psychotherapist of Analytical-Psychodramatic orientation – five-year training program at the Belgrade Psychodrama Institute accredited by EAP, which encompasses personal psychotherapy of future therapists, psychodrama and psychoanalysis theory, direct and indirect supervision and international psychodrama seminars. She is especially interested in existential psychology and psychotherapy. Since 2010 she has been engaged in psychotherapy with individuals and groups as part of her private practice. Licensed trainer and educator. For eight years she has been leading projects within the civil sector aimed at improvement of society and position of endangered groups. The areas she is working in are discrimination, violence, problem of human trafficking, human rights, corporate social responsibility, corporate philanthropy and sustainability of civil sector. Areas of interest: attachment theory, group dynamics, psychological support and counseling with persons employed as helpers (volunteers, social workers, psychologists, activists etc.) and assistance in working through difficult content they are facing daily, with the aim of preventing burnout, application of psychodrama in education and promotion of mental health. Specialized in the field of crisis interventions, psychological processing of loss of loved one and work on trauma and complex trauma.

Dr Michael Korzinski, expert on trauma and psycho-social issues

He has spent over 23 years working in the area of human rights and trauma as part of Helen Bamber Foundation for Treating Torture Victims, where he is one of the founders. He has worked with several hundred victims from diverse countries who had been subjected to violence, wars, human trafficking and similar abuse. In psychotherapeutic work with victims, he considers his main objective to be for victims to begin feeling good and safe in their bodies and regain faith and trust in people. To deal with the aftermath of such experiences and live life in the present, complex obstacles that prevent people from realising their potential have to be overcome. Developing and implementing innovative strategies to combat human cruelty and its consequences is one of the most profound issues of our times. I relish the opportunity to help teams, individuals, hospitals and governments define and achieve their aims.

Mary C. Burke, Ph.D.

Dr. Burke is a faculty member in the Department of Psychology and Counseling at Carlow University in Pittsburgh, Pennsylvania where she is the Program Director for the Doctoral Program in Counseling Psychology. Currently she represents the Association for Women in Psychology on the United Nations Conference of Non-Governmental Organizations Committee on Mental Health. Dr. Burke's scholarship and activism is in the area of human rights and specifically addresses the issue of human trafficking. In 2004 she founded the Project to End Human Trafficking (www.endhumantrafficking.org), an all-volunteer United States based non-profit group that works regionally, nationally, and internationally to raise awareness about the enslavement and economic exploitation of people. In this role, Dr. Burke has given over one hundred and fifty talks and trainings about human trafficking both in the United States and abroad and has begun anti-trafficking coalitions in Pennsylvania, Virginia, and Maryland. In addition, she has spoken to various state and regional elected officials in Pennsylvania and Virginia regarding this issue and has worked on legislation in these states in support of strengthening human trafficking laws. Dr. Burke is a member of the American Psychological Association Task Force on the Trafficking of Women and Girls and is working to advance knowledge about current best practices regarding work with survivors.

Dr Marija Vezmar, Psychiatrist, Psychoanalyst and Group Analyst

She graduated from the Faculty of Medicine in Belgrade in 1982, and in 1990 she specialized in Psychiatry. In 1995 she was awarded the title of Group Analyst (Group Analysis Institute, London, Great Britain), while in 1997 she became a Psychoanalyst and member-associate of International Psychoanalytic Association, whereas in 2002 she became a Training Analyst. From 1983 until 1999 she worked at the Mental Health Institute, outpatient department and department for affective disorders. Since 1999 she has been working in her private practice, training therapists, supervising, carrying out group therapy, conducting trainings in Analytical Theory, giving lectures to specialization students on Psychoanalytic Theory and is involved in other science related activities as part of the Belgrade Psychoanalytical Society. Chair Library Committee 2004-2007, Chair of the Training Committee 2007-2011, President BPS 2011-2012, Officer for contacts abroad, 2012-., member of EPF (European Psychoanalytic Federation) Trauma Group 2004-., teaching staff PIEE (Psychoanalytic Institute for Eastern Europe)

Danijela Budiša, Ph.D. in Psychological Sciences, Transactional Analyst

She holds a Doctorate in Psychology acquired at the Faculty of Philosophy in Novi Sad. During the past ten years she has been subcontracted by the Clinical Center of Vojvodina, working at the substance abuse outpatient center. She is the founder of psychological counseling center Psychogenesis in Novi Sad and is working as teaching assistant at the Faculty of Medicine in Novi Sad, Department of Special Rehabilitation and Education. She graduated in Psychology and completed postgraduate studies in Clinical Psychology, having presented her Master's thesis in June 2009, and acquired her Doctorate at the beginning of 2013. During the ten years that she has been in practice, she has had over 500 psycho-diagnostic evaluations and over 1000 hours of psychotherapeutic work. In the year 2008 she was awarded the title of Psychotherapist on the national level. She is preparing for the international examination in Transactional Analysis, and is also a member of International Transactional Analysis Association (ITAA) and TA Center – Association of Transactional Analysts of Serbia. She has participated in numerous local and international symposiums and conferences, where she presented scientific papers, which she has also written for diverse local and international scientific journals. She has co-authored several local monographs and handbooks. She was awarded first prize for the best poster presentation in Ohrid 2010 at the Fifth Adriatic Conference on Treating Substance Abuse Disorders. For three years she worked as coordinator and psychotherapist at the Counseling Center for Psychoactive Substance Abuse Problems, EMPRONA, at the City Healthcare Administration of Novi Sad. She is a member of the Provincial Council for Combating Drugs and Commission for drawing up a local action plan for youths of the city of Novi Sad, youths health workgroup. She has been continuously conducting training of healthcare workers and associates in the field of substance abuse disorders. She is a trainer for working with substance abuse clients certified by World Health Organization. She was a member of the workgroup for drawing up national guidelines for Methadone substitution therapy under the auspices of Republic of Serbia Ministry of Health and Global Fund.

Biljana Slavković, Psychodrama Psychotherapist

Biljana Slavković, Psychodrama Therapist, holding a European Certificate for Psychotherapy (ECP, awarded by EAP) and Yugoslavian Certificate for Psychotherapy (SDPTS)

In the period starting from 1996 she has attended a series of trainings in the country and abroad, the focus of which was primarily work with psychological trauma. In her practice she works with vulnerable groups (children and youths under institutional protection, domestic violence victims; refugees who are victims; human trafficking survivors). In addition, her psychotherapeutic work is geared towards youths who are in sensitive developmental phases (adolescents), as well as towards persons of different life stages who wish to develop and solve problems by way of therapy.

She is commissioned by institutions and organizations (CSR, Gerontology Center, Police representatives, prosecutors, attorneys, local self-rule administration representatives, preschool and school representatives, NGOs, students, legal clinics etc.). She is co-founder of the organization "Psychodrama Institute – EAPTI" (2005) and "Susret – association of citizens" (1999) and an associate of ASTRA and Autonomous Women's Center. At international and local congresses, she presents her papers and private practice.

Jelena Radosavljev Kirćanski, MA, Family Psychotherapist

Graduated in Psychology at the Faculty of Philosophy in Novi Sad. In 2004 she received her Master's degree in Clinical Psychology at the Faculty of Philosophy in Belgrade. In 2010 she passed the specialist's examination in Medical Psychology at the Faculty of Medicine in Belgrade. She is currently working on her Ph.D. thesis at the Faculty of Philosophy in Belgrade. Since 1997 she has been employed at the Mental Health Institute in Belgrade, at the Developmental Stage Department, while since 2011 she has been a teaching assistant at the Psychology Department, Faculty for Media and Communications at Singidunum University. She has completed training in several therapy modalities: Family Therapy (Family Psychotherapist), Psychodynamic Psychotherapy of Children and Youths, Gestalt and Transactional Analysis TA 101 (for last three modalities she has attained the level of counselor).

For years she has been cooperating with the NGO sector - UNICEF, organization SUSRET, Autonomous Women's Center and other organizations, primarily on problems pertaining to protection of children, youths and women from domestic violence.

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