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Caring for Torture Survivors: The Marjorie Kovler Center

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The Marjorie Kovler Center for the Treatment of Survivors of Torture, a program of Heartland Alliance for Human Needs & Human Rights, commemorated twenty years of providing comprehensive services to torture survivors in October 2007. Since 1987, the Marjorie Kovler Center has worked with more than 1,500 survivors of torture from seventy-four different countries in Africa, Latin America, the Middle East, Asia, and Eastern Europe.

Torture is the deliberate infliction of severe physical or psychological pain carried out by anyone acting in an official capacity for the purposes of extracting a confession, punishment, intimidation, or discrimination. Torture exerts control over people and communities to create a cycle of fear, intimidation, and alienation.

Survivors of torture often suffer from complex posttraumatic stress that manifests as anxiety, distrust, depression, flashbacks, intrusive memories of the traumatic event, concentration and memory problems, and a range of physical symptoms. Disempowerment of individuals and communities is the goal of torture. The goal of treatment, therefore, is to empower survivors to use their strengths and reclaim personal integrity and a sense of control in their lives. The Marjorie Kovler Center helps survivors restore trust in others and reestablish a sense of community.

This chapter will provide a brief history of the torture rehabilitation field and the development of the Marjorie Kovler Center, with its unique model of providing quality care to torture survivors using and managing pro bono professional services. The philosophy and model of care created by the center's staff and Executive Clinical Committee will be discussed through an examination of the political and cultural dynamics of torture, and its impact on individuals and communities. An overview of the center's current demographics will also be provided.

THE CHICAGO IMMIGRANT AND REFUGEE EXPERIENCE

Chicago has a long history as a port of entry for immigrants seeking to improve their lives. In 1888 the Travelers Aid Society was founded to assist young people entering the city. Two years later, activist Jane Addams founded the Hull House and was quickly providing social services to more than 1,000 individuals a week. Addams worked for legislation to protect immigrants from exploitation, limit the working hours of women, mandate schooling for children, recognize labor unions, and provide for industrial safety. In 1908 Grace Abbott, a beneficiary of Hull House's services, became the first director the Immigrants' Protective League, which combined direct service and advocacy for broader social reforms for immigrants.

Travelers Aid and the Immigrants' Protective League merged to form Travelers Aid of Metropolitan Chicago in 1967. With funding assistance from the United Way, the two organizations served travelers, immigrants, prisoners, and others living in destitution. In 1980 these two organizations legally incorporated to form Travelers and Immigrants Aid (TIA), now named Heartland Alliance for Human Needs & Human Rights. With a social justice perspective and a vision to expand services, the newly hired president, Rev. Dr. Sid Mohn, reinvigorated TIA's mission to serve the poor and most vulnerable.

The influx of refugees from Southeast Asia to the United States as the result of the Vietnam War began in 1975 and impacted refugee resettlement services and policies. In 1978 the Illinois Department of Mental Health in collaboration with the Illinois state refugee coordinator, Dr. Edwin Silverman, conducted a Community Forum on Asian mental health concerns that brought together community leaders and mental health professionals. The meeting led to the development of Asian Human Services to serve the mental health needs of the pan-Asian community in Chicago.

The Refugee Act of 1980 created the Federal Refugee Resettlement Program to diversify and provide for the effective resettlement of refugees. This was followed by a Refugee Mental Health Initiative by the Office of Refugee Resettlement, which provided funding to the Department of Mental Health in various states to develop culturally specific services for different refugee populations. In Chicago, these events resulted in Travelers and Immigrants Aid developing a refugee mental health program in 1982, which used bilingual refugee staff to assist identified refugees with mental health problems. The bilingual staff provided social services in the community and interpreted for psychiatrists conducting evaluations and monitoring medications. It was not long before the bilingual staff recognized that some refugees were torture survivors.

A RESPONSE TO TORTURE

The United Nations General Assembly adopted and proclaimed the Universal Declaration of Human Rights on December 10, 1948. Article 5 states, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or

punishment." In 1961 Amnesty International was founded and began advocating for prisoners of conscience who were being detained and were enduring cruel and inhumane treatment. In 1972 Amnesty International launched a worldwide campaign for the abolition of torture. The growing human rights movement provided a foundation for the development of the torture rehabilitation movement worldwide.

In 1979 members of a Danish medical group obtained permission to admit and examine torture victims at Copenhagen University Hospital in Denmark. Three years later, in 1982, Dr. Inge Genefke founded the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen as an independent institution with its own premises.

The Canadian Centre for Victims of Torture was founded by several Toronto doctors, lawyers, and social service professionals, many of whom were associated with Amnesty International. They had begun to recognize torture victims, many of whom were seeking refugee status in Canada, in their practices as early as 1977. This group of professionals recognized the need for specialized services for the social, health, and legal problems faced by this particular group.

In the United States, a similar process was also taking place. In 1978 Dr. David Kinzie, a psychiatrist at the Oregon Health Sciences University, began a small program to treat traumatized refugees coming to Oregon after the Vietnam War. Dr. José Quiroga, a physician who fled Chile after the coup that overthrew President Allende, and Ana Deutsch, a marriage and family therapist who had escaped with her family from the "Dirty Wars" in Argentina, began seeing torture victims in 1980 at the Venice Family Clinic in Southern California. This collaboration eventually led to the development of the Program for Torture Victims in Los Angeles. On the East Coast, Dr. Richard Mollica, a psychiatrist, co-founded the Harvard Program in Refugee Trauma with Jim Lavelle, a social worker. In the Midwest, Minnesota governor Rudy Perpich worked with the local human rights community to found the Center for Victims of Torture in May 1985 in Minneapolis-St. Paul.

Attorneys, physicians, psychologists, and other service providers were becoming aware of the growing numbers of torture survivors living in the metropolitan Chicago area. Thousands of Southeast Asians were resettled in the aftermath of the Vietnam War and Cambodian genocide. The migration of undocumented Central Americans fleeing civil conflicts in their homelands, especially from El Salvador and Guatemala, resulted in the migration of thousands of undocumented refugees. Torture-affected individuals and families began presenting in legal clinics, medical settings, and social service agencies.

Service providers were not alone in their growing awareness of the special needs of survivors of torture. The Sanctuary Movement was formed to develop a network of faith-based shelters for Central Americans fleeing the civil wars in their homelands. The Wellington Avenue United Church of Christ in Chicago was the second church in the country to declare sanctuary, housing Salvadoran and Guatemalan families in 1982. Eventually, area churches and synagogues formed

the Chicago Metropolitan Sanctuary Alliance. During 1983 and 1984, the Chicago Religious Task Force on Central America relocated Salvadoran and Guatemalan refugees by establishing an "underground railroad" from Arizona to Chicago. Also in 1984, Amnesty International launched its second Campaign against Torture. The Wellington Avenue Church was a meeting place for concerned Chicagoans. It was in this sanctuary community that TIA's president, Dr. Mohn, met Chicago attorney Craig Mousin. The meeting resulted in a collaboration that eventually led to the development of the Midwest Immigrant Rights Center (MIRC) in 1985 as a program of Travelers and Immigrants Aid. MIRC (now grown into the National Immigrant Justice Center, or NIJC) became a network of pro bono attorneys trained to represent asylum seekers who would otherwise not have access to legal representation.

Physicians and psychologists in Chicago also became engaged in the issue. Dr. Robert Kirschner, a forensic pathologist at the Cook County Medical Examiners Office, began working on the examination of remains found in Argentina in 1985. This and other experiences gave him expertise in forensic documentation of human rights abuses. Concurrently, Dr. Irene Martínez, a physician at the then Cook County Hospital (now John Stroger, Jr. Hospital) and a survivor of torture from Argentina's "Dirty Wars," began identifying torture survivors in the emergency room at the hospital. As a Spanish-speaker, she was frequently referred patients from Central America. "I thought they were torture survivors because they reminded me of me," she stated.

Martínez was a former Amnesty International prisoner of conscience and activist, coming to the United States in 1981 after her release from detention in Argentina. She first made her way to Los Angeles, California, where she met Dr. Quiroga and Ana Deutsch, then providing treatment for torture survivors at the Venice Family Clinic. It was from this encounter that Martínez learned that the feelings she had been experiencing since her release had a name: posttraumatic stress disorder (PTSD). She shared that this information helped her realize she was not losing her mind. It made her think that other torture survivors might also benefit from having a better understanding of the psychological consequences of torture.

In July 1983, Dr. Martínez began her residency in internal medicine at Cook County Hospital in Chicago. She gave a presentation titled "Psychology and Human Rights Abuses" at the Illinois Psychologists Association's (IPA) annual meeting in November 1986, which led to conversations in December of that year between psychologists from the IPA and health providers from Cook County Hospital interested in providing services to torture survivors.

It was a natural development for Chicago's Travelers and Immigrants Aid (now Heartland Alliance), which already had developed a refugee mental health program, to house a torture treatment center. Dr. Edwin Silverman, chief of the Bureau of Immigrant and Refugee Services, Illinois Department of Human Services, and long-time advocate for refugee concerns, met with Dr. Sid Mohn, president of Travelers and Immigrants Aid to discuss the need for a center in Chicago to serve torture survivors. Drs. Kirschner and Martínez began providing

valuable documentation for MIRC attorneys representing Central American asylum seekers.

Initial discussions about providing health services, including mental health and social assistance, began with Sister Sheila Lyne, president and chief executive officer of Mercy Hospital & Medical Center. In February 1987 a formal meeting occurred that included representatives of key organizations: Sister Sheila Lyne of Mercy Hospital; Steven Miles, MD, from the University of Chicago's Center for Clinical Medical Ethics; Dr. Sid Mohn, president of Travelers and Immigrants Aid; Thomas Hollon, PhD, and Susana Schlesinger, PhD, from the Illinois Psychological Association; and Robert Kirschner, MD and Irene Martínez, MD, from the Cook County health system. The idea of a Chicago center specializing in the treatment of survivors of torture had the support of people and organizations that could make it a reality. They agreed to carry out the following initiatives by the end of 1987:

1. The director of the Refugee Mental Health Program at TIA was psychologist Dr. Antonio Martínez. With funding from the Bureau of Refugee and Immigrant Services of the Illinois Department of Human Services, his position was restructured to provide him with time to help establish a model of care for a torture treatment center in Chicago to be housed under the auspices of Travelers and Immigrants Aid; he would later become the center's first director.
2. Dr. Steven Miles agreed to have the Center for Clinical Ethics host a conference at the University of Chicago on the treatment of survivors of torture. This conference would bring together the leaders in the field, including Barbara Chester from the Center for Victims of Torture in Minneapolis, MN; Dr. David Kinzie from the Intercultural Psychiatry Program, Oregon Health & Science University, Portland, Oregon; Dr. Irene Martínez, physician at Cook County Hospital in Chicago and a survivor of Argentina's "Dirty War"; Dr. Richard Mollica of the Harvard Program in Refugee Trauma at Massachusetts General Hospital; Dr. Elena Nightingale, one of the editors of the recently published *The Breaking of Bodies and Minds: Torture, Psychiatric Abuse and the Health Professions* (W.H. Freeman, 1985); and Dr. Glenn Randall, coauthor of *Serving Survivors of Torture* (American Association for the Advancement of Science, 1991).
3. Dr. Irene Martínez spoke at a Social Issues Section–sponsored presentation at the 1987 Illinois Psychological Association's annual meeting to identify other interested psychologists. Her presentation was titled "Treatment and Needs of Victims of Torture and Their Families."
4. Mercy Hospital committed to providing medical services to ten identified torture survivors, including physical and dental care as well as psychiatric services.

The collaborative and multidisciplinary spirit of this group was essential to the creation of a torture treatment center in Chicago. It reflected a synergism that would be contagious as the planned events took place throughout 1987.

During this time, Chicago philanthropist Peter Kovler had read about the Rehabilitation and Research Centre for Torture Victims in Copenhagen. Through the Blum-Kovler Foundation, Peter Kovler initiated funding in the amount of $75,000 that helped launch the financial reality for the Chicago-based torture treatment program in November 1988. The foundation's only request was to name the Center after Kovler's mother, Marjorie—thus began the Marjorie Kovler Center for the Treatment of Survivors of Torture.

The multidisciplinary working group met several times throughout the year and followed through successfully with their commitments: Dr. Antonio Martínez was named director of the Marjorie Kovler Center. He attended the conference at the University of Chicago where he announced the intent to recruit volunteers interested in providing services to torture survivors, who would be screened and referred by the newly formed Marjorie Kovler Center. A piece of paper was passed around for potential volunteers to list their contact information. A list of fifty names was compiled, and the interested individuals were invited to the first meeting of clinical volunteers on February 20, 1988.

PROVIDING SERVICES FOR TORTURE SURVIVORS

The Marjorie Kovler Center for the Treatment of Survivors of Torture was located in the diverse Uptown neighborhood of Chicago, where many new immigrants and refugees initially settle. Nestled on the third floor of a building that housed multiple refugee assistance programs, the Marjorie Kovler Center had two office spaces and three staff members. Dr. Antonio Martínez divided his time between the Refugee Mental Health Program and the Marjorie Kovler Center, providing administrative coordination. The additional staff included a full-time clinical supervisor and a half-time case manager. A staff triad of administration, clinical work, and case management/volunteer coordination provided the structure, which allowed pro bono professionals and other volunteers to contribute services. The first year's budget was approximately $80,000 for staff salaries, rent, and other direct costs. Within the first four months, thirty-two individuals were accepted as clients at the Marjorie Kovler Center. The caseload included torture survivors from Vietnam, Cambodia, Guatemala, El Salvador, Mexico, Chile, Peru, Iran, and Iraq. By the end of the calendar year, the client numbers reached seventy-four, and Ethiopia and Honduras had been added to the country of origin list.

A core group of twelve pro bono therapists emerged from the outreach efforts and became the Executive Clinical Committee. The twelve clinicians provided guidance and consultation to the staff of the Marjorie Kovler Center in developing a clinical model of care using pro bono professionals. The committee started to meet once a month for one hour to discuss program challenges such as screening and coordinating volunteers. A three-hour multidisciplinary meeting followed and provided volunteers an opportunity to discuss cases in a supportive, confidential setting. This monthly, four-hour time

slot became integral to developing a cohesive volunteer model of care for torture survivors.

Torture treatment was a relatively new field, and most of the volunteers had no practical experience in treating torture survivors. A multidisciplinary and comprehensive approach evolved.

CASE STUDY

Understanding the political and cultural context of torture survivors' experiences became an essential part of providing appropriate treatment. Most of the pro bono clinicians had experience working with trauma, but not torture; experience working in therapeutic dyads, not triads that integrated an interpreter; and experience with different economic classes, but not necessarily different worldviews. Learning to be sensitive to the consequences of officially sanctioned torture, developing a communication rhythm with an interpreter, and being open to the consideration of different ways of understanding the world presented challenges to Western-trained clinicians providing psychotherapy to indigenous and other individuals from the non-Western world.

An example that illustrates these challenges involved a clinical psychologist working with an unaccompanied minor from Central America. Maria (not her real name) had made her way to Chicago via the Sanctuary Movement. While living with a family who had agreed to provide for her needs as an adolescent, she was referred to the Marjorie Kovler Center for behaviors that included lying and hoarding food. Her trauma history included being orphaned as an infant when her parents were disappeared. She was raised by an older woman, who was taking care of many children orphaned by the civil conflict in their country. Maria also survived her village being bombed, and her own abduction and rape by soldiers. After giving birth to a child as the result of the rape, Maria worked in the city and sent the money she earned to the woman who had raised her and was now raising her child. After several harassing encounters with the military, Maria fled to the United States, fearing the harassment would escalate into more abuse. Her crossing as an undocumented minor assisted by the Sanctuary Movement provided her with some assurance of refuge once she arrived safely in Chicago.

Maria was fifteen years old when a family who agreed to provide her with basic needs and education received her. This was a difficult transition, however, and was fraught with many miscommunications and misunderstandings. Identifying and understanding these issues was a primary task of individual psychotherapy.

Maria was of indigenous descent, had a second grade education, and had been raised in a rural village where, she described, everyone contributed to the well-being of the community. Her description of the woman who raised her and other orphans was that she was her *abuela,* or grandmother, and that the other children were her brothers and sisters. Maria also described having

several different pseudonyms and indicated that using different names was part of survival when meeting strangers. She described learning as a child that it was not safe to trust people she did not know. The political context of civil war and the cultural and linguistic worldview of *campesino* life, in addition to Maria's multiple traumatic experiences, were all essential components for the therapist to understand. The use of a Spanish-speaking interpreter to assist the therapy process was a challenge for Maria, since Spanish was her second language; for the therapist, who needed to rely on the interpreter to be the conduit of communication; and for the interpreter, who had to ensure accurate representation of what was being said. All the participants were unfamiliar with these conditions of psychotherapy. There was a huge learning curve to be mastered.

Creating a safe environment became the first task of therapy. Maria's grandmother had been a significant figure in Maria's life, and she missed her very much. At her own initiation, Maria performed a ceremony where she used her indigenous belief system to call upon her grandmother to be "present" during the sessions. The blending of psychotherapy with an indigenous practice provided a cross-cultural blending of healing strategies. Fortified by the felt sense of her grandmother, Maria was able to talk about her multiple traumas in a psychotherapeutic context. Additionally, Maria found family therapy sessions an important component of her treatment, stating, "They are my family now and need to know what is happening in my life."

Maria regularly brought forth her deep connections to her community and her *abuela,* and placed her own experiences in the context of a collective experience. Center staff and volunteers recognized what the collective experience brought to Maria's reservoir of strength and resilience. The case manager, volunteers, and other service providers worked in a collective spirit, closely coordinating with the therapist to address needs that affected Maria's daily life. Maria needed medical attention for contractures secondary to scarring from napalm burns, English as a Second Language classes, intensive support during multiple housing transitions, employment assistance, and referral for legal assistance. Recruiting pro bono providers as needs arose, accompanying Maria to appointments in the community, and responding to crises was also a collaborative effort sustained for a decade. By sharing who she was with us, Maria unwittingly led our center into a deeper sense of collective responsibility, action, and joy. Maria remains engaged with the center's services, activities, and the same helping professionals after seventeen years, reflecting her resilience, independence, and connectedness.

A CLINICAL MODEL FOR TORTURE TREATMENT

The Marjorie Kovler Center's clinical model developed with special attention to three areas: (1) understanding the dynamics of torture and its psychological effects, (2) grounding treatment in a political context, and (3) adapting treatment to varying cultural concepts about torture and mental health. Initially, our knowledge of torture and its effects was limited to the kinds of trauma we were accustomed to seeing in our professional practices. Only by listening carefully to

survivors—to their stories and their feedback—and reflecting with colleagues over time did we begin to understand how we could best offer assistance as a program. Treatment constantly interacts with the dynamics of torture and its political and cultural contexts. As illustrated in Maria's story, we continue to rely on the client/survivor as expert on issues related to her own experience and as the ultimate arbiter of a treatment's success.

Dynamics of Torture

The most immediate aspects of our clients' initial presentation are the palpable feelings of vulnerability and mistrust. Whether a person's gaze is cast downward and words are spare, or eyes look fearfully to you, silently pleading for respite from pain, nonverbal expressions communicate volumes about past experiences and present needs. We wanted to communicate safety and trust to survivors. To do this effectively, we knew we had to first understand the survivors' core experiences of torture. Humiliation, threat of death, unpredictability, and complete powerlessness pervade torture. The intentional application of extreme physical pain accompanied by interrogation was also destructive to language that might describe it (Scarry, 1985). The depth of trauma was degrees of intensity beyond what most clinicians had previously encountered and treated, so we read and discussed what was available on the subject as we began meeting with new clients and listening carefully.

Social Conditions

Literature from Latin America, both clinical and autobiographical, illustrated the specific context of torture for many of our first clients. It underscored the strategic, systematic way torture was used to exert power and silence dissent. Jacobo Timmerman wrote not only of the shocking brutality to which he and others were subject in Argentina, but his narrative also provided insight into methods and psychological aspects of perpetrators in a torturing hierarchy (Timmerman, 1981). Regimes combined isolation with extreme brutality for maximum, long-term impact. It seemed clear that a central objective of perpetrators was to convince the victims that no one would believe their stories, even if they survived to tell them, leaving survivors with an enormous and unjust burden of guilt and shame. Dictatorial regimes had effective propaganda machines to generate myths about the threat dissidents constituted. Regimes tried to marginalize individuals, diminish the influence their voices could have on others, and stigmatize their families. Many regimes were able to convince sectors of civil society to collude with the idea that a political or social group could be regarded as almost subhuman, a "torturable class" of people (Conroy, 2000, p. 27). Learning about these realities helped us understand clients who avoided telling their stories or disclosing significant details about their experience of torture and persecution. We were also challenged to believe the unbelievable.

The conditions present for systematic terror often included collaborating institutional elements, such as clergy allied with dictatorships and other professionals, such as physicians and psychologists, lending credibility to inhuman methods of enforcing state control (Lifton, 2004; Scarry, 1985). Understanding this nuanced aspect of some torture experiences helped us to be sensitive to clients hesitant to seek needed treatment, and to modify how we were accustomed to conduct medical and psychological evaluations. We became more conscious that we might be perceived as authority figures and adjusted our style and workspace to convey warmth and safety. Accommodating the need for a slower pace—a first session dedicated solely to helping the client feel more at ease, explanations for reasons why questions were asked or actions taken, and reassurances that survivors were not obligated to comply with any request we might make—we proceeded with increasing awareness. The knowledge and reality that "helping" professionals collaborated with torturers also brought staff and volunteers closer to understanding that the capacity to torture could be present in all of us, however distressing the idea.

Political Asylum

These powerful psychological themes of guilt, shame, and silence had legal ramifications once a survivor had arrived safely in this country (Bogner, 2007). Many survivors avoided talking about their experiences to prevent the onset of painful, intrusive memories and to attempt to forget, however elusive the wish. In the early years, many did not apply for political asylum out of fear of retraumatization or fear of retaliation against their families at home. In 1996 Congress passed the Illegal Immigration Reform and Immigrant Responsibility Act, which profoundly restricted protection for asylum seekers by requiring expedited filing of asylum applications (McAndrews, 2002). Torture survivors were suddenly compelled to enter a retraumatizing, unpredictable legal process before they had an opportunity to stabilize their lives. There is an inherent and frightening power differential in the asylum process, increasingly adverse and accusatory. Here, the burden of proof is on the asylum seeker, who needs to produce documents to support the claim. In their home countries, however, the focus is on evading immediate danger to survival. Those who manage to flee are able to do so because a support network mobilizes on their behalf, often paying bribes to help them escape captivity, obtaining false documents if necessary, choosing the destination, and making travel arrangements. Most never imagine having to prove they were tortured, as if living through it and carrying the emotional and physical pain were not proof enough.

The psychological pressure to prepare for the asylum process often overwhelms survivors, and the discretionary nature of decisions can be devastating. Therapeutic support is critical as a client constructs a written narrative testimony of his or her persecution. Center staff and volunteers have responded to these legal imperatives with treatments that emphasize symptom management, coordination

of constant efforts to provide medical and psychological forensic documentation of torture, and the finding of resources to assist clients in chronic economic instability. Asylum applicants are not eligible for any government assistance and often have prolonged waits for work authorization. Documenting the effects of torture is a labor-intensive process for a volunteer organization, but when survivors are granted asylum, there are tremendous concrete and symbolic gains. Asylum represents a crucial step toward security and family reunification, as well as a milestone in the treatment stage of safety (Herman, 1992). Twenty years later, the legal process continues to present challenges to the treatment team—intensified by heightened suspicion of asylum seekers since September 11, 2001, and increased discretionary powers for immigration judges (REAL ID Act, 2005).

Strength in Community

The legal pressures, profound trauma, and often disabling physical and psychological symptoms facing survivors led the Marjorie Kovler Center to a collaborative, multidisciplinary treatment approach. As much for our own benefit as for the clients', a collective approach would provide peer support for intense trauma work and help us form a community of support and healing. The systemic use of torture to destroy real or perceived threats to power can result in a strong disincentive on the part of survivors and their communities to organize, take action, or voice dissent. Informed by the survivor's experience of isolation and helplessness, we hoped to recreate a sense of community. By first helping a survivor to connect with his or her innate strength and resilience, and then helping the survivor connect with our community, we were offering ours as a bridge to others.

The political context of torture, systematic in its disempowerment, permeated our understanding of empowerment as a core objective of treatment and our belief that effective treatment should extend beyond the individual (Bronfenbrenner, 1979). Offering assistance to increase English language proficiency (ESL classes and volunteer tutors), to obtain training and employment (occupational therapist), to address causes of physical pain (nurses, doctors, dentists, physical therapists, acupuncturists, massage therapists), to engage in expressive therapies (art, dance, movement), or to attend a cooking group or free cultural event are center services that complement individual psychotherapies. Reduced symptoms of insomnia, depression, and anxiety, along with participation in activities beyond the therapeutic dyad, signal an increasing sense of agency and a change from the core dynamics of torture.

Sharing Power

The dynamics of power exist simultaneously at personal, interactional, organizational, and structural levels (Wolf, 1999). Our objective to encourage empowerment influenced our organizational layers (after increased funding in 2000 from the Torture Victims Relief Act) and methods of service delivery—from administrative

to clinical, intake evaluation to case management model, and interactions with clients around health and material needs. A balance of power and awareness of choices is critical to the effectiveness of services and the quality of our relationship with survivors. Empowerment may initially manifest in a choice to accept or decline a particular recommendation in the Initial Treatment Plan. Over time, however, many clients have recovered their voices of dissent and have spoken to the media, lobbied officials in Washington, D.C., established activist organizations, and filed civil lawsuits against torturers who reside in this country. The center has been uniquely engaged at these broad levels of empowerment: supporting Torture Abolition and Survivors' Support Coalition International (TASSC), founded and run by survivors; inviting collaboration with a client advisory board; working with torture survivors who pursue justice through civil cases supported by the Center for Justice and Accountability (CJA) by providing psychological evaluations and support; and promoting clarity and consistency in our mission so that the Marjorie Kovler Center is easily identified with our model and strong public stance against the use of torture.

Importance of Relationship

Torture is a relational trauma and a political act, using a range of techniques intentionally applied by another human being for maximum humiliation and harm. One of its central aims is to undermine a person's ability to form healthy relationships. The psychological imprint of the survivor's forced relationship with a cruel and unpredictable authority confounds subsequent relationships. For survivors, the prospect of entering a relationship is anxiety provoking and potentially retraumatizing. Relationships are often avoided in early stages of recovery. For example, survivors may hesitate to come to the center after being referred by someone or may spend their days alone in their rooms, avoiding interaction with roommates or potential encounters outside the home. To the extent that any situation or relationship begins to reconstitute elements of the torture experience (i.e., a sensory piece of the present that resembles the traumatic past), a survivor will feel increasingly vulnerable and respond accordingly (e.g., shut down emotionally, show signs of central nervous system hyperarousal, have a flashback, avoid repeating the experience). Survivors who have disclosed painful details of their torture to a therapist or attorney may avoid coming to the next appointment.

To engage survivors in treatment, the center's staff and volunteers knew they would have to earn trust in clear and intentional steps. Although retraumatization is unavoidable, minimizing it is a philosophical and operational tenet for our center. All team members are mindful of incorporating choices in their interactions with survivors: to slow the pace, to not disclose a detail until ready, to sit facing the provider or not, and to accept medication or not. Clear information and descriptions of the process help shape realistic expectations. Providing choices becomes a therapeutic intervention whose effect is to convey sensitivity to their

vulnerability, gradually instill trust and safety in the relationship, and restore confidence in the survivor's own inherent ability to heal.

Survivors suffered profound betrayal in the context of a human relationship and often have needs for transparency beyond conventional clinical boundaries. They often challenge clinicians to respond to questions about our political views or stance on U.S. support for or involvement with their country's military. Having been exposed to the worst of humanity, survivors often wondered why we were doing this work, suspicious of our motives. To respond in the classical ways in which we are trained would risk retraumatizing or alienating our clients. Instead, it has been essential to demonstrate solidarity with survivors and the movements for social change with which they have typically been associated. In the center's early days, the clinical committee, struggling to respond in ways sensitive to the dynamics of torture, would openly discuss these issues. A model of therapeutic accompaniment developed to provide reassurance for the existential dilemma of trusting people again and to recognize the pervasiveness of retraumatizing experiences in survivors' daily lives.

Therapeutic Accompaniment

The practice of accompaniment challenges traditional ideas of clinical boundaries (Fabri, 2001). Often, professional boundaries are defined by meeting in an office for a set amount of time. In working cross-culturally, we have found that to engage survivors who come from countries and cultures with limited if any knowledge of the Western mental health model, it is necessary to make adjustments and modifications to conventional frameworks. This may include, but is not limited to, a physician conducting a forensic medical examination in a non-medical setting, a psychotherapist accompanying a survivor who was raped as part of her torture to a medical examination, or a case manager driving and staying with a client through her dental appointment. It may also involve therapy in a client's home. The guiding principle determining how and when to adjust conventional boundaries is found in answering these questions: Is this therapeutic for the survivor? Will it enhance engagement in treatment? Does it promote greater safety and trust? We have learned boundaries are internalized, and professional roles can be maintained in any physical environment.

A Therapeutic Partnership

The Therapeutic Partnership is a model of psychotherapy using interpreters to meet the needs of cross-cultural mental health. Using the empowerment model that permeated the philosophy of care of the Marjorie Kovler Center, the expertise of each participant—survivor, interpreter, and clinician—was acknowledged as an essential component of the therapy process. A collaborative methodology was promoted: the therapist was viewed as providing expertise on

the psychological consequences of severe trauma, such as torture, and strategies for recovery; the survivor was an expert in what trauma had occurred and its expression within his or her own cultural, linguistic, and political context; and the interpreter was the conduit for communication, an expert in the languages spoken by the therapist and survivor. There were also times when the interpreter provided more than language interpretation. When the interpreter was from the survivor's homeland, he or she was also a cultural broker, often translating the meaning of behaviors and expressions in ways that promoted deeper understanding of the communication. Additionally, the interpreter at times was an advocate for either the survivor or the therapist, assisting the other in grasping the full meaning of what was needed or being expressed. The therapeutic triad became a therapeutic partnership and reflected respect and trust, necessary ingredients for psychotherapy.

Spiritual Support

Another vital component developed by Eva Sullivan-Knopf, an early case manager at the Marjorie Kovler Center, was the Irene Pastoral Counseling Program, Irene designating "peace" in the Greek tradition. With a background in ministry, Eva recognized the importance of spirituality in a survivor's life and worldview. The Irene component essentially was organized around offering pastoral counseling to Marjorie Kovler clients. The volunteers and consultants to the program represented many faiths, including Buddhism, Christianity, Islam, and Judaism. Eva continued to consult with volunteers even after she left for a church ministry. Many of the volunteers continued this service, but the Irene component itself eventually diminished over the years without on-staff leadership. The legacy, however, continues with ongoing links to communities of faith, particularly the Chicago Theological Union and local mosques, churches, and temples that provide spiritual support to clients and consultation to staff and volunteers.

POLITICAL CONTEXT OF TORTURE

The first clients at the center were predominantly Latin American and Southeast Asian; therefore, it was imperative that we as a program understood the sociopolitical history and current policies of United States' involvement in those hemispheres. Basic questions such as how the economic and political interests of the United States interacted with the power structures of each country could have implications for treatment. One had to be able to distinguish between official reports of the "communist reign of terror" in Central America and reports from a union organizer from Guatemala or catechist from El Salvador who was systematically targeted for torture, disappearance, and assassination (President Ronald Reagan televised speech, 1984). Staff and volunteers had to demonstrate they were

not antagonistic to the opinions or activities that led to the client's persecution. Our program also had to reassure clients we did not have government ties and would protect confidentiality.

A sociological framework that explained the relationship between war, oppression, and mental health was especially useful to elucidate the psychological and spiritual effects of the wars in Central America on communities (Martin-Baró, 1994).The concept of our own liberation being tied to others' liberation was not only consistent with the guiding philosophy of liberation movements prevalent in Latin America at the time, but it was also useful to shift the inherent power differential in a treatment relationship to a more equitable balance. One therapist remembers her Guatemalan clients sharing in greater depth after they saw her marching in a protest against U.S. policies in Guatemala. Many volunteers were drawn to the center's work, appalled by knowledge that torture was prevalent and either overtly or covertly supported by our government. Learning that survivors were in Chicago in substantial numbers, they hoped they might contribute in some small way to a survivor's recovery and begin to wedge into systems perpetuating the practice of torture. This continues to be a central motive for our volunteers twenty years later.

As staff and volunteers listened for the first time and then repeatedly to stories of gross human rights violations, we looked to each other and to those we trusted for points of reference. We experienced shifts in our worldviews and episodic vicarious trauma, as in nightmares and symptoms of anxiety or depression that had not been present prior to the work. We also came to question the impact of our work as long as torture persisted with impunity all over the world. Acknowledging the presence of social phenomena such as denial and dissociation in our own society (including friends and family) compelled us to break the cycle of social denial by action and by speaking out in solidarity with our clients (Herman, 1992). The U.S. government's participation in torture is now widely known. The photos and national debate dealt a psychological blow to many clients who do not have the luxury of debating the issue in abstract terms. We have continued standing with our clients to oppose the use of torture of any kind against any human being.

EFFECTS ON FAMILIES

The Marjorie Kovler Center adopted the United Nations definition of torture: "Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in

an official capacity" (UN Convention). The Mothers of the Plaza de Mayo, from Argentina, taught us about the suffering of family members of the disappeared. Just as torture is an oppressive tool applied systemically, the center's clinical committee recognized the corresponding need to systemically treat the effects of torture in the family. Some children felt they must keep secrets about their mother's, father's, or sibling's torture or disappearance to shield the family from stigma in the community or further persecution from authorities. In many countries, there are substantial threats to families and risk of persecution once a member flees the country. Many family members have witnessed extreme violence in their communities and are traumatized, even though they themselves were not tortured.

The center's staff and volunteers understand our clients' symptoms and behaviors in relation to their experience of torture—as normal reactions to abnormal circumstances rather than pathology. This approach brings solidarity into the clinical framework and incorporates a political consciousness into our conceptualization of PTSD and its treatment. PTSD is a common, albeit imperfect, diagnosis to describe symptoms survivors frequently experience once they survive torture. Although assisting clients to decrease the frequency or intensity of these symptoms is essential to the recovery process, the center also values the long view on treatment. When a survivor recovers his or her voice, this is a political act of demonstrating to the torturing regime that they failed to silence or incapacitate the survivor. For example, although clients who bring lawsuits against torturers enter a public, prolonged, and emotionally taxing process, they have reported significant therapeutic gains from confronting the perpetrators in a federal courtroom where juries have ruled in the survivor's favor. The survivor as plaintiff often pursues this line of justice to honor the memory of so many who did not survive, reclaiming the path of social justice begun long before their persecution. Many clients, even after their lives are more stable and secure, continue to exercise power in meaningful ways. Accompanying clients in their goal to reclaim justice is a rich and complex process. Many of us who know and work with survivors have ourselves been transformed by their experiences of profound social engagement.

CULTURAL CONTEXT OF TREATMENT

Many of our early clients from Latin America and Southeast Asia came from cultures that valued the collective over the individual. They expressed themselves in the collective "we" and had always lived with extended family before fleeing their country. We considered the importance of the survivor's role in family and community, and brought clinical intervention into those dimensions. Long-term group work with both Cambodian women and Guatemalan exiles also involved seeking assistance from the community to help reframe cultural concepts and incorporating expressive therapies to facilitate the therapeutic process and engage the wider community.

CASE STUDY: CAMBODIAN WOMEN'S GROUP

The Cambodian women who had been tortured and raped by soldiers of the Khmer Rouge understood their experience in the context of karma, a Buddhist concept of cause and effect that asserts one's past actions are the cause of present circumstances. The women felt deeply responsible for their own suffering and believed it was directly related to terrible acts committed in past lives. Furthermore, they did not want to talk about it. Pat Robin, a volunteer psychologist, sought consultation from the center's then director, Antonio Martínez. Together, they invited cultural experts to help them overcome these obstacles to treatment. One was an academic who met with the clinical committee and offered to reframe the women's interpretation of karma. Rather than having had past lives as terrible people, they were likely to have been diligent caregivers in their communities, which explained why they needed to allow others to care for them in this lifetime.

A Buddhist monk in the community was consulted about how to work with the women when they did not wish to talk about their trauma in Western fashion. He shared a parable about the need to follow the river as it bends, suggesting that clinicians needed to adapt to the group's inclinations even if it meant forging a new path. The group eventually worked with a local dancer/choreographer Jan Erkert to create "Turn Her White with Stones," a dance piece where the women were able to incorporate their stories and traditional rituals into the choreography and finally into a dance, which was performed by an Erkert Company dancer at Columbia College. The women's group also collaborated with a drama therapist to produce a theatrical piece on their survival and resilience under the Khmer Rouge. The women created a dark, narrow maze through which individuals, escorted by the women, entered the theater. They led the audience members to their seats in this way to convey a sense of the fear and confusion the women had felt in refugee camps. With attention to movement and narrative, the women collectively faced and re-shaped traumatic memory with a greater sense of control, and they also were able to illustrate their stories to a wide community audience. This acknowledgement of their experience was very meaningful to them.

CASE STUDY: GUATEMALAN GROUP

Mario González, a Guatemalan psychotherapist and long-standing staff member, who understood the political culture of resistance and mistrust, organized a Guatemalan group of men and women in the late 1980s and later worked together with Antonio Martínez as co-facilitator of the group. Beginning in a church basement, the group later rotated meeting in each member's home, a step that drew members together as well as helped them feel safe. Trust and security were fleeting for Guatemalans in that period

when the approval rate for political asylum was less than 1 percent (INS *Yearbook,* 1984) and the U.S. government was funding the brutal dictatorship. The early goals were to break the isolation members were experiencing and to rebuild the sense of community they had lost in exile. The group received support from the larger community, including Casa Guatemala and Su Casa, a Catholic Worker house. Group meetings were always followed by informal social gatherings in spirited Guatemalan fashion. The group transitioned from previous discussions of traumatic material to lighter conversation in a relaxed setting, nourished by the presence of children, spouses, friends, music, dance, and traditional food.

In 1990 group members expressed concern about their children dealing with the effects of trauma, loss, and dislocation. New volunteers were recruited to meet with the children while the parents met in a separate room. This new group incorporated therapeutic activities to support the children's identity as Guatemalan as well as help them cope with the challenging transitions to life in a large North American city. As children of survivors, the young group members carried their own suffering. The group members developed a distinct role in the community, where they contributed to the cultural and political activities through traditional Maya dance, theater, and art; they named themselves Konojel Junam (All Together). They also worked with Jan Erkert and performed a piece of their own design, "Jornadas de Esperanza" (Journeys of Hope) to a full house at the Harold Washington Library.

After several years of meeting together and moving through distinct stages, the adult group focused on an oral history project to bring validation to their experiences and raise awareness about the human rights situation in Guatemala. The group had collected testimonies of members in the form of life narratives rather than focusing solely on traumatic events. They received funding for one year from the Illinois Humanities Council to present a series of public presentations they named "Twelve Parallel Lives." Each narrative represented a sector of Guatemalan civil society targeted by the repression. The series of presentations, which took place in public spaces such as the Chicago Cultural Center, universities, and bookstores, included an introduction, reading of one narrative by someone other than the author, discussion facilitated by a center volunteer with questions from the audience, and closing with a marimba and traditional dance by Konojel Junam. A community arts group created a series of paintings and prints inspired by the narratives and donated the image used on the flyer. The Guatemalan community actively participated and donated traditional food. Community support and validation was meaningful to the group, and Chicagoans benefited from the opportunity to learn directly and personally about the human rights situation in Guatemala.

INNOVATIONS

This section introduces ways in which the center's program has and continues to evolve to meet the needs of our clients. Whether challenged by changes in funding, demographics, or shifts in immigration policy, the center remains committed to develop and test creative responses.

A Community Organization

The Marjorie Kovler Center developed an individualized approach to treatment that is nonhierarchical, noninstitutional, and nongovernmental, and its organizational structure mirrored this approach. The internal structure and spirit of the center's organization of staff and volunteers remains basically horizontal. Everyone, from interns to senior directors, is encouraged to contribute ideas and opinions, make coffee, wash dishes, and mop up when necessary. Clear and direct communication is valued over chain-of-command style. Our clients tend to be hypersensitive to the power dynamics of human behavior—an open, warm community serving tea or coffee to all visitors encourages a return visit and the chance to form bonds of trust and friendship. There is no mistaking how much we have learned and still have to learn from survivors—about forming community, engaging in social action, courageously speaking out against injustice, enduring the losses, and sharing the victories together.

Recent Funding and Growth of the Torture Treatment Program

From 1987 to 2000, the center relied on numerous grants beginning with the initial grant from the Blum-Kovler Foundation that launched the Marjorie Kovler Center. This foundation has continued to support the center's work with an annual donation. Additional sources of funding have included local (e.g., Michael Reese Trust Fund) and national foundations (e.g., Rosenberg Fund for Children) as well as individual donors. Functioning on a small budget that provided two full-time and one half-time staff, the center has depended on volunteers in providing services. Maintaining consistent funding was an ongoing struggle and required administrative coordination of grant writing and reporting. In the mid-1990s, the Marjorie Kovler Center applied for and received funding from the United Nations Voluntary Fund for Victims of Torture. This additional resource has helped fund a staff position that conducts intake assessments.

Minnesota Senators Dave Durenberger and the late Paul Wellstone, a Republican and a Democrat, first introduced the Torture Victims Relief Act (TVRA) in 1994. Enacted in 1998, the TVRA had strong bipartisan support in both the House and the Senate. In 2000, the first year of appropriated funds that implemented the TVRA, the Office of Refugee Resettlement in the Administration for Children and Families awarded four-year grants to seventeen organizations.

The Marjorie Kovler Center was one of the grantees in 2000 and has continued to receive funding through the Torture Victims Relief Act. This meant that almost overnight the center staff increased from three to nine. A stronger infrastructure to support the volunteer network was a direct outgrowth of this funding, and the capacity to provide services to torture survivors doubled within twelve months.

Current Case Management and Community-Building Efforts

Case management and volunteer coordination were essential components of the initial design of the center. The growth in 2000 allowed for case management

to build a team (two full-time staff and two full-time volunteers). They have built a unique model of service provision, linking client needs with skilled volunteers. Rather than a traditional case management model, whereby each is responsible for coordinating services for a set caseload of clients, the model follows a transdisciplinary approach. As such, roles and responsibilities for each service (e.g., coordination of health appointments, forensic exams, ESL tutoring, special events) are rotated, resulting in greater knowledge of services and resources by the team and greater accessibility for clients.

Nurturing Familiar Occupations: Farms and Bees

Historically, the Marjorie Kovler Center has been committed to community building, and case management supports this through organized trips and activities. The case management team solicits free tickets and coordinates client groups to attend local cultural events, many relating to the clients' culture and others expanding exposure to local resources. Community building expanded beyond the Chicago city limits when a volunteer, Tom Spaulding, invited the center's clients and staff to visit a rural farm, Angelic Organics. Here, clients had the opportunity to participate in farm tasks and specialized workshops. The farm held special meaning for clients who reconnected with positive experiences and memories from their home countries. As a Guatemalan woman shared, "You can see many farms, but none invite you in. Here you feel at home."

After trips to the farm, clients expressed the wish to return. This inspired the development of a local urban farming project where clients could use their agricultural skills and experience connection with the earth in their own neighborhood. With staff support and resources from the Angelic Organics Learning Center, the center began collaborations with the Chicago Waldorf School, and clients have been planting and tending their organic garden located only two blocks away. This urban farm project also promoted the development of a rooftop apiary at the center, with honeybees as the "livestock." Clients have the opportunity to harvest honey and tend to the bees—an occupation familiar to many—under the guidance of volunteer, Mirsad Spahovic, who was a beekeeper for twenty years in his native Bosnia.

Nourishing Universal Rituals: International Cooking Group

Vegetable produce from the garden and honey from the roof are used every other week by the international cooking group. At each group meeting, a client oversees preparation of a meal from his or her home country, and group members follow the client's lead, pitching in with chopping, sautéing, and seasoning, culminating with sitting down to share and enjoy a delicious meal. Participation in familiar occupations and engagement in universal rituals have served to support rebuilding of community, evidenced by high turnout and sustained membership in these groups.

Dignified Work

Vocational assessment of a survivor's skills is another aspect of joint case management and occupational therapy services offered at the center. An Occupational History assessment is conducted when a client is referred to occupational therapy (OT). This assessment considers the interests, skills, and strengths of the client in the home country as well as adaptation to the new environment. OT services are primarily concerned with how the sequelae of torture, displacement, and acculturation affect a survivor's ability to perform meaningful occupational roles in the domains of self-care, leisure, and work within challenging environments that systemically restrict occupational opportunities. The new environments confronted by refugees and asylum seekers often foster "occupational deprivation," which prevents access to potential opportunities and inhibits the essential need for belonging (F. Kronenberg, N. Pollard, 2005; G. Whiteford, 2005). The most predominant environmental obstacles identified by clients in the OT assessment include (1) barriers to employment, such as long waits for work authorization, lack of readily available jobs, difficulty transferring existing skills, and limited access to further education; (2) isolation, including lack of social opportunities that feel safe and culturally comfortable as well as homesickness; and (3) diminished status secondary to the loss of occupational roles, for example, in the role as family provider, parent, or community leader. The occupational therapist works closely with case managers who assist with specific vocational tasks, including creating a résumé, filling out job applications, practicing for interviews, and obtaining educational equivalencies.

The paucity of culturally familiar social opportunities and opportunities for enhancing skills is addressed through group activity interventions such as community outings, the international cooking group, urban farming groups, and links to appropriate community resources. These services, designed to meet needs that clients identify, demonstrate that engagement in positive experiences offers a means for clients to use their skills and capacity to create safe connections and communities. These have taught us that engagement in meaningful experiences can be transformative.

CURRENT DEMOGRAPHICS

The Marjorie Kovler Center has sought to transform programming and services in response to survivors' needs and systemic environmental changes. The demographics of countries represented have shifted dramatically over the past twenty years. The number of survivors receiving services at the Marjorie Kovler Center has also steadily increased with each year. Tables 9.1 through 9.4 indicate the current demographics of survivors receiving services at the center, referral sources, and volunteer valuations.

Table 9.1 Participant Demographic Information for Fiscal Year 2007

		Age	No.	%	World region (nationality):		
Persons served: 330		0–10	5	1%	Africa	209	63%
Female	164 (50%)	11–20	23	7%	Latin America	50	15%
Male	166 (50%)	21–30	89	27%	Asia	35	11%
Survivor status:		31–40	117	35%	Europe	15	5%
Torture survivors	284 (86%)	41–50	61	18%	Middle East	14	4%
Family members	46 (14%)	51–60	30	9%	North America	5	2%
		61–70	7	2%			

Source: 2007 Annual Report, Marjorie Kovler Center of Heartland Alliance.

CONCLUSION

As demographics shift in response to worldwide conflicts, the lessons learned about providing a healing environment for survivors of torture continue. A remarkable journey has been undertaken in Chicago through the work of the Marjorie Kovler Center. This chapter shared snapshots of the journey and provided insights into the necessary social conscience and community effort that go into creating a response to a social illness such as torture. The journey is bittersweet. We are happy and saddened by our twenty-year efforts to assist survivors of torture in rebuilding their lives. It is our sincere wish to close our doors one day because our services are no longer needed—that torture is no longer practiced in the world we share.

Table 9.2 Nationalities Served in Fiscal Year 2007 (total 53)

Afghanistan	1	Eritrea	19	Nigeria	2
Albania	6	Ethiopia	15	Pakistan	2
Angola	4	Guatemala	27	Rwanda	3
Benin	1	Guinea	5	Senegal	1
Bosnia-Herzegovina	5	Haiti	4	Sierra Leone	1
Bulgaria	1	Honduras	1	Somalia	5
Burkina Faso	2	India	1	Sri Lanka	1
Burundi	2	Indonesia	1	Sudan	8
Cambodia	1	Iran	2	Thailand	1
Cameroon	33	Iraq	3	Tibet	1
Chad	5	Kenya	4	Togo	43
Chile	1	Kosovo	3	Tunisia	4
Colombia	9	Liberia	7	Turkey	4
Congo	13	Malawi	2	Uganda	11
Congo (DRC)	24	Mauritania	3	United States	5
Cote d'Ivoire	2	Mexico	1	Vietnam	15
Ecuador	6	Mongolia	1	Zimbabwe	2
El Salvador	5	Nepal	1	Total	53

Source: 2007 Annual Report, Marjorie Kovler Center of Heartland Alliance.

Table 9.3 Referral Sources in Fiscal Year 2007

Source of Referrals	Oct. 2006–Sept. 2007
Mutual Aid Associations	8
Ethnic/Religious Communities	38
Hospitals/Clinics	3
Lawyers/NIJC	43
Other	8
TOTAL	**100**

Source: Year-end Data Report, Marjorie Kovler Center of Heartland Alliance.

BIOGRAPHIES

Rev. Dr. Sid Mohn is president of Heartland Alliance for Human Needs & Human Rights, a service-based human rights organization focused on investments and solutions to help the most poor and vulnerable in our society succeed. He joined the organization in 1980, and also serves as president of its three partners: Heartland Housing, Heartland Health Outreach, and Heartland Human Care Services. Prior to his tenure at Heartland Alliance, he held positions with the Chicago Urban League, the Kane/DeKalb Counties Employment and Training Consortium, International Documentation, and La Casa Center. Dr. Mohn is a graduate of Temple University, received his Master of Divinity from the School of Theology at Claremont, California, and his doctorate from McCormick Theological Seminary in Chicago. He is a United Church of Christ clergyperson and a member of the Order of Ecumenical Franciscans. Dr. Mohn is past chair of the board of directors of the National Immigration Forum and is a member of the board of directors of International Social Services U.S. Committee for Refugees, Chicago Commission on Human Relations, and Global Chicago.

Rev. Craig Mousin has been the university ombudsperson at DePaul University since 2001. He received his BS *cum laude* from Johns Hopkins University, his JD with honors from the University of Illinois, and his MDiv from Chicago

Table 9.4 Volunteer Hours and Valuation in Fiscal Year 2006

Volunteers	Hours	Rate	Value
Amate and Mennonite Volunteers	4,800	$12	$57,600
Counseling by trainees	1,904	$50	$95,200
Clinical professionals	1,588	$100	$158,800
Interpreters	219	$40	$8,760
Case Management volunteers	810	$10	$8,100
Total	9,231		$328,460

Source: 2007 Annual Report, Marjorie Kovler Center of Heartland Alliance.

Theological Seminary. He joined the College of Law faculty in 1990, and served as the executive director of the Center for Church/State Studies until 2003, and co-director from 2004–07. He is an associate editor of the center's publication, *Religious Organizations in the United States: A Study of Identity, Liberty and the Law* (Carolina Academic Press, 2006). He co-founded and continues to co-direct the center's Interfaith Family Mediation Program. He has taught in DePaul's School for New Learning, the Religious Studies Department, the College of Liberal Arts and Sciences, and in DePaul's Peace Minor program. He has also taught immigration law and policy as an adjunct law professor at the University of Illinois College of Law. Rev. Mousin began practicing labor law at Seyfarth, Shaw, Fairweather & Geraldson in 1978. In 1984 he founded and directed the Midwest Immigrant Rights Center, a provider of legal assistance to refugees, which has since become the National Immigrant Justice Center. He also directed legal services for Travelers & Immigrants Aid between 1986 and 1990. He helped found DePaul College of Law's Asylum and Immigration Legal Clinic. Rev. Mousin was ordained by the United Church of Christ in 1989. He has served as an associate pastor at Wellington Avenue U.C.C. and was a founding pastor of the DePaul Ecumenical Gathering (1996–2001). Rev. Mousin is the secretary of the board of trustees of the Chicago Theological Seminary. In addition, he is member of the leadership council of the National Immigrant Justice Center and the Immigration Project of Downstate Illinois. Both provide legal services to immigrants and refugees. He previously served on the Illinois Equal Justice Project of the Chicago and Illinois State Bar associations.

Edwin Silverman, PhD, received his bachelor's degree from Purdue University and his doctorate from Northwestern University. He has been employed by the State of Illinois since 1973. From 1976 until 1997, he administered the Illinois Refugee Resettlement Program, which became part of the Illinois Department of Public Aid in 1980. In 1997 the program became part of the Illinois Department of Human Services, and he continues to administer it as the chief of the Bureau of Refugee & Immigrant Services. He has actively participated in the development of program and policy at the federal level, and contributed to the drafting of the Refugee Act. He is president emeritus and active on the executive board for SCORR, the national affiliation of State Coordinators of Refugee Resettlement. He has received awards from the federal government, the United Nations High Commissioner for Refugees (UNHCR), and various community groups for his contributions to the area of refugee resettlement. He also received the assistant secretary's Public Service Award from DHHS and was one of five national recipients in 1995 of the American Society for Public Administration's National Public Service Award.

Thomas Hollon, PhD, received his doctorate in clinical psychology in 1955 from Catholic University and earned the Diplomate in Clinical Psychology from the American Board of Professional Psychology in 1961. Dr. Hollon served on the staff of Rockford Memorial Hospital, on the boards of the Rock River Valley Mental Health Association and the Shelter Care Ministries (serving the homeless mentally ill), and on the faculties of DePaul University and the University of

Illinois College of Medicine. He served as president of the Illinois Psychological Association, chair of its Social Issues Section, and its representative to the council of the American Psychological Association. On a pro bono basis, Dr. Hollon served as chair of the Citizens Advisory Council of Illinois Mental Health Region 1-A and of the Winnebago County Health Planning Committee; president of the local chapter of United Cerebral Palsy; and member of the Illinois Human Rights Authority, the Suicide Prevention Council, the Health Professional Network of Amnesty International, and the Psychologists for Social Responsibility. Finally, Dr. Hollon was central to organizing the national Conference on Victims of Torture at the University of Chicago in 1987, co-sponsored by the IPA, Cook County Hospital, and Amnesty International. He then led the way the following year to the establishment of the Marjorie Kovler Center for the Treatment of Survivors of Torture under the aegis of Travelers & Immigrants Aid and IPA, and he served for the center's first eight years as a volunteer therapist and the chair of its Executive Clinical Committee.

Susana Jiménez Schlesinger, PhD, is a clinical psychologist who earned her doctorate in counseling psychology from Loyola University in 1983. She taught at Loyola University, the Institute for Christian Ministries at the University of San Diego, Central YMCA College, and the National College of Education in Evanston, IL. She served as a consulting psychologist with the Head Start Program, Enhanced Family Childcare Homes Program of El Valor, and the Boys & Girls Clubs of Chicago, and continues her longstanding private practice. She served as chair of the Social Responsibility Section for the Illinois Psychological Association from 1994–97 and is presently chair of their Peer Assistance Committee and liaison for Ethnic/Minority Issues. She also represents the IPA on the Coalition of Illinois Counselor Organizations Steering Committee for the Prevention of Violence in Schools. She volunteered as a Spanish-speaking psychologist at the John Garfield School's Family Enrichment Program. Finally, she was a founding member of the Marjorie Kovler Center, served on its Executive Clinical Committee, and was a pro bono bilingual psychotherapist.

Irene Martínez, MD, is an internist at John Stroger, Jr. Hospital of Cook County in the Division of General Medicine and is a member of the Preventive Medicine Section. A native of Córdoba, Argentina, she graduated from medical school in 1980. Dr. Martínez was a *desaparecida*/political prisoner during Argentina's "Dirty War." She was an Amnesty International prisoner of conscience and moved to the United States after she was released from prison. In the mid-1980s, Dr. Martínez became an advocate for torture survivors, recognizing their special needs from her own experiences. She was one of the founding members of the Marjorie Kovler Center of Heartland Alliance in Chicago, where she continues to contribute her expertise. She strongly encourages the practice of artistic expression to be part of the healing process and disease prevention. Dr. Martínez enjoys painting, writing, dancing, and caring for her daughter

Sr. Sheila Lyne, RSM, is president and chief executive officer of Mercy Hospital & Medical Center, Chicago's first hospital. Sister Sheila holds a master degree in

psychiatric nursing from St. Xavier University and an MBA from the University of Chicago. Sr. Sheila's association with Mercy dates back to 1958 when she was a student nurse. In 1970 Sister Sheila was appointed director of Mercy's Diagnostic and Treatment Center. She was promoted from this position to assistant vice president and director of human resources. As vice president, Sister Sheila honed her skills and solidified her role as a leader within the organization. She was named acting president in October 1976 and president in February 1977. In 1991, she was appointed commissioner of the Chicago Department of Public Health. She was the first woman to hold the position as well as the first non-physician. Since her return to Mercy in December 2000, Sr. Sheila has focused on the development and expansion of Mercy programs and services that respond to the growing communities surrounding the hospital. Sister Sheila is a member of the Sisters of Mercy of the Americas, Regional Community of Chicago, and currently serves on the board of St. Xavier University.

Steven Miles, MD, is professor of medicine at the University of Minnesota Medical School in Minneapolis and is on the faculty of the university's Center for Bioethics. He is board certified in internal medicine and geriatrics, and teaches and practices at the University of Minnesota. Previously, he was assistant professor of medicine and associate director of the Center for Clinical Medical Ethics at the University of Chicago, 1986–89. He has taught in many countries and has served as medical director for the American Refugee Committee for twenty-five years, which has included service as chief medical officer for 45,000 refugees on the Thai-Cambodian border and projects in Sudan, Croatia, Bosnia-Herzogovina, Indonesia, and on the Thai-Burmese border. He has published three books, more than twenty chapters, and 120 peer-reviewed articles on medical ethics, human rights, tropical medicine, end of life care, and geriatric health care.

Antonio Martínez, PhD, is a clinical psychologist and co-founder of the Marjorie Kovler Center, serving as its director for the first seven years. Dr. Martínez earned a PhD in clinical psychology and critical theory, at the University of Massachusetts–Amherst, a masters degree in community social psychology at the University of Puerto Rico–Rio Piedras, and a BA in general studies concentrating in psychology and anthropology at the University of Puerto Rico–Rio Piedras. Presently, he works with the Ambulatory Health Services of Cook County at the Dr. Jorge Prieto Family Health Center in Chicago. Dr. Martínez is also regular trainer for the International Office of Immigration and Naturalization Services Asylum Division at the Federal Law Enforcement Center in Glencoe, GA. He has addressed the chief justices of the Immigration and Naturalization Service at their national annual conference regarding issues of torture and credibility. Dr. Martínez has lectured about trauma and the severe consequences of abuse and torture in the United States, Mexico, Guatemala, Costa Rica, Panama, Puerto Rico, Chile, Argentina, London, and Nepal, and Colombia. He also provided expert testimony for the People's Law Office representing four survivors of police torture in Chicago under Commander Burge. He received several awards recognizing his work in the area of trauma induced by torture, including the Norma Jean Collins Award, the

Chicago Community Trust Fellowship, and the UNESCO Chair for Peace. He had the honor of being a consultant to actress Glenn Close in her Toni Award performance as Paulina, a torture survivor, in the Broadway play *Death and the Maiden*. He is an advocate of a systemic and developmental model for the accompaniment of survivors of torture. His philosophy of treatment was published by the Universidad Pontificia Javeriana and the Center Terres des Homes, Italia, Centro de Acompañamiento y Atención Psicosocial Terres des Hommes Colombia, Bogota 2004, "Modelo de solidaridad de atención a los sobrevivientes de tortura."

Fertile Soil

This life-giving soil,
On which the sower plows
One furrow after another
Terrace upon terrace
Carefully spreading seeds
With the sole purpose
Of creating a garden teeming with hope,
Watered with her children's tears,
Making her womb a more fertile place.

In this soil,
The seasons of the year are lived daily.
In autumn,
Fallen branches gently gathered
Are carried as fertilizer to the garden,
And in the gentle silence of the night,
Our hearts' anguish is softened.
When winter arrives,
And suffering's cold overtakes us,
The warm embrace and the sower's own suffering lift us.
With spring we see
The rebirth of life,
A restlessness revealed,
And a great desire to smell the scent
Of newness, of beauty and of what has been lost.
And beneath the summer's burning sun
Arises the steep slope of loneliness.
Each somber and bitter step
Accompanied by exile and torture
But soothed by mother earth's lifeblood.

On this soil,
When the tempest, the thunders, the forests' lament
Overpower the depth of your being
Snatching your breath and your reason for living,
Someone is ever present to remind you

Of the dance of the winds over the rivers,
Of the joyous and colorful song of the birds,
And of the shining rainbow
Revealing her brightness after the storm.

This fertile soil
Is indeed nurtured with love,
Her sowers keeping ignited
The eternal flame of unconditional commitment,
Defying the silence of a dark day,
Knowing that with the coming of the dawn
They will see the sun rise and,
With the delicate touch of the dew,
Will bring forth the sweet fragrance
of solidarity, respect and mutual understanding.

Beautiful soil, thank you.
For upon entering your space
The dawn springs up in us,
Though perhaps for only a moment,
And from your womb sprout
Peace, goodness, warmth, compassion.
For the fruit of your harvest is love.
Thank you, sowers,
For your difficult and steadfast work.
Graced by your dedication and affection,
From this soil we taste the sweetest of all nectars.

Matilde De la Sierra
Chicago, IL
August 25, 2007

Dedicated to Kovler Center
On its twentieth anniversary

Tierra Fértil

Esta tierra productiva,
en donde el sembrador hace un surco y otro surco,
tablón tras tablón esparciendo las semillas cuidadosamente;
con el único propósito de construir una huerta llena de esperanza.
Es una tierra regada con el llanto de sus hijos;
llanto que hace de su vientre un lugar más fecundo.

Esta tierra en donde las estaciones del año
se viven a diario.
En el otoño,
las ramas caídas recogidas gentilmente
son llevadas al huerto para que sirvan de abono,

y en el silencio de la noche
el dolor de nuestros corazones se hace suave.
Cuando el invierno llega,
y el frío del sufrir se apodera de nosotros,
el abrazo cálido y el mismo sufrir del sembrador nos levanta.
Con la primavera,
vemos el renacer de la vida,
con una inquietud descubierta,
con un gran deseo de sentir el aroma de lo nuevo,
de lo bello, de lo perdido.
Y bajo el candente sol del verano,
se sube la cuesta de la soledad,
con paso sordo y amargo,
acompañado por el destierro y la tortura;
pero atenuado por la sangre vital de la madre tierra.

En esta tierra;
cuando la tempestad, los truenos, el lamento de los bosques
dominan lo más profundo de tu ser,
siempre existe alguien que te recuerda
de la danza de los vientos sobre los rios,
del canto alegre y vívido de los pájaros,
y el arco iris reluciente que deja ver
su brillantez después de la tormenta.

Esta tierra fértil realmente está tratada con amor.
Sus sembradores mantienen encendida
la llama perenne de entrega incondicional;
desafiando el silencio de un día obscuro
a sabiendas que a la espera de la madrugada
se vislumbrará la salida del sol y,
junto al roce delicado del rocío,
traerán el perfume de la solidaridad,
el respeto y la mutua comprensión.

Tierra bella, gracias.
Porque al entrar en tu espacio nace en nosotros,
aunque sea por un instante, la aurora,
porque de tu vientre germinan
la paz, la bondad, la cordialidad, la compasión;
porque el fruto de tu cosecha es el amor.
Gracias sembradores
por su trabajo arduo y continuo.
Porque por su dedicación y cariño,
de esta tierra se obtienen los mejores néctares.

Matilde De la Sierra
Chicago, IL
Agosto 25, 2007

Dedicado a Kovler Center
Por su 20mo aniversario
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ORGANIZATIONAL SNAPSHOT

Organization: Marjorie Kovler Center

Founder/Executive Director: Mary Fabri

Mission/Description: The Kovler Center provides comprehensive, community-based services in which survivors work together with staff and volunteers to identify needs and overcome obstacles to healing. Services include mental health (individual or group psychotherapy, counseling, psychiatric services, and a range of culturally appropriate services on-site in the community), health care (primary health care and specialized medical treatment by medical professionals specifically trained to work with torture survivors), case management (access to community resources, including tutoring, ESL, food, transportation, special events), interpretation and translation (bridging cultural and linguistic barriers in medical, mental health, and community settings), and legal referral (referral and collaboration with immigration attorneys and organizations).

Website: http://www.heartlandalliance.org/kovler/index.html

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REFERENCES

Bogner, D., Herlihy, J., & Brewin, C. R. (2007). Impact of sexual violence on disclosure during home office interviews. *British Journal of Psychiatry, 191*(2), 75–81.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge: Harvard University Press.

Conroy, J. (2001). *Unspeakable acts, ordinary people: The dynamics of torture*. New York: Alfred A. Knopf.

Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005. Public Law 109-13, 109th Congress (May 11, 2005). Retrieved October 9, 2007, from http://www.epic.org/privacy/id_cards/real_id_act.pdf.

Fabri, M. (2001). Reconstructing safety: Adjustments to the therapeutic frame in the treatment of survivors of political torture. *Professional Psychology: Research & Practice, 32*(5), 452–457.

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

Immigration and Naturalization Service. (1984). *Statistical yearbook* (Table 3.3, p. 77). Washington DC: U.S. Government Printing Office.

Kronenberg, F., Pollard, N. (2005). Overcoming occupational apartheid: A preliminary exploration of the political nature of occupational therapy. In F. Kronenberg, S. Algado, N. Pollard (Eds.). *Occupational therapy without borders: Learning from the spirit of survivors* (pp. 58–86). New York: Elsevier.

Lifton, R. J. (2004). Doctors and torture. *New England Journal of Medicine*, *351*(5), 415–416.

McAndrews, R. K. (2002). Asylum Law Reform. *New England Journal of International & Comparative Law, 8:*1, pp. 103–124.

Martin-Baró, I. (1994). *Writings for a liberation psychology* (A. Aron, S. Corne, eds.). Cambridge: Harvard University Press.

National Immigrant Justice Center (n.d.). *National immigrant justice center: Home.* Retrieved October 7, 2007, from http://www.immigrantjustice.org/.

Office of the United High Commissioner for Human Rights (December 10, 1984). *United Nations Convention against torture and other cruel, inhuman or degrading treatment or punishment.* Retrieved October 7, 2007, from http://www.ohchr.org/english/law/cat.htm.

Reagan, R. (May 9, 1984). Televised speech, Retrieved October 1, 2007, from http://www.pbs.org/wgbh/amex/reagan/timeline/index_4.html.

Scarry, E. (1985). *The body in pain: The making and unmaking of the world*. New York: Oxford University Press.

Timmerman, J. (1981). *Prisoner without a name, cell without a number*. New York: Alfred A. Knopf.

Whiteford, G. (2005). Understanding the occupational deprivation of refugees: A case study from Kosovo. *Canadian Journal of Occupational Therapy, 72*(2), 78–88.

Wolf, E. R. (1999). *Envisioning power: Ideologies of dominance and crisis*. Berkeley: University of California Press.