Counselling Afghanistan Torture and Trauma Survivors

Author
Nooria Mehraby

First published in
Psychotherapy in Australia, Vol 8, Issue 3 May 2002

Introduction
The development of services to meet the needs of Afghan refugees, most of whom are traumatised by years of war and internecine violence, requires a sophisticated blend of counselling strategies and culturally-informed pragmatism. In this article Nooria Mehbraby, herself a refugee, outlines the approach that she has found most useful in dealing with this extraordinary client population.

Twenty-four consecutive years of war in Afghanistan have had, and are still . having, a profound impact on all aspects of life in my country. The problems began in 1978 when the Soviet-backed regime commenced a systematic political repression, targeting 'enemies of the revolution'. In 1979 the Soviet Union occupied Afghanistan and its army remained until1989, during which tens of thousands of Afghans, mostly educated middle class, were killed, imprisoned and tortured. Disappearances were commonplace.

After this, a bloody civil war amongst the rival political and ethnic groups took place. From 1996 to 2001 the Taliban led Afghanistan, imposing severe restrictions on the rights and freedoms of the general population. Women were targeted and suffered enormously. Since October 2001 Afghans have been caught in combat between the 'war against terrorism' and the Taliban regime, resulting in a significant number of civilian casualties.

All this has cost the country about two million dead, two million internally displaced and more than six million refugees in other countries. Consequently, Afghans comprise the wor1d's largest refugee population. Many were able to flee to neighbouring countries inc1uding Pakistan, Iran and India, and some to Australia, the USA and several European countries. These figures are conservative estimates; in Pakistan alone, there are more than three million refugees.

Afghan refugees in Australia
Afghans constitute the fifth largest group of arrivals to New South Wales. In the last decade 2400 Afghans arrived in NSW under the refugee and humanitarian program (Department of Immigration and Ethnic Affairs, 2001). Most of the estimated 8,000 Afghans who currently live in Australia came via refugee camps; the majority of them are middle-c1ass professionals. Like other refugees, Afghans face a range of settlement difficulties such as unemployment, lack of English language, accommodation, and financial problems. All these difficulties affect their integration into a new culture. .

Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
A NSW Health Department report on the health care needs of torture and trauma survivors (Reid and Strong, 1987) resulted in the establishment in 1988 of the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). A well-known feature of STARTTS is the high proportion of employees from refugee and for non-English speaking backgrounds who enrich the service with their language and cultural diversity, and their deep commitment to human rights and multiculturalism. (Bowles, 2001)

The position of Middle-Eastern Counsellor/Bicultural Worker was one of the first bicultural positions at STARTTS (in this service Afghanistan is inc1uded with Middle-Eastern countries). At present STARTTS employs over fifteen Bicultural Counsellors representing a range of refugee communities in Australia. I have been employed in this role since 1995.

Afghans comprise more than twelve percent of STARTTS' clients (STARTTS statistics, March 2002). Since the end of 1999, many Afghans arrived on Australia shores by boat and were detained in immigration detention centres. Following the determination of their refugee status they were released into the community and granted Temporary Protection Visas (TPVs) for a duration of three years only.

.

According to Centrelink statistics (January, 2002), around 3000 Afghan TPV holders are living in Australia. The majority belong to the Hazara ethnic group, who were subject to persecution from the Pashtun dominated Taliban.

Impact of the Global Terrorism Crisis

The current global terrorist crisis, resulting in the US bombardment of Afghanistan, has had a significant impact on Afghan refugees in Australia. Many have experienced re-traumatisation with severe posttraumatic symptoms, grief and loss reactions, anger, resentment, survivor guilt, anxiety and depression. Many Afghan children face stigma and are being stereotyped as terrorist supporters in school settings. This compounds the difficulties associated with attempts to regain their lost identity and cope with the individual and family impact of world events. Concern about family members in Afghanistan and neighbouring countries, as well as pressure to provide financial support to them, are additional sources of stress.

Torture and Trauma

The violence and human rights violations perpetrated against Afghans has been extensively documented in international publications:

'They witnessed the death of people in combat or bombardment, mutilation, the retrieval of bodies, complete devastation of the houses, villages and agricultural land. Some of them have actively participated in killing of their enemies, in mortar bombing, ambush, hand-to-hand fights, assassinations and interrogations. Many of them have been through the experience of a prolonged journey through mountains in very rough terrain. On this journey they experienced fatigue, change in diet and climate, and travel across time zones coupled with the constant fear of being caught, killed or imprisoned.' (Wardak, 1993,350)

Other experiences inc1ude being burned alive in tunnels and terrible deaths from poisoned water. It has also been estimated that there are about ten million land mines in Afghanistan, which could take more than seventy-five years to remove. STARTTS' c1ients have reported that their torture inc1uded verbal and physical abuse, electric shocks, beatings with electric cables, burning with cigars, mock executions, sexual assault and rape of both men and women, confinement in small crowded rooms, being forced to witness the torture and execution of friends and relatives, use of diuretic and other drugs, deprivation of food, water and light, exposure to extreme hot and cold, pub1ic beatings and stoning, and many other forms of physical and psychological torture.

The UNHCR estimates that 80% of all refugee women experience rape and sexual abuse. This not only affects individual survivors but also the family and the community to which the survivor is related. It is designed to humi1iate and destroy women who are targeted because of their ethnic, religious, racial, or political identity.

Despite a high incidence of sexual assault and rape amongst refugee women, the crime is often shrouded in

si1ence. Due to stigma, shame and guilt associated with loss of virginity or purity it is difficu1t for women to reveal their horrific experiences. This tendency is more pronounced in .some cultures, such as Middle Eastern cultures, (inc1uding Afghans) where a woman's virginity' is a prized possession and sex out of marriage is forbidden.

During the' five years I worked as a doctor in Afghan refugee camps in Pakistan, none of my female patients ever reported a sexual assault although there was much anecdotal evidence to suggest that such events were occurring among the camp population. Similarly, a study held in Winnipeg, Canada, found that over 94% of refugee sexual abuse survivors did not disc1ose their experiences to their refugee workers. For some women the threat of rape is so ominous that they have committed suicide to avoid it (even though suicide is forbidden in Islam). For instance, several women in the Shamali district in North Afghanistan killed themse1ves in a hot tanoor (a day oven) because they feared being raped by Russian soldiers attacking their village. They felt that loss of virginity would bring a lifetime of shame and wounded pride. Amnesty International documented similar cases, which had happened during the civilian war in Afghanistan (Mehraby, 2001).

The role of the Bicultural Counsellor

Since its establishment, STARTIS has relied extensively on bicultural counsellors. These are professionals from an array of disciplines, trained in counselling or health related issues, who share the language and culture of a particular client group. They provide a linguistic and cultural bridge between clients and the service. Their tasks include counselling, working in co-therapy with monolingual professionals, casework and advocacy, group work, community development, training, lobbying, consultancy and awareness raising among mainstream service providers (Becker et al., 1991: Cunningham and Silove, 1993).

Initially the service functioned using a bicultural! monolingual counsellor partnership to assist clients. However bicultural counsellors have increasingly performed the sole counsellor role and work more independently (Becker et al. 1991). Although some bicultural counsellors have been employed with minimal training or experience in counselling, their linguistic skills, profound understanding of their c1ients' cultures and history, as well as their own experiences, are invaluable. They ease the process of counselling by establishing rapport and enhancing the recovery of trauma survivors (Cunningham and Silove, 1993). Most of them have obtained their qualifications in counselling, psychology, and social work while working at STARTTS. Other bicultural counsellors have had extensive experience working as psychologists or socia1 workers in their own countries, often in war situations.

Three factors ensure the success of the bicultural counsellor model:

(i) the individual qualities and experiences of the people who have been selected to these positions,

(ii) their links with their refugee groups of their communities, and

(iii) STARTTS' clinical support structure including its consistent professional clinical supervision and c1inical training and support for pursuit of further studies in relevant areas.

However bicultural counsellors are also members of their client's tight-knit communities. This can make it hard for them to draw professional boundaries and separate their role as a professional counsellor from their roles in the community as leaders, friends and participants in various social activities. Community members expect the counsellors to be involved in social activities, cultural functions and religious ceremonies, but these often

extend beyond the counsellors' daily duties.

Additionally, many refugee communities are fragmented a10ng the lines of ethnicity, religion, language and political opinions. A client who is related to one of these groups may not be comfortable and trusting when discussing their personal issues with a counsellor perceived as belonging to the opposite faction. Conversely, some clients fear shame and stigma, and worry that their confidentiality may be compromised when discussing their experiences with counsellors from the same ethnic or religious group. Or, the personal experiences of a counsellor may prevent her/him from delivering appropriate services to the clients of an opponent segment. Some counsellors experience feelings of guilt if the perpetrators of violence against their clients belonged to the same ethnic/religious/politica1 group as themselves (Cunningham and Silove, 1993).

Counsellors working with torture and trauma survivors are also highly vulnerable to vicarious traumatisation and burnout. This is particularly the case for bicultural counsellors who have experienced trauma themselves and find it easy to identify with their clients.

Personal training in medicine and teaching

Although, counselling was not my initial career, my medical background and experience as a medical doctor in various refugee camps provided me with a deep understanding of problems faced by refugees. I have been able to utilise some of my medical knowledge and teaching experiences in counselling. For example, distinguishing between client's physical problems and psychological problems or identifying some physical symptoms that are rooted in underlying psychological problems. General education and psycho-education and assessment of their settlement needs proved a relatively easy task.

The shift from a more practical career of medicine where results of treatment could be 'magically' seen, to a counselling career that often required medium to long-term therapy, was a challenge for me. In addition, coming from an ethnic minority and known in the community as a doctor was useful in the establishment of rapport and trust, however, it often created confusion for the clients who were unfamiliar with the concept of counselling and expected medical advice and direction.

I overcame this problem with through educating clients about the value of counselling and my role as a counsellor, as opposed to my previous role of a medical doctor. Although it is not always easy to listen to the horrific experiences of survivors from your homeland, working with clients as they gradually begin to achieve their therapeutic goals, is an inspiring process.

Holistic multi-level interventions

The complex interaction of torture and trauma experiences, exile, migration and settlement issues, vary according to the stages of the life cycle which survivors occupy. Coping style is also influential, as are cultural factors, level of education, and personality variables. This interaction happens within the larger context of the clients' current environment including family, refugee community, mainstream Australian society and service providers (Aroche and Coello, 1994). Such multi-level conceptualization requires a corresponding intervention model targeting different levels of the client's individual and social systems.

On an individual level, STARTTS provides counselling and psychotherapy, psychiatric assessment and treatment, physiotherapy and other somatic approaches, employment assistance and limited casework and advocacy.

On the family level, STARTTS provides family therapy and organises activities for the clients' children. At times

it becomes very difficult for some Afghan refugees to negotiate family developmental tasks such as children growing up and role changes in the family when they themselves feel vulnerable and fragile (Haidary and Bowles, 1994). In addition, most Afghan refugees lack the traditional support of the extended family. In most cases, Afghan families have their members scattered around the world while many are still in Afghanistan where they face constant danger and deprivation. This family dislocation along with the news - generally bad news - about the continuation of the war in their homeland and the destruction of their communities adds stress to their everyday lives. Hence STARTTS provides a number of group interventions for Afghan clients. At present there are two self-support groups for male and female Afghan clients. The activities of these groups include art and craft classes, English classes, settlement information sessions, stress management, psycho education, general health education, excursions and physical exercises such as hydrotherapy.

At the community level, networking and continuous consultation are important. The counsellor participates in community functions and events in order to facilitate STARTTS' involvement and support of the community at every level. There is also regular interagency contact.

Finally, at the mainstream service provider level, STARTTS works on raising awareness. This is achieved by consultation and training other organizations. These activities have proven valuable in acquiring responsive and appropriate service provision for Afghan clients by government and non-government agencies.

Counselling Afghan clients

Afghan refugees suffer from a range of physical and psychological problems (Wardak, 1993), including post-traumatic stress disorder, generalized anxiety, panic disorders, depression, psychosis, and psychosomatic problems. They also experience intense bereavement and grief over the death of loved ones. This is exacerbated when numerous relatives or friends have died, as is often the case in war-tom countries. Although clients present with severe depression, the low number of suicides may be due to the adherence of the Afghan community to the values of Islam, which strictly forbids the taking of one's life (Wardak, 1993).

In refugee camps the psychological problems of Afghan refugees are often under-estimated due to more urgent physical health problems and the basic tasks of survivors.

The first step in the counselling process focuses on the education and discussion of the concept of counselling itself. Becker et al (1991) state that counselling is a western concept which is not likely to be familiar to many other cultural groups including Afghans. Therefore decisions of counselling require deep consideration. A positive outcome can only be expected if traditional Western counselling is adapted to the client's context. For instance, an illiterate client with strong religious belief might derive more benefit from spiritual healing rather than Cognitive Behaviour Therapy (CBT), which requires a high level of literacy.

In Afghanistan, older family members mainly conduct the counselling and it usually includes advice and direction giving, emotional and financial support and other types of material assistance. The problems are kept within the family and are rarely discussed with non-family members. Men are expected to be stoic and expression of emotion is inappropriate for them. Afghan men consider it shameful to cry, believing they should be tough enough to tolerate suffering with out tears.

While working with clients, the counsellor needs to introduce Western concepts in balance with Afghan concepts and culturally appropriate expectations. Practical assistance may need to be undertaken at the beginning of the counselling process - when appropriate - in order to build clients' trust and confidence.

STARTTS provides practical assistance with housing, Centrelink, employment seeking skills and recognition of qualifications, assistance with permanent residency or immigration issues relating to family reunion, and appropriate referral to other service providers. Since advice and material support may be what Afghan clients expect when seeking help, the encouragement to talk needs to be balanced with practical assistance. 'The inner and outer turmoil experienced by refugees is linked, both aspects must be addressed. Talking with clients about their feelings when they have nowhere to live does not address the most salient issue. At this time, only addressing practical concerns is unlikely to be successful as internal chaos of refugees may continue to destabilise their life.' (Bowles, 200 1 ,p.233). This issue has also been identified with other Asian refugee communities (Nguyen and Bowles, 1998; Tsul and Schultz, 1985), although for many Afghans asking for material assistance from an agency (as opposed to their family) is humiliating. They often choose not to ask for material help.

It is also extremely important to work on explaining and normalising the symptoms of Afghan clients. It is well known in the trauma field that emphasising the commonality of post-traumatic reactions and validating survivor's feelings, reduces anxiety and even the symptoms of the clients. The common phrase that PTSD is a 'normal reaction to an abnormal situation' often helps Afghan clients to realise that they are responding to the traumatic events that have happened to them. In other words, most people subjected to these extreme experiences would react in a similar way. Cognitive behavioural therapy such as psycho-education is useful to reduce the client's fear of being 'mad' as well as the stigma associated with mental illness.

Psychological problems among Afghan clients are often somatized or expressed in the form of physical problems. Wardak, (1993) states that 50% of Afghan clients express psychological distress through somatic complaints such as headaches, backache, and general body tension. This is the case in many non-Western cultures where psychological problems bear a lot of stigma, and sufferers risk being labeled 'mad'.

In the case of somatization, psycho-education coupled with general health education and physiotherapy tends to reduce the physical symptoms, which in turn leads to the reduction of fears and anxiety. For some clients, stress management and relaxation techniques and strategies may also be useful in the reduction of symptoms. For clients suffering from the physical consequences of torture or violence, these service s can be particularly useful.

Judith Herman' s (1992) model of trauma and recovery can inform the therapeutic process. According to Herman the creation of a safe environment and the development of trust is the first stage in the recovery process. These set the framework to initiate the counselling process, which also needs a strong emphasis on confidentiality, cultural concessions, and comfort with the process itself. With all of these, clients feel engaged in the process and use the counselling effectively, whereas without them clients become dissatisfied and leave prematurely.

In Herman's model the next stage is the in-depth exploration of traumatic experiences. For most Afghan clients it takes a number of sessions to reach this stage. The length of time could be a function of the interaction of cultural beliefs, in particular the value attributed to internalising intense emotions such as pain, anger and rage (Wardak, 1993), as well as the severity of trauma. Some' clients never feel comfortable going through this stage and they leave counselling as soon as their symptoms reduce. However the majority of Afghan clients, when the time is right, willingly explore the depth of their suffering.

According to Herman the third stage of the recovery process is social re-connection. Participation in a self-support group is crucial at this stage, as it provides a new bridge with society and creates opportunities for enjoyable and satisfying activities. However the group is also specifically used in the first stage of treatment in

order to normalize the symptoms, emphasize the commonality of experience, and to overcome isolation. This combination of group work and individual counselling seems to be the optimal combination (Aroche and Marin, 1994).

Spiritual healing and religious beliefs

Culturally, it is important for any therapeutic intervention with Afghans to support the clients in their religious and spiritual beliefs. Ninety-nine percent of Afghans follow Islam. Muslims believe that all suffering, life, death, joy and happiness are derived from Allah and Allah is the one who will give you strength to survive. Muslims also believe that Allah appoints a time for each person to pas s from this existence into the next and that death is inevitable and will take place when the time is right. These beliefs are usually sources of comfort and strength and aid the healing process. For example, in accepting grief and loss, the relatives of the deceased person are urged to be patient and accept Allah 's decree. It is permitted to cry and express grief over the death of a loved one, however extreme lamentation is discouraged. Also it is advisable to bury the dead body as soon as possible, which will help lessen the mourning of relatives. Although grieving may never fully end, the period of outward mourning lasts no more than three days.

Reciting verses (Surahs) from the Qur'an, the performance of regular prayer five times daily, and ablution (Udu) prior to each prayer, provides clients with a sense of purity and cleanness. Many rape survivors find this useful as away of cleansing their body from the impurity of rape. Hussain, 1991 states that Prayer is also a time to remember Allah, thank Him and ask for forgiveness. It also gives some exercise to the whole body and is a source of meditation, relaxation and physiotherapy combined.
The use of religious parables, the life story of the Prophet Mohammad and Surahs from the Qur'an and Hadith (sayings of the prophet Mohammad) can all be therapeutic. For example, some clients benefit from reciting the Qur'an when they are frightened, or listening to the Qur'an to acquire body relaxation.

During the Russian occupation of Afghanistan one of the common tools of torture was to humiliate and destroy prisoner's religious beliefs. One of my Afghan clients was given about thirty electric shocks per day as well as other forms of torture. While, he was tortured his religious beliefs were constantly ridicu1ed and he was repeatedly asked: 'Where is your Allah to rescue you?' Today he sees his survival being due to the strength that Allah gave him. I have uti1ised his spirituality in his hea1ing process, for examp1e, asking him to listen to the Qur'an instead of relaxation tapes.

Shahid Athar in his artic1e Islamic Perspectives On Stress Management, states that Is1amic belief provide s strength in coping with stress, managing depression and reduction of panic. He cited the fol1owing verses from the Qur'an as being useful in times of loss s and stressfu1 situations:

'Be sure we shall test you with something of fear and hunger, some loss in goods or lives or the fruits (of your toil), but give glad tidings to those who patiently persevere, who say, when ajJlicted with calamity: 'To Allah we belong, and to Him is our return. They are those on whom (descend) blessings from their Lord, and Mercy, and they are the ones that receive guidance'. (Qur'an 2:155-156 -157)

'Whatever we are given is a gift from Allah. We are not its owner. Everything belongs to Allah and returns to Him.
So if we do not own these things, why mourn their /loss or wax proud on receiving them.' (Athar, is1am-usa.com)

Athar, also states that the Prophet Mohammad used and advised the following prayers in times of

distress:

'We repose our trust in Allah is sufficient for us. (For us Allah is sufficient), and He is the best Guardian.' (Qur'an 3: 173)

In times of depression Muslims are advised to increase remembrance of Allah:

'He guides to Himself those who turn to Him in penitence, those who believe and whose heart has rest in the remembrance of Allah. Verily in the remembrance of Allah, do hearts find rest.' (Qur'an 13:27-28)

The Arab-Islamic civilization has led many people to accept traditiona1 healing as the main foundation of he1p (Driss, 2000). However, this does not prevent them from seeking professional assistance. The prophet Mohammed used to send his followers, when they suffered from disease, to a doctor trained in the medical school of Jondishapour in Persia, and he utilised various medications himself in the last years of his life.

Silove et al (1991) state that many of STARTTS' clients are intensely religious people, who require understanding of their experiences in both a socio-political context and religious framework. Corey (2001) states that religion and spirituality can be a source of healing and can give strength in critical situations, and for people to find meaning in their 1ives, that personal beliefs, directly or indirectly, can affect the process of therapy. Hence therapists must not make a decision for c1ients but assist them to choose for themselves how their values can guide their behaviour.

Conclusion

The devastation of Afghanistan has been very costly in both human and economic terms. Many Afghans have been exposed for a long period of time to several traumatic experiences; consequently they suffer from the physical and psychological sequelae of torture and trauma, ranging from mi nor anxiety to severe psychosis. This is characterised predominantly by post trauma symptomato10gy including intrusive and numbing phenomena. Multi-Level intervention has been utilised effectively with Afghan c1ients. However, counselling is a new concept for many of them and for this intervention to be usefu1 it needs to be well exp1ained and 'translated' into culturally appropriate terms. One of the ways to counsel Afghan clients is to provide the services through bicultural counsellors who would serve as a linguistic and cultural bridge between the clients and the service. Statistics avai1ab1e at STARTTS indicates more than 1200 Afghans have utilised the service and many of them are leading productive lives in Australia.

References

Aroche, J, & Coello, M. (1994) 'Toward a Systemic Approach for the Treatment and Rehabilitation of Torture and Trauma Survivors in exile: the experience of STARTTS in Australia'. Paper presented at the 4th International Conference of centres, Institutions and Individuals concerned with victims of Organised Violence: Caring for and Empowering victims of Human Rights Violations, Dap Tageytay City, Philippines, December 5-9.

Aroche, J, & Marin, L, (1994) 'An Evaluation of a Self Help Group for Latin American Women Survivors of Torture and Trauma.' Ibid.

Athar, S. Islamic perspectives on stress management. II islam-usa.com.

Becker, R, Haidary, Z, Kang, V, Marin, L, Nguyen, T, Phraxayavong, V, & Ramanathan, N. (1991) The Two

practitioner Model: Bicultural workers in a Service for Torture and Trauma Survivors.' In: Hosking, P (Ed), Hope after Horror. Uniya, Sydney. 138-156.

Bowles, R., & Haidary, Z, (1994) 'Narrative Family Therapy with Survivors of Torture and Trauma: An Afghan case study.' Paper presented at the Conference for Services Working with Victims of Organised Violence. Manila, Philippines. 1994.

Bowles, R. (2001) 'Social work with refugee survivors of torture and trauma'. in: Social Work's Fields of Practice. Edited by Alston, M., McKinnon, J. Oxford University Press, Melbourne, Australia.

Centrelink (2002), TPV Holders Statistics. Unpublished. January 2002.

Cunningham, M., & Silove, D. (1993) Principles of Treatment and Service Development for Torture and Trauma Survivors .In: International Handbook of Traumatic stress syndromes. Edited by Wilson, J.P., Raphael, B. New York. Plenum.

Cory, G. (2001) Theory and Practice of Counselling and Psychotherapy, (6th ed), Pacific Grove, California: Brooks Cole.
Driss, M. (2000) Culture, spirituality and psychiatry. Current Opinion. Vol.13 (6), 538-539.

Herman, J. (1992) Trauma and Recovery New York. Harper Collins.

Hussain, M. (1991) Islamic Women. In: Cultural Diversity and Mental Health, Section of Social & Cultural Psychiatry, Royal Australian & New Zealand College of Psychiatrists, Victorian Transcultural Psychiatry Unit, Melbourne.

Mehraby, N, (2001) 'Refugee Women: The Authentic Heroines.' In: Transitions, Vol. 9. Autumn: 8-22 STARTTS, Sydney.

Nguyen, T., & Bowles, R. (1998) 'Counselling Vietnamese Refugee Survivors of Trauma: Points of Entry. Australian Social Worker. Vo151, No 2, June: 41-47.

Reid, J. & Strong, T. (1987) Torture and Trauma: The Health Care Needs of Refugee- Victims in New South Wales. Cumberland College of Health Sciences.

Silove, D., Tarn, R., Bowles, A, & Reid, J. (1991) 'Psychosocial Needs of Torture Survivors'. ANZ Journal of Psychiatry Vol 2, 481-490.

STARTTS Internal statistics. (Unpublished) March 2002.

The Department of Immigration and Multicultural Affairs statistics (Unpublished). October 2001 .

Tsul, P, & Schultz, G.L. (1985) 'Failure of Rapport: Why Psychotherapeutic Engagement Fails in the Treatment of Asian Clients'. American Journal of Orthopsychiatry. Vol 55, (4), October.

Wardak, A.W.H. (1993) The Psychiatric Effects of War Stress on Afghanistan Society.' International Handbook of Traumatic Stress Syndromes. Edited by Wilson, J.P., & Raphael, B. New York. Plenum. 349-357.

Acknowledgements

Thanks to Mariano Coello, STARTTS Clinical Service Coordinator, for his ongoing support in writing this article, and thanks to Robin Bowles, my clinical supervisor for invaluable clinical supervision of my work with Afghan refugees.

About the author

Nooria Mehraby graduated as a medical doctor from Kabul University, Afghanistan in 1983. She worked as a lecturer at Kabul University and as a general practitioner until1987 when she and her family were forced to flee to Pakistan. Nooria worked as a doctor in various refugee camps and taught medicine at a Women 's University in Peshawar for five years. In 1993 she and her family arrived in Australia and since 1995 she has been a bicultural counsellor with the NSW Service for the Treatment of Torture and Trauma Survivors. She is studying for a Master of Counselling at the University of Western Sydney.

"No man is an island"

John Donne