

# Reconciliation in Cambodia: thirty years after the terror of the Khmer Rouge regime

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## Abstract

During the Khmer Rouge regime one quarter of the Cambodian population was killed as a result of malnutrition, overwork and mass killings. Although the regime ended 30 years ago, its legacy continues to affect Cambodians. Mental health problems as well as feelings of anger and revenge resulting from traumatic events experienced during the Khmer Rouge regime are still common in Cambodia. These conditions continue to impede social coexistence and the peace-building process in society.

Thirty years after the Khmer Rouge regime this article gives an overview on the status of the country's current reconciliation process and recommends potential future steps.

*Key Words:* trauma, reconciliation, Cambodia, war, Khmer Rouge regime

## Introduction

The psychological aftermath of civil wars and violent political conflicts can pose immense challenges for social coexistence in the population. Posttraumatic Stress Dis-

order (PTSD), depression, and feelings of anger and revenge are highly prevalent in postconflict societies such as Cambodia.<sup>1</sup> In villages throughout the country, victims and perpetrators of the atrocities committed during the Khmer Rouge regime from 1975 to 1979 live side by side. How can social reintegration be fostered under such conditions?

Desire for revenge is a common psychological response to violent events causing harm and loss.<sup>2</sup> Feelings of anger and the desire for revenge can have the important adaptive function of helping people to cope with their anxiety.<sup>3</sup> However, these feelings can also have a negative impact on mental health and interpersonal relationships, thus promoting cycles of violence among individuals and between groups.<sup>4</sup>

The purpose of this article is to analyze the current status of Cambodia's reconciliation process, 30 years after the end of the Khmer Rouge regime. We first define the term "reconciliation" and outline psychological, sociological, and educational measures that may contribute to it. After briefly summarizing the history of the Khmer Rouge era, we then evaluate approaches that have been implemented to promote reconciliation in Cambodia to date and make recommendations for the future.

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## Reconciliation

Reconciliation and the related concept of forgiveness were originally religious notions. In the wake of the civil wars and human right violations that have recently taken place in countries such as South Africa, Rwanda, former Yugoslavia, and Cambodia, interest in reconciliation as a political, juridical, and psychological construct is growing.

From a psychological perspective, the process of healing traumas and bringing closure to the relationship between victims and perpetrators is essential for reconciliation.<sup>5</sup> A psychological change has to be effected in the former opponents' beliefs, attitudes, and motivations, namely "a transition to beliefs and attitudes that support peaceful relations between former enemies".<sup>6</sup>

Most definitions describe reconciliation as a reciprocal and gradual process. Crocker<sup>7</sup> defined three consecutive stages of the reconciliation process: "simple co-existence", developing to "democratic reciprocity," and finally a third stage in which the social bonds between former victims and perpetrators are reconstructed.<sup>7</sup> Pham, Weinstein and Longman defined reconciliation as a process aiming at community, interdependence, social justice, and nonviolence.<sup>8</sup> The ultimate goal of reconciliation appears to be that people learn to live peacefully together.<sup>9</sup> This can be achieved only within a relatively stable social and political order that is robust enough to provide physical security for both former victims and perpetrators.<sup>10</sup>

Reciprocity is a crucial aspect in the process of reconciliation, which cannot take place without the perpetrators' cooperation.<sup>11</sup> This is in contrast to the similar construct of forgiveness, which is under the victims' control. The establishment of relationships between the victim and the perpetrator is therefore necessary for reconciliation. In contrast to forgiveness as an

intrapersonal process, reconciliation is understood as an interpersonal process.

The definition of reconciliation that has become widely accepted in literature and that is used in this article has five key components: a) a reduction of feelings of anger and revenge, b) the ability to take the opponent's perspective, c) reduced personal avoidance of the opponent, d) openness to positive relationships with the opponent, and e) renunciation of violence.<sup>12</sup>

Several approaches and methods to promote reconciliation are expounded in literature.<sup>13</sup> In the following, we introduce and discuss the most widespread, appropriate, and target-oriented approaches.

## Approaches and methods to promote reconciliation

### *Retributive justice*

The notions of merit and desert are central to retributive justice. This approach focuses on individual accountability and punishment of perpetrators; it can contribute to reconciliation in various ways. First, the fact that perpetrators sentenced to imprisonment after a criminal trial can no longer commit crimes increases the sense of security in society, which is an important condition for reconciliation.<sup>14</sup> Second, retributive justice responds to people's "profound sense of moral equilibrium" and satisfies their need for perpetrators to pay for the harm they have done, thus helping to rebuild an individual sense of justice.<sup>15</sup>

### *Restorative justice*

Restorative justice emphasizes the interests of the victims and is less concerned with imposing punishments on the offender. It includes non-criminal measures such as truth and reconciliation commissions, which are tasked with revealing all wrongdoings and human rights abuses in the context of a civil

war or dictatorship. The aim is to establish the truth, to encourage the perpetrator to accept responsibility and express remorse, and to stress reconciliation without the intention of prosecuting or sentencing the perpetrators. This approach has been popularly implemented in South Africa, for example.

#### *Reparations*

Reparations to individuals or communities who have suffered injustice include monetary compensation for material damage or physical injury. Reparations may also be made in the form of resources for economic development (e.g. building schools or supplying water wells) or community service by the wrongdoer. Although reparations cannot compensate all of the victim's losses, they show that the wrongdoer feels remorse, which can promote forgiveness and reconciliation and help to restore victims' sense of justice.<sup>16</sup>

#### *Sites and practices of remembrance*

Museums and memorials document and acknowledge the crimes and human rights violations of former regimes. Typical examples are the Holocaust memorials and museums built in Germany and other countries to remind current and future generations of the crimes committed during the Nazi regime. Days of remembrance serve a similar purpose. Etcheson<sup>14</sup> suggests that, if these days are properly designed, "they can bring a nation together as one in remembering shared trauma and loss."<sup>14</sup> Forgiveness and forgetting are often perceived to be similar concepts, and resistance to forgetting past atrocities may lower the readiness to forgive.<sup>17</sup> Therefore, it seems important to offer alternative ways of remembering past atrocities. Both symbolic measures and days of remembrance can contribute to reconciliation by marking, acknowledging, and honouring the victims' suffering.

#### *Educational measures*

The way a state educates its young people about its own history reflects how the government and its institutions appraise and reappraise their history. According to Cole, the reform of history education can be understood as a sign of changed identity on the part of the state.<sup>18</sup> The fact that a new regime does not deny past atrocities demonstrates that the state is not an accomplice to past crimes and that atrocities are unlikely to be repeated.<sup>19</sup>

Educating the next generation about history can also contribute to reconciliation by serving as an instrument of remembrance. The younger generation's recognition of victims' suffering through this form of commemoration may help the victims to reconcile.

#### *Therapeutic measures*

Many people in postconflict settings suffer mental trauma as a result of their experiences.<sup>1</sup> In Cambodia, many are still strongly affected by the aftermath of the genocides.<sup>20</sup> As Staub has described, reconciliation, forgiveness, and healing mutually support each other and an advance in each aspect can facilitate advances in the others.<sup>21</sup> Therapies aimed at healing traumas in individuals or groups include traditional, medical, and public health approaches, as well as counseling, self-help groups, and (trauma-focused) psychotherapy.

Table 1 (next page) summarizes the approaches to promote reconciliation outlined above.

### **A brief history of the Khmer Rouge regime**

At the end of the 1960s, Cambodia was torn by civil war. Bombings by U.S. planes during the Vietnam war in the late 1960s and early 1970s also had a hugely detrimental

**Table 1.** *Approaches to promote reconciliation in postconflict societies.*

	Primary target group	Level of intervention	Intended impact	Examples
Retributive Justice	Perpetrators	Individual	Instilling a sense of justice and security	Punishing perpetrators
Restorative Justice	Victims and perpetrators	Individual and community	Establishing the truth; encouraging perpetrators to assume responsibility	Truth commissions
Reparations	Victims	Individual and community	Instilling a sense of justice; demonstrating that the wrongdoers feel remorse	Monetary or economic compensation for victims' losses by government or wrongdoers
Sites and practices of remembrance	Victims, perpetrators, future generations	Individual and community	Remembering human rights violations; recognizing and honoring the victims' suffering; establishing sites for grieving; educating younger generations	Museums, memorials, days of remembrance
Educational measures	Future generations and others not involved in the conflict	Community	Showing the government's changed appraisal of the past; recognition of the victim's suffering by future generations and others not involved in the conflict	History textbooks, teaching students about the past
Therapeutic measures	Victims	Individual and community	Healing, psychological wellbeing	Counseling, self-help groups, psychotherapy

impact on the country.<sup>22</sup> In the late 1960s Pol Pot, the leader of the Cambodian Communist movement, also known as the Khmer Rouge gained more followers. In 1970, head of state Prince Sihanouk was deposed by the pro-U.S. general Lon Nol. Appalled by the suffering caused by the U.S. bombings, thousands of Cambodians refused to support the American-backed government and followed their revered prince in joining the Khmer Rouge.

However, when the Khmer Rouge entered Phnom Penh on April 17, 1975, Cambodian society was transformed radically. The entire urban population was evacuated; all inhabitants of Phnom Penh and other cities were forced to move to rural areas, with anyone who remained being threatened with execu-

tion.<sup>23</sup> The following years were characterized by mass killings, forced labor, forced marriages, rapes, deportations, separations from family members, torture, and starvation. The Khmer Rouge closed schools, government offices, courts, and embassies. All foreigners were expelled, religious practice was outlawed, the use of foreign languages was banned, and foreign medical and healthcare assistance was refused. Currency and the postal system were abolished; newspapers as well as television and radio stations were shut down.<sup>24</sup> In their attempt to establish an egalitarian and agrarian society, the Khmer Rouge presided over the organized killing of professionals and educated persons, especially doctors, teachers, and former government officials.<sup>25</sup> Simply wearing glasses or being

able to speak a foreign language was reason enough to be killed.

Estimates indicate the loss of at least 1.7 million lives, one quarter of the Cambodian population, during the Khmer Rouge regime as a result of malnutrition, overwork, disease, and execution without trial.<sup>26</sup>

The Khmer Rouge regime ended on January 7th, 1979, with the invasion of Vietnamese forces, but low-intensity warfare continued throughout the 1980s. After a series of complex negotiations, the Paris Peace Accord was signed by all factions (including the Khmer Rouge) in 1991, and the United Nations Transitional Authority in Cambodia (UNTAC) was established. However, the Khmer Rouge, who backed out of the peace process and refused to participate in elections, continued their guerilla warfare until the movement finally collapsed in 1998.

### **The impact of the atrocities committed during the Khmer Rouge regime on Cambodia today**

Although the Khmer Rouge regime ended 30 years ago, its legacy continues to affect the Cambodian population. Every Cambodian alive during the regime experienced on average 10 traumatic events, such as starvation, lack of shelter, being close to death, forced labor, torture, or witnessing the death or killing of family members or friends.<sup>2</sup>

In 2001, de Jong et al.<sup>1</sup> found a higher prevalence rate of PTSD in Cambodia (28.4%) than has been reported in other postconflict countries.<sup>1</sup> However, a recent study by Sonis et al. reported a PTSD rate ranging from 7.9% in the younger generation of Cambodians to 14.2% in the older group.<sup>27</sup> The difference in the PTSD prevalence rates might be due to different sample recruiting methods and measure instruments or maybe also to a change of the PTSD prevalence over time. The rates found by

Sonis et al. are similar to those found in other postwar societies: 17.1% of Kosovar Albanians suffered PTSD after the war.<sup>28</sup> 11.8% of a sample of Guatemalan refugees living in Mexico 20 years after civil conflict were found to have PTSD.<sup>29</sup>

The prevalence of PTSD also seems to be related to individual perceptions of justice. In a recent study on PTSD and disability in Cambodia, Sonis et al. found that Cambodians with low levels of perceived justice were significantly more likely to present with PTSD.<sup>27</sup>

In addition to eliciting PTSD, violence and traumatic experiences can also cause other mental health problems. Anxiety disorders and depressive disorders are common in war survivors.<sup>30</sup> General social functioning can also be impaired as a result of the traumatic events experienced.<sup>28</sup>

Man-made traumatic experiences often have devastating effects on survivors' basic psychological needs for trust, esteem, identity, feelings of effectiveness and control, and positive connections to others.<sup>4</sup> A typical epiphenomenon of posttraumatic stress symptoms is that the victims' central beliefs, such as the belief that the world is safe and people are basically good, are called into question. Victims of extreme traumatic stress feel vulnerable and often perceive the world as a dangerous place.<sup>31</sup> This may be one of the main psychological causes of political instability in postconflict societies. People who see the world and other people as threatening and dangerous may overreact violently to defend themselves in situations where violence is not provoked or warranted.<sup>32</sup> Staub and colleagues<sup>4</sup> have argued that this self-protective violence is especially likely if victims and perpetrators lived side by side under a chronic sense of injustice.<sup>4</sup>

As noted above, harm and distress can also give rise to anger and a desire for re-

venge. These feelings are common in post-conflict societies.<sup>33</sup> For example, Pham et al. found that most Cambodians who lived under the Khmer Rouge regime feel hatred toward those responsible for the atrocities (84%).<sup>34</sup> More than two thirds wished to see those responsible hurt or miserable (72%), and almost 40% would seek revenge if they could. These findings are in line with results of Lopes Cadozo et al., who found strong feelings of hatred (88%) and revenge (43%) in survivors of the war in Kosovo.<sup>28</sup> Although the emergence of these feelings is understandable, and although it is important to acknowledge and commemorate the deaths and suffering, such feelings may also have negative consequences.

Inability to reconcile or forgive and feelings of hatred and revenge are associated with poorer psychological functioning and may impede positive interpersonal relationships and social coexistence.<sup>27</sup> These conditions can seriously impair the peace-building process in society. In fact, they are a breeding ground for violence among individuals and between groups as well as for domestic violence.<sup>4</sup>

### **Evaluation of approaches and methods implemented to promote reconciliation in Cambodia**

#### *Retributive justice*

Immediately after the end of the Khmer Rouge regime in 1979, a People's Revolutionary Tribunal (PRT) was established to prosecute the genocide and crimes committed. Two symbolic personalities of Democratic Kampuchea, Prime Minister Pol Pot and Deputy Prime Minister and Minister of Foreign Affairs Ieng Sary, were accused and found guilty of the crime of genocide.<sup>14</sup> However, neither of them appeared in court or were punished for their crimes.<sup>35</sup> The tribunal was later denounced as a "show trial".<sup>36</sup> As Etcheson noted:

The people of Cambodia were suffering amidst a general climate of starvation and dislocation during 1979, physically and emotionally exhausted after the four brutal years of Khmer Rouge rule. At that time, many Cambodians were wandering the land in search of their missing relatives, while dodging the on-going combat between Vietnamese forces and the rump of Pol Pot's army. One might well wonder how deep an impression the in absentia conviction of Pol Pot and Ieng Sary actually made on the Cambodian people at large under these circumstances, and indeed how many of them even knew about it at all.<sup>37</sup>

In 1996, Cambodia's Prime Minister Hun Sen offered amnesties to several high-ranking Khmer Rouge leaders, including Ieng Sary, who was one of the main architects of the Cambodian genocide.<sup>38</sup> The prospect that there might be no future chance to prosecute or sentence those responsible for the genocide must have been unbearable for many victims.

Now, 30 years after the genocide in Cambodia, and following lengthy negotiations between the government of Cambodia and the United Nations, a new court called the Extraordinary Chambers in the Courts of Cambodia (ECCC) has been established. It started its work in July 2006 and became fully operational in June 2007.<sup>39</sup> The ECCC is known as a hybrid court because it applies Cambodian and international law and employs a mix of Cambodian and international judges. The decision was made to limit prosecutions to five of the senior leaders of Democratic Kampuchea, namely those who gave orders and those primarily responsible for the most serious crimes committed. The ECCC is the first war crimes tribunal in which the role of victims is not restricted to that of a witness. All individuals who have

suffered physical, psychological, or material harm as a result of a crime investigated by the court have the opportunity to participate as complainants or civil parties.<sup>39</sup> The first trial began on 17 February, 2009.

The ECCC has been met with both hope and criticism in Cambodia. There is controversy over the decision to hold just five individuals responsible for the entire genocide. Furthermore, there is concern that it took almost 10 years from the start of negotiations until the court started working: the defendants are now elderly and may well die before being sentenced. The lack of publicity surrounding the tribunal has also been criticized. According to Pham et al., 39% of Cambodians have no knowledge of the ECCC, and 46% have only little knowledge.<sup>34</sup> Yet people are more likely to have positive attitudes toward the tribunal if they feel informed about its work and involved in the process.<sup>8</sup> Initiatives such as increased outreach activities in the villages and greater media coverage might increase public awareness of the tribunal.

There is general mistrust of judicial and government officials in Cambodia. With a Corruption Perceptions Index (CPI) of 1.8, Cambodia is one of the most corrupt countries in the world.<sup>40</sup> The Cambodian judiciary is widely considered to be corrupt, dependent, and untrustworthy.<sup>41</sup> For this reason, some people in Cambodia “would prefer that no trial be conducted at all rather than having the country undergo a substandard judicial process”.<sup>42</sup> However, more than 50% of Cambodians who lived under the Khmer Rouge regime want those responsible to be put on trial. Additionally, one third of Cambodians identify punishment of the Khmer Rouge’s top leaders as an important precondition for their forgiveness.<sup>34</sup> A majority of Cambodians expect the ECCC to have a positive impact on victims of the Khmer

Rouge regime and to promote national reconciliation.<sup>27</sup> As Staub has argued, justice is an important need for survivors of violence, and finally seeing the former Khmer Rouge leaders sentenced may reflect the official acknowledgment of the harm and suffering caused to the victims.<sup>43</sup>

#### *Restorative justice*

Although former victims are able to participate as complainants and civil parties in the ECCC, the tribunal’s role seems to be predominantly retributive. Given the large numbers of victims and perpetrators in Cambodia, it is impossible for all of them to participate in the tribunal. Consequently, it may be important to promote reconciliation by emphasizing restorative ways of justice. To date, however, attempts to establish a public truth commission in Cambodia have been opposed by members of the current government who were previously Khmer Rouge officials themselves. In 1979, the Cambodian government established a Research Committee on Pol Pot’s Genocidal Regime. Information about killings, mass graves, and crimes committed by the Khmer Rouge was collected from victims and perpetrators.<sup>14</sup> Unfortunately, with the exception of a single report published on the commission’s findings in 1983, no information about the commission’s work was made available to the general public. As Etcheson pointed out, “truth commissions cannot work well if their findings are not widely publicized to the people.”<sup>14</sup> The Research Committee thus contributed little to reconciliation in Cambodia.

In the absence of a public truth commission, the Documentation Center of Cambodia (DC-Cam) is an independent research institute that collects, archives, and publishes data on the Khmer Rouge regime and provides objective information about the geno-

cide to the public. Its two main objectives are to preserve the history of the Khmer Rouge regime and to compile evidence of the Khmer Rouge's crimes, both being foundations for reconciliation.

#### *Reparations*

According to the United Nations list of least developed countries, Cambodia is one of the poorest countries in the world.<sup>44</sup> During the Khmer Rouge regime, Cambodia's public property (e.g., social and technical infrastructure) was destroyed and individual property was seized. Many people were forced to leave their houses and had to give away their livestock and other resources. Today, many Cambodians still live in poverty. The many negative effects of poverty include the experience of injustice, which increases the potential for anger and violence.<sup>45</sup> According to Staub, Rwandans perceived economic support to be a means of restoring justice that would help to promote reconciliation after genocide and mass killing.<sup>21</sup>

Of course, money cannot replace loved ones lost in the conflict, but material compensation of material losses may give victims a sense of justice. To date, the Cambodian government has planned no monetary compensation for victims of the Khmer Rouge regime, and the prospects of reparations being made are small.

#### *Sites and practices of remembrance*

In 1984, Cambodia's government declared May 20 a National Day of Hatred to commemorate the crimes and the victims of the Khmer Rouge regime and to give people an opportunity to vent their anger. It seems that the scope of the day of hate has changed over time. The Day of Hatred was initiated while the Khmer Rouge was still active. Originally in 1984 the objective of the day was to mobilize international public opinion

against the Khmer Rouge, their allies and their foreign backers.<sup>46</sup> In 1990 the stated aim of the Day of Hatred was to "make people realize the current crimes committed by the Pol Pot clique, and be dedicated to the prevention of the return of the regime".<sup>47</sup> Until today, each May 20 the crimes of the regime are remembered in public meetings and ceremonies at village cemeteries and the Tuol Sleng Genocide Museum. The ceremonies all include wreath laying, songs, prayers and other religious offerings to the dead, and speeches by official representatives.<sup>48</sup> Some of the activities involved in the Day of Hatred seem therapeutic, with victims recounting and re-enacting their personal experiences of Khmer Rouge crimes. Traumatic memories are invoked in a protected environment, in the same way as trauma confrontation in cognitive behavioural therapy. Learning to express one's emotions, especially anger, can be a useful therapeutic tool for dealing with chronic pain and depression.<sup>49</sup> In a Buddhist-coined society it is less esteemed to display anger. The Day of Commemoration provides a culturally accepted space for Cambodians to express their anger and pain at the crimes of the Khmer Rouge regime and can thus contribute to healing and coming to terms with the past. In 2001 the Day of Hatred has been renamed the Day of Commemoration, which might characterize another important scope of the day – to not forget about the past.

There are memorials commemorating the Khmer Rouge genocide throughout Cambodia. The Choeung Ek Memorial on The Killing Fields, where the Khmer Rouge executed an estimated 17,000 people, is probably the best known. Mass graves in this area contain a known 8,895 bodies, but many mass graves remain unopened. Today, Choeung Ek is marked by a glass-sided

Buddhist stupa filled with over 5,000 human skulls. Choeng Ek and other memorials serve as symbolic sites where Cambodians can grieve and commemorate the deceased and so reconcile with their own losses.<sup>14</sup>

Cambodia has two museums documenting the terrors of the Khmer Rouge regime. The best known is the Tuol Sleng Genocide Museum, which was built in the former Security Prison 21 (S-21). An estimated 17,000 to 20,000 people were imprisoned, interrogated, and tortured in S-21 during the Khmer Rouge era. There are only 12 known survivors. Today, the Tuol Sleng buildings are preserved as they were left in 1979. It is possible to visit the prison cells and see photographs of former inmates as well as paintings by the artist Vann Nath, who was held there. The Tuol Sleng Genocide Museum serves as an important site of remembrance, preventing past cruelties from being forgotten. The individual stories and photographs presented in the museum give the younger generation an opportunity to recognize and honor the suffering of the Khmer Rouge victims. Additionally, museums like Tuol Sleng serve to educate young Cambodians about the horrors of the Khmer Rouge years.

### **Educational measures**

Most young Cambodians know little about the Khmer Rouge regime. According to Pham et al., more than 80% of those who were not alive during the regime describe their knowledge of the period as poor or very poor.<sup>34</sup> With two thirds of the Cambodian population aged 29 years or younger, the number of people with limited knowledge of the Khmer Rouge regime is high. Scholars attribute the limited awareness of the younger generation to a lack of public education.<sup>50</sup> Although the Cambodian constitution guarantees a nine year basic edu-

cation as a right, the access to educational services, especially for remote populations, is deficient. A report by the Ministry of Education, Youth, and Sport in 2000 indicated that in Cambodia 45.1% of women and 24.8% of men are illiterate.<sup>51</sup> However even for young people with a better access to education, being informed about what happened in the past is not common. Cambodia's history between 1975 and 1979 is rarely covered in the country's schools. Only 6% of randomly sampled young Cambodians learned about the Khmer Rouge in school; 85% stated that they wanted to know more about the regime.<sup>34</sup> The first textbook about the genocide, developed by the government in collaboration with the Documentation Center of Cambodia (DC-Cam), was issued in 2009. This development might be interpreted as the first sign of a greater willingness to teach Cambodian school children about the genocide. Heightened public awareness of the Khmer Rouge atrocities may also promote dialog between the generations and help Cambodians to come to terms with the past.

In addition, the Youth for Justice and Reconciliation Project run by Youth for Peace (YFP) organizes workshops on the history of the Khmer Rouge era and the psychological and cultural factors behind collective violence. It initiates dialogs between villagers with the aim of facilitating open discussions between the younger generation and older Cambodians who experienced the regime.

### **Therapeutic measures**

The approximately 30 years of civil war destroyed Cambodia's public health infrastructure.<sup>52</sup> During the Khmer Rouge regime, the two psychiatrists practicing in the country were killed and the only mental health hospital was shut down.<sup>53</sup> With no conventional

psychiatric or psychological care, people had to rely on traditional healing. Cambodia's mental health system is still significantly underdeveloped, particularly in view of the high prevalence of trauma and PTSD in the country.<sup>54</sup> Several studies have found that poorer mental health is related to unforgiving attitudes and a lack of willingness to reconcile.<sup>55</sup> This seems to apply to postconflict settings across cultures. Pham et al.<sup>8</sup> found that Rwandans who met the PTSD symptom criteria "were less likely to support the Rwandan national trials, to believe in community and to demonstrate interdependence with other ethnic groups."<sup>89</sup> Likewise, Lopes Cardozo et al. argued that mental health problems related to the war in Kosovo needed to be addressed in order to re-establish a stable environment in the territory.<sup>28</sup>

Despite the availability of effective approaches for treating postwar mental health problems, there have been few attempts to implement treatment for Khmer Rouge victims in Cambodia or to evaluate the efficacy of such treatment.<sup>56</sup> In one Cambodian study by Leang, Andeth, Seang, & Chhim, participants showed reduced PTSD symptoms after receiving a form of cognitive behavioural psychotherapy.<sup>57</sup> In addition, their attitudes toward former perpetrators became more positive and forgiving, and the tendency to take revenge decreased.

The provision of treatment for Cambodians with mental health problems is still very limited. Currently, there are only 32 psychiatrists working in the country.<sup>58</sup> One well-known organization where people with mental illness can seek help is the Transcultural Psychosocial Organisation (TPO). It offers psycho-social education, self-help groups, counseling, and psychiatric treatment. To our knowledge, trauma-focused psychotherapy is not currently available in Cambodia.

Staub et al. developed and evaluated a psycho-educational group intervention for use in the context of genocide and war, with the aim of promoting healing, reconciliation, and prevention of violence in Rwanda.<sup>4</sup> After the intervention, participants showed reduced trauma symptoms and a more positive orientation toward members of the other group. Similar approaches may help to promote reconciliation in Cambodia.

### **Additional factors challenging the reconciliation process in Cambodia**

How soon a postconflict country is able to reconcile and reconstruct depends on various factors, including the nature of the conflict, the present-day situation of the society, and the manner in which the society deals with its past. As noted above, poverty and corruption in present-day Cambodia may fuel a sense of injustice and mistrust in the current government, thus hindering reconciliation. A society's ability to deal with the wounds of the past may be characteristic, having evolved from its unique historical and cultural development. Cambodia was occupied and oppressed by its neighbour countries at various times over the past centuries. Nearly all artists and intellectuals in the country were killed during the Khmer Rouge years; critical thinking and asserting one's rights were life-threatening undertakings.<sup>59</sup> To date, none of the perpetrators of the Khmer Rouge genocide have been sentenced. Leuprecht has described the Cambodian situation as a "persistence of impunity."<sup>60</sup> After the UNTAC era, hundreds of nongovernmental organizations came to Cambodia trying to provide aid, but also creating a culture of dependency.<sup>61</sup> Against this historical background, it seems plausible that Cambodian society lacks the self efficacy-beliefs and intellectual resources needed to restore justice with the aim of

coming to terms with the past. Cultural issues also influence how individuals in a society cope with adverse feelings such as anger. In Buddhism, displaying anger and expressing private thoughts and inner feelings openly means loss of face. It is thus desirable to avoid anger.<sup>61</sup> Yet, not being able to express anger can delay the grieving process. Murrell (p. 148) points out that the decades-long Cambodian reluctance to hold a war crimes trial may be related to the “fear of unleashing so many memories with the result that many of its peoples would lose face.”<sup>61</sup>

### Conclusion

The process of reconciliation in postconflict countries such as Cambodia requires action on several levels. An important challenge on the political level is to combat poverty and corruption, which can fuel a sense of injustice and mistrust in society, potentially giving rise to violence. On the legal level, the establishment of the ECCC represents a first step in paying public tribute to the victims of the Khmer Rouge regime. To instill a sense of justice to the Cambodian people and to foster reconciliation, the tribunal’s work must be fair, transparent, and accessible to the public. Community-building on an individual basis is equally important for social healing and reconciliation in society. It is thus vital to further promote history teaching in schools. Rituals, ceremonies, and memorials help individuals to deal with the losses of the genocide and should be cultivated. Finally, concerted efforts should be made to increase the provision of therapeutic approaches focusing on trauma reprocessing and the activation of future-orientated resources. The integration of interventions such as the one developed by Staub et al. to target both healing and reconciliation in regular health care provision can be expected

to have major benefits for social co-existence Cambodia.<sup>4</sup>

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# Psychotherapy and psychosocial care of torture survivor refugees in Hungary

“A never-ending journey”

Lilla Hárdi M.D.\*, Adrienn Kroo M.A.\*, \*\*

“Wild animals never kill for sport. Man is the only one to whom the torture and death of his fellow creatures is amusing in itself.”

*J. A. Froude*

The therapists of Cordelia Foundation have been assisting torture survivor refugees since 1996. The therapeutic activity of the Foundation includes verbal and non-verbal, individual, family and group therapies, and psychological and social counselling.

Our therapists are partly members of a mobile team and partly local therapists in the refugee shelters of Hungary.

Due to the multicultural composition of our clients, the therapists of the Cordelia Foundation continuously innovate, transform and adapt their therapeutic methods by taking into account the ethnic background and special cultural characteristics and issues of the clients.

Thanks to the therapeutic treatment our patients receive, they are able to address the traumas of uprooting and torture. Their improved adaptive and coping capacities are the most important resources in the integration process.

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We offer regular training and supervision to the staff of the refugee shelters in charge of our potential clients in order to increase the level of psychological mindedness and to prevent vicarious traumatization and burnout.

*Keywords:* PTSD – torture, refugee, psychotherapeutic methods, psychosocial care, training, supervision

## Introduction

There are more than 140 active rehabilitation centers in the IRCT network located all over the world which deal with the psychosocial rehabilitation of torture survivors. The Cordelia Foundation belongs to this network, and is in charge of the rehabilitation of refugees who have survived torture, fled their homes, and are currently residing in Hungary. The present article introduces the most relevant issues of torture, as well as the theoretical background of the rehabilitation of clients suffering from Post-traumatic Stress Disorder (PTSD) or other forms of psychological syndromes due to torture. The second part of this article describes the special rehabilitation methods adapted and implemented by the therapists of the Cordelia Foundation in order to achieve optimal results in a multicultural context.

### Torture and its sequaelae

“No one should be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”<sup>1</sup>

The chronicle of torture can be traced back to the history of human beings. It is worth comparing the meaning of torture in the past and in the present. However, the *direct aim* of torture is universal, that is to intentionally inflict and sustain intensive suffering. The *indirect aims*, forms and the legitimacy of torture have gone through great changes throughout the recent past and present.

Until the middle of the eighteenth century, torture had a dual role:

- a) to force the victim to confess;
- b) to punish criminal acts.

The main goal of torture was to demonstrate the power of the ruling government and to threaten the population in order to avoid being overruled or attacked. Presently, the aim of torture may vary; torture is still inflicted to oppress political opponents or to provoke a confession, but torture has also become a form a degrading, humiliating, or exterminating the unwanted, as is the case in the most severe form of this inhuman phenomenon, ethnic cleansing/genocide (e.g. in Armenia, Rwanda, Bosnia, Sudan etc.). Most societies accept the use of violence by law enforcement on behalf of the society in order to control antisocial behavior; democratic societies have laws to regulate the use of these methods.<sup>2</sup> As of May 2010, 146 nations have ratified The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT),<sup>3</sup> the international treaty that mandates an absolute prohibition of torture worldwide. Nevertheless, we have recently experienced the controversial

implementation of torture techniques even within the most democratic governments. Oppressive regimes might also condemn torture in their constitution, but apply torture illegally and with illegal methods in non official torture chambers. These governments legitimize their controlling and repressive function through a discourse of state protection, by declaring their oppressive acts as shield against rebellious initiatives and organizations, which pose a threat to the state. In these cases torturers are public officials or other individuals acting in an official capacity. There are a number of states however (e.g. Afghanistan, Somalia, Sudan, Kenya etc.), where the actual power is exercised by various non-governmental parties, gangs, armed groups, militias etc., who hold the population in terror, and commit a number of crimes against the unprotected and powerless civilians. The government, if there exists one, is most often incapable and helpless when it comes to protecting its citizens. According to the 2007 report of Amnesty International, the use of torture and other inhuman treatment was documented in at least 81 countries worldwide.<sup>4</sup>

### Torture trauma, PTSD and alternative diagnoses

The literature of trauma and torture dates back to ancient times. As a result of the horrific events of the twentieth century, numerous writers, philosophers, social scientists, psychologists and psychoanalysts turned their attention to the phenomenon of massive, chronic traumatization and its consequences. The Holocaust, which aimed at the destruction of a great part of the civil population, became a model for extreme traumas. Nevertheless, it took some time for it to become part of the psychotherapeutic discourse, which was especially the case in Eastern and Central European countries,

due to the political, historical and societal context.<sup>5</sup> In the sixties, psychoanalysts treating survivors of the Holocaust made a common discovery: the classical concepts of psychoanalysis applied in cases of depression, mourning and trauma, did lead to successful results in the treatment of these survivors.<sup>6</sup> Based on interviews conducted with these patients, the “survival syndrome” was developed.<sup>7-10</sup> This category became one of the first approaches to the current understanding of (Complex) PTSD. The most pertinent symptoms described by the authors were sleep disorders, nightmares, affective symptoms (chronic anxiety, depression etc.), cognitive damages (memory deficits, concentration problems) and personality change.<sup>8, 11</sup> One important distinction between the survival syndrome and the official diagnosis of PTSD is the phenomenon of identity distortion. This conceptual absence is discussed in length by Judith Herman<sup>12</sup> who suggested an alternative diagnoses (Complex PTSD) which is a result of prolonged exposure to (interpersonal) trauma in the context of captivity or entrapment where there is a violation of boundaries and lack of control. Herman<sup>12</sup> points out that as a result of this extreme type of traumatization, damaged self-perception must also be included into the diagnostic category. Another term for the concept, ‘Disorders of Extreme Stress Not Otherwise Specified’ (DESNOS), was recognized by the American Psychiatric Association (APA).

Torture survivors often suffer from Complex PTSD or DESNOS, which commonly indicates special treatment needs. The therapists of the rehabilitation centers must pay particular attention to these cases. In recent years, there has been extensive discussion concerning diagnostic differences between the consequences of torture and other forms of extreme psychotrauma. Some

researchers<sup>13-15</sup> made efforts to distinguish a separate “torture syndrome”. However, it proved problematic to order the diverse symptoms into meaningful and valid symptoms clusters, and to provide evidence for the causal relationship between torture and its consequences. Due to these obstacles, the approval of a separate diagnostic category for torture did not succeed.<sup>15, 16</sup> Based on controlled studies with torture victims, Basoglu<sup>17</sup> demonstrated that there is no real scientific proof for the necessity of a diagnosis distinct from PTSD. Other researchers and practitioners<sup>18</sup> point out that while there are a number of common symptoms between PTSD and the psychological consequences of torture, an essential distinction is the highly relevant phenomenon of altered identity and personality, already discussed above. According to Somnier et al<sup>18</sup> the most common psychological symptoms among torture survivors are sleeping disorders (often paired with nightmares), affective symptoms (chronic anxiety, depression), cognitive impairment (memory-deficit, attention disorder) and changed identity.<sup>19</sup>

An additional shortcoming of the diagnostic category of PTSD is that it does not take the political and historical context into consideration, which is highly relevant in the case of torture and other forms of inhuman treatment.<sup>16, 20</sup> Turner and Gorst-Unsworth<sup>21</sup> divided the consequences of torture into four categories, and argue that since the Freudian concept of war neurosis, numerous psychoanalysts<sup>10, 22-24</sup> have acknowledged that the premorbid personality and ego-vulnerability constitute only one part of the multifactorial causal model of post-trauma reactions. Turner and Gorst-Unsworth<sup>21</sup> point out that the political meaning also plays an essential role beyond psychological analysis, in theory and therapeutic practice alike, since torture, as already

described above, serves various and distinct functions.

Torture intrudes into the most private and intimate parts of a human being;<sup>25</sup> under torture the victim is forced into the position of an object, which leads to a loss of sense of interiority, intimacy, and privacy.<sup>26</sup> These experiences result in a psychic metamorphosis and collapse, paired with a sense of identity disorientation and depersonalization, and a fear of losing one's very essence, the soul, or spirit.<sup>25</sup> In the end scene of the Roman Polanski film 'The Pianist',<sup>27</sup> a newly freed concentration camp prisoner confronts a German prisoner of war and discloses: "You stole my violin, you stole my soul".

One of the main paradoxes of torture is that while the physical distance between the torturer and the victim is minimal or nonexistent, the moral-, existential-, and psychic gap is the largest imaginable between two human beings. This experience has important implications concerning the psychic reparation of the survivor. The aim of torture is the destruction of one's identity, the core of the personality, making the victim, and then his/her children, and the children of the children incapable of leading a "normal" daily life.<sup>28</sup> Torture does not only damage the survivor, but by diffusing deeper it wounds the next generations in the form of transgenerational trauma. The works of psychotherapist and child analyst Teréz Virág,<sup>29</sup> <sup>30</sup> founder of the Hungarian 'KÚT' center for the rehabilitation of Holocaust survivors, describe how traumatic experiences find shelter in the unconscious, and act as 'phantoms'<sup>31</sup> by effecting the next generations of survivors through silence, family secrets, 'unfinished tasks' and transmitted psychological symptoms (anxiety, aggression, guilt, shame etc.).

Torture, due to its intentional nature, destroys the fundamental trust of the survivor,

and distances the person greatly from other human beings. The internalization of the torturer's attitude, whose aim is to disgrace or even eradicate the victim and to prove that she/he is not a worthy human being, has severe consequences concerning the survivor's self image, self-esteem, and identity. It is also extremely difficult for the survivor to process how she/he reacted to the torture sequelae, in particular if the person experienced psychic breakdown. Restoring the broken trust in others and oneself is a primary objective in the therapeutic process.

During the sequelae of torture, the victim falls into a severely regressive position, and reaches for immature defense mechanisms (splitting, primitive idealization, projective identification, denial), but these reactions can serve an adaptive function during the torture episode. According to Papadopoulos<sup>32</sup> the psychological frozenness (temporary withdrawal) of refugees can limit damage and activate self-healing mechanisms. This is to ensure temporary survival, and it requires an appropriate attitude of the therapist. However, reactions given to the traumatic situation become maladaptive following escape. The defense mechanisms applied among the walls of the isolation cell can result in pathological reactions (aggression, inadequate rage, depression and suicidal ideation) within the walls of the home of the torture survivor, and can also lead to transgenerational trauma.

Psychological reports on the consequences of the Holocaust trauma<sup>5</sup> describe how the victim of severe persecution regresses back to the earliest forms of traumatization (the initial trauma of birth), which destroys the pre-oedipal structures of the mother-child relationship. Again, this leads to a damaged and constantly threatened identity structure.

Based on these accounts, it is clear that

the functioning of torture survivors is disturbed on various and multiple levels, which must be taken into consideration in the rehabilitation process. Therapists of the Danish rehabilitation center RCT<sup>33</sup> distinguish five levels of damage: somatic, psychological, social, legal and spiritual. Derrick Silove<sup>34</sup> from an Australian rehabilitation center points out that torture challenges five core adaptive systems: ensuring safety, attachment, justice, identity role, and existential meaning. Yael Danieli<sup>35</sup> focused on how becoming a victim destroys the continuity of the complex identity system, which may be effected on various layers (biological, intrapsychic, interpersonal, social-cultural), depending on the strategies of survival, the extent of losses, and secondary traumatization.

Some centers treat the traumatized population of their own country; others are challenged by the problems of multicultural issues having a pool of refugee patients or asylum seekers. The trauma of uprooting, which is the case of the traumatized refugee load of the Cordelia Foundation, means there is a fundamental damage to the human psychological structure. This object loss and the trauma of torture are multilevel difficulties facing the clients and the therapists. Akthar<sup>36</sup> describes how complex the identity change is as a result of immigration. The author, himself a practicing immigrant psychoanalyst, emphasizes the difficulties in psychological advancement (the development of a new and hybrid identity) if migration was forced, if return or visiting the home country is problematic, and if the host environment demonstrates a hostile attitude toward the migrant. Akthar<sup>36</sup> argues that the main intrapsychic conflicts of immigration is the splitting of self (home land) and object (host land). The resolution of this conflict is the key to psychic rebirth. Culture shock

is a widely-used term for the experience of encountering a new environment, and is defined as a stressful, anxiety-provoking situation which encompasses a serious threat to the newcomer's identity. It is accompanied by a process of mourning as a result of the individual's enormous loss of a variety of love objects.<sup>37</sup> The Mexican psychoanalyst Cesar Garza-Guerrero<sup>37</sup> emphasizes that one must distinguish "uncomplicated culture shock" from "complicated culture shock", which is suffered by refugees who fled from sociopolitical disruption in their homeland and thus are confronted with additional crises concerning the mourning and identity rebuilding process. Another approach to this primary object loss can be found in Papadopoulos's<sup>32</sup> description of the meaning of home and identity. According to the psychoanalyst professor, the fundamental sense of home and belonging somewhere is part of the core 'substratum of identity', which is mostly unnoticeable, but provides us with an essential feeling of humanity and a sense of predictability. However, when this substratum is disturbed, which is the case among refugees, then great confusion arises, paired with a sense of unreality and an "inexplicable gap". Furthermore, refugee torture survivors lose not only their sense of belonging to a home, people, and culture, but in a way, also to their own bodies. Papadopoulos names this state of bewilderment "nostalgic disorientation", which is not a conscious loss, but much rather a state of 'existential anxiety'.<sup>38</sup> This disturbance can cause many kinds of reactions (e.g. panic, depression, apathy, suspiciousness, splitting, etc.), and must be dealt with in therapy accordingly, bearing in mind the context which resembles an existential gap rather than a pathological state.

Through these examples and descriptions we can comprehend the magnitude of

traumas that refugee torture survivors must deal with in processing the experience. However, throughout the history of mankind, we have experienced the great potential that human nature has for survival despite adversities. This is especially true for those who have suffered and survived torture, the shame of humanity and civilization. The next section demonstrates how these courageous survivors can be supported through therapeutic interventions and psychosocial rehabilitation.

### **The rehabilitation model of the Cordelia Foundation**

The working methods of the Cordelia Foundation differ in many ways from the therapeutic models and techniques of the clinical practice applied in the outpatient centres/hospitals of general health care. Although our therapeutic services are difficult to model due to a series of specific local and cultural challenges, we have succeeded in creating a theoretical framework for our therapeutic approaches. This section of the article first provides a general overlook of the refugee situation in Hungary, and then continues on to describe the therapeutic models of the Foundation.

### **Refugees in Hungary**

Following the political and social regime change in 1989, Hungary joined the 1951 Convention relating to the Status of Refugees<sup>39</sup> and started accepting refugees and granting asylum based on the Convention, but with geographical restrictions. Since the enforcement of the Asylum Law of 1998, asylum seekers from non-European countries may also apply for asylum in Hungary. Between 1998 and 2002, an average of 8,000 to 9,000 refugees sought asylum annually in Hungary.<sup>40</sup> Following the year 2003, there was a significant decrease in this

trend with 2,000 to 4,500 refugees applying for asylum annually. The most recent statistics<sup>41</sup> for the year 2009 reflect a small increase in asylum application (4,670), though this comprises less than 2% of all applications filed in the European Union (246,200). In 2009, the number of applicants receiving some form of protection (humanitarian-, subsidiary-, or refugee status) was 390, but the number of those who received refugee status (170) was lower than all other forms of protection, which ensure less rights and support than asylum. The most common countries of origins are Serbia (including Kosovo), Afghanistan, Somalia, and Georgia. The number of unaccompanied minors seeking asylum in Hungary (170 in 2009) is higher than in any other Central European country.

In 2009, the number of refugees treated by the Cordelia Foundation was 850, out of this 288 clients were survivors of torture, and 92 were secondary torture victims. All together torture victims and secondary torture victims constitutes 44.7% of our clientele. The rest of our clients are refugees who suffered other forms of inhuman treatment and severe traumas.

Refugees who are permitted to apply for asylum first reside in the reception center in the outskirts of the city of Debrecen, where approximately 600 to 800 asylum seekers reside at once.<sup>a</sup> Here the applicants are interviewed by an official who is in charge of their asylum application. Asylum seekers generally spend three months to two years in this center depending on the progress

a) Permission to apply for asylum was previously granted in the reception center of Békéscsaba, where refugees spend 15 days for medical and legal screening. This system is now under reorganization since the change of government in April 2010.

of their asylum case. If granted asylum or subsidiary status, the refugees move on to the reception center in Bicske, which functions as a “pre-integration unit”. In Bicske refugees receive language courses daily, and often start searching for accommodation and jobs outside of the refugee center. This center is smaller in size and inhabitants, as only the “lucky” ones make it to this station. Recently, the screening center of Békéscsaba has been restructured to host families who are waiting for permission to apply for asylum. The therapists of the Cordelia Foundation visit all three centers regularly.

### **The Stay Model and the Go Model**

There are *two main models* for the care of torture survivors in Hungary, developed by the therapists of the Cordelia Foundation: the *Stay Model*- and the *Go Model*.

A) The *Go Model* is the earlier of the two and was implemented by the mobile team of the Cordelia Foundation. The psychiatrists, psychologists, social counselor and the interpreters visit the three refugee shelters described above and conduct therapies in the rooms of the clients. Until recently, the Foundation did not have a permanent location at the reception centers, so this revolutionary idea (therapies in the rooms of the clients) stemmed from the practical situation. However, it has therapeutic consequences, as well. In this model the client invites the therapist into their living space and acts as a host instead of as the guest, which is the common perception and even self-perception of refugees. This provides the client with a sense of mastery and control and lets trust be built in a special form. It symbolizes the first step, the first link, the first secure place in the host country. The security this setting offers is especially important in those cases where the patient is suffering from extreme anxiety, or is severely distrustful

of all shelter facilities (such as the social or medical unit). The “go” model also proved very efficient and successful in the treatment of families, as all family members would be present, even the youngest or most resistant ones. The situation and its meaning can furthermore be used as therapeutic material during the interpretation of uprooting and the processing of object losses.

If for some reason the client does not wish to conduct the therapy in their room, or if their room is not suitable at the time given (e.g. roommates present), we were usually permitted to use a room at the medical unit of the center.

We also have one local psychiatrist in each refugee shelter in order to have a permanent contact person with our Foundation.

Due to legal regulations, as described above, the refugees are transferred from one refugee shelter to another. It offers great relief and trust for our clients that we ensure that they will not lose contact with us despite the move; we do not cease to fulfill our role as transitional objects<sup>42</sup> throughout their plight for recognition as refugees. One of the first pieces of information we share with our patients is that wherever they are sent in the country they can turn to our therapists in every Hungarian refugee shelter. This approach is in accordance with theories of Bowlby<sup>43-45</sup> and the Hungarian psychoanalyst Imre Hermann,<sup>46</sup> who demonstrated that object attachment is a basic need, especially for those who have lost their relatives, their beloved persons and their home.

Most of our therapists were fed on the works of the Hungarian Budapest Psychoanalytic School, having a personal psychoanalytic or psychotherapeutic training. It is essential in our daily practice to be able to respect therapeutic boundaries and at the same time to be sufficiently flexible and tolerant when required.

We work with interpreters to ensure that all clients have a possibility to express their innermost feelings and thoughts in their mother-tongue. Our interpreters take part in a complex selection process and professional training. The applicant is initially invited to a first interview, conducted by the medical director of the Foundation. At this stage, the suitability and fit of the applicant is assessed, and the mission and activities of the Foundation is presented. Afterwards, the applicant takes part in a two-day intensive interpreter-training conducted by the Cordelia Foundation in partnership with two other refugee NGOs, the Hungarian Helsinki Committee (legal work) and the Menedék Association (social work). This training offers complex psychoeducation on the topic of refugees, trauma, torture, rehabilitation, human rights, and social and cultural integration, with case studies and discussion. Afterwards, the interpreter-to-be joins the mobile team of the Foundation and participates in a work day as an observer next to the trained interpreters. A debriefing and case discussion follows with the therapist at the end of the day. If the candidate withstands this test (which takes several rounds) well, the trial period continues with the applicant actually interpreting therapies. The interpreters are never selected from former patients even if they had recovered from PTSD. However, they often originate from the same country and/or culture as the clients, which often helps deepen therapeutic understanding as the interpreters act as cultural mediators as well. Thanks to their complex training, the interpreters are prepared for transference and countertransference situations, and often act as a pulling force and a source of hope for our clients. Our interpreters also take part in the regular supervisions of our staff, which prevents vicarious traumatization, especially challeng-

ing in seriously traumatizing transference-countertransference situations, and is also an essential tool in preventing professionals from burnout.

Previously our patients did not apply for therapy; they were referred to us by the medical or social staff, or by other refugees. General criteria for selection is being a torture victim, or suffering from the psychological consequences of other severe trauma. Generally we do not reject any person in need, but refer those who require non-psychological and psychiatric support to the appropriate professionals and organizations.

We make contact with potential clients by first introducing ourselves as therapists, and providing information about our mission and the services we offer. Some of our patients have never even heard about psychotherapy, so we generally begin with a short session of psychoeducation to achieve maximal transparency, understanding, and compliance. We try to give a realistic picture of what the clients can expect from therapy, what their role comprises, and we make it clear what our professional boundaries are. This provides a base for an egalitarian relationship, and prevents misunderstandings and disappointment. We often conduct an initial informal group meeting with a homogenous population of potential clients to establish a first link.

B) Thanks to new developments at the refugee centers, the Foundation established a permanent therapeutic unit in each of the two main refugee centers, Debrecen and Bicske. The *Stay Model* has been established by our therapeutic team. Due to this new situation, potential clients (residents of the centers) have started to find us on their own. They visit us in our unit, schedule an appointment for therapy, and/or use the community room of the facility to wait for their turn. This new model has therapeutic signifi-

cance as well, as it provides the clients with a sense of independence and empowerment. Nevertheless, we still pay special attention to those clients who, due to intense and severe post-trauma symptoms, are not yet capable of making these first steps on their own and require individual care. In their cases, the “Go-model” is still in use; their rooms function as therapeutic space. Often, after the decrease of stress symptoms, they start visiting our therapeutic unit.

At the Bicske refugee shelter, the Cordelia Foundation has its own complex outpatient center, with rooms for individual and group therapy, as well as a community space where patients can borrow books and art supplies, read magazines, make their own arts and crafts, have a cup of tea, and chat with staff or other clients. This is the last stop of the clients in the refugee shelter. Here their main task is to prepare for the great challenge of integration into the Hungarian society. The model applies a multi-disciplinary approach, and offers an eight-week intensive therapeutic program, which is conducted three days a week by two psychiatrists, three psychologists, one non-verbal therapist, one social counselor and two interpreters. There are two different and homogenous groups of clients (e.g. men from Afghanistan and women from Somalia) who take part in individual, group, and art and non-verbal therapies, as well as cultural-orientation workshops.

The aim of this rehabilitation program is to offer psychological support in the process of reintegration. However, this task involves new challenges, difficulties, and disappointments that may open up old wounds, enhance stress symptoms, and cause re-traumatization. Trauma processing is a continuous eternal procedure and must be appropriately handled in each phase of healing.<sup>12</sup> Thanks to the complex approach

of the program, clients can discover and develop their coping resources, strengthen their self-esteem, find new missions and paths in life, and ease their old sores. This enables them to get settled on their own outside of the shelter and determine their place in their new home. The therapeutic activity models the closing phase of their stay in the refugee shelter. The methods are more direct, and focus on creativity, inner strength, and empowerment to enhance the supportive network of the clients for their independent life.

### Therapeutic methods

The therapies we offer include individual, family and group therapies with verbal or/and non-verbal elements.

1) The *individual verbal* method is a short therapy (eight to ten sessions) focusing on the trauma of torture, uprooting, mourning, personal losses. It aims at easing post-trauma symptoms, acquiring insight, and regaining trust. However, depending on the case we conduct longer therapies (15 to 20 sessions), as well. This therapy also serves the development of coping strategies and discovering inner resources, which are vital in the future life of the refugees, who reside in a country completely different from his/her land of origin.

2) In the early stages we did not have much experience with *family therapies* with torture survivors. This treatment developed as a spontaneous therapeutic initiative as the family members were present at the first session(s) of the therapy of the patient, which took place in the living room of the refugee. In family therapies we must on one hand deal with the torture survivor's individual trauma and on the other hand with the traumatization of the family members as well, who are secondary victims (eyewit-

nesses of the traumatic event) or vicariously traumatized victims (traumatized by the torture survivor). Torture fragments the ego of the survivor, and at the same time the family also becomes disorganized by the trauma. The surrealistic world of the torture chamber is often unconsciously reconstructed in the chaotic human relationships of the family, through the mechanisms of repetition compulsion<sup>47</sup> or identification with the aggressor.<sup>48</sup> The tortured head of the family, the raped mother, the child being a survivor of violence, restructure the relationships of the traditional family in a pathological manner. The defense mechanisms appear on the family level like secret collaborators oppressing or silencing the trauma. Torture may also be experienced as a castration equivalent for the head of the family forcing the wife to take over the position of managing the family. Nevertheless, the husband may pathologically insist on securing his position by all means and despite circumstances. This can damage the children by causing serious disorientation and identity confusion. The new roles in the family are normally not acceptable for the community, which further increases the disorientation of the child.

Let's follow the therapeutic process of a hurt family:

A female patient from Iraq was struggling with dissociative symptoms as the leading problem which brought her to therapy.

Her husband was kidnapped and she received only his tortured corpse.

The young client escaped with her three children to Hungary.

She was unable to adapt to the challenges of the refugee shelter neglecting her children and herself, as well.

She got lost during shopping, and she generally began to cry instead of managing their family life.

Her 10-year-old daughter took over the role of the lost father and the sick mother and became the head of the family.

We began non-verbal group therapies together with other women of single parent and complete families. The patient's daughter participated parallel in creative therapy with our child psychologist.

Later family therapy was introduced beginning with the mourning the lost father/husband together. The therapist and the family members discussed the challenges of the distorted roles in the present family comparing them to the pre-trauma situation. Mapping the pathological family structure and working through the traumas from uprooting to other object losses helped to address these challenges.

After seven therapeutic sessions the female inhabitants of the refugee shelter opened the door to our therapists with shining faces and beautiful hair. Our client had taken over the role of the hairdresser of the refugee shelter. She found herself in her previous female role again. She went shopping together with other women of the shelter and began to cook and take care of her children again.

The ninth session was the last one in the therapeutic process, as the family was planning their move out of the shelter. The mother got engaged to a fellow Iraqi refugee, and the family was now ready for the challenging process of integration into Hungarian society.

3) The verbal therapies are often prepared for with *non-verbal group therapies*, by helping the client who is suffering from shame and the feeling of humiliation become accessible for the verbal process.

The group situation facilitates group cohesion and simulates a situation of trust. It offers a safe relationship for the patients

who are mistrustful or have a paranoid attitude.

The Hungarian non-verbal method has a dual role:

- a) it prepares the clients for verbal therapy
- b) it facilitates the decrease of PTSD symptoms with special therapeutic (art, relaxation, movement) techniques

The non-verbal methods are:

- 3/a) *communicative movement group therapies* – developed for refugees from Bosnia, based on the experiences at psychiatric departments, followed by
- 3/b) *animation group therapy* – This method is based on the animation of inanimate objects focusing on reconstructing the relationship of the torture survivor with their own body and with social contacts. Today we use this method as a link to verbal methods. The nonverbal therapist is the leader of the group session and the verbal therapist is the co-therapist. The verbal co-therapist takes the role of the individual psychotherapist later.
- 3/c) We established the *station group therapy* with refugees from the war in Kosovo, referring to Jesus Christ's stations at Mount Golgotha.  
In their case, the trauma was very near to or at the conscious level, and the experience was still actively present. Due to this special situation, it proved nearly impossible to create an intimate group situation, so sometimes there were 30 participants at a group session. This type of group therapy focuses on the reconstruction of the lost basic trust. We applied psychodrama elements as well as movement exercises.
- 3/d) We established *symbol group therapy* for Arabic speaking clients.  
Its theoretical background originates

in the Jungian symbols. We offer a symbolic object of the lost past to the clients in order to facilitate the mourning process and to decrease extreme anxiety. We evoke the object verbally and symbolically, e.g. with the smell of the Arabic coffee or with a handmade Afghan tissue. If the group offers a symbolic object it can be interpreted as a sign of the increased trust.

- 3/e) Other new initiatives are in preparation (e.g. for unaccompanied minors from Afghanistan, for Somali women etc.), which still require time to document the experiences and to standardize the methods in order to achieve maximal efficiency and validity.

4.) The *culture-orientation workshop*, developed for the new outpatient unit at the Bicske center, aims at facilitating integration skills and competence as well providing specific culture and integration related knowledge, information, and experience. These workshops were established with special care to address intercultural differences and always take the original culture of the participants into consideration. The culture-orientation workshops thus serve as a bridge between experiences, knowledge, and customs of the land of origin and those of the host country. The activities facilitate a common understanding, as well as the attainment of new experiences through exchange and participation. These sessions include role-play of everyday interpersonal and official interactions, discussions on cultural differences and similarities, and visiting various institutions to offer a possibility of practicing recently acquired skills on safe ground. Group discussion and the non-verbal processing of the experiences always follow the activities. The non-verbal therapist and the social counsellor of the Foundation

conduct the workshops, keeping in mind the special needs and sensitivity of torture survivors and other traumatized refugees. This is a strength-based practice and enhances the capacities of the individuals and groups.

### **Other activities**

One of the most important activities of our therapists is to make medico-legal reports to assist the legal process of asylum attainment. These reports are based on the principles of the Istanbul Protocol, and document the physical and psychological consequences of torture. Generally, either an official of the asylum procedure (officer, judge) or the defending lawyer requests this report, so there is no secondary gain for our clients in undergoing therapy. Through the report, the therapist can present a proper picture based on a recent and a present longitudinal relationship. The independent expert focuses on a cross-section picture, so we make efforts to collaborate with our forensic colleagues in order to provide a detailed and realistic picture for the legal process.

Our Foundation also offers support in the rehabilitation of torture-related somatic symptoms, as much as our budget allows. This comprises various medical treatment procedures (gynecological, urological, physiotherapy etc.), which are an essential part of the physical-psychological healing of the torture survivor.

Our therapists offer regular trainings and case discussions in the context of supervision sessions focusing on the sensitization of the staff of refugee shelters to assist their daily work. This supervision serves a double function: increasing psychological awareness and the prevention of burnout. Care for caregivers is vital in the prevention of vicarious traumatization of the helpers in charge of our clients. Furthermore, it strengthens the network of governmental and civil organi-

zations dealing with torture survivors and other seriously traumatized refugees.

### **Results**

The effects of the previously mentioned methods can be detected after the first three to four sessions. The agitated emotions sooth, an important phase in the mourning process comes to an end, and the symptoms of PTSD decrease. The clients begin the long and challenging process of integration from a more healthy position. Follow-up methods are under development. We currently apply a psychological questionnaire created by our psychotherapists based on validated PTSD surveys. Assessment includes two to three follow-up rounds (depending on the availability of the client) with the help of the questionnaire. Recording changes can be problematic however, since our clients move to locations throughout Hungary after leaving the shelters, and many even continue migration into other EU countries or sometimes overseas.

From time to time phone calls, letters and e-mails inform the therapeutic staff of the Cordelia Foundation that our clients are doing well and that they have found their place in society. Keeping in mind that they always have access to our assistance, some of them come back saying that Hungary is the best place to build their new life.

### **Conclusion**

”Panta rhei” – ‘Everything is continuously in motion’, according to Greek philosopher Heraclitus. The process of history, the process of a life, all around the world from the deepest point of the sea high into the sky ...

But for survivors of torture, their suffering seems constant. For these individuals, feeling of continuity does not exist. There appears to be a great division between life before and life after. Therapy for torture sur-

vivors challenges these ideas and helps with the development of a narrative and psychological reintegration.

The experiences of life-threats and other countless horrors, as well as the presence of the trauma of torture and uprooting are extremely different in each victims' psychological development.

Our strength is the ability to accommodate the challenging circumstances and facilitate the innovation of therapeutic methods and techniques.

The clinical best practices are the columns of a therapeutic building where we can engrave new lines of new methods in order to exhibit the importance and the success of the rehabilitation of torture survivors. The more ornaments we carve into these columns, the more decorative these buildings become, demonstrating the necessity of the progress of the psychotherapeutic methods. These symbolic buildings can serve as memories of people around the world investing great energies into the eradication of torture.

The aim of this article was to present the complexity of the rehabilitation issues of torture victims and to provide ideas on how to develop and expand treatment approaches that adapt to the continuously altering multitude of challenges. As we can see, the task of self-development and transformation must be undertaken by caregivers and survivors alike.

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# Evaluating the services of torture rehabilitation programmes:

*History and recommendations*

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## Table of contents

Introduction  
Background and history  
The complexity of rehabilitation:  
Some of the variables  
The challenges  
Designing outcome studies: study validity  
Programme definitions and examples  
Outcomes and indicators  
Research strategies  
Literature review  
Examples of instruments available  
Recommendations for the future  
Acronyms  
Website resources  
References

## Introduction

The authors of this document intend to review the history of evaluation of torture treatment programmes, discuss the challenges, and identify the research conducted to evaluate services. We outline research designs to measure outcome, including symptoms, level of function, and satisfaction. Research design, not data analysis, is the focus of this desk study. The outcomes research literature is summarized and categorized. Finally, we discuss the advantages and limitations of the most commonly used assessment instruments, some of them culturally-appropriate, and recommend the best approaches to measure outcomes of treatment for torture survivors.

This document intends not only to provide the context in which outcome research has been conducted in the past, but how centres can move forward today despite limitations and obstacles.

## Background and history

Since the 1970s, programmes for the rehabilitation of politically-motivated torture survivors around the world have been treating survivors of torture. However, the context in which rehabilitation occurs affects the perception of torture's sequelae, diagnosis, treatment, and prognosis. Treatment of torture survivors occurs in their countries

of origin, as well as in countries of both initial and final resettlement. Allodi (1991) defines two categories of treatment settings geographically: 1) "The North," mostly countries of final resettlement, such as the industrialized nations in the continents of Europe, North America, and Australia, and 2) "The South," mostly totalitarian "Third World" countries where torture is practiced. Allodi states that, in "The North," torture was viewed as having the medical and psychological consequences of a traumatic stress, and treatment followed this model. In "The South," on the other hand, torture was viewed as a component of the socio-political process, requiring preventive action and social change. It is important to remember that government-sanctioned torture uses the individual to repress and control the larger society and that both the individual and the society are affected.

The first programmes were in South America. In Chile, on September 11, 1973, the democratic government of Salvador Allende was overthrown by one of the more repressive dictatorships in the western hemisphere. A month later on October 19, 1973, the country's first human rights organization, the Committee of Cooperation for Peace was created. The committee through the "Vicaria de la Solidaridad" (Vicariate of Solidarity) gave legal, medical, economic, and spiritual assistance to victims of repression. In 1975 the first torture rehabilitation programme under the name of "Foundation for Social Help of Christian Churches" (Fundacion de Ayuda Social de las Iglesias Cristianas or FASIC) was created (Reiter et al., 1986).

In Argentina the most repressive and bloody military dictatorship in Latin America was in power from 1976 until 1983. It has been estimated that 30,000 people were "disappeared," later tortured and killed.

The first human rights organization in Argentina was the Mothers of the Plaza de Mayo, founded in April, 1977. The Mothers was an association of Argentinean mothers whose children disappeared during the Dirty War. In 1979, Dr. Diana Kordon started the "Group of Psychological Assistance to the Mothers of the Plaza de Mayo" (Grupo de Asistencia Psicologica de las Madres de la Plaza de Mayo) to psychologically help this group of women. This work continued until the creation in 1990 of the "Argentinian Team of Psychosocial Work" (Equipo Argentino de Trabajo e Investigacion Psicologica or EATIP). In 1980 the "Center for Legal and Social Studies" (Centro de Estudios Legales y Sociales or CELS) was founded to document and provide legal help to the victims and families of the repression (Reiter et al., 1986; Kersner D, 2002).

The democratic government of Uruguay was overthrown on June 27, 1973, and the military dictatorship and repression lasted until 1985. The "Service for Social Rehabilitation" (Servicios de Rehabilitacion Social or SERSOC), founded in October of 1984, was the first rehabilitation center for survivors of torture in that country.

In the past two centuries, at least three major events paved the way in Europe for the development of the movement: 1) France, in 1789, adopted the first human rights declaration denouncing torture. Much of the rest of Europe adopted it soon after. 2) In 1863, swept along with the rising tide of humanism, the Red Cross became the first organization to treat wounded victims during war. 3) With the discovery of the atrocities in German and Japanese prisons and camps during World War II, public awareness of government-sanctioned torture grew and research on the long-term effects of concentration camp internment began (Jaranson, 1995). 4) In 1973, Amnesty In-

ternational officially recognized and first defined torture in its initial worldwide survey on torture. The universally accepted legal definition of torture was published in Article 1 of the Convention Against Torture in 1984 (Amnesty International, 1973).

A military coup overthrew the democratic government of Greece in 1967 and a military junta seized power until 1975. Members of the opposition were subjected to severe repression and systematic torture. The first trial against a torturer since the Nuremberg trials began in Greece in August, 1975 (Amnesty, 1977a).

Elsewhere in Europe, a group of medical doctors from Amnesty's organization in Denmark published a report entitled "Evidence of Torture" (Amnesty International, 1977b) and subsequently, under the direction of Dr. Inge Genefke, founded the Rehabilitation and Research Centre for Torture Victim (RCT) in 1982 and the International Rehabilitation Council for Torture Victims (IRCT) in 1985. At least 235 treatment programmes have been identified worldwide and 144 of them are currently members of the IRCT (Quiroga and Jaranson, 2005, and recent data of the IRCT).

In North America, the Canadian Centre for Victims of Torture (CCVT) in Toronto was informally organized in 1977 and began assessing and treating torture victims in 1983. U.S. Amnesty International medical groups were founded in Los Angeles, San Francisco, Seattle, Washington and Boston in 1979-80. The Program for Torture Victims (PTV) in Los Angeles is the only survivor of these initial Amnesty groups. PTV began to document and treat Chilean survivors of torture in 1980. The Center for Torture Victims (CVT) in Minneapolis was founded in 1985. Currently 26 groups are full members of the National Consortium of Torture Treatment Programmes (NCTTP).

The first descriptive study of victims of torture in the U.S. was presented at a symposium on "Research and practice in treatment and rehabilitation of survivors of torture, terrorism and hostage taking" at the 89th annual meeting of the American Psychological Association in Los Angeles, August, 1981. Later the results were published in a joint paper with Canada (Quiroga et al., 1981; Allodi et al., 1985).

Despite the long history of torture rehabilitation throughout the world, only a small fraction of torture survivors actually receive treatment. Financial support for services never comes close to meeting the need. It is increasingly important for torture rehabilitation centres to demonstrate that the resources are used most efficiently and effectively to help survivors. Otherwise, even the financial support available may be at risk.

### **The complexity of rehabilitation: Some of the variables**

The effects of torture on the individual have interacting social, political, cultural, economic, medical, psychological, and biological dimensions. Nearly all clients have a major psychiatric disorder. Their course is chronic with exacerbations and remissions. They have multiple social problems: financial, housing, raising children, domestic strife, social isolation, etc. They may have multiple medical problems, some as a direct result of torture and others associated with severe stress, hypertension, and diabetes. The needs of survivors are multiple and, in response, the programmes have usually adopted a multidisciplinary approach. The components of these interventions vary significantly between centres as well as among the regions of the world.

The evidence that torture has psychiatric consequences is overwhelming but beyond the scope and intent of this review.

Three overview studies will be cited here. In a meta-analysis, Steel et al. (2009) undertook a systematic review and meta-regression of the prevalence rates of PTSD and depression in the refugee and post-conflict mental health field. Adjusting for methodological factors, reported torture emerged as the strongest factor associated with PTSD, followed by cumulative exposure to potentially traumatic events (PTEs), time since conflict, and assessed level of political terror. For depression, significant factors were number of PTEs, time since conflict-reported torture, and residency status. Johnson and Thompson (2008) provided a comprehensive and critical summary of the literature about the development and maintenance of post-traumatic stress disorder (PTSD) following civilian war trauma and torture. They found good evidence of a dose-response relationship between cumulative war trauma and torture and development and maintenance of PTSD, as well as some evidence that female gender and older age are risk factors in development of PTSD. They also state that most epidemiologically sound studies found relatively low rates of PTSD. Some refugee variables could exacerbate symptoms of PTSD and contribute to their maintenance, while preparedness for torture, social and family support, and religious beliefs may all be protective against PTSD following war trauma and torture. Modvig and Jaranson (2004, Table 3.5) reviewed the percentage of traumatized persons with posttraumatic stress (PTS) diagnosis or significant symptoms in population-based surveys or case-control studies ( $Ns > 100$ ) and, in contrast to Johnson and Thompson, found rates as high as 43% current and 74% lifetime among 810 Bhutanese torture survivors in a refugee camp in Nepal (Van Ommeren et al., 2001).

In general, positive prognostic factors

include cultural, religious, political convictions, preparedness for torture (Basoglu, 1994) and effective coping strategies. Factors which negatively impact recovery include prior individual or family trauma or persecution and dysfunctional personality traits. It is controversial whether the age at which the torture occurs makes a difference. Children and adolescents are potentially both more vulnerable and more resilient. Considerable work has attempted to identify what types of torture affect prognosis, but with limited success. The severity and protracted nature of torture do seem to negatively correlate with recovery (Mollica et al., 1998; Jaranson et al., 2004). However, after the torture has occurred, positive prognosis is associated with receiving treatment, achieving safety and security, such as a successful asylum claim, having stable life circumstances, and good social support. On the other hand, unstable life circumstances, discrimination, and allowing the perpetrators impunity are associated with negative outcome.

Because of the complexity of the survivors and their circumstances and their individual prognostic factors, controlling for these factors is difficult if not impossible. Particularly in western countries, but also in the rest of the world, rehabilitation centres help survivors from many different countries. To find large enough sample representing a particular ethnic or cultural group is challenging.

### **The challenges**

Studies of the efficacy of different treatment approaches and of the indicators to measure successful outcomes have not been sufficiently or adequately completed. Few outcome studies exist, and all of them have limitations such as the lack of control groups, varying definitions of diagnostic criteria, poor or absent validation of assessment

instruments, small sample size, and other factors (Gurr and Quiroga, 2001).

Consequently, it is understandable that so little outcome research has been conducted, despite the long history of torture rehabilitation. Nonetheless, critics continue to voice their discontent with the status of outcome research in torture rehabilitation. One of the more vocal critics is Dr. Metin Basoglu, a psychiatrist, an experienced researcher in the field of trauma, and a zealous advocate of cognitive-behavioral therapy as the best treatment. His 2006 editorial in the *British Medical Journal*, "Little Outcome Evaluation Has Been Done in Torture Rehabilitation," (Basoglu, 2006) generated dozens of responses from practitioners in the rehabilitation field, the vast majority questioning his conclusion that, after 20 years of research, no progress has been demonstrated scientifically. This statement about the lack of outcome data potentially threatens the already limited funding available for services. Jaranson et al. (2007), for example, responded to Basoglu's editorial by stating:

- 1) Evidence-based treatments exist for symptom clusters but not for complex problems;
- 2) Rehabilitation of torture survivors is not equivalent to treating PTSD or depression;
- 3) Rehabilitation centres for torture survivors offer multi-modal approaches to improve the lives of survivors in many ways; and
- 4) Clinicians avoid brief treatments, recognizing the enormity of clients' experiences and the consequences.

One might ask why, with all of these difficulties, outcome studies should even be attempted. However, funders are increasing their requirements to demonstrate that serv-

ices at centres are effective and cost-efficient. Centres, of course, want to provide the best, most effective, and most efficient services possible.

Does Rehabilitation Work? We don't know. Clinicians think so, but they have an investment in a positive outcome and are potentially biased. Clinicians see that their clients get better, but exactly why is unclear. If rehabilitation does work, what components are responsible? We don't know what treatments are most effective.

Despite the prevalence of torture and its well-documented mental health consequences, until recently there has been relatively little scientific interest in the study of torture and its treatment. Nonetheless, the study of torture survivors may have important implications for human rights, theory, assessment, classification, treatment of traumatic stress responses, and legal issues.

Why has so little priority been given to collecting outcome data? First of all, time and financial resources for research are scarce. Clinicians are often reluctant to prioritize research over direct clinical services, prevention and advocacy, may fear that additional questioning will re-traumatize clients or breach their confidentiality, and have been reluctant to include untreated survivors in controlled trials, feeling a need to protect all survivors from re-traumatization (Basoglu et al., 2001). Other clinical issues for research include the importance of timing, trust, and sensitivity. Research can also affect treatment, whether it is integrated into the clinical programme or separated, and the research process can potentially re-traumatize the researchers themselves.

Studies of specific high risk groups among victims of organized violence, such as women, rape victims, children, orphans, family members, ex-soldiers, and others require rigorous research methodology, often

costly research budgets, adequate sample sizes, academic expertise, and interdisciplinary collaboration.

Most torture rehabilitation programmes have neither the skilled research personnel nor the budget. Most donor organizations give funds only for the direct care of survivors and are not willing to finance necessary infrastructures for scientific research.

Studies conducted in refugee clinics and in other treatment settings rarely include control groups, generally have small samples, and are not designed to address the prevalence of torture survival in communities.

Most of the information published on torture survival is descriptive. Few clinical outcome studies exist (Basoglu, 1998; Gurr and Quiroga, 2001). Estimates of the prevalence of torture have been unreliable and rarely attempted because epidemiologic studies are extremely difficult and often impossible to conduct. The sensitivity of the topic of torture makes it difficult to study, and refugees are challenging groups for research under any circumstances.

Some relatively recent publications help to elucidate and guide research in the field. Hollifield et al. (2002) reviewed the literature measuring trauma and health status in refugees, analyzing 183 publications, concluding that most articles about refugee trauma or health are descriptive or include quantitative data from instruments with limited validity and reliability for refugees. Willis and Gonzalez (1998) reviewed the use of survey questionnaires to assess the health effects of torture. Spring et al. (2003) described an approach to gathering a sample representative of refugee communities which are difficult to access. Sjolund et al. (2009) presented the results of a conference of experts, concluding that effect studies are urgently needed.

### **Designing outcome studies: study validity**

The field of traumatic stress has experienced significant growth in the numbers of psychotherapy treatment studies conducted. The Conference on Innovations in Trauma Research Methods (CITRM), funded by NIMH in the mid-2000s, held a series of conferences to explore advances in the field of psychological trauma research. Several of the presenters published in the JTSS (Sonis et al., 2007; Schurr, 2007) and discussed ways to help both the readers of their work and psychotherapy researchers by reviewing key concepts in trial design that affect the internal validity of the research. The focus was on between-group randomized design and on outcome rather than process.

Outcome research in torture investigates possible cause-effect relationships between one or more groups of torture survivors receiving a treatment compared with control groups not receiving treatment and requires strategies to control factors that influence the validity of inferences drawn from the findings. Torture outcome research has unique problems that create challenges in the design methods but it is still possible to conduct valid research.

Psychotherapy treatment outcome research should include features intended to control threats to internal validity, such as random assignment, fidelity to the manual, numbers of sessions, and well defined outcomes.

If it is not possible to use placebo control groups in outcome research, wait-list design may be used. This method controls for most internal validity threats.

A comparison design can be used where groups are assigned to usual care versus more complex care, usual care versus prolonged exposure to care, or different type of psychotherapies. These designs permit infer-

ences of the additional benefits related to usual care.

Change can also occur for factors other than effectiveness of the treatment, or confounding. Contemporary factors not related to treatment can interfere with the results and several factors may introduce bias to the internal validity of a study. For example, the natural history of disease, e.g., torture is a chronic condition with ups and downs, or the granting of political asylum usually decreases symptoms (Gangsei and Jaranson, 1996), and other life events can confound the results and decrease the validity. Other variables include the length and number of sessions, individual vs. group therapy, or differences between therapists. Contemporary factors not related to treatment can interfere with the results. Assessment and control of confounding is discussed in detail by Kurth and Sonis (2007).

For quality control, use of a manual is useful in psychotherapy research to facilitate consistent treatment delivery and for replication and dissemination (Borkovec, 1993; Schnurr, 2007). Of course, training, supervision, and monitoring are an important part of this process.

Internal and external validity are the most important objectives in the selection of a research design and research instruments. The experimental approach is the most powerful research design because it controls the most important variables in torture outcome research but at the same time is most restrictive, requiring a control group.

Validity is defined by the degree that the instrument measures what it is supposed to measure. Internal validity gives us assurance that the differences observed in the study are due to the intervention or treatment under investigation. External validity gives us assurance that the results of the study are generalizable beyond the subjects in the study. The

instrument must also be reliable, i.e., free of measurement errors.

Torture is a chronic process with exacerbations and remissions of the symptoms through the years. A reactivation increases symptoms, and symptoms decrease during a controlled period.

Over time, the torture survivor may grow wiser, stronger, more experienced and better able to participate in interviews or answer questionnaires. In some studies the instrumentation changes between the pre- and post-test measurements. The group that drops out from the study may be different from the group that remains in the study. Each of these factors or their interactions could influence the results of the study.

The most important bias to the external validity of a study is the process of selection of participants in the research. Therefore, the validity of the study is related to the design method and the representativeness of sample. Some design methods are more valid than others. The ideal design for outcomes study should be the experimental design with a random assignment to experimental and control groups.

Unfortunately, there are factors that make the selection of an experimental design difficult. Even though we do not have a definitive study that shows the effectiveness of the treatment of torture survivors, we do have the clinical impression that treatment helps victims obtain relief of their symptoms and improvement in their functioning. By consensus, most clinicians and researchers believe that a control group is impossible because refusing treatment to torture survivors is unethical.

In addition, the populations of torture survivors treated by the majority of those torture rehabilitation centres receiving refugees and asylum seekers from other countries are neither representative of the

total universe of torture survivors in the country of origin nor in the host country. In addition, the distribution of countries or ethnic groups receiving care in a center or programme varies from one year to the next. The small numbers, e.g., by country, demographically, diagnoses, etc., can influence validity. Other factors include inconsistency of the data or inability to achieve cultural equivalence for questions or items. Finally, the difficulty separating an individual treatment from the overall intervention makes identifying the effect of a particular part of rehabilitation a challenging methodological issue.

### **Programme definitions and examples**

Issues of concern for centres and funders include access to care, quality of care and cost of care.

To improve the quality of care we need to investigate: 1) Treatment efficacy (or clinical impact), which is measured at either individual or group level; 2) Treatment effectiveness (or economic impact) which includes outputs, benefits, and outcomes; 3) Efficiency (or cost/ benefit analysis of the programme), which includes the inputs and can identify waste. Clinicians usually focus on the first, while administrators and funders tend to focus on the latter two.

#### *Example: Clinicians*

A task force of senior clinicians from the United States was organized by David Kinzie of the Oregon Health Sciences University and met annually during the years 2004-2006. Funded by the Langeloth Foundation, the purpose was two-fold: 1) to develop quality assurance criteria for torture treatment centres and 2) to develop a research plan to collect treatment outcome data across willing torture treatment centres in the U.S. This task force recommended sev-

eral principles be used by torture rehabilitation centres:

- 1) Measuring outcomes should be an integral part of the care.
- 2) Practically, assessment must be integrated into the daily routine of the programme, not as separate research.
- 3) Outcome measurement should be part of a process which includes analysis and reporting of the data and improving the quality of care through education and training of the providers.

Dr. Kinzie commented on the difficulties of doing outcome of clinical efficacy: "Outcome study of medical and psychological treatments are inherently difficult. This is even more so with traumatized patients as the trauma varies in quality and quantity, resilience and social supports are unique, and unknown genetic factors play a role. For refugees, the difficulties are compounded by low literacy rates, prolonged traumas, loss of country, property, and ongoing stress in the host country. The variables are overwhelming." (unpublished).

#### *Examples: Funding Sources*

The European Union (EU) (2008) has defined efficiency, effectiveness, impact and sustainability, concepts used to evaluate selected torture rehabilitation centres which the EU funded. The EU provides a considerable amount of general operating funding for centres in Europe and in the developing world. Definitions follow:

*Efficiency* – Quality and adequacy of management, suitable indicators or other tools of efficiency, management flexibility.

*Effectiveness* – Number of victims benefiting directly and indirectly, number of persons

benefiting from prevention activities through training and public awareness. Exchange of experiences, information, and practices among centres, effectiveness of regional projects.

*Sustainability* – Both financial and outcome sustainability improved. Visible signs of government increasing their active support of torture survivors.

*Impact* – Effect on legislative and governmental changes, on prevention of torture, using suitable indicators or reporting tools of impact assessment. Any changes in mentality, awareness, or interpretation of torture in the more difficult countries.

Obviously, impact assessment is quite different from monitoring or evaluating the efficiency or effectiveness of a programme, but the following chart provides some comparisons (see Table 1).

The U.S. Office of Refugee Resettlement (ORR), administrator of the domestic funding from the Torture Victims Relief Act, has required funded centres in the U.S. to document 17 data points. The Act was passed in 1998, and current funding has remained at \$10M USD annually for domestic centres, in addition to another \$10M USD for centres in the developing world and \$7M USD for the UN Voluntary Fund for Torture Victims.

### Outcomes and indicators

Possible outcomes include symptom reduction, quality of life, level of function, coping and resilience, social support, and client satisfaction. The most frequently measured outcomes include medical and psychological symptoms, level of functioning or disability, quality of life, and client satisfaction.

The mission of torture rehabilitation programmes has generally been to treat every survivor who requests care. For ethical reasons programmes are unwilling to allocate a random control group, in spite of the fact that no one has proven the efficacy of the interventions. Nonetheless, some programmes do have waiting lists, which could potentially be used as controls – although this presents ethical issues, as well.

The problem now faced is how to design acceptable, experimental studies in the absence of a control group. The objective of measuring survivor (consumer) outcomes in torture rehabilitation programmes is to study the efficacy of the intervention compared to the goals of the programme. The information garnered should be used to improve the quality of services and care. Additional gains from measuring consumer outcomes include professional development and empowerment for the survivors of torture.

To improve the quality of care we need to investigate treatment efficacy (clinical impact) and treatment effectiveness (eco-

**Table 1.** *Impact assessment vs. monitoring & evaluation (Rovhe C, 1999).*

Assessment	Monitoring	Evaluation	Impact
Timing	Frequently	Periodically	Infrequently, usually at the end of a project
Analysis	Descriptive: inputs, outputs, activities	More analytical; Examines processes	Mainly analytical; Concerned with Long Term outcomes
Specificity	Very specific, comparing a plan to its results	Also looks at processes	Less specific and considers external influences and events

conomic impact). Treatment efficacy can be measured at the individual and at the group level. Treatment effectiveness is measured as cost benefit and cost effectiveness of the programme to guide the allocation of resources. This type of evaluation uses a different methodology that is beyond the scope of this paper.

Programmes for the rehabilitation of torture victims vary enormously in the specific types of therapeutic interventions utilized, sizes of the target populations, duration of the rehabilitation process, clarity and specifications of goals, economic resources, professional and staff manpower, data collection capabilities, and communications skills of the staff (Amris and Arenas, 2003).

Consumer outcomes measure the “effect on a patient’s health status attributable to an intervention done by health professionals or health services”. In other words, they measure the anticipated benefits after the implementation of the programme (Andrews, 1994).

Donald et al. (2002) have three basic criteria for the development of outcomes. Outcomes should 1) be congruent with the evidence, 2) be relevant for the level of action and stated clearly and concisely, and 3) have face validity to stakeholders.

Ideally, a separate research staff would develop and monitor outcome evaluation for a given torture rehabilitation centre. However, this is not often practical. In most situations, measuring outcomes should be an integral part of the care. Practically, the assessment must be integrated into the daily routine care of clients in the programme, not as a separate evaluation research component. In addition, the measure of outcomes should be a part of a process that includes an analysis and reporting of the outcome data, as well as incorporating the information in order to improve the quality of the

care through education and training of the providers. This methodology routinely used in health care is called “Continuously Quality Development” and has been adopted as a national policy for the Regional Office for Europe of the World Health Organization (World Health Organization, 1993).

The best approach to evaluating the efficacy of the programme is a multidimensional, multidisciplinary measure of individual outcome. Another important area of evaluation and research is the perception that the participants in a programme have of the outcome of their interventions. Professionals (service providers) often have a different assessment than the survivors (consumers) in relation to parameters such as quality of life, symptoms, and social skills (Stedman et al., 1997; Amris and Arenas, 2003). Some possible outcome domains include symptom reduction, quality of life, level of function, coping and resilience, social support, client satisfaction, and cognitive ability.

In evaluation research, outcome measures may include the application of some known scales and instruments before and after intervention. There are many instruments that can be used in each of these areas of interest (See *Examples of instruments available page 128*). Several authors have defined some of the criteria for selecting a measurement or indicator for consumer outcome (Donald et al., 2002; Ciarlo et al., 1986; Green and Graceli, 1987; Andrews et al., 1994). Donald et al. (2002) have identified ten criteria to guide in the development of outcome indicators, which should be congruent with the evidence, relevant for the level of action, stated clearly and concisely, have face validity to stockholders, and be sensitive to changes over time, measurable, affordable, unique, and comprehensive.

The Consumer Outcome Project Advisory Group of the in Department of Mental Health and Family Services of Australia was created to review existing measures of consumer outcome. The group concluded that disability and quality of life were the most important outcomes to be measured, followed by consumer satisfaction and symptoms. The group recommended the further testing of six instruments as potentially useful for routine outcome measurements (Andrews et al., 1994): Consumer measures included BASIS 32 (Symptoms Identification Scales), MHI (Mental Health Inventory) and the SF-36 (Short Form Survey); Provider measurements included the HoNOS (Health of the Nations Outcomes Study), LSP (Life Skills Profile), and RFS (Role Function Scales). This is an example of how the Commonwealth Department approached this problem.

The choice of measurement instruments should be based on the specific objectives, outcomes, type of intervention implemented, and information needed, all of which will be unique to each programme.

Monzani et al. (2008) used the approach of the Australian Commonwealth Department to evaluate the effectiveness of community mental health departments in the Lombardy region of Italy. Twice a year they surveyed 4,712 patients treated in ten mental health departments using the HoNOS. Overall, the mental health departments were effective in reducing HoNOS scores, and the main predictor of improvement was treatment, although length of care, gender, and diagnosis were weaker predictors.

Many instruments that are both valid and reliable can be used in different circumstances.

There are also several publications that have analyzed the validity and reliability of each instrument and can be used for

reference in the selection of an instrument (Bowling, 1996; Bowling, 1997; Donald, 2002). Obviously, any outcome measure needs to be accepted by the professional staff and clients of the programme.

Instruments selected should be valid, reliable, standardized, translated and back-translated, and culturally equivalent. However, these criteria are rarely met and, as a result, centres find themselves compromising the ideal scientific standards.

After a measure has been selected and implemented for a defined period of time, it should be evaluated to decide if it fulfills the goals of the research evaluation. Some programmes implement outcome measurements but do not systematically analyze the data.

### Research strategies

We have chosen to categorize the types of studies according to the classic text by Cook and Campbell (1979), as follows: *Descriptive*, *Experimental*, *Quasi-Experimental Pretest-Posttest* (One Group—including retrospective chart reviews; More than One Group Randomized; More than One Group Non-Randomized); *Qualitative* (Phenomenology; Ethnography; Grounded Theory).

#### *Descriptive Studies*

The purpose of a descriptive study is to delineate the facts and characteristics of a cohort of torture survivors. The study collects detailed factual information oriented to identify problems.

Most of the currently published torture literature is descriptive. A typical example is the study of Rasmussen on the medical aspects of torture. He describes, in the Danish Medical Bulletin (Rasmussen, 1990), the torture methods and their relationship to symptoms and lesions in 200 victims of torture.

In outcome descriptive studies the author gives the details of the design of the programme and the indicators that will be used to measure the efficacy of the services given to torture survivors. An example is the Impact Assessment Study by Amris, but only two components of the five-part study were done and published (Amris and Arenas, 2003; Amris and Arenas, 2005a, 2005b; Pedersen, 2005).

#### *Experimental Design*

The experimental design is the gold standard model to measure the efficacy of an intervention because the researcher is able to control most of the confounding variables that affect the internal validity of an outcome study. The typical experimental design requires a random assignment of the torture survivors to experimental and control groups. Only the experimental group receives treatment. Treated torture survivors are compared with a control group of torture survivors who have not received treatment.

Random Selection	Pretest	Treatment	Posttest
Experimental	O1	X	O2
Control	O1		O2

Torture rehabilitation programmes have generally concluded that is unethical to stop the treatment of a group of torture survivors to create a control group. Because of this limitation we have not found any papers in torture outcome literature that follow a true experimental design.

#### *Quasi-Experimental Design*

Because an experimental design is not possible for ethical reasons, the only alternatives are the quasi-experimental designs. The classical study on quasi-experimental design is the book "Quasi Experimentation" by Thomas Cook and Donald Campbell (1979).

The quasi-experimental designs will always compromise the internal or external validity of the research, and the researcher has to understand these limitations

#### *One Group Pretest-Posttest Design*

Most rehabilitation programmes have used a pre-post design in outcome studies of torture survivors. Generally a group of torture survivors without a control group is evaluated with some measurement instruments before (pre-test) and after (post-test) a period of treatment.

Pretest	Treatment	Posttest
O1	X	O2

Some studies have repeated the number of pre-test measurements as a way to use clients as their own control; for example, using two pre- and one post-measures collected at three time points.

Pretest	Treatment	Posttest
O1 O2	X	O3

#### *More than One Group Pretest-Posttest:*

##### *Either Randomized or Non-Randomized*

Another variation is dividing at random the torture population under study to different types of treatment or to a different intensity of treatment. One group receives a baseline care or usual care and the other (one or more groups) receives additional services. One avoids the ethical problem because all of them are treated. The researcher compares the outcomes among the groups.

Pretest	Treatment	Posttest
O1	X1	O2
O1	X2	O2

*More than One group Pretest-Posttest:  
Non-Randomized Control Group*

In this situation you compare two groups that are as similar as possible and you treat only one of them. An example should be to compare a group of survivors treated in a center with a similar ethnic group in the population that has not been treated.

Pretest	Treatment	Posttest
O1	X	O2
O1		O2

*Qualitative Studies*

Qualitative Research seeks understanding of data that are complex and can be approached only in context. The methods used in qualitative studies are in the areas of Phenomenology, Ethnography and Grounded Theory.

Phenomenology is a descriptive, reflexive, interpretative mode of inquiry on the personal experience lived by a participant. The information is gathered with interviews or in-depth conversations that are audio-taped for further analysis.

Ethnography provides means for exploring cultural or smaller sub-cultural units. The information is gathered through participant observation, field notes, interviews, videotapes or secondary documents, such as records, documents. The focus group is another option.

Grounded Theory develops theories or a theoretical framework grounded in data. Questions are about changing experiences over time. The researcher uses audiotaped interviews, participant and non-participant observations, conversations, and field notes as sources of information.

**Literature review**

Nickerson et al. (2011) reviewed studies using two approaches to psychological treat-

ment of refugees: trauma-focused therapy (N= 10 with control group, N= 5 without control group) and multimodal interventions (N=4 without control group). Limitations included absence of or use of non-equivalent controls, small sample sizes, absence of post-treatment or long-term follow-up assessment, lack of blind assessment, restrictive inclusion criteria, and lack of clear delineation of treatment components. They concluded that additional rigorous research into the effectiveness of both modalities is needed in order to draw a firm conclusion. Crumlish and O'Rourke (2010) reviewed treatments evaluated with randomized, controlled methodology (N=10, total sample = 528) and found support for using narrative exposure therapy (NET) and cognitive behavioural therapy (CBT), although no treatment has a solid evidence base. Limitations included small sample size, variable trial quality (as rated with the Moncrieff scale,) rare use of power analysis, questionable minimization of bias, and infrequent use of culturally-validated outcome measures. Quiroga and Jaranson (2005), as part of a desk study reviewing the literature on torture rehabilitation from 1998 through 2004, initially reviewed 25 treatment outcome studies and were disappointed with the quality of most research. Dymi (2002), in a study at the University of Copenhagen and the IRCT intended to identify and compare methods of study suitable for analyzing treatment outcomes for rehabilitation of torture survivors, had previously reviewed outcome and related studies and reached a similar conclusion. He recommended that "the assessment of outcomes of rehabilitation treatment of torture survivors ought to make use of a combination of qualitative and quantitative studies designed in accordance with the pattern of actual services offered by the respective centres." (p. iv, abstract). Gurr and Quiroga

(2001), in the first desk study of torture rehabilitation literature until 1998, concluded that the effectiveness of available treatment programmes remained unproven. Measures differed across settings and changes could not be attributed to any single factor, including the intervention. Achievement of goals agreed upon by client and therapist was the best measure. Measurement of outcome was done by the service system, including management, supervisor, as well as individual therapists, and the client, family, and cultural group. Better scoring of severity would be helpful in detecting changes over time.

In this desk study, we have not only included the 25 studies in Quiroga and Jaranon (2005) but added more than 45 additional and more recent studies for a total of more than 70. Other ways of categorizing are important, such as whether the sample is entirely torture survivors or traumatized refugees (which may include survivors), clinical or non-clinical, and U.S. or worldwide. The studies can be longitudinal or cross-sectional and can either demonstrate improvement or no improvement.

The organization of these studies in this desk study is first by torture survivors vs. traumatized refugees (which may also include torture survivors). Secondly, the studies are organized by research design in clinical samples. Within each subsection, the studies are arranged alphabetically by the primary author. Finally, fifteen studies which assess symptomatology in untreated populations are summarized.

#### *Torture survivorst*

##### *Descriptive*

Alexander et al. (2007) described symptoms of anxiety, depression and PTSD among Bosnian (n=17) and Colombian (n=17) torture survivors served by the Florida Center for Survivors of Torture, a programme of

Gulf Coast Jewish Family Services, Inc. Information from clients enrolled in the programme for six months or more was collected over a 14-month period in order to better prioritize and design services for the two distinct populations. On average, the Bosnians in this sample experienced torture approximately 14 years ago, six years ago for the Colombians. Types of torture experienced by clients were documented using HURIDOCS and the number of family and friends affected by extreme trauma were counted. Employment and education levels were also identified. Findings showed that 100% of Bosnians were symptomatic for depression and over half experienced symptoms of PTSD compared to 35% of Colombians for depression and 18% for PTSD, despite the differences in years since the trauma occurred. High incidences of torture experienced by Bosnian clients and high numbers of family and friends affected support the high rates of symptoms. For the Colombian clients, high rates of employment and years of education, as well as earlier intervention, may contribute to their lower rates of symptoms. The two client groups are distinguished by the unique circumstances experienced by each, including punctuated wartime versus a prolonged insurgency, as well as the refugee versus asylum seeker experience. This exploratory project informs the torture treatment model while recognizing the importance of ethnic, political and cultural perspectives affecting the healing process.

Amris and Arenas (2003): The first phase of the Impact Assessment Study conducted by the International Rehabilitation Council for Torture Victims (IRCT) was an exploratory study of four centres to find the perception of torture and rehabilitation in different cultural settings by health professionals and by clients. The results of the first

phase showed that all programmes used a multidisciplinary approach in the assessment and treatment of the clients, but the clinical practice and priorities varied, reflecting the professional profile and composition of staff across centres. The programmes used a broad spectrum of theories, methods, and treatment approaches. The clients had very concrete expectations of treatment such as pain relief, improved physical function, improved relationships with their families and interpersonal relationships within the community, and the capacity to return to work and provide for the family. Across centres the clients expressed satisfaction with the support, treatment, and rehabilitation they were provided. Only the first of five planned phases of the Impact Assessment Study was completed. Figure 1 on the opposite page shows the overall plan.

The U.S. Office for Refugee Resettlement (ORR) has required the 27 torture treatment programmes that it funds to collect 17 descriptive data points, as follows:

*17 Data points collected at intake as required by the U.S. Office for Refugee Resettlement (ORR)*

#### Data Point

1. Client's self-reported age when first subjected to torture
2. Type of torture suffered
3. Primary complaint/presenting problem
4. Client's sex
5. Immigration status at intake
6. Age at intake
7. Employment status at intake
8. Date of arrival in the U.S.
9. Country of origin
10. Ethnicity
11. Religion
12. Housing status at intake
13. Total number of clients
14. Number of clients by service category (medical, mental health, social, legal)

15. Number of community trainings held
16. Number of people trained by profession
17. Number of hours contributed by pro bono service

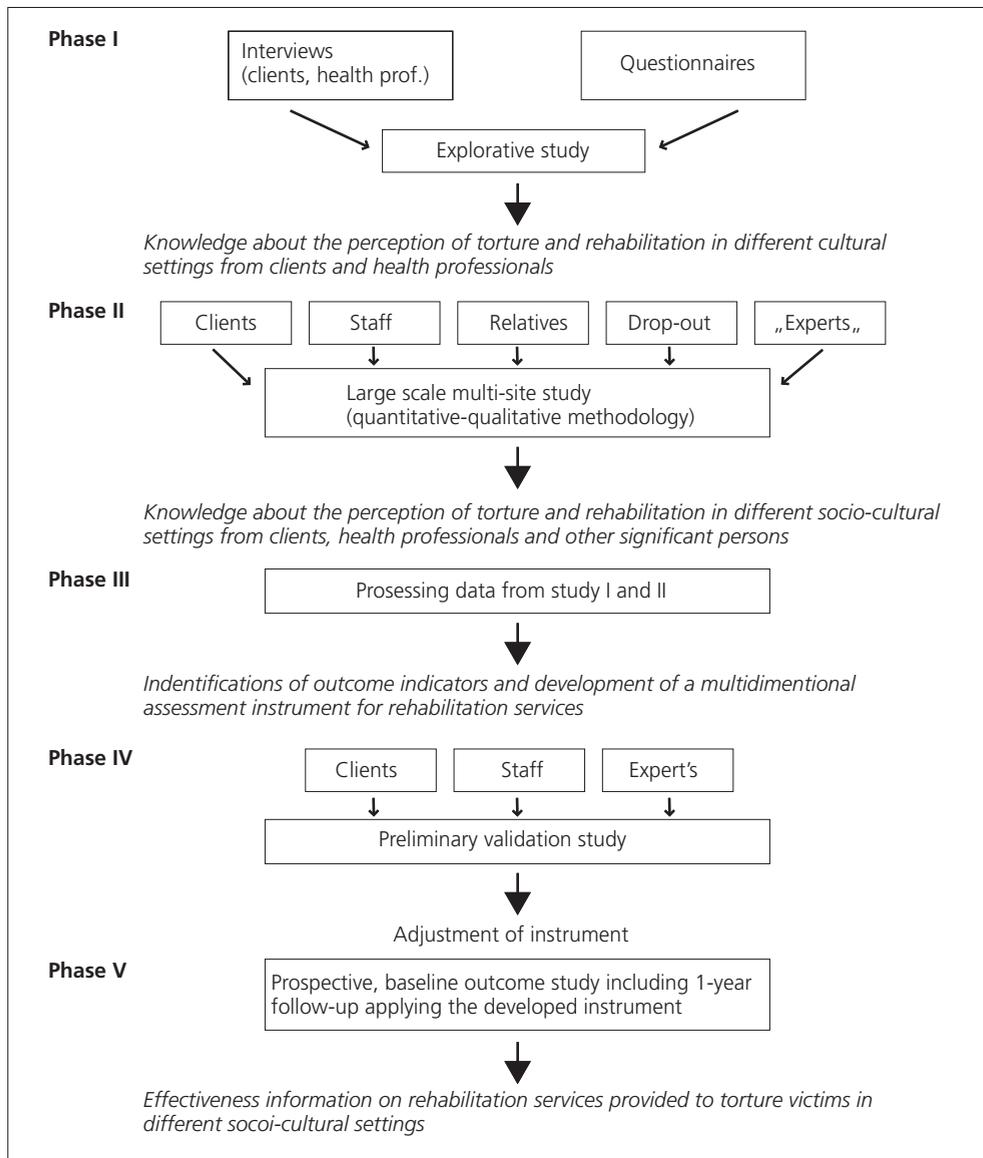
Eventually, ORR hopes to assess outcomes but is using this basic data collection as a first step.

Quasi-experimental:

One group pretest-posttest

Agger et al. (2009) tested the testimonial method, which represents a brief cross-cultural psychosocial approach to trauma, relatively easy to master in developing countries where torture is perpetrated and there are few resources for the provision of therapeutic assistance to the survivors. The method was first described in Chile by Cienfuegos and Monelli (1983) and has since been used in many variations in different cultural contexts. In this project the method was supplemented by culture-specific coping strategies (meditation and a ceremony). A pilot training project was undertaken between Rehabilitation and Research Centre for Torture victims (RCT) in Copenhagen, Denmark, and People's Vigilance Committee for Human Rights (PVCHR) in Varanasi, India, to investigate the usefulness of the testimonial method. The project involved the development of a community-based testimonial method, training of twelve PVCHR community workers, the development of a manual, and a monitoring and evaluation system comparing results of measures before the intervention and two to three months after the intervention. Twenty-three victims gave their testimonies under supervision. In the two first sessions the testimony was written and in the third session survivors participated in a delivery ceremony. Human rights activists and community workers interviewed the survivors about how they

**Figure 1.** Five Phases of the impact of assessment study.



felt after the intervention. After testimonial therapy, almost all survivors demonstrated significant improvements in overall WHO-five Well-being Index (WHO-5) score. Four out of the five individual items improved by

at least 40%. Items from the International Classification of Functioning, Disability and Health (ICF) showed less significant change, possibly because the questionnaire had not been well understood by the community

workers, or due to poor wording, formulation and/or validation of the questions. All survivors expressed satisfaction with the process, especially the public delivery ceremony, which apparently became a turning point in the healing process. Seemingly, the ceremonial element represented the necessary social recognition, re-connected the survivors with their community, and ensured that their private truth became part of social memory. Although this small pilot study without control groups or prior validation of the questionnaire did not provide high-ranking quantitative evidence or statistically significant results for the effectiveness of this version of the testimonial method, we did find it likely that it helps improve well-being in survivors of torture in this particular context. A more extensive study is needed to verify these results, and better measures of ICF activities and participation functions should be used. Interviews with human rights activists revealed that it is easier for survivors who have gone through testimonial therapy to give coherent legal testimony.

Birck (2001) used standardized instruments and interviews to assess symptom change after two years of psychotherapy with 30 former patients at the Treatment Centre for Torture Victims (BZFO) in Berlin, Germany. Although intrusive PTSD symptoms had decreased, former patients were still highly symptomatic. Birck attributes this high symptom level to the phasic course of PTSD, which can be exacerbated by post-treatment stressful events.

Boehnlein et al. (1985) characterized the symptoms of PTSD one year after the first clinic visit, when the diagnosis was made for Cambodian concentration camp survivors at the Indochinese Refugee Clinic (now the Intercultural Psychiatric Clinic) in Portland, Oregon. Patients received pharmacologic and supportive therapy. At one year, two of

the 12 patients dropped out of treatment. Using the DIS, five of the 12 no longer met criteria for PTSD and three had improved symptoms (including one dropout), three were unchanged, and one had become worse (the other dropout). Improvement was especially noted in the intrusive symptoms of PTSD.

Carlsson (2005) studied changes in symptoms of PTSD, depression, anxiety and quality of life over time and identified factors associated with mental health and health-related quality of life (QOL) of survivors treated at Rehabilitation and Research Centre (RCT) in Copenhagen, Denmark. (Carlsson JM, et al., 2006a; Carlsson JM, et al., 2005; Carlsson J, et al., 2006b). A concurrent cohort study interviewed 86 refugees attending a pre-treatment assessment at RCT in 2001-02, and 68 of them at 9 month follow-up (t9). The historical cohort study in 2002-03 included 151 of the 232 refugees attending a pre-treatment assessment at RCT in 1991-94. In both studies, mental health sequelae and poor QOL persisted even many years after exposure to torture. High emotional distress was associated with low QOL. No changes were found between the initial and the 9 month follow-up for the concurrent cohort, although the historical cohort (10 year follow-up) showed a slight decrease in psychiatric symptoms. High emotional distress was associated with low quality of life. Factors associated with emotional distress and low QOL were a large number of torture methods, lack of current occupation, and minimal social contacts. The concurrent cohort was also followed up at 23 months (t23) (Carlsson, 2008). There was an improvement in mental symptoms from t9-t23 (except for HSCL-depression). Still high levels of mental health problems persisted and no improvement in quality of life from t9-t23 was demonstrated.

No consistent findings of predictors of changes in psychiatric symptoms and quality of life were found.

Cienfuegos and Monelli (1983), in perhaps the earliest attempt to study outcome of torture survivors, studied 39 tortured Chilean ex-prisoners and others from Chile who suffered trauma but not torture. The best results were found in those who were tortured (12 of 15 improved).

Curling (2005) explored the effectiveness of the use of an empowerment workshop, called Free to Grow1 (FTG), in the treatment of a group of torture survivors who had shown great reluctance to enter into psychotherapeutic interventions. Research into the effectiveness of the method was assessed using a series of tests measuring changes in empowerment, depression, anxiety and multiple operational definitions of health. Participants were also asked for feedback using an unstructured self-report upon completion of the workshop. In addition, an exit interview was conducted after follow-up, five months after the first workshop session. Certain trends were detected despite the small numbers of participants (N=11) and incomplete questionnaires. According to most of the measures used, the intervention proved to have a positive sustained impact. At the exit interview all of the participants acknowledged experiencing increased levels of introspection and self-awareness, as well as a degree of growth and positive change. As a result, many participants were able to enter more mainstream psychotherapeutic interventions to deal with their remaining psychological and interpersonal problems.

Elsass (1998) interviewed 20 torture survivors from the Middle East and their therapists from the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, Denmark. Although this study was much more complicated than reported here,

quantitative and qualitative outcome three months after the end of treatment found that 17 of 20 survivors evaluated treatment results as extremely positive.

Gangsei, Jaranson, et al. (1996, unpublished) at Survivors of Torture-International, San Diego, interviewed 26 asylum-seekers (12 women, 14 men) newly-admitted to San Diego center under a project funded by the California Endowment to improve access to medical services for torture survivors. Average age was 32 years with a range of 18 to 68. Participants received an average of 16 different services. Clients identified the number and severity of psychological and physical health problems and the difficulties these caused in work, daily activities, outside activities, and relationships with others. After receiving services, clients again rated themselves on the same scales. Significant improvement in psychological and physical function and reduction in level of disability was found. Overall satisfaction was extremely high (3.8 of 4.0). Half of the sample was granted asylum and showed far greater post-test improvement, despite starting with more problems.

Halvorsen and Stenmark (2010) presented data on 16 torture survivors receiving 10 sessions of narrative exposure therapy (NET). Symptoms of PTSD and depression, assessed by Clinician-Administered PTSD Scale (CAPS) and Hamilton Rating Scale for Depression (HRSD), decreased significantly from pre-treatment to 6-month follow-up, with Cohen's *d* effect sizes of 1.16 and 0.84, respectively. Although treatment gains were moderate, further research on evidence-based treatments for PTSD and depression in refugee torture survivors is warranted.

Jaranson et al. (1995, unpublished) reviewed the charts of 220 clients at the Center for Victims of Torture (CVT) in

Minneapolis, Minnesota. Using independent clinician evaluators, overall 64% showed improved function, 35% were unchanged, and 3% declined. Of those who completed treatment, 86% showed improvement, while only 39% of those who left treatment prematurely showed improvement within the five-year study period (1991-95).

McCull et al. (2010) have presented the results of the IRCT's (International Rehabilitation Council for Torture Victims) Global Health Project. This project partnered five IRCT network rehabilitation centres (in Gaza, Egypt, Mexico, Honduras, and South Africa) working in very different contexts. The project provided local and regional training, facilitated knowledge exchange between centres, implemented psychotherapeutic treatment, and collected data to evaluate the interventions. In 2008, data from 306 patients and/or their records was collected, but 48% dropped out before the three month assessment and an additional 20% before the six month assessment, leaving 97 (32%) torture survivors to complete all three assessments. A high level of traumatic events was experienced (e.g. 64% with head trauma, 24% with ongoing torture injury problems), resulting in high prevalence of anxiety, depressive, PTSD, and somatic symptoms. Results indicated a modest drop in symptoms over the six months of the study.

Musisi et al. (2000) conducted a three-year (1996-99) retrospective study of 310 patients attending the Centre for Treatment and Rehabilitation of Torture Victims (ACTV) in Kampala. Treatment included psychotherapy, physiotherapy, and minimal pharmacotherapy. There was a significant reduction in symptoms with treatment in most cases, but minimal improvement in some.

Reeler and Mbape (1998) found in a pilot study at Amani Foundation in Zim-

babwe that 12 adults torture survivors who completed brief psychotherapy showed improvement, using the Clinician Administered PTSD Scale (CAPS).

Samsøe et al. (2007) monitored an extended, personally designed, multidisciplinary treatment of 21 torture victims, earlier exposed to both physical and psychological torture, over nine months with assessment of outcome. The physiotherapy comprised elements such as massage, exercise on land, balance training and stimulation of proprioception, all aiming at regaining body awareness. The effect of treatment was measured using the fibrositis index. Non-parametric statistics using the Wilcoxon test was applied. Prior to treatment the median score of the fibrositis index was 15 points (range 2-34). After nine months of multidisciplinary treatment the median score of the fibrositis index was 2 points (range 0-15). This decrease in experienced muscle pain was statistically significant ( $p < .0001$ ). Following nine months of treatment, only one torture victim in the study could be classified as suffering from fibromyalgia when applying the fibrositis index.

*Quasi-experimental: More than one group pretest-posttest non-randomized*

Neuner et al. (2010) evaluated whether stressors caused by the asylum procedure and psychological consequences of torture contribute to the maintenance of PTSD symptoms and interfere with treatment. In a pilot randomized controlled trial, the authors examined the efficacy of trauma-focused treatment in 32 asylum-seekers with PTSD resulting from state-sponsored violence and other traumatic events. Narrative exposure therapy (NET) was compared with treatment as usual (TAU), with a focus on stabilization and psychoactive medication. Six months after treatment, a significant

reduction of posttraumatic stress symptoms was found in the NET participants but not in the TAU group. Although treatment gains were moderate, these results indicate that NET is a promising approach for the treatment of PTSD in asylum-seekers living in unstable conditions.

Tol et al. (2009) examined the effectiveness of brief multi-disciplinary treatment for low-income torture survivors in Nepal using a naturalistic comparative design with help-seeking torture survivors and internally displaced persons assigned to a treatment and a comparison group respectively (N = 192; treatment group N = 111, comparison group N = 81). Baseline measurements on psychiatric symptomatology, disability, and functioning and a five-month follow-up (N = 107; treatment group N = 62; comparison group N = 45), were employed. Intervention consisted of brief psychosocial services, minimal medical services and/or legal assistance. Study groups were generally comparable and non-completers did not significantly differ from completers. The treatment group improved more than the comparison group on somatic symptoms, subjective well-being, disability and functioning, with mostly moderate effect sizes. Treatment was therefore moderately effective, reducing the nonspecific mental health consequences of torture, but disability scores remained high. For clients presenting with more severe mental health problems, other treatments in the resource-poor Nepali context need to be sought.

#### Qualitative

Moio (2008) conducted a qualitative approach to examine the consequences of state sponsored torture as experienced and made meaningful by women refugee survivors. In-depth interviews explored how women felt about life after torture: the meaning of the

experience over time, the personal, psychological, and social effects, what was helpful to healing, and their outlook on the future. Findings indicated that the overwhelming majority of participants demonstrated resiliency in response to external forces that challenged their internal coherence, systems of belief, and their re-adjustment in the aftermath of torture and forced migration experiences. Results also showed that women were capable of resiliency by using pro-active problem solving, making decisions, and carrying out plans while still suffering distress. None of the women initially conceptualized their suffering as illness. Approximately half of the participants embraced their diagnoses of PTSD and depression after exposure to therapy. The other half remained skeptical of medicalizing their distress and took an instrumental approach for the purposes of managing symptoms. Most women found the therapeutic relationship helpful to healing because it provided a trustworthy, skilled individual who encouraged and believed in their testimony and taught them practical skills. Participants overwhelmingly preferred working exclusively with women, whether in individual or group settings. Those participating in women's group therapy reconstituted the clinical environment into a social space promoting community for sharing gender-specific knowledge and mutual support. Implications for social work with survivors are discussed; contributions to the controversy over the validity and efficacy of PTSD for survivors of state sponsored torture are also discussed (<http://gradworks.umi.com/33/46/3346914.html> Retrieved 8/28/2010).

#### *Traumatized refugees*

##### Descriptive

Grodin et al. (2008) seek to explore the potential value of Qigong and T'ai Chi practice

as a therapeutic intervention to aid in the treatment of survivors of torture and refugee trauma. The common effects of torture and refugee trauma are surveyed with a focus on post-traumatic stress disorder. An alternative theoretical framework for conceptualizing and healing trauma is presented. Evidence is reviewed from the scientific literature that describes how Qigong and T'ai Chi have been used in studies of the general population to alleviate symptoms that are also expressed in torture survivors. Observations are presented from a combined, simplified Qigong and T'ai Chi intervention with a convenience sample of four refugee survivors of torture. Preliminary observations from four cases and a review of the literature support the potential efficacy of incorporating Qigong and T'ai Chi into the treatment of survivors of torture and refugee trauma.

Mueller et al. (2010) studied the mental health of failed asylum seekers (N = 40) and a matched sample of asylum seekers (N = 40). Asylum seekers and refugees often suffer from severe psychopathology in the form of post-traumatic stress disorder (PTSD). Since PTSD impacts memory functions, and because asylum applications rely on personal accounts, asylum seekers with PTSD are at greater risk of rejection than refugees. Participants were administered structured interviews on sociodemographics, flight, and exile as well as standardized questionnaires on PTSD, anxiety, depression and pain. Both samples were severely affected: >80% exhibited at least one clinically significant condition. Given the great vulnerability of these individuals, the long and unsettling asylum processes as practised in western host countries appears problematic, as does the withdrawal of health and social welfare benefits. Finally, high rates of psychopathology amongst failed asylum seekers indicates that refugee and humanitarian decision-

making procedures may be failing to identify those most in need of protection.

Pantic (1998) discussed integrative gestalt group therapy for Bosnian children and their families, helping them to overcome their problems, avoid long-term sequelae, and reach acceptance of their experiences in a search for meaning and identity.

Schwail and Rasras (2002) of Palestine conducted a cognitive behavior group primarily of survivors of torture in Israeli prisons or otherwise traumatized by Israelis. A psychotherapist and co-therapist conducted the group. The authors comment that their patients were more likely to accept education or counseling than to focus on the trauma, but many members disclosed their traumatic histories. Of the twelve group members, eight reported benefit and four were partially improved.

Quasi-experimental:

one group pretest-posttest

Abdalla and Elklit (2001) of the Danish Red Cross developed a psycho-educational project for 490 Kosovar refugee children. Intrusive memories and hypervigilance decreased, while self-satisfaction increased significantly.

Boehnlein et al. (2004) assessed treatment outcome by chart review in 23 Cambodian refugee patients with PTSD, all of whom had been treated continuously for at least ten years at the Intercultural Psychiatric Program in Portland, Oregon. Using symptom, disability, and quality of life instruments, thirteen were improved, but the remaining ten were still impaired.

Brune et al. (2002) reviewed 141 charts of consecutively treated refugees in Hamburg, Germany, finding that a firm belief system was an important predictor for better therapy outcome. Psychotherapy ranged from 3 months to 6 years with a mean of 2 years.

Eklblad and Roth (1997) tested the assessment of PTSD and associated symptoms for immigrants and refugees at a psychiatric outpatient clinic in Sweden. Thirty-three were assessed at baseline, 22 at follow-up in one year using the SCID, HTQ, and HSCL-25. No changes were found in PTSD or depression.

Farrag et al. (2007) aimed to evaluate the effectiveness of the psychosocial rehabilitation approach in helping clients with their mental health problems. The study compared the scores on tests for anxiety, depression and post-traumatic stress disorder obtained by a sample of 38 torture survivors before and after receiving services.

Folkes (2002) evaluated 31 refugee and immigrant clients' retreatment, then again after 30 days. A significant decrease in all symptom subgroupings of PTSD was found.

Goodkind (2002) studied the effect of building upon Hmong refugee strengths, experiences, and interests, finding that this was effective in increasing quality of life and English proficiency, while decreasing distress levels.

Goodkind (2005) assessed the effectiveness of a community-based advocacy and learning intervention for Hmong refugees using a comprehensive, multi-method strategy, which included a within-group longitudinal design with four data collection points and in-depth qualitative recruitment and post-intervention interviews. The intervention's impact on five aspects of refugee well-being was examined: participants' psychological well-being, quality of life, access to resources, English proficiency, and knowledge for the U.S. citizenship exam. Twenty eight Hmong adults and 27 undergraduate students participated together in the intervention, which had two major components: (1) Learning Circles, which involved cultural exchange and one-on-one learning

opportunities for Hmong adults, and (2) an advocacy component that involved undergraduates advocating for and transferring advocacy skills to Hmong families to increase their access to resources in their communities. Undergraduate paraprofessionals and Hmong participants worked together for six to eight hours per week for six months. Growth trajectory analysis revealed promising quantitative findings. Participants' quality of life, satisfaction with resources, English proficiency, and knowledge for the U.S. citizenship test increased and their levels of distress decreased over the course of the intervention. Mediating analyses suggested that participants' increased quality of life could be explained by their improved satisfaction with resources. Qualitative data helped to support and explain the quantitative data, as well as providing insight into other outcomes and processes of the intervention. Policy, practice, and research implications are discussed.

Goodkind (2006) studied refugees who resettle in a new country and face numerous struggles, including overcoming past traumas and coping with post-migration stressors, such as lack of meaningful social roles, poverty, discrimination, lack of environmental mastery, and social isolation. Thus, in addition to needing to learn concrete language skills and gain access to resources and employment, it is important for refugees to become a part of settings where their experiences, knowledge, and identity are valued and validated. The Refugee Well-Being Project (RWBP) was developed to promote the well-being of Hmong refugees by creating settings for mutual learning to occur between Hmong adults and undergraduate students. The RWBP had two major components: (1) Learning Circles, which involved cultural exchange and one-on-one learning opportunities, and (2) an advocacy compo-

ment, which involved undergraduates advocating for and transferring advocacy skills to Hmong families to increase their access to resources in their communities. The project was evaluated using a mixed quantitative and qualitative approach. This article discusses data from qualitative interviews with participants, during which the importance of reciprocal helping relationships and mutual learning emerged as significant themes.

Halcón et al. (1995; 2010, in press) found that groups of Somali and Oromo (Ethiopian) women responded positively to the health realization model of intervention. The health realization model is a community-oriented, psycho-educational intervention that shows promising results in a variety of settings and populations including high risk and traumatized individuals and groups. Based on a resiliency framework, this intervention assists people to put intrusive thoughts into a manageable perspective and improve their daily functioning through learning a process of thought recognition. (Related publication: Halcón et al., 1997).

Hermansson et al. (1996; 2002) investigated mental health over time in exile and explored variables related to mental health in war-wounded male refugees admitted for somatic care in Sweden for greater than four weeks. Measures included a well-being scale, HSCL-25, and PTSS-10. At baseline  $N=61$  and follow-up  $N=54$  and  $N=44$ , no improvement was found in well-being, but prevalence of PTSD was estimated at 50%.

Hinton et al. (2006) described for Vietnamese refugees (a) how headache- and orthostasis-focused panic attacks are generated, (b) a culturally sensitive treatment for PTSD with comorbid headache- and orthostasis-focused panic attacks, and (c) the outcome of a treatment series. In a multiple-baseline, across-subjects design ( $N = 3$ ), all patients demonstrated treatment-related

improvement of headache- and orthostasis-associated panic attacks and in the repeated-measures, within-subjects design, all patients greatly improved across treatment on measures of psychopathology.

Jorgensen et al. (2010) used the International Classification of Functioning, Disability and Health (ICF) to develop an interdisciplinary instrument consisting of a Core Set, a number of codes selected from ICF, to describe the overall health condition of traumatized refugees. The authors intended to test 1) whether this tool could prove suitable for an overall description of the functional abilities of traumatized refugees before, during, and after the intervention, and 2) whether the Core Set could be used to trace a significant change in the functional abilities of the traumatized refugees by comparing measurements before and after the intervention. In 2007, eight rehabilitation centres for traumatized refugees in Denmark agreed on a joint project to develop a tool for interdisciplinary documentation and monitoring, including physical, mental and social aspects of the person's health condition. Seven centers completed the project. The project selected a Comprehensive Core Set of 106 codes among 1,464 possible codes used by an interdisciplinary group of international and national experts in rehabilitation of traumatized refugees. The Comprehensive Core Set was furthermore reduced to a Brief Core Set of 32 codes. Six clients who fulfilled the inclusion criteria were randomly selected from each center. All were scored within a four week period after the start, before any intervention was initiated, and up to a month after the first scoring. The results from this project led to the conclusion that it is possible to develop an instrument based on the ICF classification. The instrument is useful for a general description of the total health conditions

(physical and mental functional ability as well environmental impact) of traumatized refugees. The tool helps to describe changes in the functional abilities used in connection with the preparation of the plan of action. The ICF Core Set for traumatized refugees has not yet been validated.

Kivling-Boden and Sundbom (2001, 2002) investigated the self-rated post-traumatic symptom levels compared with baseline and the subjects' life situations, emphasizing the relationship between the labor market, social contacts, and knowledge of Swedish. Subjects were traumatized refugees from the former Yugoslavia seen as outpatients at a psychiatric unit in Sweden for a minimum of a month. Twenty-seven of the initial 52 were followed-up at three years and completed the HTQ at baseline and follow-up, and a clinical interview for PTSD at baseline. No difference in PTSD symptom scores or diagnosis of PTSD were found, but unemployment, social isolation, and dependence upon social welfare were associated with PTSD symptoms at follow-up. On follow-up, social welfare dependence was high and unemployment at 32% was six fold the mainstream Swedish labor force. Positive factors were housing and a reasonable knowledge of the Swedish language.

Mollica et al. (1990) evaluated changes in symptoms and perceived distress of 21 Cambodian, 13 Hmong/Laotian, and 18 Vietnamese patients in Boston before and after a 6-month treatment period. Most patients improved significantly, with Cambodians having the greatest and Hmong/Laotians the least reductions in depressive symptoms. Although psychological symptoms improved, many somatic symptoms worsened.

Onyut et al. (2005) created and evaluated the efficacy of KIDNET, a child-friendly version of Narrative Exposure Therapy (NET), as a short-term treatment for

children. Six Somali children suffering from PTSD aged 12–17 years resident in a refugee settlement in Uganda were treated with four to six individual sessions of KIDNET by expert clinicians. Symptoms of PTSD and depression were assessed pre-treatment, post-treatment and at nine months follow-up using the CIDI Sections K and E. Important symptom reduction was evident immediately after treatment and treatment outcomes were sustained at the 9-month follow-up. All patients completed therapy, reported functioning gains and were helped to reconstruct their traumatic experiences into a narrative with the use of illustrative material. NET may be safe and effective to treat children with war related PTSD in the setting of refugee settlement in developing countries.

Stepakoff et al. (2006) described, for Liberian and Sierra Leonean survivors of torture and war living in the refugee camps of Guinea, a psychosocial programme (1999–2005) with three main goals: (a) to provide mental health care, (b) to train local refugee counselors, and (c) to raise community awareness about war trauma and mental health. Utilizing paraprofessional counselors under the close, on-site supervision of expatriate clinicians, the treatment model blended elements of western and indigenous healing. The core component consisted of relationship-based supportive group counseling. Clinical interventions were guided by a three stage model of trauma recovery (safety, mourning, reconnection), which was adapted to the realities of the refugee camp setting. Over 4,000 clients were provided with counseling and an additional 15,000 were provided with other supportive services. Results from follow-up assessments indicated significant reductions in trauma symptoms and increases in measures of daily functioning and social support during and after participation in groups.

Weine et al. (1998) studied 20 Bosnian refugees in Chicago before and after receiving testimony psychotherapy, and at two and six months. The authors found significant decreases in PTSD diagnosis and symptom severity, depressive symptoms, and increased Global Assessment of Function (GAF) scores at post-treatment, with additional effect on follow-ups. This is the first known study to use standardized instruments to evaluate the efficacy of a psychological treatment for a group of refugees with PTSD.

*Quasi experimental:*

more than one group pretest-posttest randomized Bolton et al. (2007) assessed, from May-December, 2005, the effect of locally feasible interventions on depression, anxiety, and conduct problems among 314 adolescents, ages 14-17, who had survived war and displacement. In two camps for internally displaced persons in northern Uganda, locally developed screening tools assessed the effectiveness of interventions in reducing symptoms of depression and anxiety, ameliorating conduct problems, and improving function among those who met study criteria and were randomly allocated (N = 105, psychotherapy-based intervention [group interpersonal psychotherapy]; N = 105, activity-based intervention [creative play]; N = 104 wait-control group [individuals wait-listed to receive treatment at the study's end]). Intervention groups met weekly for 16 weeks. Participants and controls were reassessed at the end of study. Primary outcome measure was a decrease in score (denoting improvement) on a depression symptom scale. Secondary measures were improvements in scores on anxiety, conduct problem symptoms, and function scales. Depression, anxiety, and conduct problems were assessed using the Acholi Psychosocial Assessment Instrument with a minimum score of 32

as the lower limit for clinically significant symptoms (maximum scale score, 105). Differences in change of the adjusted mean score for depression symptoms between group interpersonal psychotherapy and control groups was 9.79 points (95% confidence interval [CI], 1.66-17.93). Girls receiving group interpersonal psychotherapy showed substantial and significant improvement in depression symptoms compared with controls (12.61 points; 95% CI, 2.09-23.14). Improvement among boys was not statistically significant (5.72 points; 95% CI, -1.86 to 13.30). Creative play showed no effect on depression severity (-2.51 points; 95% CI, -11.42 to 6.39). There were no statistically different improvements in anxiety in either intervention group. Neither intervention improved conduct problems or function scores.

Dybdahl (2001) studied 42 mother-child dyads internally displaced in Bosnia-Herzegovina randomly assigned to psychosocial support with basic medical care compared with 45 dyads receiving only medical care. The treatment group showed positive effects on mothers' mental health, children's weight gain, and measures of children's psychosocial functioning and mental health.

Drozdek (1997) studied a sample of 120 male concentration camp survivors from Bosnia-Herzegovina in Dutch asylum centres given early outpatient treatment for PTSD for six months. Three treatment groups (group therapy, medications, combination group therapy and medications) and two control groups (refused treatment, did not meet PTSD diagnosis). Fifty randomly chosen subjects from the initial 120 were retested at the end of treatment and at three years. No differences were found among the treatment groups. The author concluded that treatment was effective in the short-term, less so in the long-term.

Neuner et al. (2004) studied the use of

narrative exposure therapy (NET), a short-term approach based on cognitive-behavioral and testimony therapy, and evaluated the efficacy of NET in a randomized controlled trial. Sudanese refugees living in a Ugandan refugee settlement (N = 43) and diagnosed as suffering from posttraumatic stress disorder (PTSD) received either four sessions of NET, four sessions of supportive counseling (SC), or psychoeducation (PE) completed in one session. One year after treatment, only 29 percent of the NET participants but 79 percent of the SC group and 80 percent of the PE group still fulfilled PTSD criteria. These results indicate that NET is a promising approach for the treatment of PTSD for refugees living in unsafe conditions.

Neuner et al. (2008) examined whether trained lay counselors could carry out effective treatment of posttraumatic stress disorder (PTSD) in refugee settlement. In a randomized controlled dissemination trial in Uganda with 277 Rwandan and Somali refugees diagnosed with PTSD, the authors investigated the effectiveness of psychotherapy administered by lay counselors. Strictly manualized narrative exposure therapy (NET) was compared with more flexible trauma counseling (TC) and a no-treatment monitoring group (MG). Fewer participants (4%) dropped out of NET treatment than TC (21%). Both active treatment groups were statistically and clinically superior to MG on PTSD symptoms and physical health but did not differ from each other. At follow-up, a PTSD diagnosis could not be established anymore in 70% of NET and 65% TC participants, whereas only 37% in MG no longer met PTSD criteria. Short-term psychotherapy carried out by lay counselors with limited training can be effective to treat war-related PTSD in refugee settlement.

Paunovic and Ost (2001) conducted the

first known randomized psychological treatment outcome study with a refugee sample. Six out of 20 were torture survivors. Both treatments showed large improvements on measures of PTSD, anxiety, depression, quality of life and cognitive schemas before and after treatment, and at six month follow-up. No difference between CBT and exposure therapy was found.

*Quasi experimental:*

more than one group pretest-posttest non-randomized

Arcel et al. (2003) studied two groups of internally displaced Bosnia torture survivors at the Centre for Torture Victims, Sarajevo. The first group (N = 65) was assessed from 1997-99, or two to four years after the end of the war in December 1995. The second group (N = 26) was assessed in 2000-01 or five to six years after the end of the war. Group 1 (N = 65), (three months pre to post assessment) was assessed two to four years after the war and Group 2 (N = 26), five to six years after the war. Both groups received intensive short-term treatment, Group 1 for three months, Group 2 for six months. Group 1 showed post-test improvement on almost all psychological symptoms, but Group 2, with longer treatment, had even more improvement except for depressive symptoms. Improvement in adaptive coping mechanisms occurred even with the shorter treatment.

Fox et al. (1998) evaluated home visits conducted with follow-up at 10, 20, and 33 weeks by school nurses and bilingual teachers to Southeast Asian refugee women in the U.S. For comparison, women who did not receive the home visits were twice evaluated for mental health status ten weeks apart. Home visits reduced depression for subjects compared with controls.

Hinton et al. (2004) examined the feasi-

bility, acceptability, and therapeutic efficacy of a culturally adapted cognitive-behavior therapy (CBT) for twelve Vietnamese refugees with treatment-resistant PTSD and panic attacks. These patients were treated in two separate cohorts of six with staggered onset of treatment. Repeated measures, Group X Time ANOVAs and between-group comparisons, indicated significant improvements with large effect sizes (Cohen's *d*) for all outcome measures: Harvard Trauma Questionnaire (HTQ; *d* = 2.5); Anxiety Sensitivity Index (ASI; *d* = 4.3); Hopkins Symptom Checklist-25 (HSCL-25), anxiety subscale (*d* = 2.2); and Hopkins Symptom Checklist-25, depression subscale (*d* = 2.0) scores. The severity of culturally related headache-and orthostasis-cued panic attacks improved significantly across treatment.

Hinton et al. (2005) examined the therapeutic efficacy of a culturally adapted cognitive-behavior therapy for Cambodian refugees with treatment-resistant posttraumatic stress disorder (PTSD) and comorbid panic attacks using a cross-over design, with 20 patients in the initial treatment (IT) condition and 20 in delayed treatment (DT). Repeated measures indicated significantly greater improvement in the IT condition, with large effect sizes (Cohen's *d*) for all outcome measures: Anxiety Sensitivity Index (*d* = 3.78), Clinician-Administered PTSD Scale (*d* = 2.17), and Symptom Checklist 90-R subscales (*d* = 2.77). Likewise, the severity of culturally-related neck-focused and orthostasis-cued panic attacks, including flashbacks associated with these subtypes, improved across treatment.

Igreja et al. (2004) examined the effectiveness and feasibility of a testimony method to ameliorate post-traumatic stress symptoms. Participants (*n*=206) belonged to former war zones in Mozambique. They were divided into a case (*n*=137) and a

non-case group (*n*=69). The case group was randomly divided into an intervention (*n*=66) and a control group (*n*=71). Symptoms were measured during baseline assessment, post-intervention and at an 11-month follow-up. Post-intervention measurements demonstrated significant symptom reduction in both the intervention and the control group. No significant differences were found between the intervention and the control group. Follow-up measurements showed sustained lower levels of symptoms in both groups, and some indications of a positive intervention effect in women. A remarkable drop in symptoms could not be linked directly to the intervention. Feasibility of the intervention was good, but controlling the intervention in a small rural community appeared to be a difficult task.

Kinzie and Leung (1989) described the results of clonidine-imipramine therapy for PTSD in 12 Cambodian refugees diagnosed with PTSD at the Indochinese Psychiatric Clinic (now the Intercultural Psychiatric Program) in Portland, Oregon. Imipramine was prescribed initially and, if symptoms persisted after one to two months, clonidine was added. Nine patients were followed-up using HDRS, PTSD, and a depression checklist adapted from the DSM-III-R. The majority no longer met criteria for depression with decreases in Hamilton scores, while PTSD global symptoms improved in six patients, but only in two to the extent that DSM-III-R diagnoses were not met.

Knezevic and Opacic (2004) studied changes in PTSD and co-morbid symptomatology in 123 clients from CRTV IAN Belgrade after three months of psychotherapy. The quality and intensity of symptomatology was measured in two time points, before treatment and after 12 psychotherapeutic sessions (three months) using self-report by clients as well as a structured clinical inter-

view by independent evaluators who did not take part in the psychotherapeutic process. The authors found a statistically significant reduction both in the intensity of PTSD symptomatology and the co-morbid symptomatology. These results were compared with the results of follow-up of the changes in identical symptomatology of internally displaced persons over a two-year period. The results from this quasi-control group reduced the possibility of attributing the reduction in psychopathological indicators of the treated group to spontaneous recovery or to the effect of other beneficial influences outside of treatment.

Smajkic et al. (2001) studied 32 Bosnian refugees at a mental health clinic receiving open trials of Sertraline (N=15), Paroxetine (N=12), or Venlafaxine (N=5). Sertraline and Paroxetine showed significant improvement at six weeks in PTSD symptom severity, depression, and Global Assessment of Function (GAF), while Venlafaxine did not improve depression and had high side effect rates. All 32 still had PTSD diagnoses at six weeks.

Salo et al. (2008) examined the role of individual and group treatment and self and other representations in predicting post-traumatic symptoms and growth among 115 former Palestinian political prisoners. Twenty participated in individual therapy and 19 in group therapy; 76 belonged to the control group. The results showed that post-traumatic symptoms decreased only in the individual therapy, whereas no decrease was found in group therapy or control groups across 1 year. Somatic symptoms decreased generally, whereas no general or treatment-related change was found in posttraumatic growth. As hypothesized, representations characterized by positive contents (benevolent, ambitious, and not punitive) predicted decrease in symptoms and increase in post-

traumatic growth. Furthermore, positive content and mature, differentiated, and not ambivalent structure of representations predicted decrease in posttraumatic symptoms and increase in posttraumatic growth in group therapy, but not in individual therapy. The role of cognitive-emotional reworking of interpersonal representations in trauma therapies is discussed.

Westermeyer (1988) studied a community sample of matched pairs of Hmong refugees who had major depression, 15 treated and 15 without treatment. The patient group had higher symptom levels prior to treatment and at follow-up reported fewer depressive symptoms than controls.

Symptom prevalence without intervention measured at >1 time

The importance of the following studies is to emphasize the long-term implications of failure to provide treatment for torture survivors and traumatized refugees. These include assessing depression and other mental health symptoms as well as general health in community samples, PTSD, depression, disability in refugees living in camps, psychological and social needs for asylum seekers and refugees, and PTSD in war refugees living in reception centres. These 15 studies measured symptom prevalence at more than one time period when no intervention was provided. These studies provide a view of the natural history of selected populations which did not receive treatment.

Beiser et al. (1993) and Beiser and Hou (2001) examined the risk-reducing effect of unemployment and the protective effect of language facility in a community sample of Southeast Asian refugees recently arrived in Canada. Three time frames (1993 study: two to four years; 2001 study: 10 years) were used. At the time of the first follow-up, comparing 319 Canadians at the first fol-

low-up with the sample, 608 of whom completed all three measurements (sample sizes 1,346, 1,169, and 647). Using the Canadian Refugee Resettlement Project symptoms inventory, prevalence of depression declined from 6.48% to 2.27%, unemployment rates declined, and English language proficiency increased over ten years.

Ekblad et al. (2000, 2002) charted psychological and social needs and constructed a model for care and support of newly-arrived asylum seekers and refugees. The authors studied 218 refugees from Kosovo in the Humanitarian Evacuation Programme a few months after their arrival in Sweden. At three months, 131 were assessed and 91 at six months using the HTQ, HSCL-25, GHQ, SOC-12, and AQ-RSV. Estimated levels of PTSD were similar at baseline and follow-up in this untreated population. Depression, anxiety and aggression (PTSD) were common in these post-migratory Kosovars.

Hauff and Vaglum (1995) studied the prevalence and course of mental disorders among Vietnamese refugees using a model including variables from different research traditions. A consecutive community cohort of 145 Vietnamese boat refugees aged 15 and older were personally interviewed upon their arrival in Norway and three years later. Unexpectedly, no decline in self-rated psychological distress (SCL-90-R) was found and almost 25% suffered from psychiatric disorder and 17.7% from depression (Present State Examination). Female gender, extreme traumatic stress in Vietnam, negative life events in Norway, lack of a close confidant, and chronic family separation were identified as predictors of psychopathology. The effects of war and persecution were long-lasting and compounded by adversity factors in exile. A uniform course of improvement in mental health after resettlement

cannot be expected in all contexts. The affected refugees need systematic rehabilitation. (See also Vaage et al., 2010)

Hinton et al. (1997) examined the impact of pre-migratory traumatic experiences and socio-demographic characteristics on future depression and compared the social patterning of depression in two ethnic groups. They used a stratified consecutive sample of Vietnamese and Chinese refugees from Vietnam (N=196) and followed up 114 between 12 and 18 months using the depression subscale of the HSCL-25. No change in depression scores was found, but older Vietnamese, single status, and pre-migratory veteran status at follow-up, and less proficiency in English at baseline were associated with depression.

Lie (2002) studied the changes in psychological symptoms and general health over three years as well as the impact of risk factors such as torture, trauma, and demographic status on distress and social function in 462 newly settled refugees, mainly Bosnians, in Norway. Using the HSCL-25, HTQ, PTSS-16, and GAF, 240 refugees showed unchanged symptoms of emotional distress, anxiety, depression, and psychological function, but an increase in PTSD. Pre-migratory life-threatening trauma and post-migratory unemployment, unresolved family reunion, and reduced social contact increased risk for elevated mental symptoms and lower levels of psychological function at follow-up. Analyses for predictors of changes in mental health over time were only significant for traumatic events in Norway.

Mollica et al. (2001) studied 1) associations between PTSD, depression, disability, baseline risk factors, and status at follow-up; 2) chronicity of psychiatric disorders and disability, and 3) the association between psychiatric disorders, disability, mortality, and emigration. Of a baseline sample of

534 Bosnian refugees initially interviewed in Croatian camps, the 376 followed-up at three years were administered the HTQ, HSCL-25, SF-20, and the WHO functional disability scale. The prevalence of PTSD, depression, and disability was still high, with 43% meeting DSM-IV criteria for depression, alone or co-morbid with PTSD, and 16% who were asymptomatic at baseline were symptomatic for psychiatric disorder on follow-up. Mortality was associated with male gender, older age, and social isolation.

Nygaard et al. (1995) studied the prevalence and course of PTSD among 150 Bosnian war refugees living in Norwegian reception centres. Of the 150 administered a PTSD checklist at baseline, 134 completed follow up at six months and one year. The number of participants with PTSD increased from baseline for first follow-up and then stayed high.

Sondergaard et al. (2001) investigated the perception of life events/conditions in relationship to the health of 86 Iraqi refugees recently resettled in Sweden. Questionnaires of life events and on-going difficulties, the SCID, CAPS, GHQ-28, HTQ, and IES were administered to 74 at baseline, 67 at three months, 57 at six months, and 53 at nine months. Positive mental health (GHQ-28) was associated with positive events outside Sweden, while negative health (GHQ-28) was associated with negative events within Sweden. Family reunion had a significant positive effect on self-rated health for those with PTSD.

Vaage et al. (2010) found that there is no long-term prospective study (>20 years) of the mental health of any refugee group. To investigate the long-term course and predictors of psychological distress among Vietnamese refugees in Norway, eighty Vietnamese, 57% of an original cohort interviewed in 1982 (T1) and 1985 (T2), com-

pleted a self-report questionnaire prior to a semi-structured interview. Mental health was measured using the Symptom Checklist-90-Revised (SCL-90-R). The SCL-90-R mean Global Severity Index (GSI) decreased significantly from T1 to T3 (2005–6), but there was no significant change in the percentage reaching threshold scores (GSI = 1.00). Trauma-related mental disorder on arrival and the trajectory of symptoms over the first three years of resettlement predicted mental health after 23 years. Although the self-reported psychological distress decreased significantly over time, a substantially higher proportion of the refugee group still reached threshold scores after 23 years of resettlement compared with the Norwegian population. The data suggest that refugees reaching threshold scores on measures such as the SCL-90-R soon after arrival warrant comprehensive clinical assessment. (See also Hauff and Vaglum, 1995).

Westermeyer et al. (1984, 1989, 1990, 1997) studied 97 of 102 Hmong refugees in Minnesota older than 16 years in 1977 and approximately 89 on follow-up at two and five to seven years using the Zung Depression Scale and the SCL-90. Zung depression scores decreased a first follow-up, then increased. SCL-90 scores increased in those with normal or borderline scores at baseline, but decreased for those with elevated scores at baseline. The largest change occurred at first follow-up, no change at second follow-up, but overall trend in SCL-90 subscale scores was improvement.

These studies evaluated: multidisciplinary and short-term multidisciplinary treatment; psychotherapy; psychiatric treatment – outpatient, pharmacology; psychotherapy versus medication; selective serotonergic re-uptake inhibitor (SSRI) treatment; outpatient psychopharmacology treatment for refugees; outpatient PTSD treatment;

**Table 2.** Number of outcome studies by research design

	Torture Survivors	Traumatized Refugees
Descriptive	2	4
Experimental	0	0
Quasi-Experimental Pretest-Posttest		
1 Group	16	21
> 1 Group Randomized	0	6
> 1 Group Non-Randomized	2	10
Qualitative		
Ethnography	1	0

culturally sensitive treatment for PTSD; cognitive-emotional reworking of interpersonal representations; psycho-educational treatment; testimony; method/therapy/psychotherapy; brief psychotherapy; narrative exposure therapy; integrative gestalt treatment; Qigong and T'ai Chi practice; Cognitive Behavioral Therapy (CBT) and CBT groups; culturally adapted CBT; belief systems model; psychosocial rehabilitation/treatment; thought field treatment; community intervention; health realization; somatic care; physiotherapy; home visit interventions; and empowerment workshops.

### Examples Of Instruments Available

The selection of instruments to use is complicated. Dymi (2002) identified 88 potential instruments in domains of outcome (Appendix 7, pp. 49-50) selected from the text by McDowell and Newell (1996).

Fabiansen (2001), in research done at IRCT to identify instruments for use in a quantitative impact assessment, recommended the Harvard Trauma Questionnaire (HTQ) to measure PTSD in combination

with the Short Form-36 Health Survey (SF-36) to measure quality of life.

Unfortunately, cross-cultural validation is rare. Scales and questionnaires are sometimes translated and back-translated into additional languages but there is no current compendium of the change in status. Since most can be accessed by typing the name of the questionnaire or scale using a search engine for the worldwide web, this may be the best way to get the latest information.

The following are examples of instruments which have been selected for use in research.

#### Symptom Checklists

- Hopkins SCL-25 (anxiety and depression)—translated into more than 30 languages with good psychometric properties
- SCL-90
- SCL-110
- Health Symptom Checklist (HSC)
- Symptoms Identification Scales (BASIS 32)

NOTE: Self-rating scales are problematic because of high illiteracy rates and lack of data from clinical observation.

#### PTSD Structured

- 1) Clinician-Administered PTSD Scale (CAPS) is the most frequently used by mental health professionals to evaluate development of PTSD and complex PTSD symptoms even after repeated events.
- 2) Watson PTSD Interview

NOTE: Clinician-administered scales are labor intensive and difficult to do in busy clinics.

*PTSD Rating scales*

- 1) Harvard Trauma Questionnaire (HTQ) includes exposure to events, brain trauma, general posttraumatic symptoms, and associated symptoms (complex PTSD) and has cut-off score for DSM criteria, translated into more than 30 languages with good psychometric properties.
- 2) Impact of Events Scale (IES)
- 3) Mississippi Combat Scale
- 4) Posttraumatic Stress Checklist-Civilian Version (PCL-C) is a self-report Likert scale with 17 items and has shown high internal consistency and reliability as well as a strong correlation with PTSD diagnosis using the CAPS
- 5) Many Others

NOTE potential problems: Cut-off scores vary by ethnic and patient group; Scoring for DSM-IV criteria (X symptoms from symptom group Y must be present – this might result in a negative or distorted finding, e.g., if avoidance is predominant, intrusion criteria might only be fulfilled later when the survivor is confronted with triggers; cultural and linguistic factors make a difference).

*Anxiety Rating Scales*

- 1) Hopkins Symptom Checklist, Anxiety Scale (HSCL-25) is short, well-validated, and translated into many languages.
- 2) Spielberger's State-trait Anxiety Inventory
- 3) Hospital Anxiety and Depression Scale (HADS)
- 4) Anxiety disorder module of the Structured Clinical Interview for DSM-IV (SCID)

*Screening Scales For Use In Primary Care Settings*

- 1) Index of Psychological Distress of Santé Québec (IDPESQ)

- 2) Prime-MD

- 3) Self-Report Questionnaire (SRQ-20)

*Depression Rating Scales*

- 1) Hopkins Symptom Checklist, Depression Scale (HSCL-25) is short, well-validated, translated into many languages, and is the best documented in torture survivors
- 2) Zung Self-Rating Depression Scale
- 3) Hamilton Depression Scale (HDS)
- 4) Beck Depression Inventory (BDI)
- 5) Hospital Anxiety and Depression Scale (HADS)

NOTE: For the above scales, a distortion of results by items based on somatic symptoms is possible and could reflect physical injury sequelae (e.g., BDI), but less prominent in the HADS. Overlap is high with brain trauma and posttraumatic stress symptoms.

- 6) Mood disorder module of the SCID

*Depression Screening Scales*

- 1) Index of Psychological Distress of Santé Québec (IDPESQ) is useful screening
- 2) Prime-MD did not adequately distinguish affective disorders when compared with the gold standard of clinician diagnosis.
- 3) Vietnamese Depression Scale (VDS) – Kinzie et al.

*Cognitive Testing*

- Mini Mental Status Exam (MMSE) is a very western ethnocentric 30-point scale. Attempts have been made to develop a shorter scale that is more culture-free. Westermeyer, Jaranson et al. developed a 13-point scale that is relatively culture-free but is neither validated nor translated into languages other than English.

*Quality of Life*

- 1) World Health Organization Quality of Life (WHOQOL-Bref, 26-Item Measure)

- 2) Quality of Life Inventory (QOLI-B) Occupation/work (level of function)

#### *Coping/Resilience*

- Minnesota International Coping Scale (MICS)—Developed by Johnson et al., Refugee Population Study, University of Minnesota

#### *Social Support*

- Duke-UNC Social Support

#### *Client Satisfaction*

- 1) Client Satisfaction Questionnaire (CSQ-8)
- 2) Sheehan Treatment Experiences and Expectancies (2-Item Measure)
- 3) Client Access to Services Questionnaire (CAS-Q)

#### *Family Function*

- 1) Sheehan
- 2) “Families in Transition” questionnaire developed by Robertson et al. of the Refugee Population Study at the University of Minnesota

#### *Diagnosis*

Structured and Semi-Structured Clinical Interviews offer a reproducible standard with good test-retest reliability. The following have been validated in many languages and are seen as “gold standards” for diagnosis, including PTSD.

- 1) Structured Clinical Interview for DSM-IV (SCID), for use by experienced raters.
- 2) Composite International Diagnostic Interview (CIDI) uses ICD-10 and DSM-IV classification systems—administered by non-professional raters.
- 3) Schedules for Clinical Assessment in Neuropsychiatry (SCAN), based on the Present State Exam (PSE) using ICD-10

and DSM-IV classification systems—administered only by trained clinicians.

NOTE: There are still problems with diagnostic assessment tools, as has been shown in minor changes leading to major variations in prevalence shown by epidemiological surveys. This has important implications for assessing services needs.

#### *Trauma History*

- 1) Harvard Trauma Questionnaire (HTQ)
- 2) Trauma Symptom Inventory (TSI)

#### *Occupation/work (Level Of Function)*

- 1) Short Form (SF-36, SF-12)
- 2) Functional Impairment Scale – Medical (FIS-M), to assess the extent to which major medical conditions interfere with functioning
- 3) Functional Impairment Scale – Psychiatric (FIS-P), to assess the extent to which PTSD symptoms interfere with functioning

NOTE: The FIS scales were developed by Johnson et al. of the Refugee Population Study at the University of Minnesota

- 4) Life Skills Profile (LSP)
- 5) Role Function Scales (RFS)
- 6) Global Assessment of Function (GAF)
- 7) Sheehan Disability Scale
- 8) International Classification of Functioning, Disability and Health (ICF), (complementary with the ICD diagnostic system). This important instrument is discussed in some detail below:

The ICF is a classification, developed by WHO, which describes health and associated conditions in terms of functioning instead of symptoms or diagnosis. Therefore, the ICF can be applied to either healthy or disabled persons.

The application of the ICF at the individual level can help assess a person's level of function, plan interventions to maximize his/her functioning, evaluate the outcomes of an intervention, and self-evaluate capacity for mobility or communication. At the institutional level, the ICF can help in education and training, for resource planning and development, for quality improvement, and for management and outcome evaluation. At the social level, the ICF can help document eligibility criteria for state or social benefits, affect social policy development such as legislation, regulations, guidelines, or needs assessments, or, in environmental assessment, changes in social policy, economic analysis, and research.

The ICF uses a bio-psycho-social model where the bodily functions, activities and participation of an individual are related to his/her health conditions, personal, and environmental factors.

Of the multiple body functions described in ICF, the most important for the study of torture victims are the mental functions.

ICF defines activity as the execution of a task by an individual and participation as the involvement in a life situation. Both activity and participation have limitations. Activity limitations are the difficulties an individual may have in executing activities and participant restrictions are the problems that an individual may experience in his/her involvement in life situations.

The activities and participation are measured in a qualifiers scale of five grades: In Grade 1 the person is normal without any limitations, in Grade 2 the person has mild, Grade 3 moderate, Grade 4 severe limitations, and Grade 5 complete limitation or disability (World Health Organization, 2001).

#### *Instruments Used By Centres*

Although now dated, Dymi (2002, p. 51) catalogued the instruments used by IRCT

centres in Table 3 next page (minor copypredits by JMJ):

To assess anxiety and depression we recommend the Hopkins Symptom Checklist 25 (HSCL-25), which has been translated into more than thirty languages, has good psychometric properties, and is relatively simple to administer. Very few instruments can claim this widespread use, and consequently the results can be compared with other studies. The Harvard Trauma Scale (HTQ) has similar claims for the assessment of PTSD. Another useful PTSD rating scale is the Posttraumatic Stress Checklist-Civilian Version (PCL-C), which has 17 items based upon the DSM criteria for PTSD, and has shown high internal consistency and reliability. These instruments can be used for the client to self-report, but are sometimes administered by clinicians for survivors who are illiterate or when the scales are not translated into their languages.

For scales that must be used by the clinician rather than self-administered, we recommend the Clinician-Administered PTSD Scale (CAPS), which is highly correlated with the self-administered PCL-C.

For cognitive testing, the Mini Mental Status Exam (MMSE) is about the only instrument available, but it has severe limitations when used cross-culturally.

For quality of life, the short version of the World Health Organization Quality of Life (WHOQOL-Bref) inventory has 26 items and has been used in many countries.

For programmes that do not wish to develop their own client satisfaction surveys, we recommend an 8-item instrument, the Client Satisfaction Questionnaire (CSQ-8).

For trauma history, the HTQ is recommended.

To assess level of function, we recommend the Short Form 12-item (SF-12) or the SF-36, the Global Assessment of Function (GAF), or the more complicated

**Table 3.** *Health Measuring Instruments and databases actually being used by various Centres for Rehabilitation of Torture Victims (incomplete data from a workshop in CPH 26 October 2001)*

Names of Instrument	Acronym	What it is used for	Centre/Country
1. The Self-Reporting Questionnaire	SRQ-20	Measure physical, psychological and psychiatric status/symptoms and depression	Calabar, West Africa
2. The PTSD Questionnaire for Adults (Watson 1991) (ref. From Libby T. Arcel's book)	DSM-III-R	Measure of PTSD	Eastern Europe
3. Harvard trauma questionnaire (version both in Chinese and in English), developed by the Indochinese Psychiatry Clinic, Brighton Marine Public Health Center and the Harvard Program in Refugee Trauma and Management, Lotus Foundation c 1991 Richard F Mollica MD	HTQ	Measure of PTSD	Chinese speaking refugee groups
4. (Simple data tables ... Instrument used?)			RESTART Center Tripoli Lebanon
5. Medical Assessment Sheet Used for refugees by UNHCR?		Measure physical, psychological and psychiatric status/symptoms and depression	Amman?
6. P.A.T. Client Registration/Referral Form		Measure physical, psychological and psychiatric status/symptoms and depression	Kampuchea
7. Rehabilitation (Types of torture documented in CVICT in 2000) Data on torture survivors provided services, in Nepal		Measure physical, psychological and psychiatric status/symptoms and depression	CVICT Nepal
8. Confidential Card for Client monitoring programme at CVICT in Nepal		Measure physical, psychological and psychiatric status/symptoms and depression	CVICT Nepal
9. The Self-Reporting Questionnaire (developed by WHO) Available in Arabic, French, Hindi, Portuguese, Somali and Spanish.	SRQ	Measure general psychological Distress	?
10. The Self-Reporting Questionnaire English and Ndebele version	SRQ-8		?
11. Hamilton Depression Scale (Hamilton 1960)	DSM-III	Measure depression	?
12. Impact of Events Scale 8 Item Child/adolescent Scale (IES-8)	IES	Measure of PTSD Measure of stress response syndromes, PTSD	?
13. Impact of Events Scale (15 questions – Michael O'Sullivan)	IES	Measure progress with private clients	?
14. The Social Adjustment Scale – Self-Report	SAS-SR		

International Classification of Functioning, Disability and Health (ICF).

### Recommendations For The Future

Nickerson et al. (2011) emphasize the necessity of developing an evidence base using a multi-stage evaluation process which establishes the efficacy of an intervention, then its impact, and finally develops implementation models. These authors warn that failing to systematically evaluate programs will result in “the stagnation of knowledge and entrenchment of practices, some of which may be without demonstrated efficacy.”

Outcome research in torture is challenging, but it is still possible to conduct valid research. When torture treatment centres conclude that is not possible to use random control groups, then the only option is to use quasi-experimental designs.

The few published studies have most frequently used a pre-post evaluation with one or more groups to measure the efficacy of the therapeutic intervention. For those studies with comparison groups, few are randomly selected, most are non-random. These latter designs permit inferences of the benefits of the study groups.

Several studies have shown that there is significant variation among centers located in the countries where torture is practiced compared with host country centres that receive refugees and asylum seekers. In the host countries, the treated population is usually much more heterogeneous than in those countries where torture occurs. The chosen therapeutic intervention can threaten the internal validity of a research design. It is very important in the design of a pre-post outcome study to include features intended to control threats to internal validity. In host countries, those of final resettlement, the effect of receiving asylum is perhaps the most important confounding factor.

Before selecting the best instrument and research design, each center should analyze the population receiving care in their programme, the types of treatment delivered, and the outcomes they want to measure.

Perhaps most importantly, centres must start collecting data. Even if only descriptive or demographic data is available, this data should be collected. Eventually programme evaluation can develop into outcome of treatment efficacy and, finally, the impact of the programme.

How can we possibly do research that is scientifically excellent? When developing an outcome study, it is important to remember a caveat by Voltaire: “The best is the enemy of the good.” Even if you can’t do an evaluation that meets all of the scientific criteria for perfection, please start doing something.

### Acronyms

*NCTTP* National Consortium of Torture Treatment Programs  
*NPCT* National Partnership for Community Training  
*NCB* National Capacity Building Project  
*IRCT* International Rehabilitation Council for Torture Victims  
*ISHHR* International Society for Health and Human Rights  
*ORR* Office of Refugee Resettlement  
*EU* European Union  
*WHO* World Health Organization  
*ICD* International Classification of Diseases (by WHO)  
*DSM* Diagnostic and Statistical Manual (by the American Psychiatric Association)

### Website resources

*National Capacity Building Project (NCB), Center for Victims of Torture (CVT)*  
[www.cvt.org](http://www.cvt.org), a technical resource funded by ORR conducts trainings on development, use, and interpretation of outcome

performance measurements and indicators and has developed a Performance Measurement Evaluation toolkit (<http://www.healtorture.org>). On this website there are four archived webinars on technical aspects of performance measurement and other related resources for programmes for torture survivors. The NCB has created and reorganized the Organizational Self-Assessment Matrix with 28 capacity-building dimensions in seven major categories. Completing this matrix is required, along with a technical assistance plan, for the sub-grants offered to support the capacity-building activities of programmes. Training institutes are also provided each year and educational webinars are offered monthly. Other activities and resources can be found on the websites.

*The National Partnership for Community Training (NPCT)*

[www.acf.hhs.gov](http://www.acf.hhs.gov), funded by ORR, is operated by Gulf Coast Jewish Family Services and its partners, the Majorie Kovler Center for the Treatment of Survivors of Torture, and the Harvard Program in Refugee Trauma. They surveyed federally-funded treatment programmes and member programmes of the NCTTP to document the best, promising, and emerging practices and evaluation methods. Nineteen respondents started the online survey and 12 completed it, providing contact information for follow-up interviews. The partnership identified the following types of studies to assess torture rehabilitation services:

*Anecdotal* – An assessment using observations and accounts from program staff, survivors and providers;

*Pre-Service Assessment* – A means of assessing existing conditions before or during engagement in programme activities;

*Pre/Post-Service Assessment* – A means of assessing conditions prior to and immediately following engaging in programme activities;

*Qualitative Documentation* – A standard assessment using standardized methodology through narratives, quotes, statements etc.;

*Quantitative Documentation* – A standard assessment using numbers and quantities;

*Randomized Control Trial* – A study design in which patients/clients with similar demographic characteristics are randomly assigned to either a treatment group or a control group. Both groups receive the same baseline services, but the patients/clients in the treatment group receive an additional service and the control group does not receive this additional service. This additional service is being studied.

Key themes in the narratives included multidisciplinary approaches, culturally appropriate and competent services, holistic, integrated services, and strength-based services. Respondents reported providing 38 services or practices each with 66% evaluated. Pre-post service assessments were the most common and case management and community training were the frequently evaluated. No RCTs were conducted.

The project has finished a compilation of the evidence-based literature about best, promising and merging practices in the torture treatment field with the goal of increasing the capacity for centres to provide effective treatment to survivors of torture. This document, entitled “Best, promising, and emerging practices: a compendium for providers working with survivors of torture”, has been published as a thematic issue of the Torture Journal.

*The National Consortium for Torture Treatment Programs (NCTTP)*

www.ncttp.org has collected five or six demographic data points since 2004. Recently, this group has increased its efforts to make it possible for all 34 centres members of the NCTTP to contribute to this effort and has expanded the scope to collect approximately 20 data points. At this stage, the effort is descriptive but the goal is to move towards multi-center outcome research.

Amnesty International (Health@amnesty.org) publishes an online Bulletin Report, Amnesty International News for Health Professionals, sent gratis to those who request it. This Report includes Amnesty reports, statements and news articles not only on Torture but also on Children, the Death Penalty, Health Workers, Mental Health, Prisons and Detention Centres, Sexual Violence, Transmissible Diseases, and Water and Sanitation. Relevant conferences/courses and publications are cited. Send an email to health@amnesty.org in order to be provided with contact details.

The International Society for Health and Human Rights (www.ishhr.com) is an association for health workers who help those affected by human rights violations that aims to gather knowledge about the effects of human rights violations, exchange experiences and information about treatment methods, and contribute to the development of psychosocial interventions on the individual and community levels. Members live in almost 50 countries. The website is a valuable resource for papers, video presentations, training materials for health workers, as well as materials aimed at assisting victims of human rights violations and dealing with community reconstruction and disaster relief.

The International Rehabilitation Council (IRCT) (www.irct.org), an umbrella for more than 140 independent torture treat-

ment organizations in over 70 countries, has an on-line newsletter, links to other organizations with similar interests, and other relevant information. Issues of the Torture Journal, published by the IRCT, are available for review or articles can be downloaded.

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# Torture rehabilitation: Reflections on treatment outcome studies

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‘Evaluating the Services of Torture Rehabilitation Programmes: History and Recommendations’ by James Jaranson and José Quiroga is the third updated version of a desk study review of the scientific literature on rehabilitation of torture survivors world-wide<sup>1</sup>. The first desk-study was published in *Torture Journal* in 2001<sup>2</sup> and the second updated and expanded version in 2005.<sup>3</sup> This most recent, and timely, desk-study was presented at the IRCT scientific conference in December 2010: ‘25 years of torture healing. Are we ready to assess outcomes?’

The authors should be greatly commended for their persistent and meticulous endeavours in exploring and documenting the evidence base within this area. In this article we offer our own reflections, as presented during the conference firstly, on the evidence presented by Jaranson and Quiroga, and some gaps; and secondly, outlining what we consider to be some of the challenges we all face in developing the evidence base for the rehabilitation of torture survivors.

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## The evidence

As Jaranson and Quiroga document and conclude in their review, the evidence for effects of torture rehabilitation world-wide is relatively scarce<sup>1</sup>. As with all desk-studies, there are likely to be some omissions, partly influenced by the inclusion and exclusion criteria adopted, and some limitations. In this review, one limitation is the almost exclusive focus on mental health problems reported by adult survivors of torture and organized violence. This is poignant as many torture survivors have a multi-faceted presentation of somatic, psychological and social problems,<sup>4</sup> as well as other difficulties impacting on their health and well-being. Jaranson and Quiroga’s review does consider one study specifically focused on somatic indicators, though other relevant studies are omitted.<sup>1,5-7</sup> Similarly, there is consideration of one study of rehabilitation of refugee or asylum-seeking children, and many others omitted (for example, see Peltonen and Punamäki, for a review on interventions with children exposed to armed conflict).<sup>8</sup>

Whilst an exclusive focus on specific problems experienced by torture survivors risks being overly narrow and neglecting the full range of torture survivors’ health experiences, such studies can contribute to the evidence base. For example, in one systematic review of treatments for Post-Traumatic Stress Disorder (PTSD) among refugees and

asylum-seekers,<sup>9</sup> 2010) ten randomized controlled trials (RCTs) of treatments for PTSD among refugees and asylum-seekers with altogether 528 participants were identified. The trials, however, were small, and allocation concealment and blinding were inadequate. No treatment was firmly supported, but there was evidence for Narrative Exposure Therapy (NET) and Cognitive-Behavioural Therapy (CBT). The authors suggest that future trials should evaluate interventions that are developed within the cultural context of refugees, based on a local understanding of trauma and psychological distress. In a recent (as yet unpublished) randomised study of testimonial therapy with Sri Lankan torture survivors<sup>10</sup> such an approach showed promising results, although more studies are necessary with different groups.

In December 2008 an international conference “Rehabilitating Torture Survivors” was organized by RCT and the Centre for Transcultural Psychiatry in Copenhagen.<sup>4</sup> In recognition of the limited numbers of randomized controlled trials of torture survivor rehabilitation, the general consensus at the conference was that trauma-focused cognitive-behavioural therapy or Eye Movement Desensitization and Reprocessing (EMDR), as well as interdisciplinary pain rehabilitation, should be components of rehabilitation programmes to address some of the common difficulties experienced by torture survivors. Furthermore, greater attention to contextual aspects, in which the facilitation of social integration and family relationships are crucial, was considered essential to positive health outcomes.

### **Why is evidence limited?**

There are many reasons why evidence is limited in this field. As with all areas of health and well-being, the development of the evidence base is continual, and studies

continue to be refined in methodology and focus, with the pace of such development being dependent on many factors, not least theoretical, methodological, contextual, financial and other reasons. With respect to this field, it is important to bear in mind that torture rehabilitation evolved as a movement, arising within a particular political, legal and historical context, only commencing about 30 years ago and thus, compared to many other areas in medicine and psychology, this field is relatively young.

Torture rehabilitation was initiated and carried out mainly by health professionals working in human rights organizations, and to date these services remain largely apart from mainstream healthcare provision. More recently, some countries in Europe, including Denmark, have made efforts to integrate such services into mainstream health services. The political and financial context in which many of these services exist is crucial to acknowledge, particularly the struggles they face for survival whilst simultaneously endeavouring to offer quality, highly complex, multidisciplinary and multi-component services to torture survivors facing a multitude of legal, social, welfare and health-related problems in a climate hostile to asylum seekers and refugees.

Many of the organisations offering rehabilitation services to torture survivors thus face a constant fight for resources and acknowledgement, with staff under immense pressure to focus on what many perceive as their core, if not primary, task – providing treatment and care. Hence, whilst outcome research is valued and recognised as crucial to the delivery of quality services, it is not seen as a priority. For some, research is viewed with deep suspicion, and dismissed, based on views that research can be harmful, that it diverts valuable, and scarce financial resources away from direct client care, and

that research on torture victims is generally unethical. Not surprisingly, research in this field has been difficult to implement, and together with methodological and theoretical complexities, and resource constraints, the development of the evidence base has been gradual and some would argue, slow.

### **The challenges**

Despite these complexities, there is an increasing commitment by practitioners, researchers and service managers to developing research on treatment/rehabilitation outcomes, whilst also recognising that there remain some serious challenges. Some of these conceptual, context-related and methodological challenges to developing the evidence base for torture rehabilitation are outlined below.

### **Conceptual/theoretical challenges**

In a field driven initially by the overwhelming need for services for torture survivors within human rights organizations, it is understandable that the development of theoretical models for rehabilitation programmes was not a priority. Whilst there have been many important theoretical contributions over the years, a lack of clarity persists, and consensus on how rehabilitation is conceptualized, what the intended outcomes of rehabilitation are and why, and which differences may be dependent on diverse country contexts (e.g. economic, political, cultural). Not surprisingly, many creative interventions have spontaneously arisen and evolved in different country settings, with many rehabilitation programmes combining multiple methods drawing on different disciplinary traditions, diverse activities, treatments, philosophies and theories. Some focus on adults only, others also on children, young people, families and communities affected by torture and organized violence. Rehabilitation activi-

ties have also included advocacy at individual and policy levels. In short, the diversity in rehabilitation approaches and programme components (as well as their particular mix and emphasis, notwithstanding the diversity in the nature and levels of competencies of practitioners) poses an important research challenge. The question is, can different programmes ever be comparable, and study results ever be generalisable, and how valid and relevant would such an approach to research be, given that there are enduring controversies in the field about what rehabilitation is and its theoretical underpinnings and what are desired outcomes, let alone which of them are measurable?

### **Context-related challenges**

Where outcome research is carried out, it is often not only under enormous resource constraints, but also faced with the challenge of addressing the somewhat unique social, legal and cultural context in which torture survivors present for health and other related services and the complexity of the interventions (invariably involving multiple interventions offered simultaneously, specific to each client/family). Importantly, diversity in torture survivors and their experiences is a reality: torture survivors have varying cultural, ethnic, religious, political and linguistic backgrounds. Their experiences of torture and their specific context vary, as do their experiences subsequently – for many seeking asylum, common experiences include hostility, discrimination, homelessness, poverty and a hostile asylum determination process. For others, torture is followed by attempts at survival, and a search for justice, or access to justice, whilst still living in insecure conflict, post-conflict or transitional states. The complexity of this diversity poses a challenge to outcome research and it is to be considered sensitively and respectfully in research,

not to be treated as an inconvenience, or hindrance to be overlooked, or ignored or overly-simplified in research efforts.

### Methodological challenges

There are also many methodological challenges to developing the evidence base, only some of which are highlighted here. The first challenge is to understand the discrepancy between the clinical impression (e.g. that therapy is beneficial, clients do seem to improve in various ways) and the often rather limited improvements that can be identified in scientific studies.<sup>11</sup> This discrepancy can present a barrier to outcome research in the absence of co-operation and sustained dialogue between clinicians and researchers within the area.

The second challenge is that there remain conflicting views on the question of how to approach the issue of randomisation, highly relevant to particular types of studies (e.g. RCTs) and particular research methodologies. Is it unethical to randomise traumatized refugees to different types of treatment or even to no treatment, or is it rather un-ethical not to conduct effect studies since the evidence is lacking or unclear?

The third challenge relates to the selection of appropriate outcome indicators. Most studies commonly use symptoms and diagnoses. A specific problem related to this is what can be termed the 'ceiling effect'. If the symptom level reported by a client is so high that it reaches the maximum level of symptom severity, for example when completing a specific measure, it would be difficult to measure improvement. The client might report that they felt better, or improved after therapy, but their reporting might still reach the maximum level of symptom severity on the outcome measures. A more appropriate approach could be to use functioning, rather than symptom level in studies of torture

victims.<sup>12</sup> Both functioning and quality of life, could be not only more relevant but essential to explore among people with multiple problems of long duration, as is the case with many torture survivors.

The last challenge that deserves attention is the question of whether or not the health effects of exposure to torture are chronic. If the health effects are chronic, how do we measure improvement? Studies using the same interventions show different results, so a related question is whether torture effects can be chronic in some contexts and not in others. And since the effects of torture are multiple, we would need to know which effects are possible to ameliorate, under which conditions, and which are unlikely to show change despite any health interventions.

### The future

In reflecting on a way forward there are many questions which arise for us, perhaps possible avenues for future joint efforts. For example:

- Can there ever be a shared conceptualisation of what rehabilitation for torture survivors is, and what it aims to change?
- Is there a possibility that we can arrive at a minimum set of shared desired outcomes in this field?
- Must there be only one approach to outcome evaluation, drawing on only particular epistemologies and research methods from natural sciences, or can we encourage and value a range of epistemologies and methodologies (including mixed methods), and therefore what we value as 'evidence'?

Jaranson and Quiroga wisely warn us not to be deterred by the complexities and challenges in conducting outcome research with torture survivors, and suggest that: "Perhaps

most important, centres must start collecting data. Even if only descriptive or demographic data is available, this data should be collected. Eventually program evaluation can develop into outcome of treatment efficacy and, finally, the impact of the program". In this sense, at the very least, we should all aim to start somewhere, and this may mean working with what we have, and what we are able to do in our unique country settings, and with the available resources and skills. Pooling together our efforts, wherever possible, would enhance our work, facilitate mutual learning and provide support to practitioners and researchers across centres or services for torture survivors. However, starting somewhere may also require that there be a shift in organizational culture to enable data collection and research, including outcome evaluation, so that traditional divisions and suspicions can be minimized, and there can be shared ownership within and across organizations/centres in seeing research as essential to developing context-relevant, culturally-appropriate and effective rehabilitation services.

In addressing their own question 'how can it be possible to do research that is scientifically excellent?', Jaranson and Quiroga quote Voltaire: "The best is the enemy of the good", as encouragement to conduct more research, and not to be deterred by the various challenges. Whilst this is a sentiment we sympathise with, we would advocate that this should not be an excuse for conducting less than rigorous research. Research in this field should aim to be relevant to the very complex social, cultural, political and legal context in which torture survivors live, access and utilize healthcare and other rehabilitation services, and it should be ethical and genuinely respectful towards those whose lives we hope to help improve. In this regard, we must not lose sight of the

primary reason why we are striving for a better evidence base – to ensure that we provide access to the highest quality of care and rehabilitation to torture survivors, which is their right, not a privilege.

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