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The IRCT Impact Assessment Study (I-V)

Phase I:
Outcome of torture rehabilitation at specialised centres from the clients' and the health professionals' perspective

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INTRODUCTION AND "POINT OF DEPARTURE" FOR THE STUDY

Developments in the understanding of torture and its consequences, in rehabilitation approaches and in the relation between rehabilitation and prevention have led to a significant broadening of the efforts, skills and methodologies needed for what is now increasingly labelled reparation of torture victims. The concept of *reparation* includes medical and psychosocial rehabilitation of the individual, including rehabilitation as societal and political actor. It also includes public recognition of the criminal atrocity committed – and, eventually, punishment of the perpetrators.

At the level of the community break down of social, political and economical networks are recognised as being consequences of torture and organised violence, afflicting dynamic relationships between individuals and the community impeding trauma recovery.

Most rehabilitation centres and programmes have therefore adopted multidisciplinary approaches, linking traditional rehabilitation of individuals and interventions provided at the community level, to the legal and political aspects of torture and are additionally engaged in medico-legal documentation, prevention and advocacy activities.

As of to day, most of the published literature on the consequences of torture and on services provided to torture victims is descriptive. Only few outcome studies exist and these studies have limitations due to the lack of definition of diagnostic criteria; theoretical framework for problem identification and understanding, goal setting in therapy and provided interventions; validation of assessment instruments and identification of relevant outcome indicators.

In a desk study summarising "the scientific state of the art" within torture rehabilitation Gurr & Quiroga[1] point out that knowledge is missing in several areas.

The implications of this lack of knowledge and the resulting lack of scientific evidence within the work field are that no clear and scientifically valid recommendations on the organisation and functioning of rehabilitation services and the interventions they offer in different environments can be put forward. The complexity of contributing factors and the lack of controlled studies mean that decisions have to be made based on simpler evaluation methods and professional judgement.

Establishment of theoretical frameworks based on health, social and political science and linkage of theory with practise within reparation of individual torture victims and within interventions provided at the community level is therefore needed in order to develop the work field.

The IRCT has drafted a long-term research strategy based on a global multi-centre study design. The research strategy comprises 5 phases, which are to be conducted within a time framework of 5 to 6 years (Fig. 1).

The main objective of the overall study is to assess *if* and *how* rehabilitation at specialised centres provided in different socio-cultural settings improves the well-being of victims of torture, and based on the achieved knowledge to establish empirically founded "best practise guidelines" for the future clinical work.

Additional outputs will be the identification of outcome indicators, which can be used in outcome monitoring at centres worldwide, and development of instruments to be used in intercultural outcome research.

The first phase – a combined qualitative-quantitative, *exploratory study* has been conducted in collaboration with IRCT affiliated rehabilitation centres in Indonesia, Bosnia, Kenya and Guatemala in the year 2002. A report, based on the results of the study, has been elaborated and will be accounted for in this paper.

Measurement of health and treatment outcome in general health care

Measurement of health and outcome of treatment are in general very complex and the scientific approach – the design of the study, the methodology, the choice of measuring instruments and outcome parameters – implicate a series of conceptual and methodological issues that need to be addressed.

Measurement of health

In order to measure health outcome a measure of health status is required, which in turn must be based on a concept of health.

Acceptable definitions of health have been changing throughout history. The past 150 years have led to a shift away from viewing health in terms of survival, through a phase of defining it in terms of absence from disease, onward to an emphasis on positive themes of happiness, social and emotional well-being and quality of life.

There is now broad agreement that the concept of positive health is more than mere absence of disease or disability and implies "completeness" and "full functioning" or "efficiency" of mind and body as well as social adjustment. Beyond this there is not one accepted definition[2].

Following this broad definition assessment of health status becomes a complex task. Health is to be seen as a construct, which cannot be measured directly. The overall concept of health or change in health status must therefore be measured through a number of indicators defined within the various domains of health.

Additionally there are multiple influences upon patient outcome, which also require a broad model of health. The non-biological factors that can affect recovery and outcome include patient psychology, motivation and adherence to therapy, coping strategies, socio-economic status, availability of health care, social support networks and individual and cultural beliefs and behaviours.

Based on the above mentioned, it is increasingly recognised that measures of "social health" and "quality of life" measures should be included when evaluating health care interventions.

The concept of "social health" in measurement of health

Donald C et al[3] have called a broader view of health than the reporting of symptoms, illness and functional ability "social health". They conceptualised social health both as a component of health-status outcomes and, in terms of social support systems that might intervene and modify the effect of the environment and life stress events on physical and mental health. Measurement of social health focuses on the individual and is defined in terms of interpersonal interactions and social participation.

Other authors have also conceptualised social health as a separate component of health status, defining it in terms of the degree to which people function adequately as members of the community[4, 5].

Lerner[6] noted that health status may be a function of non-health factors external to the individual, such as the environment, the community and significant social groups and recommended that social well-being measures focus on constructs such as role-related coping, family health and social participation. He hypothesised that socially healthy persons would be more able to cope successfully with day-to-day challenges arising from performance of major social roles;

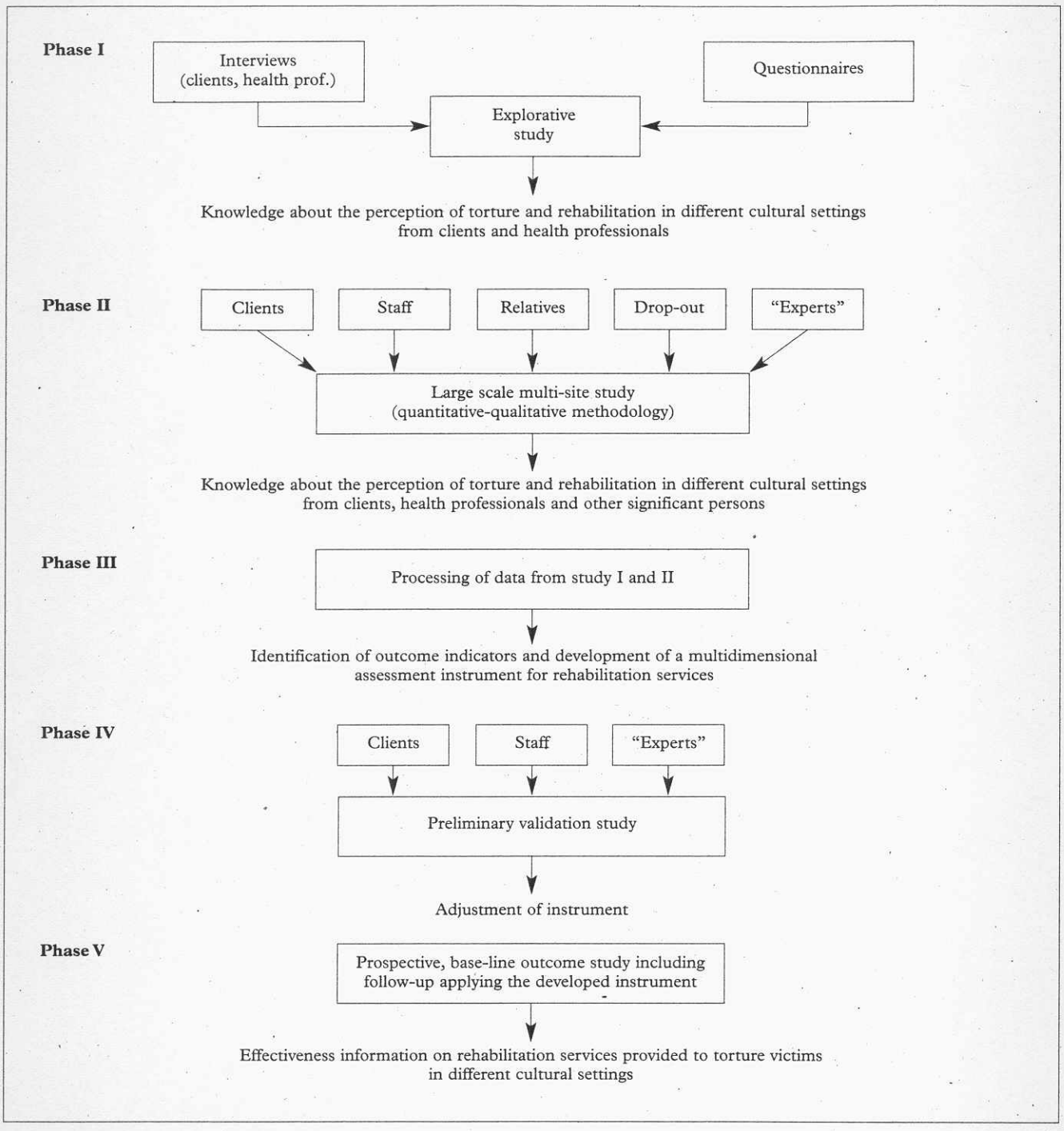

Fig. 1. *The IRCT impact assessment study.*

would live in families that are more stable, integrated and cohesive; would be more likely to participate in community activities; and would be more likely to conform to societal norms.

The concept of "quality of life" in measurement of health

"Quality of life" in relation to health is a broader concept than personal health status and also takes e.g. social well-being into account.

There is no consensus about a definition of quality of life. The literature covers a range of components; functional ability, the degree and quality of social and community interaction, psychological well-being, somatic sensation (e.g. pain), and life satisfaction. Health and functional status are just two dimensions of health-related quality of life.

Basically, quality of life is recognised as a concept representing individual responses to the physical, mental and social effects of illness on daily living, which influence the extent to which personal satisfaction with life circumstances can be achieved. It encompasses more than adequate physical well-being, it includes perceptions of well-being, a basic level of satisfaction and a general sense of self-worth.

Treatment from the patients' perspective in measurement of health

Analysis of the patient perspective – patient experiences and patient evaluations – can be incorporated in measurements of health care services and is inarguably important in understanding patients' perception of, and satisfaction with, their health outcome following treatment. Different types of measurements can be applied:

- Assessment of behaviours and attitudes, which illustrates the patients' health and disease behaviour including compliance, norms, values, expectations and experiences
- Assessment of patient satisfaction and degree of fulfilment of expectations of the treatment
- Assessment of patients' preferences for treatment in relation to the likely effect on their health and health-related outcome.

There is considerable evidence that patients' assessment of care has important consequences for their health and for the health care they receive. Patients who are dissatisfied with their health care are more likely to engage in activities, which disrupt their medical care, and could compromise their health outcome[7].

In this way patients' assessments become not only an evaluation, but also a predictor of health outcome.

Applied study designs in treatment outcome research

Various research designs are available in outcome research, but most often outcome studies are conducted using:

- Randomised controlled trials *(efficacy studies)* in which the treatment is implemented by the researcher under rigid control and the patient randomly allocated to either treatment or no treatment in a control group, or
- Quasi-experimental study designs assessing treatment as it is applied in the field *(effectiveness studies)*.

The advantages of randomised controlled trials are that the research outcome, with a high degree of possibility, can be attributed to the application of treatment.

Disadvantages are that interventions are provided under tightly controlled and largely artificial experimental conditions, while patients, clinicians and other decision-makers need to know how treatments work in the real world and whether they are cost-effective under routine conditions. Important questions relating to the organisation and delivery of services are additionally rarely addressed in randomised trials[8].

Research related to effectiveness rather than efficacy provides therefore a series of advantages, but also disadvantages. The study design involves less manipulation. It is therefore more feasible and provides clinical relevant feedback to treatment providers.

The outcome of the treatment a person receives is however determined by a number of factors. In uncontrolled studies it can therefore be difficult to attribute any difference in outcome to the treatment itself. Improvement may e.g. be explained as spontaneous recovery or related to external events. This threat to the validity of the research outcome, can be ruled out by applying a relevant comparison group.

Measurement of health and treatment outcome in torture rehabilitation

Level of knowledge – "scientific state of the art"

In 2001 Gurr & Quiroga[1] published a comprehensive desk study – "Approaches to Torture Rehabilitation" – based on material collected in 1997-1998. Out of more than 400 scanned refereed journals, other journals, books, and unpublished papers 250 were selected for review and included in the study.

In the introduction the authors state: "having done a thorough review of the literature, we are disappointed by how few questions in service provision are answered. In some areas of interest there are virtually nothing available."

Most of the published literature on the health related consequences of torture and rehabilitation of torture victims is descriptive. Only few clinical outcome studies exist and these studies have limitations due to the lack of: control groups; definition of diagnostic criteria; theoretical framework for problem identification and understanding, goal setting in therapy and provided interventions; validation of assessment instruments and identification of relevant outcome indicators.

In their conclusion Gurr & Quiroga[1] pointed out that knowledge is missing in several areas, and put forward the following recommendations for future research:

- Studies of the effectiveness of different models of organisation of torture rehabilitation services
- Studies of the efficacy of different treatment approaches
- Studies of the criteria for successful outcomes in treatment and the duration of achieving these outcomes
- Studies of the cost-effectiveness of the different treatment approaches
- Studies of the cultural influences on the response to trauma
- Studies on how the majority of people, in different cultures, who never receive treatment, cope with their trauma
- Studies on intervention strategies for the prevention of the onset, the reduction of the severity, or prevention of the recurrence of mental health sequelae in torture survivors
- Studies on specific high-risk groups among victims of organised violence, such as women, rape victims, children, orphans, family members, ex-soldiers, etc.
- Studies to separate the medical and psychological sequelae of torture from the sequelae of refugee trauma
- Studies on resilience factors and an elucidation of why not all exposed to severe trauma develop long-lasting conditions
- "Westernised" approaches, i.e. what are the respective advantages and disadvantages of the different approaches
- Studies on the coping strategies of the second generation of torture survivors, and on integrative problems to elucidate how the impact of trauma is transmitted to the next generation.

The implications of this lack of knowledge and the resulting lack of scientific evidence within the work field are that no clear and scientifically valid recommendations on the organisation and functioning of rehabilitation services and the interventions they offer in different environments can be put forward. The complexity of contributing factors and the lack of controlled studies mean, that clinical decisions have to be made based on simpler evaluation methods and professional judgement.

The problem of torture

Torture, as currently understood in international law, involves several elements: the infliction of *severe pain* (whether physical or psychological) by a *perpetrator* who acts *purposefully* and *on behalf of the state.*

There are several purposes, which torture can serve, but the broad objective includes the maintenance of social control, the defence of ruling values and the suppression and prosecution of political opponents and criminals. Where torture has become institutionalised or where police can act with complete impunity, the threshold at which torture is seen as an appropriate tool can decrease.

Torture and other forms of violence can be perpetrated to assist "ethnic cleansing" – the expulsion of one or more ethnic groups – or more generally to induce in a population a sense of terror.

The targets of torture are a mix of those who have long been recognised as potential victims – foremost, political or military opponents of the ruling power – as well as others who are under-recognised as targets of torture: alleged criminals, the poor and socially marginalised, and ethnic minorities[9].

Torture practised today is either state policy – the deliberate use of torture with the silent or open support of the government – or it can arise out of ineffective control of law enforcement personnel, including impunity for those who carry out the atrocities, or is practised in conflict zones including members of armed opposition groups.

Health-related consequences of torture

Research suggests that the consequences of torture occur in the context of personal attribution of meaning, personality development, and social, political and cultural factors (The Istanbul Protocol, 1999)[10]. For this reason one cannot assume that torture has the same outcome in different individuals and in different socio-cultural and political settings.

The health-related consequences of torture are therefore likely to be influenced by many interrelated internal and external factors, including:

- Age and developmental phase of the victim at the time of torture
- Pre-existing personality, genetic and biological vulnerability of the victim
- Prior history of trauma
- Circumstances, severity and duration of torture
- Preparedness for, perception and interpretation of torture by the victim
- Cultural meaning of torture and cultural meaning of symptoms
- The social context before, during and after torture
- Community values and attitudes
- Political factors.

Consequently there are complementary approaches applied by professionals in understanding the impact of torture on the overall concept of health.

The clinical approach utilises a medical and psychological paradigm and relies on clinical history, physical examination, and mental status examination of the individual.

The community approach involves assessment of traumatised groups or populations and focuses on the impact of torture on interrelationships and the "psychosocial health" of the community.

It is scientifically well documented that individual torture victims who are referred to treatment have a broad range of physical, psychological, social and legal problems. Most of the knowledge about the health-related consequences of torture is however based on symptom description and established in western settings focusing on refugee populations[1, 11].

Research related to other dimensions of health than the reporting of symptoms and illness is missing and e.g. systematic information on health-related quality of life including physical and mental functional ability in torture victims is not available.

Physically torture survivors present a variety of symptoms from different body systems, which have been reviewed in several publications. Most of these papers have a listing of symptoms, but no diagnoses. Frequent and typical complaints that are reported even years after torture, are chronic pain related to the musculo-skeletal system, neurological symptoms and irritative symptoms from organ systems[12].

The psychological sequelae of torture are likewise described in terms of listing of symptoms or clusters of symptoms. Despite the variability due to personal, cultural, social and political factors similarities in the psychological symptoms that emerge are described, with the main constellation of symptoms corresponding to those collected into the syndrome labelled as Post-Traumatic-Stress Disorder (PTSD). However, the utility of this diagnosis in non-western cultural groups has not been clearly established, although evidence suggests that there are high rates of PTSD and depression symptoms among traumatised refugee populations[13].

Further, cross-cultural research has revealed that phenomenological or descriptive methods are the most rational approaches to use when attempting to evaluate psychological or psychiatric reactions and disorders. What is considered disordered behaviour, a disease in one culture may not be viewed as pathological in another. Likewise, while some symptoms may be present across different cultures, they may not be the symptoms that concern the individual the most. Therefore, the assessment has to include the individuals' beliefs about their symptoms, as well as an evaluation of the presence or absence of symptoms[13].

Relatively little is known about the social and economical consequences of torture. Social effects of torture are described in the literature at the level of the individual, the family, the community and the society.

The impact of torture on the "social health" of individuals and within families is described in terms of impairment of role-model coping, interpersonal interactions, and social participation leading to social isolation and stigmatisation, poverty, and family and marital problems[1].

Flight into exile, displacement and settlement in a new country are additional events that aggravate the social and economic consequences of torture[14-16].

At the level of the community breakdown of social, political and economical networks are described as a consequence of torture and other related humans rights violation, which may afflict the dynamic relationship between individual and community and impede trauma recovery[17].

Organisation of treatment

The complexity of the health-related consequences of torture was recognised very early in the history of treatment. Most rehabilitation centres and programmes have therefore adopted multidisciplinary approaches, offering the clients a combination of medical and psychological services, social counselling as well as legal assistance. The professional staffing may include physicians, psychiatrists, psychologists, counsellors, physiotherapists, social workers, occupational therapists, nurses and lawyers.

Several models of service structure have developed within the work field:

- Integrated centres, where rehabilitation services are provided by a multidisciplinary team at the centre supplemented at some centres by coordinated referral to external experts
- Core centres, supporting and coordinating referral of clients to external experts and networks
- Networks of volunteers or part time staff offering services to torture victims without core support function
- Community based intervention, where services are provided in the field.

Not only the organisation of service delivery, but also the clinical practise vary to a great extent between centres, coun-

tries and regions of the world. Some centres apply a medical approach in assessment and treatment prioritising medical and physical aspects in rehabilitation, other centres are more oriented towards psychosocial needs and treatment models. Some centres focus on rehabilitation of individual torture victims, others provide family and group therapy, some centres offer a combination of individual, family and group therapy and finally some centres work entirely community based.

Given the different social and political contextual settings world-wide the target group also varies between centres. Some centres mainly receive clients from socially marginalised groups or ethnic minorities where torture and violence are randomly targeting whole populations, other centres work with victims of torture targeting selected individuals and in some countries of resettlement rehabilitation centres work strictly with refugee populations.

Since systematic knowledge and scientific evidence is lacking in many areas, it has not been possible to recommend or reach consensus on "best practise guidelines" within rehabilitation of torture victims or within the individual health professional disciplines that contribute in the rehabilitation process. Throughout the years many e.g. psychological treatment approaches have been applied, varying from centre to centre and from health professional to health professional and without concordance in problem understanding, and priority and goal setting in treatment.

Furthermore the "work field of torture" has utilised knowledge and methods developed in other areas e.g. mainstream mental health services and assumed that they would be equally effective in the care of torture survivors[1].

Establishment of theoretical frameworks based on research, and linkage of clinical practise with theory within rehabilitation of torture victims is therefore needed as well as operational definitions of e.g. torture as a trauma (problem identification and understanding), goal setting in therapy, successful treatment processes, and successful outcome of treatment and recovery.

Implications for measurement of health and treatment outcome in torture populations

The complexity of the health-related consequences of torture necessitating a multidisciplinary approach in treatment, and the diversity of interventions provided in different models of service structure makes outcome research a difficult task.

There is a desire within the health professional work field and by all funding agencies for indicators of individual improvement, service quality and utilisation efficiency. Literature – recognising the inadequacy – suggests that the indicators, which can be used are symptom reduction, improvements in functionality, achievements of negotiated treatment goals and consumer satisfaction[1].

However a prerequisite for developing operational and valid outcome indicators, which can be used in monitoring of rehabilitation services based on the above mentioned, is increased knowledge in several areas:

- Better understanding and definition of the health-related problems caused by torture – the objective of rehabilitation – seen from the torture victims' as well as the health professionals' perspective.
- Increased knowledge about individual responses to the physical, mental and social effects of the health-related consequences of torture on activities of daily living – functionality – and other quality of life parameters.
- Increased knowledge about the multiple internal and external modifying factors influencing mental and physical health status and treatment outcome.
- Increased knowledge about the influence of torture and health-related consequences of torture on social support systems within the family and within the community.
- Increased knowledge about the process of rehabilitation – the clinical practise and applied theories, goal setting and expectations from the clients' as well as the health professionals' perspective.
- Increased knowledge about the clients' preferences, perception of and satisfaction with their health outcome following treatment.

Development of intercultural, validated assessment instruments will be a prerequisite for conduction of outcome research establishing efficacy, effectiveness and cost-effectiveness information.

Thus, research applying qualitative as well as quantitative research methodology is needed in several priority areas in order to measure health status and treatment outcome in torture populations.

AIMS OF THE STUDY

The current study had 2 overall aims:

1) To describe – based on a phenomenological approach – the outcome of torture rehabilitation as provided at specialised centres and in different socio-cultural settings seen from the clients' and the health professionals' perspective.

A series of dependent and independent variables related to centres, clients and health professionals were identified to be elucidated by the study:

Independent variables:
- Characteristics of the centre and the frames for the intervention provided by the centre
- Therapists' characteristics
- Client demographics
- Initial severity and chronicity in the study population.

Dependent variables related to clients:
- Definition and understanding of the problem(s) caused by the torture
- Perception of the treatment course and the treatment outcome
- Daily life change
- Future wishes.

Dependent variables related to health professionals:
- Definition and understanding of the clients' problem(s) caused by torture
- Working methods
- Perception of collaboration, tasks and objectives within the work
- Perception of the clients
- Possibilities and limitations in the work
- Relation between clinical practise and theory.

2) To use the obtained knowledge in generating hypothesis to be further elucidated by subsequent qualitative and quantitative research, and to apply the knowledge in the design of such studies.

RESEARCH STRATEGY

Study design

The study was designed as a multi-site study and included 4 rehabilitation centres from 4 different UN regions of the world. This design was applied in order to heighten representativeness and in order to describe study findings across different socio-cultural settings.

Conduction of the study at individual centres took place in close collaboration between the centre and the IRCT research team visiting the centre according to a mutual agreed timetable and Terms of Reference for conduction of the study. The IRCT research team comprised 1 medical doctor and 1 psychologist.

Selection of participating centres

Four well-consolidated centres representing the Asian region, the Central and Eastern European region, the Sub-Saharan African region, and the Latin American region were identified by the research team based on the following criteria:

- Member of the IRCT network
- Location of the centre. Participating centres should be located in different regions of the world
- Age of the centre. Participating centres should be established in or before 1999
- Client characteristics at centres. Clients treated at the centres should be victims of torture or other related human rights violation
- Treatment approach and service delivery. Participating centres should represent different treatment approaches and organisation of service delivery (centre based treatment, community based treatment, referral to external network)
- Staff number and composition. Centres should have a multidisciplinary staff composition and a minimum of treatment staff.

The following centres from the IRCT network were identified and received written information and invitations to collaborate in the study:

1) Rehabilitation Action for Torture Victims in Aceh (RATA), Banda Aceh, Indonesia, established in 1999
2) Centre for Torture Victims (CTV), Sarajevo, Bosnia-Herzegovina, established in 1997
3) The Independent Medico-Legal Unit (IMLU), Nairobi, Kenya, established in 1995
4) Equipo de Estudios Comunitarios y Accion Psicosocial (ECAP), Guatemala City, Guatemala, established in 1997.

All centres accepted the invitation and were visited by the IRCT research team according to the following timetable:

1) RATA: 25th of June until 11th of July 2002
2) CTV: 28th of July until 4th of August 2002
3) IMLU: 5th of September until 15th of September 2002
4) ECAP: 17th of October until 27th of October 2002.

Data collection and methodology

Data sources

In order to obtain in-depth insight and in order to describe nuances and contrasting perspectives data collection from several complementary data sources was applied:

- Written sources: review of relevant literature and existing written background material on centres (project proposals, mission reports, annual reports, publications, etc.)
- Interviews, questionnaires and informal communication
- Systematic and sporadic observations made by the research team in the field.

Methodology

A combined quantitative-qualitative methodology was applied in the study:

The quantitative method was based on questionnaires collecting data to be analysed in numerical form. The following questionnaires were developed and implemented:

- A "Centre Questionnaire" to be filled in by the centre staff describing centre characteristics
- A "Health Professional Questionnaire" to be filled in by the interviewed health professionals describing health professional characteristics
- A "Client Information Sheet" to be filled in by centre staff on interviewed clients based on background material from existing client files.

The qualitative method was designed to get an in-depth picture of a relatively small sample of clients and health professionals' perceptions, experiences and evaluation of treatment courses within rehabilitation of torture victims. The qualitative data was obtained using semi-structured interviews and focus group interviews[18, 19].

Number of informants to be interviewed was chosen based on recommendations from the literature regarding phenomenological interview-based studies[20].

INTERVIEWS WITH CLIENTS

Semi-structured individual interviews were conducted in a cross-section of 5 clients at each centre. Interview guides applied in the interviews were elaborated to reveal a variety of attitudes, opinions and behaviours among clients within the identified dependent variables to be elucidated by the study.

Focus group interviews were conducted, when appropriate, with the same 5 clients at each centre. Topics to be discussed in the focus group were identified based on the individual interviews.

INTERVIEWS WITH HEALTH PROFESSIONALS

Semi-structured individual interviews were likewise conducted in a cross-section of 5 health professionals at each centre. Interview guides applied in the interviews were elaborated to reveal a variety of attitudes and opinions among health professionals within the identified dependent variables to be elucidated by the study.

Focus group interviews were conducted, when appropriate, with the same 5 health professionals at each centre. Topics to be discussed in the focus group were identified based on the individual interviews.

The psychologist from the IRCT research team, using an interpreter if needed, conducted all interviews. Interviews were recorded and transcribed successively at the IRCT.

Selection of informants

Purposeful sampling was applied in the selection and inclusion of informants. The following criteria were used:

Selection of clients:

- Age (18 years of age or older)
- Informed consent and willingness to participate in a recorded interview
- Heterogeneity regarding: age, gender, time framework of the therapeutic course, and problems related to the torture.

The above-mentioned criteria were applied in order to describe differences in perception, understanding, perspectives and experiences among clients.

Selection of health professionals:
- Informed consent and willingness to participate in a recorded interview
- Heterogeneity regarding: age, gender, health professional background, and years of experience within the work field.

The above-mentioned criteria were used in order to describe differences in perception, understanding and experiences among health professionals regarding the clinical practise and the theoretical framework applied in the rehabilitation of torture victims.

Data processing

Quantitative data

Numeric data from Centre Questionnaires, demographic data and other person related data were analysed using simple statistical tests in order to characterise centres, health professionals and clients.

Qualitative data

Processing of the qualitative data was based on a phenomenological approach using "practise portrait" as methodology in the analysis[21-23].

RESULTS AND ANALYSIS OF DATA

Quantitative data

The results from the processing of the quantitative data are presented in table format: Centre Questionnaires: Table 1-6, Health Professional Questionnaires: Table 1-10. In the following only selected tables will be presented.

Description of centres

Based on the results from Centre Questionnaires, Health Professional Questionnaires and observations made by the IRCT research team in the field, the frames for the provided rehabilitation services including differences and similarities across participating centres can be described in terms of:

- Characteristics of the target group – the context of torture
- Organisation of service delivery
- Organisation of treatment and health professional staffing
- Characteristics of individual clients treated by the centre.

CHARACTERISTICS OF THE TARGET GROUPS

RATA, CTV, and IMLU reported primary victims of torture as defined by the UN Convention Against Torture as being the target group for the health professional work at the centre.

ECAP reported primary victims of torture as defined by the UN Convention Against Torture and victims of organised violence as defined by WHO as being the target group.

The problem of torture and the context in which the torture takes place also varies across centres:

RATA is specially mandated to treat victims from the so-called "DOM period" – the period from 1989 until 1998 during which a repressive, government supported military regime was executed in Aceh in order to control the political opposition and the liberation movement. Torture and other human rights violation are still extensive in Aceh, perpetrated by the military and randomly targeting and intimidating the broader population.

Torture victims treated at CTV are victims from the war in Bosnia 1992 – 1997, the victims being detained in concentration camps during torture and the perpetrators military personnel of different nationality.

Torture victims treated at IMLU are mainly victims of institutionalised violence perpetrated by law enforcement personnel, the targets of torture being alleged criminals, the poor and socially marginalised.

ECAP's main target group is an ethnic minority – the Mayans – exposed to political repression through decades, culminating in government supported ethnic cleansing and displacement targeting whole communities in the early 1980s.

ORGANISATION OF SERVICE DELIVERY

Based on the inclusion criteria, the 4 participating centres represented different models of service structure:

RATA mainly functions as a core centre – a head quarter – coordinating the health professional work undertaken by 4 field offices situated in different regions of Aceh, including referral of clients to relevant external specialists and other public health care systems. Only a smaller number of clients receives treatment in RATA head quarter itself.

CTV functions as an integrated centre offering services at the centre provided by different health professional specialists.

IMLU mainly functions as a core centre assessing the needs of the clients and coordinate hereafter the referral of clients to a collaborating network of specialised health professionals.

ECAP's health professional work is community based and project oriented. The focus is reconstruction of the collective memory through testimonies, reconstruction of social, cultural and political networks in the communities, and legal justice for the suppressed population.

ORGANISATION OF TREATMENT AND HEALTH PROFESSIONAL STAFFING

As illustrated in Table 1 and Table 2 all centres offer a multidisciplinary assessment of clients either at the centre itself or by referral to various health professional specialists in a collaborating network. At some centres the collaborating network also includes legal advisors.

The organisation of treatment is likewise based on a multidisciplinary approach at all centres, even though the clinical practise and focus of the provided intervention vary across centres.

Two centres reported the combination of physical, psychological and social aspects in rehabilitation to be the most important. One centre prioritised medical and psychological aspects and one centre applied a strictly psychosocial model in assessment as well as in rehabilitation.

At one centre rehabilitation is targeting individuals, families and the community. Two centre focus on rehabilitation of individuals and families, and finally one centre offers individual and community based intervention.

Average duration of treatment and number of treatment sessions also vary across centres, as illustrated in Table 1, with a spread in average duration of treatment from 4 months up till 2 years.

Reflecting limitations and possibilities at individual centres, as well as differences in the organisation of service delivery and priorities within the clinical practise, the staffing at centres also varies to a great extent. As illustrated in Table 2, this variation includes both the number of full time employed staff and the professional composition of the staff. A health professional background however is dominating among full time employed staff across centres comprising 73%.

Table 1. *Organisation of treatment at centres.*

	Indonesia RATA	Bosnia CTV	Kenya IMLU	Guatemala ECAP
Services offered at centre/referral				
Medical	Yes	Yes	Yes	No
Psychiatric	No	Yes	Yes	No
Psychological	Yes	Yes	Yes	Yes
Counselling	Yes	Yes	Yes	No
Physiotherapy	No	Yes	Yes	No
Social counselling	Yes	Yes	No	No
Legal aid	No	No	Yes	No
Referral to other specialist	Yes	Yes	Yes	Yes
Others				
Treatment targeted at				
Individuals	Yes	Yes	Yes	Yes
Family	Yes	Yes	Yes	No
Community	Yes	No	No	Yes
Others				
Decision on treatment based on				
Medical examination	×	×	×	
Psychiatric assessment		×		
Psychological assessment		×		
Assessment by counsellor		×	×	
Assessment by physiotherapist		×		
Assessment by social worker		×	×	
Assessment by lawyer				
Others	Field worker, nurse			Psychosocial assessment
Most important part of rehabilitation				
Physical			×	
Psychological			×	
Social/legal				
Combination	×	×		
Others				Psychosocial
Average duration of treatment	24 weeks	16-18 weeks	24 weeks	2 years
Average number of treatment sessions	5	15-20	12	48-96
Criteria for ending treatment				
Mutual agreement client/health prof.		×	×	×
Client's initiative	×	×		×
Health professional's initiative	×	×		
Referral elsewhere		×		
Other		Immigration		

The majority of the staff in collaborating networks is likewise health professionals, attached to the centres on consultative basis. Only one centre reported the use of volunteers.

Additionally only one centre reported a need for the use of interpreters in their clinical work.

Table 3 describes demographic data of clients referred to treatment at individual centres as reported in the Centre Questionnaires.

The majority of the clients is between 19 and 50 years of age, predominately males in 2 centres, predominately females in 1 centre and in 1 centre the gender distribution among clients is equal.

The social status amongst clients across centres is in general low with high unemployment rates and low levels of education. In one centre 100% of the clients are reported to be peasants, 90% of which are illiterates and 80% widowers.

At all centres except one the referred clients have different ethnical backgrounds.

Table 4 lists the 5 (or more) most frequently applied psychological torture methods reported by referred clients at individual centres.

As illustrated, variation among the reported psychological torture methods across centres exists reflecting the specific context of torture in the different countries, but similarities are also present, with e.g. threats and/or witnessing of torture being reported by all centres.

Table 5 lists the 5 (or more) most frequently applied physical torture methods reported by referred clients at individual centres. All centres report unsystematic beating.

Aside from beatings the clients at CTV most often report atrocities related to deprivation – deprivation of basic needs and restriction of physical activities.

At the rest of the centres the reported torture methods represent systematic, physical torture with sexual assaults and suspension listed by all 3 centres.

Table 6 lists psychological and physical complaints presented by clients at referral across individual centres.

As illustrated, similarities are present in the symptomatology regardless of variance in applied torture methods, context of torture, and social and cultural differences.

All centres report anxiety and depression symptoms as being frequent. Physical sequelae are predominantly pain – headache and pain related to the musculo-skeletal system – reported by all centres.

Description of informants

DESCRIPTION OF THE INTERVIEWED HEALTH PROFESSIONALS

Based on the filled in Health Professional Questionnaires the

professional profile of the interviewed health professionals, the current organisation of their clinical practise, and their preferences are presented in table format, Tables 7 and 8.

In total 20 health professionals were interviewed. 17 health professionals were full time employees at the centres, and 3 health professionals employed on consultative basis as part of the collaborating network.

DESCRIPTION OF THE INTERVIEWED CLIENTS

Twenty clients, 8 females and 12 males, were interviewed. Written client files were accessible on 17 of these clients. The following descriptions are based on information from the Client Sheets filled in by health professionals at the individual centres (Fig. 2-7).

The interviewed clients were between 23 and 65 years of age, in average 42,7 years old.

All clients had a low social status and poor backgrounds; 5 being farmers, 4 being employed, 1 being occasionally employed, 5 being unemployed and 2 retired.

The torture took place between 1 and 11 years ago, in average 7,6 years ago. Twelve of the interviewed clients were tortured during confinement/imprisonment, 5 clients at their residents. Duration of confinement/imprisonment varied from 2 days to 15 years, in average 26,2 months.

At the time of the study, the individual clients had been treated from 2 months till 24 months, with an average treatment duration for the whole group of 17,6 months.

Five clients had ended their treatment courses, and 12 clients were still receiving treatment at the time of the study.

Qualitative data

How do the world-wide programmes for the rehabilitation of torture victims operate and are they effective? Who are the consumers and how do they utilise these programmes?

The programmes for the rehabilitation of torture victims are practised within, and in relation to a social work field. A work field involving different parties with different perspectives according to their positioning in the field: their positioning in relation to the problems, and their positioning in relation to each other.

Consequently, an essential question is to be asked: what is the health professional's perspective and what is the torture

Table 2. *Professional background of staff at centres.*

	Indonesia RATA	**Bosnia CTV**	**Kenya IMLU**	**Guatemala ECAP**
Number of full time employees				
Medical doctors	1	0	0	0
Psychiatrists	0	0	0	0
Psychologists	1	2	0	10
Physiotherapists	0	0	0	0
Social workers	24 field workers	1	0	1
Legal advisors	0	0	0	0
Counsellors	0	0	2	0
Interpreters	0	0	0	0
Admin. personnel	6	1	4	3
Others	7 nurses		1 socio-logist	5 health promoters 1 MSc (econ) 1 anthropologist
Employees on consultative basis				
Medical doctors	>20	2	50	1
Psychiatrists	3	5	2	1
Psychologists	0	0	2	1
Physiotherapists	5	1	4	0
Social workers	0	0	0	0
Legal advisors	0	0	3	2
Counsellors	0	0	3	0
Interpreters	0	0	0	0
Admin. personnel	0	0	0	0
Others		1 nurse		
Number of volunteers				
Medical doctors	0	0	1	0
Psychiatrists	0	0	0	0
Psychologists	0	0	0	0
Physiotherapists	0	0	0	0
Social workers	0	0	0	0
Legal advisors	0	0	0	0
Counsellors	0	0	1	0
Interpreters	0	0	0	0
Admin. personnel	0	0	4	0
Others				
Differences staff/clients regarding				
Language	No	No information	No	Yes
Culture	No		Yes	Yes
Social status	Yes		Yes	Yes
Country of origin	No		No	No
Do you use interpreters on daily basis?	No	No	No	Yes

Table 3. *Characteristics of individual clients treated by the centres. Demographic data. Clients treated in the period 1/1 1999 until 31/12 2001.*

	Indonesia RATA	Bosnia CTV	Kenya IMLU	Guatemala ECAP
Gender				
Male	996 (84%)	154 (51%)	594 (85%)	232 (29%)
Female	193 (16%)	150 (49%)	105 (15%)	558 (71%)
Age distribution				
Male				
≤18	29 (3%)	8 (5%)	38 (6%)	
19-30	967* (97%)	28 (19%)	240 (40%)	5 (2%)
31-50		52 (36%)	242 (41%)	50 (20%)
≥51		58 (40%)	74 (13%)	19 (8%)
Female				
≤18	8 (4%)	6 (4%)	9 (9%)	
19-30	185* (96%)	19 (14%)	41 (39%)	28 (5%)
31-50		66 (47%)	41 (39%)	223 (40%)
≤51	*19 years of age or above	49 (35%)	14 (13%)	84 (15%)
Marital status				
Never married	No information	18,4%		
Married	No nformation	62,5%	×	20%
Separated/divorced		4,04%	×	
Widower		11,4%		80%
Others		Spouse missing 2,6%		
Educational status				
Illiterate	×	9,9%		90%
≤ or 7 years of school	×	40,7%	×	10%
> 7 years of school		49,5%	×	
Others				
Employment status				
Unemployed	50%	82,9%	×	Peasants 100%
Housewife		27,0%		
Unskilled		3,08%		
Skilled		69,9%		
Others				
Ethnicity	Acehnese: 100%	Bosniaks: 93,9% Croats: 0,4% Albanians: 0,4% Serbs: 0,4% Romas: 1,1%	Kikuyus Luhyas Somalis Kambas Luos	Maya Achi: 70% Canjabol Man Pocomchi No indigina: 5%

×: Indicates a positive answer with no specific value.

victim's perspective on rehabilitation and the outcome of rehabilitation?

Rehabilitation and outcome of rehabilitation from the clients' perspective

"TO BE POINTED OUT"

The majority of the interviewed clients were originally referred by the public health care system, NGO's, community or religious leaders, family members or via other instances.

The point of departure in these cases is therefore that "others" than the clients themselves perceive problems in relation to the clients, approach the clients with these perceived problems and then suggest involving a specialised rehabilitation programme.

As it will become clear from the following material, the problems may have different expressions, but all of the interviewed clients describe this initial approach as a "pointing out".

"I joined the association of ex-concentration camp prisoners and they told me that I should come here. (...) Because I was beaten, I was maltreated, I was raped, I have the bones that are broken and my teeth were pulled out and broken (...) Since I am not employed I can come here because it is free and I can get that kind of help."

"My husband has been killed and burned and I have been in concentration camp (...) My brother and his wife told me to come here, because I was feeling bad, I was very skinny and was very depressed because I lost my memory when I was in XX (a town)."

"I was beaten severely. And you can see my hands (...) Because I experienced (in the prison) some things that nobody else did and I was black from bruises – like my shoes are now (...) I came here encouraged by other people living in XX (a town). They told me that I must go here and get help. Not only food but also other things in order to survive."

"I contacted the centre through Dr. XX. I contacted him because I had nightmares and I was screaming during my sleep and wetting my bed. He directed me here. Because I didn't have any means to provide necessities for myself (...) I came here because they (health professionals) could pay for my medication."

Table 4. *Most frequently applied psychological torture methods among referred clients.*

The most frequent psychological torture methods			
Indonesia RATA	**Bosnia CTV**	**Kenya IMLU**	**Guatemala ECAP**
Threats	Restriction of communication with outside world	Threats of not being able to perform sexually after sexual torture	Witnessing massacres
Sexual harassment	Restriction of visits from the outside	Sexual harassment	Threats on life
Intimidation	Forced blind obedience	Separation from family	Not permitted to conduct rituals
Witness of torture	Threats of being killed or infliction of serious injury	Confinement in small, dark cells	Displacement
Witness of sexual assaults	Threats of separation from, torture of or killing of family members	Witness of atrocities (rape, beating of others)	Witnessing torture
			Forced to become a traitor

Table 5. *Most frequently applied physical torture methods among referred clients.*

The most frequent physical torture methods			
Indonesia RATA	**Bosnia CTV**	**Kenya IMLU**	**Guatemala ECAP**
Electrical torture	Restriction of physical activity	Beating	Beating with machetes or sticks
Sexual torture (rape)	Restriction of access to food and water	Shooting	Sexual violence
Suspension	Forced to ware inadequate clothes and shoes	Falanga	Burning
Submersio	Beating	Suspension	Submarino
Beating	Restriction of access to medical care	Sexual assault	Exposure to inhuman conditions
Nail torture, burning with cigarettes			Suspension
Mutilation (amputation of body parts)			

"The chief of my village came to the committee and obtained a list of who are torture victims from the xx period (...) Thirty persons were all taken to the medical doctor in the community. The medical doctor said that they could not solve my problems so I had to go to a general hospital in the province and the general hospital referred me here."

"They shot my man and they took me to the police to torture me. They started to torture me with bottles in my secret parts. They made my uterus bleed. When I came here I was bleeding. They did different things to me. Yes, a bottle, breathing pepper.., do you understand? (...) One day I meet a man in the street and he said to me: 'we saw you were suffering, you must contact a human rights office'. I said: 'what is human rights, I have never heard that before. Where can I find that? And how I can talk with them? I am not good in English'".

A SOCIAL EVENT AND THE EXPERIENCE OF "SUDDENNESS"

An experience of "suddenness" combined with terror and helplessness is believed to be the prevailing reason for help seeking.

"Around 3 a.m. somebody requested me to open the door. I opened for I did not know who was outside. I opened and I met some police officers with guns. They started to slap me; they slapped me a lot and then they were asking me, why did I do that. I was not aware of, what they were asking me. That is when they chained me, put me in handcuffs and escorted me to the police station. When we got there, they told me to get into the cell. At around 3 a.m. there came two police officer and they started beating me and they kicked me in my private parts. I started bleeding. My fellow inmates were complaining so much that they stopped beating me."

"I was tortured for 3 days. I don't know why they arrested me. At the same time they were beating me. They were telling me that they were told by friends of mine, that I own an AK 47, and there had been a robbery, and that I was one of them (...). At the time of the robbery, I was not there (...). They beat me and at one point I became unconscious. So they took me, and threw me in their garbage (...). I stayed in the cell with out seeing anybody (...) I told them that in my entire life, I have never attempted to take or to have an AK 47, or any firearm with me (...). I could not make any decisions. When you are in a cell, you cannot move outside ... But my

Table 6. *Most frequent symptoms presented at referral by clients at individual centres.*

The most frequent psychological symptoms

Indonesia RATA	Bosnia CTV	Kenya IMLU	Guatemala ECAP
Night mares	Insomnia	Anxiety	Anxiety
Aggression, lack of control	Psychogenic headache	Depression	"Heart pain"
Depression	Intolerance and low level of tolerance for frustration in interpersonal relations	Anger	Sadness
Anxiety		Post Traumatic Stress Disorder	Fear of re-experience of trauma/victimisation
Paranoia	Anxiety	Fear about relationships	Desperation
Hallucinations	Depression		Somatisation
Changed personality			
Loss of beliefs and self-esteem			

The most frequent physical symptoms

Indonesia RATA	Bosnia CTV	Kenya IMLU	Guatemala ECAP
Chest pain	Pain in joints and lower back	Chronic headache	Headache
Pain in extremities and joints	Headache	Chest pain	Skeletal pain
Low back pain	Palpitations	Whip marks	Paraesthesia
Headache	Chest pain	Bullet wounds	High/low blood pressure
Reduced hearing	Visual disturbances	Broken limbs	Gastritis
Dental problems			Chest pain

case is so terrible that even my parents and my wife, were not allowed to see me."

This suddenness of the event and the induced feeling of terror frighten the clients and a sense of distrust in what the present might bring is therefore a general theme.

The reason for help seeking and the point of departure for the treatment course is therefore, regardless of differences in the nature of the problems and the sequences of events, described as a significant and epoch-making event – *a social event* in the clients' lives. There are numerous feelings, conflicts and decisions to relate to, which in most clients generate a profound anxiety.

"That experience, for sure, I will not forget in my life. Never in my life ... I will never forget, even today. Even the times I do not want to remember for the terror they imposed."

"I can never forget what I survived. I try, but I can never. It is hard ... I cannot forget this, because the picture, the place, is always there, always ... the worst thing is that I am living close to there and I have to go trough that place every day in the bus and I have a feeling that someone will come out and drag me out of the bus, and that I cannot resist."

This social event, taking place in the lives of the clients, furthermore brings about a lot of speculations. Speculations about what happened and why it happened, speculations that hastily lead to speculations about what is wrong with themselves and in particular what is wrong with life.

"I was tortured because these police officers they wanted me to die ... So what did they do? ... I prayed to God for keeping me/to save me: 'it is your son, who came here and died, who was tortured to death'. I normally thank God for that (...) I know that God, normally pays for/forgives any crime a person does. God always pays/forgives that. So to me, I cannot say that I want to do anything to them, e.g. to those who tortured me. But their time will come, just as it will come for me, you see. But on my side, I can say that, I will not contact them, I will not do this and that. No, what I know that one day they will pay, they will pay (...) Since they have ruined my life, forever, God will get revenge for me ... God is there for me, yes, God is there for me, to revenge for me. And I know that will happen."

The presentation of the problem and problem understanding

The way the problems are presented and described by the clients often reflects some desperation. They feel helpless and experience that they have no possibilities of solving the problems on their own.

"I am in a bad situation. I have no heating and I have no financial means because I am not working ... the situation leads to suicide because it is hard for somebody like me to

Table 7. *Profile, interviewed health professionals.*

	All interviewed health professionals (n=20)						
Gender	Male: 35%			Female: 65%			
Age	20-30 years 15%	31-40 years 40%		41-50 years 40%		51-60 years 5%	
Professional background	Medical doctor 3	Physio-therap. 2	Psycho-logist 6	Social worker 1	Coun-sellor 2	Nurse 1	Others 5
Year of graduation	1960's: 5%	1970's		1980's: 45%		1990's: 50%	
Years in the organisation/network	<1 years	1-2 years 40%		3-5 years 60%		>5 years	
Experience in the field of activity before present position	Yes: 40%			No: 60%			

Table 8. *Current organisation of clinical practise and preferences reported by interviewed health professionals.*

	All interviewed health professionals (n=17)			
	Health professional group in the organisation			
	Medical group: 4	Field work: 4	Counsellor group: 8	Physiotherap. group: 1
Tasks	35 answers			
Direct client contact/treatment	Reported by 11 staff members			
Direct client contact/counselling	Reported by 9 staff members			
Education	Reported by 1 staff member			
Administration	Reported by 3 staff members			
Research/projects	Reported by 9 staff members			
External information/advocacy	Reported by 2 staff members			
Target group	38 answers			
Children	Reported by 4 staff members			
Adolescents	Reported by 8 staff members			
Adults	Reported by 12 staff members			
Family	Reported by 5 staff members			
Community	Reported by 9 staff members			
Applied intervention	31 answers			
Medical	Reported by 7 staff members			
Psychosocial	Reported by 3 staff members			
Psychosocial counselling	Reported by 10 staff members			
Social counselling	Reported by 5 staff members			
Legal advise	Reported by 0 staff members			
Physiotherapy	Reported by 5 staff members			
Other	Reported by 1 staff member			
Preferred organisation of the treatment	26 answers			
Individual treatment	Reported by 12 staff members			
Family therapy	Reported by 4 staff members			
Group therapy	Reported by 4 staff members			
Community based	Reported by 6 staff members			
Supervision				
Provided?	Yes: 15 staff members; No: 2 staff members			
Hours per month	4-5: 4 staff members; 6-8: 6 staff members; >10: 5 staff members			
Type of supervision				
Individual	Reported by 6 staff members			
Group	Reported by 14 staff members			

come here (centre) and ask for help and I know that there is nothing. Yesterday I was not like this but today I am."

The clients also generate a lot of hypotheses related to their problems. In this way the definition of the problems becomes characterised by and a question about, *where* the problems are to be placed and *who* are responsible for solving them.

"My life has changed, since this experience (...) I was arrested, I was tortured, so what will become of my life? Who takes measures against those who tortured me? (...) Yes, I know them well, I know them ... they are still stationed down there."

"I know that you (interviewer) cannot do anything concretely, but that you came to hear about us; and I am not looking anything from you personally. Is there somebody to whom we can show how the situation is? ... We are not eat-

Physical torture methods
Sexual torture including rape
Unsystematic beating, kicking
Systematic beating
Suffocation
Suspension, fixation
Noise exposure
Mutilation, amputation of body parts
Cigarette burns
Gun/machinegun lesions
Deprivation of necessary medical care

Psychological torture methods
Sexual harassment
Witnessing killing and torture of close family members
Witnessing killing and torture of others
Solitary confinement
Threats on life
Forced obedience
Deprivation of basic needs

Fig. 2. *Torture methods reported by interviewed clients.*

Status at referral

Physical problems	Psychological problems	Social problems
Heart problems	Acute PTSD	Loss of family
Hypertension	Complex PTSD	Loss of property
Thyroid dysfunction	Depression	Loss of job
Gynaecological problems	Anxiety	Social isolation
Urinary dysfunction	No belief in the future	Social stigmatisation
Stomach-ache	Low self-esteem	Marital problems
Headache	Insomnia	Family problems
Low back pain	Psychosomatic disorder	Impaired interrelationship in the community
Pelvic pain	Intolerance towards others	Insecure economy
Pain in extremities	Speaking disturbances	Insecure housing
Chest pain	Hallucinations	
Sensory disturbances	Sexual dysfunction	
Impaired walking		
Sequelae from fractures		
Sequelae from gun wounds		
Amputation left leg		

Fig.3. *At referral the clients presented with the following symptoms/problems, recorded by the health professionals.*

Status at referral

Physical problems	Psychological problems	Social problems
Torture sequelae	Torture sequelae	Loss of family
Physical trauma	Mental trauma	Family problems
Physical problems	Psychological problems	Insecure job situation
Physical symptoms from various body systems	Specific psychiatric diagnosis (PTSD, psychosomatic disorder, psychosis)	Insecure housing situation
Pain		Insecure economy
Impaired physical function		

Fig. 4. *The clients' problems were defined/identified and recorded by the health professionals within the following categories.*

Treatment goals

Physical dimension	Psychological dimension	Social dimension
Enhancement of function	Enhancement of function	Enhancement of function
Symptom reduction	Symptom reduction	Improved social situation
Pain relief		Return to work

Fig. 5. *Treatment goals as reported in Client Sheets.*

Clients expectation to treatment

Physical dimension	Psychological dimension	Social dimension
Pain relief	To be another human being	Increased function in the family
Improved walking		Increased function in the community
Increased physical function		Return to work
To be able to perform sexually		

Fig. 6. *Clients' expectations to treatment as reported in the Client Sheets.*

ing or anything, just talking, but when I go out in the street, I see somebody's children eating ice cream and mine don't even have water. I don't expect anything from you personally, but that somebody takes responsibility for what these people have done or terminate it. The public or anybody ... But if there is some kind of power that somebody can exert so it can make a difference and we can live too as normal people, because this is unbearable if this continues without any changes. And I would like to ask you concretely: Can we survive here or should we go somewhere else?"

The way the problem is presented becomes – in some cases – part of the problem itself. The *immediate* response among some clients is to fight back – to blame the surroundings. It is not their problem, but the society's – the problem and the responsibility.

"I came here (to the centre) in order to try to help myself through conversation, try to be better, but I think the only thing that can make me better is to change the environment and to live somewhere else. I live now in the place where I used to live and people who were there before and who were helping them (the perpetrators) are here. I can see them, I can see them at my workplace and that is a constant traumatisation."

Sole responsibility and isolation

A social event has occurred and changed the clients' circumstances. The foundation for life itself has changed and along with that the clients' future possibilities have changed.

It is characteristic that the clients and their families, despite the support and co-operation of others, find themselves to be isolated and with the sole responsibility for coping with their crisis and their caring responsibilities.

Provided treatment		
Physical dimension	**Psychological dimension**	**Social dimension**
Medical examination and assistance Physiotherapy Analgesics Other medication Referral to external specialists Referral to hospital	Psychiatric assessment and assistance Psycho-pharmacological treatment Psychotherapy Counselling Group therapy Referral to external specialist Referral to psychiatric ward	Social assessment and assistance Social counselling Legal aid

Fig. 7. *The following treatment modalities were provided to the clients by the centres.*

"Right now I think about my brothers and sisters at home; because no one can take responsibility for my family ... because I cannot work at all."

"I feel somewhat isolated, and also that I am alone. I am just alone. Where do I start, and where do I share my problems of life ... Where do I start and to whom can I just tell my problems in a way that they will really understand me ... that is why actually when I start to think about all those things, I feel that I am mentally disturbed. Yes, very much, very much (...) I am always afraid, and I usually isolate my self from some of the groups, do not discuss things because I do not see any point in telling someone about my problems or about my life in jail."

The clients also express frustration and concern about the future.

"According to me, actually the only way to avoid this kind of frustration is just to leave the country, and go to some other ... Because it is painful and bitter for me when I look back: being a prisoner for no reason and after coming out of jail, no one cares about me ... nobody wants to know about me."

THE RELATIONSHIP TO THE HEALTH PROFESSIONALS AND THE CENTRE

Already at the beginning of the interviews, all clients expressed gratitude and satisfaction with the support and help they received from the health professionals and the centres. The interpersonal relationship with the health professionals and the relation with the centres are seen and understood as a very important factor and a possibility in their daily lives. A factor and a possibility that is also important in relation to the problems they want to solve.

"I am very satisfied with the treatment and support. Yes, I appreciate it very much. If I were to finance those things alone I would not make it. I would not make it. The cost of medicine is too high, so expensive. Operation requires a lot of money, see? So, for me I would not be able to make it, so I appreciate their assistance (...) They are co-operative with their clients."

"They (health professionals) are good people ... and very close to me, and they always talk to me and relieve me, and try to explain to me ... Yes, the doctors, everybody. People understand me here ... I am happy that the centre exists ... Always good things, nothing bad."

The health professionals and the centre are not perceived merely as professionals and an institution that try to solve problems – they are direct and indirect partakers in the lives of the clients.

"The people from the group, and the doctor, are very important, and they are friends now, and we can talk with each other. And some people from the group come to my home ... Yes, the doctor and the group is a very important support in my life, inside and outside."

The health professionals and the centres are otherwise an important acquaintance – an acquaintance that might lead to *a change* in the clients' socio-economic circumstances.

"XX (health professional) brings a lot of rice and money, yes. And if there is a special day, a big day, then XX gives money to me and also to my family."

This acquaintance and relationship becomes clear during some of the interviews, illustrated by remarks about how the clients feel dependent on the health professionals and the centre.

"I am waiting for XX every (day), looking in the calendar for it to come. It is very good for me ... I like to come here, and I come even if it is not for treatment (...) The clients do what the doctor tells them to, but I would be very disappointed if it (treatment) would stop ... I will stop only if they (health professionals) force me. And if they force me out of the door, I will come in through the window!"

The health professionals and the centre are (after all) a system the clients are dependent on, a system whose attitudes may have a consequence for the clients and their families – and therefore also might mean a difference to their possibilities of development in the society.

The dependency on collaboration and support from the professionals are obvious, but the clients don't seem to mind this "model in service provision".

"The centre exists for the clients and they serve them ... I do everything they (health professionals) say."

The clients' relation with the health professionals and the centres is in this way characterised both by *dependency* and *distance*.

A connection between the every day lives of the clients, the health professionals and the centres seems to be missing. This becomes important for the possibilities for mutual co-operation and influence.

"Of course when I come (to the centre) I feel better each time. But when I return to my everyday life there are still some of the problems that I had before, because I feel that a lot of injustices have been done to me and there are still a lot of injustices happening. Because I also depend on this country, and I am very sensitive about it. Maybe my situation would be better if I would not be so sensitive about these injustices."

The interviews have focused on the clients' understanding of and influence on the process of problem identification and definition. It is revealed by the interviews that in some cases, the clients are not aware of the health professional's goals, plans, means and methods. Neither are they aware of, what possibilities and limitations there are in service delivery within the given frames of the centre.

In the interviews the clients present their perception and understanding of the problems, their frustrations and their anger, themes that are often *not touched* during treatment sessions. In that context the problems as perceived by the clients seem to *vanish,* they accept that they need to be examined and treated by professionals, and *subjects* to the provided treatment and the health professional who offers the treatment.

"I always used to be satisfied but lately when I came, I was dissatisfied and they were also dissatisfied because they (health professionals) did not have resources to give anything ... can you maybe tell me something that can ease the situation for the staff here? Some of the clients, me and some other people, come here and cannot understand the situation, so we yell at the staff, and it is very hard for us and for them."

REHABILITATION AS A POSSIBILITY FOR DEVELOPMENT IN THE PROCESS OF LIFE

"The atmosphere here and the people working here mean a lot to our life ... The atmosphere of kindness and understanding, because it is the basis for a person to feel good."

Several of the interviewed clients use the work of the health professionals and the centre as an important opportunity for development in their life. They apply their experiences within their families, in the raising of their children, in their understanding of the dynamics of interrelationships within the community and in order to expand their own potentials.

It is difficult to register changes in the client's personal use of life circumstances, and it is in particular difficult to attribute such changes to an applied health professional intervention. Possible changes must therefore be ascribed the event of rehabilitation combined with other contributing and interrelated life events.

The clients tell in the interviews that during the course of the treatment they start to reflect, change their points of view on things, and wonder about possibilities and relations, which the health professionals put into perspective.

"I feel much better now. Because I feel safe here ... and the professionals understand me ... I can always come here and find a pleasant attitude ... With the other people, the other neighbours I feel very good, and people respect me and I respect other people."

"Now, I am not crying and I am not easily annoyed or frustrated (...) I feel better and not nervous, healthier, and I have a very good relationship with my neighbours."

"Maybe I feel better, because I communicate better with people now, and I talk to different people, and I like to work and do other things."

"I am very satisfied and very grateful. I haven't words to express it. Because I was referred here and I got medicine – you can see here is the prescription from the doctor. I have this problem with pain. 40% of my pain is relieved now, but I am still not able to work."

It is difficult to measure the effect of these conversations/ interventions as such, but they might be of great importance to the changes, which the clients themselves introduce into their lives.

Rehabilitation and outcome of rehabilitation from the health professionals' perspective

THE CLIENTS AND PROBLEM IDENTIFICATION

The health professionals were asked who the clients are.

"The clients are the ones, who have been subjected to torture. They have been taken and tortured, maybe because of their opinion, and sometimes for no apparent reason, and maybe just to make them do something against their will ..."

"They are different, people from concentration camps really hard torture victims, between all the people, the girls and the young maids, younger men, who were hardly tortured, and they have much headaches, spine pains, spine problems, they are very different."

"There are two categories of clients here. There are victims of torture who have been beaten by the police and some who have been e.g. shot by the police. When they are diseased the family members come to us and ask for post mortems. When it is about medical aspects we may have the immediate victim here and deal with him or her directly. If the victim is in hospital maybe we liaise with the family either first of gender or spouse, when they contact us and we get the case."

"I can put the client in two categories. In one group, there are people who are silent and do not talk much. And they always ask if the name and last name will be kept anonymous. People who have suffered a lot ... People who say that they never want to come back to the place that they lived before (...), in the place where the torture happened, where they saw their children being killed or their husbands or women being taken away. People who come here and thank very much for one medication ... The other group is also people who survived torture and lost material goods, but who come here very angry and very furious ... There is this client to whom we always explain every time he comes here, that there are things that we can and cannot do ... This client always starts from the point that 'I am a victim, and that I have to have help' no matter if he has got everything that we can offer ... The first group, would probably say to me: 'You are somebody who wants to help us', and the other group would often say to me: 'You are the one responsible for what is happening to us, we wish you the same.'"

In general the health professionals tell that it is the centre that defines the clients' problems. Additionally the health professionals also review the referring organisation/health professional's points of view and based on these elements a conclusion and a recommendation for treatment are made.

"Most of them we accept, but some we refuse. Because we know, how to sort them out. And what happens if the client comes again now, with different issues? If the first history was related to the direct torture, and this is some other side effect, I try to explain to the client, 'this is what we did, and our area is only torture. Now this is stomach pain, which is not related to that issue, and due to our donor funding, we are not allowed to do this'... So when you try to ease them back, they still want to go and talk. So it is an area, where it is very complicated. It is an area where psychologically you have to be

ready to deal with all sorts of people. Others they will speak abusive language, others they are donuts, others you really will not understand, because they are afraid to trust you."

"My first step is debriefing, because it is from debriefing that I will be able to tell what this client actually requires. During the debriefing what I start off with, after knowing each other and creating rapport with the client, I would like the client to relive the situation, just to try and recount the events ... Yes, I am able to define the clients' problem, because at the end of each – the debriefing also serves as an exploration, which is the intake."

"Let's say e.g. that somebody comes with this lack of sleep, how do I define that to him? I tell them, that you know, when you are going through all these torture problems, there was arousal within you. The body or the mind was kind of aroused. And this one is coming with the problems, such as lack of sleep, such as lack of concentration, you know. So I will tell them: 'That is not because there is something terribly wrong with you, but this is the result of the problem or the result of the torture you went through, this is why this is happening'... But basically during the first session, I am not going to have all that time to explain. It will go step by step until we cover all this, because there are quite a number of these problems ... Now what do I call what I do? I usually call it 'psychological assessment' ... When I come to doing my assessment I will do the cognitive side first, then I will go to the social one, the emotional one and then the sexual side also ... And sometimes I use the Harvard Trauma Questionnaire, and I find that one is even easier ... Now afterwards, when I have done that one, I have to do the analyses of this kind of information which I have got. What is the case, I am having here? Is it a PTSD? Is it depression? Is he now being psychotic or is it only just anxiety? So this kind of information will give ...

What do I do? When I ask them, they give me these things and then after I get them, and I know what he is having, I am going to explain to him, that 'this is what is the problem with you, and you need to be helped with this and that, so you will get your treatment plan, based on what I have found'. These findings will now guide you, as to what methods you are going to use, to help this client."

Working tasks and working conditions

The health professionals were asked about their tasks in relation to the referred clients and their problems. The picture is multifaceted – and the most characteristic about this picture is the *multi*function of the staff.

"We must be emphatic, we must be good listeners, we must also be non-judgemental when we are talking to them. We must listen with controlled emotional involvement. If we show this once, then they will see that 'this person is somebody who I can trust, and I can talk to'."

"If you work in a community, you must know as much as possible about their language, culture and race. Because all those dynamics affect the relationship and affect the way one can operate in all professions actually."

"They sometimes ask me to give them also some money, and I say that we only give treatment not money."

The health professionals recognise that the problems presented by the clients are not only physical or mental by nature, but comprise also economical, social, and legal aspects.

"These people, the torture victims, are people who need a 'holistic' management. Sincerely, if you take the torture victim, you know, first of all their problems are not just one. They have psychological problems, they have physical problems, they have social problems, they have legal problems. So if these thing could run concurrently that would be good."

"We are limited financially, and the clients need something for heating in the winter, and they need shoes, and all this costs something financially, and we are limited in that area. Because the clients mainly come for those reasons, they mainly want to solve those problems, the social problems, and the other things are secondary for them, the other kinds of help that we provide. There is no support in the law. They could maybe turn to, that there is no law to support them."

It seems as if the health professionals initially choose individuals as the object of treatment, but when the problems as well as the foundation for the understanding of these problems change, the object of treatment needs to change and expand as well, and to also include the individual's *social context.* It is the health professionals' task to focus on the clients' *overall situation* – which implicates the use of new specialised knowledge.

In the interviews it is clearly demonstrated that one of the health professionals' tasks is to intervene in social conflicts between human beings, conflicts in which the definition of the problem itself constitutes a social conflict with differences of interests involved.

"We can se that those people (the clients) are living in very bad conditions, in other people's houses, and in very bad conditions for living. They do not have health insurance, the government is doing nothing to help them, they are left to themselves ... When we speak with them, on the first place they put the providing for the family and for the children to provide for them, for the food, the clothes, for the school, and then other problems – like health problems."

Collaboration and multidisciplinary skills

The health professionals' tasks are placed in the middle of, or more accurately covering the whole spectrum of the social dimension. They have tasks related to many different people and institutions and in trying to solve these problems they are likewise dependent on many people.

"I do not see that anything is being done about social problems. They (institutions representing the government) have even told me, after a few recommendations for transition to third countries for the clients, not to do it anymore because it would look like we are sending people out of the country. Although I see that it is the only way for some people who want to go out ... I get a little bit satisfied with the small financial help we can sometime give ... but nothing concrete. There was a conference and a seminar, but I do not see that anything socially, in the social dimension, is done."

Possessing multidisciplinary skills and the demands for a thorough co-ordination of services and interventions provided by individual health professionals play a central role. The health professionals were asked about their collaborating partners – who they are and who they collaborate the most with.

"I collaborate on sharing experiences with the counsellors, in the professional meetings and supervision, and we just share our experiences ... Well in my work I collaborate mostly, it is like the people I have done some work with or where I have gone to raise awareness and so on, it is mostly the communities in the slum, the schools and families."

"We are a team work. We solve all problems together. We exchange experiences and information especially about the clients, and it is very positive and the clients feel that. Also something which are out of the centre, if somebody of us can, we do it for the client."

THE CLIENTS – SUCCESSFUL OR NOT SUCCESSFUL

The problems the health professionals deal with and thereby "solve" are characterised by conflicts in and between human beings, and cannot be solved without the active participation of the involved parties. Some health professionals talk about their frustrations due to lack of "visible" results, lack of possibilities in assisting the clients and insecurity about how the clients are going to cope.

"Concerning the clients, I think that it is the same because the service is the same. Considering the experience of the professional team – it is bigger, but maybe from the experience it is harder because you have more experience, because you know more of the problems, and you can see the old clients coming back again. I started working with what the centre can offer and now I have some experience and the things are the same, and there are some things missing all the time and things are the same as the beginning. It was okay at the beginning before I knew what really were clients' problems and what can I do in their problems. Because I do not know what I knew afterwards. Now the problem for me is bigger because I know what the problems are, and what I can offer to clients and I know that I cannot do much."

"I feel helpless. When you hear so many problems, and me personally, I cannot do much about these problems, but I can maybe refer them to somebody, somebody here or somewhere else, but there are some of the problems that nobody can help them with. There are some things that happened to them that changed their life in a way so that you can never make it better."

"Because the clients' situation is not solved. I cannot see that anything has been done (by the government) for those people. Because a woman may have lost three of her children and what can I say to her? 'Here is the medication!'"

Other health professionals are more positive in their assessment of the process and the outcome of rehabilitation.

"It is possible (success), it is very possible. Not only because of me, but especially because of the efforts of the group itself, how they try to continue with their lives."

"Seen from my point of view, there are many positive changes that can be observed, changes in the clients' behaviour, changes in their perception of life, changes in their level of participation in important development projects in the community, in their capacity – step by step – to cope with their fear and the silence. Yes, I do consider that there are changes in how the clients – step by step – appropriate different spaces where they are protagonists, "actors". From my point of view these changes are important and visible."

The criteria for finalising the clients are assessed by the individual health professionals from different perspectives and points of view.

"When I decide to stop the treatment, it sometimes depends on how many sessions I was dictated to have with the client ... Yes, I really have to do my best to see that at that time I have done what I can do. Or if I find the case still very bad, doctor XX is very understanding and I tell doctor XX: 'You see, I do find that I have not mastered this area, the client is not well, now can we give him maybe two or four sessions, to see how this client is."

"How do I decide to terminate? First of all, I have to prepare the client and I work with the client to come to that also. I will see, that the client has improved in the areas where he was having difficulties ... And I also have to know whether he is now doing activities – he has gone back to what he was doing before. And he also feels comfortable; I feel I am okay, and I do not need to keep a client in therapy who is ready to go. But still I do keep an open door. I do tell them, in case of any other thing, yes. But my aim actually is to "empower" them and they live their life."

The health professionals were asked if they could identify some typical causes for a rehabilitation course turning out to be not successful.

"If the client was not ready for therapy. You see, people who just come here they may not themselves have thoughts of going into therapy. So the client may not even come back. In fact it is also difficult to tell whether there has been success or not in that aspect, because the client did not come back again. The client may not come back because he gained insight when he got home, and now he is able to manage his life. So it is not always an indicator that it did not succeed."

"When there is no understanding from the governmental organisations, no understanding by anybody. And sometimes you can see how fast they are to reply that they cannot do anything, that they are not authorised. And they just say that they are not dealing with the clients' problems and that I should turn to somebody else."

"When there is extreme poverty, when somebody tries to recover, but they cannot recover, and usually what happens, is that they go into depression. I have observed, in my own work with these people, that when there is a lack of social support, when there is poverty, when they is previously not well functioning, before this instance of torture, then they have problems too, in recovering."

"When the clients have unrealistic expectations. They are coming here maybe for a year, and they are still expecting some things we can never give them; I mean like financial support and things like that. And you feel helpless at first because you cannot give them anything, because there is no way that we can help. And after that you feel a little bit, I don't know, disappointed because you cannot do anything but talk to them, and each time about the same things."

"When the process is very long, and the clients come from different regions, and different doctors examine the clients. This means that it is not the same doctor who is responsible for all supervision and control of the clients. It is difficult then to discuss the development of the clients between the

doctors and the field workers who have that duty. Yes it might be difficult, and the results are not effective ... The unsatisfactory results are caused by the long process and also the different opinions and thoughts of the doctors, and the minds of the clients, and also the field workers, who control the clients – they are different. And the clients they have chronic problems, very big problems, so even though we give them a treatment, the result is not satisfactory."

"When the client does not want to take medicine, maybe the lack of support, the lack of family support."

These statements express the fact that the core of the health professionals' skills and their position in a social work field, is influenced by the polemic that takes place about the clients' problems, the possibilities and responsibilities of solving them.

THE LINKAGE BETWEEN THEORY AND CLINICAL PRACTISE

The majority of the interviewed health professionals tell that they need to develop their own skills and professionalism in order to manage their tasks within the work field. They also express the necessity for the development of norms and standards in order to systematise, describe and understand their clinical practise and based on this to be able to implement theoretical frameworks that do not contradict the clinical needs. They recognise that research and analysis should be part of the practise and a basic activity at centres.

The health professionals were asked if they themselves or the centre apply an explicit theoretical framework, an explicit approach or methodology in the rehabilitation of the torture victims.

"Indirectly maybe, indirectly."

"I think that we try to adjust to the needs of the clients. Because some of the clients need only supportive psychotherapy and some of the clients need more. It depends. Because in my opinion all people cannot be satisfied with the same therapeutic approach, and some people need something and some people need something else, in the approach, I mean."

"I like using Rational Emotive Therapy. Cognitive behavioural therapy comes in, and also, I must tell you I am a "eclectic" counsellor or psychotherapist. Depending on the case, I will maybe use one form here another form there, but even in one client I may use several. E.g. I may also use client centred therapy, and this will help me to allow the client to express himself or herself, and I really want to listen, and encourage him to talk ... I also use imaginary; when the clients have these nightmares, you know when they have very scary things, I ask them to change the scene of their dreams. And this one, I find to be very, very powerful. I don't know, but I have really believed in it."

"You see in a counselling perspective, I am "eclectic". But within that eclectic model I use the humanistic base, the person centred, so, 'I am interested in you as a person, and I do not judge you'. In that non-judgemental atmosphere the client is able to feel free to self disclose, so instead of explaining who I am, then I request the client to introduce him or herself, and then I explain to the client how I work: 'this is counselling and in counselling you do not give answers, but we shall work together and get to a solution'. Then I give terms of the contract 'we shall be together for such and such a time' ... Yes, within the humanistic base I am "eclectic", and then most cases I apply behavioural therapy, because of these images they keep experiencing and the fear they have in them ... So I need to at least "empower" them so that they are assertive enough to know that it is just an image."

"As long as I have worked here, I have not received any specific training in clinical practise with torture victims or theoretical frameworks. The way I examine the clients, is based on the knowledge I got when I was studying, at the university."

"I think we have very interesting discussions about theory. These are often very emotional. In those situations it becomes clear that our points of view are quite close. Maybe we have had some problems, the biggest one I think has been related to which theoretical concepts we use to define our practise. As a psychosocial action, intervention, or ...?"

"... I don't think we have any specific common theoretical framework, because each of us have our own theoretical framework, and those are very different and we adhere to those. We have discussed at length and we still stick to it, but we have a common instrument – "the word", the discourse. 'To create space with the clients, where we are able to share experiences, especially through "the word". I think that the theoretical framework we have is "the word", a humanistic approach'."

The relation between clinical practise and research was also discussed with the health professionals. They were asked, how much they read and to what extent they apply scientific theories and research results in their concrete clinical work.

"I don't really read much. I read a little, I must say, whenever I have the time. The only thing which I find is difficult, is to find time for myself, and sometimes I know it is important, and sometimes I tend to say that I will do it ... I would like to know more."

"I have never had any chance to exchange views and experiences, and knowing how other centres deal with the torture victims."

"I read as much as I have access to. You know, because you cannot buy a lot of new things here, you cannot find it, except on the internet, and as much as I know, there is not that much literature on the internet. So I think as much as we receive from anybody, as much as we can get ..."

DISCUSSION AND PERSPECTIVES

The study had two main purposes.

One was to describe – based on a phenomenological approach – the outcome of torture rehabilitation as provided at specialised centres and in different socio-cultural settings seen from the clients' and the health professionals' perspective.

The other was to use the obtained knowledge in generating hypotheses to be elucidated by future qualitative and quantitative research projects.

The participating centres in the current study were selected based on their differences in organisation of service delivery. All centres however applied a multidisciplinary approach in the assessment and treatment of individual clients, but the clinical practise and priorities within the clinical practise varied, reflected in the professional profile and composition of staff across centres.

The torture victims treated by the individual centres

shared many characteristics. They all belonged to poor and socially marginalised populations, were all randomly targeted by the torture, and the majority presented with a multitude of physical, mental and social problems even years after being exposed to the atrocities.

In this explorative study a representative sample of clients and health professionals were interviewed in order to obtain an increased and intercultural understanding of:

- the objective of rehabilitation – problem identification and problem understanding
- the process of rehabilitation – the clinical practise and applied theories, goal setting and expectations from the clients' as well as from the health professionals' perspective
- the clients' preferences, perception of, and satisfaction with their health outcome following rehabilitation.

The results of the study show that the objective of rehabilitation – the problem identification and problem understanding – depend on the professional background and the composition of the staff at centres, as well as the socio-cultural context the individual centres are placed in.

That a broad spectrum of theories, methods and treatment approaches are applied, and that no explicit procedure/method/practise is used to elucidate, uncover and define the multitude of clinical problems presented by the clients.

That the theoretical knowledge and the practical experience available at centres often determine the way individual centres prioritise to organise their clinical practice, but that this practice is also influenced by concrete possibilities and limitations within service provision.

It therefore seems difficult – within rehabilitation as it is practised – to clearly delineate professional tasks, professional competencies and qualifications, and that this diversity of positions and perspectives might influence mutual goal setting in and planning of treatment, and the coordination of overall rehabilitation courses.

The clients present different, but specific physical and psychological problems, problems they invariably relate to the *complex social context* in which they live.

Expectations to treatment and to the health-related outcome of treatment are very concretely formulated within the physical and the social dimension: pain relief, improved physical function, improved individual function within the family; improved interpersonal relationships in the community, and return to work/being able to provide for the family.

These expectations formulated by the clients seems to be in concordance with the stated treatment goals as presented by the centres.

Across centres the interviewed clients expressed a *through-going satisfaction* with the support, treatment and rehabilitation they were provided. This satisfaction was placed in different dimensions – the psychological, the physical, and/or the social dimension – but represented in general an achievement of self-efficacy. "Empowerment" – especially in relation to the clients' daily living and future perspectives – does for that reason emerge, as an overall outcome of rehabilitation.

The interviewed health professionals' possibilities and limitations are formulated in relation to a complex work field. A work field, where many of the physical and psychological problems presented by the clients are perceived to be chronic, and where the health related problems often disperse in the social context – a dimension where most of the health professionals feel limited in providing a sufficient assistance.

Despite the complex character of the work field and the context in which it is practised, the health professionals find their work to be of great importance. They affirm that the services they provide not only have an impact at the narrow clinical level, but also an impact at the societal level. That the mere existence of rehabilitation centres specialised in treatment of torture survivors creates public awareness of "the problem of torture" and contributes to the prevention of torture, and fight against human rights violations.

Implications for future research

The work field of torture is a work field with an applied practice. Research should therefore be relevant, focusing on existing problems and possibilities related to this practice.

Problems related to practice become visible in and are outlined by the field of practice. Knowledge production as well as dissemination and implementation of knowledge should therefore not be driven by an isolated "research practice" seeking to transfer knowledge to the field of practice. It is the field of practice that defines and outlines the character and relevance of problems to be prioritised by research.

Research conducted from "above" and from the "outside" easily fails to capture how actors in the field of practice selectively focus on certain aspects while disregarding others, how they identify and define problems and possibilities, and how they realise or neglect those in the context they act in. All these aspects are pivotal in action/practice- oriented research, which aims at creating knowledge and build competencies allowing *the participants* themselves to develop their own practice.

The goal of "action research"/"practice research" is to contribute to a *systematic description* and *development* of a given practice. The knowledge the research aims at producing is an *insight* in and *understanding* of specific aspects of the practice under study – an insight that makes description of the practice possible and permits further development of the practice[24].

Given the uniqueness of torture as a trauma, the complexity of the health-related consequences with numerous contributing and modifying factors and the diversity of provided rehabilitation services to torture survivors, outcome research in this area is complex. The scientific approach still implicates a series of methodological problems, which need to be solved and the use of combined research methodologies applied in several steps in order to ensure validity of the results.

Qualitative research methodology needs to be applied in order to obtain a better understanding of phenomena such as the objective for rehabilitation (problem identification and problem understanding), the process of rehabilitation, mutual goal setting in and expectations to rehabilitation, and criteria defining a successful outcome.

Qualitative research methodology will likewise be a prerequisite to identify meaningful outcome indicators and in order to develop instruments to be used in successive quantitative outcome research including effectiveness studies of different rehabilitation models, efficacy studies of different treatment approaches and in cost-effectiveness studies.

The IRCT has drafted a long-term research strategy (Fig. 1) within the area and conducted the first in a series of studies, which is accounted for in this report. Based on the status of the existing knowledge base, which includes the results from the current study, additional priority areas have been identified and the following phases included in the long-term research strategy:

Phase II

The objective of the study in the second phase will be to further complement and increase the knowledge obtained in the first

study. Generated hypothesis is thought further elucidated by broadening the perspective on torture victims and rehabilitation adjusting the applied interview guides and questionnaires and by including other significant informants e.g. family members and other important social network members, extreme cases e.g. treatment drop-outs, and torture victims never referred to treatment in the study population.

A series of focus areas related to centres, clients, health professionals and other significant informants has been identified including e.g.:

The clients' perception of the rehabilitation course and outcome of rehabilitation in relation to other significant life events and the social context.

The health professionals' expectations to and perception of the rehabilitation process and outcome of rehabilitation in relation to other significant events in the lives of the clients and their social context.

The health professionals' working methods and clinical experience within the work field applied in clinical reasoning and as a framework of provided interventions.

Coping-strategies in relation to torture and other significant life events adjusted by torture victims never referred to treatment.

The study is planned as a large-scale multi-site study including centres worldwide. Applied research methodology will – as in the first study – be a combined quantitative-qualitative approach based on questionnaires, and semi-structured individual and focus group interviews.

Phase III

Operational, measurable outcome indicators with a relevant conceptual basis for multidisciplinary torture rehabilitation, will be developed in the third phase. Based on processing of the data collected in the first and in the second phase it will be decided, what is to be measured and the agreed concepts will be defined and translated into an observable form. Additionally each indicator will be analysed for intercultural applicability.

The outcome indicators will be defined and developed according to a broad concept of health and change in health status encompassing the various domains of health, health-related quality of life, and "social health" including occupational and social role functioning, and maintenance of social relationships and activities.

Clients' satisfaction and degree of fulfilment of expectations of treatment will likewise be analysed as potential outcome measures.

With the aim of evaluating intervention, a multidimensional outcome assessment instrument will be developed based on a combination of instruments with different properties including the identified and operationalised outcome indicators. Key characteristics that will be prioritised in constructing the instrument will be:

- A relevant conceptual basis for multidisciplinary torture rehabilitation
- High responsiveness reflecting clinical significant change in health status
- High quality of psychometric properties
- Intercultural applicability.

Phase IV

The objective of the fourth phase will be to validate and test the acceptability of the developed multidimensional assessment instrument across cultures and to adjust the instrument if needed.

Psychometric equivalence among instruments in different cultures is satisfied when the psychometric properties of two or more cultural groups are essentially the same. Key issues are comparable reliability, validity and responsiveness[25, 26]. The following will be considered validating the developed outcome assessment instrument across the participating centres:

- Content equivalence
- Criterion equivalence
- Conceptual equivalence
- Semantic equivalence.

Phase V

The objective of the study in the fifth phase will be to establish effectiveness information, conducting a prospective, baseline outcome study including a one-year follow-up applying the developed instrument.

A quasi-experimental study design (effectiveness design) is considered to be the most feasible design for the study. Since it is not ethically possible to randomise torture victims into non-treatment groups, a suitable non-randomised comparison group will therefore be identified to control for internal validity confounding.

As stated in the introduction the expected output of the overall IRCT Impact Assessment Study is to be able to provide the work field of torture with:

- Effectiveness information regarding the rehabilitation of torture survivors in different socio-cultural settings
- Knowledge on empirically validated rehabilitation of torture survivors, which can be used in the establishment of clinical guidelines and in quality development of the clinical practise within the work field
- Relevant and operational outcome indicators, which can be used in outcome monitoring at centres worldwide
- Assessment instruments, which can be used in intercultural outcome research.

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The work field of torture

Impact assessment study and anthropological reflections

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