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Conceptualising a contextually relevant torture rehabilitation framework for Sub-Saharan Africa

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CONCEPTUALISING A CONTEXTUALLY RELEVANT TORTURE REHABILITATION FRAMEWORK FOR SUB-SAHARAN AFRICA

Craig Higson-Smith

A thesis submitted to the Faculty of Humanities, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Doctor of Philosophy

February 2020

... some of those who spend their time chiefly in making of experiment
are too apt to treat those who do not with a dogmatism bordering upon contempt ...

A letter from Samuel Cooper, to Joseph Banks,
President of the Royal Society of London, 3 January 1782
(Cited in Schaffer, 2010)

I'm going to be me as I am, and you can beat me or jail me or even kill me,
but I'm not going to be what you want me to be.

Stephen Bantu Biko

Published Papers and Declaration

Chapters five, six, seven and eight have been published previously in peer-reviewed journals:

Higson-Smith, C., & Eagle, G. (2017, August 24). Counseling Torture Survivors in Sub-Saharan Africa: How Relevant Are Current Evidence-Based Practices? *Traumatology*. 24(1), 36-46. http://dx.doi.org/10.1037/trm0000131.

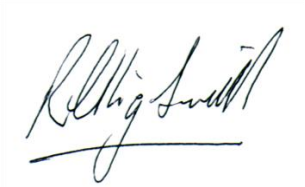
Higson-Smith, C. (2014). Complicated grief in help-seeking torture survivors in sub-Saharan African contexts. *American Journal of Orthopsychiatry, 84*(5), 487-495. http://dx.doi.org/10.1037/ort0000009

Higson-Smith, C. (2013). Counseling torture survivors in contexts of ongoing threat: Narratives from sub-Saharan Africa. *Peace & Conflict, 19*(2), 164-179. http://dx.doi.org/10.1037/a0032531

Higson-Smith, C. & Eagle, G. (2018). Towards a contextually appropriate framework to guide counseling of torture survivors in Sub-Saharan Africa, *Torture, 28*(1), 18-33. Retrieved from https://irct.org/publications/torture-journal/141

On the single author papers, I was responsible for the design, data collection, analysis, and text. Professor Gillian Eagle reviewed manuscripts before submission and offered helpful feedback and suggestions. On the co-authored papers, Professor Eagle also provided valuable clinical insights to the analysis and substantive additions to the text. Professor Eagle contributed similarly to the development of the Foundational Capacities Approach described in Chapter 9.

Except where noted above, I declare that this thesis is my own, unaided work. It is submitted for the Degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



Craig Higson-Smith

First Day of February, 2020 at 9 am

Acknowledgements

I am grateful for the financial support of the African Doctoral Dissertation Research Foundation (ADDRF), a program of the African Population and Health Research Center (APHRC) in partnership with the International Development Research Centre (IDRC). I would also like to thank the program leaders and other technical advisors of the International Capacity Building Program of the Center for Victims of Torture (CVT). Working in this program has taught me so much about the challenges of torture rehabilitation centres in sub-Saharan Africa and around the world.

Research projects should not be solo affairs and this one was not completed without the involvement and support of others. I would like to thank my supervisor, colleague and friend, Professor Gillian Eagle for her invaluable insights, trust and unwavering support throughout this process. I would also like to thank my "family that you choose", especially Denis Hutchinson, Alan McEwan Goss, Beth Hudnall Stamm, Henry Stamm IV, Kirsten Thomson and Monica Bandeira, for their practical and emotional support throughout the years it has taken me to complete this thesis.

Thank you also to the practitioners and survivors of torture who participated in this project: the executive directors of the Centre for the Study of Violence and Reconciliation (CSVR) in Johannesburg, the Centre for the Rehabilitation and Abolition of Torture (CRAT) in Yaoundé, and the Independent Medico-Legal Unit (IMLU) in Nairobi, who trusted me to work in their organizations; the clinical coordinators and program evaluation officers who gave me access to their clinical records and answered my endless questions about their record-keeping; and the counsellors who trusted me to talk to their clients and engaged so wisely and energetically with my questions.

Most importantly, I would like to express my gratitude to the men and women who met with me to tell me about their challenging journeys from torture to recovery. After everything that has been taken from you, you still volunteered to sit down with a stranger and share your experiences. You did this in the hope that your experience might at some future date ease the burden of another survivor. You inspire me with your wisdom, courage and generosity.

Craig Higson-Smith

January 2020

Abstract

The practice of torture is widespread in sub-Saharan Africa and often associated with war and oppressive rule. Hundreds of thousands of survivors of torture live in the region's cities, settlements and refugee camps, where mental health services are extremely limited. Current evidence-based practice guidelines for the rehabilitation of torture survivors provide little guidance for practitioners in sub-Saharan Africa whose clients must contend with contextual realities, often very different from those of the Global North.

Using a mixed-methods design, I investigated the work of three torture treatment centres in different parts of sub-Saharan Africa with the aim of documenting the needs of actual help-seeking survivors of torture in sub-Saharan Africa and analysing their experiences of recovery through interaction with existing mental health services. To this end, I reviewed the therapeutic charts of 85 torture surviving adults in care and conducted in-depth narrative interviews with fifteen counsellors and sixteen adult torture surviving clients. The study incorporated uni- and bivariate statistical analyses of quantitative data as well as thematic and narrative forms of qualitative analysis. The mixed method research approach shaped data collection, analysis and interpretation.

The results revealed several categories of torture survivors reporting extremely high levels of anxiety and mood-related symptomatology. The impact of recent violent bereavement and ongoing threat were identified as therapeutic issues that are inadequately addressed in existing treatment guidelines. Both counsellors and clients emphasized the importance of trauma exposure interventions, strengthening family relationships, problem solving, symptom management, and nurturing hope. Based on these findings I propose the Foundational Capacities Approach (FCA), an approach to counselling torture survivors designed in response to the contextual realities of torture survivors in sub-Saharan Africa. Although FCA was developed in sub-Saharan Africa, torture survivors in other parts of the world face many of the same challenges, and practitioners in other regions might find value in the findings and conclusions of this research.

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List of Acronyms

AI	Amnesty International
ACHPR	African Commission on Human and People's Rights
ACTV	African Centre for Treatment and Rehabilitation of Torture Victims
ADAPT	Adaptation and Development after Persecution and Trauma
APA	American Psychological Association
CAR	Central African Republic
CBT	Cognitive Behaviour Therapy
CETA	Common Elements Treatment Approach
CPT	Cognitive Processing Therapy
CG	Complicated Grief
CL	Confidence Limits
CPTSD	Complex Post Traumatic Stress Disorder
CTS	Continuous Traumatic Stress
CVT	Center for Victims of Torture, United States of America
DESNOS	Disorders of Extreme Stress Not Otherwise Specified
DF	Degrees of Freedom
DRC	Democratic Republic of Congo
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBP	Evidence-Based Practice
EBPP	Evidence-Based Practice in Psychology
EMDR	Eye movement desensitization and reprocessing
EPCACE	Enduring Personality Change after Catastrophic Experience
ES	Effect Size
FCA	Foundation Capacities Approach
GAD	Generalized Anxiety Disorder
HRW	Human Rights Watch
IAT-G	Group Integrative Adapt Therapy
ICD	International Statistical Classification of Diseases and Related Health Problems
IDP	Internally Displaced Person
IMLU	Independent Medico-Legal Unit (Kenya)

IPT	Interpersonal Psychotherapy
IRCT	International Rehabilitation Council for Torture Victims
ISTSS	International Society for Traumatic Stress Studies
KIDNET	Narrative Exposure Therapy adapted for use with children
LGBT	Lesbian, Gay, Bisexual and Transsexual people
LRA	Lord's Resistance Army
MDD	Major Depressive Disorder
MRI	Magnetic Resonance Imaging
NET	Narrative Exposure Therapy
NICE	National Institute for Clinical Excellence (United Kingdom)
NIMH	National Institute of Mental Health (United States of America)
OCD	Obsessive Compulsive Disorder
OR	Odds Ratio
OTSR	Ongoing Traumatic Stress Response
PCL-C	Posttraumatic Stress Disorder Checklist
PGD	Prolonged Grief Disorder
PTSD	Post Traumatic Stress Disorder
RCT	Randomized Control Trial
RCVTE	Rehabilitation Centre for Victims of Torture in Ethiopia
SD	Standard Deviation
SSQ	Shona Symptom Questionnaire
TF-CBT	Trauma Focused Cognitive Behaviour Therapy
TRC	Truth and Reconciliation Commission, South Africa
UN	United Nations General Assembly
UNCAT	United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
UNHCR	United Nations High Commission for Refugees
US	United States of America
USAID	United States Agency for International Development
VTF	Victims of Torture Fund
WOZA	Women of Zimbabwe Arise
WHO	World Health Organization
ZANU-PF	Zimbabwe African National Union-Patriotic Front

Chapter 1 Introduction and Rationale

In recent years news media reporters have been unusually interested in torture, a political and emotionally shocking topic that evokes strong, divided reactions. Following the Second World War the powerful democracies of North America and Europe collectively rejected the use of torture and codified this in the Geneva Conventions (International Committee of the Red Cross, 1949) and the Universal Declaration of Human Rights (United Nations General Assembly, 1948). The latter optimistically promised that no one would be subjected to torture or cruel, inhuman or degrading treatment or punishment (Article 5), or to arbitrary arrest, detention or exile (Article 9). It also guaranteed the right to effective remedy for acts violating people's fundamental rights (Article 8) and the right to seek and enjoy asylum in other countries (Article 14). And yet, only sixty years later, the world learned that the very states that forged the United Nations had repeatedly and unapologetically betrayed this vision through the detention, rendition, and torture of suspects in the "war on terror" (Blakeley & Raphael, 2017; United States Senate Select Committee on Intelligence, 2014), at times with the technical support of social scientists and healthcare professionals (Balfe, 2016).

The predominant discourse justifying such practices has centred on what Shue (1978) in his classic paper described as "interrogational torture", torture for the purpose of extracting information. This, however, is an overly narrow, misleading picture of torture in the world, a picture that ignores the use of torture as an instrument of terror. In "terroristic torture … the victim is simply a site at which great pain occurs so that others may know about it and be frightened by the prospect" (Shue, 1978, p 132). In fact, the intention of torturers around the world is much more commonly terroristic – designed to punish, intimidate, silence or coerce social minorities and political opposition members (Summerfield, 2003) - than it is to extract information supposedly in the interests of the broader populace.

Since torture is political, so too is the work of supporting survivors and conducting research concerned with their wellbeing and rehabilitation. Through this research I hope to contribute theoretically informed yet pragmatic proposals for the improvement of specialist mental health services for torture survivors in sub-Saharan Africa, one of many regions in the world where torture is still pervasive.

The Practice of Torture in Sub-Saharan Africa

Sub-Saharan Africa comprises approximately fifty countries and torture has been documented in most of them. In many cases the practice of torture is widespread, systematic and normative. There is credible evidence that many governments (including those of Burundi, Cameroon, the Democratic Republic of Congo (DRC), Equatorial Guinea, Eritrea, Ethiopia, Guinea, Kenya, Nigeria, Rwanda, Somalia, South Sudan, Sudan, Tanzania, Uganda and Zimbabwe) continue to employ arbitrary detention and torture to harass and intimidate political opponents, activists critical of the government, minority groups, and journalists (Human Rights Watch, 2019). In some cases, torture is also perpetrated by groups of supporters of the ruling party. These groups use severe beatings and other forms of torture to publicly humiliate and punish opposition and civil society leaders, thereby instilling fear and commanding obedience from the broader populace (Human Rights Watch, 2019). While not technically agents of the state, there is ample evidence that such action is ordered, facilitated, or, at the very least, condoned by the ruling parties.

Civil conflicts within the region provide fertile ground for torture by both armed rebel groups and the militaries that resist them (Karunakara, et al., 2004). There is evidence of the systematic use of torture by groups associated with Al Qaeda in Mali, Boko Haram in Nigeria, Al-Shabaab in Somalia, the various armed-groups of the Eastern DRC, as well as the Lord's Resistance Army (LRA) currently operating in the DRC, Central African Republic (CAR) and South Sudan. Similarly, violence monitors have documented torture perpetrated by the security forces of Kenya, Mali, Nigeria and Somalia as they struggle to contain insurgencies (Human Rights Watch, 2019).

In many sub-Saharan African countries, including Cameroon, Ethiopia, the Gambia, Kenya, Mali, Mauritania, Nigeria, Senegal, Sudan and Zimbabwe, torture is routinely used by police forces and gendarmerie to extract confessions from alleged criminals (Amnesty International, 2014; Viljoen, 2005). In fact, in Mauritania confessions extracted under torture are admissible in court, even if those confessions are subsequently retracted (Amnesty International, 2013).

The kinds of torture that men and women are likely to suffer differ. Men are more likely to suffer forms of torture such as beatings, mock executions, and forced conscription, whereas women are more likely to suffer sexual torture, including rape, and in many instances are forced to witness the torture and killing of others (Johnson et al., 2010; Karunakara, 2004; Solidarity Peace Trust, 2008).

In many parts of sub-Saharan Africa, lesbians, gay men, bisexual and transsexual people (LGBT) are targets of a range of acts of discrimination and violence, including torture. There is evidence of torture of members (particularly leaders) of the LGBT community in Cameroon, Kenya, Gambia, Uganda, and Zambia (Amnesty International, 2013; Human Rights Watch, 2019).

Although young adults are the most common targets of torture, children are also vulnerable during conflict and in peacetime. During conflict the greatest risk of torture is to child soldiers, children in camps for displaced persons and refugees, and children detained by the military or peacekeepers. Various authors have described the abuse and torture of children recruited into military units in civil conflicts in the DRC, Ethiopia, Sierra Leone, Somalia, South Sudan and Uganda (Amone-P'Olak, 2009; Bayer, Klasen & Adam, 2007; Betancourt, Borisova, De La Soudière, & Williamson, 2011; Csáky, 2008; Halcon et al., 2004; Human Rights Watch, 2016). Less is known about the torture of children during peacetime, but children living on the street, orphans, and children in trouble with the law are particularly at risk (Quiroga, 2009). This brief contextual background points to the severity of the problem of torture in the sub-Saharan Africa region. Further discussion of the nature and specifics of violence and torture in this region is elaborated in the subsequent chapter.

Defining Torture

The concept of "torture" is both socially and legally constructed and contested, and as such it has changed over time and will in all likelihood continue to do so. Recent attempts by military actors in the United States to define certain practices (including the infamous waterboarding) as "enhanced interrogation" rather than torture represent attempts to narrow or restrict the definition of torture (Birdsall, 2016). In contrast, arguments that patterns of gender-based violence, such as severe and repeated domestic violence, honour-related violence and killings, and female genital cutting, should be prosecuted as torture signal attempts to broaden the definition of torture (Grans, 2015; Tetlow, 2016).

As contexts, motivations and forms of torture vary widely, the concept is somewhat difficult to define. Amnesty International (1973) contributed an early attempt at a definition, arguing that torture is

> … the systematic and deliberate infliction of acute pain by one person on another, or on a third person, in order to accomplish the purpose of the former against the will of the latter. (p. 31)

In the Tokyo Declaration of 1975, the World Medical Association (1975) elaborated this definition to explicitly acknowledge the reality of psychological torture, and to emphasize that torture involves the abuse of power by those in authority in the service of particular ends. Torture was then defined as

> … the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason. (p.1)

Then in 1984, the United Nations General Assembly adopted the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) which defined torture as,

> … any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions. (Article 1)

This definition introduces a minimum required degree of harm with the words "*severe* pain or suffering". At the same time, by linking torture to "other cruel, inhuman or degrading treatment or punishment", the Convention provides for the sanction of acts not judged to rise to the level of torture. The UNCAT definition emphasizes both the terroristic and interrogational motives for torture and the involvement of a "public official or person acting in an official capacity". While international law is designed to apply to state actors, it has also been applied to non-state actors who exercise control over territory, particularly in the absence of legitimate meaningful government. Such non-state actors include de facto regimes, armed groups, and groups with close links to the state (Redress, 2006, UN Committee against Torture, 2008). Lastly, this definition addresses the question of legality within domestic law, with the effect that whippings, canings, or even mutilations that are

lawful punishments in some countries are not considered torture under the UNCAT definition.

The UNCAT definition remains the standard for international courts and tribunals, as well as human rights activists around the world. In sub-Saharan Africa, UNCAT has been signed and ratified by all countries except Angola, the Central African Republic, Sudan, Tanzania and Zimbabwe. The definition remained unchanged in the African Union's Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa, commonly called the Robben Island Guidelines (African Commission on Human and People's Rights, and Association for the Prevention of Torture, 2008) and was endorsed by the African Commission on Human and People's Rights (ACHPR) in 2002 and by the African Union Summit of Heads of States and Government in 2003. Unfortunately, most countries in sub-Saharan Africa have yet to translate the provisions of the Convention into national law.

The Right to Rehabilitation

Victims'[1] rights to redress, including rehabilitation, are addressed in the Convention, which requires that each state party,

> … ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. (UNCAT, Article 14)

This article is discussed in more detail in General Comment 3 of the UN Committee against Torture (2012). Drawing on the Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (United Nations, 2005), the committee defines "redress" in terms of five interconnected components: restitution, compensation, satisfaction, guarantees of non-repetition, and rehabilitation.

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[1] The terms "victim" and "survivor" are both used in this thesis to describe people who have been tortured. The choice of word depends somewhat on context, with "victim" being most appropriate when describing legal interpretation and rights, or contrasting the experience of those who have been tortured with that of those who perpetrated act of torture. "Survivor" is most appropriate when describing the experiences of those who are rebuilding their lives after having survived torture. The interchangeable use of these terms depending on context reflects the reality that these words do not completely capture the whole of the phenomenon and that most people who have been tortured are at different times both and neither.

Restitution is designed to re-establish the victim's situation before the violation was committed. Compensation refers to pecuniary and non-pecuniary redress to compensate for loss of earnings and earning potential due to disability, costs of past and future specialist medical care, as well as loss of education and employment opportunities. Satisfaction and the right to truth obligate state parties to investigate allegations of torture and where appropriate prosecute perpetrators. This principle also requires effective action to ensure the cessation of continuing violations, verification of the facts, full public disclosure and apology (to the extent that disclosure does not harm the victim, or other innocent parties associated with the case). It also involves identifying the whereabouts of missing persons as well as the remains of persons killed, and in the latter instance, includes recovery and reburial. The guarantee of non-repetition obligates state parties to issue clear instructions to officials on the prohibition of torture, facilitate civilian oversight of military and security forces, ensure the independence of the judiciary and that judicial proceedings meet international standards, protect human rights defenders and others who assist torture victims, and establish regular monitoring of places of detention, among other related actions.

Rehabilitation is the fifth arm of this complex package of redress. The committee affirms victims' rights to as full rehabilitation as possible and emphasizes that rehabilitation must be holistic, incorporating medical, psychological, legal and social services. The purpose of rehabilitation is described as,

> … the restoration of function or the acquisition of new skills… to enable the maximum possible self-sufficiency and function… and may involve adjustments to the person's physical and social environment. Rehabilitation should aim to restore… independence, physical, mental, social and vocational ability and full inclusion and participation in society. (Paragraph 11)

The General Comment goes on to emphasize the importance of state parties adopting a long-term, integrated approach to rehabilitation and ensuring that specialist services are readily accessible and appropriate to the needs of torture survivors. It emphasizes the importance of non-pathologizing and strength-based approaches that recognize survivors' resilience, and stresses the need for rehabilitative contexts of safety and trust in which the risk of re-traumatization is minimized. The General Comment also requires that service providers take survivors' culture, personality, history and background into account. It also holds state parties responsible for ensuring access to services for all torture survivors, especially those in

marginalized and vulnerable groups. Finally, access to rehabilitation should not depend on the outcome of judicial processes, and victim participation in the provision of services should be ensured. Victim participation includes victims' right to meaningfully influence the outcomes and methods of rehabilitation, and to select their own service providers.

The legal definitions of torture, redress and rehabilitation are fundamental to the daily work of practitioners in torture rehabilitation centres in sub-Saharan Africa and around the world. In many cases, eligibility for services is determined by a careful check against the components of the definition. Many people, although certainly in great distress and in need of assistance, do not actually qualify as torture survivors. In many cases, these people need to be referred to other service providers, providers that are few and far between in most countries in sub-Saharan Africa. Similarly, practitioners in torture rehabilitation centres often deal with therapeutic setbacks that result from profound changes in a client's life, such as a negative asylum decision or the re-traumatizing effects of participation in a truth commission or prosecution. If a set of counselling guidelines is to be useful, it must engage meaningfully with the actual challenges that counsellors face in their day to day work in this kind of context.

The Population of Torture Survivors

A range of political and methodological challenges make it extremely difficult to estimate the number of torture survivors in the world, or in any region such as sub-Saharan Africa. Firstly, governments that use torture persecute local human rights agencies that document allegations of torture, and they limit international agencies' access to vulnerable populations and areas where the torture is occurring. Secondly, torture survivors are often reluctant to disclose torture due to fear of further victimization and stigma. Thirdly, the legal definition is not well understood by victims or practitioners in the field. Many people do not realize that their experiences would be viewed as constituting torture, while others who identify as torture survivors may not actually qualify. Finally, methodologies used to identify torture are variably reliable. Westermeyer, Hollifield, Spring, Johnson and Jaranson (2011) compared the incidence of torture reporting among 1,134 refugees from East Africa using two methods simultaneously: a single query approach and a checklist approach. Fourteen percent reported an experience of torture on the checklist but then failed to endorse the single-item query for torture. Nine percent endorsed the single-item query but then listed no torture experiences in the checklist. Eaton and Esala (2016) found similar results in a clinical setting when they compared the usefulness of a screening tool, structured intake assessment,

therapeutic process notes, and a follow up assessment. The structured intake was most successful at 95% accuracy for correctly identifying torture. The other approaches were significantly less accurate.

Despite these challenges, we can infer something about the number of torture survivors in the world today from research with refugees and asylum seekers. Kalt, Hossain, Kiss and Zimmerman (2013) conducted a systematic review of 23 studies concerned with the prevalence of violence reported by asylum seekers in high-income host countries. The prevalence of torture was above 30% in all studies. Similarly, in a meta-analysis of five studies reporting torture prevalence among populations of asylum seekers in the United States, a combined prevalence rate of approximately 44% (95% confidence interval 30% – 58%) was estimated (Higson-Smith, 2015). The United Nations High Commission for Refugees estimates that there are currently about nineteen million displaced people in sub-Saharan Africa (UNHCR, 2016a, 2016b). Based on the proportions of population derived from the meta-analysis just cited there may be as many as 5.7 million torture survivors in the region.

The challenge of accurately identifying torture survivors is also evident in the literature on therapeutic outcomes. Much of the pertinent literature in this domain is conducted not with torture survivors *per se*, but with the overlapping populations of "war survivors", "refugees", "asylum seekers", and "forced migrants"; populations that typically include a substantial number of torture survivors. Studies and systematic reviews define the population of interest according to various conceptual categories and there are in fact very few studies conducted on samples comprising torture survivors exclusively. Thus for example, McFarlane and Kaplan (2012) designed their review of evidence-based interventions around "adult survivors of torture and trauma" and Bunn, Goesel, Kinet and Ray (2016) reviewed group interventions designed to assist "survivors of torture and severe violence". Even in the more rigorous Cochrane review of interventions with "torture survivors" the percentage of torture survivors in the study samples ranged from 30% to 100%, and only two studies included only torture survivors (Patel, Kellezi & Williams, 2014, 2016). Patel et al. (2014, 2016) defend this position by pointing out that non-tortured participants were subjected to organized and systematic violence that might well have amounted to torture or cruel, inhuman, or degrading treatment, that many survivors are unwilling to disclose torture, and that checklist methodologies tend to under-estimate the incidence of torture.

Supported by the work of other writers on torture rehabilitation, including those who compiled the Cochrane review, I have adopted a similar conceptual approach when considering the torture survivor population in this thesis. Although the data is derived only from torture survivors and the counsellors who serve them, the review of literature draws on research from related populations which include large numbers of torture survivors. To limit the literature review to only studies that narrowly screened for a history of torture would drastically reduce the range of rigorous scientific literature eligible for inclusion and would exclude important reflections on the characteristics and needs of this complex population. In subsequent chapters I describe the populations from which various results are drawn and the reader should not assume that conclusions about, for example, refugees from a particular country, are necessarily true for *tortured* refugees from that country.

Mental Health and Social Services for Survivors of Torture

For many survivors, the psychological and social consequences of torture are more debilitating and longer lasting than the more obvious physical injuries. For this reason, and as envisaged in the Convention against Torture, the provision of mental health and social services to survivors of torture is a fundamental component of rehabilitation. Such services need to be provided in conjunction with physically oriented health care.

As in other parts of the world, people from sub-Saharan Africa seek assistance from multiple health service systems (Olsen & Sargent, 2017). For torture survivors seeking mental health care this includes the use of: non-governmental and charitable organizations offering services to the general population or refugees and asylum seekers more specifically; faith- and community-based services and support groups; psychiatric services in government and private clinics and hospitals; traditional and spiritual healers; as well as mental health practitioners in private practice (Jaranson & Quiroga, 2011). Not surprisingly, providers serving the general population typically have very limited expertise in the provision of care for torture survivors specifically. In contrast those working in organisations specifically designed to serve refugee and asylum-seeker populations may have significantly more expertise and experience in working with survivors of war and torture.

In many cities in sub-Saharan Africa and around the world there exist independent, specialist centres, supported largely by charitable and philanthropic donors, to provide rehabilitation services specifically to torture survivors. Many of these centres (but not all) are members of a global network, the International Rehabilitation Council for Torture Victims (IRCT). At the time of writing the IRCT has more than 150 member centres in approximately

70 countries worldwide (IRCT, 2017). There are currently 22 local NGOs affiliated to IRCT in sub-Saharan Africa, these being located in Burundi (1), Cameroon (1), Chad (1), DRC (6), Kenya (3), Liberia (2), Nigeria (1), Rwanda (1), Senegal (1), Sierra Leone (1), South Africa (2), Uganda (1) and Zimbabwe (1).

The clients and counsellors who participated in this research were all associated with IRCT member centres from sub-Saharan Africa. The results and conclusions contained within this thesis and related publications are more directly relevant to rehabilitation centres providing specialist care for torture survivors in sub-Saharan Africa, but are also likely to be useful to centres operating in other low-resource, high violence contexts around the world.

Evidence-based practice and mental health services for torture survivors

As with all mental health interventions, it is essential that the counselling interventions employed with torture survivors have been empirically tested and shown to be both helpful and safe. This is the essence of the evidence-based practice (EBP) movement in mental health care. And yet, as in other aspects of mental health care around the world, the question of an evidence-base for the treatment of torture survivors is contentious. In a recent survey of stakeholders in humanitarian action, Tol et al. (2012) identified a series of "disconnects" between policymakers, academic researchers, and practitioners in the field. Practitioners expressed their concern that "policymakers and academics were not well attuned to the actual needs on the ground… [and were] not focused on the main problems" (p 32). Reviewers of EBP for refugee children make a similar point: "[t]he key problem is that evidence-based practice is not reflective of "practice" … and that knowledge derived from studying existing practice is not considered scientific evidence" (Birman et al., 2008, p130).

These "disconnects" raise a range of broader questions. Which therapeutic approaches are being studied and which are not? What therapeutic outcomes should researchers focus on? What counts as "evidence" when deciding if a certain approach is evidence-based? What importance is attached to the experiences and values of torture survivors in these debates? What space is created for the inclusion of practitioners' experience of implementing different approaches in particular contexts? Who decides the answers to these important questions that have the potential to so profoundly influence the care that torture survivors around the world receive? To what extent are the voices of stakeholders from minority-groups and low-resource settings heard, or are the debates framed and dominated by researchers and policy-makers from well-resourced settings in the Global North? What gaps in the existing torture rehabilitation literature are revealed?

The terms Global North and Global South emerged as a product of Cold War era efforts to categorize the historical inequities of Non-Aligned nation-states. Over the past several decades, this terminology has evolved and been adopted in diplomatic and developmental transnational discourse. Several definitions exist in the academic literature. For the purposes of this research I use Mahler's (2017, p.1) definition that describes the Global South as the "spaces and people negatively impacted by contemporary capitalist globalization…[as] a direct response to the category of postcoloniality in that it captures both a political subjectivity and ideological formulation that arises from lateral solidarities among the world's multiple "Souths" …". In this understanding, the Global South does not refer to specific geographies, but rather to peoples and lands that have historically lacked power, agency, and/or resources due to colonialism, the forces of capitalism, systems of racism, and globalization. Therefore, some communities in prominent, industrialized nations may still be considered to exist within the Global South, while communities in the Southern Hemisphere could also be considered part of the Global North. This term is used intentionally in identifying the intersection of low resource contexts and historical subjugation of peoples.

Of the 88 studies of mental health interventions with survivors of torture and systematic violence reviewed by Weiss et al. (2016), 67 were conducted in the Global North. Only nine were conducted in sub-Saharan Africa and seven of those were led by researchers from the Global North. When highly educated researchers and academics from well-resourced, largely secure, stable and well governed, "Western" countries so thoroughly dominate a field that is concerned in large part with assisting people in low resourced, insecure, unstable situations in other parts of the world, there is reason to be concerned. We must consider the possibility of implicit biases that limit discourse, existing findings and recommendations to the possible detriment of the kinds of assistance available to a large proportion of torture survivors. Two examples from the past decade of research and global debate illustrate this point.

In 2006, Professor Metin Başoğlu, who was at the time head of the Trauma Studies Unit of the Institute of Psychiatry at King's College, London, wrote an editorial in the *British Medical Journal* entitled "Rehabilitation of traumatized refugees and survivors of torture: After almost two decades we are still not using evidence based treatments" (Başoğlu, 2006). He argued that research and expert consensus supported the practice of brief cognitive behaviour therapy (CBT), including exposure elements, and promoted the use of a controversial single-session, early intervention exposure intervention that he had developed and tested with earthquake survivors. He made an implicit (and unsupported) assumption that

fear and trauma-based reactions are typically the core of torture survivors' distress and drew heavily on PTSD literature to support his case. He did not mention the conclusions of the two reviews of research on interventions with traumatized refugees that had been recently published at the time (Schweitzer, Buckley & Rossi, 2002; Nicholl & Thompson, 2004). Both had questioned the centrality of PTSD to the mental health concerns of refugees and had determined that while CBT seemed promising, there was insufficient evidence to support the use of any one methodology over others. They called for more research on a range of treatments, including multi-dimensional approaches.

More recently, in their review of evidence-based mental health interventions in post conflict, low resource settings, Murray et al. (2014, p 94) attempted to frame the debate on evidence-based practice in a very particular way:

> … there has been increased support for the use of evidence based treatments (i.e., those interventions that have been shown to be effective in randomized controlled trials) in these settings.

With this parenthetic remark the authors dismissed more accepted definitions of EBP in favour of one that makes experimental research the only standard. As Rousseau and Gunia (2015) have argued, the more commonly used definitions are those proposed by Sackett, Rosenberg, Gray, Haynes and Richardson (1996) and the American Psychological Association (APA, 2005). Sackett et al. (1996, p 71) described EBP as,

> … the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

The APA (2005, p 5) suggested a similar definition with the addition of important patient and contextual considerations:

> Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

These definitions emphasize the integration of research (and not necessarily experimental research), with clinical expertise and underscore the importance of taking

account of patients' realities, priorities and experience. The focus is as much on effectiveness (the performance of an intervention under real ecological conditions that preserve a high level of external validity) as it is on efficacy (the performance of an intervention under controlled conditions or situations of high internal validity). In the language of the "disconnects" identified by Tol et al. (2012), unlike that selected and promoted by Murray et al. (2014), these definitions are as much concerned with "relevance" as they are with "excellence".

For Murray et al. (2014) questions of acceptability, appropriateness, feasibility, cost, and sustainability of intervention approaches are secondary and fall within the arena of dissemination and implementation science, "an emerging field that directly addresses the transfer of evidence based, effective health care approaches from experimental settings into routine use" (p 95). Given the power differentials implicit in this approach to EBP, the "disconnects" described by Tol et al. (2012) are inevitable. It is not surprising that practitioners in the field are in many instances reluctant to adopt EBP, the development of which has not been centred upon the expressed needs of the populations they service, nor the ecological, cultural and contextual challenges inherent in sustainable service delivery in their environments.

Randomized control trials are not the standard against which treatment guidelines for mental health risk and dysfunction are typically compiled. For example, both the International Society for Traumatic Stress Studies (ISTSS) and National Institute for Clinical Excellence (NICE) guidelines for the treatment of PTSD consider a broad range of evidence, from case studies through to randomized control trials (RCTs), and meta-analyses. RCTs are rightly given greater weight than other forms of evidence, but all are considered and included (Foa, Keane, Friedman, & Cohen, 2009; National Institute for Clinical Excellence, 2018).

The approach described by Murray et al. (2014) also assumes the existence of a robust evidence base, that is, that there exists a sizeable set of high quality RCTs that test the impact of a good range of different interventions on multiple populations of torture survivors from different cultures and contexts. At present, no such evidence base exists and the summary results of the available RCTs are far from compelling. (A detailed discussion of existing therapeutic outcome research with refugees and survivors of organized violence and torture is provided in Chapter 3). Without a strong evidence base from which to draw, it is premature for researchers to limit the range of research methodologies used to inform EBP.

Perhaps most concerning is the risk that the very limited evidence currently available will be used to inappropriately constrain and control the range of services available to torture survivors. Rehabilitation centres around the world depend upon a very limited group of

governments and philanthropic organizations for the financial resources that support service delivery. Appropriately these government agencies and private organizations (virtually all of which are situated in the Global North) turn to local senior researchers with an interest in this field for guidance in how they distribute their funds. This gives those researchers a great deal of influence to directly impact service delivery around the world.

Professor Başoğlu's ended his poorly supported argument for CBT with a direct appeal to funders, arguing that if practitioners refuse to adopt his view of EBP, funders should compel them to.

> Funders of rehabilitation programmes are in an excellent position to promote progress here… Making grant support conditional on such requirements would certainly enhance the quality of work in the field. Given the painfully slow progress this appears to be the only hope for change. (Başoğlu, 2006, p 1231)

It is my intention and hope that the epistemological position and methodologies that underpin the research described in this thesis will help to balance the scales slightly, at least with respect to the discourse on the provision of mental health services in sub-Saharan Africa. Within this study, against a backdrop of theoretically informed conceptualization and research evidence, I have adopted a largely pragmatic approach that draws strongly on data derived from the actual client population being served at three centres within the region, aiming to distil and amplify the experiences of help-seeking torture survivors and the counsellors who seek to assist them. I hope in this way, to re-emphasize the place of "clinical expertise" as well as to highlight the significance of "patient characteristics, culture, and preferences" within the debates concerning torture rehabilitation and its credibility.

Having provided the background to the study, the remaining discussion outlines the structure of the thesis. Chapters one through three provide an overview of the scientific literature on patterns of torture perpetration and impact in the sub-Saharan African region, and the approaches used by mental health workers in the region to support and rehabilitate survivors. Chapter 4 describes the research aims, philosophy, design and methodology of the study. Chapters five through eight comprise the main findings and discussion component of the thesis and describe the presentation of torture survivors in sub-Saharan Africa, identify common challenges to treatment, describe the profile of counsellors in the region, investigate the prevalence and treatment of both complicated grief and continuous traumatic stress in the

treatment-seeking population, and explore torture survivors' and counsellors' lived experience of successful intervention. The final chapter integrates the findings and lays out a series of recommendations for practitioners, researchers and policy-makers concerned with the mental health care of torture survivors in sub-Saharan Africa. This final chapter also proposes a set of fundamental innovations for counselling torture survivors in sub-Saharan Africa, the Foundational Capacities Approach (FCA). The thesis ends with a critique of this doctoral research study and offers suggestions for future research.

This thesis is submitted under the University of Witwatersrand Standing Orders for a PhD including publications. In addition, the thesis conforms to the specific requirements of the Faculty of Humanities, that the PhD including publications include four published or accepted journal articles in good peer reviewed journals. The candidate must be first author on all of the publications and at least one publication must be singly authored. The published material is generally included in the final monograph thesis in the form of thesis chapters. The inclusion of journal article publications in the thesis inevitably results in a considerable degree of repetition in certain chapters, including revisiting of components of the literature review, method and results in order to contextualize each piece as a stand-alone journal article. To ameliorate this potentially irksome problem, I have included a brief introductory summary to each of the published papers. In this summary, I point the reader to new material such that they are aware of what may be repeated and may choose to focus primarily on what is unique to each of these chapters (or articles). I have also consolidated the reference lists for the previous published chapters into the reference list at the end of the thesis to reduce repetition.

Chapter 2 Collective, Family and Individual Impact of Torture

In this chapter I review literature relating to the impact of torture on the community and culture, families, and individuals, and discuss the social, psychological and physical consequences of torture. Although counselling, the focus of this research, operates mainly at the individual level, torture survivors' personal struggles to regain health and functionality are directly affected by the health of their community and broader society, as well as by the functioning of their immediate family and support networks. In the case of those who have had to flee their homes and relocate to new geographical regions these levels of systemic influence are doubly complicated. There is the question not only of the relationship to the society in which they were tortured, but also to a new society to which they have fled. There is the loss of the community of origin and the challenge of building a life in a new and foreign community. There are issues of family separation and the possibilities of building reconstituted and/or new families in the country of refuge. Both those who remain in the contexts in which they were tortured and those who have had to relocate experience difficulties with regard to the indirect and systemic effects of their experiences on families and community networks and are also reliant on such networks to recover from their torture-related trauma.

The chapter begins with a discussion of how torture impacts on communities. Having briefly examined literature on the collective and family impacts of torture, I focus on studies concerned with the physical and emotional impacts of torture on individual human beings. I argue that these impacts are inextricably bound up with the histories, cultures, and current circumstances of the societies in which torture occurs. I therefore consider four regions in sub-Saharan Africa, highlighting torture committed under different oppressive regimes and during major conflicts. In this way I hope to draw attention to the large number of torture survivors living in sub-Saharan Africa as well as the historical layers underpinning the severe human rights abuses and trauma that help-seeking torture survivors often describe to their counsellors. For each region I also briefly describe local conceptualizations of trauma-related suffering and emotional disorder.

The impact of torture on society and communities

Torture is typically thought of in interpersonal terms and generally understood to constitute a criminal interaction between a perpetrator and a victim. However, acts of torture

are also an extreme violation of the social contract between ordinary people and those who hold forms of power or authority over them. Kira (2017, p1) argues that torture is primarily "a systemic, intergroup and institutional trauma enacted by a torturer on behalf of a larger, more powerful entity." In this view, both torturer and tortured are actors in a larger dysfunctional system. Summerfield (2003) argues that ordinary citizens are outraged by torture, not because of the medical and emotional harm to victims, but because it represents an extreme violation of the social contract, a betrayal of the collective morals and values that are the foundations of society. In sub-Saharan Africa, the systematic use of torture is most often symptomatic of governments that do not enjoy the trust and support of the populace, but control citizens through military, security force, political and economic power. Friends and allies of the ruling group benefit from the country's resources and are protected. Political opponents, journalists, human rights defenders and other critics of the ruling group are marginalized, persecuted and sometimes silenced. Torture is used to instil fear and to warn of the terrible consequences of organizing against the ruling party. Dehumanizing political rhetoric that equates groups of people to cockroaches, rats, snakes, or devils, reduces inhibitions against cruelty and lays the groundwork for torture and other atrocities (Maynard & Benesch, 2016). Such rhetoric also contributes to a fracturing of society and encourages inter-group conflict and prejudice, further reducing communities' capacity to protect and care for their people.

Policies of systematic torture and harassment are typically executed by members of the police, army and intelligence forces; however civilians are also commonly implicated. In the latter instance it is often young people from poor communities who are most vulnerable to recruitment and who have been associated with some of the most horrifying atrocities in sub-Saharan African countries. There are many examples of this: the *Imbonerakure* (or "those that see far") in Burundi (Daley & Popplewell, 2016); the ZANU-PF Youth militia of Zimbabwe (Reeler, 2009); the recruitment of young men into the liberation movements of South Africa as well as conscription into the South African Defence Force (Higson-Smith, 2002; 2006); or the child soldiers of Angola, DRC, Liberia, Mozambique, Sierra Leone or Uganda (Bayer, Klasen, & Adam, 2007; Betancourt, Agnew-Blais, Gilman, Williams, & Ellis, 2010; Boothby, Crawford, & Halperin, 2006; Kiyala, 2015). Although it is certainly not automatic that militarized children will commit atrocities such as torture, their relative immaturity makes them more vulnerable to exploitation and manipulation, and less able to resist morally repulsive instructions from adults in authority over them. The militarization of youth and the accompanying losses of healthy development and education fundamentally

compromise many young people's identity and values, their ability to build a meaningful life as adults in peacetime, and their core beliefs about society and government. As these children mature into adults the impact of their distorted childhoods is felt throughout society and into the future. It is for these reasons that the development of comprehensive psychosocial rehabilitation programs (as opposed to more narrowly focused trauma healing programs) for all former child soldiers (not merely those presenting with symptoms of PTSD, depression and anxiety) is essential for peace-building in sub-Saharan Africa (Golden, Higson-Smith, Ní Aoláin, & Wühler, 2016).

One of the longer-term costs of the abuse of power by the state is a fragmentation of the social fabric and a break down in the rule of law. Such situations are fertile ground for an increase in violent crimes against vulnerable groups. For example, Stark et al. (2010) measured violence against women in the camps for internally displaced people (IDPs) of Northern Uganda. Drawing on a community sample of 299 households, they estimated that during the past year, 52% of women had experienced intimate partner violence, 41% had been raped by their intimate partner, and 5% had been raped by someone other than their intimate partner. The authors speculate that these unusually high gender violence figures relate to the breakdown in societal norms (specifically community injunctions against domestic violence) and a wartime culture of impunity for acts of violence generally.

Similar arguments have been made about high levels of violent crime, vigilantism and xenophobic violence in large urban centres like Cape Town, Johannesburg and Nairobi. Where repressive regimes have persistently blurred the line between political and criminal activity, and used police personnel for political ends, researchers argue that social sanctions on criminality are altered and police lose credibility among the populace (Landau & Misago, 2009; Ruteere & Pommerolle, 2003).

A discussion of the societal impacts of systematic torture also requires a mention of societal level healing mechanisms and the field of transitional justice. Drožđek (2010) categorizes countries in transition as "buriers" (those that deliberately hide evidence of past human rights abuses), "deniers" (those that minimize the importance of past human rights abuses in the interest of "moving on"), and "excavators" (those that deliberately search for and discuss evidence of past human rights abuses in order to achieve some shared understanding of the past). One important way of excavating the past is through truth commissions, and at least twenty countries in sub-Saharan Africa have instituted national processes of enquiry of this kind over the past three decades. These processes are intended *inter alia* to uncover the truth of past crimes and human rights violations, to hold perpetrators

to account, and to attempt to repair the harm suffered by victims. They are structured in various ways and manage the processes of accountability, outcomes for perpetrators (including amnesty) and reparation, differently. It is worth noting here that perpetration of torture is also strongly predictive of trauma related disorder (Amone-P'Olak, Dokkedahl & Elklit, 2017). Rehabilitation services for perpetrators require additional community intervention and are not the subject of this thesis. Nevertheless, in all cases, victims play a pivotal role in helping to bring the truth to light and in so doing may be further exposed to harm even when the intention is remedial.

It has often been stated that the act of public testimony is in itself healing for victims. This is most persuasively argued in the foreword to the final report of the South African Truth and Reconciliation Commission (TRC) (1998) by the Most Reverend Desmond Tutu, Archbishop Emeritus.

> … the Commission has not been prepared to allow the present generation of South Africans to grow gently into the harsh realities of the past and, indeed, many of us have wept as we were confronted with its ugly truths. However painful the experience has been, we remain convinced that there can be no healing without truth. (p. 4)

A few paragraphs later he describes the mechanisms by which he believes that this healing occurs.

> His [the perpetrator's] admission restores her [the victim's] dignity and her identity. Her experience is confirmed as real and not illusory and her sense of self is affirmed… (p. 7)

Tragically, the reality of truth commissions is in many instances somewhat different. This idealized process does not describe the experience of the thousands of victims who gave testimony but never had the opportunity to hear a perpetrator's admission of guilt. Nor does it describe the experience of those who faced their perpetrators and were met with half-truths, evasions and justifications. While it is clear that truth commissions are important mechanisms of transitional justice that allow countries to come to terms with their history, and there are few examples of this as compelling as that of South Africa, there is virtually no evidence that such processes are necessarily healing for individual victims (Mendeloff, 2009). In the South African case, Kaminer, Stein, Mbanga and Zungu-Dirwayi (2001) found no significant

relationship between participation in the TRC and psychiatric status or attitudes to forgiveness. They suggest that testifying before a public commission is a different process to the construction of trauma narratives central to many therapeutic approaches. Furthermore, the statement that "there can be no healing without truth" is patently false. For example, following one of the more horrific civil wars in modern history, many Mozambican communities and people have rebuilt productive and fulfilled lives without the benefit of a truth commission. In a world where so many have been brutally victimized and only a very few will ever have the chance to confront their perpetrators; and in a world where the processes of public accountability are so deeply flawed, it is problematic to suggest that individual healing is impossible without public truth-telling.

As discussed in Chapter 1, the right to rehabilitation includes the right to compensation, satisfaction, and guarantees of non-repetition of harm from the State under whose authority the torture occurred (United Nations Committee Against Torture, 2012). Torture survivors have the right to pursue these aspects of rehabilitation and it often falls to human rights defenders and counsellors to support them in this quest. Mental health practitioners, who consider their domain to be the counselling room rather than the courtroom and their work to be healing rather than advocacy focused, may find this challenging. Nevertheless, comprehensive rehabilitation that includes elements of social restructuring remains an unavoidable aspect of therapeutic work with many torture survivors.

Findings from more localized peacebuilding and reconciliation interventions are ambiguous. Cilliers, Dube and Siddiqi (2016) conducted an evaluation of *Fambul Tok* (literally "family talk"), a community-based reconciliation intervention in Sierra Leone. This process creates village level forums in which victims describe the human rights violations that they have suffered, and perpetrators confess and seek forgiveness for their crimes. While their evaluation revealed increased levels of community cohesion, the process increased the incidence of PTSD in participating communities by 28%, depression by 47%, and anxiety by 37%. Similar results have emerged following the Gacaca Court processes in Rwanda. Brounéus (2010) conducted a survey of 1,200 Rwandans who did and did not participate as witnesses in the Gacaca Courts. Results show that, after controlling for a range of predictors of poor mental health, the incidence of depression among witnesses was 19% higher than among non-witnesses. The incidence of PTSD was 17% higher among witnesses than non-witnesses. These studies suggest that both national and more localized truth-telling and reconciliation processes, however well intentioned, carry significant risks to mental health. We cannot responsibly speak of achieving community healing through reconciliation when

people in the community are reporting significant increases in emotional disturbance and distress.

Other interventions have yielded more encouraging results. Yeomans, Forman, Herbert and Yuen (2010) evaluated a reconciliation workshop in Burundi which is described as using conversations and experiential exercises to encourage dialogue designed to explore the roots of violence, anger, loss, trauma and trust. This evaluation indicated that the intervention had resulted in reduced symptoms of PTSD. Unfortunately, the study did not test whether this intervention also produced a meaningful impact on community cohesion or reconciliation. In Zimbabwe, an evaluation of the Tree of Life intervention revealed strong positive effects on mental health as well as modest positive effects on community engagement, contributions to the lives of others and attitudes to community healing (Mpande et al., 2013). This small group intervention shares some features with CBT and Testimony therapy (Cienfuegos & Morelli, 1983; Agger & Jensen, 1990) and involves members of the same community reflecting together on their identity, history and traumatic experiences.

These studies suggest that trauma-informed interventions that prioritize individual healing may in fact make significant contributions to community healing without the risks associated with interventions that prioritize truth-telling and reconciliation. It is unacceptable for community healing to occur at the expense of those who have already suffered most. In this light, interventions like that employed by Tree of Life, that tend to combine collective and individual therapeutic work, may point the way to more effective reconciliation and community-building interventions.

The impact of torture on families

Torture impacts family systems directly and indirectly. The most obvious direct impact on family systems is the killing of members of the family in war, through torture, or as a form of torture itself. While less is known about bereavement of torture survivors specifically, surveys from populations affected by civil wars in which acts of torture are common have recorded a very high prevalence of traumatic bereavement. In community surveys in Sierra Leone, 54% of respondents reported a death in the family (Cilliers, Dube, & Siddiqi, 2016). Similarly, in conflict affected areas of the eastern DRC, 64% of people surveyed had lost a member of their family (Pham, Vinck, Kinkodi, & Weinstein, 2010).

Families become separated when members are abducted or detained, during attacks, and in the flight from the fighting. People are separated when some family members in danger flee to neighbouring African countries and during resettlement abroad. In a survey of

treatment-seeking torture survivors in five countries, McColl et al. (2010) noted that 48% of participants had been forcibly separated from their families. Similarly, of 134 treatment-seeking refugees assessed in Switzerland, 60% had been forcibly separated from their families (Nickerson et al., 2015). Children who have fled from conflict and repression without adult family members are a particularly vulnerable group. The UNHCR (2016b) recorded close to 100,000 asylum applications from unaccompanied children in 2015 alone, with significant numbers coming from Eritrea and Somalia. Most of these children were living in camps in Ethiopia and Kenya at the time.

Even in families that have survived intact, or partially intact, the loss of immediate and extended family members, of home, community, familiar environment and economic security, have profound impacts on the boundaries, structures and roles that make up the family system. For example, Whyte, Iha, Mukyala and Meinert (2013) studied the lives of families in the IDP camps of northern Uganda. When peace returned to the area most people left the camps and returned to their homes. However, due to the patrilineal structure of the local Acholi culture, inheritance norms and land ownership, a sizeable group of women and their children were unable to re-integrate into their communities. These were women for whom the lengthy Acholi marriage process had begun (including having children) but had not been completed when their partners were killed. This placed them in an ambiguous position in relation to their own families and to those of their deceased partners. It prevented them from reclaiming a position (and land) in the rural communities from which either they or their partners originated. Years after the end of the war, these women remained internally displaced, not only geographically but in relation to the community around them. This fine-grained analysis serves as an example of the specificity of challenges faced by some families impacted by torture and war, and caught in the crossfire of powerful cultural, religious and political forces. The results speak to the need for interventions that are deeply contextually informed and designed to address the specific situations of particular groups of people.

Losses of individual capacity and functioning are also deeply linked with family systems and many adult treatment-seeking torture survivors find it impossible to separate the individual and family problems arising from their torture. How is a survivor to do this when, for example, her pain prevents her from providing for her family and forces her to rely on a child for support, or when emotional dysregulation expressed through alcohol abuse and domestic violence threaten to tear her family apart? As Bala and Kramer (2010) point out, roles and relationships within the family must undergo dramatic shifts if the family system is to adapt to new challenges, both internal and external.

An important dimension of family systems is the relationship between parents and children. In times of crisis consistent and healthy parenting is even more vital to the emotional wellbeing and development of children than in less stressful periods. However, at such times, the capacity of parents to be emotionally available may be limited as they struggle with their own fear, acute trauma and grief reactions, as well as the relentless struggle to keep themselves and their children alive in a hostile world. These burdens may take internal resources away from personal recovery and make it particularly difficult for unsupported parents to engage meaningfully with potentially supportive, therapeutic services. For example, a parent who is preoccupied with seeing their children safely to and from school may compromise on therapy attendance to ensure this.

Nor are the impacts of torture, loss and dislocation on the family only felt in the short term. There has been extensive study of the transgenerational transmission of trauma, based on the observation that children and grandchildren of survivors of torture and other atrocities sometimes develop symptoms of PTSD and depression apparently relating to the experiences of their parents or grandparents (Danieli, 1998; Daud, Skoglund, & Rydelius, 2005). More recently Dalgaard and Montgomery (2015) reviewed the literature on trauma communications in refugee families and concluded that it is not only the pattern of open communication or silencing that predicts transgenerational transmission, but also the timing and manner of disclosures. These authors emphasize a modulated approach to disclosure which involves a gradual sharing of information in line with the child's developmental stage and emphasize that patterns of communication within families as well as the process of trauma disclosure are highly culturally embedded. Counsellors who work with torture survivors are often asked for advice on whether and how to disclose to children and it is worth noting that there has been almost no research on transgenerational transmission of trauma within families in sub-Saharan Africa.

For the most part, family is thought of by mental health practitioners as a key supportive resource for torture survivors. While this is often true, the reality maybe much more complicated. Torture survivors commonly report feelings of guilt and shame at having brought danger to their family and community. For example, in a study of mental health outcomes in a sample of South African torture survivors, Halvorsen and Kagee (2010) found that *negative* social support was a stronger predictor of emotional distress and trauma-related symptoms than positive social support. Negative social support is indicated by feelings of being let down, unfairly criticized, or anxious when in the presence of family members. Similarly, research into community reintegration of child soldiers in Sierra Leone identified

community acceptance (or lack thereof) as a key predictor of longer-term psychosocial outcomes (Betancourt, Brennan, Rubin-Smith, Fitzmaurice, & Gilman, 2010). These examples illustrate how torture, more than many other traumatic events, can break down the supportive bonds of family, leaving some survivors isolated and stigmatized. In many cases, helping communities and families better support torture survivors is vital in helping survivors rebuild a network of positive social support shattered by the impact of their experiences.

In summary, the impact of torture on survivor's families is complex and long-lasting, with families potentially contributing to both effective support and additional strain. Either way, family members, family systems, close friendship networks, shared religious practice, occupational networks, and political allegiances are profoundly changed by the torture of a member. This is another essential consideration in the development of treatment approaches.

Having briefly considered the communal and familial impacts of torture, I turn now to the common impacts on the individual person, separating the discussion into the interconnecting areas of physical and psychological impact.

Individual physical consequences of torture

The full range of physical sequelae of torture is broad and depends greatly upon the methods of torture employed. Sequelae include renal distress and failure, spinal cord bleeding, intracranial and cerebral oedema, subdural haemorrhage, impairment to eyes, ears, nose and throat, damage to tissues and joints, as well as generally increased vulnerability to infectious diseases, strokes, and heart problems. Given the focus of this thesis, I review literature on three broad areas of physical damage that relate most directly to emotional functioning: disfigurement and disability; traumatic brain injury; and enduring pain.

Permanent disfigurement and/or physical disability are in fact seldom included as predictor variables in studies of overall quality of life among torture survivors. This is surprising given evidence that these kinds of harm are common among treatment-seeking torture survivors. In an analysis of a clinical sample of tortured exiles living in Johannesburg, Higson-Smith and Bro (2007) recorded an 11% incidence of permanent physical disability. Similarly, in a study of clinical samples from five different countries, McColl et al. (2010) recorded mutilation or permanent scarring in 6% of the overall sample. Amputation and other forms of mutilation are almost characteristic of atrocities committed in wars in parts of sub-Saharan Africa. In Sierra Leone, Cilliers et al. (2016) estimated that 2% of the general population had been tortured through mutilation, most commonly by means of upper limb amputations.

Another area of physical damage with direct implications for psychosocial functioning is neurocognitive impairment derived from traumatic brain injury (TBI). In the five country study cited above, 64% of torture survivors seeking care had sustained some kind of head or brain injury (primarily due to blows to the head, suffocation, drowning, and/or loss of consciousness) (McColl et al., 2010). Although no systematic neurological assessments were carried out within the study it is not unreasonable to expect some neurocognitive impairment in a substantial number of these patients. Similarly, in a chart review of 488 treatment-seeking refugees resettled in the United States, 69% reported blows to the head, and 38% had lost consciousness. Men were more likely to be beaten about the head and to lose consciousness than women. Loss of consciousness was associated with increased headaches and sleep disturbances (Keatley, Ashman, Im, & Rasmussen, 2013). Mollica, et al. (2009) performed magnetic resonance imaging (MRI) scans on 42 torture survivors who had sustained head injuries due to torture and on sixteen comparison subjects. They found significant cortical thinning and bilateral amygdala volume loss in the group with head injury and noted that these neurological changes were associated with elevated scores for depression.

Chronic pain, a phenomenon so central to torture, is less studied than other physical and emotional impacts of torture. Pain is often classified according to aetiology. Nociceptive pain is caused by tissue damage and is typically ameliorated by tissue healing. Neuropathic pain is caused by damage to the nervous system and is often chronic. Psychosomatic pain is caused by emotional distress which for various reasons is expressed through the body. The few studies that have systematically investigated pain in tortured populations find that it occurs very frequently in treatment-seeking groups (Williams & Amris, 2007). For example, a study of torture survivors in Uganda revealed that 87% of treatment- seeking torture survivors suffered from debilitating musculoskeletal pain (Amone-P'Olak & Omech, 2020; Musisi, Kinyanda, Liebling, & Kiziri-Mayengo, 2000). Similar reports have been found in torture rehabilitation clinics in Europe with pain often being persistent or worsening over time (Olsen, Montgomery, Bøjholm, & Foldspang, 2007; Williams, Peña, & Rice, 2010).

In torture survivors, neuropathic pain is most often the result of physical trauma, but can result from infection, ingestion of toxins, and other health conditions related to inhuman treatment and prolonged deprivation (Quiroga & Jaranson, 2005). The most commonly reported forms of pain are headaches, back and neck pain, joint pain, pain in the feet, and abdominal or pelvic pain. Some types of pain are associated with particular torture methods, for example, pain in the shoulders resulting from suspension, pain in the feet caused by

falanga (beating of the soles of the feet), and abdominal or pelvic pain associated with rape. Other types are much less specific to forms of torture or observable injury. These may arise from multiple assaults over time with fists, boots or implements, accompanied by prolonged incarceration in cold and wet conditions and involving being forced to endure stressful body positions, such as being prevented from sitting or lying down, as well as from denial of medical care for pre-existing medical conditions and injuries sustained during torture. Such forms of torture related damage are in fact highly prevalent and even routine in some contexts but the more generalized pain that they cause is most likely to be classified by both medical and psychological practitioners as "psychosomatic". Williams and Baird (2016) put this labelling bias down to the myth of "medically unexplained pain", or the false belief that in the absence of physical signs of injury, pain must be emotional in origin. When nociceptive or neuropathic pain is prematurely diagnosed as psychosomatic, torture survivors do not get the pain treatment they need. They will often receive counselling in pain management, but outcome studies suggest that counselling interventions for the management of neuropathic pain have limited impact (Williams, Eccleson, & Morley, 2009).

Of course, such common misdiagnosis of pain as psychosomatic does not imply that torture survivors' physical suffering is never emotional in origin. There is strong evidence that some pain does in fact have emotional causes, and somatic expressions of distress seem particularly common in "non-Western" populations, including those from sub-Saharan Africa (Rohlof, Knipscheer, & Kleber, 2014).

Appreciating the interactions between pain, psychological processes and disability is important to the rehabilitation of torture survivors. There is evidence that hypervigilance to pain is associated with increased pain levels, disability and distress. PTSD related intrusive symptoms may also increase attention to injuries and pain. The relationship between intrusive symptoms and experiences of heightened pain may be mediated by avoidance patterns whereby fear of pain leads to avoidance of activity, which in turn exacerbates pain and delays recovery from disability. Hypervigilance and avoidance may have particularly profound effects when accompanied by catastrophic thinking of the kind where the experience of pain is interpreted as having extremely severe or global causes and consequences. For example, survivors may fear that pain symptoms, such as chest pain, are a presentiment of immanent death. Finally, disability due to pain, as well as anger, frustration, helplessness and shame arising from such disability, are associated with depression, and in addition, chronic pain and disability are associated with loss of self-esteem and changes in identity (Eccleston, 2001; Liedl et al., 2010; Taylor, Carsewell, & Williams, 2013). Chronic pain and disability also

serve as a constant reminder of the torture experience and may in turn evoke intrusive memories and associations, as well as a sense of having been permanently damaged or marked, which may further impede psychological recovery.

Ultimately the rehabilitation of torture survivors requires the healing of both body and mind. In a ten year follow up study of a sample of tortured refugees from the Middle East who received treatment in a specialist clinic in Denmark, mental health and health-related quality of life was more strongly predicted by the physical complaints registered at intake than by emotional complaints registered at the same time (Carlsson, Olsen, Mortensen, & Kastrup, 2006). Such findings highlight the importance of integrated treatment models and coordinated care systems. They also point to the importance of comprehensive assessment and follow up with clients to identify areas of fundamental harm that must be addressed if progress is to be made overall.

Individual psychological consequences of torture

While physical consequences of torture are very significant, the longest lasting and most debilitating of the sequelae of torture are more commonly those involving survivors' emotional and psychological lives. Exposure to torture is associated with impairment in virtually all psychological dimensions. Impairments include the full spectrum of anxiety, stress and mood related symptoms and disorders (including PTSD); difficulties with arousal regulation; emotional lability; pervasive sadness; generalized anxiety; hyper-sensitivity to, and avoidance of reminders of the torture; suicidal ideation; changed sense of self and diminished self-esteem; altered belief systems and thought processes; irritability; inability to regulate strong affect; aggression; self-isolation; substance abuse; confusion; disorientation; memory difficulties; impaired concentration and difficulty solving problems; challenges in initiating and sustaining targeted effort; risk taking and impulsivity; insomnia; nightmares; and sexual dysfunction. It is evident how far reaching the impact of such features may be for daily functioning, including occupational capacity and social integration. Well-being may be compromised in almost every sphere of life.

A review by Quiroga et al. (2005) highlights the importance of pervasive loss in understanding the psychological impact of torture. They list losses of close family members, friends and compatriots, physical health, employment, status and identity, as particularly salient in torture survivors. However, loss of function, safety, property, as well as cultural and community connection must also be considered.

It is in relation to these impacts and losses that the emotional health of torture survivors becomes inseparable from their social and cultural origins, as well as the contextual realities in which they find themselves in the aftermath of such experiences. Mental health, mental illness and healing are all socially constructed in extraordinarily complex ways that are typically not well understood. In addition to the findings relating to torture survivors generally, the literature also speaks strongly to the nuances and patterns of presentation associated with particular populations, the particular form of torture, the particular context within which with the torture took place, and the nature of the recovery environment. Torture survivors in sub-Saharan Africa are widely displaced and it is common for rehabilitation centres to serve clients from many areas across the continent. This presents a profound challenge to counsellors who must be knowledgeable of the complex political histories of many countries and be able to navigate different cultural expressions of distress that are context related.

With this in mind, and given the limitations of space, the following sections reflect findings from research with torture survivors in four broad regions of sub-Saharan Africa. Without claiming to be comprehensive, I introduce the most significant political drivers of torture in each region over the past fifty years. I then summarize key published research on the reported incidence of torture in general populations and the prevalence of mental health conditions associated therewith. Finally, I summarize work on local idioms of emotional distress and dysfunction in each region.

The "Horn of Africa"

The Horn of Africa region comprises Djibouti, Eritrea, Ethiopia and Somalia, countries that have all endured protracted civil conflicts, border wars, and oppressive regimes during the past thirty years. For example, in Ethiopia during the 1970s, Mengistu Haile Mariam led a campaign of terror and mass killings against political opponents that came to be known as the "Red Terror" (Tegegn, 2012). Hundreds of thousands of civilians fled to other countries in sub-Saharan Africa, and a much smaller number were resettled in North America and Europe.

One of the routes for refugees escaping countries like Eritrea, Ethiopia and Sudan is across the Sinai Peninsula to Israel. This is an extremely dangerous journey where forced migrants are dependent on smugglers and human traffickers. Nakash, Langer, and Nagar (2015) documented the experiences of 1,044 men and women from Eritrea and Sudan seeking primary health care. Their findings reveal concerning incidences of violent experiences

during their flight to Israel. For example, 35% of Eritrean men were beaten during the journey, and 5% of women reported being sexually assaulted.

War affected Somali and Ethiopian populations have been studied both in Africa and in countries of resettlement. De Jong, Komproe and Van Ommeren (2003) studied populations exposed to armed conflict in Ethiopia and estimated prevalence rates of 19% for PTSD, 5.8% for any mood disorder, 11.3% for any other anxiety disorder, and 27.8% for one or more common disorders.

Studies of Somali and Oromo (from Ethiopia) refugees resettled in the United States found that 36% of Somali and 55% of Oromo refugees had been tortured. A history of torture correlated positively with all problem scales (social, psychological and physical) as well as scores on the Posttraumatic Stress Disorder Checklist (PCL-C). PCL-C scores suggested that 25% of torture survivors in this resettled population suffered from PTSD (Jaranson et al., 2004; Halcón et al. 2004). Longer term follow-up assessments of the same sample of Somali and Oromo refugees revealed that pre-migration and transit trauma histories predicted PTSD symptoms more than 18 months after resettlement, but that post-migration stressors were important mediating variables. The demographic variables of culture, gender and length of time in the resettlement country were also distinctive (Perera et al., 2013).

These studies also suggested that women were more likely to feel isolated than men following resettlement (Halcón et al., 2004; Jaranson et al., 2004). Robertson et al. (2006) looked more closely at the experience of these women and found that women who reported higher levels of trauma and torture were older, had more family responsibilities, less formal education and were less likely to speak English. Similarly, a study of the emotional health of Eritrean women found that displacement and the associated disruption of the social fabric negatively impacted their sense of coherence and resilience (Almedom et al., 2005).

Research on Ethiopians resettled in Canada revealed a lifetime prevalence of depression of 9.8%, approximately three times higher than that of the general population in Ethiopia. Somatic symptoms were common in this refugee population with 63.2% reporting at least one symptom, and 12.9% reporting five or more. Somatic symptoms were significantly associated with both Major Depressive Disorder (MDD) and PTSD. Ethiopians with diagnosable mental disorders were less likely to seek health care than those with somatic symptoms. In general Ethiopians were more likely to seek out traditional healers than "Western" health-care professionals (Fenta, Hyman, & Noh, 2004, 2006; Fenta, Hyman, Rourke, Moon, & Noh, 2010).

Bentley, Thoburn, Steward and Boynton (2011) studied Somalis resettled in Seattle. They found that they were likely to present with prominent physical symptoms associated with depression and generalized anxiety, but not with PTSD. These authors hypothesized that somatic symptoms are central to identifying culture specific idioms of distress in this group.

Although the use of "Western" diagnostic categories in the studies described above provide important indicators of mental health concerns in refugee populations from the Horn of Africa, these categories do not necessarily reflect local understandings of emotional suffering. Zarowsky (1997; 2004) explored narratives of suffering of Somali refugees in Ethiopia. She emphasized that narratives of individual suffering were nearly always located within narratives of collective dispossession and victimization and elaborated on a range of cultural constructs associated with mental health difficulties. *Hummad*, a word expressing the yearning for homeland and community, permeated survivors' expressions of distress, incorporating at once both sadness and solidarity with other Ethiopians in their collective loss. Somalis emphasized loss and its emotional expression as *murugo* (chronic sadness characterized by rumination over insoluble problems or losses) and *marrora dilla* (anguish over sudden overwhelming loss expressed as rage, uncontrolled weeping or hopelessness). *Argegah* describes an acute reaction to frightening and traumatic events, expressed as physical and behavioural reactions such as shock, vomiting and a temporary inability to respond. *Wareer* describes a state of confusion and delirium brought on by worrying about life so much that one is unable to function normally. Finally, *niyed jab* refers to a state of demoralization, hopelessness and broken will. *Niyed jab* is viewed as particularly serious since it permanently reduces one's capacity to meet one's responsibilities to the community. It is worth noting that amongst these Somali constructs of suffering, which seem to roughly parallel Western constructs of grief, acute stress reactions, generalized anxiety, and depression (respectively), there seems to be no single indigenous construct that parallels PTSD. However, some symptoms associated with PTSD are characteristic of several of the conditions documented by Zarowsky (1997; 2004).

Central Africa and the Great Lakes Region

The region highlighted under this heading includes Burundi, Cameroon, Central African Republic (CAR), Chad, the Democratic Republic of Congo (DRC), Kenya, Rwanda, South Sudan, Tanzania and Uganda. Researchers in Kenya and Uganda have identified that torture is most frequently reported after arrest and detention by police, at the hands of special police, and in Uganda, by the National Army. The most common forms of torture reported in

these countries were beating and kicking, death threats, witnessing the torture of others, and solitary confinement (African Centre for Treatment and Rehabilitation of Torture Victims, Independent Medico-Legal Unit, & Rehabilitation Centre for Victims of Torture in Ethiopia, 2008).

Many countries in this region have suffered under military dictators and in civil and border wars during the past several decades. During the 1970s Burundi experienced its first genocide in which as many as 200,000 civilians were killed. At the same time, General Idi Amin maintained his control of Uganda through mass killings in which at least 80,000 died. The late 1980s saw the rise of the Lord's Resistance Army (LRA) which would terrorize the towns and rural villages of northern Uganda, southern Sudan, and north-eastern DRC for the next thirty years. They would kill approximately 100,000 civilians, abduct a further 100,000 children and displace 2.5 million people in the region. The conflict in Uganda was characterized by atrocities on both sides. In a survey of help-seeking torture survivors in Gulu, Northern Uganda, 51% of incidents of torture were reported to have been committed by the Ugandan Peoples Defence Force and 8% by the Uganda National Police. In comparison, only 33% of incidents were attributed to the LRA (ACTV, IMLU & RCVTE, 2008).

The 1990s were characterized by the second Burundi genocide of 1993 which resulted in the killing of approximately 50,000 civilians, an event overshadowed by the 1994 Rwandan genocide in which 800,000 civilians were killed and a further 1.2 million displaced. Many of these people fled to the eastern DRC, a destabilizing factor that contributed to the outbreak of the first civil war in the DRC. This war, which implicated Ugandan and Rwandan forces, resulted in the deaths of at least 250,000 civilians and led almost immediately to a second civil war which would come to directly involve nine African countries including Angola, Burundi, Chad, Namibia, Rwanda, Sudan, Uganda and Zimbabwe. The second DRC civil war claimed at least 3 million civilian lives and resulted in the displacement of several million more. Although a peace agreement was signed in 2002, conflicts continue in North and South Kivu, Ituri and Northern Katanga. These wars have resulted in the killing of an estimated 250,000 civilians and the displacement of a further 2 million people.

The civil war in South Sudan which began in 2013 and has recently resolved in an uneasy truce claimed the lives of at least 50,000 civilians and displaced 3.5 million. In the past ten years civil wars in CAR and Chad have displaced more than a million people from those countries; and in 2015 tensions have flared up again in Burundi displacing 380,000 people and raising fears of a third genocide (Africa Research Bulletin, 2017; Human Rights Watch, 2015).

Given this history, it is not surprising to discover that researchers have consistently found extremely high prevalence rates of traumatic exposure and mental disorders in general and treatment-seeking populations from this part of the world. In 1999, five years after the Rwandan genocide, Bolton, Neugebauer and Ndogini (2002) investigated the prevalence of depression among a random sample of 368 adults in rural Rwanda. They found that 15.5% of adults met diagnostic criteria for depression and showed significant functional impairment. Eight years after the genocide, Pham, Weinstein and Longman (2004) assessed 2,074 randomly selected adult Rwandans and found a PTSD prevalence of 24.8%. Ten years after the genocide Schaal and Elbert (2006) interviewed 68 young Rwandans (aged 13 to 23 years). All were orphaned as children during the genocide. They found that 30 children (44%) met the diagnostic criteria for PTSD. Older children and girls were more likely to meet the PTSD criteria, as were children who had experienced more traumatic events. Then twelve years after the genocide, Schaal, Jacob, Dusingizemungu and Elbert (2010) recorded prevalence rates for prolonged grief disorder (PGD) of about 8.8% in widows (n=194) and 7.3% in orphans (n=206). Almost half of those bereaved in the genocide had not been able to retrieve the body of their loved one. PGD scores were predicted by the level of violence associated with the death(s), PTSD severity, and recency of the bereavement. Religious beliefs were shown to be significantly protective. Seventeen years after the genocide, Rugema, Mogren, Ntaganira and Gunilla (2013) found that young people who had witnessed and survived more extreme childhood exposure during the genocide were less educated, less likely to have children, earned less, and expressed greater insecurity with regard to their futures than their less exposed peers.

Karunakara et al. (2004) conducted a survey of Ugandan nationals living in northern Uganda (n=1,419), Sudanese nationals living in southern Sudan (South Sudan had not yet achieved independence) (n=664), and refugees from southern Sudan living in northern Uganda (n=1,240). Among Ugandan nationals, 24.5% had been beaten or tortured and 50% had been forced to witness torture; 3% had been raped. Similar figures were recorded for the Sudanese nationals: 29% had been beaten or tortured and 56% had been forced to witness torture; 2.4% had been raped. The figures for refugees from Sudan living in northern Uganda were notably higher: 34% had been beaten or tortured and 65% had been forced to witness torture; 10% had been raped. Eighteen percent of Ugandan nationals screened positive for PTSD, compared with 48% of Sudanese nationals and 46% of the refugee group. Seven years after the war, 11.8% of the population still met diagnostic criteria for PTSD. In another community survey conducted seven years after the war, Mugisha, Muyinda, Malamba and

Kinyanda (2015) found that the risk of PTSD was predicted by exposure to war trauma events, childhood trauma, negative life events, coping style and food insecurity.

Internally displaced populations within Sudan are also at extremely high risk of mental disorders. A community survey in two camps revealed an estimated prevalence rate of 53% for any mental health disorder, with the most common disorders being depression (24%), generalized anxiety (24%), social phobias (14%) and PTSD (12%) (Salah, et al., 2013). In this case the relatively low incidence of PTSD (although still clearly in excess of expected levels in a healthy population) is unusual in a population displaced by war.

In a large self-report community survey conducted by Pham, et al. (2010) in the eastern DRC, 84% of respondents had witnessed combat; 34% had sustained a serious injury during the war, 36% had been abducted, 16% had been raped, and 16% had been forced to commit acts of violence. In this study, 42% of respondents met the diagnostic criteria for PTSD, and 27% met criteria for MDD. The authors do not report what percentage of the sample met diagnostic criteria for both disorders, but scores on the PTSD and MDD scales used were highly correlated.

These population-based studies of war and torture exposure, and prevalence of trauma-related mental health conditions used different methodologies and recruited samples of varying size. Nevertheless, the overall picture is of very high levels of exposure to a wide range of atrocities, including torture, resulting in extremely high rates of significant and chronic mental health disorders. Such figures represent a significant challenge to the health and mental health systems in these countries.

A particularly vulnerable group in the Ugandan and DRC conflicts is children abducted and deployed as soldiers. Since these children are within the control of the *de facto* authority in the region and are subjected to intentional harm for the purposes of coercion and punishment, the treatment of these children amounts to torture. An early study of former child soldiers by Derluyn, Broekaert, Schuyten and De Temmerman (2004) suggested that 97% of children abducted by the LRA met screening criteria for PTSD. Bayer, et al. (2007) surveyed 169 children (mean age 15.3 years) who had been demobilized in DRC and Uganda two months previously. On average, they had served as child soldiers for 38 months. During this time, 84% had been severely beaten, 54% had killed a person, and 54% had been forced to punish other children. Fifty-seven percent of girls and 28% of boys had experienced forced sexual contact. Thirty-five percent of these children met symptom criteria for PTSD.

Klasen, Oettingen, Daniels and Adam (2010) assessed a sample of 330 former Ugandan child soldiers who had been freed 2.5 years earlier. In this sample 91% had been

beaten, 86% had been threatened with death, 26% had been raped, 46% had punished or tortured other children and 53% had killed someone. There was no significant difference in the prevalence of reported rape between boys and girls, although boys were more likely to have been threatened with death, to have punished or tortured other children, and to have killed someone. Symptom checklist scores suggested that 33% of children were suffering from PTSD and 36% from depression, while 19% met the diagnostic criteria for both disorders. There were no significant differences in mental health outcomes between boys and girls.

Other researchers extended their assessment to mental states commonly associated with Complex PTSD and found that 90% of former child soldiers reported a pervasive state of "hopelessness", 65% of being "sensitive", 64% of being "suspicious", and 56% of being "depressed" (Amone-P'Olak, 2006; Amone-P'Olak, Garnefski, & Kraaij, 2007). In a later study in the same part of Uganda, Amone P'Olak, Ovuga, Coudace, Jones and Abbott (2014) investigated the particular war experiences most likely to be associated with psychological disturbances. They found that witnessing violence and the deaths of family and friends were most predictive of enduring anxiety and depression. In girls, sexual abuse proved to be additionally predictive of disorder.

In rural Burundi, Yeoman et al. (2010) worked with 124 participants in a trauma and reconciliation workshop. In this sample 99% had experienced combat and 97% has lost a family member in the fighting. Twenty-four percent had been imprisoned, 10% had been sexually abused or humiliated, 10% had been forced to harm or kill a stranger and 9% had been forced to harm or kill a family member or friend. Here again, acts of sexual violence and being forced to kill others amount to torture and blur the line between victims and perpetrators, a fact that must be considered in the design of both individual and community healing interventions. Mean scores for anxiety, depression and somatization were reported as being higher than would be expected in a North American psychiatric inpatient population.

In 2007 in Kenya, post-election violence resulted in the deaths of at least 800 people and the displacement of as many as 600,000. Widespread reports of rape, forced male circumcision, the destruction of homes and businesses, as well as police brutality and killings, were reported. Six months after the end of the violence, a community survey in the informal settlements of Nairobi revealed that 18% of adolescents screened positive for PTSD (Harder, Mutiso, Khasakhala, Burke, & Ndetei, 2012). A sample of younger children displayed marked adjustment difficulties, increased aggression and decreased prosocial behaviour (Kithakye, Morris, Terranova, & Myers, 2010).

In Chad, Rasmussen et al. (2010) studied a random sample of adult refugees from the Darfur region of Western Sudan. Twenty-seven percent had been held captive, 44% had been beaten, 14% had been burned and 11% had experienced suffocation or strangulation, acts commonly associated with torture. Virtually all had had their homes destroyed and livestock stolen or killed. These authors recorded high levels of distress on measures of depression and PTSD as well as significant functional impairment. Measures of Darfuri idioms of psychological distress were identified through focus groups and card sorts. They recorded high levels of *hozun* (literally "sadness") and *majnun* (literally "madness"). The authors described the latter as sharing some features with depression, PTSD, and brief psychosis.

In northern Uganda, Bolton et al. (2007) investigated a sample of adolescents displaced by war and noted several depression-type syndromes in the local idiom. *Two tam* appears to be most like the "Western" construct of depression. *Par* is similar but includes aspects of interpersonal aggression, such as being rude or disobedient and insulting others[2]. *Kumu* is also similar but emphasizes somatic symptoms including loss of appetite, pain in the heart, headaches, and feeling cold and weak. These authors also identified *ma lwor* as an anxiety-like syndrome including fearfulness, exaggerated startle response, sleeplessness and elevated arousal. Finally, *kwo maraco* is a term used to describe a problem of unacceptable behaviour including fighting, being deceitful, abusing drugs and alcohol, and being disrespectful.

Moving further south, there are clear similarities between torture and war related constructs of mental illness among communities of South Sudan, DRC and Burundi (Irankunda, Heatherington, & Fitts, 2017; Ventevogel, Jordans, Reis, & De Jong, 2014). *Moul*/*mamali* (South Sudan), *erisire* (DRC) and *ibisazi*/*ibisigo*/*gusara* (Burundi) are characterized by chaotic or aimless behaviour, nonsensical speech, poor hygiene, and interpersonal violence, and seem to parallel the psychotic disorders of "Western" diagnostic construction. *Nger yec*/*yeyeesi* (South Sudan), *alluhire* (DRC) and *akabonge*/*kuyinga* (DRC) describe a state of sorrow and withdrawal associated with loss or bereavement. They are typically associated with people having lost many loved ones, often due to war. These conditions are also associated with headaches, confusion, thinking too much, worrying,

[2] There are other interpretations of the Luo word *Par* where it is used to mean depression without interpersonal characteristics noted. (Personal Communication with Dr Amone-P'Olak of the University of the Witwatersrand: South Africa, April 2, 2020)

irritability and feelings of remorse. This group of symptoms seems to roughly parallel grief in "Western" construction but incorporates anxieties about survival and the future.

A condition called *ihahamuka/guhahmuka* (literally "without lungs") is commonly described in both Rwanda and Burundi (Familiar et al., 2013; Hagengimana & Hinton, 2009; Irankunda, et al., 2017). *Ihahamuka* is characterized by shortness of breath, being fearful and alert to danger, being easily startled and distracted, agitation, "being afraid of things that aren't frightening", sleep disturbances and bad dreams, concentration difficulties, and loss of appetite. *Ihahamuka* seems to closely parallel the diagnostic features of PTSD although the emphasis rests on arousal symptoms, rather than on the symptoms of intrusion and avoidance characteristic of PTSD. It is important to note that *ihahamuka* is almost exclusively used in relation to the recent wars in Rwanda and Burundi, and according to Hagengimana and Hinton (2009) the construct and condition appears to have only emerged after those wars. Researchers must consider the likelihood that this description is a local translation of a construct imported through humanitarian assistance efforts by "Western" trained psychologists.

Southern Africa

The Southern Africa region comprises Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The two Portuguese colonies in this list, Angola and Mozambique, were among the first to win independence and challenge minority white rule in the region but both descended into civil war within two years of independence. The Angolan civil war broke out in 1975 and continued for 27 years with some sporadic periods of peace during this period, ending finally in 2002. The war left 500,000 civilians dead and displaced at least one million others. The Mozambican civil war lasted from 1977 to 1992. Shortly after coming to power in 1975 the new Mozambican government created re-education camps in which up to 300,000 citizens were imprisoned, tortured and sexually harassed and abused. Both governmental and rebel forces committed war crimes including mass killings, rapes and mutilations during raids on rural villages and towns. This together with the indiscriminate use of landmines resulted in approximately one million civilian deaths and the displacement of five million people, as well as countless disabling war injuries.

Zimbabwean independence was won after a fifteen-year guerrilla war and was followed almost immediately by the ruling party allegedly executing as many as 20,000 citizens, and torturing tens of thousands more, in an attempt to quell political opposition from

other revolutionary groups. State oppression continued through the 1990s but came to a head in the 2008 presidential elections where violence monitors reported widespread and systematic torture that resulted in several hundred thousand people fleeing the country, large numbers of these to neighbouring South Africa (Idemudia, 2017).

In South Africa, the final report of Truth and Reconciliation Commission report of 1998 summarized human rights violations perpetrated through the era of apartheid by both agents of the state and the liberation movements. The report details 78,000 political detentions, and 47,000 human rights violations perpetrated against approximately 28,750 victims. Torture is defined in this report as only occurring with custody or captivity, a significantly narrower definition than that laid down in UNCAT (and discussed in Chapter 1). Nevertheless, the commission documented more than 5,000 instances of torture perpetrated against 2,900 people. Victims were most commonly young men and the perpetrators were overwhelmingly associated with the South African Police Service. The most common forms of torture were beatings, electric shocks, suffocations and psychological torture, including death threats, mock executions and threats against the victims' families. Several thousand additional cases of severe ill-treatment (many of which rise to the level of torture under the UNCAT definition) were also recorded. Again, most victims were young men and while perpetrators were dominantly associated with the South African Police there is also evidence that torture was committed by agents of the liberation movements, particularly against those thought to be informers or traitors.

Approximately five years after the end of apartheid, Halvorsen and Kagee (2010) conducted a mental health survey of 143 former detainees and recorded extremely high prevalence rates for various disorders: 52% scored in the clinical range for PTSD, 78% for depression, and 83% for anxiety. Virtually all of those who screened positive for PTSD also screened positive for depression. The number of episodes of detention, the type of social support available, and female gender predicted worse mental health outcomes. Interestingly, longer periods of detention predicted better mental health outcome, possibly due to opportunities for positive social support between detainees and greater sense of personal meaning through identification with the political struggle.

As the passage of time takes South Africa further away from the apartheid era, the focus of practitioners working with torture survivors has turned to the tens of thousands of torture survivors from other African countries who have sought refuge in the country. Higson-Smith and Bro (2007) described the experiences of a community sample of 77 torture-surviving refugees and asylum seekers living in Johannesburg. Thirty-four percent

reported symptoms associated with PTSD or CPTSD, and 32% reported symptoms associated with depression. Although 65% reported serious current health concerns, only 46% had ever visited a clinic or hospital in South Africa. Those that had visited a clinic or hospital gave very positive evaluations of the services available, but very negative evaluations of the way service providers interacted with them. This reflects the difference in health infrastructure in South Africa relative to exiles' countries of origin, as well as the discriminatory and xenophobic attitudes of many South African health care providers. Bandeira, Higson-Smith, Bantjes and Polatin (2010) described how torture survivors from other African countries hope to find safety and care in South Africa but are faced instead with a long bureaucratic struggle for asylum, limited support and services, and an often-hostile host community. Higson-Smith and Bro (2010) have argued that tortured exiles living in the urban centres of sub-Saharan Africa are amongst the most vulnerable of forced migrant populations.

In Zimbabwe, a survey of 1,195 respondents from high density wards in three urban centres was conducted by ActionAid in collaboration with the Counselling Services Unit, the Combined Harare Residents' Association and the Zimbabwe Peace Project (2005). In this sample, 20% of respondents reported severe beatings, 14% reported torture, 23% had been imprisoned, and 8% had been raped. Nearly 70% reported clinically significant psychological disorders with exposure to organized violence and torture emerging as an important risk factor. In his summary of research into the prevalence and impact of torture in Zimbabwe between 2000 and 2008, Reeler (2009) described a study in the capital city of Harare using the Shona Symptom Questionnaire (SSQ) (Patel, Simunyu, Gwanzura, Lewis, & Mann, 1997). This study found that 38% of respondents screened positive for a common mental health disorder, with exposure to violence (particularly witnessing violence and having been raped) and having had belongings confiscated by the authorities, as the most significant risk factors. In fact, people who had had their possessions taken were 14 times more likely to screen positive for a common mental disorder than the general population. This study did not investigate causal mechanisms further, but we can speculate that the property taken was often essential for survival and almost impossible for impoverished people to replace, and that the blatant theft of personal possessions is a powerful communication of totalitarian control over the populace.

A 2008 survey conducted by Women of Zimbabwe Arise (WOZA) focused on the experiences of 1,983 women activists across the country. In this sample 61% reported being arrested at least once, 37% had been unlawfully detained (more than 48 hours), 37% reported psychological torture, 32% reported physical torture, and 64% reported degrading treatment

at the hands of the authorities. Incidents of torture were most commonly reported to have been perpetrated by Zimbabwe Republic Police at police stations or in police vehicles. Again, exposure to torture was significantly linked to elevated levels of clinically significant emotional distress (WOZA, 2008).

Igreja (2003) interviewed 40 *Naanga* (traditional healers) in the war-affected region of Gorongosa, Mozambique. The people of this region have long had a belief that innocent people (usually men) who died violently could return to possess their murderer's family members and descendants in the form of an *N'Fukua* (or *Mipfhukwa*) spirit. This spirit would bring great suffering to the possessed person in retribution. However, following the civil war in Mozambique, a new vengeful spirit called *Gamba* emerged. The signs of *Gamba* possession are extremely broad and include chronic headaches, nightmares, body pain (especially abdominal), poor appetite, difficulty breathing, sleep difficulties, malaria, diarrhoea, sexually transmitted diseases and infertility. Special emphasis is given to particularly vivid nightmares from which the dreamer cannot awaken, called *Mawewe*. The content of such dreams is specifically related to the war. In a later study, Igreja, et al. (2010) found that approximately 19% of a community sample of 941 people reported that they suffered from possession by at least one spirit. Importantly, *Gamba* is different to *N'Fukua* in that, after a necessary period of suffering, those possessed by the *Gamba* spirit have the possibility of recovery following a healing ritual. Treatment for *Gamba* involves components similar to "Western" PTSD treatments including the recovery and narration of previously concealed memories. The spirit cannot be appeased by gentle words from a healer but requires reparation in the form of public confession. After the healing ritual the former sufferer often becomes a *Gamba* healer.

West Africa (excluding the Maghreb)

West Africa includes Benin, Burkina Faso, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, and Sierra Leone. The history of West Africa over the past sixty years is one of independent African governments struggling to hold on to power. Many resorted to military rule and the persecution of political opponents, and the history of many of these countries is rife with successful and unsuccessful coups d'état. In the late 1960s images of the Biafran War (also called the Nigerian Civil War) shocked the international community and the history remains strongly contested to this day. Nevertheless, it is clear that atrocities were committed by a range of groupings and that at least 2.5 million civilians were displaced.

The civil conflicts in Liberia and Sierra Leone in the 1990s were characterized by the extensive abduction of children for use in soldiering and extreme war crimes. These conflicts resulted in the deaths of at least 400,000 civilians and the displacement of a further three million. Similarly, the civil wars in Guinea-Bissau and Côte d'Ivoire displaced 450,000 people. More recently the Northern Mali civil conflict and the Tuareg rebellion in Niger have resulted in 600,000 people being displaced.

The report of the Truth and Reconciliation Commission of Sierra Leone (2004) estimated that at least 4,000 people, including women and children, had limbs amputated as punishment for supporting the enemy and to send a message to their families and communities. This form of torture was committed by multiple parties and approximately three out of four victims of such amputations died as a consequence. In a baseline survey for the evaluation of a broad-based community healing intervention in Sierra Leone, Cilliers, et al. (2016) found that 33% of the population they assessed had been beaten and 3% reported that they had been raped.

Many of these atrocities were carried out by teenage boys and images of child soldiers clutching Kalashnikov automatic rifles were characteristic of international media coverage of the wars in both Sierra Leone and Liberia. Tens of thousands of children were abducted and forced into soldiering in these wars in West Africa (Medeiros, 2007). In a survey of former child soldiers in Sierra Leone conducted approximately three years after demobilization (Betancourt, et al, 2011), 63% of respondents had been threatened with death, 59% had been severely beaten, 34% had been forced to take drugs, 29% had killed a person and 27% had lost at least one parent in the war. In addition, 44% of girls and 5% of boys had been raped. Seventy-two percent of girls and 55% of boys scored in the clinical range for depression, and 80% of girls and 52% of boys scored in the clinical range for anxiety. Betancourt, et al. (2010) assessed these children again six years later. They found that they struggled with both externalizing (hostility) and internalizing (depression and anxiety) problems. The relationship between war time experiences and later externalizing problems was mediated by stigma, daily stressors and community acceptance. Age at the time of abduction, having been raped, as well as daily stressors and community acceptance mediated internalizing problems. These findings are very similar to those described previously in relation to former child soldiers in Central Africa and the Great Lakes region suggesting that cultural and contextual differences may be outweighed by more universal processes in human development. Certainly, the assault on childhood, often including the torture of minors, is a particularly shameful feature of some wars on the continent.

In a random sample of Tuareg refugees living in a refugee camp in Burkina Faso, Carta et al. (2013) found that 62% screened positive for both PTSD and serious psychiatric morbidity. Being older, the death of a family member, severe problems with food, physical injury, and poor housing, were associated with increased risk of either PTSD or serious psychiatric morbidity. Similarly, in a qualitative analysis of the mental health and quality of life of West African refugees in a refugee camp in Nigeria, Akinyemi, Owoaje and Cadmus (2016) found that post-migration factors were the primary drivers of poor mental health and quality of life. The post-migration factors highlighted were poverty and unemployment, poor physical health, lack of family support, abuse suffered within the camp, poor housing, the lack of security in the camp, and stigma.

Local constructions of emotional disorders following traumatic experiences vary widely across West Africa. Stark (2006) described a state of *noro* or "spiritual pollution" that affected girls who had been raped and tortured during the Sierra Leone civil war. These girls described having poor emotional health, feeling ashamed, being stigmatized in the community, and having bad luck which prevented them from getting married and negatively affected their families' crops and health. While some of these responses parallel "Western" conceptualization of rape impact, as with other traumatic stressors and mental health conditions discussed here and described previously, it is evident that familial and community outcomes of various kinds are viewed as part and parcel of the condition. *Noro* requires spiritual cleansing through a traditional healer.

In the Gambia, Fox (2003) explored traditional nosologies of post-trauma syndromes among the Mandika through focus group discussions with traditional healers. These healers identified four progressive levels of emotional dysfunction following trauma. The traumatic experience can cause *masilango* (an initial acute fear response), which if strong enough affects the heart, causing *kidja farro* (literally "heart shakes"). When a person thinks too much, *mira kurango* (thinking sickness) may develop into *perrio* (which translates to "mind out of place"). *Perrio* is viewed as part of a broader category of *nyamato* (or "madness"). Although these disorders may be caused by traumatic events, they may also arise from spiritual trauma caused by evil spirits and sorcerers, or some combination of the two.

Perhaps the most striking of the documented responses to political violence and repression in West Africa is the Kiyang-Yang movement that developed among the Balanta people of Guinea Bissau in the early 1980s. Authors de Jong and Reis (2010, 2013) point out that this movement emerged following the massive traumatic stress of a 22 year war of independence that ended in 1974. It emerged among the Balanta people who bore the brunt of

the traumatic burden in terms of personal and communal losses. The movement began as a healing cult of the god Nhaala under leader Ntombikte. Over time, approximately 12% of the Balanta population experienced dissociative experiences that led them to join the movement. Followers described how they struggled to breathe, became light-headed, felt their hearts beating hard, heard a buzzing sound, and experienced rapid thoughts. Their bodies felt cold and strange, and their limbs trembled. They described being forced to run without sense of direction, a behaviour that lasted for several days and was usually followed by total amnesia of the period. The exponential spread of Kiyang-Yang became a threat to the government and in November 1985, approximately 150 Balanta were accused of planning a coup d'état with their support. Many were tortured and several were executed. Today Kiyang-Yang has evolved into a decentralized regional institution. This phenomenon is interesting in that it seems to have arisen out of personal and collective trauma and developed into an organized community healing response. That it resulted in further victimization and re-traumatization under a new set of oppressors is tragic.

Abramowitz (2010) working in Liberia describes the symptoms and evolution of *open mole* (or "hole in the head") which is an adult condition associated with the sunken fontanelle sometimes observed in infants. *Open mole* is understood to occur in adults who have experienced a traumatic event or endured chronic adversity. The defining feature is a soft spot on the top of the head, although associated symptoms include headaches, pain in the back and neck, loss of appetite, fatigue, weakness, troubled sleep and nightmares, and social withdrawal. She describes how in the aftermath of the civil war, *open mole* has been transformed from a culture-bound form of somatic illness to a gateway diagnosis for PTSD and other trauma-related mental health disorders.

Conclusion

It is apparent from this overview of the recent history of wars and oppressive regimes in sub-Saharan Africa that millions of people have been exposed to torture, war and displacement in the region. It is difficult to imagine the costs of this unmitigated brutalization of human beings and society, with the impacts rippling forward through subsequent generations and into present cycles of victimization. It is also difficult to comprehend the burden on the multiple healing resources within communities: support networks of family, friends and fellow activists; traditional healing systems; communities of faith; as well as formal health care providers. This results in a daunting "treatment gap", language used by the World Health Organisation to describe situations where large numbers of people need care

but are unable to access services (Kohn, Saxena, Levav, & Sarceno, 2004). It is essential that African researchers, policymakers, health professionals and teachers responsible for the development and resourcing of health and mental health systems on the continent, think deeply about the implication of this traumatic history on their work.

The literature on the psychosocial health of war survivors, displaced persons, refugees and torture survivors in sub-Saharan Africa is substantial and fast growing. Nevertheless, researchers are a long way from documenting the specific effects of torture in all the different situations touched on in this chapter. It is however clear that while symptoms of PTSD and other trauma-related disorders may serve as effective proxy indicators for the impact of torture on individuals, such measures fail in significant ways to capture the complexity of torture survivors' daily suffering. To apprehend the full impact of torture it is necessary to consider the person's relationship to the society that permitted such violation; the losses of home, community, safety, status, agency and identity that so many survivors suffer; the strain of in many instances having to rebuild a new life in a foreign and often hostile country of refuge; the complex and multi-generational struggles of families of torture survivors; the effects of chronic pain and disability; the grief for loved ones that did not survive; as well as the full range of enduring trauma-related symptoms.

Such complex and layered impacts make the work of rehabilitation extremely demanding, especially in parts of the world with few highly trained mental health practitioners who understand the local realities of survivors. Chapter 3 introduces the available literature on torture rehabilitation with a focus on research conducted with populations in sub-Saharan Africa.

Chapter 3 Mental Health Interventions with Adult Torture Survivors

In this chapter, I begin with a high level summary of global research on mental health interventions with adult torture survivors, focusing on the multiple systematic reviews and meta-analyses. After discussing some of the limitations of this body of research, I describe five distinct theoretical paradigms that I argue underpin many of the key differences between rehabilitation approaches. I illustrate these paradigms with reference to various treatment outcome studies, highlighting wherever possible studies conducted with populations in and from sub-Saharan Africa.

Clinical and systematic reviews of treatment outcomes with torture survivors

As Pérez-Sales (2017) has noted, two recent and highly regarded reviews of mental health interventions with torture survivors have come to strikingly different conclusions and recommendations. Using the rigorous inclusion and analytic criteria of the Cochrane review system, Patel, et al. (2014, 2016) reviewed clinical trials of psychological, social and welfare interventions with torture survivors. Nine studies met the inclusion criteria and the authors found some evidence that NET and CBT produced moderate effects in the medium term only. However, they concluded that the evidence was too limited and of insufficient quality to recommend the use of these approaches over other techniques used in the treatment of torture survivors. In contrast, Weiss et al. (2016) included a much broader set of research methodologies and reviewed 88 studies. Based on this analysis they recommended the use of techniques that include exposure elements, including CBT and NET.

The two sets of reviewers come to rather different conclusions based on a similar evidence base. To better understand this contradiction, it is helpful to review the history of similar attempts to summarize this literature during the past two decades. In fact, the two systematic reviews referenced above are merely the most recent in a long series of similar reviews, reviews in which researchers have struggled to find a compelling path through the complexity of existing research on the effectiveness of mental health interventions with populations in which a history of torture is prevalent. Given the limited number of published studies, a surprising number of systematic reviews and meta-analyses have been published. Twenty-two of these are summarized in Table 3.1 below.

Table 3.1 Systematic reviews of mental health treatment outcome research in populations with a high prevalence of torture survivors

Authors	Population	Outcomes	Design	Interventions	Location	Reports
McIvor & Turner (1995)	Torture survivors	Various	All	All	Global	30
Nicholl & Thompson (2004)	Adult refugees	PTSD	Prospective*	All	Global	10
Crumlish & O'Rourke (2010)	Refugees/asylum seekers	PTSD	RCT	All	Global	10
Murray, Davidson, & Schweitzer (2010)	Refugees	Various	Prospective	All	Resettlement	22
Robjant & Fazel (2010)	Refugees/asylum seekers/IDPs	PTSD & MDD	Prospective	NET/KIDNET	Global	14
Palic & Elklit (2011)	Adult refugees	PTSD	Prospective	All	Global	25
Nickerson, Bryant, Silove, & Steel (2011)	Refugees	PTSD	Prospective	Trauma focused vs multimodal	Global	19
McPherson (2012)	Mass violence, torture	PTSD	RCT	NET	Global	8
Dossa & Hatem (2012)	Women war survivors	PTSD & MDD	RCT	CPT & NET	Global	10
McFarlane & Kaplan (2012)	Torture survivors	Various	Prospective	All	Global	40
Gwozdziewycz & Mehl-Madrona (2013)	Refugees	PTSD	RCT	NET	Global	7
Patel, Kellezi, & Williams (2014, 2016)	Torture survivors	Various	RCT	All	Global	9

Authors	Population	Outcomes	Design	Interventions	Location	Reports
van Wyk & Schweitzer (2014)	Adult refugees/asylum seekers	Various	Prospective	Naturalistic	Resettlement	7
Lambert & Alhassoon (2015)	Adult refugees	PTSD & MDD	RCT	All	Global	12
Slobodin & de Jong (2015)	Traumatized refugees, asylum seekers	Various	Prospective	Family	Global	6
Bunn, Goesel, Kinet, & Ray (2016)	Torture survivors	Various	All	Group	Global	36
Salo & Bray (2016)	Torture survivors	Psychosocial	All	All	Resettlement	11
Weiss et al. (2016)	Adult survivors of systematic violence	Various	All	All	Global	88
Nosè et al. (2017)	Refugees/asylum seekers	PTSD	RCT	All	Resettlement	12
Thompson, Vidgen, & Roberts (2018)	Refugees/asylum seekers	PTSD	RCT	All	Global	15
Hamid, Patel, & Williams (2019)	Torture survivors	Various	RCT	All	Global	15
Turrini et al. (2019)	Refugees/asylum seekers	PTSD, MDD & anxiety	RCT	Psychosocial interventions	Global	26

* Any design including a comparison of an intake and at least one follow-up assessment.

The earliest clinical reviews (not systematic) of interventions with torture survivors (Jaranson et al., 2001; Laurence, 1992; Schweitzer, et al., 2002) emphasized the complexity of torture survivor's mental health challenges and identified fundamental principles that should underpin treatment including: doing no harm; comprehensive assessment to inform treatment; concurrent support for medical and social needs; and sensitivity to cultural and religious differences. Later clinical reviews (Campbell 2007; Fabri, 2011; Slobodin & de Jong, 2014) began to differentiate between different approaches, summarizing the evidence in support of psychodynamic, cognitive, cognitive-behavioural, testimony based, family, and community interventions separately. These reviewers emphasized the need for specialist rehabilitation centres for torture survivors and repeatedly noted the chronic lack of research on therapy outcomes with this population.

The earliest attempt at a systematic review (McIvor & Turner, 1995) stressed the need for integrated approaches drawing on the "common elements" emerging from different therapeutic approaches. These common elements included trust and the quality of the therapeutic relationship, the creation of both physical and emotional safety, retelling the trauma story, and cognitive restructuring. McIvor and Turner (1995) also emphasized the importance of an explicit ideological commitment to human rights on the part of counsellors and treatment centres, and the need for therapists to deeply understand their clients' political, social and cultural worlds. However, they also warned against over-identification with clients and cautioned against avoidance of working with the client's most traumatic experiences.

Five review teams have looked at the very much narrower set of studies of PTSD treatment outcomes with refugees and torture survivors that met RCT criteria specifically. Nicholl and Thomson (2004) and Crumlish and O'Rourke (2010) concluded that no treatment had yet developed a solid evidence base, but that CBT and NET showed promise. Palic and Elklit (2011) conducted a similar review but concluded that sufficient support had been accumulated for the use of CBT and NET as evidence-based treatments. Nosè et al. (2017) conducted yet another review of PTSD outcomes for refugees in resettlement contexts. They concluded that NET showed the strongest support base. Thompson et al. (2018) are the most recent team to repeat this analysis. In a meta-analysis of fifteen studies, they found evidence to support the use of eye movement desensitization and reprocessing (EMDR) and NET. Both review teams, in keeping with all those that have preceded them, qualified their results with observations that the number of studies was very limited, that many treatment approaches had not been adequately tested (if at all), and that those studies that have been published have serious methodological weaknesses.

Murray, et al. (2010) examined results for a broader set of treatment outcomes with refugees in resettlement countries specifically. They found no evidence to recommend particular treatments over others and emphasized common elements. They noted that effect sizes were greatest for PTSD and anxiety symptom outcomes, and in culturally homogenous samples. These reviewers commented that PTSD symptoms represent only a part of refugees' overall symptom presentation and recommended inclusion of at least one global mental health or quality of life measure in future treatment outcome studies.

Nickerson, et al. (2011) tackled a core question in the field: whether it is more important to focus treatment on resolving past traumatic experiences or on helping survivors cope more effectively with current stressors in their lives. They contrasted the outcomes of a range of trauma-focused approaches with the outcomes reported by researchers testing multi-modal approaches that included significant social support interventions. Most of these studies were conducted in resettlement contexts. The authors concluded that while there is evidence in support of trauma-focused approaches, multi-modal therapeutic approaches have not been sufficiently researched and the role of contextual factors on treatment outcome with refugees is not yet adequately understood. It is worth noting that Nickerson et al. (2011) were able to identify only four studies of multi-modal approaches and that all of these were located within resettlement contexts in Europe or North America. There remains a significant gap in the literature with respect to treatment outcomes associated with multi-modal interventions in low or middle income countries, contexts that are often poor and lacking in security in which the daily stressors on torture survivors are arguably greater and supportive resources fewer.

Dossa and Hatem (2012) attempted to explore the effectiveness of CBT approaches, specifically culturally adapted cognitive processing therapy (CPT) and NET, in the treatment of PTSD and depression in woman survivors of torture and war. Unfortunately, despite significant research highlighting the gendered nature of torture and war and the impacts thereof (Sideris, 2003; Stark et al., 2010; Stark & Ager, 2011; Tappis, Freeman, Glass, & Doocy, 2016), none of the published studies included an analysis of the mediating role of gender on treatment outcomes. Using results that were not gender disaggregated, Dossa and Hatem (2012) concluded that both approaches were effective, but that culturally adapted CPT resulted in greater effect sizes on symptoms of depression than NET. In addition to their call for more gender focused research, these authors emphasized the importance of cultural adaptation and repeated earlier calls for researchers to investigate treatment effectiveness beyond PTSD outcomes.

McFarlane and Kaplan (2012) cast their net over a broader range of research methodologies, treatment approaches and therapeutic outcomes. This review included forty studies with survivors of torture and gross human rights abuses, conducted in resettlement countries (twenty-four studies), countries of first refuge (nine studies), and countries of origin (twelve studies). The authors noted that nearly all studies demonstrated positive therapeutic impact lasting at least into the medium term and concluded that there is little evidence to support the use of particular treatments over others. This review team drew attention to the confounding effects of context in systematic review and meta-analytic studies. They noted that most studies were conducted with refugees in resettlement contexts, in which treatment typically comprised at least twelve sessions and often many more. Most studies conducted in countries of origin or first refuge offered much shorter treatments, typically between one and four sessions. Several of these brief interventions demonstrated lasting positive effects of significant size, suggesting that such approaches are both feasible and useful in resource poor environments.

Van Wyk and Schweitzer (2014) further elaborated on the fundamental importance of context in their systematic review of treatment outcomes with refugees in naturalistic settings in resettlement contexts. Naturalistic settings refer to existing treatment services, as opposed to treatment offered as part of a treatment outcome study. The value of this review was its high external validity, as it reflected on the challenges of treating a diverse and complex range of client conditions and needs. In contrast to the treatment-specific trials focused on by other reviewers, all seven studies included in this review employed multidisciplinary interventions and assessed a range of clinical outcomes. At least in resettlement contexts, it seems that specific evidence-based treatments are not being relied upon by practitioners who work with refugees daily. The seven studies included in this review were all located within resettlement contexts in Europe and the United States. There is almost no systematic evidence of treatment outcomes in naturalistic settings in any low or middle-income settings, the contexts in which the vast majority of torture survivors are found.

Lambert and Alhassoon (2014) conducted a meta-analysis of 12 trials of trauma-focused therapies with adult refugees. As with previous reviews they found strong effect sizes for both PTSD and depression outcomes, but no evidence to support the use of one trauma-focused therapy over another. This analysis is particularly important because the meta-analytic approach was able to separate out the variance in treatment outcome due to a range of methodological factors rather than in treatment approaches. Some factors such as the method of assessing outcome variables were not significant. However, the number of sessions

significantly predicted effect size, and smaller effect sizes were found in studies that used active control groups (for example, treatment as usual or supportive counselling). An important finding for multi-cultural contexts was that the use of interpreters did not significantly impact effect size in either direction.

Later reviews began to target different forms of intervention. For example, Slobodin and de Jong (2015) reviewed interventions that focus on refugees and asylum seekers as members of family systems and systemic type interventions. All interventions studied produced moderate to good effect sizes but given the paucity of research (six experimental studies), the reviewers were unable to reach any conclusions regarding the relative effectiveness of different approaches. These authors emphasized the importance of family to the adjustment and mental health of refugees and called for more research into family focused interventions. Salo and Bray (2016) made a similar point in their review using Bronfenbrenner's (1977) ecological theory as an analytic framework. At the level of microsystems, they found that only four of the 22 studies reviewed targeted the family context, six addressed the legal domain, three explored social domains, and only two dealt with occupation related issues. At the macrosystemic level they found that some treatments had been culturally adapted and some studies made use of interpreters to bridge cultural divides. At the level of the chronosystem they noted the very limited number of studies that assessed long term impact of treatments. In summary, the authors commented that very little research had been done on how best to address the ecological needs of torture survivors and offered suggestions as to how this gap might be addressed in future.

Bunn, et al. (2016) conducted a systematic review of thirty-six studies of group interventions with adult survivors of torture and mass violence. They pointed out that group interventions are particularly poorly described and have seldom been empirically tested. Existing studies provide tentative evidence that group interventions are effective with torture survivors. Apart from the potential opportunities to provide services to larger numbers of survivors simultaneously, these authors emphasized the usefulness of groups in directly addressing issues of interpersonal and social functioning. They argued that groups offered the possibility of developing new relationships and reclaiming the capacity to trust, thereby decreasing social isolation and increasing support.

More recently, Hamid, Patel & Williams (2019) updated their previous review including six newer RCTs. The inclusion of the new studies did not substantially change their earlier conclusions (Patel, et al., 2016). Finally Turrini et al. (2019) tackle both prevalence of psychological disorder and intervention outcome among refugees and come to the same

conclusions as many of their predecessors, that studies should look at the prevalence of a broader range of clinical outcomes and that there is currently insufficient evidence to support the use of any particular treatment over others. These reviewers note the importance of internal practice guidelines and call on the World Health Organization and/or the United National High Commission for Refugees to issue such guidelines.

It is encouraging to look back over two decades of research and note developments in the field. Early research defined treatment outcomes almost exclusively in terms of PTSD diagnosis and symptoms, but over time researchers have started to consider a broader set of outcomes including depression and anxiety symptoms, somatic expressions of distress, daily functioning and quality of life. As the field has grown a range of more analytical reviews has emerged, such as those focusing on naturalistic interventions, family interventions and group interventions, or those comparing categories of intervention (such as trauma focused versus multimodal) and context (resettlement vs country of origin and first refuge). Researchers are drawing on an ever expanding literature to ask more and more searching questions about how best to provide care to torture survivors.

Despite these advances it is impossible to avoid the tensions introduced by attempts to ensure scientific rigour and validity when analysing and reflecting on this literature. Most of the treatment approaches tested have shown positive results, with CBT and NET having been most frequently and rigorously researched and showing the strongest effect sizes. And yet, with more rigorous standards of review, such as the meta-analyses by Patel et al. (2014) and Lambert and Alhassoon (2014), even these conclusions are brought into question. We find that not only when more rigorous criteria for review are employed but also when treatment is assessed against a broader set of treatment outcomes, as for example by Murray et al. (2010) or McFarlane and Kaplan (2012), or in terms of the challenges of service provision in naturalistic settings (Van Wyk and Schweitzer, 2014), the evidence base supporting torture rehabilitation looks very thin indeed. With this in mind, it is worth summarizing the methodological flaws that have generally concerned reviewers.

Methodological issues in treatment outcome research with torture survivors

As has been pointed out repeatedly, sample sizes in torture treatment outcome research have tended to be small and power analyses have seldom been reported. Small samples limit generalizability and reduce the possibility of detecting between group differences. These problems have been exacerbated by authors reporting statistical significance without effect sizes or confidence intervals. Few studies have used random

assignment, included a control condition, or employed blind assessments. As should be appreciated some of these difficulties relate to ethical concerns, for example delaying treatment for highly damaged populations. In many studies the assessments of improvement were conducted by the counsellors themselves. Even where randomized control trials have been reported, reviewers have drawn attention to problems with the integrity of blinding, high attrition rates, and otherwise incomplete data sets. These compromises to experimental rigour have seldom been fully acknowledged or adequately described.

Reviewers also mentioned weaknesses in the way target population and treatment outcomes have been defined and described. Studies of refugee groups have not always clearly documented or discriminated between participants' experiences of war, organized violence and/or torture, and have seldom considered the length of time between the most critical traumatic events and treatment. Similarly, insufficient attention has been given to the varied needs and presentations of clients who have experienced single events, repeated victimization, or protracted torture, or of those who have been indirectly rather than directly traumatized, through for example, witnessing the torture of others, including loved ones. Intergenerational effects as well as the impact of ongoing threat have typically not been evaluated. Although research into the impact of torture has documented a broad spectrum of mental health sequelae (see Chapter 2), the treatment outcome literature has still focused rather narrowly on reduction in symptoms associated with PTSD, depression and anxiety. Other outcome variables such as improved daily functioning, the quality of inter-personal relationships, occupational functioning, or survivors' sense of self, might be more germane to the care of torture survivors in some contexts, particularly given the intention of torture to disrupt victims' sense of identity and social integration. Furthermore, even if we were to accept the cross-cultural validity and utility of PTSD and other diagnostic categories (a questionable premise), the assessment measures used have often not been validated for use in target populations. It has also been noted that questions of adverse effects, chronicity and relapse have seldom been explored (Patel, et al., 2016).

A further area of concern is that treatments have often been poorly defined or described, particularly those described as "multi-disciplinary". It has therefore been very difficult to separate specific from common therapeutic elements or to identify active components. Little attention has been given to the core question of the impact of contextual factors on treatment delivery and efficacy. For example, the differences in length of treatment, described by McFarlane and Kaplan (2012) among others, reflect service delivery constraints but may also point to differences in whether survivors have managed to establish

a safe and consistent home base to support rehabilitation. Recent work on continuous traumatic stress (Eagle & Kaminer, 2013; Kira, 2017) suggests that torture survivors compelled to remain in dangerous contexts of civil or political strife, or precariously located as refugees, may well remain vulnerable to significant traumatic stressors, compromising their capacity to engage in any rehabilitation program.

Given all these factors, it seems essential that researchers take a critical yet balanced view of the last twenty years of mental health treatment outcome research with overlapping populations of refugees, asylum seekers, and survivors of torture and organized violence. Research into the outcome of mental health interventions with survivors of torture and organized violence remains compromised by a range of difficulties and is rather fragmented. While some studies have attempted to look at a broader range of inter-personal and social integration outcomes, the dominant scientific discourse on treatment outcome remains concerned with the reduction of individual symptoms associated with stress, anxiety and mood disorders. Relatively little attention has been given to the impact of social, economic, and political factors on the provision of mental health services and treatment outcome.

A fundamental concern is the paucity of rigorous research on the impact of clearly described interventions conducted in those contexts in which the vast majority of torture survivors live. All these reviews and nearly all the studies are conducted by researchers from the Global North using assessment tools to measure a narrow set of therapeutic outcomes. Although many reviews are described as encompassing studies of all treatment approaches conducted with refugees and torture survivors globally, the reality is that only a narrow subset of therapeutic approaches have in fact been studied and the vast majority of studies have been conducted with the relatively small subset of refugees and torture survivors who have been resettled in the Global North. The fact is, most torture survivors are living in the cities and refugee camps of the Global South where services are extremely limited and where practitioners have not adopted the EBPs tested in studies conducted in the Global North.

Research in this area is extremely challenging. Issues of trust and security make it difficult to recruit large samples, and experimental manipulation is difficult in the face of urgent needs and extremely vulnerable populations. It is also challenging to achieve equivalence in the range and degree of traumatic exposure or in the nature of the recovery environment. Although it is difficult to achieve the kinds of ‘gold standards’ of treatment outcome research aspired to by scientific reviewers, counselling with torture survivors must and does continue, both globally and in sub-Saharan Africa. In the next section I review the

multiple ways in which existing research informs the provision of mental health services to torture survivors more generally and in sub-Saharan Africa specifically.

Paradigms underlying the development of torture rehabilitation theory

In contrast to the empirical focus of the earlier parts of this chapter, the remaining material is more theoretical in nature. Based on a close reading of this literature, I offer a conceptualization of mental health interventions with torture survivors that is organized around distinct paradigms that I have labelled: (1) the torture syndrome and complex PTSD paradigm; (2) the social justice paradigm; (3) the PTSD and trauma-focused paradigm; (4) the multi-disciplinary response to complex presentations paradigm; and, (5) the integrative, trans-diagnostic and common elements paradigm. I organize there paradigms chronologically with respect to when they appear in the literature on torture rehabilitation. Emerging paradigms have critiqued or elaborated the positions of earlier paradigms as the field has developed in scope and complexity, and yet each has offered something vital to the contemporary discourse on the rehabilitation of adult torture survivors. Below I describe the core premises of each paradigm and summarize research evidence related to that approach, emphasizing wherever possible research conducted with populations from sub-Saharan Africa.

The Torture Syndrome and Complex PTSD Paradigm

Earlier writings concerned with the mental health impacts of torture specifically did not assume a PTSD frame for the field. These authors considered the experience of torture to be characteristically different to other kinds of traumatic exposure and victimization. They argued for a special diagnostic category to reflect the impacts of torture. Eitinger (1961, 1980) and Thygeson (1980) both proposed "concentration camp syndrome" to describe the long-term emotional impacts experienced by survivors of the German concentration camps in World War II. Allodi (1991) continued this line of thinking:

> What is so unique in torture victims, compared with other cases of PTSD, is the sense of personal humiliation and shame, the mistrust of friends, neighbours, authorities, or institutions, and, at times, the confusion of values and of self at a most intimate level. Those after effects are related to the circumstances and the very objectives of the torture: to regress, humiliate, and devastate the self-esteem of the victims and to confuse their

> values and philosophy of life … Torture is also unique in that it requires a personal, often close and repeated contact between two individuals. (p. 7)

Based on this argument for the uniqueness of torture as a form of traumatization, Allodi (1980) proposed the diagnostic category "torture syndrome", separate from PTSD but incorporating some features of that diagnosis.

And yet, many of the features that Allodi (1980) describes as unique to torture are in fact fairly common in other kinds of exposure to violence. Severe and chronic forms of domestic violence and child abuse share the features of humiliation, mistrust of others and confusion of values and distortions in sense of self. They involve intimacy between perpetrator and victim and in many cases the perpetrators' intentions are identical to those ascribed to torturers. Nevertheless, although the features and impacts of torture might not be unique, torture survivors seem to fall within a broader category of victims whose suffering is inadequately described by the PTSD diagnosis. The evolution of this paradigm finds expression in contemporary theory in the distinction being made between complex traumatic experiences and the relatively isolated, life-threatening events implied in the aetiology and diagnostic criteria of PTSD. Complex traumatic events are described as repeated, prolonged, or multiple incidents of interpersonal trauma often occurring in situations where escape is not possible (Cloitre et al., 2011; International Society for Traumatic Stress Studies, 2018). For example, Kira et al. (2019) found that adding attachment and collective identity trauma types to Criterion A increased its incremental predictive validity six-fold.

Three additional diagnostic labels have been proposed to describe the psychological impact of complex traumatic exposure. "Complex PTSD" (CPTSD) was originally described as having features of PTSD as well as more characterological disturbances in self-regulation and affective control, dissociation, aggression and social withdrawal (Herman, 1992b). A recent confirmatory factor analysis of the structure of CPTSD in tortured refugees produced a two-factor model that distinguished PTSD symptoms and "difficulties with self-organization" (Nickerson et al., 2016). This analysis offered preliminary evidence of the validity of CPTSD as a construct to describe the emotional consequences of torture. "Disorders of Extreme Stress Not Otherwise Specified" (DESNOS) was characterized as encompassing alterations in affect regulation, attention and consciousness, self-perception, relations with others, systems of meaning, and somatization (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). "Enduring Personality Change after Catastrophic Experience" (EPCACE) was described as a lasting hostile or distrustful attitude towards the world, social withdrawal, feelings of

hopelessness, and of being constantly threatened (World Health Organisation, 1992). Although different in approach and emphasis, each of these proposals attempted to describe a condition resulting from experiences like torture and encompassing the wide range of profound impacts reported by many survivors, recognizing that such conditions might also encompass or be co-morbid with conventional PTSD symptoms.

More recently, a survey of expert clinicians (most from the Global North) on approaches to the treatment of CPTSD indicated a strong preference for the use of multiple components tailored to address each client's specific symptom clusters (Cloitre et al., 2011). Eleven symptom clusters were identified: re-experiencing; avoidance/constriction; hyperarousal; affect dysregulation; relationship difficulties; behavioural dysregulation; attentional dysregulation; somatic symptoms; dissociation; and, identity disturbance. There was also a high degree of consensus on the importance of phased treatment with emphasis being given to building "safety", and improving affect regulation and self-management skills before beginning to address the other symptom clusters. In this discussion "safety" refers to the client's feelings of safety in the therapeutic work, and the need to establish self-regulating capacities in face of the likelihood that interventions may temporarily exacerbate symptoms. This survey produced the basis for the ISTSS treatment guidelines for CPTSD (Cloitre et al., 2012; ISTSS, 2018), guidelines that are consistent with those of the National Institute for Clinical Excellence (NICE, 2018) in the United Kingdom, and of the Australian Centre for Posttraumatic Mental Health (2013).

As fundamental as this work has been for the development of interventions for survivors of complex trauma experiences like torture, it is not without complications. Neither CPTSD nor DESNOS have been included in the DSM classification system. In DSM-IV, more complex traumatic responses were described as "additional characteristics of PTSD" (American Psychiatric Association, 2000), and in DSM-5 some of these symptoms (persistent and exaggerated negative beliefs, persistent negative emotional states, risk-taking, depersonalization and de-realization) were integrated into the PTSD diagnosis itself (APA, 2013). This broadening of the description of PTSD makes it unlikely that CPTSD will be validated as a separate disorder in future diagnostic classifications (de Jongh et al., 2016). EPCACE was included in ICD-10 (World Health Organization, 1992), and following substantial motivations (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Maercker et al., 2013) evolved into CPTSD was included in ICD-11 (WHO, 2018).

However, if any of these constructs is indeed characteristic of torture survivors' experience, we would expect a sizeable percentage of treatment-seeking refugees to meet

these diagnostic criteria. Ter Heide, Mooren and Kleber (2016) conducted a meta-analysis of three studies of treatment-seeking refugees in Europe and estimated that only 15% met the diagnostic criteria for DESNOS. However, the inclusion of CPTSD in the ICD-11 has facilitated new studies into the validity of this diagnostic formulation for work with refugees. Liddell et al. (2019) conducted a latent class analysis of symptom profiles of 112 refugees resettled in Australia. The analysis yielded a four-factor model of which the first two factors differentiated CPTSD and PTSD. In this case 25.9% of the sample met criteria for categorisation into the CPTSD class, and membership was predicted by cumulative trauma, female gender, and insecure visa status.

These mixed findings remind us that experiences of torture and exile are varied, complex and multi-dimensional. However, they suggest that CPTSD is a useful diagnostic formulation for describing some important aspects of many torture survivors' experience.

This paradigm has provided an important therapeutic and ethical framework that continues to inform the work of torture rehabilitation to this day. Allodi (1991), approaching the work from a psychodynamic perspective, emphasized the critical importance of the therapeutic alliance, and the challenges of establishing such an alliance with torture survivors. He examined the impact of humiliation and shame, as well as mistrust of authorities and institutions, on the therapeutic alliance. He also warned of the dangers of denial and avoidance of traumatic material by both therapist and clients. He described potential countertransference dynamics and how these may be mediated by the cultural and ideological distance between therapist and client.

As Fischman (1998) pointed out, torture is fundamentally about controlling and silencing people. Torturers impress upon their victims that every relationship has the potential to bring danger, and that individuals are powerless in the face of oppressive authority and its institutions. This experience must find expression in the therapeutic relationship and consideration of emotional and interpersonal safety is essential. Fabri (2001) suggested that counsellors work with these relationship dynamics by giving the client the power to determine key aspects of the therapeutic work, including where meetings will happen, how the space is arranged, the boundaries of the therapeutic relationship, and how counsellor and client are to be addressed. She noted that when clients are not given enough power to influence the therapeutic frame, assessment and counselling may be experienced as re-enactments of interrogation.

A tension emerges between private suffering and healing on the one hand, and civic accountability and justice on the other. Under this paradigm, counsellors are encouraged to

facilitate the creation of protected, private spaces in which clients can come to terms with the shaming and debilitating experiences that they have survived. However, counsellors are cautioned against collusion with torturers, and a society that would prefer that torture remains hidden behind screens of secrecy, privacy and shame. Fischman (1998) and others have argued that as witnesses to large scale, premeditated and ongoing crimes, medical providers including counsellors have a moral and ethical responsibility to collect and disseminate information about human rights violations.

Blackwell (2007) constructed the therapeutic relationship as an encounter between two people which occurs within the shadow of violent oppression and totalitarian control. Each person comes to this encounter with his or her own political history, culture, style of relating, and intrapsychic experience, a situation that may be complicated when counsellors share the same political history as the client or have themselves been victims of state violence. It is important to acknowledge the potential for emotional overwhelm and over-identification with the client, often experienced as fear of treatment failure, helplessness and despair on the part of the counsellor. This introduces important ethical concerns as well as increased risk of secondary traumatic stress for practitioners. Researchers and practitioners writing within the torture syndrome or complex PTSD paradigm have laid out many of the core ethical and conceptual principles in torture rehabilitation. Contemporary practitioners and researchers are challenged to apply these principles in the contexts in which they provide mental health services to torture survivors.

The Social Justice Paradigm

Many of the authors whose work is described above emphasized the explicitly political nature of conducting psychotherapy with torture survivors. Psychotherapy is presented as an important step in breaking the silence enforced by torturers. They argued that clients might wish to use progressively more public forums to share their experiences, such as moving from individual to family, group or community oriented work, and to confront the tendency towards collective denial and legal impunity for perpetrators (Allodi, 1991; Fabri, 2001; Fischman, 1998). In this way, the social justice paradigm arose as a logical extension of the torture syndrome and complex PTSD paradigm.

The social justice paradigm foregrounds the fact that torture is a crime and a fundamental violation of the social contract between citizens and the state and consequently grapples with the relationship between emotional health and social justice. Is it meaningful to talk about healing when the injustices suffered by torture survivors have not been made

public and when the perpetrators of those crimes have not been held accountable? Would such forms of intervention not substantially contribute to some form of healing in survivors? These are difficult questions to answer, especially in a world where only the smallest minority of torture survivors is given the opportunity to pursue justice. Nevertheless, as discussed in Chapter 1, the UNCAT clearly positions the pursuit of justice as a central component of the rehabilitation of torture survivors.

Cienfuegos and Monelli (1983) reported on the use of written testimony as a therapeutic tool to assist survivors of military atrocities following the 1973 coup in Chile. Thirty-nine torture survivors or close relatives of "the disappeared" participated in a process whereby they tape recorded a detailed description of the events that resulted in their suffering. This testimony was provided in the survivors' own words with the therapist only interjecting questions to help clarify points. The purpose of these recordings was explicitly twofold: (a) to enable survivors "to understand more fully the emotions associated with their trauma", and (b) "to denounce, through a written essay, the violence and injustice to which they had been subjected" (p. 48). The authors reported therapeutic success in twenty-seven clients (79% of participating clients), with success described as significant mitigation of the most acute symptoms including anxiety, depression, sleeplessness and bouts of weeping. The authors suggest various therapeutic mechanisms to explain these positive results: being able to share their experiences with a receptive and sympathetic audience thereby restoring affective ties with other human beings; finding a way to channel anger into social action; and, creating meaning by identifying the significance of their experiences as part of their personal histories as well as in relation to the broader social and political context.

Testimony therapy was then picked up by practitioners and researchers in the Global North. Agger and Jensen (1990) articulated the approach in greater detail and illustrated its use by means of case studies. Weine, Kulenovic, Pavkovic and Gibbons (1998) used Testimony Therapy with twenty Bosnian refugees in the United States. These authors used a protocol which involved six weekly sessions of approximately ninety minutes each. Semi-structured testimonies were recounted in Bosnian and tape-recorded and then transcribed. This draft was amended and elaborated by the client. A final version was signed by the client and a copy was lodged with the oral history archives of the Project on Genocide, Psychiatry and Witnessing. The authors reported significant reduction in PTSD and depression symptoms following treatment and at six-month follow up.

Agger, Igreja, Kiehle, and Polatin (2012) described an action-research initiative to combine testimony therapy with culturally adapted spiritual ceremonies in India, Sri Lanka,

Cambodia and the Philippines. In this significantly shorter approach, community workers met with clients twice to help them develop a written testimony of the human rights violations they had experienced. The clients then participated in an "honour ceremony" in which they were publicly presented with their testimony documents. These ceremonies included local healing practices and honouring traditions from each country. Community workers later met with participating clients to reassess their emotional wellbeing. Clients reported relief from symptoms, and the authors speculated that the honour ceremonies mobilized community support, offered symbolic reparation, and served as rites of passage from the role of victim to empowered survivor. The project in India included a comparison of assessments of emotional wellbeing (measured using the WHO-5) at baseline and one or two months after the end of treatment. Significant improvement was recorded for almost all participants (Agger, Raghuvanshi, Shabana, Polatin, & Laursen, 2009).

A more recent clinical trial of culturally adapted testimony therapy in Cambodia offered a more rigorous scientific test of this approach. Esala and Taing (2017) randomly assigned 120 survivors of the Khmer Rouge's reign of terror to a treatment and a waitlist control group. The treatment group received four days of therapy in which they prepared testimonies with their counsellors. On the fifth day clients in the treatment group attended a Buddhist ceremony at the infamous "Killing Fields". During this ceremony offerings were made to the ancestors and each client, supported by his or her counsellor, read from their testimony to the invited guests. Each client named a deceased person to whom the ceremony was dedicated. All participants completed measures of PTSD, depression and anxiety at intake and follow up after three and six months. Testimony therapy produced significantly greater improvements in all outcome variables in the short term and with modest effect sizes (Cohen's d of between 0.44 and 0.53). The authors noted that treatment group symptom scores dropped significantly at the three month follow up, but then increased again to close to baseline scores at six months. The authors speculated that this might have been due to the brevity of intervention and the passage of time since the violations (forty years).

In sub-Saharan Africa, Igreja, Kleijn, Schreuder, van Dijk and Verschuur (2004) randomly assigned 137 victims of the Mozambican civil war (1977-1992) to treatment (n=66) and control (n=71) groups. Individuals in the treatment group received a single session of testimony therapy in their homes. Testimonies comprised the notes taken by the facilitator. The researchers assessed psychological wellbeing, prevalence of nightmares and PTSD symptoms at baseline, immediately post-intervention, and at eleven months follow up. No

significant differences between the treatment and control group were identified, with both groups demonstrating significant symptom reduction.

Traditional cleansing rituals represent a second set of interventions that aim to address questions of social justice through rebuilding the relationship between torture survivors and their community. Stark (2006) describes healing ceremonies conducted in Sierra Leone with girls who had been recruited or abducted to serve as child soldiers and who had typically been overlooked in demobilization initiatives. These girls were viewed by their families and communities as "impure", were stigmatized, verbally attacked, isolated from the rest of the community and blamed for misfortune within the community. Traditional cleansing ceremonies were used to facilitate these girls' reintegration into their communities. The ceremonies lasted several days and were presided over by a local traditional healer. They involved living in seclusion where the girls slept, cooked and ate together, ritual washing, storytelling and singing traditional songs. The period of seclusion was followed by a public return to the village to be presented to community leaders who welcomed them home. Stark (2006) presented a qualitative analysis based on interviews with twenty-five girls who had been through this process and concluded that the ceremonies had improved the girls' psychosocial health and contributed to their reconciliation with their communities.

Amone-P'Olak (2006) described similar cleansing rituals used in Northern Uganda where perpetrators and victims live together in the same community. These rituals incorporated traditional singing and dancing, the performance of dramas around the themes of forgiveness, reconciliation and perseverance, and the enactment of traditional rituals. These rituals were historically used to welcome people back to the community after an extended period away, for grieving and breaking with the past, and for cleansing and reconciliation following a rape or murder within the community. As with the other ceremonies and rituals described above there was public recognition of the victim's suffering and a fresh start towards community inclusion and reconciliation.

The transitional justice processes discussed in Chapter 2, although concerned primarily with social justice, typically also hope to contribute to victims' emotional recovery. As discussed previously, research on recent transitional justice processes in sub-Saharan Africa, including the South African Truth and Reconciliation Commission (Kaminer, Stein, Mbanga, & Zungu-Dirwayi, 2001; Mendeloff, 2009), *Fambul Tok* in Sierra Leone (Cilliers, et al., 2016) and the Gacaca processes in Rwanda (Brounéus, 2010), have not been shown to facilitate individual healing. In fact, each of these studies suggests that participation in such transitional justice processes may in fact be emotionally harmful to torture survivors.

The fact that torture survivors are silenced, stigmatized and isolated lends weight to this paradigm which places social justice at the heart of rehabilitation. Human rights defenders have argued that unless the crimes committed against torture survivors are publicly acknowledged and compensated for, healing can never be complete. And yet, the current evidence, based on studies of testimony therapy, cleansing ceremonies and transitional justice initiatives, does not suggest that these approaches are necessarily likely to facilitate lasting improvement in emotional and social functioning. Nevertheless, practitioners working with torture survivors cannot ignore the social justice dimensions of their experience. These approaches may be more usefully viewed as important adjunct interventions to follow or accompany more private work on intra-psychic functioning, given that torture is highly personal even if it takes place in a broader context of perverse socio-political relationships.

The PTSD and Trauma-Focused Paradigm

In contrast to the first two paradigms which were ideologically rooted in political activism by and with torture survivors, the PTSD and trauma-focused paradigm is more closely associated with the humanitarian and public health movements of the Global North of the late twentieth century.

This paradigm is focused on adaptive and pathological human responses to life-threatening events. In the absence of a unifying construct that encapsulates the diversity of survivors' emotional response to torture many researchers have reverted to using PTSD as the core descriptive and explanatory construct. This approach has been highly successful in documenting the profound and chronic distress experienced by survivors of torture, war, and forced migration around the world (see Chapter 2 for examples of such work from sub-Saharan Africa).

And yet, as discussed previously, torture survivors report a range of symptoms much broader than those directly associated with PTSD. Several authors have argued that much of this broader range can and should be understood as secondary to a primary traumatic, or fear-based response. Carlson and Dalenberg (2000) differentiate between core, secondary, and associated responses to trauma. Core responses are those contained with the diagnostic descriptions for PTSD. Secondary responses to trauma present later due to problems arising out of core PTSD responses, specifically re-experiencing and avoidance. Associated responses are those that arise from concomitant elements of the traumatic situation. The main secondary and associated responses described by Carlson and Dalenberg (2000) are depression, aggression, substance abuse, physical illness, problems with self-esteem, changes

in identity, difficulty in interpersonal relationships, guilt and shame. For example, depression might result from uncontrolled intrusive and avoidant symptoms leading to feelings of helplessness and despair about suffering from PTSD (secondary); or from overwhelming losses of property, home, status and support related to the original trauma (associated). Similarly loss of self-esteem and feelings of shame might arise from not being able to take care of one's children adequately due to an inability to manage PTSD symptoms (secondary), or they might arise from a negative appraisal of one's actions at the time of the trauma (associated). In this way, a broad range of complaints are constructed as arising from the original trauma, and treatment emphasizes the processing of traumatic memories and the reduction of PTSD symptoms as PTSD is considered the core feature of impact.

Neuner (2010) made a similar argument in relation to the struggles of war survivors. He argued that exposure to armed conflict creates trauma-related mental health concerns that then lead to further complications in survivors' lives. He proposed that people suffering from post-traumatic stress are likely to experience everyday stressors as significantly more stressful than healthier people, that is, past trauma exacerbates the experience of daily stressors and not the other way around. He also argued that trauma-related mental health problems can put people at greater risk for stressful life events. For example, impaired mental health due to trauma manifesting as dysfunctional behaviour such as outbursts of anger, aggression and substance abuse, may exacerbate unemployment, and poverty, and may compromise family functioning. Amone-P'Olak and Elklit (2018) reached similar conclusions in a study of interpersonal sensitivity as a mediator of post-conflict mental illness. From this perspective, the suffering connected to daily stressors is viewed as a consequence of mental health concerns rather than a cause, suggesting once again that treatment should be focused on the past traumatic experiences and the direct emotional consequences thereof.

Various trauma focused interventions have been tested with torture survivors, including with survivors in sub-Saharan Africa. Trauma focused cognitive behaviour therapy (TF-CBT) is the most rigorously tested intervention for PTSD and has long been the primary approach recommended in treatment guidelines (Foa, et al., 2009; NICE, 2018). TF-CBT protocols vary but typically include the following components: psychoeducation aimed at normalizing and explaining the client's symptoms and responses to the event; increasing capacity for arousal and affect regulation, including stress inoculation training, as well as behavioural tools such as progressive muscle relaxation and breathing, and cognitive ones such as thought stopping, self-talk, and imagining a safe place; increasing coping and

symptom management by exploring and altering patterns of thoughts, feelings and behaviour; imaginal exposure to traumatic memories and/or in vivo exposure to reminders of the traumatic events; construction of a trauma narrative; and, cognitive work to identify and alter irrational beliefs or unhealthy thought patterns.

TF-CBT interventions have been tested with torture survivors and refugees in a range of contexts (see for example, Grey & Young, 2008; Hinton, et al., 2005; Hinton, Hofmann, Pollack, & Otto, 2009; Paunovic & Öst, 2001). In sub-Saharan Africa, McMullen, O'Callaghan, Shannon, Black, and Eakin (2013) randomly assigned fifty adolescent boys from the DRC (former child soldiers and war affected children) to an intervention or waitlist control group. The intervention group received fifteen sessions of group TF-CBT. At the end of treatment, in comparison with participants in the control group, participants in the intervention group showed significantly reduced PTSD symptoms, as well as reduced anxiety, depression, conduct problems and a significant increase in prosocial behaviour. Unfortunately, no longer term follow up was conducted.

Cognitive Processing Therapy (CPT) was originally developed as a treatment for survivors of sexual assault (Resick & Schnicke, 1992) but has also been shown to be effective with torture survivors, including when it is administered by non-professional counsellors (Kayson et al., 2013). CPT emphasizes the cognitive components of the traumatic experiences, focusing on the client's beliefs and attributions about the causes and consequences of the traumatic event. Counsellors assist clients to identify their beliefs about their experiences and use Socratic questioning and other techniques to challenge unhealthy or irrational beliefs. CPT also involves processing of the traumatic memory through the construction of a trauma narrative.

A large-scale trial of CPT with survivors of war-related rape and sexual violence was conducted in rural villages in Eastern DRC (Bass et al., 2013). Fifteen villages were randomly assigned to participate in either a CPT or individual support intervention. Four hundred and two women were recruited into the study. Although women in both the CPT and individual support interventions showed significant improvements in PTSD, as well as in depression and anxiety scores six months after treatment, CPT produced significantly greater effect sizes than individual support. Experimental attrition in this study was high (43%) and was predicted by older age, pregnancy at baseline, a greater range of traumatic experiences, problems with security, and assignment to the individual support arm of the study. To measure mental health outcomes beyond symptom reduction, these researchers also looked at

structural social capital (participation in community support and financial networks) and found a modest positive effect in the CPT-serviced villages (Hall et al., 2014).

A technique that draws strongly on both cognitive-behavioural and testimony therapies and is designed to treat PTSD related symptoms is Narrative Exposure Therapy (NET) (Schauer, Neuner, & Elbert, 2011). NET was originally developed for use in refugee camps by non-professional mental health workers. The approach incorporates elements of exposure work and is informed by work on trauma activated fear networks within the neurological structure of the brain. Such networks activate non-declarative and fragmented "hot" memories that include sensory and emotional information, physiological and motor responses, as well as cognitive responses to the traumatic event. Hot memories are contrasted with declarative and contextualized "cold" memories. The NET counsellor works to enhance the encoding of declarative or cold memory as hot memories are activated. In this way, memories of past traumatic events are more securely situated within autobiographical memory and the sense of current threat that they evoke is reduced.

An early trial of NET was carried out in a camp setting in northern Uganda with forty-three adult refugees from Sudan with a PTSD diagnosis (Neuner, Schauer, Klaschick, Karumakara, & Elbert, 2004). The participants were randomly assigned to one of three treatment groups. One group received a single session of psychoeducation; the second received one session of psychoeducation plus three sessions of supportive counselling (with no exposure to past traumatic experiences); and the third group received psychoeducation plus three sessions of NET. One year after treatment, only 29% of those in the NET group fell within the diagnostic range for PTSD, compared with approximately 80% of those in the other two groups.

A few years later, NET was tested again in a different refugee settlement in Uganda, this time administered by local non-professional counsellors to Sudanese and Rwandan refugees (Neuner et al., 2008). Two hundred and seventy-seven adults with PTSD were recruited into the study and randomly assigned to a NET group, a general trauma counselling group, and a waitlist control group. Treatment comprised between four and six sessions of either NET or trauma counselling. Trauma counselling was less directive than NET and included discussions of current life stressors. Nine months after treatment PTSD was no longer present in 70% of NET participants, 65% of trauma counselling participants, and 37% of those in the control group. Experimental attrition of more than 50% weakened the internal validity of this trial, but the researchers were able to conclude that non-professional mental

health workers under supervision could successfully implement NET after a short training period (six weeks).

Working with twenty-six orphans from the Rwandan genocide, Schaal, Elbert and Neuner (2009b) compared the effectiveness of NET and interpersonal psychotherapy (IPT). All participants met the diagnostic criteria for PTSD and had been younger than eighteen years at the time of the genocide. The participants were randomly assigned to two groups. One group received three sessions of individual NET and one group session of guided mourning; the other received four group IPT sessions. Six months after treatment NET participants were significantly more improved than IPT participants with respect to both the severity of symptoms of PTSD and depression. Only 25% of NET participants were still within the clinical range for PTSD, compared with 71% of IPT participants.

NET has been tested with torture survivors and refugees in a range of other settings in both the Global North and Global South (see for example, Bichescu, Neuner, Schauer, & Elbert, 2007; Hensel-Dittmann et al., 2011; Neuner, et al., 2010). These findings have been summarized in three systematic reviews (Gwozdziewycz & Mehl-Madrona, 2013; McPherson, 2012; Robjant & Fazel, 2010), all of which concluded that NET produces a greater decrease in PTSD symptoms than other treatments, is suitable for survivors of organized violence, and can be provided by lay counsellors in a wide range of settings, including insecure settings.

These studies demonstrate the profound contribution of the PTSD and trauma focused paradigm and related intervention modalities to the treatment of torture survivors in sub-Saharan Africa. The treatment approaches that have grown out of trauma theory have produced the strongest therapeutic outcome studies and results, at least in terms of the reduction in PTSD and related symptomatology. These results seem to refute earlier suggestions that the complexity of torture survivors' experiences demands more complex interventions than those designed for PTSD treatment, or that highly structured approaches focused on the internal processes that maintain PTSD are less effective with torture survivors than more socio-politically and community-oriented interventions. However, as noted previously, the research base in this area is still rather limited.

The Multi-Disciplinary Response to Complex Presentations Paradigm

Despite the above conclusions, it is impossible to ignore the fact that PTSD and trauma-focused interventions fail to directly impact other aspects of many torture survivors' struggles, particularly in relation to psychosocial adjustment. The Multi-Disciplinary

Response to Complex Presentations Paradigm is championed by researchers who emphasize the physical, emotional, social and political complexities of torture survivors' experiences and argue for models that aim to impact on multiple domains, typically though the coordinated efforts of multi-disciplinary teams.

Despite the strong research findings reported in studies of trauma-focused interventions, many practitioners and researchers have argued that traumatic stress theory is insufficient to explain the totality of most torture survivor's experiences. There is evidence that clients with more complex symptom presentations respond less well to trauma-focused interventions than do those with simpler presentations. Gerger, Munder and Barth (2013) investigated the complexity of clinical presentation as a moderator of treatment outcomes comparing PTSD-specific interventions with non-specific, multidisciplinary approaches. They found moderate superiority of specific over non-specific interventions with less complex PTSD cases. However, in cases with great symptom complexity the difference between specific and non-specific interventions was greatly reduced. More recent findings from a study of treatment outcomes with 72 refugees receiving trauma-focused treatment following a PTSD diagnosis, suggest a similar conclusion (Haagen, Ter Heide, Mooren, Knipscheer, & Kleber, 2017). In this study, the presence and severity of a comorbid depression diagnosis predicted poor PTSD treatment outcome, and 39% of the variance in treatment outcome between individuals. This suggest that, for some torture survivors at least, depression and other comorbid disorders should not be thought of as secondary to trauma related concerns, but as primary mental health concerns.

Others have argued the need for torture rehabilitation to include interventions that directly address the causes and symptoms of a range of other disorders including: depression (Bolton et al., 2007; Bolton, et al., 2002; Fenta, et al., 2004); panic attacks (Hinton et al., 2005; Hinton, Safren, Pollack & Tran, 2006); prolonged grief (Nickerson et al., 2014; Stammel, et al., 2013); explosive anger (Silove, et al., 2009): and, chronic pain (Williams & Baird, 2016; Liedl, et al., 2010). Many of these authors have also suggested treatment approaches that target these concerns and are appropriate for torture survivors.

Additional complicating stressors relating to daily survival in difficult or hostile environments have been examined by many researchers, including those working in sub-Saharan Africa (Amon-P'Olak et al., 2014). Miller and Rasmussen (2010a, 2010b, 2017) reflected on studies of the relationship between traumatic experiences and mental health sequelae in which the addition of daily stressors greatly improved the explanatory power of the overall model and weakened the direct relationship between traumatic experience and

mental health. Important daily stressors faced by refugees and torture survivors include poverty, unemployment and dependency on aid, family conflicts and domestic violence, loss of possessions, discrimination, separation from family members, uncertainty pertaining to asylum status, repeated detention and loss of social support networks. These authors argue that these kinds of daily stressors may have greater impact on emotional health than past torture experiences because they are current, pervasive and uncontrollable.

Practitioners and researchers have developed a range of terms to describe the impact of repeated traumatic events that occur in the present as opposed to the past. Kira (2001) and Kira et al. (2013) proposed a taxonomy of traumatic experience that differentiated a single traumatic event (Type I), a series of repeated and connected events (Type II), and the cumulative trauma of the additive effects of multiple, direct and indirect traumatic experiences (Type III). Using this system, virtually all torture survivors would be described as having suffered, or currently suffering Type II or III traumas. An alternate formulation is that of ongoing traumatic stress response (OTSR) (Diamond, Lipsitz, Fajerman, & Rozenblat, 2010; Diamond, Lipsitz, & Hoffman, 2013; Lahad & Leykin, 2010). These authors contrasted OTSR with PTSD in situations of ongoing conflict, arguing that traumatic stress responses under conditions of ongoing threat should not be thought of as pathological. A third formulation is continuous traumatic stress (CTS) (Eagle & Kaminer, 2013; Nuttman-Shwartz & Shoval-Zuckerman, 2015; Stevens, Eagle, Kaminer, & Higson-Smith, 2013) which has been applied in a broader range of contexts including communities living with high levels of criminal violence and refugee and asylum seeker populations struggling to find a place within a society in which they are often made to feel unwelcome and threatened with violence. CTS is presented as a range of responses or adaptations to living in a dangerous world; adaptations that make it possible to survive but may be clinically concerning and may have serious psychological and inter-personal repercussions in the longer term.

The complexity of presentations, frequency of comorbid disorders, and ever-present daily stressors and threats, are well understood in specialist torture treatment clinics around the world. Counsellors in these clinics argue that competent intervention requires multi-disciplinary treatment tailored to the specific needs of individual clients. The literature on torture rehabilitation in these clinics, includes many outcome studies of this approach to intervention (see for example, Carlsson, Mortensen, & Kastrup, 2005; Carlsson, Olsen, Kastrup, & Mortensen, 2010; McColl et al., 2010; Renner, 2009; Salo, Punamäki, Quota, & El Sarraj, 2008; Tol et al., 2009; Wang et al., 2016).

By way of example, the Centre for the Study of Violence and Reconciliation (CSVR) in South Africa has developed a model organized around a broad range of fourteen common areas of client difficulty (Bandeira, 2013). This approach was developed in response to a perceived need for a standardized treatment protocol at the centre and emerged from a process of literature review, analysis of existing therapeutic process notes, and a Delphi process with a panel of experienced people in the field. The fourteen areas addressed are: difficulties with accommodation, meeting daily needs, and generating income; anger management; bereavement; coping difficulties and stress; difficulties with other service providers; management of symptoms and overwhelming distress; family breakdown; family-related stressors; isolation; loss of status, recognition, and position in society; mood disturbances; pain; safety concerns and repeated victimization; and, traumatic responses and intrusions. Several specific intervention strategies are recommended for each of these problem areas, providing counsellors with a set of therapeutic tools with which to construct an individualized treatment plan for each client.

Dix-Peek & Werbeloff (2018) tested the efficacy of the CSVR model by comparing the results of torture survivors in treatment (n=44) with a waitlist comparison group (n=38). Therapeutic outcomes were measured at baseline, after three months of treatment, and again after six months of treatment on thirteen indicators including: measures of PTSD, depression and anxiety symptoms; physical pain; coping; loneliness; and, overall functioning. At six months the treatment group had shown significantly greater improvements on anxiety and overall functioning measures although the authors note high attrition from both arms of the study.

Kira's (2002) Wraparound Approach is another well-articulated example of a multi-disciplinary and community-based approach in which psychotherapy is one of many resources available to the torture survivor. This approach uses activist led community teams that include representatives of multiple community resources available to torture survivors, including health, social and mental health services; local government; faith communities; neighbourhood networks; social clubs, and so on. These teams are responsible for case management and treatment planning which is based on a flexible intervention approach aimed at mobilizing the strengths and resources of the individual, the family, and the community, including service providers. Multidisciplinary treatment is coordinated through interagency treatment teams in liaison with the community teams and includes ongoing monitoring and follow-up of clients. Raghavan, Rasmussen, Rosenfeld & Keller (2013) conducted an evaluation of the Wraparound Approach with torture survivors living in New

York City. They found that both clinical and "nonclinical" services (specifically support for gaining secure immigrant status and attendance at educational sessions) were associated with symptom improvement.

Despite the considerable effort expended in developing multi-faceted interventions, treatment outcome research conducted in many parts of the world does not strongly support the hypothesis that individually tailored, multidisciplinary treatment produces better mental health outcomes than more structured trauma-focused interventions. Nickerson, et al. (2011) conducted a systematic review comparing treatment effectiveness in fifteen studies of trauma-focused interventions, and four multidisciplinary treatments. The authors noted some positive impacts for trauma-focused approaches but noted serious methodological flaws in the research. They found no lasting positive effects for multidisciplinary treatments but noted the severity of cases being seen in specialist centres as well as the research challenges in measuring the impact of complex and variable treatments in naturalistic settings. Van Wyk and Schweitzer (2014) published a systematic review of seven studies of treatment outcome in naturalistic settings. They concluded that although studies show decreases in PTSD, anxiety, depression and somatization, these differences are primarily predicted by symptoms at baseline, and not the interventions received. The authors were unable to link clinical improvements to interventions or identify the mechanisms underlying symptom change. The authors of both systematic reviews conclude that multidisciplinary treatment approaches show potential for benefit, especially for the most complex cases, but that more and better research is needed before any well-substantiated conclusions can be drawn. Nevertheless, this fourth paradigm is important in that it reminds practitioners of the complexity of torture survivors' experiences and the need to locate mental health needs within a broader set of concerns affecting the whole person.

The Integrative, Trans-Diagnostic and Common Elements Paradigm

Over the past decade a fifth paradigm has emerged that offers an alternate response to the complexity inherent in most torture survivors' psychosocial presentation. Instead of trying to respond to multiple needs in piecemeal fashion, the integrative, trans-diagnostic and common elements paradigm attempts to identify underlying psychological mechanisms that produce or maintain multiple psychosocial problems and to target intervention at these underlying mechanisms. In so doing, these approaches aim to offer more focused solutions that can be successfully implemented in a standardized manner with a broad range of clients.

As Farchione and Bullis (2014) have argued, the lack of integration among evidence-based practices (EBPs) for torture survivors may be the greatest barrier to their implementation globally, especially when many of clients present with extensive comorbidity. They maintain that practitioners do not have the time or resources to become competent in all the EBPs for the range of disorders with which their clients present. Even when practitioners do become competent in multiple EBPs there is little guidance on which treatment to use or how to prioritize different evidence-based treatments for clients with multiple comorbidities. As a result, they have argued, many practitioners view EBPs as largely irrelevant to their clinical practices.

Integrative and trans-diagnostic approaches address this problem by attempting to identify causal and maintenance factors that are common to a range of mental health and psychosocial complaints. In this construction of the psychological impacts of torture the focus is not on specific disorders but on underlying psychological mechanisms implicated in a range of mood and anxiety disorders. For example, disruption to the mechanisms of affect regulation is associated with a range of problems including major depressive disorder (MDD), bipolar disorder, obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD) and PTSD. Problems in affect regulation are also likely to impact daily functioning and contribute to problems with employment, family conflict and domestic violence. As such, interventions aimed to improve a client's capacity for affect regulation should contribute positively to his or her emotional and social health, regardless of specific diagnoses.

Straker and colleagues (Straker & the Sanctuaries Team, 1987; Straker & Moosa, 1994) developed one of the earliest models of this kind. They pioneered the use of a single therapeutic interview to guide counsellors supporting liberation struggle activists and their families at a time when the apartheid regime in South Africa showed little restraint in the face of increasing opposition. This approach was specifically designed for work in highly insecure environments and was organized around six steps: establishing trust; establishing ground themes; facilitating catharsis; facilitating a sense of mastery; work on current stressors and safety; and, termination.

This early work was further developed by Eagle (1998; 2000) and others at the Wits Trauma Clinic[3], also in South Africa. This brief model integrated psychodynamic and

[3] This Wits Trauma Clinic was originally attached to the University of the Witwatersrand and created to support victims of political violence. Later it became independent of the university

cognitive-behavioural thinking and was organized around five steps: telling and re-telling the trauma story; normalizing symptoms; addressing self-blame or survivor guilt (and thereby restoring self-respect); encouraging mastery; and facilitating the creation of meaning. The authors argued that the effectiveness of this model lay precisely in its integrative approach to trauma that goes beyond reintegration of traumatic memory to the creation of meaning and a sense of mastery that supports living in a continually dangerous world.

Pelzer's (2001) model of ethnocultural counselling was developed for work with African victims of political violence in Northern Uganda and Germany. This model integrates thinking from psychodynamic, cognitive-behavioural and supportive counselling and comprised six sets of therapeutic tools: therapeutic relationship and transference; modelling techniques; extra-psychic techniques; somatic techniques; working through traumatic/grief/repressive experiences; and re-educative and supportive techniques. This model's emphasis on extra-psychic and somatic work as well as the inclusion of grief as an important dimension of survivors' experience anticipated more recent work in this field.

It is worth noting that both these models (Eagle, 1998; 2000 and Pelzer, 2001) incorporate therapeutic components that have much in common with TF-CBT (Foa et al, 2009) and CPT (Resick & Schnicke, 1992). However, these integrative models emphasize the importance of targeting core areas of difficulty and are less concerned with processing of particular traumatic events.

A related model can be found in the work of the Center for Victims of Torture (CVT) which used a group model based in cognitive-behavioural theory with torture survivors in camp and urban settings in Guinea, Sierra Leone, Liberia, the DRC, Ethiopia, Kenya, Uganda, and Jordan. This phased model emphasizes building internal resources and coping capacity, processing traumatic memories and mourning multiple losses, as well as planning for the future (CVT, 2016; Kastrup, 2017). Non-experimental impact studies have demonstrated positive results on PTSD, anxiety and depression symptoms, as well as daily functioning (Hubbard & Pearson, 2004; Stepakoff et al., 2006).

Silove (1999, 2013) argued that the traumas and stressors associated with war, torture and displacement are complex and occur both concurrently and sequentially. He drew attention to the multiple points in time during the survivor's trauma story at which adaptations (both healthy and less healthy) are possible. The line between adaptive and

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and developed into the Centre for the Study of Violence and Reconciliation (CSVR), a participating organization in this research.

maladaptive psychological responses is fluid and contextual, an understanding that he argued is missing from models based on simple causal models linking traumatic exposure and mental health disorders. Silove's (2013) model posited that in stable societies citizens (1) feel secure; (2) have healthy social networks; (3) experience a sense of justice; (4) have clear roles and identities; and (5) are able to find existential meaning to make sense of their lives. He examined adaptive and maladaptive responses to the disruption of each of these societal "pillars" and proposed the Adaptation and Development after Persecution and Trauma (ADAPT) model. The ADAPT model emphasized interventions designed to increase physical and emotional safety, to focus on loss and bereavement, and to offer explicit recognition of injustice, as well as to support role transitions and the forging of new identities. He also recommended the explicit inclusion of work with existential issues. Recently, Mahmuda et al. (2019) piloted a culturally adapted group format of ADAPT that they call Group Integrative Adapt Therapy (IAT-G) with Rohingya refugees in Bangladesh. The focus of the intervention was on helping refugees to develop capacity and resilience for managing maladaptive reactions to trauma and post-migration living difficulties. The research results from the pilot study appear promising but remain to be replicated in further research.

As with the multidisciplinary approaches, these early integrative approaches have generally not been subjected to rigorous or experimental study. However, there is one model to have emerged from this paradigm that has been more meticulously studied, with very encouraging results. Murray et al. (2013) developed the Common Elements Treatment Approach (CETA) for use with adults in low or middle-income countries suffering from depression, anxiety and/or traumatic stress concerns. The intervention is built out of multiple components which can be selected and ordered to meet the needs of individual clients. Intervention components include: engagement; psychoeducation; anxiety management strategies; behavioural activation; cognitive coping/restructuring; imaginal gradual exposure; in vivo exposure; suicide or homicide risk assessment and planning; and a screening and brief intervention for alcohol abuse. Murray et al. (2013) have also developed structured packages for training and supervision of non-professional counsellors. Pilot studies in Burma and Iraq demonstrated that local counsellors and supervisors were able to implement the approach with high fidelity and that many clients completed treatment indicating cross-cultural acceptability. Reliable change indices indicated positive effects in both populations across depression, posttraumatic stress, and general functioning outcomes. These pilot studies are discussed in more detail below.

Bolton et al. (2014) completed a clinical trial of CETA with Burmese survivors of torture, imprisonment and war trauma. Participants suffering from depressive and traumatic stress symptoms were randomly assigned to a CETA treatment group (n=182) and a waitlist control group (n=165). All participants were assessed by blind assessors for depression, post-traumatic stress, functional impairment, anxiety, aggression and alcohol use. Measures used had been adapted to the local culture and assessments were conducted at intake and one-month after the end of treatment. CETA produced significantly greater reductions in all symptom categories apart from alcohol use.

Another randomized trial tested the efficacy of CETA with survivors of torture and systematic violence in southern Iraq (Weiss et al., 2015). Participants receiving CETA (n=99) were compared with a wait list control group (n=50). All participants were assessed for post-traumatic stress symptoms and functional impairment, depression and anxiety at baseline and approximately four months after the end of treatment. Participants receiving CETA demonstrated significantly greater reductions in symptoms on all outcome measures.

Pacichana-Quinayáz, Osorio-Cuéllar, Bonilla-Escobar, Fandiño-Losada, and Gutiérrez-Martínez (2016) presented a case study of the implementation of CETA in the Pacific region of Colombia plagued by two decades of armed conflict between groups disputing control of natural resources and the drug trafficking business. Semi-structured interviews were conducted with practitioners and coordinators who had received training and then implemented CETA under supervision. A narrative analysis of these interviews revealed that practitioners noted early changes due to CETA (including reduced anxiety, increased engagement with therapy and increased confidence). They also noted increased capacity to manage anxiety and implement strategies learned during counselling, as well as improvements in interpersonal relationships. Respondents felt that CETA reduced stigma associated with mental health issues. They did, however, note that more cultural adaptation was needed for CETA to be truly effective in the community. Respondents emphasized the importance of community networks within the Afro-Colombian culture and the need to provide tools to equip people for responding to similar victimization that is likely to occur in future.

Trans-diagnostic approaches are intuitively appealing for psychosocial intervention with torture survivors in sub-Saharan Africa and other low or middle income contexts. With the proponents of CETA rapidly developing a strong evidence-base, it is likely that this paradigm will have a strong impact on the development of the field in the future.

Conclusions

In this review I have focused on models of individual and group counselling intended for use with adult torture survivors, war survivors and refugees. I have included those for which there is at least one treatment outcome study and have emphasized those that have been developed, implemented and/or tested in sub-Saharan Africa. I have not covered the range of community-based and peace-making interventions that have been explored in sub-Saharan Africa and elsewhere in the Global South. These include, for example, self-help programs in Uganda (Tol, et al., 2020), empowerment workshops in Namibia and Uganda (Curling, 2005; Sonderegger, Rombouts, Ocen, & McKeever, 2011), reconciliation interventions in Rwanda (Gishoma et al., 2014; Staub, Pearlman, Gubin, & Hagengimana, 2005), psychoeducation programs in Gautemala (Anckermann, et al., 2005) and school-based interventions in Rwanda and Sierra Leone (Gupta & Zimmer, 2008; Olij, 2005). Similarly, I have not covered some approaches based on "Eastern" spiritual practices such as Qigong and T'ai Chi (Grodin, Piwowarczyk, Fulker, Bazazi, & Saper, 2008), and expressive-type therapies such as movement therapy (Harris, 2007). In many cases, no rigorous therapeutic outcome studies have been conducted on these approaches and the literature is limited to descriptions of the interventions, accompanied in some instances by summaries of client and/or counsellor feedback. I have also not done justice to the extensive research on the use of psychotropic medication with torture survivors (Otto, et al., 2003; Smajkic, et al., 2001; Turner, 2000). Psychotropic medications are not widely and reliably available in much of sub-Saharan Africa and licensed prescribers may be few. The exclusion of psychotropic medication from this review is not meant to imply that such treatments cannot be effective and appropriate in contexts where medication is readily available.

Looking back, in Chapter 1 I presented definitions of both torture and rehabilitation, and argued that torture is nearly always terroristic in intent, not interrogational as is often portrayed in popular media. I summarized evidence of the ongoing practice of torture in many countries in sub-Saharan Africa, thereby demonstrating the ongoing need for mental health services that target this particularly vulnerable group.

In Chapter 2 I explored the impact of torture on communities, families and individuals with an emphasis on the emotional and interpersonal impacts. I emphasized the layering of conflict and oppressive rule in four different regions of the continent and argued that competent counselling with torture survivors requires an understanding (or at least a curiosity about) the particular political context from which each client comes and the culturally determined conceptualization and idioms of suffering.

In Chapter 3, I provided an overview of global research on clinical outcomes with populations that include large groups of torture survivors and highlighted both the strengths and the limitations of this literature. Finally, I have constructed five paradigms in the recent history of writing about the rehabilitation of torture survivors. In doing so, I have attempted to present the challenges in framing, designing, implementing and evaluating mental health services for torture survivors. Each of these paradigms has limitations but has offered something important to contemporary understanding of this work.

Throughout this literature review I have argued that the field is in large part defined by researchers and policymakers from the Global North. That the research is dominated by work with torture survivors resettled in countries in the Global North is of serious concern when one understands that the vast majority of torture survivors actually live in the camps, settlements and cities of the Global South. Similarly, I believe that the field has foregrounded the interests of practitioners and researchers in North America and Europe, in many instances to the detriment of work in the Global South. I argue that to dismiss the political, historic, cultural, social, economic, and security contexts in which both torture survivor and counsellor meet, is to dismiss important elements of our clients and their experience.

The themes introduced here are present in subsequent chapters that cover the results of this research (chapters five through eight), the model of treatment (chapter nine), and the recommendations for policy, practice and research suggested by the results (chapter ten).

Chapter 4 Research Methodology

As discussed in the preceding chapters, theory and research into the effectiveness of different mental health and psychosocial interventions with torture survivors is rich and challenging. While some of this research has included client populations from sub-Saharan Africa, many studies have been conducted with refugees and asylum seekers in the resettlement contexts of North America and Europe. Far less attention has been given to the relevance of emerging evidence-based practices in poorer and less secure contexts.

Research Aims and Questions

In this research, I closely examined the needs of torture survivors in sub-Saharan African contexts and their experiences of recovery through interaction with existing mental health services. I have also explored the practices and reflections of counsellors who work with these survivors. Finally, I have proposed adapting existing theory and empirical knowledge in the light of these results and offer recommendations for a contextually informed approach to torture rehabilitation in sub-Saharan Africa.

The study is informed by three broad research questions:

1. What is the range of mental health and psychosocial needs presented by help-seeking torture survivors in sub-Saharan African contexts?
    a. What are the most prevalent psychological symptoms and complaints in this population?
    b. What are the most prevalent social needs in this population?
    c. How do these psychological complaints and social needs interact?
2. What evidence-based practices (if any) are currently being used by counsellors who work with torture survivors in sub-Saharan Africa?
    a. What interventions do counsellors experience as having the greatest positive impact on the psychosocial wellbeing of help-seeking torture survivors in sub-Saharan Africa?
    b. What interventions do counselling clients experience as having the most positive impact on their psychosocial well-being?

   c. How do such impactful interventions relate to the psychological and social concerns identified in question 1?

3. How should existing best practices in torture rehabilitation be adapted for use in sub-Saharan African contexts?

   a. To what extent do existing evidence-based practices address the needs of torture survivors in sub-Saharan Africa?

   b. What indicators should be prioritized in clinical assessments?

   c. What psychosocial outcomes should be considered in future research on treatment outcomes with torture survivors in sub-Saharan Africa?

   d. What are the essential features of a counselling approach adapted to torture survivors in sub-Saharan Africa?

Epistemological Stance and Research Approach: Pragmatism and Mixed Methods

These research questions are located within and between two very different bodies of knowledge. On the one side is the extensive body of work relating to the efficacy of various treatments with survivors of trauma. On the other is the literature on the experiences and challenges of mental health practitioners working with trauma and torture survivors in insecure and less developed contexts, including those of sub-Saharan African. The former is characterized by quantitative and experimental research and emphasizes scientific rigour, deduction, measurement and generalizability. The latter is more descriptive in character and emphasizes induction, qualitative data, and the context of findings. The former is located largely within the positivist (or post-positivist) and realist traditions of social science, whereas the latter is located largely within the constructivist (or interpretivist) and relativist traditions of social science.

A challenge in this research was to identify an appropriate epistemological frame capable of bridging this philosophical divide. Pragmatism is an epistemological position that challenges the fundamental incompatibility of the positivist and constructivist world views (Howe, 1988). Pragmatism proposes that a proposition should be evaluated in terms of the practical consequences of accepting it. Thus, the usefulness or "workability" of constructs and theory is all important, and impractical ideas are to be rejected. Theory and data are connected through "abductive reasoning", reasoning that oscillates between induction (using observations to develop more generalizable theory) and deduction (evaluating existing

theoretical propositions against particular observations). Similarly, the struggle between generalizability and contextual specificity is resolved in the concept of "transferability", the extent to which findings from one context are workable in another. Finally, the epistemological struggle between objectivity and subjectivity is replaced with the idea of "intersubjectivity". Intersubjectivity posits the existence of a single "real world" which is uniquely interpreted by each individual. The pragmatic researcher is concerned with identifying areas of consensus and contention in the pursuit of workable solutions to problems in the community (Morgan, 2007). Pragmatism is most closely associated with mixed methods research designs.

This research was conducted at a time when mixed methods are becoming increasingly important in research into evidence-based practices. Dattilio, Edwards and Fishman (2010, p. 427) point out the ongoing alienation between evidence of efficacy generated by researchers in "a laboratory atmosphere" and practitioners' experience of "what really works in treatment". For these authors the solution lay in mixed methods research with its emphasis on pragmatism and multiplicity. They propose that qualitative systematic case studies and comparative case studies are necessary to evaluate treatments in context and to refine them as needed. Such methods are intended to complement (not replace) experimental evaluations of treatment efficacy. Cresswell and Zhang (2009) have made similar arguments for research on traumatic stress specifically, suggesting that the field would benefit greatly from precise mixed methods research that bridges the divide between research and practice. Bolton, Wietse and Bass (2009) extended this to work in complex emergencies, emphasizing the necessity of involving practitioners in research on psychosocial programming and advocating for more rigorous work on the development of culturally appropriate assessment measures and intervention strategies. The present study is therefore located within a broader movement of researchers and practitioners who are embracing mixed methods research in the service of more effective services to survivors of trauma, organized violence and torture.

The uneasy relationship between researcher and practitioner introduces the question of power and its influence on the generation of knowledge, and how this influence plays out between highly resourced regions and the rest of the world. The majority of torture survivors live in poorer countries, while wealthier countries have greater resources to provide rehabilitation services and to study the impact of those services. The inevitable result of these disparities is the ever-increasing export of rehabilitation technology and research from countries in the Global North to those in the Global South. Power imbalances between the Global North and South are aggravated by the fact that those who control the financial

resources that support both research and intervention with torture survivors internationally are typically located in the Global North. As discussed in Chapter 1, it is too easy for well-meaning researchers and policymakers, supported by substantial funds, to impose their values, beliefs and methods on over-stretched and impoverished practitioners in other parts of the world. If mental health services to torture survivors are to become more effective it is necessary for researchers, trainers and practitioners from all backgrounds to vigorously question the assumptions that underlie the questions that they ask, the teaching they offer, and the services they provide.

Given these tensions in the field of torture rehabilitation, I have adopted the philosophical positions of critical and community psychology (Eagle, 2014; Kira, 2017; Painter, Terre Blanche, & Henderson, 2006; Ruto-Korir, 2006) with their concern for addressing power imbalances within society, including in the way knowledge is generated. In the following section, I have attempted to reflect upon my own position as a knowledge generator relative to the practitioners and torture survivors who are both the participants and intended beneficiaries of this research.

In summary, while critical and community psychology have provided the ideological underpinnings for my positioning as a researcher and the kinds of questions I have asked, pragmatism has provided the criteria against which I have judged the emerging solutions, and mixed-method research has provided the means of generating those solutions. In the dissemination of the findings from this research I have attempted to amplify the voices of torture survivors and practitioners whose potential contribution to knowledge generation is in danger of being eclipsed in the face of expensive controlled trials conducted by experts from the developed world and disseminated through leading scientific journals.

The relational context

Goffman (1959) proposed the metaphor of front and backstage for thinking about the relational context of research with populations that are generally closed to outsiders. This metaphor has been used in reference to research with refugees (Miller, 2004), and is equally applicable to research with torture survivors and those who work closely with them. As has been discussed in earlier chapters, torture survivors are often stigmatized or otherwise separated from their communities. Counsellors who choose to work in small, often poorly funded, torture rehabilitation centres are also somewhat separated from colleagues who hold more mainstream positions in public or private health services. Goffman (1959) proposed that such populations develop a self-protective narrative and style of presentation, which he

described as the “frontstage”. A valid exploration of their true feelings, attitudes and beliefs, the “backstage”, requires a deeper kind of access built on a sufficiently trusting relationship. The possibility of such relationships existing in this investigation depends on my background as a researcher and my relationship with the research participants.

I am an English-speaking South African, born in Zimbabwe and of British ancestry. I grew up as a member of the privileged and protected white minority of apartheid South Africa. I became involved in the anti-apartheid struggle in my late teens. My earliest work with torture survivors was as a student volunteer in the late 1980s with the Detainees Support Committee in Pietermaritzburg, South Africa. Since then I have worked with survivors of violence and war in a range of community and clinical settings.

During the past two decades I have been employed and contracted by several international organisations (including the Center for Victims of Torture (CVT), the International Rehabilitation Council for Torture Victims (IRCT) and Dignity (the Danish Institute Against Torture) to provide capacity building in torture treatment centres in Africa, the Middle East, Eastern Europe and South-East Asia. It is through this role that I became acquainted with the organisations and practitioners who participated in this research.

At the time of conducting the counsellor interviews, I had enjoyed a professional relationship with each of the respondents for between one and eight years. These relationships certainly influenced the process and content of the interviews. During this period, I visited each of the three centres within which the research was undertaken several times per year to provide training, consultation on programming, organisational development and strategic planning, as well as personal mentoring and staff support. Over the years I was also the lead facilitator on several international training programs and presented at numerous professional meetings attended by these counsellors. My relationship with them has always been as trainer, consultant and colleague, never as manager or evaluator.

In these roles I have consistently taken theoretical and ideological positions with which I am associated, and which will also have influenced the results of this research. I have been, and remain, convinced that it is essential that the torture rehabilitation movement on the African continent develop a pool of professionals competent to adapt international approaches to local contexts and cultures, develop new approaches, and train and supervise others. More specifically, I have argued: (1) that ongoing capacity building of African practitioners and organisations located within civil society should be prioritized over the provision of services by international organisations; (2) that capacity building should be based on the most recent and advanced theoretical and practical knowledge; (3) that all

training should have a broad theoretical base and mental health professionals should be trained in multiple, evidence-based approaches; (4) that an advanced understanding of traumatic stress and PTSD is critical to torture rehabilitation, but that it does not encompass the whole of the field; and, (5) that practitioners and researchers have complementary roles and responsibilities in contributing to the development of knowledge and practice in torture rehabilitation. In many ways this study was the inevitable product of these ideological and theoretical foundations.

I am hopeful that my years of supportive work with these centres have earned me the right to visit backstage, to see something of what goes on behind the performance frontstage. It is inevitable that some private spaces will remain invisible, but I believe our shared history and values allowed me to see more of their work than might have been shared with other researchers.

Definition and elaboration of key terms

As discussed in Chapter 1, the definition of torture is itself a controversial issue. For the purposes of this research I use the definition provided in the UNCAT (UN General Assembly, 1984). This is the most widely accepted definition of torture and is the definition used by the organisations that participated in the study as well as the funding agencies that support their work. Torture in this definition includes "cruel, inhuman and degrading treatment or punishment", such as psychological manipulation, being subject to forced stress positions, and humiliating treatment. Although such acts might not rise to the severity required by legal definitions of torture *per se*, there is evidence that the distinction makes little difference to the psychological consequences experienced by victims (Başoğlu, Livanou, & Crnobaric, 2007). Within the category of "torture survivor" I have included direct survivors of torture and cruel, inhuman and degrading treatment or punishment, as well as members of their immediate families (sometimes referred to as indirect or secondary victims of torture). This too is consistent with international practice within the torture rehabilitation movement.

I have used the term "counselling" in preference to "psychotherapy" because the former encompasses a broader range of interventions and implies less about the theoretical foundations, content, methods, structure or duration of intervention. I use the term "counselling" to refer to any intervention primarily aimed at improving the psychosocial health of clients. Similarly, I refer to practitioners as "counsellors" rather than as "therapists" or "psychologists". "Counsellors" implies less in relation to the training, skills, and regulation

of practitioners. In sub-Saharan Africa, torture rehabilitation services are provided by a range of practitioners, including psychologists, psychiatrists, psychiatric nurses, social workers, general nurses, and lay counsellors. There is also considerable variation in the training, theoretical orientations and job functions of these categories of practitioners across the continent. Therefore, I define "counsellors" as the people providing the "counselling" interventions defined above.

Feasibility Study

The mixed methods study design was preceded by a small qualitative and exploratory feasibility study. As the results of the feasibility study had significant impact on the design of the methodology, a brief summary is included here.

The purpose of the feasibility study was twofold. Firstly, it was important to understand whether senior counsellors working in torture rehabilitation in sub-Saharan Africa were concerned about the appropriateness of existing counselling models to their contexts, and whether they would be motivated to participate in the research and be open to using the products of the research in their ongoing work. Secondly, as the core beneficiaries of the research, I wanted senior African counsellors to have a significant voice in the design of the research methodology and instruments.

Seven senior counsellors or supervisors from five organisations offering counselling to torture survivors in in sub-Saharan Africa were selected using purposive sampling. These organisations were located in South Africa (two organizations), Kenya, Uganda and Cameroon. The counsellors were people with whom I enjoyed an existing professional relationship. Each potential respondent received a letter explaining the research, a copy of a draft research proposal, and a signed written consent to participation. All seven agreed to participate in a single in-depth interview to be conducted at their offices. All were licensed mental health professionals and had been working with torture survivors in sub-Saharan Africa for an average of six years. Three respondents had over fifteen years' experience.

The interviews were conducted in English, lasted an average of fifty minutes and were audio-recorded and transcribed verbatim. The transcripts were analysed using emergent thematic coding. Coding was done manually using NVivo9 qualitative analysis software. The interview schedule is summarized in Table 4.1.

Table 4.1: Feasibility study interview schedule

Question	Probes
Please describe the general characteristics of the torture survivors seen at your centre.	Demographics; legal status; presenting problems; underlying problems.
What approaches to counselling torture survivors are used at your centre?	Theoretical underpinnings; format of intervention; length of intervention.
How are counselling services organized and managed in your centre?	Process intake to closure; case management; clinical supervision.
What challenges does your centre face in offering services to torture survivors?	Related to clients, community, organization, counsellors.
What critiques or suggestions do you have of my proposed methodology?	Research objectives; sampling; data collection; data analysis.
Do you think that your centre might be interested in participating in this research?	Reasons for participation/non-participation

Each of the senior counsellors expressed enthusiastic support for the overarching objective of the proposed research. They expressed a desire to provide better care to torture survivors and described their frustration with the therapeutic approaches currently at their disposal. Analysis of the counselling challenges reported produced a list of recurrent themes. Counsellors reported that their formal professional training had not adequately prepared them for work with torture survivors, nor had it given them the knowledge to implement current evidence-based practices. All had had to supplement their professional training through "on-the-job training" and short courses focused specifically on mental health services (including evidence-based practices) for refugees and survivors of violence and torture specifically.

They reported that the evidence-based practices that they had studied were difficult to implement within the context of existing health and mental health systems in the region, and that these approaches and practices generally failed to consider clients' culturally and contextually determined expectations of mental health service providers. Respondents were very critical of the fact that the treatment outcome research underpinning existing evidence-based practices typically defined treatment efficacy as a reduction in PTSD symptoms. They felt that clients in sub-Saharan Africa were much more likely to think about their own emotional health in terms of their capacity to protect and care for their families, and to be productive members of their communities. They argued that emotional health would be more appropriately defined in terms of interpersonal functioning (as opposed to individual

pathology) in sub-Saharan Africa. Respondents repeatedly remarked that existing evidence-based practices failed to acknowledge the dramatic changes in social and legal status that most torture survivors had experienced and made unfounded assumptions about the physical safety of clients. They also argued that existing approaches failed to adequately recognize the impact of collective denial of torture, or the centrality of religious belief, practice and community to torture survivors' experience and recovery. Finally, respondents reiterated how difficult it is to earn the trust of some torture survivors and the implications of this for the therapeutic relationship and the ongoing health and capacity of counsellors. These factors have far-reaching implications for clients' capacity to engage with, and benefit from, existing evidence-based practices.

Respondents critiqued the research proposal on several points. Firstly, multiple respondents felt that the research design should give greater weight to the direct experience of torture survivors in the region and do more to explore and amplify survivors' voices. Respondents urged me to consider including interviews with survivors who had received counselling, something that I had avoided due to the practical and ethical complexities that this would introduce. Secondly, respondents felt that the inclusion of organizational and contextual factors (such as training and supervision structures, clinical funding and management, etc.) were somewhat secondary to the core research questions which concern the relationship and work that happens between counsellor and client. I was encouraged to focus more closely on the actual counselling approach and less on the systems that support service delivery. Respondents also felt that I should include treatment outcome measures in my analysis with one going so far as to suggest that I create a battery of measures to be administered by all participating centres to all clients over a certain period. Finally, respondents asked me to consider more closely the impact of work with torture survivors on counsellors' emotional health. They noted that they had to work hard to stay emotionally healthy and motivated in their work.

These recommendations led to several changes in the design of the study. I decided to include an equal number of interviews with clients and counsellors and to find ways to solve the practical and ethical challenges that this would create. I removed managers from the sample of providers who I intended to interview, except in the cases where those managers were also active counsellors. I did not include a standard set of measures for centres to administer to all clients. This would have placed too great a demand on participating sites and would have been disruptive of existing systems and services. I did however extract baseline and follow up measures from client files where they were available. I included questions

about counsellors' emotional health in the interview schedule and administered a measure of secondary trauma, the Professional Quality of Life (ProQOL) measure (Stamm, 2010), to participating counsellors. Finally, the long list of frustrations with evidence-based practices summarized above provided rich content for elaborating the interview structure, probes and an initial set of *a priori* analytic categories used in the study.

All respondents felt that they were already adapting the counselling approaches in which they had been trained and were motivated to describe those adaptations. Counsellors from all five centres stated that their organization and staff would be motivated to participate in a more extensive study, despite high caseloads and limited resources. Based on these formative inputs I adapted the design accordingly and proceeded with the study.

Research Design

This study was conducted using a two-stage design, each of which is more fully elaborated in subsequent sub-sections. Stage I employed a fundamentally quantitative design that entailed analysing a representative sample of client files from the population of torture survivors receiving assistance from three torture rehabilitation centres in three countries in different parts of sub-Saharan Africa, according to a range of categories and markers. Parts of these client files comprised descriptive text (for example, trauma histories and session notes). Emergent thematic coding was used to analyse these aspects of the client files. In this way, qualitative methods were embedded within a quantitative methodology.

Stage II employed a fundamentally qualitative design comprising semi-structured interviews with a purposive sample of torture survivors who had received and completed counselling at the centres, and with counselling staff at these centres. The administration of the ProQOL accompanied the counsellor interviews. Thus, stage two was primarily qualitative but included supplementary quantitative data.

Mixed methods methodologists emphasize the importance of explicitly describing the combination of methodologies used in a mixed methods design as well as the way those methodologies are combined or "mixed" (Leech & Onwuegbuzie, 2009; Tashakkori & Teddlie, 2010). Using the emergent standard notation for mixed methods designs (Cresswell, 2010; Nastasi, Hitchcock, & Brown, 2010), the design for this study is summarized as:

$$\text{QUAN(qual)} \rightarrow \text{QUAL + quan}$$

Mixing can be accomplished during data collection, analysis and/or interpretation. In this case there was some mixing at the level of data collection, as well as in the analysis and

interpretation stages of the study. As described in the previous logic statement, when the file analysis of Stage I showed the person was a primary victim of torture, had suffered a recent bereavement, and/or had experienced additional threats, a secondary qualitative analysis was triggered. In these cases, the entire file would be scrutinized to uncover further descriptive details of these events. In Stage II, the individual results of the professional quality of life measure informed aspects of the interviews with counsellors. Counsellors received a summary of the results of the measure and were asked to comment on stressors and coping strategies in their work. Nevertheless, most of the mixing was accomplished during analysis and interpretation, and the published papers combine results from different components of the data, while findings and conclusions draw from the overall integrated methodology.

A detailed research proposal was reviewed by the Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand, Johannesburg and approved unconditionally (Protocol Number H1 10206). The clearance certificate is included as Appendix A. As the researcher had been employed by the Centre for Victims of Torture (CVT) and had worked with the African partner organisations in that capacity for several years it was important to ensure that the project also had CVT's support. After studying the research protocol and university ethical approval, CVT's director of research supplied a letter of support for the project (Appendix B). Further details of the ethical provisions involved in this study are described in subsequent paragraphs.

Methodology – Stage I

Multistage Sampling

A two-step multistage sampling process was used to recruit a sample of records of torture survivors who had sought psychosocial care from torture rehabilitation centres in Sub-Saharan Africa. In the first step, three study sites were purposefully selected. A site was considered for inclusion if it: (a) was currently providing counselling to torture survivors; (b) was registered as a torture service provider within the Sub-Saharan Africa region of the International Rehabilitation Council for Torture Victims (IRCT) which monitors a minimum standard of service provision; (c) was founded and managed by people from Africa; (d) was predominantly staffed by people from Africa; and (e) had been continuously operational for a period of at least five years prior to the start of this research. Study sites were selected to reflect something of the economic, linguistic, and cultural diversity of Sub-Saharan Africa. The sites selected were the Centre for the Rehabilitation and Abolition of Torture (CRAT) in Cameroon, the Independent Medical and Legal Unit (IMLU) in Kenya, and the Centre for the

Study of Violence and Reconciliation (CSVR) in South Africa. All three had participated in the feasibility study and were distributed between East, Southern and West Africa. Both Anglophone and Francophone contexts were represented. Cameroon and Kenya are classified by the World Bank as low-middle income countries (with per capita gross national incomes in the range of $1,006 to $3,955) whereas South Africa is classified as upper-middle income (per capita gross national income in the range of $3,956 to $12,235) (World Bank, 2019). In South Africa income is extremely unevenly distributed (Statistics South Africa, 2019) and those seeking care from NGO providers are typically from impoverished backgrounds. All three countries receive significant numbers of refugees including torture survivors from other countries on the continent.

The second step of the sampling procedures required the selection of individual case files for review. At each site, a random set of client files was selected. Inclusion criteria for client files were: (a) the client underwent an intake assessment and was referred for counselling and/or psychopharmacological intervention; (b) the client reported being tortured as defined under the UNCAT; (c) the client was at least eighteen years old at the time of seeking services; and, (c) the client was first assessed between 1 January 2007 and 31 July 2011.

In order to balance the sample across the three participating centres, 33 files were sampled from each. The sample was selected using interval sampling on consecutive lists of clients by client identification number. Client identifications numbers were organized by date of first assessment at all centres. At each site, the sampling interval was calculated to cover the full range of client files at that site and a random number generator was used to identify the first client file sampled. The sample included between twelve and twenty-three percent of the total set of eligible client files at each site. As a result of record-keeping and filing errors, there were three occasions in which the randomly sampled file was not accessible. In this case, the next file in the record was selected instead. Following subsequent analysis (see *Secondary coding of client files* below), fourteen cases were excluded as not meeting eligibility criteria.

Procedure

The three sites were approached through their executive directors who received a verbal briefing about the study, a detailed written research proposal and a letter inviting participation (Appendix C). The proposal and letter clearly specified the anticipated demands on the organization as well as the ethical provisions in place to protect individual participants

(both counsellors and clients) and the participating organisations. Following internal consultation with staff and board members, all three executive directors responded positively to the invitation.

At each site a staff member responsible for the management of client records explained the details of the local client information system. At the time of data collection, CRAT and IMLU employed paper-based systems whereas CSVR used an electronic client record system. At the sites with paper-based systems the sample was selected using a client register. The actual files of the sampled cases were then located, analysed on site and immediately returned. At CSVR the monitoring and evaluation officer generated a complete list of client identification numbers which was used to select the study sample. The same staff member then retrieved the data for selected clients from the system and made it available in de-identified electronic form to the researcher.

Each record was scored for percentage completeness across four typical sections of client records: client demographic information; client's description of presenting problem; counsellor's clinical assessment; and, counselling session notes. Finally, each record was coded for the presence or absence of a clinical assessment beyond the initial intake assessment. The completeness and quality of record keeping varied significantly across centres and individual counsellors. All available data was used in the subsequent analysis. A list of record keeping concerns was compiled for each research site and discussed with the senior clinician or supervisor responsible for each site's client information management system. Where appropriate the researcher offered recommendations as to how the record system might be improved.

Primary coding of client files

An *a priori* coding scheme was constructed based on a typical structure of client clinical records in torture treatment centres. Categories within this foundational coding scheme included: client identifiers (treatment centre and client identification number); indicators of counselling dosage (duration of treatment and number of sessions); demographic information (gender, age, marital details; number of dependents, nationality, legal status in the country of residence, education and employment details); primary and

comorbid diagnoses; presenting symptomatology[4]; intake assessment measures and scores; follow up assessment measures and scores (where available); and current status of treatment (ongoing, completed, client has dropped out of treatment). In additional any medication prescribed to the client was noted and a brief qualitative summary of the clients' trauma history was recorded. Where available the trauma history, including the dates, duration, location, forms of torture, and alleged perpetrator details, was recorded for key incidents reported by the client.

Primary coding data was recorded in a single spreadsheet organized by site name and client identification number in order to facilitate further analysis of particular client files where required. No further identifying information was recorded in the data set.

Secondary coding of client files

When data collection and primary coding from all three sites was complete, the combined sample was subjected to a second round of coding. This was done to: (a) check the eligibility of each case in the sample; (b) systematically code the qualitative fields detailing trauma history; and (c) check the consistency of coding across sites.

During secondary coding it became apparent that the events described in fourteen cases did not specifically and explicitly meet the UNCAT definition of torture. Typically, the events described were acts of war in which the alleged perpetrator was not a public official or person acting in an official capacity or there was no clear intention to cause harm to the individual in question. As mentioned previously, these fourteen cases were subsequently excluded from the sample.

The trauma history was used to create a set of additional codes. Each case was classified with respect to the way each client self-identified, and their understanding of the reasons for their torture. Four categories emerged from this analysis. "Citizens" includes ordinary people caught up in a civil conflict but without political or leadership roles in their communities. Typically, these people were tortured as part of forced conscription, as punishment for alleged support of the enemy, to coerce them into providing supplies to militias, or because of their ethnic or religious identity. "Activists" included political and

[4] Centers used some combination of the PTSD Checklist, Civilian Version (Weathers et al., 2013), the Harvard Trauma Questionnaire (Mollica et al., 1992), the Hopkins Symptoms Checklists for Anxiety and Depression (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983).

community leaders as well as journalists. They were tortured in order to extract information, punish them for their political work, speeches or writing, or to make an example of them to the broader community. “Family members” included relatives of activists who were targeted in order to punish their activist family members, or in order to extract information about their loved one’s activities or whereabouts. Finally, a category of “People accused of a crime” included people who were tortured as part of a police investigation or as summary punishment for an alleged crime.

During the coding it became apparent that a substantial subset of the sample had reported a sudden or violent bereavement in their recent personal history. To facilitate further exploration of this initial finding, I created a code to track the presence or absence of such reported bereavements in the files. In cases where bereavement was reported additional codes were created to capture the relationship to the deceased, the length of time that had passed between the most recent bereavement and the intake assessment, the means by which the person had died (violence, accident or natural causes), and whether or not the client had witnessed the death(s). In cases where the death was due to violence further codes were created to capture the form the violence took and details of the alleged perpetrator of the killing, if known. I also recorded any additional traumatic violations that occurred simultaneously with the bereavement (typically being raped, tortured and/or forced to flee the person’s home and/or community). Finally, I created codes to capture whether the client was in anyway “implicated” or “involved” in the killing. For example, several clients had been accused of murdering the deceased and were tortured by police in order to extract a confession. In other cases, family members were killed trying to protect the client, or in order to punish the client for political activity.

The case files from the CSVR which were available in de-identified electronic form were independently coded by a colleague with appropriate experience in qualitative methodologies. Mean percentage agreement of secondary coding was 91%. Case files from CRAT and IMLU were not independently coded as this would have required removing or creating hard copies of extremely sensitive client torture exposure and health-related information.

Quantitative analysis of coded case files

Descriptive statistics (frequencies or means and standard deviations) were calculated for all demographic variables and are presented in Tables 5.1 (p. 121) and 6.1. (p. 143). Results of the secondary coding of case files were treated in the same way, particularly with

respect to categories of torture survivors, reasons for seeking services, and histories of bereavement. Where appropriate, 95% confidence limits associated with prevalence estimates within the help-seeking samples were calculated (see, for example, Chapter 6 results dealing with complicated grief).

In Table 8.1 (p. 186) the demographic results are presented, disaggregated by data collection site. Systematic differences between sites were tested for using chi-square or Kruskal-Wallis H tests. Nonparametric tests were chosen due to the small sample sizes and non-normal distributions. As it turned out, the sites differed only with respect to the distribution of clients' countries of origin.

As the three study sites employed different measures in the initial assessment of clients' emotional functioning it was necessary to develop a standard method of scoring symptoms and associated psychological disorders. I developed an overarching checklist of 48 symptoms associated with a range of mental health conditions common in torture survivors, as well as pain and physical complaints commonly associated with psychological disorders. I recorded a symptom as present if it was mentioned in intake or follow up assessments, or in counselling notes. Prevalence rates for common symptoms are presented in Tables 5.2 (p. 124).

To facilitate more advanced analyses, these symptoms were also categorized according to the symptom descriptions associated with PTSD, Major Depressive Disorder, and Generalised Anxiety Disorder, according to disorder descriptions and symptom lists contained within the DSM-5 (American Psychiatric Association, 2013). An additional category of physical symptoms was added that included complains of body pain, persistent headaches, persistent nausea, etc. Such symptoms may be emotional in origin but may also result from current illness or past injuries (possibly but not necessarily torture related). The presence/absence of symptoms was combined additively to create the five scales listed in Table 4.2. The internal consistency of these scales was assessed using Cronbach's coefficient alpha, which provides an estimate of the extent to which a collection of items is assessing a common underlying factor. The rule of thumb for interpreting this statistic with dichotomous items (as in this case) is $\alpha \geq 0.7$ is acceptable, $\alpha \geq 0.9$ is excellent. Only the physical symptoms scale did not demonstrate acceptable reliability, which is most likely due to the uncertain and complex aetiology of these symptoms.

Table 4.2 Internal consistency of symptom checklists

Scale	Items	Cronbach α
PTSD Symptoms	17 items	0.912
Depression Symptoms	11 items	0.714
Anxiety Symptoms	8 items	0.706
Physical Symptoms	8 items	0.669
Overall Distress	48 items	0.908

Based on initial observations of the data and the frequency of reports of bereavement within the case files the associations between the prevalence of individual symptoms and bereavement were tested for all symptoms using chi-square analyses, and significant results are presented in Chapter 6 together with odds ratio estimates (with 95% confidence intervals) that express increased risk. In addition, one-way analyses of variance and Student t-tests for independent samples were used to test whether clients who had experienced bereavement showed significantly different symptom profiles than clients who had not, and whether clients who sought help within one year of bereavement showed different symptoms to those who sought help later. Effect sizes of significant results were calculated using the Cohen's d estimate. These results are presented in Tables 6.3 and 6.4 (p. 149). The patterns emerging in these quantitative results are supported and elaborated through the findings that emerged from Stage II of the mixed methods approach.

Methodology – Stage II

Purposive sampling and recruitment of counsellors

Having previously received permission to work with each of the three participating centres, I sent letters to all employees (including full time, part time and occasional workers) with responsibilities for mental health care (Appendix D). These letters explained the rationale, goals, methodologies, outputs, and ethical provisions of the proposed research and were accompanied by a detailed research proposal.

Sixteen staff were approached and all sixteen expressed interest in participating. I met with each of the invited staff individually to review the details the contents of the letter and answer any questions. One person was excluded as she had no counselling training or duties and had been erroneously included in the original sample. Therefore, fifteen counsellors agreed to participate in the study and provided separate, individual, written consents to participate in the study and to have their interview audio recorded.

The sample comprised eleven women and four men. Seven were trained as psychologists, three were trained as social workers, three were lay counsellors, one was a general nurse, and one was a psychiatric nurse. Seven people had supervisory duties in addition to their counselling work. As demographic information (age, years of experience in mental-health work generally, and years of experience in torture rehabilitation work specifically) was included in the published papers (chapters five through eight), particularly Tables 7.1 (p. 161) and 8.1 (p. 186), it is not reproduced again here. There were no significant differences between men and women in age, years in mental health work, or years in torture rehabilitation. Although sample sizes are too small for meaningful significance testing, staff at the Cameroon centre were more commonly medically trained (psychiatric or general nursing), whereas those in the centres in South Africa and Kenya were more likely to be trained as psychologists or social workers. As expected, those with supervisory responsibilities tended to be older, and to have more years' experience in both general mental health work and torture rehabilitation work. Only the differences in age reached statistical significance (t [equal variance not assumed]=2,27, df=10.085, p=0.046). All participants had participated in various short courses on counselling skills, trauma counselling, and torture rehabilitation. These courses were offered by psychologists associated with international nongovernment organizations.

Interviews with counsellors

I met with each counsellor individually in a private office within the centre in which that person was employed. All counsellors were fluent English speakers and the meetings were conducted in that language and without interpretation. The meetings began with a review of the letter of invitation, the aims and methods of the research as well as all ethical provisions. I answered any questions that the counsellor might have had and thereafter they signed the consent forms for participation and recording. I kept the original signed consent forms and provided the counsellor with a copy for future reference.

I then introduced the ProQOL measure explaining its purpose and use. Counsellors were given time alone to complete the measure after which I demonstrated the scoring and interpretation procedure.

<u>The Professional Quality of Life Measure (ProQOL)</u>

The Professional Quality of Life (ProQOL) measures the experienced quality of life of "helpers" who work with traumatized individuals (Stamm, 2010). The "word" helper is

used in the measure to include a wide range of practitioners who are exposed to people suffering from traumatic stress. Users are encouraged to substitute a word such as "counsellor" that is more appropriate to their context. The ProQOL has been used in nearly half of all published papers on secondary traumatic stress and vicarious trauma, including in work with torture survivors (Deighton, Gurris, & Traue, 2007). It has been used in many countries, including several countries in Sub-Saharan Africa, and is available in more than twenty languages. The ProQOL is free for use if it is not used to generate financial profit.

ProQOL, Version 5 was used for this research. This measure comprises thirty items scored on a five-point Likert scale. The items are organized into three scales: compassion satisfaction, burnout and secondary traumatic stress. These concepts are described in the ProQOL manual as follows:

Table 4.3 Descriptions of the ProQOL Scales

Compassion Satisfaction	Compassion satisfaction is characterized by feeling satisfied by one's job and from the helping itself. It is characterized by people feeling invigorated by work that they like to do. They feel they can keep up with new technology and protocols. They experience happy thoughts, feel successful, are happy with the work they do, want to continue to do it, and believe they can make a difference.
Burnout	Burnout is characterized by feelings of unhappiness, disconnectedness, and insensitivity to the work environment. It can include exhaustion, feelings of being overwhelmed, bogged down, being "out-of-touch" with the person he or she wants to be, while having no sustaining beliefs.
Secondary Traumatic Stress	Secondary Traumatic Stress is characterized by being preoccupied with thoughts of people one has helped. Caregivers report feeling trapped, on edge, exhausted, overwhelmed, and infected by others' trauma. Characteristics include an inability to sleep, sometimes forgetting important things, and an inability to separate one's private life and one's life as a helper—and experiencing the trauma of someone one helped, even to the extent of avoiding activities to avoid reminders of the trauma.

(Adapted from Stamm, 2010, p. 21)

Each of the three subscales comprises ten items and scores are obtained by calculating the sum of the responses to items on each scale with reverse scoring of some items. Although the authors recommend using the subscale scores in continuous form, they do suggest cut off scores for "low", "moderate" and "high" scores on each subscale. These cut off points are set at the 25th and 75th percentiles. Table 4.4 contains key psychometric information for the three scales that comprise the ProQOL. As will be evident, the three sub-scales generally have good internal consistency as assessed using Cronbach alpha.

Table 4.4 ProQOL Scale distributions and reliability estimates (t-scores)

	Compassion Satisfaction (CS)	Burnout (BO)	Secondary Traumatic Stress (STS)
Mean	50	50	50
Std. Error of Mean	0.29	0.29	0.29
Median	51	49	49
Mode	53	51	49
Standard Deviation	10	10	10
Skewness	-0.92	.25	.82
Kurtosis	1.51	-0.31	0.87
Cronbach Alpha	.88	.75	.81

(Adapted from Stamm, 2010, pp. 13-14)

The completed ProQOL measure of each participant was retained by the researcher for analysis purposes. In addition, to ensure that the use of the instrument might be beneficial to participants, each participant received a clean copy of the ProQOL, a page which described the three subscales, their score for each subscale, and the category (low, moderate, or high) associated with each score. They also received a brief written interpretation of their particular set of scores as provided in the ProQOL manual. One such description, that was provided to counsellors who scored high on compassion satisfaction and moderate to low on burnout and secondary traumatic stress, is included here by way of example.

> *This is the most positive result. This result represents a person who receives positive reinforcement from their work. They carry no significant concerns about being "bogged down" or inability to be efficacious in their work—either as an individual or within their organization. They do not suffer any noteworthy fears resulting from their work. These persons may benefit from*

engagement, opportunities for continuing education, and other opportunities to grow in their position. They are likely good influences on their colleagues and their organization. They are probably liked by their patients, who seek out their assistance.

(Stamm, 2010, pp 22-23)

Descriptive statistics for the sample of fifteen participating counsellors are included in Table 4.5. It is worth noting that the burnout scale showed lower internal consistency than expected although the study sample is very small making it somewhat difficult to interpret this result. This result may be due to contextual influences, including counsellors being reluctant to complain about their work conditions out of loyalty to their employers. These results should be treated with caution and were used in this study only as a starting point for a more in-depth conversation about the work.

Table 4.5 ProQOL Descriptive statistics for counsellor sample (raw scores)

	Compassion Satisfaction (CS)	Burnout (BO)	Secondary Traumatic Stress (STS)
N	15	15	15
Mean	42.33	19.4	20.8
Standard Deviation	4.42	3.76	4.81
Minimum	33	15	14
Maximum	49	27	30
Cronbach Alpha	.84	.45	.76

Application of the recommended cut-off scores to determine categories of low, medium and high risk produced the categorical data summarized in Table 4.6.

Table 4.6 ProQOL data organized categorically

	Compassion Satisfaction (CS)	Burnout (BO)	Secondary Traumatic Stress (STS)
Low	-	12	9
Moderate	5	3	6
High	10	-	-
Total	(15)	(15)	(15)

This pattern of results (the caution about interpretation of the burnout scores not withstanding) is extremely encouraging with no participants falling into categories of low compassion satisfaction, or high risk of either burnout or secondary traumatic stress. Approximately one third of participants did fall into the moderate categories which may reflect the ongoing challenge to manage the impact of the work and to engage in the necessary self-care to ensure personal stability in these counsellors' professional lives. Non-parametric inferential tests revealed no significant differences related to country, treatment centre, gender, age, years of experience, professional registration/identity, or between those with supervisory responsibilities and those without.

During the interview that followed the administration and scoring of the ProQOL, the researcher and respondent discussed that individual's results laying a foundation for a conversation about which aspects of the work provided meaning and satisfaction, and which resulted in frustration and exhaustion. Participants were encouraged to continue to self-administer the ProQOL on a quarterly basis, to notice changes in their scores (using the continuous scores rather than categories) and to discuss these changes with their supervisors.

Semi-structured interviews with counsellors

Interviews with counsellors proceeded immediately following the discussion of the ProQOL results. Qualitative research and narrative analysis depend on the detailed and vivid recreation of the respondents' lived experience, expressed through examples, narrative descriptions and stories that pertain to the research question. This is achieved through dialogue where the conversation between researcher and respondents facilitates the expression, elucidation and disclosure of the phenomenon in question (Jovchelovitch & Bauer, 2000; Moustakas, 2001).

Narrative research and analysis is a social constructionist approach which posits that the self is essentially storied, that is, that we define ourselves, at least in part, through the stories that we tell about ourselves, as well as the stories that others tell about us (Sarbin, 1986). Narrative researchers differ as to exactly how "narrative" is to be defined. Waitzkin and Magaña (1997), in their work on trauma and somatization, note that narratives are often fragmented, interrupted or referenced in passing. Following their lead, I did not require completeness (or a beginning, middle, and end) in my definition of narrative. Instead, I developed the following, broad operational definition.

> *Narratives are attempts at storytelling that portray the interrelationships between the therapeutic work of torture survivors and their counsellors, and the economic, political, and cultural context in which that work takes place.*

Such "attempts at storytelling" do not refer to random moments of experience, but instead refer to moments of increased significance: moments of joy or suffering; accomplishment or disappointment; connection or betrayal; and, moments which represent turning points in the course of the storyteller's life. Stories locate individuals' lived experience in time and place. That is, they position those significant moments in relation to particular places, events, and people, and within broader social, political, economic and cultural milieux. Stories link the past to the present and allow people to project their selves into the future. In creating their narratives, clients and counsellors tell themselves and their audience where they come from, where they are today, and where they hope (or fear) that they will be in the future. Their stories include a cast of characters and levels and types of agency are attributed to each of these. Finally, narratives include a sequence of events between which causal links are inferred.

Interview schedules were organized around broad themes extracted from the literature, the feasibility study and initial analyses of Stage I data. Each theme was supported by key questions that addressed important aspects of that theme. Each key question was further supported by possible probes to facilitate more detailed exploration. Wherever possible I asked respondents to describe in narrative form their experiences of particular clients they had worked with, and particular moments in those clients' therapeutic journeys. The following are two examples of the style of questions used in this research.

a) "Would you tell me the story of how you came to be working in torture rehabilitation?"
b) "Would you describe your work with a client with whom you feel you were really successful as a counsellor?"

The themes that were explored with each counsellor through such narratives and examples are summarized in Table 4.7 below. Seven of the clinical staff had supervisory and/or managerial responsibilities in addition to conducting direct counselling themselves. In such cases questions relating to these functions were added to the interview schedule and are included in Table 4.8. A more detailed interview schedule including prompts to deepen the exploration of these themes is included as Appendix F.

Interviews ranged in length from 28 to 102 minutes (mean length=56 minutes). There were two moments during the data collection with clinicians where respondents became tearful. When this happened, I immediately suggested that we stop the interview. In both cases the respondents preferred to continue with the interview and since they were both sad but calm, I agreed to complete the interviews with them. I allowed these respondents to complete the difficult story that they were telling me without additional probing. I then moved the interview on to less difficult themes. In both cases I was reassured by the fact that the interviews ended on a positive and relaxed note.

Table 4.7 Interview themes – Counsellors
Respondent's qualifications and training
Respondent's work experience
Respondent's motivations for torture rehabilitation work
Characteristics of the client population seen at the centre
Most helpful interventions for clients in this population
Therapeutic relationships with tortured clients
Models or approaches being used to counsel tortured clients
Issues involved in counselling tortured clients
Constraints on intervention arising from the client
Constraints on intervention arising from the organization
Constraints on intervention arising from the context
Counsellor's emotional health

Table 4.8 Additional interview themes – Supervisors
Common supervision issues
Supervisees' emotional health

Purposive sampling and recruitment of clients

At my request the participating counsellors invited clients who met the following inclusion criteria to participate in the research: (a) the client was eighteen years or older; (b) the client had reported being tortured as defined under UNCAT; and, (c) the counsellor and client agreed that the therapeutic work was complete or at least at a stage where the client could engage with the research process without undue fear of re-traumatization. Counsellors

informed clients verbally of the opportunity to participate in the study and one centre placed a notice in the waiting area.

Fourteen clients who met the inclusion criteria volunteered their participation. Each of these clients was sent a letter of invitation (in either English or French) explaining the rationale, method, outputs and ethical provisions of the research. Once clients had agreed to participate with this understanding of what the research study entailed, administrative staff at the centres arranged appointments for these clients to meet with me. (It was felt that contact by an administrator would reduce any sense of obligation to take part that might occur if the counsellor were to facilitate participation at this point).

Meetings with clients began with a detailed review of the letter and ethical provisions involved in the research. All fourteen clients agreed to participate in the study and provided separate, individual, written consent to participate and be recorded (Appendix E). Participating clients were aged between 25 and 63 years of age (mean age=44, standard deviation=12). Eight clients were men (57%) and 6 were women (43%). Six were citizens of the country in which they were receiving assistance (43%), and seven were refugees from other countries in sub-Saharan Africa (50%). One person (7%) had had her application for refugee status denied and was in the process of appealing that decision. The missions of the three participating centres differed with respect to their target population. One centre focused on citizens of their own country that had been tortured, while the other two focused on providing services to refugees who had been tortured in other countries in Sub-Saharan Africa. This difference in focus is a function of past and present security issues in different countries as well as national policies regarding the handling of asylum seekers and refugees.

Interviews with clients

The interviews with clients drew on the same narrative theory and framework as that discussed above in reference to interviews with counsellors. Interview content also closely paralleled that of the counsellor interviews and narrative questions were phrased in a corresponding form. Two examples are included here:

a) Would you describe a moment in your counselling journey which stands out as important to your recovery?
b) Would you tell me how it was decided that you had reached the end of your counselling journey?

The themes that were explored with each client through such narratives and examples are summarized in Table 4.9 below. A more detailed interview schedule including prompts to deepen the exploration of these themes is included as Appendix G.

Interviews lasted between 28 and 66 minutes (mean length=45 minutes). Thirteen of the fourteen meetings with clients took place in a private room in the centre where the client would usually come for counselling. One meeting took place in a private place close to the client's workplace as requested by the client.

Table 4.9 Interview themes – Clients

Intervention length
Access to services
Initial impressions
Most helpful therapeutic interventions
Specific therapeutic interventions
Unhelpful therapeutic interventions
Therapeutic relationships
Final recommendations

Two clients became distressed during the interviews. These clients were receiving assistance at the same centre and under the same psychologist. When they became distressed, I immediately stopped the interview and assisted them to regain their composure. Once they were calmer, I suggested ending the interview. In both cases the respondents said that they preferred to complete the interview. I allowed them to finish the story that they had been telling and then continued through the rest of the interview themes without probing as deeply as I might otherwise have done. Both clients were calm and cheerful at the end of the interviews. At the completion of the interviews, and with the clients' permission, we asked their psychologist to join us in the interview room and informed him of what had happened during the interviews. He spent a short period (about fifteen minutes) with each client after which they left the centre. The counsellor later assured me that all was well with both clients.

Work with interpreters

Six of the fourteen client interviews were conducted in French with the assistance of interpreters. At one centre I was permitted to work with an experienced interpreter employed by the centre. At the other I employed an independent interpreter, a student working towards her master's degree in psychology. Both interpreters were familiar with interpretation for

counsellors, and with discussions of traumatic stress and violence. I provided both interpreters with a thorough briefing on the purposes, methodology and ethical provisions of the study. Interpreters were also debriefed after every interview in order to mitigate the risk of vicarious traumatization.

Analysis of counsellor and client interviews

The audio recordings of the interviews with both counsellors and clients were transcribed verbatim in English. Thereafter I began the analysis by reading and rereading the complete set of transcripts (immersion). To facilitate the process of "mixing" of data sources during analysis, I intentionally alternated between interviews with clients and counsellors, making notes of snippets of narrative, potential themes, connections and points of similarity and difference within and between transcripts. In this way the perspectives of clients influenced initial coding of counsellor interviews and vice versa. The analysis of qualitative data in this study comprised both thematic and narrative forms of analysis.

Thematic analysis

Braun and Clark (2006) argue that thematic analysis should be recognized as an analytic methodology, not wed to any particular epistemological or theoretical framework but adaptable for use across various approaches to qualitative and mixed-methods research. The thematic analysis conducted for the purposes of this research study is constructionist and contextualized in approach, that is, I assume that clients' and counsellors' experiences are informed by the social context, including the therapeutic context. Meaning is produced and reproduced within these contexts and in the context of the research interview. Thematic analysis thereafter adds a further layer of meaning making. The analysis process broadly followed the six phases of analysis proposed by Braun and Clark (2006): (1) becoming familiar with your data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report.

Having familiarized myself with the detail of the transcripts and identified various themes and hypothesized linkages (phase one), I began the process of coding. Given my linguistic and cultural distance from most of the respondents, I approached initial coding (phase two) from the perspective of *in-vivo* coding (Manning, 2017). *In-vivo* coding (also called natural or verbatim coding) emphasizes coding in terms of respondents' own language and has its roots in grounded theory (Charmaz, 2014). I proceeded by underlining salient words and phrases on the printed transcriptions. I then generated a complete list of all

potential codes identified in this manner and listed them in a spreadsheet for ease of organization and editing.

I then organized the codes into clusters based on similarity and defined these clusters as an initial set of themes (phase three). The process of constructing a thematic structure required that I bridge the gap between the data itself and existing theory on recovery following torture. In practice this began with an inductive process working from the initial codes towards more abstract themes, and then became more deductive in nature as I began connecting the emergent thematic hierarchy to the fundamental theoretical constructs outlined in the literature review. This is the abductive reasoning approach emphasized in pragmatic epistemologies.

Having achieved a relatively clear set of initial themes, I gave each theme a shorter descriptive label and loaded them into NVivo 9, together with the complete data set of counsellor and client interviews. Using this software, I continued with the thematic analysis using *memos* to track challenges with certain themes, similarities and differences between codes, as well as potential linkages. As expected, the material demanded further development of the thematic structure (phase four). New themes were introduced, existing themes were more clearly defined, and the system was again reorganized. After several iterations I arrived at a stable thematic structure that was no longer evolving (see Appendix H).

The final thematic analysis (phase five) produced a list of extracts categorized under each code across all interviews. In the results that follow (phase six), I report the extent to which codes were expressed across interviews, and by both clients and counsellors. This aligns with the pragmatic values of inter-subjectivity and transferability. I also report typical verbatim quotations from the transcripts that illustrate the content or meaning attached to the code.

Narrative analysis

During the thematic coding process, I created an administrative (as opposed to conceptual or thematic) code labelled “Narratives”. This code was used to tag, for subsequent narrative analysis, sections of the transcripts that described a client’s experiences of trauma or therapeutic progress from either client or counsellor perspective (Waitzkin & Magaña, 1997). These stories ranged from snippets expressed in as little as three lines, to more complex narratives that stretched to several pages of transcription.

Each interview yielded multiple narratives, each one referencing different aspects of the person’s experience. Through deconstructing these stories into their common and diverse

elements, I endeavoured to systematically describe respondents' experiences of torture and recovery as documented in this dataset. These narratives expressed what appeared to be most salient to clients and counsellors, the remembered sequences of events, the important agents that supported or undermined recovery, and the perceived causes of therapeutic change.

Narrative research includes analysis of both content and form. While the analysis of content is largely subsumed under the kind of thematic analysis described above, the analysis of narrative form allows the researcher to map respondents' causal attributions, that is, it facilitates an understanding of how respondents construct the "how" and "why" of their experience. For each narrative I isolated and listed three broad components: (1) the selected moments of lived experience that the respondent described; (2) salient contextual features relating to the selected moments; and, (3) the causal inferences that appeared to link selected moments. I then deconstructed causal inferences further by compiling a list of actors implicated in the story together with each actor's actions and reactions. Some moments were not linked to any human actor's action but were left unexplained or presented as "acts of god". This type of analysis facilitates an understanding of how respondents understand their own agency as well as that of others, and how they construct or attribute causality. For the purpose of this study, I used narrative analysis to explore how respondents understood their own experiences of violent victimization, healing and recovery.

By comparing the convergence and divergence of multiple narratives across these various components, I proceeded to build testable conceptual models that were intended to reflect respondents' constructed memories and causal attributions of experiences as accurately as possible.

Trustworthiness of thematic and narrative analyses

Schwandt, Lincoln & Guba (2007) suggest that the trustworthiness of a qualitative analysis is best understood as an assessment of the parallel criteria of credibility, transferability, dependability and confirmability. Credibility refers to the extent to which a set of research results and the conclusions that those lead to comprise plausible findings drawn from a correct interpretation of participants' original views. Studies that involve lengthy and intensive contact with respondents in the field; triangulation of different methods and data sources; in-depth analysis of those elements found to be especially salient; peer debriefing; negative case analysis; and member checks are likely to be most credible. In the case of this research, the findings presented in the following chapters emerged from several years of in-depth consulting work in which the researcher had many conversations with respondents

describing the everyday challenges of their work. Observations based on this more extended contact with counsellors were confirmed in a more formal manner in the feasibility study, and then studied systematically through the analysis of these interviews. The comparison of interviews with torture-surviving clients and those with their counsellors offered an opportunity for triangulation and points of convergence and divergence are discussed in the following chapters. As described above, the analysis was iterative and two salient issues, namely the impact of recent bereavement and the presence of ongoing threat, became the subjects of more in-depth coding and analysis (see Chapters 6 and 7). Two colleagues, one a licensed counselling psychologist and the other a licensed clinical social worker, both with experience in qualitative analysis, reviewed the emergent coding system and checked substantial sections of the primary and secondary coding. Their questions and suggestions led to small but meaningful changes to the definition of several codes. My academic supervisor, Professor Gillian Eagle, supported the analysis at a higher level of abstraction, assisting me to think through some of the more complex constructs underlying this analysis. Finally, draft manuscripts of each of the four published papers were distributed by email to the participating counsellors before submission. Counsellors and clinical supervisors were asked to comment on whether they felt that the manuscripts accurately reflected the information that they had shared with the researcher and meaningfully addressed the clinical challenges facing centres. They were asked to comment on any descriptions or narratives that they felt distorted the material that they had shared. Those respondents that responded (between three and seven of the original sample) supported the overall descriptions and analyses contained within the draft manuscripts. Two minor alterations were requested during this process. I discussed both requests in more detail with the respondent and made the appropriate changes.

Transferability refers to the extent to which a set of findings derived from one study context with particular respondents is likely to hold true in other contexts and with other respondents. Transferability is enhanced in studies that offer detailed description of sampling and recruitment practices (see discussions of design, method and procedure earlier in this chapter) and rich description of respondents' context and experience. In the chapters that follow I have included (as far as the common format of scientific articles allows) case vignettes, verbatim quotations, and transcripts of interview dialogue, that offer the reader a direct window into the linguistic and conceptual world of the respondents. I hope that these words and vignettes will resonate with readers working in similar contexts and allow them to draw their own conclusions as to transferability.

The related criteria of dependability and confirmability speak to the neutrality of the analytic process and the probability that a different researcher might recreate a similar analysis, thus confirming the findings and conclusion. Dependability and confirmability are more likely in studies with a clear audit trail and tests of inter-coder reliability. In this case the original transcripts, detailed notes taken during initial immersion, final coding, as well as the coding system itself, are all available for audit if necessary. To ensure inter-coder reliability I compared the coding of the two colleagues described above with my own. Percentage agreement in thematic coding ranged from 79% to 86%. The mean Cohen's Kappa Coefficient for reliability in narrative coding was .79. Percentage agreement of 80%, or Kappa Coefficients greater than .75 are typically regarded as adequate in estimates of inter-coder reliability (Saldaña, 2016).

Summary of Ethical Provisions

Several ethical protections have been mentioned in the description of the method and research procedures above. However, given the extreme vulnerability of many of those who contributed to this research, further summary is warranted. The privacy of clients who participated in the case file analysis was guaranteed in several ways: (1) no names or other identifying details were included in the data files for this study; (2) all qualitative descriptions of events were scrubbed for potentially identifying details (such as dates, detailed geographic locations, or specific perpetrators); (3) no case files were removed from the study sites at which clients received treatment and no files were copied in whole or part. The privacy of both clients and counsellors who participated in the interviews was guaranteed by: (1) removing key identifying information from the transcripts (including treatment site, counsellor's name, and potentially identifying details in event descriptions; (2) including only very general identifying information in the published articles (for example, "a Kenyan father"); and (3) changing key identifying information in case vignettes in a manner that obscured identity without detracting from the essential authenticity of the vignette. All data was stored on an encrypted laptop computer that was always physically secured. Backups were stored on a secure server located at CVT headquarters in the United States. Any transfer of data occurred over virtual private network and never by unsecured email.

Respondent autonomy was ensured through the informed consent processes at the three study sites. As part of clients' consent to treatment, they consented to their private information being stored by the clinic for use in treatment and research. They did not consent to the use of their data for this study in particular but given the secondary nature of this

analysis, the use of this client data within the confines of the clinical facility was approved by the Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand. Interview respondents, both clients and counsellors, underwent a more rigorous informed consent process specific to this study in which they agreed separately to be interviewed and recorded.

The nature of the interviews themselves included some risk of harm through the triggering of unpleasant or traumatic memories. Interestingly, a meta-analysis by Jaffe, Hoffman, Haikalis and Dykstra (2015) into respondents' responses to trauma reactions found that although trauma-research can undoubtedly lead to emotional distress, such distress is typically moderate and that respondents generally report a positive experience of being asked about their traumatic experiences. Nevertheless, a number of steps were taken to mitigate the risk of causing distress to interview participants: (1) only clients purposively selected by their counsellors as being sufficiently recovered and stable so as to be able to participate without undue risk of traumatization, were invited to participate; (2) the information process that preceded the consent process emphasized consideration of the potential for distress; (3) interviews were conducted directly by the researcher who has worked with trauma-survivors in multiple contexts for many years and is skilled in containment and crisis counselling; (4) interviews were conducted in clinic sites familiar to the clients with the client's counsellor easily available but not present during the interview; (5) interview design and implementation focused away from past traumatic events, losses and current stressors and towards the experience of the therapeutic work. In the few cases where respondents become distressed the interviews were respectfully brought to a close, after which the person's counsellor spent some time with them before they left the clinic. In each of these cases distress was judged by the attending counsellors to be transitory and successfully managed.

Although benefit to the actual respondents was limited, counsellors did value the opportunity to discuss these clients' needs and progress with an experienced and sympathetic external consultant. The four publications have all been made available to all participating centres and to counselling supervisors at CVT. In time, the same will be true of this thesis. It is hoped that this material will assist these counsellors in their ongoing work.

Chapter 5 Counselling Torture Survivors in Sub-Saharan Africa: How Relevant are Current Evidence-Based Practices?

This chapter was originally published in the journal *Traumatology*. The full reference is Higson-Smith, C., & Eagle, G. (2017, August 24). Counselling Torture Survivors in Sub-Saharan Africa: How Relevant Are Current Evidence-Based Practices? *Traumatology*. 24(1), 36-46. http://dx.doi.org/10.1037/trm0000131

In this chapter we briefly describe the nature and extent of torture in sub-Saharan Africa (see Chapter 2) and summarize recent reviews of treatment outcome research with torture survivors (see Chapter 3). The literature review then closely examines research conducted in sub-Saharan Africa and queries the extent to which results are finding expression in the practice and research of torture rehabilitation in the region. The method section recaps analysis of case files and structured interviews (see Chapter 4) that comprise the data set for this research. The results section describes key features of the treatment-seeking population of torture survivors in the region, provides a profile of practitioners offering mental health services to this group, and examines the typical course of therapeutic process. These findings show that practitioners are seldom employing evidence-based practices, and never as stand-alone treatment protocols. Key issues that counsellors struggle with include: clients' attitudes to and understanding of mental health; the wide range of mental health concerns reported; working with complicated grief reactions; the impact of daily stressors and ongoing threat; coping with chronic pain; and high dropout rates after only a few sessions.

As such, this chapter provides a detailed description of multiple contextual factors that are critical to an understanding of counselling with torture survivors in sub-Saharan Africa. Key issues are introduced briefly and will be examined in greater detail in subsequent chapters. Finally, it is these conceptual challenges to which the counselling approach and recommendations outlined in the final chapters are intended to respond.

Counselling Torture Survivors in Sub-Saharan Africa: How Relevant are Current Evidence-Based Practices?

Abstract: Torture continues to be practiced in many countries around the world and its impact on the psychosocial functioning of survivors is profound. A great deal of clinical and research effort has been dedicated to developing an evidence-base of the most efficacious approaches to the mental health care of this population. Questions arise as to whether the evidence-based practices that have been studied are relevant to the needs of torture survivors in sub-Saharan Africa, and how they might best be implemented in these contexts. The counselling of torture survivors in specialist centres in 3 countries in sub-Saharan Africa is analysed in a mixed-method study using data derived from a review of 85 case files and semi-structured interviews with 15 counsellors and 14 clients. Results show that counsellors use a range of practices including but not limited to those with the strongest empirical base. Counsellors emphasize the diversity of needs of individual clients and the challenges of client engagement. These findings suggest that current evidence-based practices do not adequately meet the needs of torture survivors in sub-Saharan Africa or the counsellors that serve them.

The recent Human Rights Watch World Report documents torture by many governments in sub-Saharan Africa, including Angola, Burundi, Cote d-Ivoire, Democratic Republic of Congo (DRC), Ethiopia, Gambia, Guinea, Kenya, South Sudan, Uganda, and Zimbabwe (Human Rights Watch, 2016). This list is not comprehensive and does not focus on the severe crimes associated with terror groups like Al-Shabaab and Boko Haram, nor rebel armies active in the region.

The popularized understanding of torture as a strategy to extract information from terrorists in the interests of security is highly misleading when appreciating its impact in sub-Saharan Africa where torture is almost always used as an instrument of oppression, a tool to enforce obedience, silence dissent, and punish political opponents. Torture has been repeatedly documented in civil conflicts in the region, perpetrated by both rebel and government forces. It is used regularly by the security apparatus of oppressive regimes, including police and prison authorities. Torturers work to destroy the emotional and physical integrity of their victims and to isolate them from the support of family and community.

As torture in such contexts is a political act, so too is the work of rehabilitating torture survivors. Spread across sub-Saharan Africa is a network of independent torture rehabilitation centres offering a range of services to torture survivors. This research examines patterns and concerns in the provision of quality mental health services to torture survivors living in the region, in contrast to much of the existing research that assumes treatment in better resourced and safer contexts.

Mental health workers should use the established methods and standards of their professions, including interventions that are efficacious and ethically defensible, that is, interventions that are evidence-based to the extent of current empirical knowledge. Practitioners in applied settings, including those working in torture rehabilitation and humanitarian centres, have been criticized for not more fully or quickly adopting evidence-based practices (EBP) (Başoğlu, 2006). Yet counsellors must also be responsive to the pressing concerns and contextual realities of the populations they serve. This tension is at the heart of the definition of EBP suggested by the American Psychological Association (APA) (2005, p. 5), that EBP represent "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

In this article we review aspects of the therapeutic work of three indigenous torture treatment centres in sub-Saharan Africa holding in mind the competing demands of EBP and relevance to context and culture. We document the nature of the client base presenting at such centres, the profile of the counsellors seeking to address their needs, and the prevalent forms of intervention. We critically examine the extent to which the current evidence-base for counselling of torture survivors meets the needs of tortured clients in this region and is viewed as appropriate and helpful by the counsellors. Based on this assessment, we offer suggestions as to how researchers, practitioners, and policymakers might usefully advance knowledge and practice to better support survivors in these and other poorly resourced and less stable contexts.

Global reviews of treatment outcomes with survivors of torture

In the last decade more than 10 reviews have attempted to summarize different aspects of the literature on mental health treatment outcomes with torture survivors, or populations that include many torture survivors, such as war survivors and forced migrants. Some have chosen a high methodological bar and included a smaller set of studies. Others have chosen to cast their nets further, including a broader range of material.

McFarlane and Kaplan (2012) reviewed 40 studies that used prospective designs and found that most published studies showed positive effects for the treatments tested, but that the evidence does not support the use of any particular intervention over others. Patel, Kellezi, and Williams (2014), in their review of nine randomized control trials (RCTs), found no differences between therapies and controls immediately after treatment, and moderate reductions in posttraumatic stress symptoms and distress at 6-month follow up in some therapeutic groups.

In their meta-analysis of 13 RCTs of "trauma-focused therapy for refugees," Lambert and Alhassoon (2015) concluded that length of treatment (12 sessions or more) was predictive of improvement in posttraumatic stress disorder (PTSD) symptoms. They found no difference in outcome when interpreters were involved in treatment delivery and endorse the possibility of well-trained para-professionals delivering sound treatment.

Examining the literature on group approaches, Bunn, et al. (2015) emphasized the need to rebuild torture survivors' social networks and human connection. They divided group approaches into supportive and Stage 1 and Stage 2 interventions. Supportive interventions encompass nonspecific or psychosocial interventions aimed at addressing "concerns such as immigration, resettlement, housing, employment, trauma education, life skills and opportunities to connect and socialize" (p. 50). Stage 1 groups were generally time limited and focused on anxiety management, safety concerns, enhancing emotion regulation capacities, and more immediate stabilization. It was only in Stage 2 groups that trauma processing work took place and these groups were generally of longer duration and were usually conducted in post conflict or resettlement settings. It is notable that together the three types of group interventions encompass the full spectrum of issues that affect many displaced torture survivors and that all three types of intervention may be useful depending upon context and phase of life adjustment.

Weiss et al. (2016), in a review of 88 papers that provided any evidence of the effectiveness of interventions with survivors of "torture and other systematic violence," concluded that cognitive behaviour therapy (CBT) including exposure components showed the best evidence for relieving symptoms of PTSD, depression and anxiety, but that narrative exposure therapy (NET), interpersonal therapy (IPT), pharmacotherapy, and multidisciplinary therapies all warrant further investigation.

Finally, van Wyk and Schweitzer (2014) reviewed seven studies of treatment outcome in naturalistic interventions within resettlement countries. Interventions were poorly described but were commonly multidimensional and varied. Effect sizes were variable and

modest overall. The authors concluded that although the overall results support the value of naturalistic interventions it was not possible to identify the mechanisms underlying symptom change.

The conclusions we must draw from this brief examination of some of the global treatment outcome literature are disappointing but should not come as a surprise. The damage perpetrated by torturers is profound and the process of rehabilitation is complex and slow. Similarly, it is difficult to rigorously test the efficacy of multiple treatment approaches with diverse therapeutic goals with markedly different populations in various and often challenging contexts. We should not equate the lack of evidence with evidence for a lack of efficacy (APA, 2005). Reviewers have repeatedly pointed out that the research is limited and methodologically flawed (Nickerson, et al., 2011; Patel, et al., 2016). Small samples restrict generalizability and reduce the possibility of detecting between group differences, a problem often exacerbated by failure to report effect sizes and confidence intervals. Few studies use random assignment, include a control condition, or use blind assessments. Where RCTs have been conducted, reviewers draw attention to problems with integrity of blinding, high attrition rates, and incomplete data sets. Studies do not always discriminate between participants' experiences of torture, war, organized violence, and displacement, nor is much attention given to the methods by which a history of torture is actually assessed. Similarly, insufficient attention is given to the different needs of clients who have experienced single events, repeated victimization, or protracted torture, as well as those who may have witnessed the torture of others. Treatment outcomes and treatments themselves are sometimes poorly defined and described. Although research into the impact of torture documents a broad spectrum of mental health sequelae (Quiroga & Jaranson, 2005), outcome studies have focused rather narrowly on reduction in symptoms associated with PTSD, depression and anxiety. With very few exceptions, research in this area has failed to ask which treatment outcomes are viewed as most helpful either by counsellors delivering services or by torture survivors themselves. Assessment of efficacy has tended to focus on symptoms and less frequently on adjustment-related measures, but it has failed to seek and report on the more person-centred feedback that may be particularly important in thinking through the implications of delivering mainstream approaches in non-Eurocentric settings. Furthermore, even if we were to accept the cross-cultural validity and utility of PTSD and other diagnostic categories, the assessment measures used have often not been validated for use in target populations.

Patel et al. (2016) argued that some of these methodological shortcomings constitute ethical concerns. They raised questions about the use of exposure components in brief interventions conducted by relatively unqualified personnel and without establishing the level of safety required by PTSD treatment guidelines. They pointed out that adverse effects, chronicity, and duration of improvement were seldom explored in treatment outcome studies. Finally, they reminded researchers that alternative treatments of some credibility must be provided to participants in control groups.

It is evident in these reviews that a wider array of interventions is used than might be the case with conventional treatment of PTSD and related conditions. It is also noteworthy that with few exceptions the bulk of research has been conducted in developed country settings and among populations who have been resettled or are no longer resident in the countries within which they were victimized. Studies have seldom taken into account the profile of service providers in different contexts, nor considered the impact of clients' beliefs and attitudes on service delivery. Treatment in sub-Saharan torture rehabilitation centres, however, often entails offering intervention in highly unstable, under-resourced contexts that remain directly or indirectly affected by the conflicts that produced the mental health difficulties in the first instance. With that in mind we look more closely at treatment outcome research conducted with torture survivors in sub-Saharan Africa.

Treatment outcomes with survivors of torture in sub-Saharan Africa

Although not prolific, treatment outcome studies with comparison or control groups have tested various interventions with different populations in sub-Saharan Africa (some of which have been included in reviews described above). Bolton et al. (2007) conducted a RCT of group interpersonal psychotherapy (G-IPT) and creative play with Ugandan adolescents displaced by war. They found that both treatment approaches were feasible and that G-IPT was particularly effective for the treatment of depression-like symptom clusters among girls. This work is significant in that the constructs and measures used to assess treatment outcomes were culturally embedded and extended into interpersonal domains.

There is some evidence for the effectiveness of exposure- and cognitive restructuring-based approaches with populations in sub-Saharan Africa. Two studies of NET for the treatment of PTSD have been conducted with Somali and Rwandan refugees in a refugee settlement in Uganda (Neuner et al., 2008; Neuner, et al., 2004). The results suggest that NET is more effective than supportive counselling, psychoeducation, or no treatment in reducing symptoms of PTSD, depression, and anxiety. Structured trauma counselling also showed

good results. In the 2008 study, counselling was successfully provided by lay counsellors with limited training, an important contextual consideration in settings with few mental health professionals. Bass et al. (2013) compared the efficacy of group cognitive processing therapy and individual support for treating female sexual-violence survivors in the DRC. Those receiving the group therapy demonstrated significantly greater reductions in PTSD, anxiety, and depression symptoms. Sonderegger, Rombouts, Ocen, and McKeever (2011) assessed the effectiveness of a culturally adapted CBT intervention with internally displaced persons in Uganda and reported a significant reduction in anxiety and depression-like symptom clusters, as well as an increase in prosocial behaviour.

Several programs have attempted individual healing as part of peace-making and reconciliation interventions. Staub, Pearlman, Gubin, and Hagengimana (2005), working in the aftermath of the Rwandan genocide, compared trauma-informed group interventions with non-trauma informed reconciliation groups and no intervention comparison groups. The trauma-informed intervention was associated with greater reduction in trauma symptoms and more positive orientation toward members of other groups. Yeomans, Forman, Herbert, and Yuen (2010) conducted an RCT of a 3-day trauma healing and reconciliation workshop (with or without a PTSD psycho-education component) following civil war in Burundi. Both workshop formats produced a significant reduction in PTSD-related symptoms, with the format that included psychoeducation being less effective, a surprising result that the authors speculated might have arisen from an increase in distress over symptoms not explicitly mentioned in the intervention. Cilliers, et al. (2016) evaluated the impact of *Fambul Tok* ("family talk" in Krio), a community-level reconciliation intervention in Sierra Leone. They found that although social capital and willingness to reconcile improved, symptoms associated with PTSD, depression, and anxiety worsened significantly, and that this negative impact lasted for more than 2 years following the intervention. These adverse effects call into question assumptions about the individual benefits of participation in reconciliation processes. It seems possible that in cultures in which community solidarity is particularly highly valued, identifying oneself as a victim and naming others as perpetrators might have social costs and negative consequences that outweigh the assumed psychological benefits of testimony and acknowledgment. This is likely to be particularly challenging in transitional contexts in which narratives of victimization and perpetration are contested and opportunities for justice, public censure, and reparation are limited.

Igreja, et al. (2004) tested a single session of testimony therapy with survivors of war and torture in Mozambique. They reported significant reduction in PTSD symptoms and

other mental health indicators in both the treatment and control groups. This "testifying" element appears to be particularly significant in torture cases where shame is commonly a prominent affect and victims are frightened into nondisclosure. It is also likely to be important in situations where survivors feel responsible for harm to others whether deliberately intended, coerced, or unanticipated.

In Zimbabwe, Mpande et al. (2013) compared the efficacy of the locally developed Tree of Life Trauma Healing methodology, which draws on cognitive– behavioural, narrative, and testimony work, with a psychoeducational and coping skills focused program. Both interventions showed significant impact on both mental health and community engagement indicators, the latter assessed using a measure developed specifically for the target population. Both community-focused and culturally embedded meaning-making elements may be important as a complement to more conventional trauma-focused interventions.

Given the size and complexity of sub-Saharan Africa and the millions of people who have been tortured by oppressive regimes and in civil and cross-border wars, it is disappointing that only a few rigorous studies are available to guide the work of mental health practitioners. These studies have investigated only a small subset of the rehabilitation approaches currently in use at torture rehabilitation centres around the region, in part because of limited resources to move beyond offering interventions to devoting energy and skills to conducting rigorous research. However, it is evident that more research into the needs and priorities of torture survivors on the African continent is required, as well as into the efficacy of programs designed to address those needs. Practitioners and researchers continue to develop intervention strategies suited to the needs and contexts of torture survivors in the region. Pertinent questions include: To what extent do these interventions draw on the existing evidence base? How do they respond to the contextual realities of the region? Do they meet clients' expressed needs and to what extent do clients engage with services?

Method

In this article we present the results of a mixed-methods study conducted in three torture rehabilitation centres in sub-Saharan Africa: the Centre for the Rehabilitation and Abolition of Torture (CRAT) in Yaoundé, Cameroon; the Independent Medical Legal Unit in Nairobi (IMLU), Kenya; and the Centre for the Study of Violence and Reconciliation (CSVR) in Johannesburg, South Africa. Centres were purposively selected to reflect something of the political, economic, cultural, and linguistic diversity of the region.

The research findings in this article are comprised of quantitative and qualitative analyses of a representative sample of client case files, and a content analysis of semi-structured interviews with torture surviving clients and their counsellors. The review of case files offers a profile of treatment-seeking torture survivors in the region, together with a high-level view of their symptom presentations, needs, and reasons for seeking help. Client interviews provided both triangulation on this information and an opportunity to explore some of the tensions related to competing needs of intervention as perceived by clients and the way that inputs were understood within their cultural and social milieu. Review of counselling notes provided insight into the course and progress of rehabilitation, as documented in counsellor reflections and this material was also cross-referenced with client's own experience of their rehabilitation journey. To ensure trustworthiness of both findings and conclusions drawn, initial analyses were shared and discussed with participating counsellors from all three centres. In all cases counsellors confirmed the researchers' findings, offering suggestions that extended initial interpretations and conclusions.

All research participants were adults who were informed about the study aims, procedures and ethical protections before giving written consent for participation. The research protocol was approved by the Ethics Committee for Research on Human Subjects of the University of the Witwatersrand, South Africa. Aspects of the data analysis have been published previously in papers dealing with ongoing threat (Higson-Smith, 2013) and complicated grief (Higson-Smith, 2014).

Case File Reviews

A set of 99 case files was assembled by selecting the records of 33 clients from each of the three selected torture treatment centres. Case files were selected on an interval basis from consecutive lists of a total of 577 adult counselling clients seeking mental health care at the three centres. It was thought that this sample of just short of 100 files was adequate for a substantive analysis. In scrutinizing the case files, it was ascertained that 14 clients did not qualify as torture survivors when their reported histories were tested again the definition of torture in the United Nations Convention against Torture and other Cruel, Inhuman, and Degrading Treatment of Punishment (UNCAT; United Nations General Assembly, 1984). As survivors of war or organized violence but without specific experiences of torture, these clients were excluded from the overall sample producing a final sample of 85.

Case file contents and documentation standards differed somewhat between centres. However, all case files included a psychosocial intake assessment that included the client's

demographic details including legal status, work authorization, past and current occupations, income and housing situation, family structure and dependents, as well as brief summaries of current medical conditions, injuries, and prescription medications. A brief history of traumatic experiences, including torture, was also recorded, as well as items relating to the clients expressed needs and reasons for seeking treatment. Centres routinely administered clinical assessment measures, using some combination of the following: the PTSD Checklist, Civilian Version (Weathers et al., 2013), the Harvard Trauma Questionnaire (Mollica et al., 1992), the Hopkins Symptoms Checklists for Anxiety and Depression (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983). Practitioners documented subsequent meetings with clients whether for the purposes of counselling or some associated activity such as referral or assessment. These annotations also mentioned major events in the client's life including changes in asylum status, housing conditions, bereavements, illnesses and medical care, and further experiences of victimization. The structure, length, and regularity of case documentation and annotations differed markedly across the centres.

Each case file was analysed using a range of quantitative and qualitative codes that encompassed demographic indicators; duration and frequency of counselling sessions; the current status of the therapeutic work; key features of reported torture, trauma, and loss; expressed reasons for seeking assistance; as well as observations regarding obstacles or advances in therapeutic progress. Using iterative thematic analysis (Braun & Clarke, 2006), we searched across individual case files to identify repeated patterns of meaning or themes in an inductive manner. Themes were then coded at an explicit (or semantic) level to ensure that the coding system remained strongly "data-driven" (as will be evident in the tables presented in the Results and Discussion section). Initial codes were developed on site in the three torture treatment centres where the original analysis was conducted. Codes were subsequently reviewed and refined across the entire data set to ensure standardization in coding across the three centres.

In addition, all intake and, where available, follow up assessment scores that made use of recognized assessment measures were recorded. As the three centres employ different measures and because many clients reported symptoms not specifically assessed on the available assessment measures, we coded the presence of a wide range of psychological symptoms, as well as pain and other physical complaints. Such symptoms were identified either through a formal assessment measure or were documented in counsellor notes.

Results are presented as descriptive statistics. Differences between groups are described through the use of univariate nonparametric tests and longitudinal impact using Cohen's d estimate of effect size.

Semi-structured interviews

All 15 counsellors working in the three centres accepted the invitation to participate in the study. The interviews with counsellors were conducted in English and lasted 57 min on average. Interviews explored counsellors' qualifications, experience and personal motivations for work with torture survivors; approaches and techniques used in counselling; and counsellors' emotional wellbeing. We encouraged counsellors to offer illustrative examples of significant successes, as well as challenges and constraints that they experience.

As negotiated with centres at the outset, the counsellors invited adult clients who met the following inclusion criteria to participate in the research: reported torture as defined under the UNCAT and were at a point in their therapeutic process where both counsellor and client agreed that the client was sufficiently healthy to participate without undue fear of retraumatization. Counsellors were also asked to invite clients who in their opinion would be best able to reflect on and verbalize their experiences of counselling and recovery. Of 14 clients who accepted this invitation, eight were interviewed in English and six in French using an interpreter with a post-graduate psychology qualification. Counsellors were present at the centre in case the client needed emotional support but did not sit in on the interviews. Six clients were women, and the entire group ranged in age from 25 to 63 years. Six clients were citizens of the country in which they were treated and eight were refugees or asylum seekers from other African countries. Interviews lasted 45 min on average and explored access to service; frequency and duration of counselling; reasons for seeking counselling; and aspects of counselling perceived as being most and least helpful. Interviews were transcribed and analysed using an iterative thematic approach (Braun & Clarke, 2006) and aspects of this analysis have been published previously (Higson-Smith, 2013, 2014). In this article, we included selected quotations to give voice to torture survivors and those who assist them and to triangulate and elaborate on key findings emerging from the case reviews.

Results and discussion

This section comprises three parts. The first part provides an overview description of the treatment-seeking torture survivor population being assisted at the centres. This data is drawn primarily from the review of client files, supplemented in places by illustrative material in the form of quotations from the interviews conducted with clients. The second part presents an overview of counsellors' training and professional backgrounds as well as a summary of their preferred ways of working. This data is drawn from the interviews with counsellors. The third part reflects on therapeutic process and outcomes and draws again from the review of case files.

Client population characteristics

The case files documented clients from 12 countries: Kenya (22), DRC (20), Zimbabwe (14), African Republic (CAR) (9), Rwanda (9), Chad (4), South Africa (2), Angola (1), Burundi (1), Central, Congo (1), Tanzania (1), Togo (1); reflecting the proximity of centres to humanitarian crises on the continent.

Further demographic features are summarized in Table 5.1 Men and women presented in fairly equal numbers for treatment, with women often reporting rape as part of their torture. Almost two thirds of the sample reported being responsible for the care of children, adding to the burden they carried and the potential for bidirectional indirect traumatization. Occupations and income levels varied widely, and even within centres clients differed in terms of nationality, language, cultural identity and religious affiliation. Counsellors thus need to relate to a diverse client population in which the only common denominator is the experience of torture and war. Centres use a variety of approaches to manage the language challenges including counselling in a second or third shared language and using professional or volunteer interpreters (often a member of the client's family or community). Although pragmatic, these solutions present additional challenges to the counselling situation.

Table 5.1 Demographic characteristics of case review sample (n=85)

Demographic Characteristic	n (%)
Gender	
Men	39 (46%)
Women	46 (54%)
Age at first contact	18 – 66 years
Mean age (sd) at first contact	33.9 (10) years
Country of current residence	
Cameroon	30 (35.3%)
Kenya	23 (27.1%)
South Africa	32 (37.6%)
Marital situation	
Married/partnered	45 (54.2%)
Single	21 (25.3%)
Widowed	11 (13.3%)
Divorced/separated	6 (7.2%)
Children	
Caregiver to children	60 (73.2%)
Median number of children in care (n=60)	3

Demographic Characteristic	n (%)
Education	
Primary incomplete	5 (6.4%)
Primary complete	28 (35.9%)
Secondary complete	29 (37.2%)
Tertiary qualification	16 (20.5%)

A thematic analysis of the circumstances surrounding the allegations of torture produced four distinct client groups. The largest group of 34 (40%) included people who were caught up in war or genocide. Although some reported being forcibly conscripted, most were civilians who had been tortured, raped, and/or forced to witness the torture and murder of loved ones. Thirty clients (35%) self-identified as activists. This group included leaders of political opposition groups, student leaders, journalists, and lawyers who had generally suffered direct torture. A smaller group of 15 (18%) described themselves as family members of political or military leaders or activists. These clients were either seeking assistance following the violent death of a loved one or were tortured to locate or intimidate their loved ones. The remaining six clients (7%) were accused of a crime, although only one reported being formally charged. These categories highlight the ways in which torture and forced migration cut across the boundaries of education, class and income - in the waiting rooms, societal leaders mourning the loss of position, income, and stability sit across from subsistence farmers bewildered at having to navigate the world of urban health and social services.

Two centres recorded the primary reasons for which clients sought help. A thematic analysis of these revealed that the majority of clients prioritized needs that could not be resolved in the counselling room. Of the 55 clients for whom presenting problems were recorded, 28 (51%) sought help for a medical condition, 26 (45%) with a mental health concern, 26 (45%) for assistance with basic or survival needs, and 18 (33%) for assistance in legal matters including asylum applications (with some evident overlap between categories). It is hard to imagine that clients might engage deeply and persistently with the work of rehabilitation when their intrinsic motivation and primary reason for seeking help is not being addressed in a meaningful or enduring manner. At the same time, emotional needs remain

core to each person's experience as the following quotations from the client interviews reveal. A middle-aged woman living in a shelter for asylum seekers in Johannesburg sought medical assistance for chronic headaches.

> *I was getting medication but the medication was not helping … At the clinic they did all the tests and they were saying that I do not have anything that I'm suffering … Then the shelter referred me here … Since I came here I didn't miss any sessions with my counsellor … and that helps me a lot.*

Similarly, a Kenyan father sought legal assistance and was subsequently referred for counselling.

> *My son was killed sometime last year … I got so mad, disturbed … somebody advised me as to how I could try to know why my son was to be killed without good reason. I came here … I explained my matter and so far they took it … and they have been giving me some advice as far as counselling is concerned, as to how I can try to conduct myself to understand myself and to face the reality that however my son was killed without reason, one, I must agree that he died, and now that he died I should try to understand which is the way forward.*

Competing demands on time and energy in attempting to manage a range of imperatives including meeting survival needs, securing personal safety, accessing medical care, and addressing legal status and protection, were referenced in the majority of client interviews. These tensions are exacerbated by fears of social and cultural stigma associated with identifying oneself as a torture survivor and being in need of mental health care. These issues are intimately connected with later findings relating to therapeutic process and outcome and suggest that effective case management is essential to successful torture rehabilitation in sub-Saharan Africa. At the same time, as will be evident from the above quotations, clients also generally placed considerable weight on the emotional support they received in counselling and the significance of a consistently available relationship with a person who recognized their suffering.

Clients described a wide range of symptomatology associated with various disorders. Of the 48 symptoms identified in the sample, 23 were observed in more than 50% of cases and are listed in Table 5.2 in rank order.

Table 5.2: Frequency of reported symptoms of psychological distress (n=85)

Symptom	n (%)
Pervasive worries	60 (72)
Intrusive thoughts and memories	58 (70)
Difficulties falling or staying asleep	57 (69)
Generalized body pain	55 (66)
Avoiding people, places and activities associated with traumatic experiences	50 (60)
Emotional reactivity to reminders of traumatic experiences	50 (60)
Low mood	49 (59)
Anger	48 (58)
Fatigue	48 (58)
Nightmares	48 (58)
Feelings of hopelessness	47 (57)
General anxiety	46 (55)
Hypervigilance	46 (55)
Unexplained fears	46 (55)
Feelings of worthlessness or shame	46 (55)
Physiological reactivity to reminders of traumatic experiences	45 (54)
Concentration difficulties	44 (53)
Foreshortened sense of future	43 (52)
Restlessness	43 (52)
Avoidance of memories and thoughts associated with traumatic experiences	42 (51)

Symptom	n (%)
Dissociative flashbacks	42 (51)
Isolation from others	42 (51)
Exaggerated startle response	42 (51)

It was evident that many case files documented the presence of PTSD-related symptoms, including symptoms from all five clusters of the DSM–5 (American Psychiatric Association, 2013) diagnostic profile. For example, intrusion-related and sleep disturbance symptoms were the second and third most prominent features of client presentation to be noted. This PTSD related profile is not unexpected given prior exposure to multiple, severely traumatic events. However, it is also notable that a large proportion of the sample reported worry, anxiety, and fear, suggesting that other anxiety related conditions feature alongside PTSD. In addition, there was evidence of mood disorder related conditions. Suicidal thoughts or feelings were reported in 19 cases (23%). Interestingly substance abuse was reported in only seven cases (8%), split equally between abuse of alcohol and "over the counter" sleep medication.

The profile of symptom presentation suggests that counsellors need to be skilled to work with mental health conditions beyond PTSD. It is evident that it may be quite difficult to distinguish between situationally appropriate as opposed to pathological symptom presentations. For example, hopelessness, unexplained fears, and foreshortened sense of future may reflect realistic appraisal of current and future circumstances.

Bodily ailments such as physical pain and fatigue were prominent. Even when the most common physical indicators of emotional distress (such as headaches, general weakness, loss of appetite, and nausea) were excluded, 65 clients (76.5%) reported chronic and/or debilitating pain or loss of physical function of some kind. This is probably to be expected given high levels of exposure to torture, combat, assaults, and rapes, incarceration in poor conditions and forced labour (Quiroga & Jaranson, 2005). Assumptions that such presentations necessarily represent culturally inflected somatic expressions of distress need to be revisited in this context. Counsellors face the challenge of differentiating between nociceptive or inflammatory pain (which is often medically treatable), neuropathic pain (which may be less treatable but nevertheless has a physiological source), and psychogenic pain which may respond best to a psychotherapeutic intervention. Counsellors require some

basic knowledge of pain and counselling for pain management, as well as sound referral relationships with medical practitioners (notably physiotherapists).

The review of case files included 24 clients who were citizens of the country in which they were being treated (28%), many of whom had been displaced from rural communities and small towns to the relative safety of the larger capital cities. The sample also contained 21 refugees (25%), 27 asylum seekers (32%), and 13 clients who either admitted to being undocumented or preferred not to disclose their legal status (15%). Nearly half the clients whose cases were reviewed were undocumented or asylum seeking, and so lived with the prospect of being forcibly returned to the countries in which they were tortured and in which risk was ongoing. Refugees, asylum seekers, and undocumented migrants reported approximately twice as many different symptoms (combined mean was 22.7 symptoms) than clients who were receiving care in their own country (mean was 10.6 symptoms; Kruskall Wallis H=28.71, df=2, p=0.0000). Research conducted in resettlement countries has focused on the particular vulnerability of asylum seekers as contrasted with refugees (Chu, Keller, & Rasmussen, 2013). Our results confirm previous suggestions that the cities of sub-Saharan Africa are particularly challenging and dangerous for forced migrants (Higson-Smith & Bro, 2010), and that a positive asylum decision in this context offers less actual protection and benefit than in other parts of the world.

The uncertainty that colours all aspects of asylum seekers' experience is a fundamental consideration for counselling (Utržan & Northwood, 2017). It is almost impossible for insecure migrants to reflect on their traumatic past without also thinking about ongoing violence and torture affecting family and friends in the community from which they have fled, as well as the fear that they themselves might be forcibly returned to the same situation in the near future. For these clients the thorny tangle of past, present, and future is particularly pernicious, and reflects vulnerability to continuous traumatic stress (Eagle & Kaminer, 2013). Forced migrants' marginal status in their host countries also places them at risk of exploitation and limited access to resources.

Almost half of the client sample was unemployed at the time of treatment, in large measure linked to their transitory status. Less than 20% were formally employed. A significant number of clients (39) had suffered traumatic bereavement in the 2 years before they sought assistance. In many instances, the deceased was a family member and breadwinner. Thus, it is evident that many features of the clients' current living circumstances contributed to a precarious existence in which losses of many kinds needed to be processed and in which concerns about safety and practicalities such as housing, food,

medical care, and legal status were prominent. It is extremely difficult for these survivors to engage with the work of rehabilitation while simultaneously grappling with ongoing anxiety over current survival needs. Counselling needs to address psychosocial needs and fears for current and future safety, in conjunction with dealing with processing of experiences of torture and violation (Miller & Rasmussen, 2010a, 2010b).

Neuner (2010) and others have argued that traumatic or fear-based reactions represent the core of torture survivors' suffering and that other symptoms are most often secondary, arising from the struggle to cope with traumatic-stress disorders and associated loss of functioning. The daily stressors, current dangers, and layers of loss apparent in the lives of the people reviewed in this research suggest that, in some cases at least, symptoms of depression, anxiety, and complicated bereavement might arise from causes other than traumatic exposure. A narrow focus on PTSD treatment is inappropriate in such contexts and it is evident that stress and crisis management, traumatic bereavement, adjustment and identity-related existential issues, among others, are all likely to be prominent in counselling. Furthermore, it is unlikely that clients will engage deeply with counselling while being offered no direct support for their most pressing concerns.

In summary, the client data paints a picture of a diverse group of people with high levels of traumatic exposure, bereavements, and losses struggling to survive in extremely challenging, sometimes hostile contexts. Their help seeking is motivated by a range of concerns of which mental health needs are seldom the highest priority. What then is the profile of the counsellors attempting to offer meaningful mental health interventions to these clients?

Profile of counsellors working with torture survivors in sub-Saharan Africa

Of the 15 counsellors who participated in the research, the majority (11) were women. All but one was born in the country in which they were working, and their ages ranged from 26 to 65 years (median of 40). All had tertiary education ranging from 3 to 7 years (median of 4 years). Six had a background in clinical psychology, four trained in general nursing, three were social workers, one was a psychiatric nurse, and one a general practitioner who provided counselling in addition to medical care. In addition to their formal mental health training, all had participated in one or more short training courses on specialized aspects of counselling with survivors of torture. These courses were offered by psychologists associated with international nongovernment organizations. Counsellors ranged widely in terms of work experience between one and 30 years (median of 10 years). Time spent working in torture

rehabilitation specifically was significantly less, ranging from 1 to 22 years (median of 6 years).

Each respondent was asked to describe his or her approach to counselling with torture survivors. It was notable that no respondent provided a specific theoretical label for their work. When pressed, some described their work as "integrative" or "eclectic" or invented other terms to describe what it is that they do, for example "psycho-political therapeutic work."

In the course of describing particular cases, counsellors spontaneously mentioned using between four and eight different counselling approaches (median of 7). The relative frequencies with which various approaches were mentioned are summarized in Table 5.3.

Table 5.3 Counselling approaches mentioned by at least three (out of fifteen) counsellors

Counselling approach	**n**
Psycho-education - Naming and normalizing particular symptoms and syndromes; explaining the purpose, process and boundaries of counselling interventions; and, offering advice for symptom management.	14
Cognitive intervention - Disputing beliefs about the self, particularly beliefs relating to helplessness, isolation, marginalization, and guilt.	11
Work with families - Strengthening relationships and improving communication within families; and, prevention of domestic violence and protection of family members.	11
Building coping skills and resources – Teaching skills for affect and arousal regulation; identifying and promoting use of internal resources; stress management skills; self-talk; and coping with the reminders of traumatic experiences.	9
Strengths-based, empowerment and skills development approaches – Building self-esteem; planning and skills for income generation; parenting skills; threat appraisal and security planning; communication, and assertiveness skills.	9
Psychopharmacological interventions – Prescription and management of anti-depressants (most commonly selective serotonin reuptake inhibitors), neuroleptics, and anxiolytics.	9

Counselling approach	n
Promoting religious and traditional healing adjuncts – Prayer; rituals of death and grieving; family and communal healing rituals; faith healing and exorcism; and the use of traditional herbal remedies.	8
Exposure work – Intervention chiefly concerned with integration of traumatic memories and/or reduction in emotional and physiological reactivity to reminders of traumatic experiences.	7
Problem solving counselling – Assisting clients to identify and implement solutions to pressing inter-personal, social and economic problems.	6
Body oriented approaches – Helping clients become more aware of their bodies' reactions to stressful stimuli, and to use breathing, movement, stretching and massage to modify those reactions.	5
Promoting client activism – Support for activism around issues of poverty, marginalization, ongoing threat, access to services, primary mental health care in vulnerable communities, and peace-making.	5
Crisis intervention – Support in securing emergency accommodation and food, and suicide prevention.	4
Interventions to increase social support – Encouragement to make new connections, and group activities (often social in nature) designed to reduce isolation.	4
Grief counselling – Assisting clients in the processes of remembrance and mourning.	4
Client-centred approach – Approaches emphasizing equality in the counselling relationship with the work being led by the client in less structured or technique-driven ways.	3

Several other approaches were mentioned by less than three counsellors. This list included anger management, creative arts therapies, hypnotherapy, and psychodynamic psychotherapy.

Although difficult to establish in this small sample, the deployment of the therapeutic approaches did not appear to be systematically related to the gender, age, profession, years of

tertiary education, or years of experience in mental health or torture rehabilitation. Despite apparent access to the broad range of approaches as reflected in the counsellors' narratives, one highly educated and experienced supervisor argued the need for both greater depth and diversity in approaches, suggesting that given the range of difficulties with which clients present, counsellors require a "toolbox" of diverse competencies.

The results suggest that counsellors very seldom rely solely on the trauma-focused interventions most strongly supported by existing therapeutic outcome research discussed previously. In contrast to trauma-focused interventions where much of the focus is on past traumatic experiences, the majority of the approaches listed focus on the client's present circumstances. These approaches include support for solving survival and safety concerns, improving family functioning, and immediate symptom management and coping. Since the precondition of safety is not met in many instances it is difficult for counsellors to undertake trauma-focused work without fear of destabilizing the often-precarious current adjustment of clients. It is perhaps useful for counsellors to be able to work flexibly and to be able to draw on the broad repertoire of approaches apparent in Table 6.3, in part to undertake the full spectrum of supportive, stage one and stage two type interventions (Bunn et al., 2015).

It was notable that only six of the 15 counsellors had a psychological registration and it is likely that the sizable group of nurses and one doctor would have received very little specific mental health or psychotherapy training besides some core counselling and referral skills. Social work training also tends to be oriented toward social development rather than clinical work in many contexts. This counsellor profile suggests that many have had to acquire their trauma and torture specific intervention skills through on the job training, and that they may not have a strong theoretical understanding of the mechanisms that produce effective outcomes in psychotherapeutic work. It is therefore important that selection and delivery of intervention approaches and tools takes account of the range of different professional backgrounds from which counsellors are likely to be drawn and seeks to draw upon existing strengths. Treatment centres should also consider the employment of para-professionals and the training of formal and informal interpreters who often serve as co-therapists.

It was evident, as highlighted by several counsellors, that the political credibility of therapists and settings was crucial in establishing rapport with clients.

> *I think it's where I started like seeing that … we [needed] to have a strong political orientation. We did some bit of reading on Paul Friere, Franz*

> *Fanon … we need psychology that is relevant, that is going to respond to the needs of our people.*

As indicated at the outset of the article, counselling in these kinds of sub-Saharan contexts assumes political connotations as helpers need to remain aligned to human rights principles in executing their work. This may mean adopting principled positions that run counter to state policies, practices and structures, and also requires cultivating knowledge about conflict settings and actors on the continent. In addition to cultivating an awareness of regional politics, counsellors need sensitivity to a range of cultural beliefs and practices. They may need to assume the role of "cultural adaptors" and therapeutic approach must allow for fine-tuning in this respect. Cooperation with traditional and spiritual healers may be important, as may be the incorporation of such elements into comprehensive interventions.

Therapeutic process and outcome

In the review of case files, 13 clients (17%) were in active counselling when the review was conducted and 17 clients (22%) had completed a counselling process in a negotiated manner. The remaining 46 clients (61%) were recorded as having dropped out of counselling, that is, they had not participated in counselling for more than 3 months despite efforts on the part of counsellors to re-establish contact and continue or terminate the counselling work in a more appropriate manner. Although counsellors reported that a small number of clients do return after extended absences, it is likely that the majority would not be seen again. The number of counselling sessions recorded ranged from 1 to 60, albeit with a highly skewed distribution indicated by the fact that the median number of sessions was 3.5 and that 28% of clients only attended one session. Only a small number of clients (11%) received the 12 or more sessions of treatment found to be optimal by Weiss et al. (2016). It is evident that some of the briefer term interventions described previously may require consideration in these contexts and that factors influencing high drop-out need to be carefully examined.

The high incidence of client drop-out is sometimes explained in terms of the transient nature of refugee life, the costs of transport, and competing demands of family and income generation. Although these are no doubt important, they may only tell part of the story. CSVR looked more closely into their data on this issue, comparing clients who attended two or less sessions with those that attended 19 or more (Dix-Peek, 2014). They discovered that those who left later in the process provided a reason for dropping out, typically indicating

intention to leave the city for work or family reasons whereas the early drop-outs did not supply these kinds of explanations. The two groups were not significantly different with respect to baseline scores for PTSD, depression, anxiety, or pain. However, those that dropped out early reported more traumatic experiences and were more likely to provide a detailed account of these experiences early in the counselling process. It is suggested that the counselling model might not have been sufficiently protective of these clients who may have experienced an increase in distress and symptoms, a concern being addressed by the CSVR clinical team. A range of clinician characteristics was also linked to longer client attendance. More experienced, full-time clinicians had fewer clients who left in the first two sessions. Although it is possible that this is an artefact of the way cases are assigned within the team, Dix-Peek (2014) suggests that the pattern may be related to a perception by clients that these counsellors are able to provide support across a wide range of problem areas and are more flexibly available than part-time staff.

It is worth noting that across all three centres counselling sessions are not the only contact that clients have with counsellors. In fact, only half the client contacts are for what could be understood to comprise counselling sessions. The other contact times relate to the preparation of reports and letters to authorities responsible for asylum processes, and referral for emergency accommodation, food, and medical treatment.

For a number of reasons, counsellors had seldom conducted formal clinical follow up assessments with their clients. Chief among these is the fact that so many clients drop out of treatment in unplanned ways; but lack of resources and clinical approaches that do not prioritize follow up assessment are also important factors. CSVR demonstrated the highest follow up rate. Of 32 client files reviewed from this centre, 17 (53%) were followed up at least once after a minimum of six counselling sessions. Mean self-report scores for symptoms of PTSD, depression, and anxiety symptoms among the CSVR client group decreased, with modest effect sizes (Cohen's *d* ranging between 0.41 and 0.88), at least within this limited sample. These results are comparable with outcomes reported in naturalistic settings in other parts of the world (van Wyk & Schweitzer, 2014).

Interestingly, few counsellors were able to elaborate on what appeared to make counselling particularly successful or unsuccessful, beyond referring to the kinds of contextual factors raised already, such as the political credibility of services and the (mis)matching of client needs and expectations, often of a material nature, with the psychologically focused provision of counselling. Nevertheless, counsellors felt that their work was valuable and meaningful.

Conclusion

This analysis suggests that despite the enormous effort by practitioners and researchers to develop and test mental health interventions with torture survivors the field is still some way away from being able to clearly articulate a set of evidence-based practices. Although there have been attempts to encourage the use of those techniques for which the evidence base is strongest, most counsellors in sub-Saharan Africa do not in fact rely on such practices. They do report finding interventions like CBT and NET effective but include these in a longer list of useful therapeutic tools. Clients and counsellors appear to be seeking a counselling process that is broad and flexible enough to credibly address a range of direct, individual client concerns rather than focusing more narrowly on an identified or hypothesized trauma-related condition.

To be effective an appropriate treatment model for this kind of context will need to be time limited and to engage seriously with questions related to maximizing client engagement. Assessment and treatment planning processes must be manageable within client resources and the technical capacity of a broad range of counsellors. The model itself will need to include possibilities of work on current safety and stability, mourning, and family problems, alongside trauma focused treatment modalities.

Recently, this need for an expanded torture treatment intervention approach for unstable, unsafe, and under-resourced contexts has been recognized by other teams who have proposed promising models such as the Delphi-method derived CSVR treatment model (Bandeira, 2013) and the Common Elements Treatment Approach (Murray, et al., 2013). Questions remain as to whether the Common Elements Treatment Approach adequately covers some of the core areas of need identified in this article. These include the impact of ongoing threat and ambiguous legal status within the country of residence, the stress of generating sufficient income to provide for and protect one's family, and the impacts of recent violent bereavement. Similarly, we question whether the more comprehensive but open-ended CSVR model, organized as it is around 14 groups of client needs (each of which may be addressed in multiple ways), places sufficient weight on more nuanced relational, cultural, and contextual factors. Further work is needed to refine and test these emerging models for work with torture survivors in sub-Saharan Africa. As others have pointed out, research on treatment effectiveness must consider not only efficacy but also such outcomes as client and counsellor acceptability and satisfaction, client uptake, feasibility within specific contexts, and sustainability (Murray, et al., 2014). Hopefully, within this article we have been

able to flesh out and illustrate important aspects of characteristics and constraints that affect the provision and receipt of torture counselling in the under-researched region of sub-Saharan Africa.

Chapter 6 Complicated Grief in Help-Seeking Torture Survivors in Sub-Saharan African Contexts

This chapter was previously published in the American Journal of Orthopsychiatry. The full reference is Higson-Smith, C. (2014). Complicated grief in help-seeking torture survivors in sub-Saharan African contexts. *American Journal of Orthopsychiatry*, *84*(5), 487-495. http://dx.doi.org/10.1037/ort0000009.

The prevalence of sudden or violent bereavement among torture survivors in sub-Saharan Africa was one of the key contextual issues discussed in the previous chapter. This issue is tackled in much greater detail here. In this paper the prevalence and nature of sudden or violent bereavement among torture survivors from sub-Saharan Africa are described, and well as the associated mental health outcomes. I introduce theory not included in previous chapters relating to sudden and violent bereavement and describe pathological grief reactions that are qualitatively different to PTSD or depression. Only six studies were located that explore complicated grief in torture survivors, and these are reviewed. The method section summarizes material covered in Chapter 4 but adds detail of the coding and thematic analysis of sudden or violent deaths noted in the review of case files. In the results and discussion, I present illustrative case examples and argue that sudden or violent bereavement is somewhat common among treatment-seeking torture survivors and is significantly associated with poor mental health outcomes even within this highly traumatized population. I propose a three-level approach to counselling torture survivors who have experienced recent bereavement, illustrating this approach with excerpts from client interviews. These recommendations for counselling are picked up again in the last two chapters in which they are integrated into a broader counselling approach and set of recommendations.

Complicated Grief in Help-Seeking Torture Survivors in Sub-Saharan African Contexts

Abstract: Many help-seeking torture survivors in sub-Saharan Africa report sudden or violent bereavements, as well as risk factors associated with complicated grief. This mixed-methods article reviews 85 therapeutic client files from torture treatment centres in 3 countries in sub-Saharan Africa. Thirty-nine clients had lost loved ones and were at greater risk for depression (effect size 0.65) and thoughts of suicide (OR = 4.99). Qualitative analysis of case histories and interviews with clients elaborate the links between torture and complicated grief. Recommendations are offered for the treatment of complicated grief in sub-Saharan torture survivors, and implications for assessment, timing, and treatment duration are discussed.

Many survivors of torture receiving mental health care in sub-Saharan Africa have also suffered sudden or violent bereavements. Sudden or violent bereavements include deaths from accidents, suicides, homicides, and disasters, and are associated with difficult recoveries (Kristensen, Weisæth, & Heir, 2012). Among torture survivors, sudden or violent bereavements are nearly always inextricably bound up in the circumstances of the person's torture and the consequent suffering. Despite this, dominant approaches to counselling torture survivors focus primarily on direct torture-related traumatic experiences. Minimal attention has been devoted to understanding the significant links between trauma sustained during torture and associated bereavements.

In this article, I present a subset of data from a broader mixed-methods study that examines the wide range of contextual factors that impact the lives and recovery of torture survivors seeking treatment in sub-Saharan Africa. A better understanding of these factors is necessary to evaluate the contextual appropriateness of the trauma-focused treatments currently recommended, and to guide the development of more useful strategies. One feature of this population is the high frequency of recent and often violent bereavements. In this study, I explore the nature of such bereavements, and discuss their bearing upon subsequent counselling processes. Drawing on this analysis, I offer recommendations for mental health practitioners, researchers, and policymakers involved in the delivery of mental health services to torture survivors and suggest that, where relevant, considerations of complicated grief should be an integral part of assessment and treatment.

Sudden or violent bereavement

The impact of death on the mental, social, and physical health of the deceased's loved ones has been well documented by many authors, and much work has been done to identify a comprehensive set of factors that reliably predict bereavement outcome. As Stroebe, Folkman, Hansson and Schut (2006) point out, such research is important in that it facilitates the construction and testing of explanatory theories, and suggests ways in which grieving people might be most effectively supported and assisted. An integrative model of bereavement should include a broad range of risk and resilience factors, and should describe the pathways by which these factors impede or facilitate adjustment.

In keeping with interactional stress models, Stroebe et al. (2006) suggest that bereavement outcome is best understood as a function of each person's appraisal of the stressors involved in the death, and his or her capacity to cope with those stressors. They summarize work on the intra- and interpersonal risk and resilience factors that influence the appraisal of coping capacity as well as bereavement outcome. Intrapersonal factors include attachment style, personality, socioeconomic status, gender, religious beliefs and other meaning systems, intellectual ability, childhood and preceding losses, existing mental and physical health problems, age related frailty, and substance abuse. Interpersonal factors include social support, family dynamics, cultural setting and available cultural resources, religious practices, material resources, and the availability of services to bereaved persons.

In the dual process model of coping with bereavement (Stroebeet al., 2006; Stroebe & Schut, 1999), stressors are divided into two categories: loss-oriented and restoration-oriented stressors. Loss-oriented stressors are characteristics of the loss experience itself. Chief among these are the suddenness of death, the relationship to the deceased, the quality of the relationship with the deceased, and possible multiple, simultaneous losses. Restoration-oriented stressors reflect ensuing consequences such as loss of economic support and increasing poverty, conflict within families or communities, increased burden of care for children and other dependents, legal problems, media attention, and so on. Many tortured people in sub-Saharan Africa survive for extended periods with greatly diminished social support and in hostile communities. Very often they live under ongoing threat and have lost their occupation, possessions, and income (Almedom et al., 2005; Bandeira, et al., 2010; Higson-Smith, 2013; Higson-Smith & Bro, 2010).

The challenge that bereaved people face is grieving the loss of a loved one while continuing to live in a world that is very often dramatically changed. Thus, bereavement

outcome is predicted not only by risk and resilience factors, but also by the capacity to commit personal resources to coping with both loss and restoration related demands in a dynamic and oscillating manner. This kind of dual demand may be particularly pertinent to torture survivors in sub-Saharan Africa who have very often been forced to relocate because of ongoing risk and conflict in their country of origin and, therefore, face multiple adjustment difficulties.

The difficult question of when a grief reaction should be thought of as a psychological disorder remains unresolved. As Lichtenthal, Cruess and Prigerson (2004) and others have argued, a disorder is usually defined as a lasting condition involving marked distress and significant loss of functioning. Ordinary grief could be understood to meet these criteria, although it is seldom thought of as a disorder.

Various terms have been used to describe responses to sudden or violent bereavement, such as traumatic loss (Green et al., 2001) and traumatic bereavement (Raphael & Martinek, 2004). In the traumatic stress literature, exposure to the sudden or violent death of a loved one is viewed as an event that commonly leads to the development of posttraumatic stress disorder (PTSD) and/or related conditions. In the grief literature, terms such as prolonged grief disorder (PGD; Prigerson et al., 2009) and complicated grief (CG) (Horowitz et al., 1997; Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011) have been used to conceptualize the circumstances surrounding the death of a loved one as potentially delaying or disrupting a process of healthy adjustment and recovery. In expanding on the experiences of torture-survivors in this article, I have chosen to use the term complicated grief as it suggests something of the emotionally complex nature of these deaths and the grief that follows.

Complicated grief

A range of published work demonstrates that CG is conceptually and statistically independent of PTSD and depression (Bonanno et al., 2007; Lichtenthal et al., 2004; Prigerson et al., 2009), and proposes that a diagnosis of CG be made where a person experiences yearning on a daily basis or to a disabling degree 6 months or more after the loss of a significant other. In addition, at least five of the following should be reported as experienced on a daily basis or to a disabling degree: confusion about role in life or diminished sense of self; difficulty accepting the loss; avoidance of reminders of the reality of the loss; inability to trust others since the loss; bitterness or anger relating to the loss;

difficulty moving on with life; absence of emotion since the loss; feeling that life is empty or meaningless since the loss; and feeling stunned or shocked by the loss. Finally, the disturbance should cause clinically significant impairment in functioning, and should not be better accounted for by other disorders such as major depression, generalized anxiety, or PTSD (Prigerson et al., 2009).

In a review of 20 studies, Kristensen et al. (2012) list risk factors for CG identified in at least two of these. At a personal level, female gender and pre-existing mental health difficulties are predictive of increased risk; and at the interpersonal level, close kinship with the deceased, and perceived lack of social support and isolation. Situational risk factors include violent causes of death, blaming others or being blamed for the death, guilt or self-blame, life threat, witnessing the death or finding the deceased, having to wait for the death to be confirmed, having the loved one presumed dead without confirmatory evidence, and multiple simultaneous losses. Many of these situational risk factors for CG may be present in the case histories of torture survivors, as will be further explored.

It is worth noting that of the 20 studies reviewed, only four investigated bereavements because of terrorism or genocide, and all of these related to civilian deaths. Much more in known about CG arising from disasters, accidents, homicides, and suicides (Craig, Sossou, Schnak, & Essex, 2008; Kristensen et al., 2012; Nickerson et al., 2011; Schaal, et al., 2010; Silove, Momartin, Marnane, Steel, & Manicavasagar, 2010; Wittouck et al., 2011). It cannot be assumed that risk factors for CG derived from these populations apply to torture survivors, or that they have the same relative weight.

Wittouck et al. (2011) conducted a meta-analysis of 14 randomized control trials concerned with the prevention and treatment of complicated grief. The results suggest that preventative interventions have no significant effect, but treatment interventions do appear to be modestly efficacious (standard mean difference of -0.71). The goal of these interventions was to change CG reactions into normal grief reactions, and the benefit of treatment increased significantly with the passage of time after the bereavement.

Complicated grief in contexts of violent conflict

Research with survivors of war, genocide, and terrorism suggests that CG is often a long-term and debilitating aspect of their suffering. Craig et al. (2008) investigated CG in a sample of 126 Bosnian refugees resettled in the United States between 6 and 12 years earlier. Fifty-four percent of this sample scored positive for CG, with women over 55 years of age

being particularly vulnerable. Using sequential regression analyses, these authors found that CG accounted for 31% of the variance in general mental health, while PTSD predicted only 6%, suggesting that unresolved grief may be more significant than traumatization in these kinds of populations. Similarly, in a study of 126 Bosnian refugees resettled in Australia at least 3 years earlier, 30% were diagnosed with CG (Silove et al., 2010). Path analysis of data collected by Nickerson et al. (2011) from 315 Mandaean refugees from Iraq and Iran, resettled in Australia ~5 years earlier, suggests that CG mediates the pathways from traumatic exposure and bereavement to PTSD and depression. A survey of 775 Cambodians victimized under the Khmer Rouge regime revealed that 14.3% met the criteria for Prolonged Grief Disorder (PGD) more than 30 years later. The closeness of the relationship to the deceased as well as PTSD and depression scores predicted PGD (Stammel et al., 2013).

In sub-Saharan Africa, working with a sample of 40 women who lost their husbands during the Rwandan genocide, Schaal, Elbert, and Neuner (2009a) found that 12.5% met diagnostic criteria for PGD 13 years later. A much larger group reported subclinical distress and functional impairment including disruptive bouts of separation distress. PGD scores correlated strongly with depression scores and risk of suicide. A larger study of 400 Rwandan widows and orphans (Schaal et al., 2010) revealed a PGD prevalence rate of 8% with the cause of death, the number of years since the loss, and religious beliefs being significant predictors. PTSD scores were also predictive of PGD. The relationship between PGD, depression and PTSD appears complex. It is, however, evident that the conditions are not synonymous suggesting that assessment and treatment planning needs to take account of a range of different kinds of vulnerabilities in help-seekers.

This literature suggests that CG remains a debilitating mental health challenge for a significant number of war and torture survivors decades after the deaths of their loved ones. While PTSD and depression are intricately connected disorders, they do not in themselves explain the full range and course of survivors' emotional journeys. The few studies or CG in sub-Saharan populations emphasize demographic factors but have paid very little attention to the situational factors surrounding the deaths. They also offer few recommendations for intervention.

In this article, I begin to provide answers to the following specific questions:

1. How common is recent sudden or violent bereavement in samples of help-seeking torture survivors in sub-Saharan Africa?
2. Is it possible to identify particular themes in the nature of reported bereavements?
3. How common are the range of situational risk factors associated with CG?

4. To what extent is a history of one or more violent bereavements related to reported mental health in this population?

Method

This study comprised a review of a random sample of case files as well as semi-structured interviews with help-seeking torture survivors and their counsellors. The research was conducted at three sites: Johannesburg, South Africa; Nairobi, Kenya; and, Yaoundé, Cameroon. These cities are located within Southern, East, and West Africa, include Anglophone and Francophone societies, and represent a range of economic contexts. Each city is home to large populations of refugees and torture survivors, and is the base for an independent, torture treatment centre.

Case file reviews

Using interval sampling, I constructed a random sample from consecutive lists of all adult counselling clients reporting at least one incident of torture. Thirty-three clients from each of the centres were selected. However, closer examination of client histories revealed that certain cases did not in fact meet the criteria for torture as defined in UNCAT (United Nations General Assembly, 1984). These clients, more appropriately described as war survivors, were removed from the sample, leaving a total of 85 cases.

I coded each case file using both quantitative and qualitative indicators. Comprehensive demographic information and details of the therapeutic work such as duration and frequency of sessions, and whether the treatment was ongoing or properly terminated, were elaborated. The client's trauma history was recorded directly from the file with identifying information removed. In addition, for the specific purposes of this subcomponent of the research, study content analysis was employed to code the following: whether the client had experienced a sudden or violent bereavement, how long before seeking care the most recent bereavement had occurred, the cause of death (violence, accident, or natural cause), and the relationship to the deceased. In cases of violent death, I coded information about the alleged perpetrators, whether the client had witnessed the death, and whether they had experienced simultaneous traumatic stressors (including being tortured, raped, or forced to flee their home). Although rape in these cases was used as a form of torture, this crime is singled out because of its particularly strong association with PTSD and other trauma-related disorders (Johnson et al., 2010). I conducted a further thematic analysis to examine the extent to which bereaved clients were implicated in the death of their loved ones because of their

actual or suspected actions, beliefs, or identity. Four prominent themes emerged as will be elaborated in the discussion. The case files were independently coded by a colleague with appropriate experience in qualitative methodologies. Mean percentage agreement over nine coding variables was 91%.

The three centres use different measures for the initial assessment of clients' psychological functioning. For this reason, I developed a broader checklist of 48 symptoms that included symptoms associated with a range of mental health conditions, as well as pain and physical complaints commonly associated with psychological disorders. I recorded a symptom as present if it was mentioned in intake or follow up assessments, or in therapy notes. These symptoms were combined into scales for PTSD, Depression, Anxiety and Physical Symptoms, with Cronbach αs of 0.91, 0.71, 0.71, and 0.67, respectively. Overall distress, a combination of these scales, had a Cronbach's α of 0.91, indicating satisfactory internal reliability. It was not possible to create a scale for CG because the key feature, yearning for the deceased, was not systematically recorded given that at the outset of the study this was not a specific focus of interest but rather emerged as salient at the stage of analysis.

The predominant languages of counselling were English, French, and Kiswahili, although clients spoke a wide range of mother tongues and came from a many countries: Kenya (23), Democratic Republic of Congo (20), Zimbabwe (14), Central African Republic (9), Rwanda (9), Chad (4), South Africa (2), Angola (1), Burundi (1), Congo (1), and Togo (1). Virtually every person described themselves as religious, with the sample being evenly split between followers of Christianity and Islam. Thirty-four (40%) people described themselves as ordinary citizens who had been caught up in wars plaguing the region, whereas 30 (35%) described themselves as activists whose torture related to their political work. Fifteen people (18%) were tortured as a result of being closely related to a political activist. Only six people (7%) were accused of a crime, and it is worth noting that only one of these reported being formally charged. Further demographic data is summarized in Table 6.1 below.

Table 6.1 *Demographic characteristics of case review sample (n=85)*

Gender	
Men	39 (46%)
Women	46 (54%)
Mean age (sd)	33.9 (10)
Country of current residence	
Cameroon	30 (35.3%)
Kenya	23 (27.1%)
South Africa	32 (37.6%)
Legal status at intake	
Asylum seeker	36 (42.4%)
Citizen	25 (29.4%)
Refugee	21 (24.7%)
Undocumented	3 (3.5%)
Marital situation	
Married/partnered	45 (54.2%)
Single	21 (25.3%)
Widowed	11 (13.3%)
Divorced/separated	6 (7.2%)
Children	
Caring for children	60 (73.2%)
Median number of children (n=60)	3

Semi-structured interviews with help-seeking torture survivors

Counselling staff at the three centres were asked to select current clients or those who had recently completed counselling, and whom they were sure were able to reflect upon and talk about their experiences without becoming distressed or dysregulated. They were asked to select adult clients (18 years or older) who were articulate in either English or French, and who had reported at least one incidence of torture as defined in UNCAT. Counsellors were asked to invite suitable clients to participate in the study. In so doing, they explained that the goal of the research was to learn from their experience so as to better assist others who had experienced similar victimization. The counsellors explained that the researcher (myself) had worked in the field of torture rehabilitation for many years and was a trusted colleague. Ethical conditions of confidentiality and voluntary participation were emphasized. In particular, counsellors explained that should a client prefer not to participate, this decision would in no way influence the relationship with the counsellor of the centre where services were offered. Clients were offered no incentive for participation although any costs incurred were reimbursed. Fourteen clients were approached and all agreed to take part.

Six clients were interviewed in French through an interpreter with training and experience in mental health work. The remaining eight were interviewed in English. Mean interview length was 45’23”. Clients were aged between 25 and 63 years of age (mean age = 44 years, SD = 12 years), and eight were men and six were women. Six were citizens of the country in which they were receiving assistance, and seven were refugees from other countries in sub-Saharan Africa. One person had had her asylum application denied and was in the process of appealing the decision.

Interviews were conducted in private spaces of convenience to the respondents. All interviews began with a review of the purpose, method, and ethical provisions of the study. (Research procedures received prior approval from the relevant Research Ethics Committee of the University of the Witwatersrand, South Africa). I conducted the interviews in accordance with a semi-structured interview schedule informed by the literature and designed to address the research questions posed. The focus of the interviews was the basis for help-seeking, nature and course of therapeutic treatment, and what was deemed most helpful and most challenging. Interviews were digitally recorded, transcribed, and edited to remove identifying information. I did not ask questions relating directly to bereavement or CG because at the time of undertaking the study, as indicated previously, this was not a central focus. However, in the course of conducting the interviews and subsequent data analysis, it spontaneously emerged that bereavement was an important concern for many participants.

Recognition of this prompted the exploration of the issue of CG as central to the formulation of a comprehensive approach to counselling torture survivors in this context.

It should be noted that all interviews are performative in nature, that is, they are reconstructions and presentations of experience for a particular audience. In this case, the primary audience was myself, a highly educated White foreigner from a relatively privileged background, and associated with an international humanitarian organization. It is quite likely that interviewees would feel a debt of gratitude to their counsellors for the free services received and might present their experiences of counselling in a positive light. They are also thoughtful and motivated people who have a personal stake in the enhanced care of torture survivors that might lead them to emphasize perceived failings in the services received. Such is the nature of interview data and the reader should hold such influences in mind when considering the arguments that follow.

Results and discussion

To give torture survivors voice in academic research pertaining to their welfare and to provide some qualitative substantiation for the inferences drawn, I have included illustrative verbatim quotations from my interviews with clients where pertinent to the discussion that follows.

Bereavement patterns and prevalence

Thirty-nine tortured clients (46% of the sample; 95% confidence limit [CL] 35–56%) described a significant bereavement during their intake assessments or subsequent counselling. Refugees and asylum seekers were more likely to report having been bereaved than citizens (odds ratio [OR] = 2.9; 95% CL 1.1– 8.1; $\chi^2 = 4.57$, $df = 1$, $p = .0364$). Ten clients (12%; 95% CL 5–19%) described multiple bereavements. Most commonly, clients described the death of a spouse (33%), parent (31%), or sibling (18%). Less commonly, the deceased was a member of the extended family (18%), a child (10%), or a close friend (5%).

In 13 cases (33%, 95% CL 23–43%), the most recent bereavement had occurred during the 12 months before the client entered care, although nine people (23%, 95% CL 14–32%) were still suffering as a result of losses endured 5 or more years previously. (Median time for the bereaved group between the loss and entering care was 2 years.) It is worth noting that four clients (5%, 95% CL 0.5–10%) experienced violent bereavements after starting therapy. The ongoing threat endured by many torture survivors and refugees on the

continent, as evidenced in this kind of exposure to subsequent traumatic bereavements, has been elaborated in a previous article (Higson-Smith, 2013).

Situational risk factors for CG

A closer analysis of the most recent bereavements reveals that in 33 cases (85% of the bereaved group) the loved one died violently at the hand of another. Five deaths (13%) were because of sickness, and one was accidental (3%). Deaths because of violence were directly witnessed in 16 cases (49% of cases involving death by violence).

Many clients experienced simultaneous victimization at the time of the most recent bereavement. Fifteen people (39% of the bereaved group) were tortured during the incident in which their loved one was killed, and 25 (64%) were forced into exile by the incident. Eight people (21%) were raped while their loved one was killed. Seven of the eight rape survivors were women, and 33% of the women who reported the violent death of a loved one were raped during the same incident in which their loved one died. Three people (8%) also reported being attacked or threatened during the incident in which the person they were attached to was killed.

Through their choices, actions, or identities, nine clients (23% of the bereaved group) felt themselves to be implicated in the deaths of their loved ones. Through the following vignettes, reconstructed from the reported histories of four clients of these nine clients, I hope to convey something of the emotionally complex ways in which this happened.

Many activists live with the possibility that their work may have serious consequences for the people around them. In three cases, a loved one was killed because of their association with the torture survivor.

At 26 Michael was a student leader in Bangui, Central African Republic. He had grown up in the city and came from a middle-class family. He had been politically active for several years and had been repeatedly arrested by police. This had not deterred him from his political work. During this time he and his partner Martha were preparing to marry and already had a young child. Martha was not politically active and Michael's activities made her afraid. In 2005 police arrested Michael and Martha together. They were tortured in the cells of a district police station and released several weeks later. Martha died shortly afterward of complications arising from injuries suffered during her torture. Michael fled to Cameroon with their child and two years later was referred to a torture treatment centre for counselling.

In three cases, the deceased was murdered while trying to protect the survivor. In these cases, the client is left wondering what the outcome might have been had their loved one not intervened.

Gabriel (37), a husband and father of three, was surviving through subsistence farming in his rural village in Chad, when military officers visited and demanded that he take up arms to defend his country against rebels in the north-east of the country. Gabriel did not want to join but was afraid of what they would do if he refused. In an attempt to save Gabriel, his father began arguing with the officer. Without warning or hesitation this man shot and killed his father. Gabriel was conscripted, but later escaped and fled to Cameroon. Two years later he was referred for counselling by doctors who have been treating him for various nonspecific but recurring physical ailments, without success. They suspected that Gabriel's health problems had emotional roots.

At times, the harm done to clients' loved ones is a component of the client's torture and the result of premeditated choices by the torturers. The tortured person can never know what action is most likely to have saved their loved one's life, or whether they in fact had any real agency in this regard. Only one case of this kind emerged in this sample.

Ayanda (48) was a married mother of four living in Harare, Zimbabwe when she was arrested by Central Intelligence Officers on charges of treason. When Ayanda denied the charges, her youngest teenage daughter Zanele was arrested. In the subsequent interrogation, the torturers began to systematically break the bones in Zanele's limbs. Ayanda quickly confessed. At this point, one of the interrogators broke her daughter's neck. Ayanda tried to get help but received none. Zanele died and Ayanda fled to South Africa where she is still receiving care several years later. She returns periodically to visit her husband and remaining children but is unable to stay.

Finally, two clients were tortured after they were publically accused of murdering their loved ones.

Mpho (30) came from a rural South African background but completed a university degree and worked for a large company in Cape Town. When her husband died of meningitis, his parents believed that Mpho had poisoned their son. They publically accused her of murdering her husband and people in the community took their side. They did not believe that a healthy young man could die so quickly from illness. When Mpho denied the charges her father-in-law paid the local police to arrest and interrogate her. She was repeatedly suffocated using plastic sheeting but refused to confess. When she was released she fled to Johannesburg, where she has found work but remains isolated from her extended family and community.

Symptomatic indicators

Bereaved clients tended to report more symptoms than clients who had not been bereaved, although in this particular sample only the depression scale reached statistical significance (see Table 6.2).

Table 6.2 *Comparison of bereaved and non-bereaved clients on key mental health indicators*

	No Bereavement (n=46)		Bereavement (n=37)		Analysis		
	Mean	*SD*	*Mean*	*SD*	*F*	*P*	*ES*
Anxiety Symptoms	0.44	0.26	0.54	0.26	0.79	0.077	0.38
Depression Symptoms	0.38	0.24	0.53	0.23	0.85	0.006	0.65
Physical Symptoms	0.28	0.18	0.34	0.22	1.31	0.194	0.27
PTSD Symptoms	0.46	0.31	0.53	0.30	0.99	0.327	0.23
Overall Distress	0.39	0.21	0.47	0.21	1.799	0.076	0.38

The report of a sudden or violent death at intake was associated with significantly elevated prevalence in some specific symptoms (see Table 6.3).

Table 6.3 *Odds ratios and significance testing of symptoms associated with bereavement*

Symptom	OR (95% CL)	Analysis
Crying easily	6.03 (2.26 – 16.07)	χ^2=13.947, df=1, p=0.000
Suicidal thoughts	4.99 (1.59 – 15.6)	χ^2=8.449, df=1, p=0.004
Pounding heart	4.06 (1.37 – 12.01)	χ^2=6.892, df=1, p=0.009
Headaches	2.56 (1.05 – 6.22)	χ^2=4.352, df=1, p=0.037

Although group sizes are small, there does seem to be a relationship between the number of symptoms reported by bereaved clients and the length of time that has passed since the death (see Table 6.4).

Table 6.4 *Time of help-seeking impact on key mental health indicators*

	Sought help within 1 year of bereavement (n=11)		Sought help more than 1 year after bereavement (n=22)		Analysis		
	Mean	*SD*	*Mean*	*SD*	*t*	*p*	*ES*
Anxiety Symptoms	0.39	0.26	0.58	0.26	2.06	.048	0.73
Depression Symptoms	0.39	0.16	0.59	0.21	2.69	0.011	1.25
Physical Symptoms	0.19	0.17	0.41	0.21	3.03	0.005	1.29
PTSD Symptoms	0.26	0.22	0.64	0.25	4.26	0.000	1.73
Overall Distress	0.29	0.16	0.55	0.18	4.09	0.000	1.63

Something of the chronicity of CG in torture survivors is captured in the words of a Kenyan torture survivor in his 50s who had spent several years in prison. He is describing the suffering of a colleague whose parents had died while he was incarcerated. This colleague had not been informed of their deaths. He believes that earlier intervention might have helped his friend.

> *When he got home after release and he found his mother was dead, his father was dead. …. Nobody came to see him. No one! He just expected the negative and up till now, he's a madman. … It becomes impossible. It reminds me of a saying, that if you want to straighten a tree, you straighten it when it is a still, uh, green. You get me? But when you wait it will become thick, a big tree, then you cannot straighten it.*

Implications for Counselling

Based on these findings, it seems sensible that torture treatment centres in the region actively screen for sudden or violent bereavement, and assess the key features of CG at client intake. Unfortunately, because the centres included in this study do not assess for CG specifically, I am not able to accurately estimate the prevalence of CG in this sample. However, from the data available and the discussion thus far, there is compelling evidence to suggest that CG may be prominent in a significant number of torture survivors. Although many features of CG can be identified within measures of PTSD, anxiety, and depression, the core differentiating symptom, yearning for the loved one (Prigerson et al., 2009), is generally not systematically assessed. Until this cardinal feature and other symptoms associated with CG are included in assessment protocols, practitioners will remain in danger of underestimating the links between the symptoms that they observe and violent bereavement.

These results also have implications for the timing and duration of mental health intervention. In this sample, those who entered treatment more than 1 year after bereavement reported significantly more distress on all symptom dimensions than those who entered treatment earlier. This suggests that many bereaved torture survivors in the region initially believe that they will recover without professional assistance, but discover over time that their emotional suffering increases to intolerable levels. We can speculate that it is around this time that grieving clients become fully aware of the losses that they have endured and are able to begin the recovery process. It is possible that what leads some torture survivors to seek treatment is an awareness of the salience of this kind of loss in their lives, rather than the impact of the torture per se. More important, we should expect that the recovery of bereaved torture survivors may be slow, even taking several years in some cases.

Drawing on theories of recovery after sudden or violent bereavement, I propose a three dimensional approach when treatment for CG is indicated. Recovery demands that the client develop the capacity to distribute coping resources between these three dimensions in a

healthy way. The three dimensions are coping with: (a) loss-oriented stressors, (b) recovery-oriented stressors, and (c) traumatic stressors implicit in the manner of the death.

The following extracts from my interview with Francois, a refugee from the DRC now living in South Africa, illustrate the significance of these different dimensions. Francois was 19 when his father, the village chief, was burnt to death by the military for not supplying sufficient recruits to the army. He was responsible for the family farm but had made plans to study engineering at the University of Lubumbashi. The first dimension, coping with loss-oriented stressors, is characterized by yearning for the deceased.

> *Losing my father on that time, at that age …. it was like a, part of my body has been cut off. You just see the darkness! … You can't see even the happiness of living, you see? … I was just thinking about dying.*

Recovery on this dimension demands that Francois accept the death of his father and mourn his loss. Culturally determined rituals of death and mourning, both personal and communal, are particularly important as they provide the mechanisms, social support, and time frames of grief. Many torture survivors are cut off from these cultural processes, either as a result of having been exiled from their homes or because family and friends are afraid to be associated with them. Key therapeutic goals include accepting the death, mourning the loss of the person, and identifying and connecting with a supportive community.

The second dimension, that of coping with recovery-oriented stressors, is characterized by encountering increased stressors, diminished support and resources, and very often a sense of helplessness and hopelessness.

> *Of course it was that I lost everything . … Because he was always supporting me … And it's not only me, behind me there is another three young brothers. They were still small at that time.*

With many life difficulties and limited resources and social support networks, refugees are particularly vulnerable to ongoing violence, exploitation, and xenophobic aggression (Miller & Rasmussen, 2010a, 2010b). Nationals who have been tortured are often among the poorest members of society who, unable to access legal support, find themselves powerless in the face of corrupt and violent police or army officials. For the bereaved torture survivor, recovery on this dimension demands adapting to a life without the support of the deceased, a life that was already extremely challenging. Often this involves managing enormous changes to the survivor's day to day life, and the development of new skills (such

as income generation or childcare) and new support networks. Key therapeutic tools include goal setting, problem-solving, skills development, and action planning.

The third dimension is characterized by coping with the intrusive and avoidance symptoms relating to the manner of the death, as well as other forms of violence that might have taken place at the same time.

> *But those people when they come they just found my daddy there and they closed the house and put fire and everything . … They burnt everything like that. You must do whatever you want to do to escape. Otherwise you will die if you go there! … I was a little bit conscious you know. You can just imagine if they tell you that your house is burning and your father they throw him inside. Even the food which I was having in my hand is falling down from my hand, you see? So, confused!*

Recovery on this dimension demands both the integration of traumatic memories into narrative memory, and habituation to stimuli associated with the traumatic event (Foa, Keane, Friedman, & Cohen, 2009). Trauma focused techniques most commonly associated with treatment for torture survivors such as narrative exposure therapy (NET) (Schauer, Neuner, & Elbert, 2011), cognitive therapies (Bass et al., 2013; Kaysen et al., 2013), and cognitive behaviour therapy (Bisson et al., 2010) are most appropriate here.

There is a danger when working with refugees and displaced people of focusing purely on the struggle to meet basic needs, thereby ignoring the first and third dimensions proposed above. Similarly, the treatment approaches most commonly advocated for torture survivors are trauma-focused (Başoğlu, 2006; Crumlish & O'Rourke, 2010; Nickerson, et al., 2011), but these approaches may minimize the losses implicit in the first and second dimensions.

Working with his counsellor, Francois learned to separate the emotional burdens associated with his father's murder from current more adjustment-related burdens, and to commit coping resources to each in turn. Today he has taught himself English and has paid for his wife and children to come to South Africa and live with him. They live in a rented apartment and he works as a vendor on the streets of Johannesburg.

> *I am living now with my family. My children are here! … I became my own, my own father, you see? I am now able to focus on my life. Now I can phone home and found out my mother … how is she doing?*

It is also essential that counsellors not avoid discussion of the moral responsibility that survivors might be feeling regarding the death of their loved one. Theoretical work on moral injury and repair (Litz et al., 2009) suggests that it is essential to assist clients to confront any choices and actions about which they may feel guilty or ashamed. By taking responsibility for that part of events for which they are responsible, clients may be prevented from withdrawing into chronic isolation and self-condemnation. My interview with Maria, a middle aged woman from the political elite of the DRC who feels responsible for her husband's murder, touched on this issue.

> *I was always condemning myself about the death of my husband. I married him but I was feeling guilty of introducing him in the government. From there, he was killed because he was working for the government. Always, I was feeling guilty that yes my husband, I didn't shoot him or kill him myself, but it is because of me. And when I shared that with the counsellor I got the advice of saying, "No, it's not you who killed him." And that was a release for me to understand that I didn't. ... [My counsellor] told me that, "No, you didn't kill him. Don't condemn yourself. It is a matter of political problems. It happened to everybody. You're not the first woman to become widowed."*

These findings, together with stories like those of Francois and Maria, reveal that for many torture survivors, coming to terms with the violent deaths of their loved ones might be among the most important and difficult aspects of their recovery.

More research into the impact of sudden and violent bereavement on the functioning and recovery of torture survivors is needed. Although existing models of CG provide a starting point for describing this particularly vulnerable population, findings arising from other forms of sudden bereavement do not capture the premeditated cruelty of many torture survivors' experiences, nor the multiple ways in which survivors are often affected by and implicated in the deaths of those they love.

This study is limited by the reduced range of distress and dysfunction reported by the help-seeking sample. A more general population of torture survivors would likely have yielded a broader range, and the impact of sudden and violent bereavements might have been more marked. Furthermore, the three centres studied differ in their assessment protocols, measures used, and in their therapeutic approach. The training and experience of practitioners also differed somewhat between centres, as did the quality of record keeping.

Conclusions

A significant portion of people seeking mental health services at torture treatment centres in sub-Saharan Africa have lost a loved one to sudden or violent death. In such cases, a number of situational risk factors are often present. Many directly witnessed the violent deaths of their loved ones, and were sometimes privately or publically blamed for the death, or took this burden upon themselves. Multiple simultaneous events such as additional bereavements, torture, rape, intimidation, and being forced into exile are frequently reported.

In this clinical sample, reports of sudden or violent bereavement were associated with a statistically significant increase in depressive symptomatology of moderate effect size. Smaller increases in anxiety, PTSD, and physical symptoms were also recorded although these did not reach statistical significance. Torture survivors who had been bereaved were approximately five times more likely to have thoughts of suicide than those who had not been bereaved.

Trauma focused treatment approaches that are most commonly recommended for the treatment of torture survivors do not adequately recognize the prevalence of sudden or violent death and CG within this population. Those treating torture survivors should explicitly enquire about recent, violent bereavements, and tailor their treatment plans to incorporate this element where indicated. Until this happens, there is a real danger that important aspects of torture survivors' suffering will be minimized or ignored.

Finally, standing with a client in the face of death is one of the more emotionally demanding tasks required of mental health practitioners. Practitioners who work continually with the complicated grief of those who have been tortured, must do so in full awareness of the possible cost to their own emotional health, and must undertake the work with appropriate support and supervision. In my interviews with survivors, we spoke about many of the horrors of torture and war. For the most part, these narratives were told with dry-eyed determination. Only the accounts of brutal bereavements brought loss of composure and tears.

Survivor: My mother was killed in CAR [Central African Republic] …
Interviewer: I am very sorry.
Survivor: [Silent and tearful]
Interviewer: You are still feeling very sad when you talk about these things?
Survivor: [Nods silently]
Interviewer: We don't need to talk about them more now.

Chapter 7 Counselling Torture Survivors in Contexts of Ongoing Threat: Narratives from Sub-Saharan Africa

This chapter was previously published in Peace and Conflict: The Journal of Peace Psychology. The full reference is Higson-Smith, C. (2013). Counselling torture survivors in contexts of ongoing threat: Narratives from sub-Saharan Africa. *Peace & Conflict: Journal of Peace Psychology, 19*(2), 164-179. http://dx.doi.org/10.1037/a0032531

In this paper I briefly review the evidence linking experiences of torture and mental health outcomes (see Chapter 2) and describe three theoretical approaches to the relationship between past traumatic experiences and current threats (introduced in Chapter 3). The aim of the paper was to conduct a narrative analysis of accounts of ongoing threat in the lives of torture survivors in treatment, and to determine how survivors and their counsellors constructed the relationship between past traumatic experiences and ongoing threat. In the method section I briefly review the overall study methodology (see Chapter 4) and elaborate on the analytic steps used to identify and categorize narratives of ongoing threat. In the results section I describe five categories of ongoing threat emerging from the narratives and explore the complex relationship between objective indicators of danger and the subjective experience of threat. I then examine the extent to which existing theoretical approaches capture the ways in which ongoing threat is constructed and present a case analysis in which all three theories play a role in the survivor's description of her own life. Finally, I propose a descriptive framework and testable model that serves as a basis for understanding the impact of ongoing threat on the mental health of torture survivors in sub-Saharan Africa. This framework has a number of implications for counselling that are discussed. These are picked up in chapter nine and woven into an integrated counselling approach and set of counselling recommendations.

Counselling Torture Survivors in Contexts of Ongoing Threat: Narratives from Sub-Saharan Africa

Abstract: The mental health of torture survivors is most commonly conceptualized in terms of posttraumatic stress disorder (PTSD) and related theory. This body of work is based on the assumption that the trauma is in the past and that care takes place in a relatively safe environment. However, many torture survivors in Africa live in extremely precarious situations and their mental health must also be understood in relation to the continuous traumatic stress under which they live. In this paper, I present a narrative analysis of interviews with torture survivors and their counsellors. These narratives draw on constructs relating to PTSD, as well as to those associated with continuous traumatic stress. A descriptive framework of continuous traumatic stress in torture survivors is developed from the narratives and its implications for counselling are discussed.

Models of traumatic stress typically assume that mental-health care occurs within a context of relative safety. Where clients are still in danger, practitioners are advised to limit their efforts to assisting clients to achieve greater physical and emotional safety (Herman, 1992a; Weingarten, 2003). However, many torture survivors in sub-Saharan Africa, and other parts of the world, live with unavoidable danger on an ongoing basis. Practitioners face difficult clinical choices with little theoretical guidance on how best to assist these clients. In this paper, I explore how torture survivors and their counsellors understand traumatic stress responses in situations of ongoing danger. I identify constructs present in client and counsellor narratives and reflect on how these might be used by mental health practitioners to more effectively disrupt the cycles of violence and fear associated with torture and intimidation.

Torture is very seldom about extracting information necessary to protect civilians. It is typically about punishing, intimidating, or silencing social minorities and political opposition. In a very real sense, the practice of torture is a form of terrorism (Summerfield, 2003), a practice that continues to destabilize societies around the world. Not only does torture impact victims' physical health severely, the impacts on society flow from the psychological injuries sustained. The mental health of torture survivors, refugees, and war-

affected populations is most commonly measured in terms of the prevalence of posttraumatic stress disorder (PTSD) and major depressive disorder (MDD).

Two meta-analyses have attempted to summarize this body of research. Johnson and Thompson (2008) conducted a meta-analysis of 48 studies and demonstrated consistently high prevalence of PTSD in populations of torture survivors. A broader analysis was conducted on 181 surveys of refugees and conflict-affected persons in 40 countries (Steel et al., 2009). Even after adjustments for methodological variation, these studies reported large ranges in the prevalence of both PTSD and MDD, with averages of 30.6% and 30.8%, respectively. The presence of torture specifically increases the prevalence of both diagnoses dramatically.

Although PTSD and MDD are common among torture survivors the world over, these two diagnostic formulations do not necessarily provide the most complete or useful clinical picture of the psychological impacts of torture. Quiroga and Jaranson's (2005) review of the literature on the impact of torture, which included a range of studies from different parts of the world, listed a range of mental-health concerns that are significantly broader than PTSD and MDD, yet are commonly experienced by torture survivors. These authors emphasize the importance of loss in understanding the psychological impact of torture. They list the loss of close family members, friends and compatriots, physical health, employment, status and identity, as particularly salient in torture survivors. However, in order for the list to be in any way comprehensive, losses of functioning, safety, property, and cultural and community connections must surely be added. The psychological sequelae of torture reported in the literature cover a broad range, including the full spectrum of anxiety and mood symptomatology, suicidality, irritability, aggression, emotional lability, self-isolation, substance abuse, confusion, disorientation, memory difficulties, impaired concentration, impaired reading ability, fatigue, a wide range of somatic complaints, various personality changes, and sexual dysfunction (Quiroga & Jaranson, 2005).

Researchers and practitioners have struggled with how best to conceptualize the impact of torture. Thygeson (1980) proposed the term "concentration camp syndrome," and Allodi (1991) proposed "torture syndrome." Herman (1992b), observing that people trapped in traumatic situations often presented with a particular pattern of symptoms, introduced the concept of "complex PTSD." Although her work focused more on situations of domestic captivity, such as child and spousal abuse, she explicitly drew links to work with torture survivors, too. The International Statistical Classification of Diseases and Related Health Problems (World Health Organisation, 1992) includes "enduring personality change after

catastrophic experience," a diagnostic category that specifically mentions the impact of torture and is classified not as an anxiety disorder, but as an adult personality disorder (Beltran, Silove, & Llewellyn, 2009). All of these researchers' attempts to describe the psychosocial impacts of torture recognize that the pattern of symptoms observed is much broader and more complex than those described in the PTSD and MDD diagnostic criteria.

However, none of these formulations adequately explains the impact of ongoing, current threats in torture survivors' lives. In many cases, the symptoms observed and experiences reported by torture survivors may result not from their original torture, but from exposure to ongoing danger, or an interaction of the two. At least three different approaches to the relationship between past trauma and current threat can be found in the existing traumatic stress literature.

The first theoretical approach, referred to here as the past trauma approach, suggests that the torture survivor's symptoms and behaviour are primarily the result of the fragmented way memories of the torture were coded. These fragmented memories produce the primary symptom clusters of avoidance, intrusion, and arousal. More complex symptom patterns are described as arising from comorbid conditions, or as secondary or associated symptoms (Carlson & Dalenberg, 2000). Ongoing threats, if they are considered at all, are thought of as triggers for distressing memories and other symptoms, or as independent stressors adding to the allopathic load and drawing valuable internal resources away from the survivor's core challenge - that of reprocessing the traumatic memories and associated cognitions. These ideas are common to a range of therapies including cognitive processing therapy (Schulz, Resick, Huber, & Griffin, 2006); eye movement desensitization and reprocessing (Shapiro, 2001), prolonged exposure (Foa, Hembree, & Rothbaum, 2007), and narrative exposure therapy (Neuner, et al., 2004; Schauer, et al., 2011).

A second theoretical approach is an extension of the former, and is referred to here as the stress-generation approach. Neuner (2010) argues that certain mental-health outcomes resulting from past traumatic experiences intensify survivors' experience of current threats, and may actually exacerbate existing threats, or create new ones. This approach explains why torture survivors sometimes act in ways that aggravate their situations. The stress-generation approach also supports the use of interventions that address the psychological consequences of original traumatic experiences, rather than addressing the ongoing threats that might be part of clients' lives.

A third theoretical approach is referred to here as the continuous traumatic stress approach. This approach, originally posited by Straker and the Sanctuaries Counselling Team

(1987), suggests that the torture survivor's symptoms and behaviour are primarily an adaptation to living with continuous threat. Such threats are understood to be real, neither imagined nor exaggerated. Past traumatic experiences may influence the way survivors respond or adapt to their precarious circumstances, but it is the circumstances themselves that produce and maintain the client's psychological state. More recently, Diamond, et al. (2010) have proposed a similar formulation they refer to as ongoing traumatic stress response (OTSR).

This continuous traumatic stress approach is linked to work on daily stressors, summarized by Miller and Rasmussen (2010a, 2010b). Reflecting on studies conducted in several countries, these authors demonstrate that the predictive power of models of mental-health outcomes in war-affected populations is consistently enhanced by the inclusion of daily stressors. Similarly, post-migration factors are significant predictors of mental-health outcomes among refugees. Daily stressors appear to operate directly on mental-health outcomes, and to mediate the relationship between traumatic exposure and mental-health outcomes. Miller and Rasmussen (2010a, 2010b) offer four explanations for the level of impact of daily stressors: They are proximal and immediate in comparison with past events, which may have taken place far away; they are often intractable and beyond people's control; they affect everyone in the population; and, they may include stressors that are traumatic in their own right.

It is on this point that the continuous traumatic stress approach differs from existing work on daily stressors. Though daily stressors include a broad range of stressors, the continuous traumatic stress approach focuses on threats to survival that occur on a daily basis. I propose that the adaptations necessary to survive in circumstances of constant threat to life are different than those demanded by less intense stressors, and that it is these adaptations that underlie the broad range of symptoms, experiences, and behaviours reported by many torture survivors. The continuous traumatic stress approach suggests that intervention should prioritize helping people to live successfully in a dangerous world, including building the capacity to assess and respond to threat appropriately, securing and organizing material resources, and building social support networks (Miller & Rasmussen, 2010a, 2010b).

These three approaches to theorizing the impacts of past traumatic experience and current and ongoing threat on mental-health outcomes are not mutually exclusive. It is possible, that all three operate simultaneously in particular clients.

Method

In this paper, I present one aspect of the results of a mixed-methods study concerned with conceptualizing a contextually appropriate torture-counselling framework for sub-Saharan Africa. The study included a review of a random sample of case files from three torture-treatment centres, as well as narrative interviews with counsellors, clients who had been tortured, clinical supervisors, and centre managers. Only data from the narrative interviews are presented in this paper, and then, only those narratives that dealt explicitly with the experiences of work with clients living with considerable ongoing threat.

Selection and Recruitment of Participants

To reflect something of the economic, linguistic, and cultural diversity of sub-Saharan Africa, I situated my research in three large and very different cities: Johannesburg, South Africa; Nairobi, Kenya; and, Yaoundé, Cameroon. Each of these cities has a torture-treatment centre and is home to many torture survivors, both nationals and refugees. These cities are located within countries with purchasing power parity estimates ranging from U.S. $1,750 to $11,000 per annum (International Monetary Fund, 2011). They are distributed between eastern, southern and western Africa, and both Anglophone and Francophone contexts are represented.

The urban refugee population in each of these cities is large and services are few. Refugees are typically excluded from what little opportunity for employment exists within these countries. With many vulnerabilities and limited social support networks, they are particularly vulnerable to xenophobia, exploitation, and abuse (Higson-Smith & Bro, 2010). Nationals who are tortured are most commonly the poorest members of society, who, unable to access legal defence, find themselves powerless in the face of corrupt and violent police or army officials.

I invited all counselling staff at the three torture rehabilitation centres in these cities to participate in the research and all accepted - 15 in total. I conducted the interviews in English (with a mean interview length of 56 min, 41s). Twelve were women and seven had supervisory functions. Five were trained as psychologists with a four-year curriculum, three were trained as social workers, three were lay counsellors, two were trained as psychologists with a seven-year curriculum, one was a general practitioner, one was a general nurse, and one was a psychiatric nurse. All had participated in various short courses on counselling skills, trauma counselling, and torture rehabilitation. These courses were offered by psychologists associated with international nongovernment organizations. Table 7.1 contains

descriptive statistics of age, years of experience in mental-health work, and years of experience in torture-rehabilitation work. As expected, those with supervisory responsibilities tended to be older, and to have more years of experience in general mental-health and torture-rehabilitation work.

Table 7.1 Descriptive statistics for sample of counsellors

	Age	Years in Mental Health work	Years in Torture Rehabilitation
Mean	42.31	11.56	7.5
Median	40.50	11	7
Standard Deviation	11.09	8.64	5.66
Minimum	26	1	1
Maximum	65	30	22

Participating counsellors approached selected clients whom they felt might be appropriate respondents and invited them to participate in the study. Fourteen clients, meeting the following inclusion criteria, participated: over 18 years old, reported torture as defined in the UNCAT (United Nations General Assembly, 1984), and both counsellor and client agreed that the therapeutic work was at a stage where the client was sufficiently healthy to engage with the research process without undue fear of retraumatization. Six clients were interviewed in French through an interpreter with training and experience in mental-health work. The remaining eight were interviewed in English (with the mean interview length being 45 min, 23s). Participating clients were aged between 25 and 63 years of age (average age = 44, standard deviation = 12). Eight clients were men, six were citizens of the country in which they were receiving assistance, and seven were refugees from other countries in sub-Saharan Africa. One person had had her application for refugee status denied and was in the process of appealing the decision.

All research participants were adults who were informed about the study's purposes, procedures, and ethical protections before signing informed consent. Research procedures were approved by the Human Research Ethics Committee of the University of the Witwatersrand, Johannesburg, South Africa.

Narrative Interviews

Interviews were conducted in private spaces of convenience to the respondents. All interviews began with a review of the purpose, methodology, outputs, and ethical provisions of the study. I conducted the interviews in accordance with the semi-structured interview schedules outlined in Table 7.2.

Wherever possible, I prompted participants to tell me a story about whatever topic we were discussing. For example, I asked counsellors questions such as, "Tell me the story of how you got involved in torture treatment work in the first place?" and clients, "Tell me the story of how you first came to this centre for help?" In this way, I elicited narratives relating to different aspects of the healing work. Interviews were digitally recorded, transcribed and edited to remove identifying information. I did not ask questions relating directly to ongoing danger or continuous traumatic stress, as I wanted to determine the extent to which such thematic content emerged spontaneously within the data.

Table 7.2 Broad themes explored in narrative interviews with counsellors and clients

Interviews with Counsellors	Interviews with Clients
Qualifications and training	Intervention length
Work experience	Access to services
Motivations for torture rehabilitation work	Initial impressions
Characteristics of the client population	Most helpful therapeutic interventions
Most helpful interventions	Specific therapeutic interventions
Therapeutic relationships	Unhelpful therapeutic interventions
Models or approaches to counselling	Therapeutic relationships
Issues involved in counselling tortured clients	Final recommendations
Intervention constraints arising from the client	
Intervention constraints arising from organization	
Intervention constraints arising from community	
Counsellor's emotional health	

Thematic and Narrative Analyses

Narrative analysis is a social constructionist approach which posits that the self is essentially storied, that we define our selves, at least in part, through the stories that we tell about ourselves, as well as those that others tell about us (Sarbin, 1986). Narrative researchers differ as to exactly how "narrative" is to be defined. Waitzkin and Magaña (1997)

note that narratives are often fragmented, interrupted, or referenced in passing. I have adapted these authors' work to my investigations, defining narratives as attempts at storytelling that portray the interrelationships between the therapeutic work of torture survivors and their counsellors, and the economic, political, and cultural context in which that work takes place.

Narratives, like all forms of self-report data, are performative in nature, that is, they are reconstructions of experience for a particular audience within a particular context. In this case the audience is myself, an English-speaking, South African man of European descent who grew up and was educated under the apartheid government (and perhaps also the participants' imagined interlocutors who would apprehend these stories). I have worked in the fields of torture rehabilitation, war trauma, and peace building for over 20 years, originally in South Africa, but more recently in many African countries as well as parts of Southeast Asia, the Middle East, and Eastern Europe. At the time of conducting these interviews, I had had a professional relationship with each of the counsellors for between one and eight years. I have visited all the centres included in this research regularly over many years to provide training, consultation on programming, personal mentoring and support to staff. As an educated foreigner, I am associated with international nongovernment organizations and funding agencies that underwrite torture-treatment work in sub-Saharan Africa. Counsellors and clients understand that the ongoing availability of such services depends upon the goodwill of international supporters.

Ongoing threat themes emerged strongly in five of the 15 interviews with counsellors, and within these interviews I identified 12 distinct narratives. The counsellor narratives must be read as accounts constructed by one professional mental-health worker for another. Certainly questions of professional respect, pride in one's work, a desire for understanding and support must inform both the content and form of the narratives.

Ongoing threat was a significant theme in four of the 14 clients' interviews, and these interviews yielded eight separate narratives. I had not met the clients prior to the interviews. These narratives, therefore, are accounts constructed for a relatively privileged, foreigner and stranger who obviously has some influence in the clinic. Some are presented as appeals for sympathy and greater assistance. Others have the tone of fierce independence and a demand for respect.

Miller (2004) uses the metaphor of frontstage and backstage, in his writing about the relational context in which all research with refugee communities takes place. I argue that this metaphor works equally well for the counsellors in torture treatment centres. My years of work with these centres have earned me the right to visit backstage, to see something of what

goes on behind the scenes. Nevertheless, these narratives should not be read as an objective account of reality.

The analysis presented here represents my interpretation of counsellors' and torture survivors' constructed narratives of their own experience. These narratives do not refer to random moments of experience, but to moments of particular significance: moments of joy or suffering, accomplishment or disappointment, connection or betrayal, and moments that represented turning points in the course of the storyteller's life. Stories locate individuals' lived experience in time and place, positioning those significant moments in relation to particular places, events, and people, and within broader social, political, economic and cultural contexts. They link the past to the present, and allow people to project their selves into the future. In creating their narratives, clients and counsellors tell themselves and their audience where they come from, where they are today, and where they hope (or fear) they will be in the future. Their stories include a cast of characters, each to which levels and types of agency are attributed. Finally, narratives include events, which the narrator places into a particular sequence, and between which the narrator suggests particular causal links. In this way, the narrator constructs and communicates a personal theory of the impact of past and present experiences, as well as of how counselling has impacted his or her life.

An analysis of narrative involves an investigation of both content and form. At the thematic level, I began by identifying the kinds of ongoing threat described in the narratives. I clustered the narratives into five thematic categories; these are presented in the first part of the results section.

Thereafter, and still on a thematic level, the presence or absence of each of three underlying constructs was noted. These constructs are associated with the three theoretical approaches to the relationship between past trauma and current danger, outlined in the literature review, and are defined in Table 7.3.

Table 7.3 Definitions of three key organizing constructs

Past trauma construct: The presence in the narrative of emotional or behavioural responses to actual current danger that the narrator describes as a post-traumatic stress response resulting from past torture or other traumatic experiences.

Stress generation construct: The presence in the narrative of emotional or behavioural responses which the narrator describes as resulting from past torture or other traumatic experiences, and as resulting in increased danger or increasing reactivity to existing dangers.

Continuous traumatic stress construct: The presence in the narrative of emotional or behavioural responses to actual current danger that the narrator describes as resulting from living under conditions of ongoing danger.

The second part of the results section describes the ways in which these constructs appear in the narratives, and what this suggests about the way torture survivors and their counsellors think about the relationship between past trauma and current, ongoing threat. This step essentially explored the form of the narratives. I began this process by coding each narrative in four ways:

1. A list of actors was compiled. The most common actors in the narratives were the client, the counsellor, the client's children, other family members, and the police.
2. Each actor was then linked to his or her actions and reactions. Examples included "policeman - visits client's home and threatens her," "client - locks herself in her home," "client - calls counsellor," "counsellor - tries to calm client over the phone," "counsellor - suggests client get legal advice."
3. Events that were not linked in the narrative to an actor's agency were listed, for example, "client's child gets sick."
4. Each event was then linked to the results of that event as presented in the narrative. For example, "child gets sick – client misses an important appointment."

This analysis provides a sense of how these torture survivors and their counsellors construct the "causal explanations" that underlie their understandings of the client's mental health and the therapeutic work. In the third part of the results section, I present a more detailed analysis of a single therapeutic process through the separate accounts of client and counsellor.

Finally, by overlaying the narratives and generalizing between the kinds of experience reported and "causal attributions" made, I was able to build a descriptive framework of

continuous traumatic stress in torture survivors. In doing this, I worked to create the simplest framework that could encompass all the narratives in my dataset. I present this framework in Part Four of the results section as a starting point for further discussion and empirical testing.

To ensure inter-coder reliability, I trained an additional coder who coded six narratives (three client and three counsellor). Kappa for thematic coding of the narratives was 0.79, and the mean percentage agreement for the analysis of form was 81%.

I shared a draft of this paper with a subset of the counsellors I interviewed and asked for feedback as to the accuracy of my recounting of their narratives and the appropriateness of my interpretation and conclusions. Eight counsellors responded and all said they felt that my analysis, descriptive framework, and conclusions matched their own experience. Several suggested further points, some of which I have incorporated into the text.

Results and discussion

Part One: The nature of continuous traumatic stress in this population

The narratives analysed in this paper are drawn from the experiences of people who have survived torture and continue to face threats to their safety on a continuous basis. Though they have these two things in common, these narratives vary greatly. By classifying the threats reported in the 14 client narratives, I hope to provide the reader a sense of the range of continuous traumatic stress reported by this population.

One category is continued harassment by the original torturers or their colleagues. A young man who has laid charges against the police relating to the deaths in custody of his father and brother is continually harassed by the alleged perpetrators' colleagues; the family of a detained activist is visited everyday by the police so that nobody in the community is brave enough to interact with them; and a journalist who is being hunted by the military and lives in hiding while searching for a way out of the country.

A second category relates to ongoing threat from police, army, and other government offices. This category includes a man who has repeatedly had his roadside vendor stand destroyed by police when he refused to give them his produce for free and a woman whose asylum papers were destroyed at a roadblock and now lives with the ever present fear of deportation.

A third category relates to threats from members of the community and neighbours. A mother and child are summarily and illegally evicted from their home by an unsympathetic landlord, a young man is threatened and then beaten by xenophobic neighbours, and two

refugees describe how enemies from their country of origin attacked them in their host country.

A fourth category is that of domestic violence and includes a mother with children forced to move into her abusive mother-in-law's home after her husband is arrested, a women being physically abused by her husband after his return from detention, and, two children who are subjected to abuse by their parents.

A fifth category is that of sexual violence. One respondent described the constant sexual harassment that she and other women are subjected to on the streets of major cities in sub-Saharan Africa. She described how unfamiliar men felt entitled to make openly sexual remarks and suggestions, expecting her to be flattered.

It is important to note that the line between actual danger and daily stressors is not easily drawn. It seems reasonable to define continuous traumatic stress, in parallel to Criterion A1 of the PTSD diagnosis in the *DSM-IV-TR* (APA, 2000), as ongoing threats to physical safety and survival, as opposed to daily stressors which may not be life threatening. However, these narratives reveal that the difference is not always that clear, an observation that also came out of the dialogue between Neuner (2010), and Miller and Rasmussen (2010a, 2010b).

Although there are certainly narratives where the continuous threat is unquestionably life threatening, there are also those in which factors that might generally be categorized as everyday stressors become life threatening in very precarious situations. Two examples from the narratives illustrate this.

In the first, a counsellor emphasizes her clients' determination to keep a roof over her children no matter the cost. In this case, the client is a Congolese woman with two teenage children. Over several years, she and her counsellor have explored various possibilities by which she might earn a steady income and stabilize her life. Though there have been small successes along the way, the fact remains that she has few resources in an extremely hostile environment. A previous period in which they could not afford to pay rent left them literally struggling to survive.

> *Whatever money they earn goes into the kitty to pay for rent. That money does not get touched. They would rather go hungry than not have money. Because they know how it is to be homeless, and "No! We'll never! We will not allow ourselves to get into that space!"*

In this narrative, saving enough to pay rent at the end of the month has greater imperative than eating, the most basic act of survival. A second example comes from a counsellor working with a young activist from Zimbabwe who has applied for asylum in South Africa and is living in Johannesburg. This man's asylum application papers have been destroyed and he is facing deportation back to Zimbabwe. If this happens, he believes he will be killed by supporters of the ruling party. In desperation, he appeals to his counsellor for help, even though they both know that there is very little that the counsellor can actually do, as refugee reception centres in South Africa are overwhelmed by the number of asylum applications being logged in the country. The counsellor describes the pressure that he experienced when confronted with this request.

> *I mean, there is, is that conflict around, you know, your training, like you need to be boundaried … But now, this is like a genuine case, you know? Where it's like, um, it's do or die, you know? "If you don't, then I'm dead! If you do, at least I'll survive!" You know? … So then you, you spend a lot of time like, you know, writing all those, you know, letters.*

On the one hand, writing these letters of support seems like such small assistance in the face of the client's urgent need. And yet writing such letters must change the therapeutic relationship dramatically, as would not writing them. Counsellors working with people living with ongoing threat must face these choices on a regular basis.

These cases illustrate the repeated failures by governments and communities in sub-Saharan Africa to adequately protect and support asylum seekers. As both of the aforementioned people continue to struggle for a better life, one wonders how long they can continue to do so, especially when the distinctions between everyday stressors and life-threatening events are blurred. For people whose circumstances are so precarious, having one's asylum papers destroyed, being evicted, not being able to earn enough to pay rent, and many other daily stressors become literally life threatening.

Part Two: Meaning making, past trauma, and current threat

Not one of the 20 narratives analysed was constructed purely in terms of the past trauma construct. This is striking given that the dominant theoretical construct underpinning counselling with torture survivors is past trauma. Past trauma was used in combination with other constructs in four counsellor's narratives. An illustration is the case of a young man who reported physical abuse by his father as a small child. He was placed in an institution

that he described as a "reform school," where he reports being subjected to further physical and emotional abuse. Later he was accused of belonging to the *Mungiki*, a movement of disenfranchised youth associated with criminal and political violence, and against whom the Kenyan police have been accused of acting without restraint. Following medical treatment for torn ligaments in his shoulders, allegedly sustained after being dragged behind a police vehicle, he was referred for counselling. According to the counsellor, the work began well, but after the fourth session, in which she reminded him that she could only provide brief psychotherapy and that they should try to achieve their goals within six to eight sessions, he abandoned counselling and avoided her attempts to contact him.

> *[He] took it upon himself to kind of run away from the situation … but I could understand. We never dealt with his early childhood issues because this was very, you know, the rejection he went through as a child is in fact now, now he is an adult, he is going through equally very rejecting issues. Because he didn't feel guilty for anything. It's just that he's the victim of this.*

She links his response to his past experiences of being betrayed by people who were supposed to take care of him. We can speculate that he would rather rely on his own resources than risk trusting others. Though this may have been protective in the past, in this instance, his untrusting self-reliance is preventing him from receiving the assistance he needs.

The stress-generation construct emerged in two of eight client narratives, and six of 12 counsellor narratives. An activist from the Central African Republic was forced to flee with his young family after political enemies, who were looking for him, murdered his father.

> *But after that, I get more, more traumatized from the place here … I thought maybe the same problem that I, that makes me to flee my country is that the same problem that I came meet here. You see? Because I couldn't found peace of my heart, in my heart, in myself. You see?*

He describes how memories of his past resulted in his responding badly to further threats in his host country, a form of catastrophic thinking that made it more difficult to establish life as a refugee.

Another male client, this time from Rwanda, describes how he had given up on any future for himself and was bent on exacting revenge, even at the cost of his own life. This fatalistic position that almost invites danger was present in several narratives: "Because I was

just in, in the middle of life, which can maybe any time I'm gonna go to revenge. … No, I'm just here for a time. I'm gonna go back. [laughs]."

In another case, a young Kenyan woman endangers her safety when complimented by a tout, a clear example of the client's behaviour negatively impacting her safety: "She came in, and the reason why she wanted to deal with her anger is because she had beaten up a tout [laughs]. …"

I said, "What was that? So that man, he could have beaten you up! You are putting yourself in danger."

[She said,] "Oh, he said I was beautiful." And it struck me, that, okay, so I asked if she had in her past life someone who told her she was beautiful, that she felt important.

She said, "Oh yeah. When a man says that, he wants to take advantage of you."

These examples illustrate how some torture survivors adopt strategies such as determined self-reliance or fatalism to survive in a continuously threatening world. Others may see threats in their current environment through the lens of past traumatic experiences. In either case, these responses may result in increased stress and danger.

Six out of eight client narratives were dominated by the continuous traumatic stress construct. A young Zimbabwean living in South Africa, a country which has become notorious in recent years for xenophobic attacks on foreigners, describes his experiences.

> *[People in my community are] saying that, "Here, you can't live here!" Where foreigners are killed. Where foreigners are chased, you see? If you want to go and open a business, "Foreigner! Makwerekwere!" They chase you out. … If you go with your documents you say that I'm going to look at a job somewhere they will just look at your document and take it and throw it out. Then I was already losing hope. I say, "Ah," and thinking that how can someone came to, to be a refugee and then the government, they are the one who is supposed to protect us, and they only gave a document and tell you, "Go and sleep outside."*

This client emphasizes how any attempts to create a life are thwarted by repeated attacks from multiple quarters, including neighbours, potential employers, and government agents. These repeated attacks leave him feeling abandoned and hopeless.

A refugee from the war in the Democratic Republic of Congo describes an attack by people from his own country.

> *And one day they come there. They found me at my place, one of them. I didn't know because it was little bit dark and I was just sitting at the, in the front of the door like that. I heard someone calling my name and when I turned like this I found another one was next to me already. I tried to run in my house but one is stronger …*

He recounts his failed attempts to gain protection from the police and the resulting sense of constant danger. In conversation with his counsellor he decides that the only thing he can do is move on once again. He describes how, by being extremely pragmatic and lowering his expectations, he is able to survive from day to day, never achieving a stable life, but also never surrendering.

Then I asked [my counsellor] about it. I told her about what is happening to me and I went to the police and opened a case, but the police doesn't want to arrest … Then I tell [my counsellor] of this story … she just advised me to move on.

Eight out of 12 counsellor narratives were also dominated by this construct. Here a Kenyan counsellor describes her client's mental defeat and emotional collapse following multiple bereavements and ongoing threat from the police.

… I also had a lady … whose son was also shot dead by the police. And her husband had died a year ago of liver cirrhosis. … At 52, she was kind of, you know, completely disoriented. The son, you know, was, kind of, had kind of replaced her husband's role in terms of providing and here she was, seeing no future, you know, really, purely doom. Her other son was also being threatened by the police because he would be as a possible claimant against, you know, the police for what they did, so he was also on the run. He was able to adjust his life to the new situation where he didn't feel directly threatened, but this lady, was really seeing everything as doom, you know, catastrophic thinking.

A different Kenyan counsellor tells another story featuring an older woman.

[This] client had been tortured and she had to go back to the same compound with her sons. … The older son … has been numbed by this, so much so that when he walks he wouldn't even, he doesn't have the confidence. He is struggling with he could not protect his mummy, and still cannot because of the system. The police harass him, are harassing him! Anybody who comes in the compound is looked at with suspicion. … And looking at how the whole family, that was neatly bound together, and were able to fend for themselves and doing

very well, are being reduced slowly. It's like they are being sliced slowly! Slowly! Because now [the mother] cannot do the farming that she used to do because of the beatings. Even the son can't walk with the head high. Right now the mother is actually sharing a room with one of the cows in the compound and there is not much he can do. People look at them, "Oh your mother was just being beaten there and you couldn't, you couldn't help her."

We are presented with a picture of emotional collapse and helpless paralysis. In this case there is the added layer of a family from whom every social and material resource is being systematically removed. In a situation like this, the counsellor must ask whether it is his helplessness in the face of witnessing his mother's torture that is affecting the son so deeply, or the fear, shame, and poverty that have resulted from the continued harassment by police and increasing isolation from the community.

Part Three: Complex narratives of past trauma, stress generation, and continuous traumatic stress

Two narratives in this collection made use of all three organizing constructs and illustrate how clients and counsellors use these constructs in combination, thereby highlighting that actual experiences are often much more complex than the dominant theoretical approaches available to us. I summarize one of these narratives here.

Agnes (not her real name) is a refugee who is being pursued by her original torturers in her country of asylum. At the time of our meeting, her application for relocation was far advanced and she was hoping that she and her two younger children would be able to move soon. Without being asked, she wanted me to hear her story.

The story I can share with you is a story which might be forgotten, but for me it's important. It is when the soldiers came to my house and they took me and my husband. I was raped in front of my husband and in front of my children. I had a child who is 18 years old. They asked my son to rape me and the husband was burnt alive. I dug the grave of my husband together with him. We were thinking that maybe they would bury other people there, but I was digging our grave … In prison I was beaten up and I was raped. I was having wounds everywhere. All of that gave me this kind of sickness.

As in other narratives we see severe mental defeat and emotional collapse. In fact Agnes has suffered multiple psychotic episodes and been repeatedly hospitalized.

I couldn't take care of my children. I couldn't see that there is a future in front of me. And even my body was paralyzed. I couldn't even walk. I was thinking that I could not be able to do anything. I was only taking my medication, then sleep, taking medication, and sleep. I was having heavy head, like a storm on top of my head. My heart was very, very heavy. It was like I couldn't breathe. Sometimes I was asking my children, "Am I breathing?" And the children will say, "Yes, you are breathing." I could feel that my face in front was at the back of my head, and the back of my head was the front.

Eventually, with the encouragement of her counsellor, Agnes confronted her past trauma in therapy.

When I shared that story with my counsellor, when I arrived at home I was very, very sick. … Arrived at home I was seeing the scenario of what happened and I was becoming like crazy. I couldn't sleep. I couldn't eat. I couldn't allow people to approach me. I [would] go down the park and sit lonely there. It was terrible for me. Terrible!

She seemed to emphasize the difficulty of revisiting her past experiences and so I asked her if she was sorry that she had told her story at that time.

No. I like sharing the story . . . Because the burden that I was carrying, it was revealed. It was loosed. For me it was like being free . . . When I shared that to my counsellor I was set free. I couldn't feel that heaviness that I was having. It was like that.

In telling her story, Agnes focuses on her traumatic past, her sickness, the experience of confronting the traumatic past including a short-term worsening of her symptoms, and the longer term relief that came through the process. So far Agnes' narrative relies completely on the construct of past trauma. It is interesting that when Agnes' counsellor talked about their work together, her focus was somewhat different.

She was a functional psychotic when she was first referred to us. We worked with her, tried to get the shelter staff to provide her support, you know, just getting her together … because it's those moments where she goes psychotic that are quite difficult … there was one time after she left the shelter that she was staying with this woman. She stole money from this woman. She said she needed it. And then she comes here with a bag of clothes - clothes that had holes in it … I got so worried about her. Oh dear! Do we need to hospitalize her, or what? And I was thinking of the two children.

The therapist focused on Agnes' safety and living arrangements, aspects of her life that Agnes herself hardly mentioned but which were clearly somewhat precarious. The therapists' narrative began with questions of continuous threat and stress generation, and continued in this vein with a story of Agnes considering a return to her home.

"So she was quite stressed end of last year, early this year, when her, everybody, she felt that everybody ganged up on her and wanted her to go back home. And I, and she, almost believed it."

[Agnes] said, "If I go to the border town, then maybe I will be safe."

I said, "Who told you? Because if people are still looking for you … then they will hunt you down."

But she says, "But life here is nothing. Why suffer here?"

And I said, "So, if you get arrested?"

"Well," she said, "then that's the price I pay. Then at least my children will be back home safely, not suffering the way they are here."

And I said, "But what makes you so sure that they will not be arrested with you?"

In fact, Agnes did refer to these events too, but in a somewhat more offhand manner.

I was having this idea of going back home. And I had already taken a decision to go home. But when I spoke with her, shared with her, and explained that problem, she advised me. And the advice I got really helped me to change my mind … Because she made me see the danger that might be happening if I were to go, and also what might happen to me. And then I understood.

However the story is told, it seems that Agnes was exhausted by her life in exile and overwhelmed by pressure from other people. In this state, she almost made a very poor decision, because the country to which Agnes wished to return is still at war, and her enemies are still very aware of her movements. In light of this and her personal history, it is quite likely that returning home would have been disastrous. As in other cases, Agnes became fatalistic and almost invited in the danger that she has struggled to evade so hard and for so long. Should we classify this part of the story as an example of stress generation or of continuous traumatic stress? Has Agnes' traumatic past contributed to this poor decision? Or, could we imagine that an otherwise healthy person, pursued by her enemies and exhausted by living in a strange, hostile country, might make similar choices?

As Agnes' case illustrates, the constructs underpinning the narratives told by client and counsellor greatly influence the treatment goals and methods employed. For this reason, helping counsellors reflect more critically on their own thinking and assumptions is of the utmost importance. Theory provides the tools with which counsellors do this. Though the constructs of past trauma and stress generation are clearly mapped out in the literature, there is not yet a coherent framework to guide counsellors' thinking about continuous traumatic stress. By expanding the theoretical tools available, I hope to assist counsellors to more fully apprehend the complexity of people's lives in relation to past trauma and ongoing threat.

Part Four: A descriptive framework of continuous traumatic stress

Each narrative arises out of a past which included torture and other traumatic experiences, and describes a present in which danger remains a central feature. For many, the emotional, social and physical consequences of past traumas remain central to their current lived experience. For some, however, their torture is truly history and current dangers eclipse the past (see Figure 7.1).

It is common when torture survivors first seek assistance, that their core challenge is to build a safer, more stable life for themselves and their families. Many torture survivors spend years struggling to recreate a decent life for themselves and are often repeatedly thwarted in these attempts. As one client running a barbershop on the pavement commented,

... those police they come. They wanted to cut for free, to shave the beard for free. I refused for them. They say, "No, we are the ones who have money. We are gonna come and chase you here because you are using your business next to the road.

Government agents in both their own countries and countries of refuge are often hostile, and mechanisms for the protection and support of refugees are often overwhelmed.

I was not formally charged . ... at the end of seven months I'm told, "You are dismissed. Go away." It is very bad. ... but there was a curfew. After we were released that, you know, you don't, you know, go out from your locality for a period of time. So we were, I was informed, I was required to report to our respective location chiefs every week.

Family, friends, comrades, and members of the community are often afraid to become too close to torture survivors, or are also hostile.

Then I was in trouble in my house. They wanted to kick me out. I came here (the counselling centre) and I explained it.

Without support or opportunities, many torture survivors struggle and repeatedly fail to create a safe and stable life. Various strategies are available to the counsellor at this point. She might focus on past traumatic experiences, hoping that improving overall emotional and interpersonal functioning will increase the likelihood of her client being able to build a safer, more stable life. Alternatively, the counsellor might assist the client to secure the necessary resources and opportunities to make her life safer, in the hope that a reduction in external threats and stressors will facilitate the client's psychological recovery. Equally, she might assist her client to cope better with ongoing threats and instability, hoping that persistence will ultimately result in the client's situation improving. All of these appear to be valid strategies and the counsellors participating in this research made use of a broad range of techniques: trauma focused techniques; psycho-education; affect regulation strategies; anger management techniques; problem-solving and planning; and, referral to other complementary service providers.

I propose that counsellors working with clients in situations of continuous traumatic stress must repeatedly evaluate these various strategies, and choose between them. These are complex decisions made under conditions of uncertainty for at least three reasons: (a) the line between continuous traumatic stress and daily stressors is often blurred; (b) clients' experiences commonly comprise a complex intermingling of continuous traumatic stress, past trauma, and stress generation factors; and, (c) the direction of causality might be in either, or both directions. How should counsellors decide in the case of a particular client whether the consequences of past traumatic experiences underlie the ongoing threat and instability in a client's life, or whether that threat and instability is maintaining the psychosocial sequelae of past trauma? Though no framework can provide the answers for every counselling situation, counsellors with a strong theoretical understanding of continuous traumatic stress will be able to make these choices in a reflective and strategic manner.

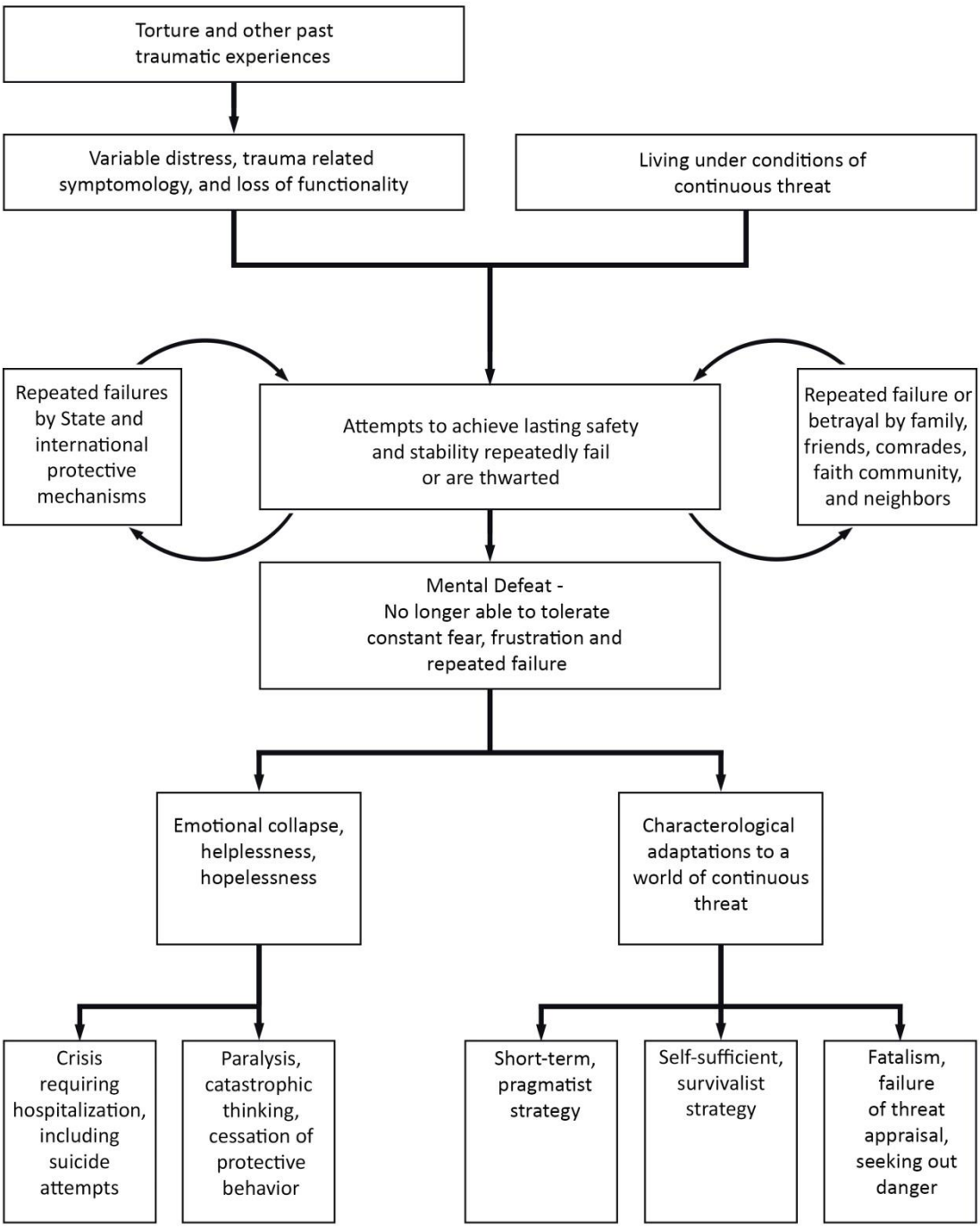


Figure 7.1 **A descriptive framework of continuous traumatic stress in torture survivors.**

These narratives do paint a picture of common outcomes for torture survivors living in situations on ongoing threat. Many clients, with their counsellors' support, continue to struggle to improve their lives. Some succeed, either as a result of external intervention or through their own resourcefulness and persistence. Others reach a point where they are no longer able to tolerate the ongoing threat and repeated failures. One client described this in the following words: "I had stopped having hope for living anymore. I was forgetting. … I lost control at that time and I could see in myself that I am no more existing … that I was having no hope."

A counsellor describing a different client paints a similar picture: "She was kind of saying now there's no future. You know, losing hope … she was kind of now going into despair."

They are overcome by helplessness, hopelessness, and may succumb to mental defeat, a state wherein an individual loses the sense of herself as a person with her own will, as having the capacity to plan to escape or ameliorate the situation in which she finds herself (Ehlers, Maercker, & Boos, 2000). I suggest that two kinds of outcome flow from mental defeat. Some clients experience a profound emotional and psychological collapse; others appear to make potentially permanent characterological adaptations to living in a continuously dangerous world. Narratives involving psychological crisis included a suicide attempt; a psychotic break requiring hospitalization followed by extensive outpatient care; and, behavioural paralysis with an inability to take self-protective actions maintained by catastrophic thinking. In one client's words, "I heard voices talking to me, and those voices were telling me to kill myself, for there was no reason for living anymore."

Faced with this kind of crisis, counsellors acted to ensure the safety of the client and small children, and where possible to engage the support of older children, adult relatives, neighbours, or members of the client's faith community.

Characterological adaptations include narratives of short-term pragmatism where people do what needs to be done to get through each day without any expectations or plans for improving their long-term situation. One client put it very clearly: "[It is] quite difficult, I am always escaping."

A second adaptation is to adopt an isolating and distrustful strategy which involves depending only on oneself, abandoning service providers, employers, and counsellors when threatened. One counsellor expressed her frustration in these words:

She was emotionally numbed … I found it challenging because I, I saw that she really required support. I felt like she was very vulnerable … [but I said,] "Okay, if she doesn't want help, that's up to her. We cannot help her and we are going to close her case."

A third option is a fatalistic position, in which protective behaviours are abandoned and danger may actually be courted. In a previous example, Agnes was planning to go home regardless of the danger to her and her children. A different client described his indifference to his own safety: "I don't have to worry about looking after things that can make me to survive …"

In all of these cases, counsellors worked at a cognitive level to help clients understand the reasons for these characterological shifts, as well as the potential negative impacts upon them and the people around them.

It is important to note that, although these various continuous traumatic stress outcomes seem similar to complex PTSD (Herman, 1992b) and enduring personality change after catastrophic experience (World Health Organisation, 1992), there is an important distinction. Very often, in the view of torture survivors and their counsellors, these outcomes arose not from the original torture with which they would be more commonly associated, but from the experience of living under continuous threat. This suggests that psychosocial interventions designed to increase protection and support should always be fundamental to the treatment of torture survivors who still face danger on a regular basis.

Conclusion

The constructs associated with past trauma and stress generation are not in and of themselves adequate to guide the work of counsellors working with torture survivors who live with ongoing threat. My interpretation of these narratives suggests that a more clearly articulated descriptive framework incorporating continuous traumatic stress would be helpful to clinicians working with clients whose lives are not stable or secure.

My analysis suggests answers to the question raised by several authors (Başoğlu, 2006; Nickerson, et al., 2011), which is "Why do torture counsellors continue to use multimodal or integrative approaches when the literature on PTSD so clearly supports particular trauma-focused treatment approaches?" Counsellors continue to use multimodal methods because trauma-focused treatments alone do not address issues of current threat, and often fail to strengthen clients' capacities to the point where they are able to ensure their own safety. I predict that, until a theory of continuous traumatic stress is integrated into treatment-

outcome research and practice guidelines, practitioners working with torture survivors will continue to work in a way that they feel is most helpful to their clients and ignore pressures to adopt trauma-focused approaches. Such approaches will always be important in work with torture survivors, but in some cases, they will be a minor component of a far longer, and more complex intervention.

Though the narratives and arguments of this paper come from work with refugees and citizens in sub-Saharan Africa, my experience in other countries suggests that they would resonate with counsellors in many parts of the world. One of the strengths of this research is that it includes the voices and experience of practitioners, something that is arguably missing from current debates (Tol et al., 2012). However, the study is limited by the fact that the narratives come from work with a clinical sample, those torture survivors who wanted and were able to access mental-health services. This group is clearly not representative of torture survivors generally. Future studies of survivors of torture and other trauma who are living in situations of ongoing danger should test the causal pathways suggested in this paper. It is likely that similar pathways exist for other groups, including survivors of domestic violence and people living through complex emergencies such as civil wars. In this way, researchers and practitioners interested in continuous traumatic stress may be able to develop a more generic model applicable to people facing a broad range of ongoing dangers.

Ultimately, the impact of torture is not only about an individual's fear and intrusive memories of the torture itself. The impact of torture is felt as much in the way that it changes survivors' capacities to control their own lives and influence the world around them. Torture is a profoundly political act, and by extension, so too is the work of the torture counsellor. Many torture counsellors in sub-Saharan Africa join their clients in contributing to a safer world, and in so doing, they knowingly sacrifice their own peace of mind and security.

Chapter 8 Towards a Contextually Appropriate Framework to Guide Counselling of Torture Survivors in Sub-Saharan Africa

This chapter was previously published in the Torture Journal. The full reference is: Higson-Smith, C. & Eagle, G. (2018). Towards a contextually appropriate framework to guide counseling of torture survivors in Sub-Saharan Africa, *Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *28*(1), 18-33. Retrieved from https://irct.org/publications/torture-journal/141

This journal was selected because its content is available online and disseminated free of charge to all members of the International Rehabilitation Council for Torture Victims (IRCT) globally. Members of IRCT are approximately 160 specialist torture treatment organisations spread across the globe, and include the centres that participated in this research, as well as other centres in sub-Saharan Africa and the Global South.

Given the very specific audience that this journal reaches, this paper is framed in terms of torture survivors' right to rehabilitation and the need for evidence based practices that are informed both by the best available research and expert clinical opinion, and adapted to the context in which services are being provided (discussed in greater detail in Chapter 3). The original intention in this paper had been to focus on disseminating the key clinical findings. However, the reviewers and editors of the *Journal on Rehabilitation of Torture Victims and Prevention of Torture* felt that the clinical findings required more empirical support, and space in the journal was limited. As a result, the final published version briefly reiterates several of the findings laid out in chapters five through seven, using these as a springboard for a comparative analysis of the clinical tools described as most useful by counsellors and their clients. There is considered elaboration of the thematic analyses pertaining to client and counsellor reports as to what they perceived to be most beneficial in the counselling interactions, including how these experiential accounts resonate with documented trauma treatment recommendations. A lengthy section detailing the clinical recommendations flowing from these findings in the form of a potential model for treatment was removed from the original manuscript and is included instead in Chapter 9 of this thesis.

Towards a Contextually Appropriate Framework to Guide Counselling of Torture Survivors in Sub-Saharan Africa

Abstract: Introduction: If the right to rehabilitation is to become a meaningful reality for torture survivors in sub-Saharan Africa, it is necessary that counselling practice be responsive to the contextual and cultural demands of the region. Recent reviews of evidence-based practice with torture survivors are discussed with a focus on those approaches developed and/or tested with torture survivors in sub-Saharan Africa.

Methods: The results of a mixed methods study of ongoing torture rehabilitation work are reported. This study incorporated a review of 85 case files of torture survivors treated at torture rehabilitation centres in three countries in sub-Saharan Africa, and in depth interviews with fifteen counsellors and fourteen clients at those same centres. Quantitative data are presented in tabular form supported by uni- and bi-variate statistical analyses as appropriate. Qualitative data are presented in terms of themes identified through emergent coding.

Results and discussion: Help-seeking torture survivors in this region are a diverse and highly symptomatic group, often struggling to survive with their families in precarious circumstances and under ongoing threat. In addition to incorporating key aspects of existing evidence-based practice, counsellors also use a range of psychosocial approaches to assist torture survivors to protect and support their families in the face of seemingly overwhelming life challenges. We propose that more systematic methodologies that facilitate the inclusion of the voices of clients and clinicians in ongoing international debates relating to evidence-based practice with torture survivors will enhance the application of such practices in diverse contexts.

Torture is practiced in many countries in sub-Saharan Africa, a problem greatly exacerbated by ongoing civil and cross-border conflicts in the region (Amnesty International, 2014, Human Rights Watch, 2017). Most countries in the region fall into the low-income bracket and have extremely limited mental health services (World Health Organisation, 2010). These countries host millions of refugees and displaced persons, including many torture survivors in desperate need of effective mental health intervention (United Nations High Commission for Refugees, 2016b). In these contexts, survivors turn to a broad range of health systems, often in parallel. Such medical pluralism includes traditional and faith-based healing systems, public and private health services, as well as more specialist clinics designed to meet the particular needs of torture survivors (Olsen & Sargent, 2017). It is essential that African researchers and practitioners adapt their models of intervention with torture survivors to the particular demands and resources of our continent while remaining cognizant of the available evidence-base on effective practice.

In this paper we summarize previously published findings from a mixed-methods study of the client populations and counselling work of three specialist torture rehabilitation centres in Cameroon, Kenya and South Africa. To this summary we add a qualitative analysis of the specific therapeutic interventions noted by torture surviving clients and their counsellors as having been particularly effective in furthering rehabilitation. The results show some significant divergence from currently accepted evidence-based practice, divergence that we argue springs from the particular context of torture survivors in sub-Saharan Africa. We note that much of what we discuss in this paper might have relevance for other parts of the developing world but leave it to practitioners and researchers from other regions to assess the value of our work in their contexts.

Article 14 of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations General Assembly, 1984) promises torture survivors the right to redress including rehabilitation, specifically:

> … the restoration of function or the acquisition of new skills … to enable the maximum possible self-sufficiency and function … and may involve adjustments to the person's physical and social environment. Rehabilitation should aim to restore … independence, physical, mental, social and vocational ability and full inclusion and participation in society. (United Nations Committee Against Torture, 2012, Paragraph 11)

The question then arises as to the most effective means by which this restoration of function might be achieved in different contexts. At least within the mental health and counselling arenas, answering this question relates to what is most strongly indicated in terms of evidence-based practice (EBP), or,

> … the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. (American Psychological Association, 2005, p. 5)

This definition requires that empirical evidence be weighed within the parameters of various contextual features, including the availability of skilled practitioners, economic and security conditions, and local attitudes and norms.

Evidence-Based Practice for Rehabilitation of Torture Survivors

A Cochrane Review of research on interventions for the psychological health and well-being of torture survivors lists only nine randomized control trials (RCTs) that met standard inclusion criteria (Patel, et al., 2014). The reviewers found no immediate benefits from psychological therapies in comparison with control groups, but noted some moderate benefits in reducing PTSD symptoms and distress six months after the end of treatment. They concluded that the evidence does not support the use of any particular intervention over others.

Another review of torture treatment outcomes cast a broader methodological net and included 88 treatment outcome studies (Weiss et al., 2016). These reviewers concluded that cognitive behaviour therapy (CBT) that included exposure components was best supported by the research for reducing symptoms of post-traumatic stress disorder (PTSD), depression and anxiety in survivors of torture. They noted that narrative exposure therapy (NET), Interpersonal Therapy (IPT), pharmacotherapy (alone or in combination with CBT), and multi-disciplinary approaches also showed promise, warranting further research.

Some treatment outcomes studies have been conducted in sub-Saharan African contexts. Igreja, et al. (2004) demonstrated the positive impact of a single session testimony approach with rural survivors of the Mozambican civil war. Studies have examined the efficacy of NET for the treatment of PTSD in various populations in Uganda (Neuner et al., 2008), Rwanda (Schaal, et al., 2009b) and South Africa (Hinsberger et al., 2017) with encouraging results. In the Democratic Republic of Congo (DRC), cognitive processing therapy was shown to reduce the incidence of depression, anxiety and PTSD symptoms

among female survivors of sexual violence (Bass et al. 2013). Mpande et al. (2013) tested the Tree of Life intervention, an approach that draws heavily on Zimbabwean cultural beliefs and practices, and demonstrated positive impact.

Despite these and other studies, it is disappointing that after decades of treatment outcome research, the guidance to practitioners working with torture survivors in sub-Saharan African remains equivocal. The global literature is sparse and dominated by studies of refugees resettled in Europe and North America, not the contexts in which the majority of torture survivors are located. Many interventions have not been rigorously tested and the existing studies have significant methodological flaws (Patel et al., 2014). Most importantly, the focus on symptom reduction falls short of the vision of rehabilitation described in UNCAT. In this paper we hope to contribute to the development of treatment approaches by examining the characteristics of torture survivors seeking treatment in sub-Saharan Africa, and by exploring what they and their counsellors experience to be the most helpful therapeutic interventions.

Method

This mixed-methods study consisted of two distinct parts which are combined during analysis and interpretation. The first part was a quantitative and qualitative analysis of randomly selected case files documenting the mental health treatment of 85 torture survivors. The second was a qualitative analysis of semi-structured narrative interviews with 15 counsellors and 14 torture surviving clients (see Table 8.1 below). Case files, counsellors and clients were selected from three specialist torture rehabilitation centres in sub-Saharan Africa: the Centre for Rehabilitation and Abolition of Torture (CRAT) in Cameroon; the Independent Medical Legal Unit (IMLU) in Kenya; and the Centre for the Study of Violence and Reconciliation (CSVR) in South Africa. By selecting centres in diverse parts of the continent we hoped to capture something of the political, economic, cultural and linguistic breadth of sub-Saharan Africa.

Table 8.1: Sociodemographic characteristics of the three study samples

	Case files reviewed	Key respondent interviews	
		Counsellors	**Clients**
Total N	85	15	14
Gender			
Men	39 (46%)	4 (27%)	8 (57%)
Women	46 (54%)	11 (73%)	6 (43%)
Country of contact			
Cameroon	30 (35%)	6 (40%)	4 (29%)
Kenya	23 (27%)	5 (33%)	6 (42%)
South Africa	32 (38%)	4 (27%)	4 (29%)

The Ethics Committee for Research on Human Subjects of the University of the Witwatersrand, South Africa approved the research protocol. Some results from this study have been published previously (Higson-Smith, 2013; Higson-Smith, 2014; Higson-Smith & Eagle, 2017).

Case file review

Clinical records for 33 clients were selected from each of the three centres, on an interval basis from consecutive lists. Fourteen cases did not meet the UNCAT definition of torture and were excluded, producing a final combined sample of 85 cases.

Case files included a comprehensive psychosocial intake assessment that included demographic details such as legal status, work authorization, past and current occupations, income and housing situation, family structure and dependents, as well as brief summaries of current medical conditions, injuries, and prescription medications. A brief history of traumatic experiences, including torture, was also recorded, as well as items relating to the clients expressed needs and reasons for seeking treatment. Centres routinely administered clinical assessment measures and practitioners documented subsequent meetings with clients whether for the purposes of counselling or associated tasks such as referral or assessment.

These annotations also mentioned major events in the client's life including changes in asylum status, housing conditions, bereavements, illnesses and medical care, and further experiences of victimization.

Case files were analysed using a range of quantitative and qualitative codes that encompassed demographic indicators; duration and frequency of counselling sessions; the current status of the therapeutic work; key features of reported torture, trauma, and loss; expressed reasons for seeking assistance; the range, severity and number of psychological and somatic symptoms reported; as well as observations regarding obstacles or advances in therapeutic progress. Using iterative thematic analysis (Braun & Clarke, 2006) we searched across individual case files to identify repeated patterns of meaning or themes in an inductive manner. Themes were coded at an explicit (or semantic) level to ensure that the coding system remained strongly "data-driven". Initial codes were developed on site in the three torture treatment centres where the original analysis was conducted. Codes were subsequently reviewed and refined across the entire data set to ensure standardization of coding. Where appropriate, basic uni- and bivariate statistics were calculated to describe the composition of the sample and to highlight differences between groups within the sample.

This adult sample ranged from 18 to 66 years (mean=33.9, sd = 10) with no significant difference between the samples from the three centres. Further demographic details are presented in Table 8.2.

Table 8.2 Demographic characteristics of case review sample by participating centre

	CRAT n=30	IMLU n=23	CSVR n=32	Total Sample N=85	
Gender					n.s.
Men	14 (47%)	12 (52%)	13 (41%)	39 (46%)	
Women	16 (53%)	11 (48%)	19 (59%)	46 (54%)	
Country of origin					χ^2=125.8, df=14, p=0.000
Kenya		22 (96%)		22 (26%)	
Democratic Republic of Congo (DRC)	9 (30%)		11 (34%)	20 (24%)	
Zimbabwe			14 (44%)	14 (16%)	
Central African Republic (CAR)	9 (30%)			9 (11%)	
Rwanda	7 (23%)		2 (6%)	9 (11%)	
Chad	4 (13%)			4 (5%)	
Other	1 (3%)	1 (4%)	5 (16%)	7 (8%)	

Family situation					n.s.
Married/partnered	15 (50%)	17 (74%)	13 (43%)	45 (54%)	
Single	10 (33%)	2 (9%)	9 (30%)	21 (25%)	
Widowed	5 (17%)	1 (4%)	5 (17%)	11 (13%)	
Divorced/separated		3 (13%)	3 (10%)	6 (7%)	
Caring for children (median children = 3)	20 (67%)	19 (83%)	21 (70%)	60 (71%)	n.s.
Education					n.s.
Primary incomplete	2 (7%)	2 (11%)	1 (3%)	5 (6%)	
Primary complete	10 (34%)	9 (50%)	9 (29%)	28 (36%)	
Secondary complete	13 (45%)	6 (33%)	10 (32%)	29 (37%)	
Tertiary qualification	4 (14%)	1 (6%)	11 (36%)	16 (21%)	

Current employment					n.s.
Unemployed	18 (60%)	6 (31%)	15 (50%)	39 (49%)	
Informal employment	8 (27%)	10 (53%)	5 (17%)	23 (29%)	
Artisans / skilled labour	3 (10%)	3 (16%)	8 (27%)	14 (18%)	
Professional			1 (3%)	1 (1%)	
Student	1 (3%)		1 (3%)	2 (3%)	

Interviews with counsellors

The first author invited staff who provided counselling at the centres to participate in semi-structured interviews relating to their counselling practice. All 15 counsellors working at the centres accepted this invitation. Interviews were conducted in English and included questions about counsellor's training and experience, personal motivation for work with torture survivors, emotional well-being, and approaches and methods used in counselling. Average interview length was 57 minutes. During the interviews counsellors were asked to think of two or three specific clients for whom they considered the therapeutic work to have been particularly helpful. They were then asked to narrate the story of their work with those clients. In the course of their narrations, respondents were asked to identify particularly helpful therapeutic interventions that enabled the client to take a significant step forward in his or her recovery.

The counsellors interviewed ranged in age from 25 to 65 years and all but one were citizens of the country in which they were working. Six were clinical psychologists, four were general nurses, three were social workers, one was a psychiatric nurse, and one was a general medical practitioner. The aggregate term "counsellor" is used to describe this diverse group and the activity that is the focus of this study. These counsellors had a median of ten years work experience (ranging from one to thirty years). Their experience in torture rehabilitation specifically was shorter (one to 22 years with a median of 6 years). In addition to their professional training, all had participated in one or more shorter training courses on evidence-based approaches to counselling people who have survived torture. The first author had worked for several years with the selected centres in a capacity building role, covering topics including evidence-based treatments for PTSD, effects of trauma on the brain, arousal regulation skills, CBT and trauma-focused counselling skills, treatment planning, conducting clinical assessments, and ethical concerns in the treatment of torture survivors. Although this existing relationship must influence counsellors' responses it also provides a foundation of trust necessary for counsellors to describe their true experiences of this challenging work.

Interviews with clients

Participating counsellors invited clients to take part in a similar interview concerning their experience of counselling (and explicitly not about the traumatic experiences that led them to seek assistance). We invited adult clients who had experienced torture and who were at a point in their therapeutic work where counsellor and client agreed that the client could participate in the interview without undue risk of re-traumatization. Fourteen clients accepted

the invitation. Eight were interviewed in English and six in French with the assistance of an interpreter, a post-graduate psychology student. Average interview length was 45 minutes and included questions about access to services, obstacles in attending counselling, frequency and duration of sessions, length of intervention, as well as therapeutic experience. In particular, clients were asked to describe therapeutic moments which they felt had been most helpful to them. The first author had no previous relationship with these clients. His being a professional man of European descent associated with an international organization is likely to have influenced clients' responses in important ways.

Participating clients ranged in age from 25 to 63 years. The eight clients treated in South Africa and Cameroon were refugees or asylum seekers from other African countries. The six interviewed in Kenya were all Kenyan citizens.

Qualitative analysis of interviews

Both counsellor and client interviews were translated where necessary and transcribed verbatim. For the purposes of this analysis any content relating to successful therapeutic intervention was extracted for independent thematic analysis. A total of 125 incidents (75 from counsellors and 50 from clients) ranging in length from a couple of sentences to several paragraphs were identified. Using an iterative thematic analysis process the material from the two groups was initially analysed independently. The two sets of themes were then integrated into a final set of the 15 most salient emergent themes. These themes were labelled and described with respect to the intervention itself and the associated therapeutic intention. Thereafter, the combined set of incidents was analysed using the 15 thematic categories. Due to the interconnected nature of the themes (and the therapeutic work itself) some incidents were coded under more than one theme. Since most counsellors described successful work with several clients the same theme sometimes emerged repeatedly in a single interview. Clients described only their own experience and so each theme was only counted once. In the final analysis we recorded how often each theme was mentioned by the two groups of respondents and how those responses were distributed across the three centres (see Table 2).

An independent researcher coded a sample of 50 incidents which were then checked for reliability against the authors' coding. Percentage agreement was 86%.

Results and Discussion

Results of case file review

The review of a representative sample of 85 case files showed that clients came from a wide range of countries and represented a broad range of ethnicities, cultural traditions and languages. Such diversity demands a high degree of cultural competence from counsellors, as well as the capacity to work effectively with interpreters. In some cases interpreters were employed by the centres, but at times interpretation was provided by friends or family of the client. This has important consequences for what is possible in counselling.

An analysis of the specific torture experiences reported divided clients into several groups. Approximately 40% were people who had been caught up in a civil conflict in the region. They were tortured as part of forced conscription, as punishment for alleged support of the enemy, to coerce them into providing supplies to militias, or because of their ethnic or religious identity. Approximately 35% self-identified as activists and included political and community leaders, as well as journalists targeted by oppressive regimes. A third group comprised spouses, parents and children of activists and accounted for 18% of the sample. This group was tortured to punish their family members or to extract information about those peoples' whereabouts or activities. Finally, the sample included several people (7%) who had been accused of a crime and tortured as part of a police investigation or as punishment. The varied circumstances under which torture occurred has profound implications for counselling, impacting the possibility of finding safety, the availability of support within families and communities, as well as ways in which clients are able to construct meaning.

Fifty-five percent of clients receiving counselling did not originally approach the centres for mental health care. More commonly clients sought medical or social welfare assistance. This has profound implications for the manner in which clients are introduced to mental health services, their understanding and expectations of services, the way in which initial assessments are conducted, as well as for sustained client engagement.

The course of treatment recorded in the client files varied greatly in complexity and length. The number of counselling sessions attended ranged from 1 to 60. However, the distribution was highly skewed with a median of 3.5 sessions. Very few clients (11%) received the 12 or more sessions of treatment found to be optimal (Weiss et al., 2016) and only 39% of the files reviewed reported the counselling process ending in a planned or negotiated manner. Most clients stopped attending counselling without explanation after fewer than three meetings. A range of explanations for such low completion rates have been

advanced, including difficulties in reaching service delivery sites, the cost of transport, challenges in managing the care of small children, moving away to pursue employment or safer living conditions, and the loss of time to income generating activities. Nevertheless, we must also consider the possibility that some clients felt that the benefit of the first few sessions of counselling was not worth the effort of attending. Counselling models adapted to the sub-Saharan African context must grapple with questions of motivation for counselling, and develop strategies to increase access and engagement.

Regardless of engagement, clients reported high levels of distress and symptomatology relating to depression, anxiety and PTSD. The most common complaints included pervasive worries (72%), intrusive thoughts and memories (70%), sleep difficulties (69%), and low mood (59%). Many clients (66%) reported somatic complaints without a clear medical cause. It can be difficult to determine whether non-specific but chronic somatic complaints (including generalized pain, weakness and fatigue, and a weakened immune response) arise from physical damage caused by prolonged torture and incarceration in poor conditions, or have their origins in emotional distress (Williams & Baird, 2016). Such determinations are further complicated in sub-Saharan Africa where emotional distress is often communicated through idioms rooted in the body (Ventevogel, Jordans, Reis & de Jong, 2013).

The majority of case files reviewed was of younger adults, married and/or caring for children. Twenty-eight percent were citizens of the country in which they sought help, but many more were refugees (25%), asylum seekers (32%), or undocumented persons (15%). Citizens were also often displaced, having been driven out of rural communities and forced to seek refuge in the relative anonymity of larger urban areas. Refugees, asylum seekers and undocumented people reported many more symptoms than citizens and we speculate that this is due to the confluence of past traumatic experiences and ongoing threat. Asylum seekers and undocumented people must cope with the continuous fear of being incarcerated and/or returned to the country where they were originally tortured. Refugees and internally displaced people must as times cope with being an outsider in openly hostile host communities. This hostility is expressed on a daily basis in interactions with neighbours, as well as service providers and police. At times it spills over into physical attacks on foreigners, their homes and businesses.

An analysis of accounts of current danger identified five types of continuing threat: harassment by the original torturers or their colleagues; harassment by government officials unrelated to the original torture; threats from neighbours and other members of the

community; domestic violence; and gender-based violence. The presence of ongoing threat in all these forms is another important consideration in counselling torture survivors, one that is often neglected in counselling models developed in more protective contexts.

Forty-six percent of the cases reviewed disclosed a significant recent bereavement, the majority of which were violent (85%). Thirty-nine percent of the bereaved group reported being directly victimized during the event in which their loved one died. Such victimization included torture, rape, and intimidation. In many cases the client was directly implicated in the violent death of their loved one. For example, the loved one died trying to protect the client, or from torture linked to the client's political activism. Bereaved clients reported significantly elevated depression-related symptoms (effect size=0.65) and increased suicidal ideation (odds ratio = 4.99). Current assessment batteries do not assess for complicated bereavement and counselling models used with torture survivors seldom address grief explicitly.

These results paint a picture of a highly diverse population of treatment-seeking torture survivors on the continent. They are a highly symptomatic group having often survived complex and repeated victimization, including violent bereavement. Many are struggling to survive in precarious circumstances or under active, ongoing threat. These factors impede access to services and undermine progress in rehabilitation. In the next section we examine what a sample of clients and their counsellors describe as the most significant components of their therapeutic work.

Results of interviews with counsellors and clients - most helpful therapeutic interventions

The qualitative analysis of incidents of therapeutic change narrated by clients and counsellors resulted in a set of inter-connected themes which are summarized in Table 8.3 and elaborated below.

Table 8.3: *Therapeutic interventions most frequently described by client and counsellors as particularly helpful to torture survivors*

Theme	Description	Frequency
Trauma exposure work	Intentional, graduated retelling of trauma narratives combined with active affect and arousal regulation intended to integrate and habituate traumatic memories.	7 clients and 7 counsellors from all 3 countries (14 incidents)
Strengthening families	Interventions intended to strengthen support within families and reduce vicarious and transgenerational trauma, including education around interpersonal effects of torture, parenting support, and conflict management.	5 clients and 5 counsellors from Kenya and South Africa (15 incidents)
Problem solving	Collaborative problem solving intended to stabilize the client and increase agency and self-sufficiency in the face of persistent life challenges.	4 clients and 6 counsellors from all 3 countries (15 incidents)
Psychoeducation	Explanations of underlying causes of distress in order to normalize reactions and encourage healthy coping. Explanations of counselling interventions to increase engagement with treatment.	4 clients and 6 counsellors from all 3 countries (12 incidents)
Symptom management	Guidance and skills-building intended to reduce the frequency and severity of disruptive symptoms and improve global functioning.	4 clients and 6 counsellors from all 3 countries (11 incidents)

Encouraging Spirituality	Supporting spiritual beliefs and encouraging participation in religious practices with the intention of sustaining hope and perseverance.	4 clients and 5 counsellors from all 3 countries (11 incidents)
Disputing irrational beliefs	Exploring and testing evidence in relation to beliefs and thought patterns (particularly in relation to helplessness and isolation) with the aim of reducing distress and building support and agency.	1 client and 7 counsellors from all 3 countries (11 incidents)
Sustaining hope	Holding a vision of an improved future in order to reduce hopelessness and increase agency in the face of persistent life challenges.	10 clients from all 3 countries (10 incidents)
Dignity and respect	Treating client with respect thereby upholding human dignity, establishing a therapeutic relationship and increasing engagement, and counteracting experiences of stigma and discrimination.	6 clients and 1 counsellor from all 3 countries (7 incidents)
Encouraging activism and volunteer work	Encouraging advocacy and community work of importance to the client with the intention of increasing community connection, self-esteem and personal meaning.	2 clients and 4 counsellors in Kenya and South Africa (6 incidents)
Case management	Identifying additional needs and referring client to other service providers with the intention of increases access to services and stabilizing the client	6 clients in all three countries (6 incidents)

Grief counselling	Providing support for healthy grieving and encouraging community and private rituals of remembrance to reduce symptoms of complicated grief.	3 clients and 2 counsellors in Kenya and South Africa (5 incidents)
Support for medications	Explaining purpose and proper dosage of medications to stabilize clients and reduce physical and emotional symptoms.	1 client and 4 counsellors in all three countries (5 incidents)
Focus on strengths	Recognize and encourage use of personal strengths employed during and after traumatic experiences with the aim of improving coping and self-sufficiency.	1 client and 4 counsellors in all three countries (f incidents)
Home practice	Agreement and monitoring of key activities to be practiced between sessions with the aim of stabilizing the client, improving coping, and building self-sufficiency.	2 counsellors from Kenya and South Africa (4 incidents)

The theme mentioned by most respondents (both clients and counsellors) was **trauma exposure work**, a theme that aligns well with existing EBP recommendations. The salience of this theme supports the position that a focus on past traumatic experiences is important in work with torture survivors in sub-Saharan Africa. While counsellors emphasized the integration of traumatic memories and the empathic witnessing of gross human rights violations, clients were more likely to emphasize the cathartic benefits, describing the pain of telling and the relief that followed. A middle aged man who fled to South Africa after being tortured in Zimbabwe described his experience as follows:

> *In the beginning it is difficult to tell or retell the story. Because initially you just browse the story without going into, into details. And then you tell it the second and third. And then when you are now settled you actually tell the story as it is and with all the details. Whatever, actually telling the story with your heart and actually seeing, visualizing what has been happening. You can feel that there is an impact in you. … It had more meaning emotionally and then after that, with some sessions and retelling details, and doing some exercise, it no longer was, it was no longer necessary.*

The next two most commonly described themes were more rooted in current life challenges. That therapeutic work focused on **strengthening families** was important to both clients and counsellors is not surprising given the proportion of clients who are married and caring for children, and the precariousness of their lives. Strain within families may result from direct traumatization, vicarious and transgenerational trauma, increased stressors due to forced migration, bereavement, and changing family roles. An older Kenyan man struggling with his wife's depression and suicidal thoughts after the couple were driven from their community described the help he received as follows:

> *We talked about my wife and how I am experiencing because still I was sick and, still I'm thinking how I cannot sleep well because I was thinking my wife can wake up and do something terrible. But [my counsellor] explains … that the only thing she needs is care. Slowly with her I showed her I cared for her. I told her, "Okay, we can talk slowly, I never come with sharp word" or telling her anything she can be angry. And now I experience and I become okay with her.*

Therapeutic approaches that are too individualistic in focus may fail to address anxieties relating to family health, something that is inseparable from personal wellbeing to many people in sub-Saharan Africa.

Problem solving interventions were also often mentioned as being particularly helpful and are strongly connected to the challenges and threats in clients' daily lives. Therapeutic interventions focused solely on past trauma may be experienced as less helpful by clients who need assistance in dealing with immediate problems with important consequences for their survival. The Zimbabwean man quoted above had this to say,

> *I would prefer to talk about other people's problems. And, in a way, to me when I am talking other people's problems, and solving other people's problems, I would discover that I am also solving my own personal problems. They're the same.*

In these words we hear not only an increased sense of control but also solidarity with others who are suffering. Problem solving is most strongly linked with the seemingly overwhelming daily stressors that so many torture survivors, particularly people who have been displaced from their communities, are living with.

Understanding of the underlying causes of mental illness and the purpose of mental health services varies greatly in sub-Saharan Africa. For this reason, **psychoeducation** may be more important in this context than it is in others. A Kenyan counsellor described how she uses metaphors and physical objects to help clients understand and label the underlying causes of their distress.

> *Simple ways of understanding in psychoeducation ... finding practical ways of educating them to understand the root cause and how it's connected to their symptoms and the reactions that they are having. Because once they understand that, it makes sense to them. Then the treatment plan, that if they try this it could help relieve [their suffering]*.

This counsellor also links psychoeducation to the rationale for the treatment plan, implying that this is also important for client engagement in counselling.

Closely linked to psychoeducation is work on **symptom management**, which includes helping the client develop skills for arousal and affect regulation, as well as finding ways to cope with disruptive symptoms. A Kenyan client struggling with persistent and severe headaches described his counsellor's intervention as follows:

> *I was coming here with headache. But [my counsellor] told me there is something which I will be remembering … He shows me how I need to, to remove that kind of headache. I only start. Find somewhere comfortable, somewhere quiet. I sit myself there. I come to relax and he shows me how I can stay relaxed somewhere. And then I experienced that my headache become low. I found that was only stress … Yes, it goes away, yeah.*

Both psychoeducation and symptom management are often included (at least implicitly) in current EBP recommendations.

Many people in sub-Saharan Africa are devout Christians or Muslims with many also honouring traditional African gods and ancestral spirits. A range of interventions that **encouraged spirituality** as a source of resilience were judged important by both clients and counsellors. An older woman of strong Christian faith receiving treatment in Cameroon found it helpful that her counsellor could work with her on a spiritual level too.

> *[I had] lost my hope. [My counsellor] used to tell me that I don't have to lose my spirit. I have to continue with my faith in God. Even if the world is rejecting us, only Him, He change our situation … so I have understand that God was above us. That is why now I am stress free. I'm stress free and I continue to do my life.*

In this way the counsellor is using a religious belief in divine care and protection to support the client's agency and sense of control in her life.

A related theme was that of **disputing unhealthy beliefs** and thought patterns, which was mentioned almost exclusively by counsellors. A Kenyan counsellor describes working with a client who had lost her husband violently and whose grief had left her feeling marginalized and alone:

> *… to reframe "that everybody is against me, nobody wants me in this community" … So if people came and they quickly organized about how this body can be buried, they notified her parents, they built a house for her. And the visitors who came for the burial were taken care of and all that. That was some support! So although she thought everyone hated her, that wasn't strictly true.*

Serving a similar purpose were therapeutic interventions intended to **sustain hope.** Ten clients told us how their counsellor instilled hope in them when they felt hopeless, and it is interesting to note that none of the counsellors emphasizes this theme. In the words of a Kenyan woman:

> *From the time I was given counselling, that power I get from that time … because all things I struggle with will come in the end … the life is going different sometimes, sometimes it's okay. … [My counsellor] told me this problem is to test my heart whether I'm strong enough to hold these problems and I have to be strong enough to … overpower my problems. He told me, "Never, never give up!"*

These themes of encouraging spirituality, disputing irrational beliefs and sustaining hope are all associated with building clients' capacity to persevere in the face of seemingly overwhelming challenges and threats to their present survival. The emphasis is powerfully on the present and not on past traumatic experiences.

Other important themes included case management and referral, as well as assistance with medications. All three centres were able to refer clients to a range of other services and did so routinely. Services offering emergency shelter and food were typically in high demand and over-subscribed. Referral for medical and psychiatric care was also available to all centres through either government or humanitarian agencies. Medical personnel are often limited in the time they have available to explain the purpose and dosage of medications and so counsellors were often called upon to explain prescriptions and encourage adherence. In contexts where clients have less familiarity with "Western" health systems, the value placed on help in navigating these complex systems is significantly greater.

Also mentioned were more general principles of care including encouraging home practice, intentionally acting to protect the clients' human dignity, and recognizing the strengths that they displayed both during and after traumatic experiences.

Limitations of this study

This study has several limitations. Firstly, the findings are based on a narrow sample of cases drawn from only three of the multiplicity of sites across the continent at which torture survivors seek mental health and psychosocial services. Similarly, a review of 85 cases is unlikely to contain the full complexity of the challenges experienced by torture

survivors in sub-Saharan Africa. Likewise, interviews with only 14 clients and 15 counsellors cannot hope to be representative of the full range of experiences of rehabilitation in the field. Nevertheless, we hope these samples are diverse and large enough to identify key contextual challenges in the rehabilitation of torture survivors pertinent to the region.

Secondly, as with all key respondent data, the findings are dependent on the background, experience and training of the respondents. In this case and for ethical reasons, we interviewed only clients who had shown marked improvement during their time in counselling. The responses of clients who were less resilient or who had a negative experience of counselling might have been very different. Counsellors' responses were also heavily influenced by their professional and subsequent training. Respondents are likely to favour interventions in which they have been trained and ignore others to which they have had limited exposure. Also, counsellors' responses must be viewed within the frame of their relationships with the first author. However, it is important to remember that these are seasoned mental health and health professionals. The interview transcripts reflect informed, thoughtful and self-critical conversations about the work of torture rehabilitation in the region. With the exceptions of the emphasis on gradual exposure to traumatic memories and disputing irrational beliefs, the themes emerging from this analysis do not reflect the content of training material covered by the first author. Nevertheless, his influence as a capacity building consultant cannot be discounted. It is difficult to know how the results might have varied had a less trusted, but also less involved, person conducted the interviews.

Thirdly, the questions posed to counsellors and clients were not identical and intentionally framed in broad terms. As a result, the responses include a mix of specific and non-specific factors. Specific factors, for example the recounting of traumatic memories and disputing of irrational beliefs, may be more directly relevant to debates around particular therapeutic approaches. Less specific factors, for example upholding clients' human dignity and case management, arguably apply to all competent forms of psychosocial intervention. Nevertheless, we feel they are relevant to discussions of how EBP is developed and implemented in sub-Saharan Africa.

Finally, the participating centres were able to conduct follow-up assessments on only a very few clients. Our analysis therefore offers no quantitative estimate of the effectiveness of the interventions discussed.

Conclusions

The strengths of this study lie in the intersection of our analysis of the profile and needs of a representative sample of the actual client population served by these clinics, with an in-depth analysis of the experience of the counselling work from the perspectives of both client and counsellor. The findings emerge from the real-world of service provision, reflecting a wide range of case presentations many of which are extremely complex, and drawing on the experience of actual counsellors working in the region today.

The results suggest that counsellors working in torture rehabilitation centres in sub-Saharan Africa incorporate key aspects of currently accepted EBP into their work. Foremost among these is the work of retelling narratives of past traumatic experiences with the intention of integrating traumatic memories. However, it seems that counsellors also invest a great deal of counselling time into interventions intended to assist the client to survive and to hold their families together in the face of overwhelming current stressors and threats. These interventions involve problem-solving, instilling hope through spiritual and other means, and encouraging perseverance. Counsellors also spend significant time helping their clients understand and manage their emotions, reactions and symptoms, and in navigating health and social welfare systems. Clients experienced value in virtually all these interventions.

These findings suggest a significant gap between those treatment approaches currently described as evidence-based, and the needs and experiences of torture survivors and their counsellors in sub-Saharan Africa. These counsellors would benefit greatly from training and supervision in clearly articulated treatment approaches that are less focused on individual recovery from past traumatic experiences, and instead recognize that most torture survivors have lost family, property, occupation, and community and are often struggling to survive in a dangerous world with little support. Such approaches need to be accessible and rooted in African understandings of mental health and healing. Counsellors also need approaches that increase clients' resourcefulness and capacity for focused action and persistence in the face of adversity, as well as tools to strengthen families' capacity to protect and nurture their members. In this way the definition of treatment outcome may be expanded into something closer to the vision of rehabilitation expressed in UNCAT.

In torture rehabilitation, as in other aspects of mental health service delivery, evidence-based practice is insufficiently informed by counsellor expertise and client preferences in particular contexts. It is our hope that methodologies such as the one we have utilized in this study will assist in more systematically integrating clinical and contextual knowledge in the ongoing discourse on therapeutic effectiveness and that these findings will

encourage innovations in the structure, content and process of therapeutic approaches to torture rehabilitation that are more effective in realizing torture survivors' right to rehabilitation in our region and around the world.

Chapter 9 Summary of Findings and Proposal for a Contextualised Approach to Torture Rehabilitation for Sub-Saharan Africa

As described in preceding chapters, the overarching goal of this research has been to examine the experiences and needs of treatment-seeking torture survivors and counsellors in sub-Saharan Africa, as well as their experiences of existing psychosocial rehabilitation services. This analysis is framed by reference to international conventions relating to the rehabilitation of survivors of torture, and by a growing scientific and academic literature on psychosocial treatment outcomes with this extremely vulnerable population. The international conventions describe rehabilitation in broad terms with the aim of returning torture survivors to their premorbid physical, emotional and inter-personal functioning, including self-sufficiency and full social, economic and political inclusion in society, at least to the extent to which that is possible. To achieve this vision, rehabilitation services must by necessity be multi-disciplinary and layered. Although the focus of this research has been on the counselling and psychotherapy components of rehabilitation, as mental health professionals we are called on to define the outcomes of rehabilitation in context-sensitive and holistic ways that speak to our clients' capacity to survive and thrive in a challenging world and thus may need to consider inputs beyond the directly therapeutic.

There exists a substantial and rich scientific and academic literature dealing with psychological rehabilitation of torture survivors. With notable exceptions, this literature fails to engage with the comprehensive definition of rehabilitation envisaged in international policy frameworks. Clinical outcome studies remain focused for the large part on symptom reduction and the field as a whole is largely blind to context, with most studies being conducted with torture survivors living in situations of resettlement in the Global North (a minority), but findings being generalized to torture survivors globally.

Against this background, this study was focused on three broad and interconnected questions relating to the practice of torture rehabilitation in urban centres in sub-Saharan Africa (see Chapter 4). In the following sections I briefly draw together the findings contained within the four published papers (Chapters 5 through 8) with respect to each of these questions. Building on these findings, I introduce an original approach to rehabilitation that I believe may better address many of the challenges faced by torture survivors in sub-Saharan Africa.

Psychosocial needs of help-seeking torture survivors in sub-Saharan Africa

The client populations focused upon in this study were very diverse with respect to country of origin, ethnicity, language, culture and religion. They presented with varied traumatic histories and their accounts of torture differed considerably in relation to attributed causality, form, duration and consequence. It was noted that at the time of counselling many adults struggled with competing demands on their time, energy and resources and were thus preoccupied with both past and present life stressors. The majority had children in their care and were concerned about lack of stability and insufficient income to support their families. A large proportion of clients had suffered a recent bereavement and most of these bereavements were of a violent nature. Thus, it was evident from both the case files and the interviews that torture survivors presenting for counselling in the three selected sub-Saharan centres brought a diverse set of experiences and presented with a multiplicity of problems.

An analysis of a broad range of symptoms reported at intake produced results in line with other studies conducted with torture survivors in sub-Saharan Africa and globally. These client population reported high prevalence of symptoms associated with PTSD, depression and anxiety. Symptoms were typically sufficiently severe to interfere with daily functioning. Although the participating centres did not typically conduct formal diagnostic interviews, most clients were checklist positive for PTSD, depression and anxiety, with the majority presenting with comorbid complaints.

Neither country of origin (a somewhat limited proxy for cultural and linguistic background) nor country of treatment predicted systematic differences in symptomatology at intake. However, two factors that have received limited attention in the literature on torture rehabilitation did predict clinically significant differences in symptoms. The first of these was whether clients were treated in their country of origin as opposed to being treated in a setting to which they had been displaced. In general, the latter group displayed more severe levels of symptomatology than those clients who were treated in their home country. Displaced people are removed from the supportive community and family networks which typically provide a safe place to live, help with basic needs (including for example, food, shelter and assistance with care for children), access to primary health care, and everyday emotional and spiritual support. As previously argued (Higson-Smith & Bro, 2010) displaced people living in the large urban centres of sub-Saharan Africa have lost these indigenous forms of support and do not receive the protections and services that refugees in camp settings receive. Displaced clients in the samples spoke at length about the emotional toll of the constant struggle for basic resources and the impact of ongoing danger in their lives, of the need to rebuild a life in

a new and often hostile society, and of difficulties in creating some continuity of identity between their past and present lives.

The second factor that predicted significant differences in symptom scores was whether clients had experienced a recent bereavement. As described in Chapter 6, nearly half the clients sampled in this study had experienced a recent bereavement and most of the reported deaths were due to intentional acts of violence. Clients who reported bereavement scored significantly worse than other clients on all measures of mental health at intake, with the highest effect sizes being recorded for depression and suicidal thoughts. Bereaved survivors who delayed seeking help for more than a year after their torture and/or bereavement reported statistically more symptoms than those that sought help earlier.

While there are no doubt methodological concerns that impact these findings (including small sample size and measurement biases), these observed patterns suggest that efforts to build more effective treatment approaches for torture survivors in sub-Saharan Africa would do well to focus more on both specific aspects of trauma history and on current context, and less on cultural adaptation of established treatment approaches to overcoming past traumatic experiences.

Use of evidence-based counselling practices in sub-Saharan Africa

The counsellors that participated in this research had all acquired tertiary education qualifications in a range of mental health or health disciplines and described a broad range of therapeutic modalities that they employed in their work with torture survivors. Although none described their work strictly in terms of existing EBP, all were aware of approaches that are considered evidence-based, and some had received training in these approaches. Based on counsellor accounts of their work in practice the results strongly suggest that many counsellors working with torture survivors in sub-Saharan Africa consider existing EBP guidelines inadequate or even irrelevant to the needs of their clients and the demands of their context. And yet, it is acknowledged that EBP guidelines are fundamental to establishing a minimum quality of service provision in the interests of clients. Such guidelines also provide boundaries and protection for counsellors working in unpredictable and poorly resourced contexts with intense traumatic material. As described in Chapter 4, the counsellors who participated in this research showed generally low risk of burnout and secondary traumatic stress and high levels of compassion satisfaction. Nevertheless, the dangers of vicarious traumatization are well documented in the literature (Akinsulure-Smith, Keatley, & Rasmussen, 2012; Deighton, Gurris, & Traue, 2007), and the availability of evidence-based

guidance would serve this group of mental health professionals well. This may explain some of the enthusiasm with which participating counsellors engaged with this research. They are motivated to share their experience of work with torture survivors in the region and to learn from others.

The analyses of counselling related data highlighted some additional features of typical therapeutic processes with these torture survivors. Most clients did not seek help primarily for reasons of poor mental health, although all reported significant and enduring psychological symptoms. Often clients were seeking referral to medical practitioners due to chronic health problems or untreated injuries, legal assistance, or support for basic survival needs. This focus on immediate practical difficulties suggests that motivation to commit to intensive therapeutic work of longer duration was uncommon. The observation that it may be difficult to retain clients in these kinds of contexts in medium to longer term therapy is reflected in the relatively short courses of therapy documented in case files, the fact that very few clients ended their therapeutic work in a managed fashion, and the fact that in most instances it was not possible to conduct follow up clinical assessments. Rather than striving to get clients to accommodate to intervention protocols requiring lengthy dedicated commitment to attendance it seems more appropriate to recognise the contextual pressures that both clients and counsellors face and to aim to adapt interventions accordingly.

There was a high degree of agreement between torture survivors and their counsellors on what aspects of the therapeutic work were particularly helpful. These included work to process past traumatic experiences, work aimed at supporting and strengthening family bonds, and pragmatic approaches to coping with difficult life challenges including advice on symptom management, problem solving, and sustaining hope and disputing beliefs about helplessness and hopelessness.

As one of the outcomes of the research process it seemed important not just to engage in rigorous exploration of existing patterns and to offer an informed critical perspective but also to attempt to propose what might be required in a framework for intervention that is better adapted to this context. The findings suggest that torture survivors in sub-Saharan Africa would be well served by an approach that: recognizes that mental health concerns are typically not clients' most pressing concern; that offers meaningful practical support and relief from symptoms that will continue to help clients even if they leave counselling after only two or three meetings; that builds skills and resources to cope with difficult life challenges and ongoing and future threats; that recognises that bereavement and loss related work may be required as central to intervention; and that recognizes that despite lack of

stability and safety many survivors can tolerate and benefit from opportunities to process traumatic memories. With this in mind, I have developed an original approach to intervention that might be more helpful to counsellors and torture survivors in sub-Saharan Africa than existing practices and models. This approach attempts to address some of the challenges related both to the context and to client population characteristics that emerged from the review of case files by integrating existing evidence with the learnings gleaned from the narrative interviews with survivors and their counsellors. I have labelled this approach the Foundational Capacities Approach (FCA) to emphasize its focus on the development of skills and resources for surviving under conditions of ongoing insecurity and deprivation.

The Foundational Capacities Approach (FCA)

In the sections that follow I present a set of principles that underpin the FCA and explain its rationale, and then describe the proposed process and therapeutic components.

Underlying Principles

The FCA is proposed as a time-limited approach (12-18 individual sessions) targeting torture survivors presenting with severe and lasting distress. The need for this level and kind of intervention is clear from the results of this research and falls in line with recent reviews of clinical outcome data (Lambert & Alhassoon, 2015). It is necessary to find an appropriate balance between various competing factors. These include developing interventions of sufficient intensity and duration to make a significant impact on the psychosocial functioning of torture survivors; offering some variation in duration depending upon the needs, circumstances and resources of the client; and, ensuring feasibility and scalability given the large populations of torture survivors in need of assistance.

Therapeutic outcomes are broadly conceptualized in terms of functional independence and healthy social functioning, with more specific therapeutic goals under these general headings being identified in conversation with the client. Assessment is brief and directed towards clients' expressed needs, expected therapeutic outcomes, and level of functioning with regard to core psychological capacities.

The FCA is assessment-based. The assessment process is designed to be as efficient as possible so as not to delay direct supportive intervention and increase client engagement in the early stage of the therapeutic process. Haroz, et al. (2020) offer practical suggestions for shortening assessment measures for use in humanitarian contexts while retaining validity and reliability. Rather than eliciting a detailed trauma history, counsellors are encouraged to ask

about torture and related violations only to the extent that is needed to confirm eligibility for services. The recent discussion in the journal *Torture* about the usefulness of the Istanbul Protocol (IP) as a standard assessment process for torture survivors, especially those in low resource settings (Kelly, Jensen, Koch Anderson, Christiansen, & Raj Sharma, 2016; Beriashvili & Iacopino, 2016; Özkalıpcı, 2016) is important background here. The results of this study suggest that extensive assessment for the purposes of documentation at the beginning of a counselling intervention is impractical in many settings in sub-Saharan Africa and may reduce client retention. More in-depth assessment and documentation in line with the IP might be appropriate for some clients at a later stage in their recovery.

The FCA draws upon research that demonstrates the centrality of non-specific therapeutic factors in work with traumatized clients, particularly with more complex presentations (Gerger, et al., 2014). The quality of the therapeutic relationship is fundamental to rehabilitation and starts with essential respect for the personal dignity of the survivor. Genuine warmth and interest in the history and circumstances of the survivors' community and country of origin is important, as is transparency and trustworthiness in all aspects of the therapeutic work.

The FCA is trans-diagnostic in the sense that therapeutic work targets psychological capacities of importance to a spectrum of mood and anxiety disorders. Treatment planning includes selecting the most appropriate components in relation to the needs of individual clients. This approach is in line with the findings of recent commentators who argue that trans-diagnostic approaches are the likely to overcome the clinical and logistical challenges associated with the dissemination of EBP (Farchione & Bullis, 2014).

The FCA is delivered in phases. Early phases are designed to provide immediate support, increase engagement, and create a suitable foundation for therapeutic work. Later phases aim to strengthen core psychological capacities that support recovery after traumatic experiences, loss and dislocation. Phases are designed in such a way that clients who are unable to complete the full 12-18 sessions can end treatment at the end of earlier phases in a managed way and derive some benefit from such limited engagement. All phases emphasize "home practice", that is encouragement to practice the skills developed with the counsellor between sessions.

The question of safety is always important for trauma victims and for torture survivors in particular. In their review of the therapeutic outcome literature with torture survivors, Patel, et al. (2016) raise an ethical concern about the use of brief exposure methods for complex trauma presentations without sufficient contextual understanding of torture, or

the necessary safety described in highly regarded PTSD treatment guidelines (National Institute for Clinical Excellence, 2018; Foa, et al., 2009; International Society for Traumatic Stress Studies, 2018). In this case "safety" is described as a state in which further victimization is extremely unlikely. If, as counsellors, we accept the argument that it is unsafe, and therefore unethical, to conduct exposure work with survivors who are living in situations of ongoing threat, we are effectively denying the most refugees and torture survivors the potential benefit of exposure-based therapeutic approaches. As described in Chapter 3, these are the most rigorously researched and best supported counselling approaches. This is not merely a temporary delay for most refugees and torture survivors, many of whom will live with ongoing threat in their daily lives for the foreseeable future, perhaps even for the rest of their lives. In contrast to this untenable position, others have argued that complex forms of PTSD are somewhat rare in refugee populations (Ter Heide et al., 2016) and that interventions that include brief exposure components have been shown to be effective even in volatile settings (Robjant & Fazel; 2010). If this is true, then at least some torture survivors living under ongoing threat will be able to tolerate exposure-based counselling approaches and reap the therapeutic benefits associated therewith.

The FCA conceptualizes safety as a fundamental principle of trauma-focused intervention but notes that torture survivors in sub-Saharan Africa are commonly trapped in precipitous situations for many years. Situations of "continuous traumatic stress" (CTS) may result from ongoing harassment by authorities, prolonged civil conflicts, lengthy asylum procedures, hostile host communities, and inadequately secured refugee camps (see Chapter 7). Therapeutic work in some form needs to continue despite such conditions. The FCA advocates a multi-level response to the question of safety that includes building internal and external resources for living under conditions of ongoing threat, developing strategies to reduce risk and increase safety, and proscriptions on exposure work in situations in which clients are at risk of further victimization.

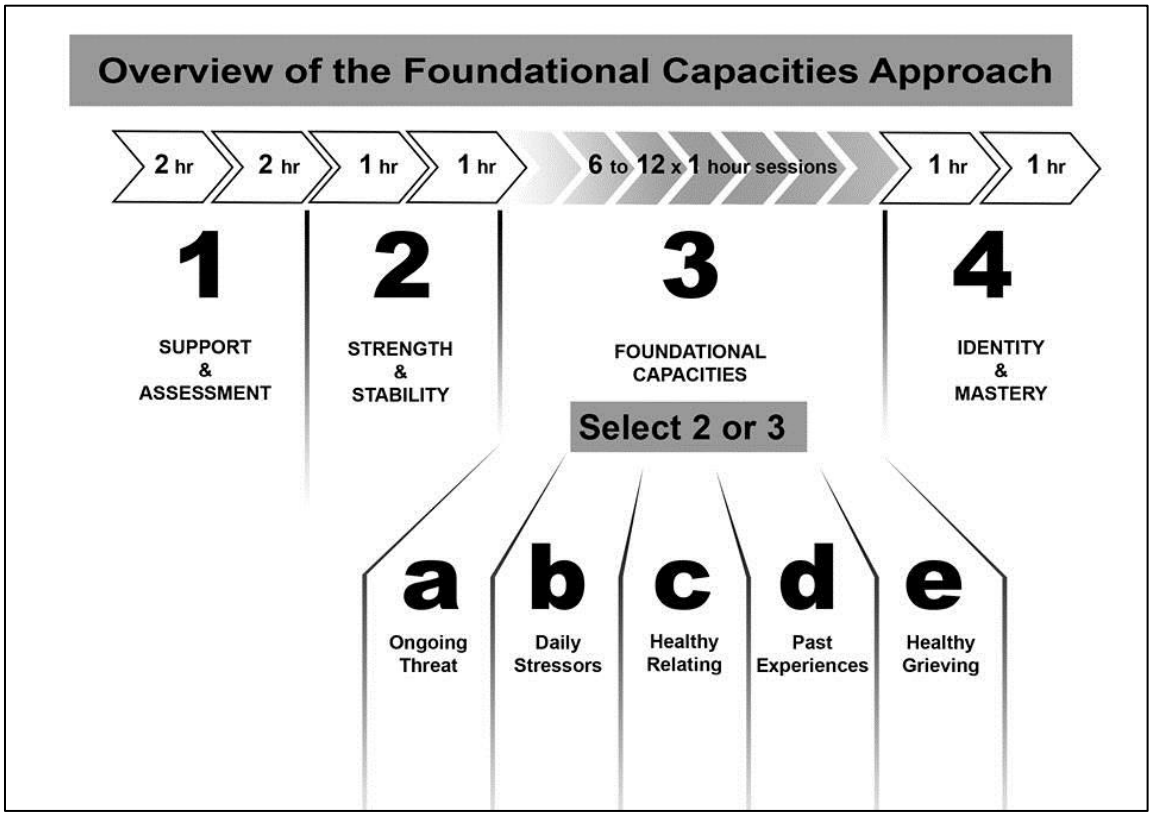
The FCA is broadly specified so as to be applicable to a range of cultural and religious groups. The broad parameters of the FCA are intended to provide guidance for counsellors, recognizing that they are most appropriately positioned to adapt details to the preferences of the communities they serve. The FCA requires limited knowledge of psychological theory and can be mastered by practitioners from a range of backgrounds following limited training. However, as with all approaches that employ paraprofessionals and lay counsellors, implementation of the FCA would requires close supervision and

ongoing training by licensed and experienced mental health professionals. The apprenticeship model is an excellent approach in this regard (Murray et al., 2011).

Therapeutic Components and Process

As illustrated in Figure 9.1, the FCA comprises four broad phases. In the third phase the counsellor selects two or three components from a possible set of five.

Phase 1: Initial Support and Assessment



The goals of Phase 1 are to: (1) build rapport with the client; (2) outline the ethical and pragmatic boundaries of the intervention; (3) complete a brief assessment and identify the client's goals; (4) develop a shared language to communicate meaningfully about bodily sensations, emotional states and thought processes; (5) offer immediate support and guidance concerning the client's most pressing concerns; and (6) agree the duration and course of the therapeutic process.

This phase is designed to address three dynamics identified in the research. These are that clients value practical information and tools that help them understand and manage incapacitating symptoms in the short term; that contextual features mean that client attendance tends to be brief or short term; and that existing assessments are commonly experienced to be too long and of little immediate benefit to clients. By making assessments

shorter and integrating practical support from the very start of counselling practitioners will provide valued assistance in the initial sessions and possibly increase client engagement for longer term work. To achieve this, counsellors are encouraged to schedule more time (approximately two hours) for each of the first two sessions. Although longer sessions introduce the risk of emotional exhaustion, this can be ameliorated by scheduling a short break during which the client is offered something to eat and drink, limiting the discussion and elaboration of traumatic material in the initial sessions, and closely monitoring the client's energy level.

The counsellor uses these first sessions to systematically document the client's core concerns and complaints, and to offer some immediate guidance on how the client might better cope with these issues, including giving suggestions and advice as to how to cope with the most troubling symptoms, at least in the short term. An excellent resource in this regard is the Dignity Field Manual on Rehabilitation (Dignity, 2013) which offers practical and evidence-based suggestions on how practitioners might respond to a wide range of complaints commonly reported by torture survivors. Clients are encouraged to implement this guidance as part of home practice and to report back to the counsellor on the results. This phase might also require referral to additional service providers, as well as support for the use of psychotropic medications.

Phase 2: Strengthening and Stabilizing

The second phase of the FCA is designed to build the client's capacity to engage with life challenges through the strengthening of internal resources and external support systems. The goals of the second phase are to: (1) strengthen the client's capacity to monitor and modulate arousal and affect; (2) instil hope and a commitment to sustained, cooperative rehabilitation work; and (3) to assess the client's emotional capacity to engage with more challenging therapeutic work.

Both clients and counsellors affirmed the value of psychoeducation, skills for arousal and affect regulation in the therapeutic process, as well the value of strengthening spiritual and familial support. In the FCA emphasis is placed on existing capacities and coping skills, which may be enhanced using breathing techniques, systematic muscle relaxation, guided imagery, prayer, or mindfulness practice, providing these are personally and culturally acceptable. The effective use of existing support systems, including family and friends, as well as members of faith and community networks, is also important here. The client is

encouraged to work on enhancing these dimensions and sources of support as part of home practice.

In this phase "safety" is assessed not as an absolute, but in terms of the client's readiness to engage effectively with the potentially distressing conversations related to their torture experiences and their capacity to manage to engage in challenging therapeutic work. Decisions about what is appropriate in Phase 3 are based in part on the counsellor's observation of the client's capacity to regulate affect and arousal, and to effectively use available support structures.

Phase 3: Developing Core Capacities

Based on the outcomes of the first two phases and collaborative exchanges, the counsellor selects between one and three components (of five) that are judged to be most likely to benefit the individual client. The therapeutic goal in this phase is to strengthen foundational capacities that are most likely to enhance the client's overall functioning. The findings in this research, combined with client and counsellor reflections on most helpful therapeutic interventions, suggest that the following five core capacities are essential for work with torture survivors in sub-Saharan Africa: living with ongoing threat; effective action to ensure basic survival needs; healthy relating; healthy grieving; and, processing of traumatic memories.

3a Living with ongoing threat

As described in Chapter 7, many clients reported threats to their physical safety or that of their family (including direct threats and actual attacks) within their current context. These clients typically feel unable to secure a tolerable level of physical safety. Counsellors are encouraged to collect more information, being aware of the increased sensitivity to threat cues associated with post-traumatic stress but starting with the assumption that the client may realistically be in current danger. The therapeutic goal is to increase the client's capacity to conduct effective threat appraisal and to implement effective security measures. (Note that although the goal is not to take responsibility for the client's safety, since this is typically beyond a counsellor's sphere of control, it may be necessary to advocate on behalf of the client and use referral mechanisms to assist the client in becoming safer). During the research many counsellors underlined the importance of helping clients with reality-testing and thought patterns associated with fears about safety and future vulnerability. Should threats be found to be exaggerated in seriousness or frequency, cognitive work to assist the client to

more accurately differentiate situations of safety and threat is indicated. Once a reliable threat assessment has been conducted the counsellor should be able to assist the client to develop risk mitigation and safety plans. Such plans need to be pragmatic, feasible and with a reasonable chance of success. Implementation of safety plans becomes the work of home practice, with the counsellor and client assessing progress and refining the plans during subsequent sessions. Reinforcement of Phase 2 coping strategies is also useful in reducing anxiety and increasing access to protection.

3b Effective action in response to demands of daily life

This component is appropriate for clients who report feeling helpless and being inactive in the face of the most fundamental demands of daily living. Such demands include being able to provide food and shelter for themselves and their family; accessing medical, legal or other important services; or generating a basic income. During the research both clients and counsellors emphasized the importance of problem solving and planning interventions. The therapeutic goal in this phase is to have the client take effective and sustained action towards meeting life demands. (Note that the goal is not necessarily that the problem be entirely resolved since accessing resources cannot be guaranteed by counsellors). Cognitive work may be indicated to confront beliefs of helplessness or hopelessness, with attention being given to the competencies, resources and opportunities that are available to the client. The counsellor should help the client with effective planning (defining the problem, considering multiple options, selecting the option most likely to lead to success) and implementation (determining manageable action steps). Implementation becomes the work of between session practice with the counsellor supporting and encouraging further and sustained action in subsequent sessions.

3c Healthy relating

Interventions concerned with strengthening the family unit emerged as the second most important category of therapeutic work in the research. This component is important for clients who report being isolated from, or in conflict with, family and other members of their community. The goal is to help clients give and receive meaningful emotional support, and to take pleasure in the company of others. Cognitive work may be needed to explore beliefs and negative thought patterns about self and others. Capacity building in effective communication, anger and conflict management, and interpersonal problem solving may be

helpful. Together counsellor and client develop a strategy to assist the client to strengthen existing relationships and to form new supportive relationships.

In many cases this component is focused directly on relationships with the clients' partners and other members of the immediate family. Counsellors with the relevant training are encouraged to conduct couple or family sessions as appropriate. It may be helpful to provide members of the family with psychoeducation about torture and its impact, as well as possible indirect effects on people living with someone who is suffering. Advice to family members on how best to support the victim can be empowering, as can guidance on how to speak to children of different ages about torture, trauma, dislocation and their impact.

Active engagement with religious communities, as well as with appropriate support groups may be helpful in building a stronger social network. Implementation happens through home practice with counsellor support and encouragement of sustained work towards building a supportive social network.

3d Processing and integration of traumatic memories

Both clients and counsellors reported that the retelling of stories of traumatic events was particularly helpful. This is supported by substantial evidence that brief exposure work, having clients remember and recount a detailed narrative of their traumatic experiences within a supportive context, is effective in reducing symptoms associated with PTSD. A range of studies have demonstrated the effectiveness of Narrative Exposure Therapy, Testimony Therapy, and other cognitive behaviour therapies that include an exposure component (Esala & Taing, 2017; Robjant & Fazel, 2010; Schauer et al., 2011; Weiss et al., 2016). This component is indicated for clients whose functioning is impaired by the intrusive and avoidance type symptoms associated with PTSD. This component is not recommended for clients with limited capacity to manage their own arousal and affect (Phase 2), those struggling with ongoing threat (Phase 3a), or those who are currently unable to meet the demands of their daily lives (Phase 3b).

Counsellors with training in exposure techniques such as those mentioned above are encouraged to employ them within the broader FCA approach. Regardless of the approach to brief exposure employed, it is essential that adequate time be allowed for the full habituation and integration of traumatic memories. For this reason, this component is recommended only for clients who can attend counselling on a regular, predictable basis.

3e Healthy grieving

As discussed in Chapter 6, this research shows that a significant number of torture survivors in sub-Saharan Africa struggle with complicated grief reactions following sudden and often violent bereavement. This component is indicated for clients who have lost a loved one in the past two years, and who report that their associated grief impairs their functioning. Recovery requires that the client be assisted to distribute coping resources across three dimensions of loss: (a) role and identity related stressors, (b) traumatic stressors related to the manner of death, and (c) loss-oriented stressors. Role related stressors pertain to more material consequences of the loved one's death, such as loss of income, increased burden of supporting a family, and increased burden of childcare and care for other members of the family. Relevant therapeutic interventions supported by clients and counsellors include family interventions, problem solving and planning, and instilling hope. In relation to (b) managing traumatic stressors means reducing or coping with any debilitating traumatic stress symptoms linked to witnessing or imagining the circumstances of a loved one's violent death. This process requires aspects of the brief exposure work described under 3d. Central to this component of intervention is coming to terms with (c) loss-related stressors, that is, everything that has been lost with the relationship with the deceased such as love, companionship, support, dreams for the future and self-esteem. Healthy grieving includes remembering and honouring all that has been lost, as well as engaging in the personal and public rituals of mourning that provide the mechanisms, social support and time frames for grief. Since these are typically culturally determined and communal, displaced persons often struggle to enact these rituals fully. Therapeutic interventions include grief counselling, family interventions, and encouraging complementary spiritual practices. Home practice comprises problem solving and planning so that the appropriate rituals may be completed.

Phase 4: Continuity of Identity and Tempered Mastery

The FCA closes with two final sessions in which the client and counsellor collaborate in a retrospective assessment, paralleling the phase one assessment and providing the client with an opportunity to note any changes in functioning. Where areas of difficulty remain, the counsellor assists the client in thinking about how that area of need could be managed in the future. It may be that further or alternate intervention is indicated, or it may be possible for the client to keep on working on that issue with the support of family and community.

These final two sessions also provide an opportunity for the counsellor to engage with questions of identity and tempered mastery (Utržan & Northwood, 2016), issues considered

core to client's future functioning. The counselling is centred on two inter-related questions. The first is, "when thinking about the experiences that brought you here and our counselling work together, what parts of you have changed, and what parts are still the same?" This conversation creates opportunities for the client to acknowledge aspects of core identity that may have been lost, but also to identify those parts that remain, and which may serve as core internal resources and strengths. Religious, cultural and political identities are important aspects of personal identity that are commonly preserved, as is the strength and commitment to continuing to struggle for a better life.

The second question is, "in what areas of your life do you feel that you are in control, and in what areas do you feel that you have less control?" This question invites the client to recognize the uncertainties and constraints of their current situation, but also to notice the aspects of their existence over which they can exercise control. This question leads into a final discussion of the client's intentions and plans for moving forward with their life after counselling. In some cases, these questions open up the possibility of other forms of redress that may be important to the client. For example, at this point, some clients may wish to have the details of their torture and the impact thereof formally documented. Although both narrative exposure and testimony therapy emphasize the production of a written narrative, more formal documentation may be required for future investigations and accountability processes.

Conclusion

As described in Chapter 4, the published papers emerging from this research have been shared with the participating counsellors and their organizations, as well as the Center for Victims of Torture (CVT). CVT has incorporated the work on traumatic bereavement and ongoing threat into its revised adult group counselling model (Center for Victims of Torture, 2016). Over 3,500 refugees and torture survivors, the majority of whom live in sub-Saharan Africa, receive counselling using this model every year. At the time of completing this thesis only one organization has received a presentation on the FCA. This organization has expressed interest in incorporating some of the principles and components of the approach into their clinical programming. At present, although the various components of the FCA are based on therapeutic tools with moderate to strong empirical support in populations exposed to war and torture (including populations in sub-Saharan Africa), the integrated approach remains untested. It is offered here as a contextually responsive, feasible and evidence-based starting point on which other African researchers and clinicians will hopefully build.

Chapter 10 Recommendations for Policy, Practice and Future Research

In this chapter I reflect on the strengths and weaknesses of this research study and consider the policy implications of the findings as they apply to the work of donor agencies, INGOs, national NGOS, and researchers.

Strengths and Limitations of this Research Study

As described in Chapter 3, although there have been a number of research studies (including clinical trials) relating to counselling torture survivors in sub-Saharan Africa, very few studies have investigated the counselling approaches, challenges and outcomes that characterize everyday practice in existing rehabilitation centres. The pragmatic, real-world focus of this study is both a strength and a limitation.

It is a strength in that a deep understanding of the capacities, contextual challenges, and constraints of existing service delivery systems is a necessary starting point for the further development of those systems and the delivery of hopefully more impactful services to a broader group of torture survivors in the region. However, the real-world focus is a limitation in that it raises questions as to the generalisability or transferability of these findings. Sub-Saharan Africa is a huge region incorporating more than forty countries and hundreds of cultural and linguistic groups. Many of these countries share similar histories of colonialism, armed struggle for independence and protracted internal conflict; similar economic challenges, including high levels of poverty and unemployment; less security and more fragile government than is common in the Global North; as well as, limited health and social services. However, there are also important differences which should not be under-estimated. Some countries on the continent remain embroiled in internal and cross-border conflicts while others are peaceful. Some states in the region systematically employ torture to maintain political control, while others may have challenges in responsible law enforcement, but incidents of torture tend to be occasional rather than systemic. Of those countries that have transitioned out of past conflicts, some have engaged publicly with processes of reconciliation and truth-telling with regard to past practices of torture and other gross human-rights violations; others have publicly dismissed or minimized their violent histories; and still others continue to systematically cover up evidence of torture and war crimes. Drožđek (2010) describes countries as “excavators”, “deniers” or “buriers”, and discusses the impact of the various approaches that countries choose to adopt in relation to their past on the rehabilitation of torture survivors, collective healing, and peace-making. As has been argued,

these and many other contextual factors have a profound effect on the mental health of torture survivors, their response to opportunities for redress and recovery, and on the work of mental health service delivery. It is inevitable that different contexts will emphasize different forms of torture or other gross human rights violations, including sexual torture, trafficking and slavery, use of children as combatants. These didn't emerge as the most salient issues in this research but they are all well documented as distinctive violations that might require additional targeted intervention. As with all research, readers are encouraged to be judicious in considering the relevance of these findings to other service delivery contexts.

Readers may also notice the lack of coverage of concepts like resilience and post traumatic growth. One of the ways of understanding resilience is as having the resources (both internal and external) to survive in the face of adverse circumstances. Given this understanding of the concept, the therapeutic approach outlined in Chapter 9 can be understood and disaggregating this complex construct into a set of achievable capacities. As with many other constructs, post-traumatic growth did not emerge as a salient issue in the data. That is not to say that growth may not emerge from the approach proposed, especially in relation to the final phase with its focus on continuity of identity and tempered mastery. Growth should be noted and appreciated when it materializes, but it is not proposed as an expectation in models of torture rehabilitation

It is also important to note that the three participating centres were all located in large urban areas. As such, these results do not speak to service provision in rural communities, camps or settlements. Based on my reading of the literature and experience in the field over many years, there are in fact almost no specialist services for torture survivors in sub-Saharan Africa that are easily accessible to people in rural communities, and services in camps and settlements tend to be run by United Nations entities, and their international NGO partners. Rural and camp settings present their own challenges, opportunities and constraints, many of which have not been addressed in this study.

The use of client file review as a core component of the methodology also has advantages and disadvantages. This study focused on the needs and experiences of help-seeking torture survivors. The findings say very little about the vast majority of torture survivors who are unable or unwilling to seek assistance for any psychosocial challenges they might be experiencing. This is a common problem in much research with torture survivors due to the nature of this crime. As an unobtrusive method of data collection, the review of client files has the advantage of avoiding issues of reactivity on the part of both clients and their counsellors. With such vulnerable populations and sensitive material, questions of

reactivity can be highly problematic. By reviewing client files I was able to analyse how torture survivors presented for care outside of a research context, and how mental health practitioners experienced and recorded their meetings with these clients. As a research methodology, case file review is not without its challenges. This approach is heavily reliant on the consistency of each organization's clinical and record-keeping systems, and the thoroughness of individual practitioners' record keeping. At each centre, the review of case files showed up issues in record-keeping, including entire missing files, misfiled information, incomplete assessment data, and missing counselling notes. In each case, I met with the person responsible for client record systems to discuss the gaps in record keeping that my research had brought to light, and to suggest ways of strengthening the system. For the purposes of the research, and as discussed in Chapter 4, missing records were replaced with the next available record and for each record in the sample an estimate of record completeness was included in the coding.

Perhaps the greatest limitation in the case reviews was the lack of assessment data at the time of discharge or follow up. As a result, this component of the research was without any measures of clinical outcome that can be compared across time, client group or centre. Practitioners were aware of this problem as well as the importance of having defensible clinical outcome data. They reported that the lack of such data was due to the high number of clients who ended the therapeutic work in unplanned ways, leaving no opportunity to collect data at discharge. This explanation is borne out by the analysis of the client files, with relatively few files recording an intentional process of therapeutic termination. While this is a problem for research on therapeutic efficacy, it is an even bigger problem for the therapeutic work itself. If counsellors cannot predict how long clients will be able to attend sessions and when and how they will leave therapy, they are unable to implement a thoughtful therapeutic plan and to end the intervention in a healthy, professional manner. This learning was fundamental to the design of the FCA outlined in the previous chapter.

The recruitment of torture survivors to participate in the in-depth interviews as well as the design of the narrative interviews emphasized successful therapeutic work. For ethical and logistical reasons, I did not try to sample torture survivors whose therapeutic journey had been unsuccessful, and in interviewing torture survivors I focused on the positive aspects of their experience. As such, this data has little to offer in terms of counselling work that was not seen as helpful, that might have damaged the therapeutic relationship, or indeed that may have caused distress or harm to clients. Interviews with counsellors also focused on positive outcomes, although in these interviews many counsellors also chose to describe setbacks and

challenges that they had experienced in their work with torture survivors. Any research intended to offer guidance to practitioners working with vulnerable populations must carefully consider the potential for harm. However, for the purposes of this research it was considered ethically responsible to focus on interviewing torture survivors who felt they had benefitted from counselling and were sufficiently stable to take part in the research. It is maintained that despite the focus on 'what worked' rather than 'what didn't' the research findings still offer responsible and useful insights to guide contextually appropriate and client-focused intervention. Clinical supervisors and centre managers, in their review of the draft and published papers, confirmed that they considered this work helpful in refining their centres' assessment, client information management, and counselling work.

Implications for policymakers and funders of torture rehabilitation work

Over the past decade policymakers and funders have begun focusing more intensely on the use of evidence-based practices (EBP) in torture rehabilitation. This is an important positive development in the field with the potential to increase the quality and effectiveness of mental health service delivery to torture survivors. However, in order to achieve these aims the conceptualization of EBP must be well-informed and nuanced.

The review of the current treatment outcome literature (see Chapter 3) raises several important points for policymakers and funders to consider. Firstly, the notion of EBP for torture rehabilitation is a problematic one. Typically, EBP is developed for particular conditions or diagnoses (for example, EBP for treatment of PTSD). The crime called "torture" is a complex legal construct that takes many forms, and the symptomatic and psychosocial consequences of surviving torture are even more varied. In a strict sense, it is nonsensical to speak of EBP for survivors of torture. And yet, at a pragmatic level, many torture survivors do share some common features and disorders for which there are well established, evidence-based treatment approaches that have been tested with multiple populations in varied contexts. It is appropriate that torture rehabilitation practice draws heavily on such approaches, but it is counter-productive to imagine that all torture survivors will be best treated using a single manualised approach.

Secondly, the existing evidence base for the treatment of torture survivors is in fact very limited. As discussed in Chapter 3, studies are relatively few and often methodologically weak. Multiple reviews of this evidence base have been inconclusive and have offered only highly qualified guidance to clinicians. The evidence base for treatments of torture survivors

in sub-Saharan Africa and other parts of the Global South is even smaller and many approaches are yet to be rigorously tested.

Thirdly, the evidence base that does exist is mostly focused on a very narrow set of clinical outcomes (typically reduction in symptoms associated with PTSD, depression and anxiety). Such clinical outcomes fall far short of the vision for rehabilitation laid down in UNCAT (UN General Assembly, 1984), or the General Comment Three (United Nations Committee Against Torture, 2012) that provides elaboration on the clauses relating to rehabilitation in the convention. Existing EBP guidelines are limiting in that they largely restrict the definition of rehabilitation to those aspects that have been the traditional focus of medicine (namely symptom reduction) and are easiest to measure with existing assessment tools. As discussed in Chapter 3, there is evidence that these outcomes are not necessarily the outcomes that are of greatest concern to torture survivors in sub-Saharan Africa.

Finally it is important that policy-makers and funders recognize that the failure by practitioners in sub-Saharan Africa to employ EBP in their work is not necessarily the result of ignorance or a lack of professionalism, but is often due to strong conviction that narrowly conceived and overly rigid practices detract from the quality of care provided to survivors. There is also a sense that having attempted to implement such approaches in accordance with international prescripts clients may experience such interventions as alienating for a range of context-related reasons. As discussed in this research and elsewhere, there exists substantial evidence supporting such convictions.

With the above points in mind, it is recommended that policymakers and funders adopt a three-dimensional definition of EBP that integrates (i) scientific evidence derived from a range of methodological approaches; (ii) clinical judgment and expertise; and, (iii) awareness of the contextual and cultural characteristics of clients. Thus, it is recommended that policymakers and funders not require the use of particular kinds of EBP at this time if research into torture interventions is to expand and deepen across contexts. Instead it is recommended that funders encourage practitioners in sub-Saharan Africa to use, adapt and evolve a range of approaches that have an existing evidence base. It is recommended that practitioners are requested and supported to document the approaches that are employed in practice and the related clinical outcomes that are anticipated. In addition, practitioners should be supported, as far as possible, to measure those outcomes in a routine and replicable manner, at least at intake and discharge. Funders interested in the development of the field of torture rehabilitation should prioritize clinical innovation, documentation, assessment and evaluation over the ever-present desire to increase client numbers. Funders should also work

to enhance the capacity of torture rehabilitation centres to develop contextually and culturally embedded measures of clinical outcome, to conduct valid and reliable clinical assessment, and to more rigorously evaluate clinical impact.

Implications for INGOs from the Global North working in the Global South

This research was conducted with mental health practitioners trained and working in countries in sub-Saharan Africa. The analysis of these practitioners' work (described in chapters five through eight) reveal how few they are in number, how little support they have, and how limited their capacity is relative to the enormous and growing need for their services. Without discounting the various technical concerns discussed previously, the prevalence studies described in Chapter 2 underline the staggering extent of emotional suffering caused by torture, war and displacement in sub-Saharan Africa, suffering that remains largely unaddressed by existing health systems (including traditional, faith-based, state-run, or non-government systems). In this situation there is a clear moral imperative for international human rights and humanitarian action to ease suffering wherever possible. However, such action must always remain cognisant of the fact that the individual, family, community and societal impacts of torture and war are complex and lasting (see Chapter 3). It is therefore necessary that humanitarian efforts are accompanied by significant and intentional capacity development work that aims to build indigenous mental health and social support systems that will survive beyond the crisis that resulted in intervention in the first place. Examples of such systems include: community-based mental health services that are able to provide information and brief supportive services, as well as referral to further care as necessary; increased cooperation and understanding between cultural and religious healers and their counterparts in the medical professions; and community based healing and peacebuilding structures to support transformation following conflict.

The data for the study was collected in the context of a positive capacity development relationship between INGOs from the Global North and their African partners. Despite the intrinsic power differentials in these relationships, the interviews with practitioners were often deeply reflective and surprisingly frank. Counsellors spoke proudly of their successes but also openly about their limitations and doubts. Such dynamics speak to the potential value of international collaboration and the value of capacity development interventions in the Global South facilitated by experienced practitioners from the Global North. As a mental health professional who was born and raised in sub-Saharan Africa, and who has been trained and worked in the region for several decades, I do not take the position of some other

commentators that capacity development interventions are intrinsically more harmful than beneficial to mental health in the Global South (Summerfield, 2012). Instead, I argue, as many others have, that capacity development interventions that are politically engaged, culturally informed, and actively concerned with subverting the inevitable power imbalances of such relationships, can and do produce meaningful information exchange, innovation and increased therapeutic impact (Radice, 2019; Patel, 2019).

That said, mental health capacity development interventions that train large numbers of para-professionals in the use of a single methodology but do not simultaneously contribute to building sustainable mental health systems to support those counsellors, are at risk of doing harm to mental health providers, the torture survivors they serve, and the health systems within which they are located. A counsellor with nowhere to refer people whose needs are different to those that they have been trained to address is placed in an invidious position. They must either turn a suffering person away or try to help using the inadequate skills that they do have at their disposal. Either choice increases the counsellors' risk of burnout and vicarious traumatization, and is unlikely to result in a positive outcome for the client. It is therefore essential that capacity development interventions by INGOs prioritize the development of a cohort of highly skilled indigenous counsellor supervisors who are capable of critical analysis of the global literature; who are equipped to adapt EBP approaches to the contextual and cultural demands of their communities; and who can provide sustainable training and supervision to others.

Capacity development of local providers should be respectful of local knowledge and cultural norms, and indigenous providers should be supported to adapt counselling models to their local contexts. It is also important that local practitioners develop skills for interdisciplinary case management and consultation as well as clinical supervision. At an institutional level, service providing agencies in the Global South should be supported to build strong clinical systems including: outreach to affected populations; screening and intake assessment; informed consent for treatment processes; client information management systems; staff care policies; and, supervisions structures. The objectives of interventions by INGOs should include building mental health capacity and infrastructure that is integrated with the tertiary education, health and social service systems of the countries in which they are operating. CVT and other organizations have demonstrated that when intervention is conducted in this way for sustained periods (often more than ten years) it is possible for INGOs to remove their direct services and leave behind a sustainable infrastructure and service capacity that did not previously exist.

Implications for Future Research on the Rehabilitation of Torture Survivors

Although there are marked similarities between the psychosocial impacts of torture and other forms of violence, including war, forced displacement, domestic violence, and child abuse, there are also characteristics associated with torture, particularly the survivor's relationship to the state and its agents, which present special challenges. Much of the therapeutic outcome research that is applied to mental health work with torture survivors (see Chapter 3 of this thesis) is derived from mixed populations of refugees, war survivors and torture survivors. Where researchers have systematically assessed for a history of torture, the methods used vary widely from single item assessments using the word "torture" without further explanation, to detailed qualitative analysis of reported histories in relation to the criteria contained within the definition of torture laid down in UNCAT (see Chapter 1) as used in this thesis. Such detailed analyses are time consuming and require significant sensitive information from research participants. However, single item assessments are unlikely to be reliable, producing false negatives from participants who define torture in an overly narrow physical sense and who would not, for example, define witnessing the torture of others or mock executions as torture. Similarly, false positives are common from participants who might define acts of domestic violence and cruelty as torture. These problems are compounded in cross-cultural work where translation is necessary. In some languages it is difficult to find words that distinguish between the English words for "torture", "abuse" and "violation". The concept of "torture", although clearly defined in UNCAT, is often distorted by powerful voices in public discourse, adding to the confusion. Consider for example the use of the term "enhanced interrogation" by the United States government in international propaganda. Where detailed analysis of reported histories is not possible researchers have successfully used a series of nested questions that touch on specific aspects of the experience to reach a more reliable assessment of torture history. Regardless of the methodology employed researchers who wish to contribute to the literature on torture rehabilitation should strive for greater rigour in identifying and describing torture survivors as a clinical population.

As described previously, the field remains dominated by researchers from the Global North. What research has been done in the Global South has often focused on trans-cultural effectiveness and acceptability. Without detracting in the least from the importance of trans-cultural research, it is important to note that research in the Global North tends to focus on torture survivors living in resettlement contexts. And yet, many torture survivors are located within the refugee camps, cities and settlements of the Global South. Questions of context are

at least as important as questions of culture in the study of rehabilitation in sub-Saharan Africa. The domination of researchers from the Global North and the emphasis on trans-cultural work in the Global South results in a structural bias that runs through the contemporary scientific discourse on the rehabilitation of torture survivors. It is essential that future research in this field privilege work with torture survivors living in the Global South, and that it should be conceived and designed in relation to contextual factors, including those identified in this thesis.

A leading concern when considering contextual appropriateness must be the outcomes by which the effectiveness and appropriateness of therapeutic interventions are judged. As described in Chapter 3, the science of torture rehabilitation remains largely concerned with symptom reduction across a limited set of mood and anxiety disorders. Beyond the well-developed discussion of how universal such conceptualizations of mental health are, is a broader question of what kinds of outcomes are prioritized by torture survivors themselves, particularly torture survivors who are struggling to survive in dangerous and poorly resourced contexts. Various authors have recommended the use of different therapeutic outcome variables such as quality of life and daily functioning, either in addition to mental health outcome measures or as primary measures instead of those related to psychiatric diagnostic features. While a few empirically supported measurement tools have been developed to asses these complex constructs, many researchers have been reluctant to shift their gaze, preferring instead to focus on the tried and tested symptom indicators.

In order to better understand the recovery trajectories of torture survivors receiving mental health care it is essential that the existing set of treatment outcome studies be supplemented by studies of therapeutic process. The reflection in this thesis on the therapeutic components that were most helpful represents some indication of therapeutic process, but more nuanced analyses are needed. It may be that such analyses will advance our understanding in ways that break the current impasse in outcome-focused research where various approaches demonstrate positive impact but there is little evidence to support the use of any one over others. Similarly, more detailed analysis of the trajectories of clients who do not respond positively to treatment modalities may develop the field more than more treatment outcome studies. For example, Dattilio et al. (2010) advocate the use of a layered methodology that includes randomized clinical trials of therapeutic outcomes, more fine-grained qualitative analysis of the treatment implementation process, and systematic case studies. Such research calls for deep collaboration between researchers and practitioners,

something that is critical to the future development of research that meaningfully informs mental health intervention with people who have survived torture.

Conclusions

In this thesis I have attempted to offer an informed critique of the state of torture rehabilitation services in sub-Saharan Africa. I have endeavoured to carefully and systematically document and evaluate current practice from a ground-up perspective, across three different countries and centres in different parts of sub-Saharan Africa. Drawing from this analysis I have imagined an approach to torture rehabilitation that is reasonably comprehensive, responsive to the contextual demands of the region, and feasible given the resources of both clients and counsellors. Although developed from work in sub-Saharan Africa, it is likely that many of the methodologies and insights contained within this thesis have resonance with other parts of the Global South. I leave that to practitioners and researchers in those parts of the world to judge.

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APPENDIX A Clearance Certificate (Protocol Number H1 10206), the Human Research Ethics Committee (Non-Medical) University of the Witwatersrand, Johannesburg.

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)
R14/49 Higson-Smith

CLEARANCE CERTIFICATE **PROTOCOL NUMBER H1 10206**

PROJECT Conceptualising a contexually relevant torture counselling framework for sub-Saharan Africa

INVESTIGATORS Mr CH Higson-Smith

DEPARTMENT Psychology

DATE CONSIDERED 11.02.2011

DECISION OF THE COMMITTEE* Approved unconditionally

NOTE:

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

DATE 04.03.2011 **CHAIRPERSON** (Professor R Thornton)

cc: Supervisor : Prof G Eagle

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX B Letter of Support from The Center for Victims Of Torture (CVT)

THE CENTER FOR VICTIMS OF TORTURE℠

30 November 2010

Attention: Craig Higson-Smith
302 Ideal Village
30 Hannaben Street
Cyrildene, 2198
Johannesburg
South Africa

Dear Mr. Higson-Smith,

Your doctoral research proposal entitled, "Conceptualizing a Contextually Relevant Torture Rehabilitation Framework for Sub-Saharan Africa" has been read by our research director as well as key personnel in our projects in Sun-Saharan Africa. We feel that the proposed research has the potential to produce important insights for work in the field of torture rehabilitation.

While we understand that this research is independent of your work for the Center for Victims of Torture (CVT), your past and current relationship with CVT and the partner centers makes it important that your research meets CVT's ethical rules and standards. We are satisfied that your proposal covers the necessary ethical concerns in an appropriate manner, and are happy to have you proceed with the research under the auspices of the University of the Witwatersrand.

We understand that it might be possible to extend your CVT-based visits to centers and so save the cost of additional airfares. This is acceptable provided that no additional costs are incurred by CVT and that your data collection does not interfere with your trip objectives as defined in the relevant scope of work.

We wish you success with this project.

Yours Sincerely,

Jon Hubbard, PhD, LP
Research Director

APPENDIX C **Letter of Invitation to Participate and Associated Consent Form Addressed to Executive Directors of Three Torture Treatment Centres in Sub-Saharan Africa**

Psychology
School of Human & Community Development

University of the Witwatersrand
Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

October 6, 2011

Attention: Dr Joan Nyanyuki
Executive Director
Independent Medico Legal Unit
Kenya

Dear Dr Nyanyuki

I have recently begun work on a Doctorate in Psychology through the University of the Witwatersrand in South Africa. The proposed title for my dissertation is: *Conceptualising a contextually relevant torture rehabilitation framework for Sub-Saharan Africa*

As you are aware, torture rehabilitation has been my core research interest and work area for several years now. In my experience, most torture rehabilitation centres in Sub-Saharan Africa are working with a mixture of different psychosocial approaches and methods, often without any clear strategy or rationale. While African practitioners are aware of the models of torture rehabilitation supported by empirical research and guidelines coming out of Europe and North America, we are not using such methods. This suggests that we do not see those approaches as meeting the needs of our clients. The aim of this research is to develop a conceptual framework that does meet the needs of torture survivors in Sub-Saharan Africa and that can guide our practitioners. I am hopeful that the existing of such a framework will result in a higher quality of psychosocial intervention, greater positive impact for our clients, and a more contained work experience for our practitioners.

I plan to build this conceptual framework by bringing together the empirical research on torture rehabilitation with the experiences and knowledge of torture rehabilitation of African practitioners and their clients. More specifically, I plan to conduct the research in three torture rehabilitation centres in different parts of the continent.

I hope that the Independent Medico Legal Unit (IMLU) will participate in this study. Participation would involve the following components:

1. Allow me to interview clinicians, managers and clinical supervisors who are directly involved in psychosocial rehabilitation services at IMLU. Interviews would of course be entirely voluntary and confidential, and I would ask you as Executive Director to underline this so that staff do not participate out of loyalty to you and the organisation. Interviews would be

semi-structured and would explore your staff's experience of their work in rehabilitation. We would look at what approaches they are currently using, what they feel works well, and what areas they feel they are struggling with.

2. Allow me to interview two adult clients who have previously received psychosocial services through IMLU. I would ask that counselors assist me to identify clients who have completed their counseling and are currently sufficiently healthy and stable to be interviewed without undue risk of retraumatization. Again, this interview would be entirely voluntary and confidential and I would ask you as Executive Director to underline this so that clients do not participate as a result of loyalty to their counselors. Interviews with past clients will focus on their experience of services at IMLU, including what helped them the most and what they feel was less helpful. Clients will not be asked to speak about their traumatic experiences and I will terminate the interview and contain the client if he or she begins to get distressed.

3. Allow me to draw an interval sample of 30 case files of torture survivors from your existing files. I would like to analyse this sample of files on your premises so that I do not have to remove any files from your office. No names or identifying information will be recorded. Data to be recorded will cover client's identifying problems, client demographics, time between the most recent traumatic experience and presentation for care, number of sessions and duration of intervention, and measures or observations of client's recovery. I would also ask that a senior IMLU clinician check my coding of 5 case files for the purpose of a reliability check.

In reporting on this research (either in academic papers or in the dissertation itself), IMLU's participation will be acknowledged but the organisation's name will not be attached to any specific findings. I will also provide IMLU with copies of any academic papers published off this research and the dissertation itself. In addition, I would be happy to give feedback to yourself (and other staff or board members) on findings that come specifically from your organisation. Such report back would not of course compromise the confidentiality of your staff or clients.

I would like to stress that this work is entirely separate from my work with the Centre for Victims of Torture (CVT). Should you choose not to give me permission to work with IMLU in this regard, this decision will not affect IMLU's relationship with CVT, or indeed my personal commitment to supporting IMLU's work.

This work is to be conducted under the auspices of the University of the Witwatersrand and my supervisor Professor Gillian Eagle who can be contacted at Gillian.Eagle@wits.ac.za. I should also assure you that in order to proceed with the research I will submit the research study details to the relevant ethics committee of Wits University and will obtain the necessary approval to proceed with the actual data collection.

I have attached a copy of my research proposal for your further information.

Should you be willing to give permission for your organization to participate in the research, please complete and sign the attached letter and forward it to me.

Yours Sincerely

Craig Higson-Smith

Attention: Craig Higson-Smith

Email: craighs@telkomsa.net

Fax: +27-11-6166169

I have read the letter and the accompanying research proposal which details the logistical and ethical parameters of IMLU's participation in the research entitled, *Conceptualising a contextually relevant torture rehabilitation framework for Sub-Saharan Africa*, to be undertaken by yourself with the oversight of the University of the Witwatersrand.

The Independent Medico Legal Unit WILL / WILL NOT (delete whichever is not applicable) be available to participate in the research as detailed in your letter of request and the accompanying research proposal.

Signed on _____ at _____

_____
Dr Joan Nyanyuki
Executive Director
Independent Medico Legal Unit

APPENDIX D **Letter of Invitation and Consent Forms Addressed to Counselling Staff at Three Torture Treatment Centres in Sub-Saharan Africa**

I

School of Human & Community Development

University of the Witwatersrand
Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

Dear [INSERT CENTRE NAME] Counsellor

Invitation to participate in research

I am currently conducting doctoral research aimed at developing a contextually relevant framework to guide work on the rehabilitation of torture survivors in Sub-Saharan Africa. The desire to conduct this study arises from my work with several torture rehabilitation centres in the region, including with [INSERT POTENTIAL SUBJECT'S ORGANISATION]. Clinicians often request guidance or a "model" to guide their practice. This study is concerned with the adaptation of tested therapeutic approaches to the context of torture rehabilitation in Sub-Saharan Africa. I would like to invite you to participate in this research. Part of my chosen methodology is to interview people who are providing counseling to torture survivors directly. Through these interviews I hope to:

a) Develop a clinical description of the range of psychological and social needs with which tortured clients present.

b) Understand the training (both formal and informal) and experience and counselors working with torture survivors.

c) Document the details of current approaches to counseling torture survivors.

d) Discuss the effectiveness of current approaches to counseling torture survivors. Where are they most effective? What are the areas in which current approaches are less effective?

e) Discuss significant cases which are instructive in the treatment of torture survivors.

f) Discuss the organizational and logistical context within torture counseling takes place.

g) In addition I would like to measure counselor's emotional wellbeing through the use of the Professional Quality of Life Scale (ProQOL). I will score this test immediately and discuss the results with participating counselors.

Should you wish to participate in this research there are several important ethical provisions that you should be aware of.

1. Participation is entirely voluntary. Should you prefer not to participate, this decision will have no consequences for our future working relationship, or for my support for [INSERT CENTRE NAME] work.

2. Should you wish to participate, the interview will take approximately 90 minutes and will be held at [INSERT CENTRE NAME] at a time that is convenient for you.

3. I would like to record the interview so that I can be sure not to miss anything that you say to me. Nobody other than me will listen to the recording and the transcription will not include your name or any other identifying information. No identifying information will be attached to the ProQOL test. All data (original recordings before transcription, completed transcriptions, and completed ProQOL questionnaires) will be kept in a locked cabinet in my home in South Africa. Once the research is complete and the appropriate papers have been published the recordings and transcriptions will be destroyed.

4. No information will be shared with your managers or with anyone else at [INSERT CENTRE NAME]. No report or paper that I write will include any information that can be used to identify you.

5. Should you wish to stop the interview at any time you will be free to do so. Similarly, you will be able to choose not to answer any question that you are not comfortable with. What you choose to say or not say is entirely up to you.

6. I do not plan to ask any questions that might be upsetting to you. However, if by any chance you do start to find the interview distressing we will immediately stop and I will work with you until you are feeling better. We will not continue the interview after that.

This research is being conducted through the University of the Witwatersrand in Johannesburg, South Africa and has been reviewed by the Ethics Committee for research with human subjects. A detailed research proposal is attached. My research supervisor is Professor Gillian Eagle and she can be reached on Gillian.Eagle@wits.ac.za. Please do not hesitate to ask me any questions that you might have about this research. I can be reached at craighs@telkomsa.net. If you would like to participate please sign the informed consent forms attached.

Yours Sincerely

Craig Higson-Smith

Psychology
School of Human & Community Development

University of the Witwatersrand
Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

6 October 2011

Consent to participate in research

I _____ would like to participate in the research entitled *Conceptualising a contextually relevant torture counseling framework for Sub-Saharan Africa*, to be conducted by Craig Higson-Smith.

I have read and understood the ethical provisions as outlined in the participant information letter.

Signed: _____ Date: _____

Psychology
School of Human & Community Development

University of the Witwatersrand
Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

6 October 2011

Consent for interview to be recorded

I _____ consent to the audio recording of my interview with Craig Higson-Smith, to be conducted as part of the research entitled *Conceptualising a contextually relevant torture counseling framework for Sub-Saharan Africa*.

I have read and understood the ethical provisions as outlined in the participant information letter.

Signed: _____ Date: _____

APPENDIX E **Letter of Invitation and Consent Forms Addressed to Clients at Three Torture Treatment Centres in Sub-Saharan Africa**

Psychology
School of Human & Community Development

University of the Witwatersrand
Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

6 October, 2011

Dear [INSERT CENTRE NAME] Client

Invitation to participate in research

My name is Craig Higson-Smith. Part of my work is teaching and supporting counselors who take care of victims of war and torture in Africa. I am doing research to find ways to increase the helpfulness of these counselors. I would like to invite you to participate in this research.

I would like to speak to people who have been helped by a counselor in order to find out several things:

a) What things did the counselor do that were most helpful?

b) Were there things that the counselor did that were not helpful?

c) What other things might counselors do that would be helpful in counselling?

Should you wish to participate in this research there are several important ethical provisions that you should be aware of.

1. Whether or not you choose to participate is entirely up to you. If you choose not to participate this will not affect your relationship with your counselor or with [INSERT CENTRE NAME] in any way. You will still have access to the same support and services that you have at the moment.

2. Should you wish to participate, the interview will take approximately one hour and will be held at [INSERT CENTRE NAME] at a time that is convenient for you.

3. I would like to audio-record the interview so that I can be sure not to miss anything that you say to me. All information that you provide will be kept confidential. Nobody other than me will listen to the recording, and the transcription (the recorded interview written out) will not include your name or any other information that might be used to identify you. All data (original recordings before transcription

and completed transcriptions) will be kept in a locked cabinet in my home in South Africa. Once the research is complete and the appropriate papers have been published the recordings and transcriptions will be destroyed.

4. No information will be shared with your counselor or with anyone else at [INSERT CENTRE NAME]. No report or paper that I write will include any information that can be used to identify you.

5. Should you wish to stop the interview at any time you will be free to do so. Similarly, you will be able to choose not to answer any question that you are not comfortable with. What you choose to say or not say is entirely up to you.

6. I do not plan to ask any questions that might be upsetting to you. Most particularly I will not ask the details of any traumatic events that have happened to you in the past. I would however like to know something about how your physical and emotional health have been affected by your experiences. If by any chance you do start to find the interview distressing we will immediately stop and either I or your counselor will work with you until you are feeling better. We will not continue the interview after that.

This research is being conducted through the University of the Witwatersrand in Johannesburg, South Africa and has been reviewed by the Ethics Committee for research with human subjects. My research supervisor is Professor Gillian Eagle and she can be reached on Gillian.Eagle@wits.ac.za.

Please do not hesitate to discuss this request with your counselor or to ask me any questions that you might have about this research. I can be reached on craighs@telkomsa.net or through the [INSERT CENTRE NAME] office. If you would like to participate please sign the informed consent forms attached.

Yours Sincerely

Craig Higson-Smith

Psychology
School of Human & Community Development

University of the Witwatersrand
Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

6 October 2011

Consent to participate in research

I _____ would like to participate in the research entitled *Conceptualising a contextually relevant torture counseling framework for Sub-Saharan Africa*, to be conducted by Craig Higson-Smith.

I have read and understood the ethical provisions as outlined in the participant information letter.

Signed: _____ Date: _____

Psychology
School of Human & Community Development

University of the Witwatersrand
Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559

6 October 2011

Consent for interview to be recorded

I _____ consent to the audio recording of my interview with Craig Higson-Smith, to be conducted as part of the research entitled *Conceptualising a contextually relevant torture counseling framework for Sub-Saharan Africa*.

I have read and understood the ethical provisions as outlined in the participant information letter.

Signed: _____ Date:_____

APPENDIX F Counsellor Interview Schedule including Participant Information and Informed Consent Script

Participant information and informed consent script

Hello, my name is Craig Higson-Smith. Thank you for meeting with me today.

Have you had a chance to read through the letter that I sent to you? Do you have any questions or concerns that you would like to discuss with me?

[Address any questions or concerns that the subject has.]

Just to be very clear I would like to go over some of the key points in that letter.

1. I am currently doing research for my studies at the University of the Witwatersrand in South Africa. My University is very careful to ensure that my research is done properly, and in a good and ethical way.

2. The research that I am doing is about how people who have been through difficult experiences such as war or torture can best be helped. I hope that what I learn will help counselors in this country and in other places give the best possible support to survivors. I would like to talk to you about the work you do at this centre. I am interested in what you have learned about how best to support torture survivors, and in what you think needs to change for you to be able to help your clients more.

3. The interview will take about 90 minutes and I would like to invite you to participate as part of all our efforts to help people who are suffering because of war and torture. I do have permission from your executive director to conduct this research during work hours, but am afraid that I am not able to pay you for your time here today.

4. I would also like you to complete the Professional Quality of Life Scale. This is 30 item test that will give us an estimate of your current compassion satisfaction, burnout and secondary traumatic stress. I will score this test immediately and discuss the results with you after the interview. Each counselor who participates in this research will be given an identifying number and no identifying information will be attached to your test scores.

5. Participation in this research is entirely voluntary. Should you wish not to participate that is absolutely fine. Nobody here, including myself, or your managers will be upset. You will still get exactly the same support from me, and nothing will change.

6. If you do wish to participate then you should know that you can withdraw at any time and again nobody will have any difficulty with that. You can also decline to answer any question that you feel is too personal or might be too troubling to you.

7. I have tried to make sure that my questions will not be upsetting to you. However, if by any chance you do get upset by any of my questions we will immediately stop the interview. I will then stay with you until you are feeling better. We will not carry on with the interview after that.

8. What we talk about here will stay between you and me. I will not discuss what you tell me with anybody, including anyone else here at the centre. I will be interviewing many counselors in several centres in different countries. All the thoughts and ideas that I gather from those interviews are combined into a general report which is then published and given back to the counselors and managers of the centres. This report does not mention any person by name and there is no way for people to identify who said what to me.

Naturally I will not be asking you to break confidentiality with regard to any of your clients. Should you wish to talk to me about a client in order to illustrate a point please make sure that you take the usual measures to conceal the client's identity from me.

9. I would also like to record our conversation. This enables me to listen to you carefully without having to worry about taking notes. I take the recording home to South Africa with me and then write out the interview word for word. When I do this, I take out any information that can be used to identify you. Once the recording has been written down in this way, the recording is destroyed. In this way my supervisor at the University is able to check my work, but will not know who it is that I have spoken to.

Do you have any other questions or concerns about these points?

[Address any further questions or concerns the subject has.]

Would you like to participate in this research?

If subject declines: That is fine. Thank you for the time you have given me this morning. Have a good day.

If subject accepts: Thank you. Are you happy for me to record our conversation?

If subject declines: That is fine, but I will need to take notes as we talk.

If subject accepts: That's good. Thank you.

Would you sign the consent form on the bottom of the letter? This says that you understand the research and all the ethical issues that we have discussed and that you wish to continue with the interview.

[Ensure receipt of signed informed consent form.]

Thank you. I am switching the recorder on now and we can begin.

Interview schedule

The following schedule is organized around three columns:

> Topic – High level structure to assist with flow and time management. For the interviewer only.
> Core questions – Key questions under each topic that are asked of all clients.
> Notes and prompts – Notes to guide direction, focus and probing. These are suggestions and will vary between subjects.

General note: If the subject begin to tell the story of past traumatic events or losses, remind him/her that this is not required if it is uncomfortable. If the subject wishes to explain what happened to them in order to provide context to the discussions about therapy then allow them to continue. Prompt about events in order to move the subject quickly and more superficially through the story. Do not probe any thoughts or feelings associated with the story. Do not allow the interview to be sidetracked by the trauma story.

Topic	Core questions	Notes and Prompts
Qualifications and training	Can you tell me about your formal mental health training?	Professional qualification? When did you qualify? At which institution? How many years? What subjects? Internship under supervision?
	Can you tell me about any shorter courses or informal training that you have complete?	What topics? Offered by which institutions? Length of courses?
Work experience	Can you tell me about your previous work in mental health?	Institution? Years of work? Primary responsibilities?
	Can you tell me about any previous work in torture rehabilitation?	Institution? Years of work? Primary responsibilities?
	Can you tell me more about your current work?	Years in the position? Primary responsibilities?

Topic	Core questions	Notes and Prompts
	To what extent do you feel that your training prepared you for the work you do today?	
Motivation	How did you get into torture rehabilitation work originally?	Probe for story of original interest and entry into the work.
	What keeps you interested in torture rehabilitation?	Probe for examples of events or experiences that maintain the subject's motivation for this field.
Client population	Would you describe the range of tortured clients that you see?	Demographic range Time since most recent experience Most common life situations Most common past experiences Most common presenting problems Most common underlying problems In terms of diagnostic categories
Most helpful interventions	In your experience what is the most helpful thing that you as a counselor give to your client who have been tortured?	Probe for stories where clients have clearly benefitted greatly from a particular intervention. What did you do? What difference did it make for the client? Why do you think it made such a big difference? What kind of clients is such an intervention appropriate for? At what point in the therapeutic process is such an intervention appropriate
Therapeutic relationship with torture survivors	What special issues are there in creating and managing the therapeutic relationship with tortured clients?	Probe for trust and power issues. Transference issues Counter-transference concerns Probe for stories of therapeutic relationships.

Topic	Core questions	Notes and Prompts
Current model of counseling or counseling interventions	What are the goals of your counseling interventions?	Probe for definitions of healing. Probe for story of someone who the subject will describe as "having recovered".
	Do you follow a particular counseling model in your current work? If so would you describe it to me please?	Probe for steps or principles. What makes you choose this counseling model over the alternatives? Probe for stories of success using the model.
	If not, would you describe any counseling interventions that you use with many of your tortured clients?	For each intervention listed: What kinds of clients would you use this with? At what point in the therapeutic process? What are the steps or principles? Why do you feel this intervention is particularly helpful? Prove for stories of success using each intervention.
Issues in counseling torture	What do you think are the most challenging issues in counseling torture survivors?	Probe for examples and stories. How do you deal with these issues?

Topic	Core questions	Notes and Prompts
survivors	What other issues come up often in counseling torture survivors, and how do you respond to these?	*Probe for:* Managing current life challenge; Clients' physical safety; Symptom management; Pain management; Disability management; Processing past traumatic experiences; The tension between past and present; Bereavement; Other losses; Relationships with families; Relationships with broader community; Importance of justice / reparation. In each case probe for stories or examples.
Client constraints on intervention	How do clients' expectations of assistance impact on the effectiveness of your counseling?	Cultural awareness and understanding of mental health and mental health services.
	To what extent do clients' life circumstances impact on the effectiveness of your counseling?	Overwhelming life challenges Lack of safety Transient population – irregular attendance
	How do you respond to these challenges relating to your clients' lives?	Look for examples and stories.
Organisation constraints on intervention	To what extent do you feel supported by your organization for doing this work?	Training Supervision Administrative support Physical spaces
	To what extent do you feel constrained by your organization for doing this work?	

Topic	Core questions	Notes and Prompts
		Internal referral options Care for caregivers
	What changes in your organizational context would enable you to achieve more in your counselling?	
Community constraints on intervention	To what extent do you feel supported by the broader community?	Community of mental health workers External referral mechanisms Stigma and marginalization Harassment External care for caregivers
	To what extent do you feel constrained by the broader community?	
Caregiver health	How would you describe your own mental health as a caregiver?	Prompt for secondary trauma, burnout, compassion satisfaction, depression, anxiety, substance abuse, relationships
	What do you do to keep yourself healthy?	Prompt for actual (not intended) behaviours.

Once again, thank you so much for your time. You have given me so much useful information. I am very grateful. I am going to switch off the recorder now.

APPENDIX G Client Interview Schedule including Participant Information and Informed Consent Script

Participant information and informed consent script

Hello, my name is Craig Higson-Smith. Thank you for coming in to meet with me today.

Have you had a chance to read through the letter that I sent to you? And have you discussed it with your counselor? Do you have any questions or concerns that you would like to discuss with me?

[Address any questions or concerns that the subject has.]

Just to be very clear I would like to go over some of the key points in that letter.

1. I am currently doing research for my studies at the University of the Witwatersrand in South Africa. My University is very careful to ensure that my research is done properly, and in a good and ethical way.

2. The research that I am doing is about how people who have been through difficult experiences such as war or torture can best be helped. I hope that what I learn will help counselors in this country and in other places give the best possible support to survivors. I would like to talk to you about the support you have received at this centre. I am interested in what helped you, as well as what was less helpful? I am interested in how you think counselors could do a better job of supporting people like yourself.

3. The interview will take about 1 hour and I would like to invite you to participate as part of all our efforts to help people who are suffering because of war and torture. I am afraid that I am not able to pay you for your time here today.

4. Participation in this research is entirely voluntary. Should you wish not to participate that is absolutely fine. Nobody here, including myself, your counselor, or the managers will be upset. You will still get exactly the same support from this centre that you have at the moment, and nothing will change.

5. If you do wish to participate then you should know that you can withdraw at any time and again nobody will have any difficulty with that. You can also decline to answer any question that you feel is too personal or might be too troubling to you.

6. I have tried to make sure that my questions will not be upsetting to you. Most particularly, I will not ask about any bad things that may have happened to you, because I know those can be very difficult to talk about, especially someone that you don't know well. However, if by any chance you do get upset by any of my questions we will immediately

stop the interview. Either I or your counselor will stay with you until you are feeling better. We will not carry on with the interview after that.

7. What we talk about here will stay between you and me. I will not discuss what you tell me with anybody, including your counselor or anyone else here at the centre. I will be interviewing several past clients from several centres in different countries. All the thoughts and ideas that I gather from those interviews are combined into a general report which is then published and given back to the counselors and managers of the centres. This report does not mention any person by name and there is no way for people to identify who said what to me.

8. I would also like to record our conversation. This enables me to listen to you carefully without having to worry about taking notes. I take the recording home to South Africa with me and then write out the interview word for word. When I do this, I take out any information that can be used to identify you. Once the recording has been written down in this way, the recording is destroyed. In this way my supervisor at the University is able to check my work, but will not know who it is that I have spoken to.

Do you have any other questions or concerns about these points?

[Address any further questions or concerns the subject has.]

Would you like to participate in this research?

If subject declines: That is fine. Thank you for the time you have given me this morning. Have a good day.

If subject accepts: Thank you. Are you happy for me to record our conversation?

If subject declines: That is fine, but I will need to take notes as we talk.

If subject accepts: That's good. Thank you.

Would you sign the consent form on the bottom of the letter. This says that you understand the research and all the ethical issues that we have discussed and that you wish to continue with the interview.

[Ensure receipt of signed informed consent form.]

Thank you. I am switching the recorder on now and we can begin.

Interview schedule

The following schedule is organized around three columns:

> Topic – High level structure to assist with flow and time management. For the interviewer only.
> Core questions – Key questions under each topic that are asked of all clients.
> Notes and prompts – Notes to guide direction, focus and probing. These are suggestions and will vary between subjects.

General note: If the subject begin to tell the story of past traumatic events or losses, remind him/her that this is not required if it is uncomfortable. If the subject wishes to explain what happened to them in order to provide context to the discussions about therapy then allow them to continue. Prompt about events in order to move the subject quickly and more superficially through the story. Do not probe any thoughts or feelings associated with the story. Do not allow the interview to be sidetracked by the trauma story.

Topic	Core questions	Notes and Prompts
Intervention length	When did you first come to this centre?	
	When did you stop, or do you still visit sometimes?	
	Who did you meet with when you came here?	I am particularly interested in the help that you received from your counselor. How often did you meet with her/him?
	How often did you come here?	Did this change over time?
Access	How did you originally hear about this centre?	Referring agency (if by referral) Person/relationship (if by word of mouth) Exact media (if by publicity efforts)
	Can you remember what made you decide to come here the first time?	Initial service expectations Was counseling one of the expectations?
	Did you have any doubts about coming here?	Try to go beyond economic and logistical barriers which are well documented.
Initial	Would you tell me about the first time you came to the centre? What	Narrative - steps in the process

Topic	Core questions	Notes and Prompts
Impressions	happened?	Staff actions and attitudes Client's feelings and thoughts throughout the process
	How did you feel when you were referred to the counselor?	
	Would you tell me about your first meeting with your counselor?	Narrative of the initial meeting Counselor's action and attitudes Client's feelings and thoughts throughout the process
Most helpful therapeutic interventions	Were there any parts of your counseling process that stand out for you as being particularly helpful?	Narrative of the therapeutic process Counselor's actions and attitudes Therapeutic relationship dynamics Emotional changes in client Cognitive changes in client Behavioural changes in client Changes in client's circumstances
Therapeutic interventions	Did your counselor talk to you much about how our minds and bodies respond to difficult experiences?	What material was discussed? What difference did it make knowing this about yourself?
	Did you talk much about past bad experiences during your counseling process?	What was it like talking to your counselor about these experiences? What difference did talking about these experiences make for you?
	Did you talk much about the problems that you were facing in your life at the time?	What was it like talking about these problems? Probe for physical safety, shelter, food, etc. What difference did talking about these problems make for you?
	Did you talk much about how to	What symptoms did your counselor help

Topic	Core questions	Notes and Prompts
	manage any symptoms you might have been having?	you with? Probe for range of psychological symptoms. Probe for physical pain. Probe for physical disabilities. What advice did they give you? What difference did help managing your symptoms makes for you?
	Did you talk much about your relationships with people in your family?	What was it like talking about your family? What difference did talking about your family make for you?
	Did you talk much about relating to other people in your community, and in the broader society?	What was it like talking about other people in your community? Probe for people in positions of authority: police officers, army, government health personnel, etc. What difference did talking your other people make for you?
	Did you talk much about people you might have lost?	What was it like talking about people you have lost? What difference did talking about people you have lost make for you?
	Did you talk much about other things that you may have lost in your life?	What was it like talking about other losses? What difference did talking about these other losses make for you?
	Where there any other things that you remember your counselor discussing with you that were helpful?	What were they? What made them helpful?

Topic	Core questions	Notes and Prompts
Unhelpful intervention	Sometimes it is difficult to know how best to help people who have been through difficult experiences. Was there anything that your counselor said or did that was not helpful to you?	What was it? How did you experience it? What impact did it have on you? What impact did it have on the counseling relationship?
Therapeutic relationship	How did you feel about your counselor when you first met him/her? Did those feelings change over time? How do you feel about your counselor today?	Probe for good and bad feelings.
Final recom-mendations	In conclusion, what do you think are the most important things that counselors need to do to help people who have been through the difficult kinds of events that you have experienced?	

Once again, thank you so much for your time. You have given me so much useful information. I am very grateful. I am going to switch off the recorder now.

APPENDIX H **Final Hierarchy of Short form Codes Employed in the Thematic Coding of Narrative Interviews with Counsellors and Clients**

Respondent nodes
Counsellor codes
Experience in counselling
Experience working with torture survivors
Formal training for work with torture survivors
On the job training for work with torture survivors
Motivations for work with torture survivors
Case load description
Preferred therapeutic approach
Counsellor supervisor nodes
Experience in supervision
Training in supervision
Motivation to work as a supervisor
Supervision caseload description
Client nodes
Length of contact with centre
Services received
Current client status
Counselling nodes
Counselling narratives
Therapeutic process
Therapeutic relationship
Therapeutic progress
End of therapy
Therapeutic goals

- Therapeutic actions
  - Work with losses
  - Work with pain or disability
  - Work with anger
  - Therapeutic models
  - Skills building
  - Psychoeducation
  - Problem solving
  - Present focus in therapy
    - Parenting concerns
    - Intimate partner relationships
    - Family dynamics
    - Current threat
    - Basic needs
  - Past focus in therapy
    - Past traumatic experiences
    - Bereavements
    - Past other
  - Mobilizing coping and inner resources
  - Grief and mourning
  - Building hope
  - Arousal regulation
- Referrals
- Recommendations for future practice
- Principles underlying therapeutic practice
- Medications
  - Psychotropic medication
  - Other medication
- Interpretation in therapy
- Frequency of counselling sessions
- Framing of therapy
- Duration of therapeutic process

Delay in accessing counselling
Assessment
Alternative practices
Cultural adaptations
General nodes
Recommendations for practice