CSVR
The Centre for the Study of Violence and Reconciliation

DEVELOPING AN AFRICAN TORTURE REHABILITATION MODEL:

A contextually-informed, evidence-based psychosocial model for the rehabilitation of victims of torture

PART 1

Setting the foundations of an African Torture Rehabilitation Model through research

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A NOTE OF THANKS

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Monica Bandeira

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY

Torture remains a reality in many countries around the world. As one of the largest recipients of refugees in the world, South Africa has become home to many victims of this extreme form of human rights violation. Sadly torture continues to be perpetrated within South Africa, which has high rates of violent crime as well as one of the highest levels of economic inequality in the world. These factors continuously impact on the rehabilitation of victims of torture.

The impacts of torture are diverse and include biological, psychological, and social dimensions. In many instances, the impacts of torture are exacerbated by additional, external stressors that victims are exposed to, either directly or indirectly, related to their experience of torture. The torture rehabilitation field has been criticised for not implementing evidence-based interventions in the treatment of victims of torture. However, several important reasons exist for this. Most importantly for torture rehabilitation centres in developing countries, is the fact that evidence-based treatments have been developed in relation to the treatment of Post-Traumatic Stress Disorder (PTSD), providing a limited perspective of the impact of torture. In addition, these evidence-based treatments have not been conducted with victims of torture. So, although such treatments are important in the rehabilitation of torture victims (many of whom present with PTSD), they fall short of addressing the broader impacts of torture. Some authors have developed different concepts to explain this broader range of impacts, pointing to the complexity of the issue.

These challenges require more creative ways of developing appropriate interventions. This project encompasses one such attempt. It incorporates research and clinical team engagement as a way of developing a contextually-based, evidence-informed intervention. The goal is to gain an understanding of what the main challenges faced by victims of torture are, and how these can be addressed effectively.

In order to do this the CSVR has embarked on a three step process. Step one, upon which this report is based, involved conducting research to set the foundations of a rehabilitation model. In the second step, the clinical team at the CSVR will detail the components of this model.

Finally, the model will be implemented and tested. In addition to this, a report on gender and torture will be published.

The first step in setting the foundations of a torture rehabilitation model through research involved a review of the literature available on victims of torture. The aim of this literature review was to identify the main impacts of torture. A total of 77 research articles were analysed using thematic content analysis to produce a list of impacts most commonly reported. Thematic content analysis was also used to extract impacts from 514 session notes captured by CSVR clinical staff who counselled individual victims of torture. A comparison of the top ten impacts emerging from the literature versus the counselling process notes produced interesting results, as summarised in Table 1 below.

Table 1: A comparison of the top ten impacts of torture from literature and process notes

No.	Impacts from literature	Impacts form process notes
1	Mood disturbances	Economic difficulties
2	Traumatic responses or PTSD	Family stressors
3	Anxiety	Anger
4	Pain	Mood disturbances
5	Other mental health problems	Health problems
6	Reduced physical health	Coping difficulties
7	Sleep disturbances	Difficulties with service providers
8	Somatisation	Fear
9	Anger	Frustration
10	Hyper-arousal	Helplessness

To build consensus on what impacts are experienced by most torture victims and which have the most severe impact within our context (that of a developing, multi-cultural urban setting) the Delphi technique was used. A panel of 18 experienced and respected people in the field, from around the world was assembled, including researchers, practitioners, and supervisors

with experience in torture rehabilitation within developing contexts. The panel provided feedback over email on five rounds all aimed at building consensus on the most common impacts experienced by victims of torture within our context, the level of severity of each of these, and the most appropriate interventions. A total of 62 impacts were identified at the start of the Delphi process. Through the rounds, these were reduced to a total of 18 impacts (listed in **Table 2** below) considered by the panellists to be those which most victims of torture experience and that have the most severe impact on them.

Table 2: Final list of impacts which most victims of torture experience

1.	Accommodation difficulties	**10.**	Mood disturbances
2.	Bereavement	**11.**	Pain
3.	Coping difficulties and stress	**12.**	Safety concerns
4.	Distress	**13.**	Traumatic responses
5.	Economic difficulties	**14.**	Concern for employment opportunities
6.	Family breakdown	**15.**	Loss of status, recognition, position in society
7.	Family-related stressors	**16.**	Anger
8.	Intrusions	**17.**	Difficulties with service providers
9.	Isolation	**18.**	Repeated victimisation

Information on the most appropriate interventions for each of these impacts was obtained from the analysis of the individual session process notes and elicited from the panellists. These were then given back to the panellists who rated each intervention in terms of appropriateness within our context. The panellists also rated which form of intervention (i.e. individual, couple, family, and group) was most appropriate for each impact. The interventions suggested varied from 1 to 15 per impact. Examples include:

- Conduct skills development with clients so that they are able to address this impact.
- Identify existing and previously used coping mechanisms.
- Explore underlying emotions.
- Address blame.
- Encourage relaxation exercises.
- Support problem solving.

These interventions will be used by the clinical team at the CSVR to develop detailed interventions in the second part of this project. When considering interventions, it is important to note that the development and evaluation of these occurs within a broader context, which includes aspects such as assessment, treatment planning, on-going review, and support for clinicians. According to the information obtained from panellists on these aspects, the main goal of the initial assessment, which must be undertaken by qualified practitioners, is to gather information that will inform treatment planning. The two key aspects that assessment should focus on are firstly, individual functioning (including psychological, social, spiritual, and emotional) and secondly, the availability of resources (including internal and external). In order to support clinicians, appropriate supervision and a supportive working environment are needed. Clinical work should be monitored through the review of client progress and supervision.

This report highlights important differences between what is emerging in the literature and what occurs in developing contexts. It calls for a broader perspective on the rehabilitation of victims of torture than what evidence-based treatments currently offer. It provides a solid foundation upon which the CSVR's clinical team can develop a model that is both contextually-driven and evidence-informed. ■

2. INTRODUCTION AND BACKGROUND

Human rights monitors have documented the practice of torture in more than 130 countries around the world. With reference to Africa, Amnesty International concludes that, "there is still an enormous gap between the rhetoric of African governments, which claim to protect and respect human rights and the daily reality where human rights violations remain the norm" [1]. The actual prevalence of torture in these countries is extremely difficult to measure, however, several reports point to its occurrence and reveal some sobering results [2-4]. In South Africa, our review of media reports of torture [5] and the use of a street corner approach in one community [6] demonstrates that torture does still happen in this country.

The impact of torture is diverse and includes: mood disturbances [7-44]; traumatic responses, including PTSD [9, 11-14, 16-19, 22, 24, 26-31, 33-37, 40, 41, 43, 45-58]; anxiety [7, 9, 14-16, 18-20, 23, 25-27, 29-32, 38, 40-44, 48, 55, 56, 59, 60]; pain [7, 8, 10, 14, 15, 25, 26, 41, 44, 59, 61, 62]; other mental health problems (e.g. personality disorders, Obsessive-Compulsive Disorder, and phobias) [10, 18, 26, 27, 30, 32, 56, 58-60]; reduced physical health [7, 10, 14, 26, 36, 40, 44, 59, 61, 63]; sleep disturbances [7, 10, 14, 15, 20, 21, 26, 41, 44]; somatisation [18, 27, 30-32, 40, 43, 51, 56]; anger [7, 20, 21, 25, 26, 37, 41, 44]; hyper-arousal [10, 15, 18, 20, 21, 26, 44, 52]; injuries [7, 14, 26, 27, 36, 44, 61, 62]; intrusions [7, 10, 14, 20, 21, 26, 41, 52]; self-harm [12, 25, 27, 41, 42, 56]; avoidance [21, 25, 26, 52, 55]; coping difficulties [8, 11, 36, 41, 64]; dissociation [17, 19, 26, 27, 53]; fear [7, 11, 25, 41, 44]; health problems [7, 10, 14, 15, 61]; isolation [18, 20, 41, 44]; and relationship difficulties [32, 41, 44, 55]. In addition to these, torture victims often need to deal with the ripple effect of torture on their families, status, and community standing. For several, this includes fleeing from their country in search of a safer place, which in-and-of itself brings additional challenges and stressors.

Recently Metin Başoğlu, a longtime contributor to the field of torture rehabilitation, criticised the lack of integration between knowledge generated by research on the treatment of post-traumatic stress disorder (PTSD) and treatment of victims of torture [65]. A close reading of the literature, however, suggests that there may in fact be a number of substantive reasons that explain the lack of take up of PTSD treatments in the care of torture victims, such as: evidence-based treatment exists for symptom clusters but not for complex problems; rehabilitation of victims of torture is not equivalent to treating PTSD or depression;

rehabilitation centres provide multi-modal approaches to improve the lives of victims in many ways; and clinicians avoid brief treatments, recognizing the enormity of clients' experiences and the consequences [66]. Many rehabilitation practitioners also complain about the disjuncture between existing suggested models and the contextual realities that their clients face [67].

There seems to be a move towards the idea that the best available outcome evidence should guide ethical and effective psychological practice [68]. Several difficulties exist with this move for those working with victims of torture, especially in challenging contexts. Firstly, the studies that have made use of control groups and are seen as evidence-based, were not conducted with victims of torture [69]. Secondly, these studies tend to focus on the treatment of PTSD. As Fabri [69] points out "PTSD as a shared diagnosis is not enough to generalize best practices from a general American population to a culturally, religiously, and ethnically diverse refugee population" (p. 33). Indeed, several researchers have highlighted the complexity of the symptom picture and impacts relevant to torture and/or refugee populations. These include: daily stressors, which could be worsened by or are unrelated to the event [70, 71]; secondary and associated symptoms to trauma [72]; impacts on families and communities that need to be addressed [73, 74]; the role of ethnic, cultural, and religious perspectives of victims on recovery [75]; and the issue of lack of safety and its impact on treatment [76]. Some authors have suggested concepts like "complex PTSD or cumulative trauma disorders" [74]; "complex trauma" [77]; and "continuous traumatic stress" [67] as better ways to understand the complexity of experiences for torture victims. Using the words of Higson-Smith, until a more complex understanding of the experiences of torture victims is integrated into outcome-based research, "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" (p. 178) [67].

It should also be remembered that torture rehabilitation has largely been taken up by Non-Governmental Organisations (NGOs) which are often faced with the strain of limited resources. In these situations, the fight for survival occurs simultaneously with attempts to provide quality, highly complex, multi-disciplinary and multi-component services to victims of torture [66]. Under these circumstances, practitioners tend to focus their energy, time and resources

on the provision of treatment. Although documentation, research, and monitoring and evaluation are recognised as important, they are often not prioritised. There is, however an increased acknowledgement and willingness to expand in these directions. In addition, there is a thirst among practitioners for interventions that speak to the contextual realities faced by victims of torture. One of the major limitations in the rehabilitation sector is the generation, documentation, and sharing of knowledge in more formal ways. This is vital to facilitate the transfer of information to other professionals, thus ensuring the sustainability of offering effective services to the victims of torture.

This complex picture therefore requires more creative processes to developing appropriate interventions. This report outlines one such attempt. By triangulating information available in literature, data gathered by clinicians on sessions held with victims of torture, and a consensus building process with several leaders in the field of torture, the CSVR created a solid evidence-informed and contextually-based foundation upon which the clinical team will build their own model of intervention. The focus was on what the most common impacts are for victims of torture that have the most severe effect and the corresponding best interventions for these. Once a detailed model of intervention has been developed by the clinical team, it will be implemented and tested. ■

3. CONTEXT

This report documents the development of a contextually-informed rehabilitation model for victims of torture. It is therefore important to further describe the context within which the Centre for the Study of Violence and Reconciliation (CSVR) exists and the realities faced by the clients who access our services. The CSVR is based in Johannesburg, South Africa. It is therefore located within a developing, multi-cultural, urban setting. South Africa has high levels of violence; "...South Africa is not completely unique, but is one of a relatively small group of countries which currently suffer from exceptionally high rates of violent crime..." (p. 4) [78]. According to the United Nations Office on Drugs and Crime (UNODC), in 2008, South Africa had the 9th highest homicide rate per 100,000 of the population in the world. At the time, South Africa's rate was 36.5, compared to the global average of 7.6 per 100,000. Although this has decreased to 31,9 [80], it is still 4.2 times higher than the global average. More recent statistics from the South African Police Service (SAPS) [80] indicate that that South Africans reported a total of 638,468 contact crimes between April 2010 and March 2011. Contact crimes include: murder; sexual crimes; attempted murder; assault with the intent to inflict grievous bodily harm; common assault; common robbery; and robbery with aggravating circumstances. Within Gauteng, the province within which the CSVR is located, 181,683 contact crimes were reported, comprising 28% of the total contact crimes in the country. In addition to high levels of crime, South Africa has one of the highest levels of economic inequality in the world, scoring 63.1 on the GINI Index in 2009 [81]. This coefficient ranges from 0 (no inequality) to 100, which indicates complete inequality [82]. This is the reality within which our clients live. Given the fact that we work with some of the more vulnerable groups of the population such as forced migrants and poorer South Africans, their risk factors are higher.

Our torture client group comprises mostly of non-nationals (88%) from different African countries such as Angola, the Democratic Republic of Congo (DRC), Rwanda, Somalia, Uganda, and Zimbabwe. The highest number of clients come from the Democratic Republic of Congo (DRC), followed by Zimbabweans and South Africans. Between 2009 and 2011, 45% of this group were men and 55% women (n=102). Most clients have experienced more than one traumatic event and 67% were unemployed at the time of intake. Information obtained from

half the number of clients seen over the last three years provides insight into the psychosocial situation of clients at intake. According to this, 72% were checklist positive for PTSD, 78% met clinical levels of depression, and 62% met clinical levels of anxiety. In relation to functioning, the following was reported: difficulty in managing daily tasks (90%); difficulty in solving complex problems (94%); difficulty in managing symptoms (96%); difficulty in controlling reactions to others (65%); and difficulty in managing family connections (71%). As can be seen, this is a traumatised group that is vulnerable to additional stressors in daily life.

According to the United Nations High Commission for Refugees, South Africa was the largest recipient of asylum applications in 2008, receiving more than a quarter of asylum applications lodged worldwide [83]. Torture victims, who have been forced to flee their homes, communities and countries, must simultaneously face the multiple and significant losses associated with exile. They often live with on-going threat and victimisation; struggle for basic needs such as shelter, clothing and food; have limited personal resources; are separated from family, community, cultural and language groups; have limited access to employment and education; and, have limited access to services and care [84, 85].

In the past, victims of torture in South Africa comprised mostly anti-apartheid activists and therefore warranted sympathy from the public post 1994, when South Africa's first democratic elections were held. Although the CSVR still provides services to some of these victims, attempts are being made to access current victims of torture. As a result, the face of victims of torture in South Africa has changed to include young men who may be in conflict with the law. As such, many current torture victims are not popular and do not attract public sympathy. Both these groups, however, face several challenges such as unemployment and lack of access to opportunities, which make them more vulnerable to being victims and less likely to access support [6, 86].

The CSVR's previous work in the field of torture includes: providing therapy and in-depth long-term counselling to torture victims in South Africa (over 800 victims of torture received psychosocial services at CSVR between 2005 and 2010); working with complex trauma victims including victims of torture and forced migrants for over 20 years; establishing networks and partnerships with relevant communities, service providers and some

government departments; conducting research and advocacy on the issue of torture; lobbying and advocating for the domestication of the United Nations Convention Against Torture (UNCAT) and Optional Protocol of the Convention Against Torture (OPCAT); providing training on trauma and torture related topics to various audiences; and establishing the South African No Torture Consortium (SANToC).

In summary, the context within which the CSVR operates is one which involves work with very poor clients who have experienced more than one trauma, who may be exposed to further dangers, who experience further daily stressors (directly and/or indirectly related to their experience of torture), who are marginalised (either as foreign nationals, ex-combatants, or suspected criminals), who have limited access to psychosocial care (state or other), and, finally, where limited resources are available to provide these services. The torture rehabilitation model under review focuses on psychosocial rehabilitation services for victims of torture within this context. Here, the focus is on the individual (rather than the family, group, or community). So, although work may happen with groups, families, and/or couples, at a centre or in the community, the focus is ultimately on the individual's well-being and recovery. This is largely focused on psychosocial support in the form of counselling/therapeutic services, but may include referral to partner organisations and individuals addressing other relevant issues (psychiatric, medical, economic, and legal) and support for application processes to access legal status. The CSVR engages in other work which has a community-based focus. ■

4. PROBLEM STATEMENT

No psychosocial, rehabilitation model for victims of torture has been developed specifically for the South African and similar contexts.

The project seeks to address this gap.

5. AIMS

The project has two aims:

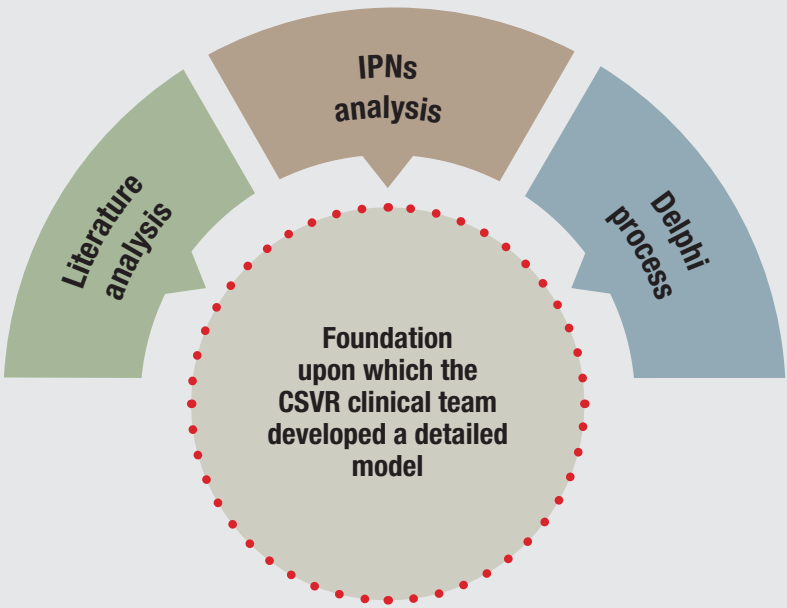
To gather detailed information on the challenges faced by victims of torture within similar contexts.

To develop a contextually-informed, psychosocial rehabilitation model for victims of torture.

6. THE MODEL DEVELOPMENT PROCESS

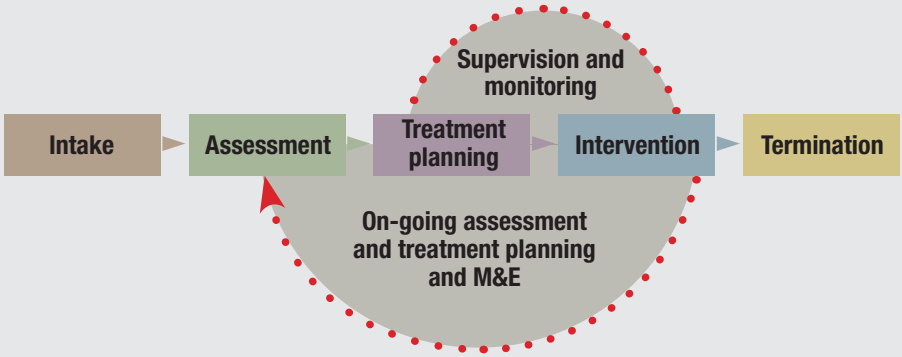
In order to develop a solid foundation upon which the clinical team could build a contextually-driven, evidence-based intervention model for the psychosocial rehabilitation of victims of torture, a mixed-methods approach was selected. This included a triangulation of data sources as illustrated in Figure 1 below. A review of existing literature was conducted, followed by an analysis of individual session process notes (IPNs) completed by clinical staff providing psychosocial rehabilitation services to victims of torture at the CSVR, and finally a Delphi process was conducted with a panel of experienced people in the field. The focus of the process was on impacts that victims of torture experience and interventions developed for these.

Figure 1: Triangulation of data sources to develop an African torture rehabilitation model



These three sources of information, which are discussed in detail below, established a sound starting point from which the clinical team developed their intervention model. It should be kept in mind that the process outlined in this report is understood to form part of a larger clinical management picture, as illustrated in Figure 2 below. The focus of this work has been on what happens with "intervention", though broader discussions regarding other aspects of clinical management will also take place.

Figure 2: Overview of clinical management process



6.1. Literature Review

To ensure that the model development process was evidence-based, existing data from research conducted on victims of torture was reviewed. The literature review focussed on information available electronically through the following academic databases: EBSCO Host, PILOTS, PsycARTICLES, PsycINFO, Sage Journals Online, ScienceDirect, and SocINDEX. In addition, the TORTURE Journal: Journal on Rehabilitation of Torture Victims and Prevention of Torture was also included in the search. The keyword "torture" was used in the initial search.

This search produced a list of 162 articles published between 1989 and 2011, with 80% published between 2006 and 2011. Of these, only articles where data was collected on victims of torture (either directly or indirectly) were included. This meant that theoretical/ conceptual, review, or intervention-only focussed articles were excluded. A total of 77 articles were included in the final analysis.

Each article was read and a literature review summary developed. This consisted of a table collecting the following information from each article: Title, authors and journal, methodology, sample, forms of torture reported, symptoms (or impacts as collected from participants), interventions described, and results (change after interventions).

This summary document was then imported into QSR Nvivo (a qualitative data analysis programme) before being reviewed and coded using Thematic Content Analysis (TCA) to identify the reported impacts experienced by victims of torture in each article. Through this process the thematic content of the data was obtained through the identification of common themes [87]. This was seen as the most appropriate method of analysis for this process as "(t)he researcher groups and distils from the texts a list of common themes in order to give expression to the communality of voices across participants" (p. 1) [87]. The focus is on "what" is said rather than "how" it is said as an attempt is made to find common themes across responses [88]. Although broad categories of impact may already exist (i.e. economic, physical, psychological, and social), coding within these will emerge from the material being analysed [89].

The literature analysis resulted in a list of 36 impacts. Of these, 33 were classified as negative impacts, while three were positive (see Table 3: Impact themes from literature review on Page 4 for a list of impacts identified).

A list defining the impact themes that emerged can be found in APPENDIX 1.

6.2. Data Analysis – Individual Sessions Intervention Process Notes

The CSVR has developed an extensive monitoring and evaluation (M&E) system for its clinical work with victims of torture. Through this system, data is collected on a regular basis, which assesses clients' progress over time. Information is collected directly from clients, through regular assessments, and from clinicians through the writing of Intervention Process Notes (IPNs). IPNs are completed for any intervention done with a client and include process notes on individual sessions with clients. These notes cover the content of the session, notes for supervision (areas of concern), and main themes to emerge from the session.

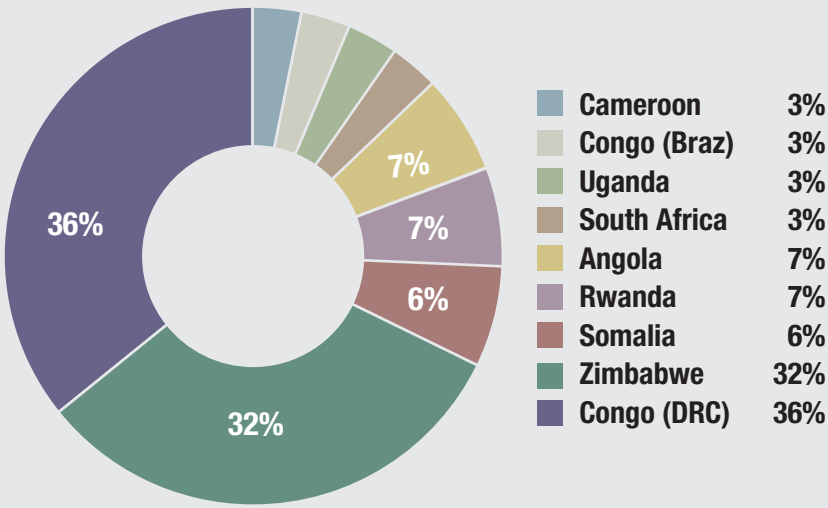
An analysis of the IPNs for individual sessions conducted with victims of torture was

completed. Our goal was to select a sample of 20% of the total number of clients that accessed our services between 2007 and 2011. An attempt was made to ensure that the sample was stratified by nationality and gender so that it reflected the broader population of victims of torture accessing the CSVRs services. In addition to this, we sought to include a spread of clinicians in order to obtain a broader picture of the interventions. Finally, we only included clients that had a minimum of 5 individual session IPNs, so that notes analysed were as comprehensive and detailed as possible.

The final sample analysed represented 17% of the total population (n=31) and included:

- 11 men (35%).
- 20 women (65%).
- 9 different nationalities (see Figure 3 below).
- 5 different clinicians [2 (40%) male and 3 (60%) female].

Figure 3: Nationality of clients included in the sample of IPNs analysed



The average of individual session IPNs was 16.5 (range: 5 to 35). A total of 514 individual session IPNs were analysed. As with the literature review, TCA was used to identify impacts and interventions.

6.2.1. Impact themes emerging from the IPNs analysis

The analysis produced a list of 51 impacts; 44 were classified as negative, while 7 were classified as positive, see Table 4 on 19 below for a list of impacts.

6.2.2. Intervention themes emerging from the IPNs analysis

The analysis produced a list of 30 interventions; see Table 6 on page 23 below for more information.

6.3. Delphi Technique

In order to obtain input beyond the views of clients and clinicians, a panel of 18 people experienced in the field of torture was assembled. The role of the panel was to assist in building consensus on both the impact of torture and the most adequate intervention options. This was achieved by using the Delphi technique, which "is in essence a series of sequential questionnaires or 'rounds', interspersed by controlled feedback, that seek to gain the most reliable consensus of opinion of a group of experts" [90]. The technique has been adapted for use to various questions or processes [91], which means it "is well suited as a means and method for consensus-building by using a series of questionnaires to collect data from a panel of selected subjects" [92]. The technique is set up in the format of rounds, whereby the panel respond to questions independently. In between rounds, the data is analysed and feedback given to the panel, which indicates the position of the individual panellist and the position of the whole group. Each member is given an opportunity to change their position or to provide justification for remaining outside of the group position [92]. The initial round usually consists of open-ended questions but can also consist of structured questions based on literature. Subsequent rounds seek to quantify the results gathered. Through the use of ranking and rating techniques, consensus is finally built. Most often, a percentage agreement level is used for inclusion [90].

The Delphi technique does not specify the ideal number of participants or panellists, as this depends on factors such as the problem statement, the resources available (time and money), and the availability of experienced people in the field.

6.3.1. The CSVR Delphi Panel

Our process sought to include a minimum of 10 panellists including a range of academics, practitioners, and researchers with experience and knowledge in this field and/or with this context/client population. Both international and local people were sought, while CSVR's own clinicians, who met the criteria, were also included on the panel. Criteria for inclusion included:

Practitioners were required to have:

- A minimum of 5 years of experience in working with victims of torture, and/or
- Provided interventions to a minimum of 50 torture victims, and/or
- Provided supervision to a minimum of 10 clinicians providing interventions to victims of torture in the last 5 years.

Researchers/academics were required to have:

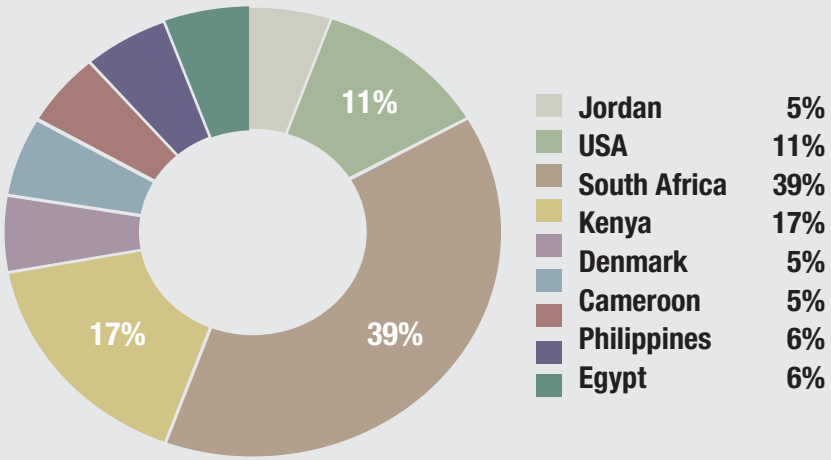
- A minimum of two publications in the last 5 years in the field of torture rehabilitation, and/or
- Provided supervision to researcher(s) exploring the topic of torture rehabilitation in the last 5 years.

The final panel consisted of 18 panellists and included:

- 11 women (61%).
- 7 men (39%).
- 5 panellists from the global north (28%).
- 13 panellists from the global south (72%).
- At the time of participating in the process, panellists were based in 9 different countries (see Figure 4).
- Except for the panellists based in Jordan and Egypt (who are originally from North America), all the other panellists come from the countries they are based in.

- 5 (28%) of the panellists came from the CSVR (this included practitioners and supervisors).
- 16 panellists met the “practitioners” criteria (89%).
- 13 panellists met the “supervisors” criteria (72%).
- 6 panellists met the “researchers” criteria (33%).

Figure 4: Countries where panellists were based



6.3.2. The CSVR Delphi Rounds

The Delphi process for this project was originally designed to include 4 rounds, which panellists responded to. A fifth round was added during the process. The focus of the process was to gain consensus regarding which impacts are the most common and severe in our context, what the most appropriate interventions for these impacts are, and the role gender plays in relation to torture impacts and interventions. Below is a description of the questions asked in each round. This document does not report on all the aspects of the Delphi process, as these will be included in other documents. Those aspects not reported on in this document are in italics.

Round 1 asked panellists:

- Information on themselves.
- To rate each of the 42 impacts that emerged from the literature and from the IPNs analysis in terms of how common they were for clients in the CSVR context [0 - Present in no (0%) clients; 1 - Present in a few (+- 25%) clients; 2 - Present in some (+- 50%) clients; 3 - Present in most (+- 75%) clients; 4 - Present in all (100%) clients] and the level of impact it had on most of the clients that experienced this impact (0 - No impact; 1 - Low impact; 2 - Moderate impact; 3 - Severe impact; and 4 - Extreme impact).
- To add any other impacts they felt were relevant to the CSVR context that were not included in the list from the literature and IPNs. In total, an additional 20 impacts were added by panellists.
- If, in their experience, men and women experience torture in different ways (open-ended question).
- If, in their experience, the daily stressors that follow a torture experience are felt differently by men and women (open-ended question).

Round 2 asked panellists:

- To rate each of the 20 impacts added by panellists in Round 1 in terms of how common they were for clients in the CSVR context and the level of impact on most of the clients that experienced this impact (using the same scales as in Round 1).
- To provide detailed intervention options for the impacts where agreement was reached in Round 1 (open-ended question). The impacts included here were those where more than 75% of panellists said it occurred in more than 50% of clients AND more than 75% of panellists said it had a severe or extreme impact on clients. Out of the initial 42 impacts, a total of 13 impacts met the above criteria.
- To rate their level of agreement with 29 gender-related statements that emerged from the data gathered in Round 1, the INPs analysis, and literature (1- Strongly agree; 2- Agree; 3- Neither agree nor disagree; 4- Disagree; 5- Strongly disagree).

Round 3 asked panellists:

- To provide detailed intervention options for the additional impacts where agreement was reached in Round 2. The impacts included here were those where more than

75% of panellists said it occurred in more than 50% of clients AND more than 75% of panellists said it had a severe or extreme impact on clients. Out of the initial 20 impacts, a total of 2 impacts met the above criteria.

- To rate each intervention in terms of its appropriateness for each of the 13 impacts that met the consensus criteria (1 – Highly inappropriate; 2 – Inappropriate; 3 – Neither appropriate or inappropriate; 4 – Appropriate; 5 – Highly appropriate). Interventions emerged from the analysis, using TCA, of the responses to the open-ended question asked in the previous round and the interventions that emerged from the IPNs analysis. Only those interventions which at least two panellists mentioned or that emerged in more than 70% of process notes where that impact emerged were included. The latter was calculated by using Jaccard's Coefficient, which measures similarity between sample sets, and is defined as the size of the intersection divided by the size of the union of the sample sets [93, 94].
- To rate each form of intervention (individual, couple, family, or group) in terms of appropriateness for each impact (1 – Highly inappropriate; 2 – Inappropriate; 3 – Neither appropriate or inappropriate; 4 – Appropriate; 5 – Highly appropriate).
- To describe aspects of interventions that should differ between male and female clients. In other words, the gender considerations that affect the nature/type of intervention used for a client.
- To describe any issues that clinicians should consider when working with a client of the opposite or same gender.
- To describe the implications for intervention for both male and female clients of the gender statements that 80% of panellists agreed with. In other words, how each of these gender differences would be addressed within the therapeutic space. 10 statements met the criteria.
- To comment on their position regarding 7 gender statements where there was no clear consensus among panellists, or with which panellists disagreed with the statement (optional section).

Round 4 asked panellists:

- To rate each intervention in terms of its appropriateness for each of the 2 impacts added by the panellists that met the consensus criteria (1 – Highly inappropriate; 2 – Inappropriate; 3 – Neither appropriate or inappropriate; 4 – Appropriate; 5 – Highly

appropriate). Interventions emerged from the analysis, using TCA, of the open-ended question asked in the previous round.

- To rate each form of intervention (individual, couple, family, or group) in terms of appropriateness for each of the 2 impacts added by the panellists (1 – Highly inappropriate; 2 – Inappropriate; 3 – Neither appropriate or inappropriate; 4 – Appropriate; 5 – Highly appropriate).
- To discuss if they consider therapeutic rehabilitation services or programmes to be a form of justice for victims of torture.
- To discuss what they think is the most effective form of justice for victims of torture that should be provided and prioritised by governments and international funders.
- To discuss broader clinical considerations that are relevant to the CSVR context, including: assessment, support for clinicians, and monitoring services provided (optional section).

Round 5 asked panellists:

- To provide detailed intervention options for three impacts that emerged as contextually-relevant, but did not meet the consensus criteria used in the Delphi process. In order to ensure that the final list that emerged from the Delphi process was in line with contextual reality, the following steps were undertaken. First, a list of impacts that met the consensus criteria of the Delphi process when only the responses from the CSVR panellists were looked at was generated. Next, a list of the 15 impacts mentioned across most clients from the IPNs analysis was generated. Three impacts were present on both of these lists, but were not in the final list from the Delphi process. Finally, panellists were asked to describe interventions for these in an additional round, for which only open-ended responses were obtained.

The average response rate across the four rounds was 89% [completed all rounds = 13 (72%); completed 3 rounds = 3 (17%); completed 2 rounds = 1 (5%); completed 1 round = 1 (5%)]. Round 5, which was an additional, optional round added at a later stage in the process, recorded a 50% response rate.

The accumulated number of impacts (from literature, IPNs, and Delphi panellists) was 62. The panellists were asked to rate each of these impacts in terms of how common

it was for clients in the CSVR context and the level of impact it had on most clients that experienced the impact. In order to narrow the list and focus on those impacts where most consensus existed, only those impacts that more than 75% of panellists said occurred in more than 50% of clients, AND more than 75% of panellists said had a severe or extreme impact on clients, were selected.

A total of 15 impacts met these criteria. In addition, 3 impacts that emerged as contextually- relevant, but did not meet the consensus criteria used in the Delphi process were added. This produced a final list of 18 impacts, for which panellists were asked to describe the most appropriate interventions.

6.4. Clinical Team Process

This report collates information that will be used by the CSVR clinical team to develop a contextually-based model for therapeutic rehabilitation of victims of torture. The following process will be completed with the clinical team:

- Feedback will be given on the results of the data collected and analysed thus far, as summarised in this report.
- Each Impact will be discussed in terms of:
  - What needs to be assessed in relation to it?
  - What the theory of change is in relation to the impact (if x then y because z)?
  - What interventions emerged from the research?
  - Which of these interventions are broader than the particular impact?
  - How could these interventions be grouped together?
  - How each of the interventions grouped together are implemented (detailed descriptions)?
  - What will not be done in relation to the impact?
- Broader assessment questions will be identified.
- Discussions on the broader process of intervention will be facilitated (including, for example, treatment planning).
- The foundations of this work will be identified.
- The implications for broader clinical processes and procedures will be discussed and managed and decisions will be made on how these should change with regards to assessment, structure, support for clinicians and monitoring. ■

7. RESULTS

7.1. Impacts:

7.1.1. From Literature

Table 3 below lists the 36 most common impacts of torture identified during the literature review process, of which 33 were classified as negative and 3 positive.

Table 3: Impact themes from literature review

No.	Negative Impacts	Number of articles	% of articles	Number of coding references	Articles
1	Mood disturbances	39	48%	48	[7-44]
2	Traumatic responses or PTSD	39	48%	43	[9, 11-14, 16-19, 22, 24, 26-31, 33-37, 40, 41, 43, 45-58]
3	Anxiety	27	33%	38	[7, 9, 14-16, 18-20, 23, 25-27, 29-32, 38, 40-44, 48, 55, 56, 59, 60]
4	Pain	12	15%	26	[7, 8, 10, 14, 15, 25, 26, 41, 44, 59, 61, 62]
5	Other mental health problems	10	12%	16	[10, 18, 26, 27, 30, 32, 56, 58-60]
6	Reduced physical health	10	12%	17	[7, 10, 14, 26, 36, 40, 44, 59, 61, 63]
7	Sleep disturbances	9	11%	15	[7, 10, 14, 15, 20, 21, 26, 41, 44]
8	Somatisation	9	11%	10	[18, 27, 30-32, 40, 43, 51, 56]
9	Anger	8	10%	8	[7, 20, 21, 25, 26, 37, 41, 44]
10	Hyper-arousal	8	10%	15	[10, 15, 18, 20, 21, 26, 44, 52]
11	Injuries	8	10%	29	[7, 14, 26, 27, 36, 44, 61, 62]
12	Intrusions	8	10%	10	[7, 10, 14, 20, 21, 26, 41, 52]
13	Self-harm	6	7%	6	[12, 25, 27, 41, 42, 56]
14	Avoidance	5	6%	7	[21, 25, 26, 52, 55]
15	Coping difficulties	5	6%	5	[8, 11, 36, 41, 64]

No.	Negative Impacts	Number of articles	% of articles	Number of coding references	Articles
16	Dissociation	5	6%	6	[17, 19, 26, 27, 53]
17	Fear	5	6%	6	[7, 11, 25, 41, 44]
18	Health problems	5	6%	42	[7, 10, 14, 15, 61]
19	Isolation	4	5%	5	[18, 20, 41, 44]
20	Relationship difficulties	4	5%	4	[32, 41, 44, 55]
21	Bereavement	3	4%	3	[32, 41, 60]
22	Blame and guilt	3	4%	5	[7, 10, 18]
23	Difficulties with the community	3	4%	5	[7, 8, 11]
24	Distress	3	4%	3	[20, 26, 42]
25	Economic difficulties	3	4%	4	[7, 8, 64]
26	Family breakdown	3	4%	4	[7, 32, 41]
27	Spiritually-related difficulties	2	2%	2	[8, 11]
28	Stress	2	2%	2	[18, 27]
29	Education-related difficulties	1	1%	2	[7]
30	Family stressors	1	1%	1	[41]
31	Frustration	1	1%	1	[25]
32	Helplessness	1	1%	1	[7]
33	Worry	1	1%	1	[25]
34	Spirituality	2	2%	2	[8, 11]
35	Community support	1	1%	1	[8]
36	Family support	1	1%	1	[8]

7.1.2. From Data

a) **Impact themes emerging from the IPN analysis**

The IPN analysis produced a list of 51 impacts of which 44 were classified as negative, while 7 were positive, as summarised in Table 4.

Table 4: Impact themes from IPN analysis

No.	Negative Impact Themes	Number of items coded	% of clients	Number of coding references
1	Economic difficulties	28	90%	249
2	Family stressors	28	90%	272
3	Anger	26	84%	123
4	Mood disturbances	26	84%	134
5	Health problems	25	81%	89
6	Coping difficulties	25	81%	85
7	Difficulties with service providers	25	81%	120
8	Fear	23	74%	82
9	Frustration	23	74%	70
10	Helplessness	23	74%	142
11	Difficulties with the community	22	71%	62
12	Anxiety	21	68%	64
13	Stress	21	68%	78
14	Accommodation difficulties	21	68%	92
15	Repeated victimisation	21	68%	67
16	Safety concerns	21	68%	103
17	Reduced physical health	20	65%	46
18	Medication-related concerns	19	61%	76
19	Bereavement	18	58%	58
20	Pain	17	55%	46
21	Family breakdown	17	55%	56
22	Worry	16	52%	59

No.	Negative Impact Themes	Number of items coded	% of clients	Number of coding references
23	Let down by others	16	52%	37
24	Lack of trust	16	52%	36
25	Education-related difficulties	15	48%	61
26	Blame and guilt	13	42%	28
27	Distress	13	42%	40
28	Injuries	12	39%	14
29	Intrusions	11	35%	15
30	Relationship difficulties	11	35%	35
31	Isolation	10	32%	24
32	Avoidance	9	29%	17
33	Self-esteem issues	9	29%	15
34	Resettlement focus	9	29%	46
35	Self-harm	8	26%	13
36	Spiritually-related difficulties	8	26%	11
37	Psychosis	7	23%	16
38	Sleep disturbances	7	23%	14
39	Hyper-arousal	6	19%	9
40	Dissociation	5	16%	9
41	Other mental health problems	5	16%	6
42	Somatisation	3	10%	3
43	Reduced risk assessment capacity	2	6%	10
44	Traumatic responses or PTSD	2	6%	2
45	Support received	28	90%	102
46	Positive feelings	26	84%	162
47	Income generation attempts	25	81%	134
48	Agency	23	74%	129
49	Family support	23	74%	106
50	Spirituality	14	45%	55
51	Community support	11	35%	20

7.1.3. From Delphi Process

Table 5: Additional impacts added by panellists

No.	Impact
1	Altruism
2	Being too religious
3	Concern for remittances
4	Concern for employment opportunities
5	Disappointment with host country
6	Exposure to emotional danger (especially activities) e.g. a rape victim starting an organisation to support other rape victims before fully recovering herself
7	Flattened affect
8	Ideology issues – questioning their known and established ideology
9	Lessened or no sex libido
10	Loss of status, recognition, position in society
11	Loss of gender roles
12	Loss of interest in seeking help
13	Numbing
14	Paranoia
15	Present focused
16	Role of ancestral spirits; derived from family deaths due to violence, and results in aggrieved spirits continuing to afflict the family as a whole.
17	Severe dissociation (especially in cases of long-term abuse, imprisonment, ritual abuse or mind control)
18	Sexual dysfunction
19	Stressors as a result of a confluence of factors on top of the torture-related impact (e.g. long-term imprisonment resulting in a combination of boredom, anxiety and helplessness)
20	Substance abuse (including alcohol and drug abuse)

The accumulated number of impacts (from literature, IPNs, and Delphi panellists) was 62. Panellists were asked to rate each of these impacts in terms of how common they were for clients in the CSVR context, and the level of impact they had on most of the clients who experienced them. In order to narrow the list and focus on those impacts where most consensus existed, only those impacts that more than 75% of panellists said occurred in more than 50% of clients, AND more than 75% of panellists said it had a severe or extreme impact on clients, were selected.

A total of 15 impacts met these criteria. For a list of the percentage scores of all impacts, please see APPENDIX 2. In addition, 3 impacts that emerged as contextually-relevant, but did not meet the consensus criteria used in the Delphi process were added. This produced a final list of 18 impacts, for which panellists were asked to describe the most appropriate interventions. Definitions of these can be found in the beginning of APPENDIX 1.

Final list of 18 impacts resulting from process:	
1.	Accommodation difficulties
2.	Bereavement
3.	Coping difficulties and stress
4.	Distress
5.	Economic difficulties
6.	Family breakdown
7.	Family-related stressors
8.	Intrusions
9.	Isolation
10.	Mood disturbances
11.	Pain
12.	Safety concerns
13.	Traumatic responses
14.	Concern for employment opportunities
15.	Loss of status, recognition, position in society
16.	Anger
17.	Difficulties with service providers
18.	Repeated victimisation

7.1.4. Summary of Impacts over Process

Figure 5 below summarises the impacts identified during the three methods making up the process, including the final impact list.

Figure 5: Summary of impacts over process

Negative Impacts from Literature and IPN analysis:
1. Accommodation difficulties
2. Anger
3. Anxiety
4. Avoidance
5. Bereavement
6. Blame and guilt
7. Coping difficulties and stress
8. Difficulties with service providers
9. Difficulties with the community
10. Distress
11. Economic difficulties
12. Education-related difficulties
13. Family breakdown
14. Family-related stressors
15. Fear
16. Frustration
17. Health problems
18. Helplessness
19. Hyper-arousal
20. Injuries
21. Intrusions
22. Isolation
23. Lack of trust
24. Let down by others
25. Medication related concerns
26. Mood disturbances
27. Other mental health difficulties
28. Pain
29. Psychosis
30. Reduced physical health
31. Reduced risk assessment /threat appraisal capacity
32. Relationship difficulties
33. Repeated victimisation
34. Resettlement focus
35. Safety concerns
36. Self-esteem issues
37. Self-harm
38. Sleep disturbances
39. Somatisation
40 Spiritually-related difficulties
41. Traumatic responses
42. Worry

Additional impacts added by panellists:
1. Altruism
2. Being too religious
3. Concern for remittances
4. Concern for employment opportunities
5. Disappointment with host country
6. Exposure to emotional danger (especially activities)e.g. rape victims starting an organisation to support rape victims before her full recovery
7. Flattened affect
8. Ideology issues – questioning their known and established ideology
9. Lessened or no sex libido
10. Loss of status, recognition, position in society
11. Loss of gender roles
12. Loss of interest in seeking help
13. Numbing
14. Paranoid
15. Present focused
16. Role of ancestral spirits; derives from family deaths due to violence, and results in aggrieved spirits continuing to afflict the family as a whole.
17. Severe dissociation (especially in cases of long term abuse, imprisonment, ritual abuse or mind control)
18. Sexual dysfunction
19. Stressors as a result of confluence of factors on top of the torture-related impact (e.g. long held imprisonment results to combination of boredom, anxiety and helplessness)
20. Substance abuse (including alcohol and drug abuse)

Final impacts list	
(15 Impacts that met the Delphi consensus criteria and 3 contextually relevant ones that did not)	
1.	**Accommodation difficulties**
2.	**Bereavement**
3.	**Coping difficulties and stress**
4.	**Distress**
5.	**Economic difficulties**
6.	**Family breakdown**
7.	**Family-related stressors**
8.	**Intrusions**
9.	**Isolation**
10.	**Mood disturbances**
11.	**Pain**
12.	**Safety concerns**
13.	**Traumatic responses**
14.	**Concern for employment opportunities**
15.	**Loss of status, recognition, position in society**
16.	**Anger**
17.	**Difficulties with serivice providers**
18.	**Repeated victimisation**

7.2. Interventions:

7.2.1. From IPNs Analysis

The IPNs analysis produced a list of 30 interventions used by clinicians at the CSVR as summarised in Table 6. Definitions of these interventions can be found in APPENDIX 3.

Table 6: Intervention themes from IPN analysis

No.	Interventions	Number of items coded	% of clients	Number of coding references
1	Supportive therapy	28	90%	140
2	Exploring options	27	87%	117
3	Referral	27	87%	144
4	Problem solving	26	84%	90
5	Focus on positive	25	81%	122
6	Information giving	24	77%	140
7	Guidance	20	65%	175
8	Link to past trauma	20	65%	60
9	Symptom management	20	65%	80
10	Boundary setting	19	61%	58
11	Exploring reactions	19	61%	61
12	Skills development	18	58%	76
13	Confrontation	17	55%	53
14	Reality testing	17	55%	36
15	Termination	17	55%	36
16	Resistance	16	52%	37
17	Trauma exposure	16	52%	32
18	Relationship building	15	48%	46
19	Exploring support and resources	14	45%	36
20	Building trust	13	42%	25
21	Exploring past (not trauma)	10	32%	15

No.	Interventions	Number of items coded	% of clients	Number of coding references
22	Financial assistance	10	32%	23
23	Meaning making	10	32%	22
24	Crisis management	9	29%	24
25	Cognitive Behavioural Therapy	4	13%	8
26	Grounding	4	13%	6
27	WITS Trauma Model [95]	3	10%	7
28	Thought stopping	1	3%	1
29	Dream exploration	1	3%	2
30	Psychodynamic therapy	1	3%	5

When looking at the interventions most linked to the final list of impacts, only interventions which appeared in at least 70% of the IPNs were included. This was calculated by using Jaccard's Coefficient, which measures similarity between sample sets, and is defined as the size of the intersection divided by the size of the union of the sample sets [93, 94]. For a complete list of the different interventions linked to each impact, please refer to APPENDIX 4.

7.2.2. From Panel

The panellists were asked to describe, through an open-ended question, the most appropriate intervention for each of the 18 impacts that formed part of the final list. They were reminded to consider the contextual realities present. Each response was then analysed using TCA to extract intervention themes. Only interventions mentioned by at least two panellists were included in the final consensus list. For a complete list of interventions mentioned by all panellists per impact, please refer to APPENDIX 5.

7.2.3. Final List of Interventions

A final list of interventions per impact that emerged from the IPNs and the Delphi process was then distributed back to the panellists, who rated each one in terms of appropriateness of the intervention for that impact within the CSVR context (1 – Highly inappropriate; 2 – Inappropriate; 3 – Neither appropriate or inappropriate; 4 – Appropriate; 5 – Highly appropriate). Only those interventions with an average rating above 4 were included in this final list. For a complete list of all interventions and average appropriateness ratings refer to APPENDIX 6.

This list, which forms the basis upon which the clinical team the final torture rehabilitation model, is comprised of the interventions that appeared in at least 70% of the IPNs where the impact was mentioned and/or were mentioned by at least two panellists, AND which scored an average of 4 and above in terms of appropriateness.

Table 7: Final list of interventions

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
1.Accommodation difficulties	1. Refer client to other organisations that deal with addressing accommodation difficulties	4.86
	2. Problem solve with client in relation to this	4.50
	3. Network with relevant organisations to establish close working relationships	4.36
	4. Conduct skills development of clients so that they are able to address this issue	4.29
	5. Provide supportive counselling	4.00
	Form of intervention:	
	1. Couples	4.31
	2. Group	4.15

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
2. Bereavement	1. Demonstrate empathy	4.79
	2. Encourage and allow emotional expression	4.71
	3. Provide supportive counselling	4.64
	4. Address feelings of guilt	4.64
	5. Address any unresolved issues related to the loss	4.64
	6. Facilitate meaning making in relation to the loss	4.64
	7. Provide psycho-education in relation to bereavement	4.64
	8. Assist client to create a ritual for closure	4.57
	9. Provide grief/bereavement counselling	4.57
	10. Assist with anger management	4.50
	11. Integrate cultural and religious practices for healing	4.43
	12. Assess client in relation to bereavement	4.43
	13. Provide individual therapy	4.36
	14. Address feelings of shame	4.29
	Form of intervention:	
	1. Individual	4.79
	2. Family	4.43
	3. Couples	4.07
3. Coping difficulties and stress	1. Identify existing and/or previously used coping mechanisms	4.79
	2. Assess client in relation to coping and stress	4.77
	3. Cognitive Behavioural Therapy	4.64
	4. Skills development	4.57
	5. Encourage client to make use of or connect to social support	4.57
	6. Conduct relaxation exercises with client	4.50
	7. Provide psycho-education in relation to coping and stress	4.50
	8. Provide supportive counselling	4.36
	9. Problem solve with client	4.29
	10. Provide more direct guidance on how client could reduce stress or coping difficulties	4.07
	Form of intervention:	
	1. Individual	4.57
	2. Group	4.46

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
4. Distress	1. Identify existing and previously used coping mechanisms	4.79
	2. Conduct crisis management with client	4.71
	3. Demonstrate empathy	4.71
	4. Conduct a detailed assessment in relation to the distress	4.64
	5. Provide containment	4.57
	6. Cognitive Behavioural Therapy	4.43
	7. Develop a plan of action with client	4.36
	8. Conduct relaxation exercises with client	4.29
	9. Provide supportive counselling	4.29
	10. Encourage client to make use of or connect to social support	4.29
	11. Problem solve with client	4.29
	12. Provide psycho-education in relation to distress	4.21
	Form of intervention:	
	1. Individual	4.71
5. Economic difficulties	1. Provide information for client regarding what they could do or where they could go to address their economic difficulties	4.50
	2. Problem solve with client	4.50
	3. Assist client to identify and explore opportunities for income generation	4.50
	4. Encourage client to make use of or connect to social support	4.43
	5. Provide skills development	4.14
	6. Refer clients to organisations and/or institutions that could assist them to reduce stress or coping difficulties	4.07
	7. Provide supportive counselling	4.07
	Form of intervention:	
	1. Individual	4.64
	2. Group	4.08

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
6. Family breakdown	1. Use a family systems approach	4.71
	2. Build trust and safety within the therapeutic space	4.71
	3. Conduct a detailed assessment in relation to the family breakdown	4.57
	4. Assist client with relationship building	4.46
	5. Address trauma(s)	4.43
	6. Provide psycho-education in relation to family breakdown	4.36
	7. Assist client with family tracing if client does not know where family members are	4.14
	8. Link current family breakdown to past trauma(s)	4.08
	9. Cognitive Behavioural Therapy	4.00
	Form of intervention:	
	1. Family	4.79
	2. Couples	4.54
7. Family-related stressors	1. Problem solve with client	4.69
	2. Use a family systems approach	4.64
	3. Conduct a detailed assessment in relation to the family-related stressors	4.57
	4. Refer clients to organisations and/or institutions that could assist them with this issue	4.43
	5. Provide information to client regarding what they could do or where they could go to address their family-related stressors	4.36
	6. Provide psycho-education in relation to family-related stressors	4.29
	7. Network with relevant organisations to establish close working relationships	4.29
	8. Conduct crisis management with client	4.21
	9. Conduct skills development of clients so that they are able to address this issue	4.14
	Form of intervention:	
	1. Family	4.79
	2. Couples	4.69
	3. Individual	4.29

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
8. Intrusions	1. Build trust and safety within the therapeutic space	4.86
	2. Provide psycho-education in relation to intrusions	4.71
	3. Assist client with symptom management	4.71
	4. Ensure that client feels contained	4.50
	5. Cognitive Behavioural Therapy	4.43
	6. Apply grounding techniques	4.43
	7. Engage in trauma exposure with client	4.29
	8. Conduct relaxation exercises with client	4.21
	9. Assist client to manage intrusions through habituation	4.08
	10. Eye movement desensitization and reprocessing (EMDR)	4.07
	11. Engage with stress management	4.07
	Form of intervention:	
	1. Individual	4.57
9. Isolation	1. Encourage client to participate in external/social activities	4.71
	2. Build trust and safety within the therapeutic space	4.71
	3. Conduct skills development of clients so that they are able to address this issue	4.50
	4. Conduct a detailed assessment in relation to the isolation	4.50
	5. Provide supportive counselling	4.50
	6. Link isolation to past trauma(s) the client may have experienced	4.21
	Form of intervention:	
	1. Group	4.38
	2. Family	4.23
	3. Individual	4.14
	4. Couples	4.00
10. Mood disturbances	1. Assess for suicide	4.93
	2. Conduct a detailed assessment in relation to the mood disturbances	4.71
	3. Cognitive Behavioural Therapy	4.57
	4. Provide psycho-education in relation to mood disturbances	4.50
	5. Provide supportive counselling	4.43

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
10. Mood disturbances (cont)	6. Refer client for psychiatric assessment	4.21
	7. Encourage client to exercise	4.21
	8. Encourage client to participate in external/social activities	4.21
	9. Assist client to access medication	4.00
	10. Conduct relaxation exercises with client	4.00
	11. Focus on/highlight positive aspects in the client's life	4.00
	Form of intervention:	
	1. Individual	4.79
	2. Group	4.14
11. Pain	1. Refer clients to organisations and/or institutions that could assist them with this issue	4.62
	2. Provide psycho-education in relation to pain	4.50
	3. Conduct a detailed assessment in relation to pain	4.36
	4. Engage with symptom management	4.36
	5. Cognitive Behavioural Therapy	4.29
	6. Assist client to access medication	4.14
	7. Conduct relaxation exercises with client	4.07
	8. Provide supportive counselling	4.07
	9. Conduct skills development of clients so that they are able to address this issue	4.00
	Form of intervention:	
	1. Individual	4.64
	2. Group	4.07
12. Safety concerns	1. Reality test client's safety concerns	4.69
	2. Develop a plan of action with client	4.62
	3. Build trust and safety within the therapeutic space	4.62
	4. Problem solve with client	4.46
	5. Conduct a detailed assessment in relation to safety concerns	4.38
	6. Provide information for client regarding what they could do or where they could go to address their safety concerns	4.38
	7. Provide more direct guidance on how client could reduce their safety concerns or increase safety	4.38

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
12. Safety concerns (cont)	8. Provide psycho-education in relation to safety concerns	4.31
	9. Encourage and allow emotional expression	4.31
	10. Provide supportive counselling	4.15
	11. Provide practical support to address safety concerns	4.08
	12. Refer clients to organisations and/or institutions that could assist them with this issue	4.00
	Form of intervention:	
	1. Individual	4.77
	2. Couples	4.17
13. Traumatic responses	1. Build trust and safety within the therapeutic space	4.93
	2. Provide psycho-education in relation to traumatic responses	4.79
	3. Conduct a detailed assessment in relation to traumatic responses	4.79
	4. Engage with symptom management	4.71
	5. Assess trauma history	4.71
	6. Facilitate meaning making in relation to the trauma	4.57
	7. Encourage and allow emotional expression	4.54
	8. Cognitive Behavioural Therapy	4.43
	9. Engage in trauma exposure with client	4.38
	10. Conduct relaxation exercises with client	4.21
	11. Engage in narrative therapy	4.14
	12. Eye movement desensitization and reprocessing (EMDR)	4.07
	13. Encourage client to participate in external/social activities	4.07
	14. Provide supportive counselling	4.07
	15. Assist client to access medication	4.00
	Form of intervention:	
	1. Individual	4.71
	2. Group	4.38

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
14. Concern for employment opportunities	1. Network with relevant organisations to establish close working relationships	4.65
	2. Problem solve with client in relation to this	4.60
	3. Assist client to identify and explore opportunities that may resolve the issue	4.59
	4. Develop a plan of action with client	4.53
	5. Provide information for client regarding what they could do or where they could go to address their concern for employment opportunities	4.35
	6. Refer client to other organisations that deal with addressing employment difficulties	4.29
	7. Encourage client to participate in external activities that may assist with this issue	4.24
	8. Provide supportive counselling	4.12
	9. Address issues related to self-esteem	4.06
	Form of intervention:	
	1. Group	4.71
	2. Individual	4.56
15. Loss of status, recognition, position in society	1. Address issues related to self-esteem	4.65
	2. Demonstrate empathy	4.65
	3. Explore and address self-blame	4.59
	4. Cognitive Behavioural Therapy	4.47
	5. Use an empowerment-based approach	4.41
	6. Encourage and allow emotional expression	4.35
	7. Take a strength-based approach with client, focussing on his/her abilities and skills	4.35
	8. Assist client to identify and explore opportunities that may resolve the issue	4.29
	9. Encourage client to participate in external activities that may assist with this issue	4.29
	10. Facilitate meaning making in relation to this loss	4.29

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
15. Loss of status, recognition, position in society (cont)	11. Conduct a detailed assessment of the issue 12. Provide psycho-education in relation to loss of status, recognition, position in society **Form of intervention:** 1. Individual 2. Group	4.24 4.06 4.65 4.24
The three impacts below did not get sent back to panellists, therefore no rating on appropriateness of intervention or form of intervention is available		
16. Anger	From IPNs (>70%): 1. Exploring options 2. Supportive therapy 3. Problem solving 4. Information giving 5. Symptom management 6. Focus on positive From Panellists: 1. Assessment 2. Emotional expression 3. Empathy 4. Explore underlying emotions 5. Relaxation exercises 6. Skills development 7. Cognitive Behavioural Therapy 8. Explore alternative behaviours 9. Explore consequences 10. Psycho-education 11. Boundary setting 12. Explore legitimacy of reactions 13. Symptom management	

Impacts where consensus was obtained:	Interventions that appeared in at least 70% of the IPNs and/ or were mentioned by at least two panellists in relation to an impact, AND which scored an average of 4 and above in terms of appropriateness	Average appropriate-ness rating from panellists
17. Difficulties with service providers	From IPNs (>70%): 1. Supportive therapy 2. Problem solving 3. Referral 4. Exploring options **From Panellists:** 1. Information giving on rights, recourse, and what to expect from service providers 2. Networking with service providers 3. Provide training to service providers 4. Advocate for the needs of clients based on their experiences 5. Empower clients to address the issue themselves	
18. Repeated victimisation	From IPNs (>70%): None **From Panellists:** 1. Develop a safety plan 2. Assess safety 3. Trauma therapy	

7.2.4. Summary of Interventions over Process

Figure 6 below summarises the interventions identified during the three methods making up the process, including the final list of 51 interventions.

Figure 6: Summary of interventions over the process

Interventions for final impacts from IPNs analysis - 30
Problem solving
Reality testing
Referal
Relationship building
Skills development
Supportive therapy
Symptom management
Termination
Trauma exposure
Using specific therapeutic approaches
WITS Trauma Model
Link to past trauma
Meaning making
Resistance
Thought stopping
Information giving
Financial assistance
Focus on positive
Grounding
Guidance
Exploring options
Exploring past (not trauma)
Exploring reactions
Exploring support and resources
Crisis management
Dream exploration
Boundary setting
Building trust
CBT
Confrontation

Additional interventions added by panellists - 43
Assessement
Psychoeducation
Empathy
Emotional expression
Relaxation exercises
Empowerment
Network
Containment
Using social support
Develop plan
Reframing
Advocacy
Case manager to handle
Encourage client to participate in external activities
Strength-based approach
Stress management
Encourage client to exercise
Encourage self-sufficiency
Holistic treatment
Integrate cultural and relegious practices for healing
Medication
Address blame
Address guilt
Address shame
Anger management
Anger management
Work on self-esteem
Art therapy
Assist to create a ritual for closure
Mindfulness
Psychiatric assessment
Relationship building
Address legal obstacles to ability to work
Address unfinished business
Assess suicidality
Explore underlying emotions
Family tracing
Find or provide secure accomodation
Focus on current relationships
Grief counselling with focus on remembrance and mourning
Habituation
Massage
Practical support
Provide training to service providers

Final list of Interventions for 18 final impacts - 51
Assessement
Psychoeducation
Supportive therapy
CBT
Problem solving
Relaxation exercises
Skills development
Referal
Building trust
Encourage client to participate in external activities
Information giving
Using specific therapeutic approaches
Develop plan
Emotional expression
Empathy
Exploring options
Network
Symptom management
Meaning making
Medication
Using social support
Containment
Crisis management
Empowerment
Engage in trauma exposure with client
Identify existing and previously used coping mechanisms
Link to past trauma
Provide more direct guidance
Work on self-esteem
Address blame
Address guilt
Address shame
Address unfinished business
Advocacy
Anger management
Assist client to create a ritual for closure
Boundary setting
Encourage client to exercise
Explore underlying emotions
Family tracing
Focus on positive
Grief counselling with focus on remembrance and mourning
Grounding
Habituation
Integrate cultural and religious practices for healing
Practical support
Provide training to service providers
Psychiatric assessment
Reality testing
Relationship building
Stress management

7.2.5. Broader Clinical Considerations

Panellists were asked a number of questions regarding their views on broader clinical considerations, the findings of which are summarised in the tables below. Questions covered a range of issues, such as: what the main goal of the initial assessment should be, what core aspects should be assessed at the initial assessment, who should conduct the initial assessment, ways in which clinicians doing this work should be supported, and how best to monitor services provided. Only responses mentioned by at least 3 panellists were included.

As shown in the tables below, clinicians reported back that the main goal of initial assessment is to gather information that will inform treatment planning (Table 8), the two key aspects to be assessed are client level of functioning and availability of resources (Table 9), and assessments should be undertaken by qualified practitioners (Table 10). In order to support clinicians, panellists identified the need for appropriate supervision and a supportive working environment (Table 11) while monitoring of clinical work should be through reviewing client progress and supervision (Table 12).

Table 8: Panellists views on the main goal of initial assessment

No.	Main goal of initial assessment	No of panellists	% panellists	References
1	To gather information that will inform treatment planning	9	56%	12
2	To gain a picture of the client's level of functioning (including psychological, social, and emotional functioning)	6	38%	12
3	To gather information regarding the client's current context	5	31%	5
4	To assess the client's resources (internal and external)	5	31%	5
5	To gain a picture of the client's history	4	25%	6
6	To evaluate the impact of torture on client	3	19%	3
7	To gather information on symptoms the client is experiencing	3	19%	4

Table 9: Panellists' views on key factors to be assessed in initial assessment

No.	Key or core things to be assessed	No of panellists	% panellists	References
1	Functioning (including psychological, social, spiritual, and emotional functioning)	10	63%	24
2	Resources (internal and external)	10	63%	13
3	Context of client	7	44%	8
4	Client history	4	25%	5
5	Health status	4	25%	5
6	Trauma-related symptoms present	4	25%	4
7	Treatment-client fit	3	19%	3

Table 10: Panellists' views on who should conduct initial assessment

No.	Who should conduct the initial assessment	No of panellists	% panellists	References
1	Qualified practitioners	11	69%	12
2	Experienced staff members	7	44%	7
3	Whoever will conduct the intervention	4	25%	4

Table 11: Panellists views on ways to support clinicians

No.	Support for clinicians	No of panellists	% panellists	References
1	Supervision	12	75%	17
2	Create a supportive working environment	9	56%	13
3	Debriefing	6	38%	7
4	Manage staff workplans	6	38%	8
5	Provide opportunities for professional development	6	38%	9
6	Case management spaces	3	19%	3

Table 12: Panellists views on ways to monitor interventions

No.	Monitoring services	No of panellists	% panellists	References
1	Review client progress	9	56%	11
2	Supervision	8	50%	9
3	Access clinical sessions	6	38%	7
4	Case presentations and discussions	6	38%	6
5	Obtain client feedback	4	25%	4
6	Review process notes	4	25%	4

8. Conclusion

This report assimilates all the key information analysed to date for the torture rehabilitation model development process. Through the triangulation of data (from literature, IPNs, and the Delphi process) it provides an evidence-based foundation upon which the detailed model development process can occur.

The review of literature highlights what researchers are focussing on in the field of torture, namely mood disturbances, traumatic responses or PTSD, and anxiety (appearing in between 33 to 48% of articles reviewed). There is some contrast between what the literature reveals and the themes that emerged from the process notes of individual sessions with victims of torture at the CSVR. In the latter, the leading themes were economic difficulties, family-related stressors, and anger. A broader understanding and exploration of the impacts of torture would benefit centres such as the CSVR. Indeed, looking at the impacts added by the panellists provides some idea of the broader view that practitioners in the field hold.

The final list of impacts, which included those seen as the most common and with the most severe impact on victims, cover an array of experiences, which trauma treatment literature does not sufficiently address. This provides support for the need to build contextually-located models rather than importing existing interventions. The array of impacts that need to be addressed highlights the complex nature of torture treatment in this context and requires a more complex treatment strategy for rehabilitation to really occur. It is clear that a narrow focus on trauma and/or PTSD is insufficient, which has implications for what treatment centres should focus on.

The interventions used with victims of torture at the CSVR also demonstrate a variety of strategies employed by trauma practitioners in an attempt to address the complex clinical picture clients present with. It demonstrates the need for several strategies to address the myriad of needs present in the lives of victims of torture, some of which fall outside of the traditional view of clinical work.

This process provided a great deal of insight into the impacts victims of torture in a specific context experience and how this experience is both similar and different from current literature on trauma treatment. The impacts present in the lives of victims of torture are varied and complex and therefore require broader intervention strategies. ■

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A NOTE ON APPENDICES

Given the length of the Appendices for this report, these could not be included in this document and are therefore available on our website www.csvr.org.za. Alternatively, you can send an email to info@csvr.org.za to request the link or a PDF version of the Appendix Report itself. ■

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