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IMPACT ASSESSMENT IN REHABILITATION OF TORTURE SURVIVORS – a long-term research strategy based on a global multi-centre study design. Part II: An exploratory study of outcome of torture rehabilitation at specialised centres from the clients' and health professionals' perspective

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Summary of this article can be found at page 401-402.

1. Introduction

The work field of torture is a work field with an applied practice, which involves several parties with different positions and perspectives, different goals and means, and different opinions about standards and desired changes. Knowledge generation aiming at a systematic description, evaluation, and development of this practice should therefore be *collaborative* and *participatory* based on the knowledge and experiences of local practitioners and relevant, focusing on existing problems and possibilities related to the practice.

Problems related to practice become visible in and are outlined by the field of practice. Knowledge production as well as dissemination and implementation of knowledge should therefore not be driven by an isolated »research practice« seeking to transfer knowledge to the field of practice. It is the field of practice that defines and outlines the character and relevance of problems to be prioritised by research (Dreier O, 1993; 1996; Markard M, 1994).

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

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The goal of action research/practice research is to contribute to a *systematic description* and *development* of a given practice. The knowledge the research aims at producing is an *insight* in and *understanding* of specific aspects of the practice under study – an insight that makes description of the practice possible and permits further development of the practice (Dreier, 1996).

To conduct action research/practice research within the work field of torture is a demanding and complex assignment, the task being to »portrait« the applied practice through description, analysis, and conceptualisation.

Practice portrait (Dreier O, 1993, 1996; Markard M, 1994) is one possible method – an instrument – by means of which, a given practice can be analysed when conducting action research/practice research. It is also to be seen as a method – a framework for reflections about specific *condition-meaning constructions* existing within the practice under study.

Consequently, practice portrait, as a method, can be applied at two levels:

1. To explicate *problem areas* – the applied practice within the work field of torture, and
2. To acquire a general insight in *the conditions – the meanings* of certain aspects of the practice, through which these can be assessed and evaluated.

The practice portrait delineates important focus areas analysing a given practice:

1. *The organisational frame* – its development and change, the internal structure, and the interrelation with other institutions
2. *The professional content* – including theoretical frameworks, working methods, and modes of intervention.
3. *Situational aspects* – including possibilities for planning of tasks, conflict constellations, and specific approaches in the management of the practice.
4. *Communicational aspects* – internal as well as external communication and the relation between practice and research.

Conducting the first phase of the Impact Assessment Study, the research team reviewed existing material describing the history and the development of 4 identified, well-consolidated rehabilitation centres for victims of torture. The centres were representing the Asian region (Indonesia), the Central and Eastern European region (Bosnia-Herzegovina), the Sub-Saharan African region (Kenya), and the Latin American region (Guatemala).

In this first phase – an exploratory study – the objective was to expli-

cate and assess relevant aspects of the practice – problem areas – to be elucidated applying practice portrait as a method in the analysis and at the same time to describe – based on a phenomenological and ethnographic approach – the outcome of torture rehabilitation as provided in different socio-cultural contexts seen from the clients' and the health professionals' perspectives.

We have aimed at assessing the *internal organisation* across centres – the formal and informal – and tried to capture the development as well as the current organisation.

The organisational structure at centres was assessed as related to the actual organisation of service delivery: decision-making, theoretical and practical understanding of practice/rehabilitation, working methods, collaboration, tasks and goals, the clients, possibilities, limitations, and future prospects, and the relation between practice and research.

We have attempted to emphasise the complexity of the work field and at the same time to make clear, that the construction of the relation between torture survivor, torture, trauma, and rehabilitation is dependent on the position, the experience, and the perspective of the actors and the socio-cultural context in which the act in.

Applying practice portrait as the framework of analysis we have tried to assess existing relations in the field of practice – what is the rationale behind clinical decision-making and mode of intervention and how is this influenced by the organisational structure across centres.

2. Aims of the study

The current study had 2 overall aims:

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

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

Independent variables:

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

Dependent variables related to clients:

- Definition and understanding of the problem(s) caused by the torture
- Perception of the treatment course and the treatment outcome
- Daily life change
- Future wishes

Dependent variables related to health professionals:

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

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

3. Research strategy

Study design

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

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

SELECTION OF PARTICIPATING CENTRES

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

- Member of the IRCT network
- Location of the centre. Participating centres should be located in differ-

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

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

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

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

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

Data collection and methodology

Data sources

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

- Written sources: review of relevant literature and existing written background material on centres (project proposals, mission reports, annual reports, publications, etc.)
- Interviews, questionnaires and informal communication
- Field notes, and systematic and sporadic observations made by the re-

search team in the field

METHODOLOGY

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

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

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

The qualitative method was designed to get an in-depth intercultural picture and understanding of a relatively small sample of clients and health professionals' perceptions, experiences and evaluation of treatment courses within rehabilitation of torture victims. The qualitative data was obtained using semi-structured interviews and focus group interviews (Bojlèn J, 1995; Kvale S, 1997).

Number of informants to be interviewed was chosen based on recommendations from the literature regarding phenomenological/ethnographic interview-based studies (Denzin NK, 1994; Holstein JA, 1994; Morse JM, 1994).

The interviews:

The interviews were elaborated within the theoretical framework offered by *Participatory Action Research* (PAR) (Pratt B, 1992; Roche C, 1999). The structure and content of the interviews, which are relevant for the work field of torture, the clinical work and context-specific, were inspired by the *Practice Portrait* method (Dreier O, 1993, 1996; Markard M, 1994).

Our point of departure was various discursive experiences, positions and perspectives, as they appear from a series of interviews (individual and focus group interviews), and divided into a series of themes we wished to elucidate, and for which we had formulated a number of questions.

Interviews with clients:

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

clients within the identified dependent variables to be elucidated by the study.

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

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

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

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

Selection of informants

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

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

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

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

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

3.3 Data processing

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

QUALITATIVE DATA
Processing of the qualitative data was based on a phenomenological and ethnographic approach (Atkinson PA, 1982; 1994; Holstein JA, 1994) utilising the various positions and perspectives offered by the interdisciplinary research team (Denzin NK, 1994). »*Practise portrait«* was applied as the overall instrument and method in the analyses (Dreier O, 1993; Markard M, 1993; Markard M, 1994).

4. Results and analysis of data

Quantitative data
The results from the processing of the quantitative data are presented in table format: Centre Questionnaires: table I-VI, Health Professional Questionnaires: table I-X. In the following only selected tables will be presented.

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

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

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

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

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

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

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

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

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

Organisation of service delivery:
Based on the inclusion criterions, the 4 participating centres represented different models of service structure:

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

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

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

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

Organisation of treatment and health professional staffing:

Table I. *Organisation of treatment at centres*

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

Table II. *Professional background of staff at centres*

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

As illustrated in Table I p. 46 and Table II p. 47 all centres offer a multidisciplinary assessment of clients either at the centre itself or by referral to various health professional specialists in a collaborating network. At some centres the collaborating network also includes legal advisors.

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

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

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

Average duration of treatment and number of treatment sessions also vary across centres, as illustrated in Table I p. 46, with a spread in average duration of treatment from 4 months up till 2 years.

Reflecting limitations and possibilities at individual centres, as well as differences in the organisation of service delivery and priorities within the clinical practise, the staffing at centres also varies to a great extent. As illustrated in Table II p. 47, this variation includes both the number of full time employed staff and the professional composition of the staff. A health professional background however is dominating among full time employed staff across centres comprising 73%.

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

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

Characteristics of individual clients treated by the centres:
Table III on p. 49 describes demographic data of clients referred to treatment at individual centres as reported in the Centre Questionnaires.

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

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

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

Table III. *Demographic Data.*
Clients treated in the period 1/1-99 until 31/12-01

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

* X = positive indication without specification.

Table IV lists the 5 most frequently applied psychological torture methods reported by referred clients at individual centres.

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

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

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

Table V lists the 5 most frequently applied physical torture methods reported by referred clients at individual centres.

All centres report unsystematic beating.

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

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

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

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

Anxiety and depression symptoms are being frequently reported by all centres. Physical sequelae are predominantly pain – headache and pain related to the musculo-skeletal system – reported by all centres.

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

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

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

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

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

Description of informants

Description of the interviewed health professionals:
Based on the filled in Health Professional Questionnaires the professional profile of the interviewed health professionals, the current organisation of their clinical practise, and their preferences are presented in table format below, Table VII and VIII.

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

Description of the interviewed clients:
20 clients, 8 females and 12 males, were interviewed. Written client files were accessible on 17 of these clients. The following descriptions are based on information from the Client Sheets filled in by health professionals at the individual centres.

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

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

The torture took place between 1 and 11 years ago, in average 7,6 years ago. 12 of the interviewed clients were tortured during confinement/imprisonment, 5 clients at their residents. Duration of confinement/imprisonment varied from 2 days to 15 years, in average 26,2 months.

Table VII: *Profile, interviewed health professionals*

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

Table VIII. *Current organisation of clinical practice and preferences reported by interviewed health professionals*

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

Torture methods reported by interviewed clients:

Physical torture methods	**Psychological torture methods**
Sexual torture including rape	Sexual harassment
Unsystematic beating, kicking	Witnessing killing and torture of close family members
Systematic beating	Witnessing killing and torture of others
Suffocation	Solitary confinement
Suspension, fixation	Threats on life
Noise exposure	Forced obedience
Mutilation, amputation of body parts	Deprivation of basic needs
Cigarette burns	
Gun/machinegun lesions	
Deprivation of necessary medical care	

At referral the clients presented with the following symptoms/problems, recorded by the health professionals:

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

The clients' problems were defined/identified and recorded by the health professionals within the following categories:

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

Treatment goals as reported in Client Sheets:

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

Clients' expectations to treatment as reported in the Client Sheets:

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

The following treatment modalities were provided to the clients by the centres:

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

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

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

Qualitative data

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

The programmes for the rehabilitation of torture victims are practised within, and in relation to a social work field. A work field involving differ-

ent parties with different perspectives according to their positioning in the field: their positioning in relation to the problems, and their positioning in relation to each other.

Consequently, an essential question is to be asked: what is the health professional's perspective and what is the torture victim's perspective on rehabilitation and the outcome of rehabilitation?

Rehabilitation and outcome of rehabilitation from the clients perspective. »To be pointed out«

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

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

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

> *»I joined the association of ex-concentration camp prisoners and they told me that I should come here. (...) Because I was beaten, I was maltreated, I was raped, I have the bones that are broken and my teeth were pulled out and broken (...) Since I am not employed I can come here because it is free and I can get that kind of help.«*
>
> *»My husband has been killed and burned and I have been in concentration camp (..) My brother and his wife told me to come here, because I was feeling bad, I was very skinny and was very depressed because I lost my memory when I was in xx (a town).«*
>
> *»I was beaten severely. And you can see my hands (...) Because I experienced (in the prison) some things that nobody else did and I was black from bruises – like my shoes are now (...) I came here encouraged by other people living in xx (a town). They told me that I must go here and get help. Not only food but also other things in order to survive.«*
>
> *»I contacted the centre through Dr. xx. I contacted him because I had nightmares and I was screaming during my sleep and wetting my bed. He directed me here. Because I didn't have any means to provide necessities for myself (...) I came here because they (health professionals) could pay for my medication.«*
>
> *»The chief of my village came to the committee and obtained a list of who are torture victims from the xx period (...) Thirty persons were all taken to the medical doctor in the community. The medical doctor*

said that they could not solve my problems so I had to go to a general hospital in the province and the general hospital referred me here.«

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

A social event and the experience of »suddenness«

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

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

»I was tortured for 3 days. I don't know why they arrested me. At the same time they were beating me. They were telling me that they were told by friends of mine, that I own an AK 47, and there had been a robbery, and that I was one of them (...). At the time of the robbery, I was not there (...). They beat me and at one point I became unconscious. So they took me, and threw me in their garbage (...). I stayed in the cell without seeing anybody (...) I told them that in my entire life, I have never attempted to take or to have an AK 47, or any firearm with me (...). I could not make any decisions. When you are in a cell, you cannot move outside ... But my case is so terrible that even my parents and my wife, were not allowed to see me.«

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

The reason for help seeking and the point of departure for the treatment course is therefore, regardless of differences in the nature of the problems and the sequences of events, described as a significant and epoch making

event – *a social event* in the clients' lives. There are numerous feelings, conflicts and decisions to relate to, which in most clients generates a profound anxiety.

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

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

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

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

The presentation of the problem and problem understanding

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

> *»I am in a bad situation. I have no heating and I have no financial means because I am not working… the situation leads to suicide because it is hard for somebody like me to come here (centre) and ask for help and I know that there is nothing. Yesterday I was not like this but today I am.«*

The clients also generate a lot of hypotheses related to their problems. In this way the definition of the problems becomes characterised by and a

question about, *where* the problems are to be placed and *who* are responsible for solving them.

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

> *»I know that you (interviewer) can not do anything concretely, but that you came to hear about us; and I am not looking anything from you personally. Is there somebody to whom we can show how the situation is? … We are not eating or anything, just talking, but when I go out in the street, I see somebody's children eating ice cream and mine don't even have water. I don't expect anything from you personally, but that somebody takes responsibility for what these people have done or terminate it. The public or anybody…But if there is some kind of power that somebody can exert so it can make a difference and we can live too as normal people, because this is unbearable if this continues without any changes. And I would like to ask you concretely: Can we survive here or should we go somewhere else?«*

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

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

Sole responsibility and isolation

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

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

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

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

The clients also express frustration and concern about the future.

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

The relationship to the health professionals and the centre

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

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

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

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

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

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

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

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

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

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

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

> *»The centre exist for the clients and they serve they serve them... I do everything they (health professionals) say.*

The clients' relation with the health professionals and the centres is in this way characterised both by *dependency* and *distance*.
A connection between the every day lives of the clients, the health professionals and the centres seems to be missing. This becomes important for the possibilities for mutual co-operation and influence.

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

The interviews have focused on the clients understanding of and influence on the process of problem identification and definition. It is revealed by the interviews that in some cases, the clients are not aware of the health professionals' goals, plans, means and methods. Neither are they aware of,

what possibilities and limitations there are in service delivery within the given frames of the centre.

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

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

Rehabilitation as a possibility for development in the process of life

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

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

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

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

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

> *»Now, I am not crying and I am not easily annoyed or frustrated (…) I feel better and not nervous, healthier, and I have a very good relationship with my neighbours«*

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

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

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

Rehabilitation and outcome of rehabilitation from the health professionals' perspective

The clients and problem identification

The health professionals were asked who the clients are?

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

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

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

»I can put the client in two categories. In one group, there are people who are silent and do not talk much. And they always ask if the name and last name will be kept anonymous. People who have suffered a lot…People who say that they never want to come back to the place that they lived before (...), in the place where the torture happened, where they saw their children being killed or their husbands or women being taken away. People who come here and thank very much

for one medication… The other group is also people who survived torture and lost material goods, but who come here very angry and very furious… There is this client to whom we always explain every time he comes here, that there are things that we can and cannot do… This client always starts from the point that 'I am a victim, and that I have to have help' no matter if he has got everything that we can offer… The first group, would probably say to me: 'You are somebody who wants to help us', and the other group would often say to me: 'You are the one responsible for what is happening to us, we wish you the same.«

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

»Most of them we accept, but some we refuse. Because we know, how to sort them out. And what happens if the client comes again now, with different issues? If the first history was related to the direct torture, and this is some other side effect, I try to explain to the client, 'this is what we did, and our area is only torture. Now this is stomach pain, which is not related to that issue, and due to our donor funding, we are not allowed to do this'…So when you try to ease them back, they still want to go and talk. So it is an area, where it is very complicated. It is an area where psychologically you have to be ready to deal with all sorts of people. Others they will speak abusive language, others they are donuts, others you really will not understand, because they are afraid to trust you.«

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

»Let's say e.g. that somebody come with this lack of sleep, how do I define that to him? I tell them, that you know, when you are going through all these torture problems, there was arousal within you. The body or the mind was kind of aroused. And this one is coming with the problems, such as lack of sleep, such as lack of concentration, you know. So I will tell them: 'That is not because there is something terribly wrong with you, but this is the result of the problem or the result of the torture you went through, this is why this is happening'…But

basically during the first session, I am not going to have all that time to explain. It will go step by step until we cover all this, because there are quite a number of these problems… Now what do I call what I do? I usually call it 'psychological assessment'…When I come to doing my assessment I will do the cognitive side first, then I will go to the social one, the emotional one and then the sexual side also…And sometimes I use the Harvard Trauma Questionnaire, and I find that one is even easier…Now afterwards, when I have done that one, I have to do the analyses of this kind of information which I have got. What is the case, I am having here? Is it a PTSD? Is it depression? Is he now being psychotic or it is only just anxiety? So this kind of information will give…

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

Working tasks and working conditions

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

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

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

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

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

»These people, the torture victims, are people who need a 'holistic' management. Sincerely, if you take the torture victim, you know, first of all their problems are not just one. They have psychological prob-

lems, they have physical problems, they have social problems, they have legal problems. So if these things could run concurrently that would be good.«

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

It seems as if the health professionals initially choose individuals as the object of treatment, but when the problems as well as the foundation for the understanding of these problems change, the object of treatment needs to change and *expand* as well, and to also include the individual's *social context.*

It is the health professionals' task to focus on the clients' *overall situation* – which implicates the use of (new) specialised knowledge.

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

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

Collaboration and multidisciplinary skills

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

»I do not see that anything is being done about social problems. They (institutions representing the government) have even told me, after a few recommendations for transition to third countries for the clients, not to do it anymore because it would look like we are sending people out of the country. Although I see that it is the only way for some people who want to go out…I get a little bit satisfied with

the small financial help we can sometime give... but nothing concrete. There was a conference and a seminar, but I do not see that anything socially, in the social dimension, is done.«

Possessing multidisciplinary skills and the demands for a thorough co-ordination of services and interventions provided by individual health professionals' play a central role.

The health professionals were asked about their collaborating partners – who they are and who they collaborate the most with.

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

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

The clients – successful or not successful

The problems the health professionals deal with and thereby »solve« are characterised by conflicts in and between human beings, and cannot be solved without the active participation of the involved parties.

Some health professionals talk about their frustrations due to lack of »visible« results, lack of possibilities in assisting the clients and insecurity about how the clients are going to cope.

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

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

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

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

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

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

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

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

»How do I decide to terminate? First of all, I have to prepare the client and I work with the client to come to that also. I will see, that the client has improved in the areas where he was having difficulties…And I also have to know whether he is now doing activities – he has gone back to what he was doing before. And he also feels comfortable; I feel I am okay, and I do not need to keep a client in therapy

who is ready to go. But still I do keep an open door. I do tell them, in case of any other thing, yes. But my aim actually is to 'empower' them and they live their life.«

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

»If the client was not ready for therapy. You see, people who just come here they may not themselves have thoughts of going into therapy. So the client may not even come back. In fact it is also difficult to tell whether there has been success or not in that aspect, because the client did not come back again. The client may not come back because he gained insight when he got home, and now he is able to manage his life. So it is not always an indicator that it did not succeed.«
»When there is no understanding from the governmental organisations, no understanding by anybody. And sometimes you can see how fast they are to reply that they can not do anything, that they are not authorised. And they just say that they are not dealing with the clients problems and that I should turn to somebody else.«

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

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

»When the process is very long, and the clients come from different regions, and different doctors examine the clients. This means that it is not the same doctor who is responsible for all supervision and control of the clients. It is difficult then to discuss the development of the clients between the doctors and the field workers who have that duty. Yes it might be difficult, and the results are not effective ...The unsatisfactory results are caused by the long process and also the different opinions and thoughts of the doctors, and the minds of the clients, and also the field workers, who control the clients – they are different. And the clients they have chronic problems, very big

problems, so even though we give them a treatment, the result is not satisfactory.«

»When the client do not want to take medicine, maybe the lack of support, the lack of family support.«

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

The linkage between theory and clinical practise

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

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

»Indirectly maybe, indirectly.«

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

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

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

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

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

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

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

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

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

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

5. Conclusion

The study had two main purposes.

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

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

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

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

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

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

Findings in the study were:

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

That the theoretical knowledge and practical experience available at

centres often determines the way individual centres priorities to organise their clinical practice, but that this practice also is influenced by concrete possibilities and limitations within service provision.

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

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

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

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

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

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

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

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

REFERENCES

AMRIS, K. & PRIP, K. (2000): Chronic pain in torture victims. Possible mechanisms for the pain, and treatment. *Torture* 10.

AMRIS, K. & PRIP, K. (2001): Torturoffer – et liv i smerte. In: Fasting, U. & Lundorff, L. (eds.): *Smerter og smertebehandling i klinisk praksis.* København: Munksgaard.

ARENAS, J.G. & STEEN, P. (1994): Exile psychology and psychotherapy with refugees in a transcultural perspective – some theoretical considerations. *Torture* 4 no.2.

BOJLÉN, J. (1995): Det fokuserede gruppeinterview. I: Lunde, I. & Ramhøj, P, (eds.): *Humanistisk Forskning inden for sundhedsvidenskab kvalitative metoder*. København: Akademisk Forlag.

BURR, U. (1995): *An introduction to social construction.* London: Routledge.

CRAMER, M. (1982): *Psychosoziale arbeit.* Stuttgart: Kohlhammer.

DAVIES, B. & HARRÉ, R. (1990): Positioning:The discursive production of selves. *Journal for the theory of Social Behavior* 20 no.1.

DENZIN, N.K. & LINCOLN, Y.S. (ed) (1994): *Handbook of Qualitative Research.* London: SAGE Publications

DREIER, O., (1978): Retninger, moder og idoler i psykologien. *Udkast* 1.

DREIER, O. (1979): *Den kritiske psykologi.* København: Rhodos.

DREIER, O. (1993): *Psykosocial behandling. En teori om et praksis-område.* København: Dansk psykologisk Forlag.

DREIER, O. (1996): *Forskelle og forandring –bidrag til humanistisk sundhedsforskning.* Aarhus: philosophia.

DREIER O. (1996): Subjectivity and the practice of psychotherapy. In: Tolmann, (ed.): *Problems of theoretical psychology.* York, Canada: Captus Press.

DREIER O. (1998): Client perspective and uses of psychotherapy. *The European Journal of Psychotherapy, Counselling and Health* 1 no.2.

DÖPPING, J. (1992): *Problemer i og med psykosocial rådgivning.* Prisopgave. Københavns Universitet.

ENDERUD, I. (1986): *Hvad er organisations-sociologisk metode?* København: Samfundslitteratur.

GURR, R. & QUINOGA, J. (2001): Approaches to torture rehabilitation – a desk study covering effects, cost-effectiveness, participation, and sustainability. *Torture*; Suppl.1

HOLZKAMP, K. (1979): Den kritiske psykologiske overvindelse af psykologiske teoriers videnskabelige vilkårlighed. In: Dreier, O. (ed.): *Den kritiske psykologi.* København: Rhodos.

HOLZKAMP, K. (1984): *Til en kritisk psykologisk teori om subjektiviteten.* Ref Type: Hearing.

HØJHOLT, C. (1990): Tværfagligt samarbejde. *Udkast* 2.

HØJHOLT, C. (1993): *Brugerperspektivet. Forældre, lærerne og psykologens erfaringer med psykosocialt arbejde.* København: Dansk psykologisk Forlag.

JACOBSEN, B. (2001): *Hvad er god forskning ? – psykologiske og sociologiske perspektiver.* København: Hans Reitzels Forlag.

JUUL JENSEN, J. (1986): *Sygdomsbegreber i praksis.* København: Munksgaard.

KITZINGER, J. (1994): *The methodology of focus groups – the importance of interaction between research participants.* Sociology of Health and Illness .

KVALE, S. (1997): *Interview. En introdukton til det kvantitative forskningsinterview.* København: Hans Reitzels Forlag.

LENNÉER-AXELSON, B. & THYLEFONS, I. (1993): *Arbejdsgruppens psykologi – om det psykosociale arbejdsmiljø.* København: Hans Reitzels Forlag.

LEWIN, K. (1951): *Field theory in social science.* New York: Harper and Sons.
LIMA, C. (1994): Proffession – eller – handling. *Udkast* 1.
MALUCCIO, A. (1979): *Learning from clients.* New York: Norton.
MARKARD, M. & HOLZKAMP, K. (1993): Praxis-Portrait. *Forum Kritische Psychologie* 23.
MARKARD, M., HOLZKAMP, K. & DREIER, O. (1994): *Praksisportrættet.* Revideret udgave. København.
MORS, J. (1994): Designing funded qualitative research in N, Denzin, & Y, Lincoln (ed) *Handbook of Qualitative Research.*
MØRCH, S. (1987): Teori eller empiri – empiriproblemet i empirisk forskning. *Udkast* 1.
MØRCH, S. (1993): *Projektbogen – teori og metode i projektplanlægning.* København: Rubikon.
NYGREN, P. (2002): Psykosocialt arbeide som kvalifisering av subjekter. *Nordiske Udkast* 1.
OLSSON, E. (1985): *Mellanmänskliga förändringsprocesser.* Lund: Studentlitteratur.
PATTON MQ. (1990): *Quantitative Research and Evaluation Methods.* California: Sage Publicatons.
PETERSEN, J. (1980): *Hvad er effekt måling.* København: Munksgaard.
PETZER, K. (1996): *Counselling and Psychotherapy of victims of Organised Violence in Sociocultural Context.* Frankfurt: IKO –Verlag für Interkulturelle Kommunikation.
Psyke og Logos. (1998): Tema: Terapeuten – psykoterapiens svage led.
RATTLEFF, S. (1992): Introduktion til kvalitative metoder i psykologisk forskning. København: Semi-forlaget.
SCHEIN, E.H. (1990): *Organisationspsykologi.* Herning: Systime.
SCHEIN, E.H. (1986)*: Organisationskultur og ledelse.* København: Valmuen.
SCHÖN, D.A. (1983): *The reflective practitioner: How professionals think in action.* New york: Basic Books
SPRADLEY, J.P. (1979): *The ethnographic interview.* New York: Holt, Rinehart & Winston.
SPRADLEY, J.P. (1980): *Participant observation.* New York: Holt, Rinehart & Winston.
STAUNÆS, D. (1995): "De andre" i skiftende perspektiver. *Udkast* 1.
STEIER, F. (1992): *Research and Reflexivity*. London: SAGE Publications.