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Introduction to Volume 29, Issue 3

Torture Journal Editorial Team*

We close Volume 29 with an issue of Torture Journal focused on measuring processes and results, a subject that has always been considered a priority for the sector. There is a dearth of studies on long-term follow-up to assess rehabilitation success. The paper by Martin Hill and Mary Lynn Everson, "*Indicators likely to contribute to clinical and functional improvement among survivors of politically-sanctioned torture"* is unique in the length of post-treatment follow-up, and provides an innovative approach in the measurement of rehabilitation outcomes through a structured measure of functional aspects with an instrument designed at the Kovler Center in Chicago. In addition, in the framework of the interminable debate over whether clinical categories of psychiatric classifications respond effectively to the experience of torture victims, Marie Louison Vang and colleagues present in their paper "*Testing the validity of ICD-11 PTSD and CPTSD among refugees in treatment using latent class analysis*," a validation study through multivariate models to distinguish between the classic Post-Traumatic Stress Disorder (PTSD) diagnosis and the new Complex Post-Traumatic Stress Disorder in refugee and torture survivor populations. The results show that this new diagnosis not only complements the previous one but both approaches represent an improved nosological classification and definition of the experiences of torture survivors. Kim Baranowski and collaborators, in their paper, "*Experiences of gender-based violence in women asylum seekers from Honduras, El Salvador, and Guatemala*" propose, supported by the evidence gathered, that types of violence experienced by these women are multi-intersectional, and that restricted categorisation of the concept of torture can ignore the experiences of asylum-seeking women, whose lives, both in their countries of origin, in transit and in the host country, are persistently affected by structural, psychological and physical violence perpetrated by state and non-state actors alike. Finally, Kristi Rendahl and Pamela Kriege Santoso offer in their contribution *"Organizational development with torture rehabilitation programs: An applied perspective,"* a personal, non-data-driven text representing their experience in supporting the creation of torture victim centres in different countries within the framework of the CVT's Partners in Trauma Healing (PATH) Project.

In this last issue of the journal we would like to thank all the authors that have chosen Torture Journal as the platform to share their research. In particular, we extend

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our thanks to those anonymous reviewers who have devoted hours and effort to the indispensable task of giving us their critical and constructive view of the journal's articles. Without them the publication would not be possible.

We believe that this issue of the Torture Journal will undoubtedly provide many elements of reflection for our readers. We hope you enjoy reading it as much as we enjoyed preparing it.

Torture Journal Editorial Team

Letter from Ms. Lisa Henry, Secretary-General of the International Rehabilitation Council for Torture Victims

Lisa Henry*

Transitioning into the role of Secretary General for the IRCT from a position in East Jerusalem as Country Director for Palestine was an interesting move. My previous work with rights-based humanitarian response was informed by the humanitarian principles of humanity, impartiality, independence and neutrality. Now in IRCT my work is with rights-based rehabilitation for torture survivors as underpinned by the Right to Rehabilitation under the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT, Article 14). The importance of having an international, rights-based policy framework to advocate for, in combination with results and knowledge from health-based experts, is essential to deliver the IRCT vision of "A World Without Torture".

My first-hand experience of the shrinking space for civil society organizations who are delivering life-saving services while working creatively and persistently to gather and analyze data to influence decision and policy makers, equips me well for the job at IRCT. I know that we need to work efficiently and smart because of the challenging context in which our IRCT member centers operate. We need to share knowledge, inspire innovation and persistently pursue justice and holistic rehabilitation so that torture victims can become fully functioning members of society again.

The Torture Journal, started in 1991, is an important contribution by IRCT to the global knowledge platform for academics, practitioners and activists, as it gathers trend-setting data, articles and opinions with a significant scientific value. It is a reference source for professionals, a source of leading research in the field, and a forum for debate and knowledge exchange. Most recently the Torture Journal included articles and debate about forensic documentation

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of torture, sexual, gender-based torture, forced migration and sleep deprivation. The strategic selection of these timely topics has fostered an interdisciplinary, global learning community where young scholars, field practitioners, medical professionals and torture survivors can exchange views, and most importantly improve rehabilitative practices for torture survivors through new knowledge. The combination of research on medical, psychological and social impact of torture is unique to the Torture Journal.

In 2019, I am proud that IRCT is delivering on its objective of a global rehabilitation knowledge platform thru publication of the Torture Journal. As we move into the year 2020 we will listen to the specific needs of our membership and community related to an innovative, relevant global knowledge platform to find the particular form that will support learning and debate up to the Tbilisi Scientific Symposium and IRCT General Assembly in October 2020 and also in the follow up and action points from that Symposium and GA. The 157 members in 75 countries and the wider anti-torture community have the right to relevant, timely knowledge which improves health practitioners ability to support torture victims to take control of their lives, be self-supporting and contribute to society.

Respectfully,
Lisa Henry

Indicators likely to contribute to clinical and functional improvement among survivors of politically sanctioned torture

Martin Hill, PhD, Mary Lynn Everson, MS, LCPC*

Key points of interest

- The paper introduces a holistic approach to assessing treatment programs for survivors of torture.
- Medical, psychological, and social indicators are demonstrated to correlate with, or predict clinical outcomes.
- The authors provide long-term follow-up at 24 months post-intake.

Abstract

Introduction: Heartland Alliance Marjorie Kovler Center (Kovler Center) is a torture treatment program located in Chicago, Illinois. Established in 1987, Kovler Center provides medical, mental health, and social services, as well as coordination with legal services, to a diverse population of survivors. Historically, Kovler Center used clinical measurement instruments to assess depression, anxiety and post-traumatic stress, but staff was challenged with finding the best way to assess and ultimately measure changes in functional domains. The purpose of this paper is to describe (1) the Kovler Center framework, philosophical pillars, and model of treatment; (2) the comprehensive outcome evaluation program, including the Marjorie Kovler Center Well-Being Questionnaire (MKC WBQ); and (3) the results and implications to date. *Methods:* Kovler Center measured outcome data utilizing three instruments including a well-being tool and supplemented the data with a satisfaction survey. These instruments were administered at intake and re-administered at six-month intervals up to 24 months. *Results/Discussion:* With nine years of data, Kovler Center can now provide valid and reliable findings in diagnostic and functional changes, with 86.6% of its clients reporting fewer symptoms of anxiety and depression, 83.1% reporting fewer symptoms of trauma, and significant improvement in employment status, housing status, and physical health after receiving services for 24 months. Indicators significantly correlated with clinical improvement at 24 months include stable housing, stable employment, region from where survivors came, English language proficiency, number of days between initial assessment and program admittance, number of services (medical, psychological,

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social) received while in the program, number of medical problems diagnosed with while in the program, and number of psychological problems diagnosed with while in the program. From the Generalized Linear Mixed Models (GLMM) analysis, the total number of psychological problems and whether or not the participant had a secure legal status while in the program were demonstrated to explain the variance in anxiety, depression, and PTSD. Females were more likely to experience depression while in the program compared to males, and participants from the Middle East were more likely to experience symptoms of depression and PTSD compared to participants from Africa. *Conclusions:* Since medical, psychological, and social indicators are demonstrated to correlate with or predict clinical outcomes, this highlights the need for comprehensive and holistic treatment programs for survivors of torture.

Keywords: torture treatment, holistic, evaluation, trauma, asylum seekers.

Introduction

Established in 1987, Heartland Alliance Marjorie Kovler Center (Kovler Center), a program of Heartland Alliance International, treats survivors of politically-sanctioned torture, as well as family members affected by this brutal human rights violation (Fabri et al., 2009). Annually, 350-400 survivors representing 60 countries (89 since inception) engage in its services.

The *framework for services* as originally conceptualized remains in place today (Fabri et al., 2009): community-based, volunteer-based, and with no cost to survivors. Survivors seeking services are considered from an ecological perspective that includes the context of migration, adaptation, family and professional life, and trauma suffered (Bronfenbrenner, 1979). With that in mind, Kovler Center has adopted six *philosophical and aspirational pillars of service*: a holistic approach to integrated services; a trauma-informed approach that is empowerment-focused, strength-based, and survivor driven; an approach that is inclusive of supporting spiritual well-being (Piwowarczyk, 2005); a commitment to the provision of culturally and linguistically sensitive services; a focus on rebuilding community (Black, 2011); and access to justice.

Kovler Center's *treatment model*, inclusive of the framework and aspirational pillars, follows the three stages of recovery as described by psychiatrist Judith Herman (1992): the establishment of safety; remembrance and mourning, and reconnection with community and ordinary life. Clinical volunteers embrace a number of theoretical frameworks; however, all are educated in this model and encouraged to adopt it (Hill & Everson, 2016a). Additionally, Kovler Center stresses the importance of empathy, warmth, congruence, and a therapeutic relationship as critical to positive outcomes per Lambert and Barley (2001).

As key elements of accountability, the collection and dissemination of outcome data hold Kovler Center answerable to its clients, funders, and to itself. In 2007, Kovler Center began investigating ways to track *outcomes* deemed important and critical to survivors of torture which included non-clinical functional domains, in addition to diagnostic. With domains identified by survivors as areas of desired change and confirmed by clinicians (immigration/legal status, physical health, employment, education, housing, English proficiency, personal relationships, emotional health), Kovler Center replaced the use of the World Health Organization

Quality of Life Survey with its own non-clinical measurement tool that is more nuanced to the population of torture survivors that complement measures such as symptoms of anxiety, depression, and post-traumatic stress. A literature review, as detailed below, concluded that the field of torture survivor intervention rarely employs a well-being approach (Salo & Bray, 2016).

On January 1, 2010, after a year-long pilot period, Kovler Center formally implemented the Marjorie Kovler Center Well-Being Questionnaire (MKC WBQ) to measure and track non-clinical functional domains. At the same time, Kovler Center formally implemented the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist-25 (HSCL) to measure clinical status during intake evaluations, with re-administration at six-month intervals up to 24 months.

Literature review

The literature describing the impact of torture treatment services, measuring change, and determining indicators of success for torture survivors is scant. Primary reasons for this are the tendency of agencies with limited resources to focus more on service delivery and treatment, as well as the conceptual, context-related, and methodological challenges present when attempting to formulate a research plan or design (Montgomery and Patel, 2011). Some treatment centers are reluctant to conduct outcomes research for fear that the research process, in terms of re-administration of any data collection instruments, is potentially re-traumatizing (Jaranson & Quiroga, 2011).

To evaluate the services of torture treatment programs, Jaranson and Quiroga (2011) conducted an expansive literature review. Until then, most of the literature published on torture treatment programs had been descriptive in nature, and they found no studies had implemented a true experimental design. The greatest barrier to using an experimental design for measuring outcomes in torture treatment evaluation is the ethical problem that would arise by denying needed care to survivors who would be assigned to a control group (Connor, 1980; Jaranson & Quiroga, 2011; Montgomery & Patel, 2011; Schwartz et al., 1997). For purposes of this paper, and to be consistent with our own methodology, the focus of this literature review is on research studies that employed quasi-experimental, one group, pretest-posttest designs.

Carlsson et al. (2006a) examined 63 male traumatized refugees at a treatment center in Denmark. The researchers found that after nine months of treatment, the significant predictors of emotional distress were previous torture and trauma, lower education, no occupation, pain, and fewer social contacts. Further, the authors determined that even with the passage of extended periods of time, past torture was significantly associated with emotional distress. In a concurrent study in Denmark, Carlsson et al. (2006b) followed 139 refugee torture survivors 10 years after their referral to a treatment center. Their findings were similar, in that social relations and unemployment at follow-up were important predictors of mental health symptoms and low health-related quality of life.

In Germany, Birck (2001) reassessed a small sample (n=21) of Bosnian torture survivors following two years of psychotherapy. Although PTSD symptoms had decreased within that timeframe, many of the clients continued to be symptomatic for PTSD. More recently, Stammel et al. (2017) evaluated a

multidisciplinary approach of a treatment center in Germany. They followed 76 traumatized refugees between 7-14 months post-intake. Clients demonstrated significant improvements in symptoms of PTSD, anxiety, depression, somatoform symptoms, and quality of life. The only variable that was found to be a significant predictor was age: younger patients showed greater improvement in somatoform symptoms compared to older patients.

Kivling-Boden and Sundbom (2001; 2002) followed 27 former Yugoslavian refugees at a treatment center in Sweden following three years of program intervention. Although the authors found no differences in PTSD scores or symptoms at follow-up, they did find that unemployment, social isolation, and dependence on social welfare were associated with PTSD symptoms at follow-up. Positive factors were housing and a reasonable knowledge of the Swedish language.

Raghavan et al. (2013) evaluated a torture treatment program in New York City with a multinational refugee population. Following six months of treatment the authors found significant improvements in symptoms of PTSD, anxiety, depression, and somatization. Multivariate analysis demonstrated a strong correlation between gaining secure immigration status and clinical improvement. However, stronger predictors of clinical improvement were receiving psychotherapy and attendance at educational sessions.

Some researchers have tracked clinical symptoms of post-migratory torture survivors who received no intervention. Ekblad (2000) and Ekblad et al. (2002) studied 218 Kosovar refugees who immigrated to Sweden and measured their symptoms of anxiety, depression, and PTSD upon arrival. They followed 131 refugees at three months and 91 at six months, and found that symptoms of anxiety, depression, and PTSD were similar to baseline. Lie (2002) conducted a three-year study of 462 mostly Bosnian refugees in Norway. Over half of the sample showed no improvement in symptoms of emotional distress, anxiety, depression, or psychological function, but did show greater symptoms of PTSD at follow-up.

Methodology

Processes

Participants in this study were admitted to Kovler Center's treatment program because they met the screening criteria for having experienced state-sponsored torture outside of the United States. At intake, three instruments, as detailed below, were administered by clinicians to gather data on both clinical and non-clinical indicators. The instruments were administered via in-person interviews at intake to all new, adult, primary and secondary survivors of torture seeking treatment at Kovler Center. The results of these intake interviews were then used as baseline measures.

Subsequent to the intake process, the Associate Director, Research and Evaluation at Kovler Center re-administered the three instruments at 6, 12, 18, and 24 months post-intake. Similar to intake, most follow-up interviews were conducted in-person. A couple were conducted via telephone for clients who found meeting in-person to be challenging. Clients were considered to have matriculated through the treatment program at 24 months following the completion of their initial individual treatment plan. Interpreters were provided for those clients with limited English proficiency.

For clinical indicators, Kovler Center's outcome evaluation protocol utilized the Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist-25 (HSCL). The HTQ is a 40-item instrument that measures the severity of trauma symptoms (Mollica et al., 1992). The first 16 items (subscale) measure the existence of Post-Traumatic Stress Disorder (PTSD) per the DSM-IV diagnostic criteria. The remaining 24 questions measure the impact that trauma has had on one's perception of their ability to function in daily life. A total score is computed by the average score of the 16 or 40 items. A score of 2.50 is considered a threshold where any score at or above this mark is symptomatic for post-traumatic stress.

The HSCL is a 25-item instrument that measures the severity of symptoms of anxiety and depression (Hesbacher et al., 1980; Winokur et al., 1984). The first 10 items measure symptoms of anxiety and the remaining 15 items measure symptoms of depression. Similar to the HTQ above, the HSCL is administered in-person and utilizes the same four-point scale. A score of 1.75 is considered a threshold where any score at or above is deemed symptomatic for anxiety or depression.

The Marjorie Kovler Center Well-Being Questionnaire (MKC WBQ)[1] is a 49-question instrument and was utilized to measure and track multiple functional domains, or non-clinical measures, at 6-month intervals (up to 24 months) post-intake and included the following:

1. Immigration (legal) status: planning to apply for asylum, not planning to apply for asylum, applied for asylum, was granted asylum, refugee, legal permanent resident, U.S. citizen, or case was in appeal.
2. Employment status: (1) whether or not the client had authorization to work, and (2) whether employed full-time, part-time, self-employed, student, stay-at-home spouse, disabled, unemployed but looking for work, or unemployed and not looking for work.
3. Housing status: 10 categories ranging from homelessness to home ownership.
4. English language ability: self-reported ability to speak or read English rated on a four-point scale, where 1 was not at all well, 2 was slightly well, 3 was somewhat well, and 4 was very well.
5. Interpersonal relationships: satisfaction with how clients get along with family and friends rated on a four-point scale, where 1 was very dissatisfied, 2 was dissatisfied, 3 was satisfied, and 4 was very satisfied.
6. Physical pain/illness: whether or not clients currently had migraine headaches, pain in their joints, pain in their neck/shoulders, pain in their lower stomach, pain in their backs, numbness in their extremities, rapid heartbeat, difficulty breathing, night sweats, high blood pressures, diabetes, or digestive problems.

Further information was extracted from Kovler Center's Electronic Health Record System (EHRS) database. At intake, clinicians entered client demographic information such as gender, marital status, age at intake, country/region, level of education upon entering the program, and religion. Other information important to this analysis included time between initial assessment and program admittance, whether or not the client

[1] For the full Well-Being Questionnaire, please refer to the Torture Journal website: https://tidsskrift.dk/torture-journal/

required an interpreter, number of services received while in the program (medical, psychological, social), number of medical problems while in the program, and number of psychological problems while in the program.

In addition to the three instruments described above, a satisfaction survey was also administered to clients at each re-administration. This survey provided a comprehensive assessment of clients' experiences with Kovler Center. Clients rated Kovler Center on how well the Center and its staff performed on nine specific attributes (e.g., timeliness of services, relevance of services, professionalism of staff, etc.) using a four-point scale. They also rated their overall experience with Kovler Center. Additionally, two open-ended questions gathered substantive qualitative feedback on Kovler Center's strengths and areas where there was opportunity to improve. The feedback gathered from this survey was used internally to continually improve the program and address any needs or issues that had arisen.

The data utilized was collected between January 1, 2010 and December 31, 2018. During that time, 441 new adult clients consented to treatment and any follow-up re-administrations to measure and track clinical progress. A total of 334 clients (75.7%) had received at least one re-administration and were entered in Kovler Center's SPSS tracking database. Because Kovler Center's approximate treatment program duration is 24 months, this study primarily focuses on 182 of the 334 (54.5%) clients who had completed a 24-month re-administration. The 182 clients in the final sample represents 41.3% of the 441 clients who were eligible for any re-administrations, including one at 24 months.

To our knowledge, this is the first study of torture survivors participating in a holistic treatment program that compares baseline clinical measures with multiple time points, including 24 months post-baseline. Prior research studies of holistic treatment centers have focused on shorter intervals (e.g., 6 months post-intake) (Raghavan et al, 2013). The intervention period was considered optimal for demonstrating program efficacy and sustainability.

Statistical analyses

Descriptive statistics were used to provide a portrayal of client demographics, as well as the number of program services clients received while in the program, the number of medical or psychological problems with which they were diagnosed while in the program, and aggregate HSCL and HTQ measures at intake and each six-month interval following intake.

Paired sample t-tests were used to compare pre- and post- differences between HSCL and HTQ measures (total and subscale) at intake and at 24-month re-administration. For categorical data, McNemar's test was used to compare differences between pre- and post-proportions. These variables came from either the MKC WBQ or the EHRS database and were dichotomized for proper comparison.

Correlations were used to measure the association between several potential predictor variables and the following clinical outcomes at 24 months: (1) HSCL anxiety subscale, (2) HSCL depression subscale, and (3) HTQ PTSD subscale. Controlling for baseline HSCL and HTQ subscale measures was important, thus partial correlation was utilized for continuous variables and partial eta squared was used for categorical variables.

Next, we wanted to address temporal autocorrelation by looking at the clients who received a follow-up at multiple time points post-intake. All of the potential predictor variables from the correlations were entered into a Generalized Linear Mixed Model (GLMM) using a normal probability distribution and an identity link function. This method allowed us to account for the nested structure of the data where multiple outcome measures every six months nest within participants. Participants were treated as random effects and all other variables in the model (including time) were treated as fixed effects. Intraclass Correlation Coefficients (ICC) were calculated to demonstrate the variance in the dependent measures attributable to the effect of individuals. The GLMM method was chosen because it accounts for the dependency of outcome measures within individuals over time, provides an account of cluster level effects on the outcomes of interest, and preserves the sample due to missing data issues, such as HSCL or HTQ subscale measures which may be missing at 6, 12, or 18 months.

Results

Table 1 displays the characteristics of the final sample of 182 Kovler Center clients included in this analysis. The vast majority of the group was comprised of primary survivors of torture.

After 24 months in Kovler Center's treatment program, 70 clients (38.5%) had a secure legal status, meaning they had been granted asylum (25.3%), were legal permanent residents (8.8%), were U.S. citizens (3.8%), or were a refugee (0.5%). Also, at this point, three-fourths of the sample (n=136, 74.7%) was employed (or had a spouse who was employed full-time), while 25.3% (n=46) were unemployed (including students and those who were disabled). At 24 months, 150 (82.4%) clients had stable housing where they either owned their home, rented their own apartment or townhome, or contributed to rent by living in a shared space.

From their initial intake through their 24 months of treatment at Kovler Center, clients averaged 80.0 total services (range 10 to 288, Standard Deviation (*SD*) = 55.3), which was comprised of an average of 19.3 medical services (range 0 to 147, *SD* = 20.1), 26.5 psychological services (range 3 to 82, *SD* = 19.4), and 34.6 social services (range 2 to 188, *SD* = 34.1). Additionally, clients averaged 7.3 medical problems (range 0 to 29, *SD* = 5.7) and 2.3 psychological problems (range 0 to 6, *SD* = 1.3) while in the program.

Figure 1 reveals that Kovler Center clients experienced a reduction in symptoms of anxiety, depression, and trauma from baseline to program completion (24 months). The average HSCL score decreased from 2.66 to 1.88, and the average HTQ score declined from 2.57 to 1.87, over the 24-month program period. Both HSCL and HTQ total scores are considerably lower at each re-administration when compared to intake.

Figure 2 shows that the proportion of Kovler Center clients who were symptomatic for anxiety, depression, and trauma decreased notably from intake to each re-administration. For example, 94.0% of clients were symptomatic for anxiety and depression at intake; however, this proportion decreased to 50.5% at 24 months. Similarly, the proportion of clients with symptoms of trauma decreased from 54.4% at intake to 20.9% at 24 months.

Table 1: *Characteristics of the Sample (n=182)*

	N (%)
Torture Survivor Type	
Primary	173 (95,1)
Secondary	9 (4,9)
Gender	
Male	110 (60,4)
Female	72 (39,6)
Marital Status at 24 Months	
Single	92 (50,5)
Married	82 (45,1)
Other (divorced, separated, widowed)	8 (4,4)
Region	
Africa	137 (75,3)
Europe	19 (10,4)
Asia	15 (8,2)
Americas	8 (4,4)
Middle East	3 (1,6)
Religion	
Christian	149 (81,9)
Other (Buddhist, Hindu, Jewish, Muslim, other)	32 (17,6)
Non-believer	1 (0,5)
Employment Status at 24 Months	
Employed (full-time, part-time, self)	126 (69,2)
Stay at home spouse	10 (5,5)
Student (attending school full-time)	4 (2,2)
Disabled	3 (1,6)
Unemployed	39 (21,4)
Legal Status at 24 Months	
Applied for asylum	107 (58,8)
Granted asylum	46 (25,3)
Legal Permanent Resident	16 (8,8)
U.S. citizen	7 (3,8)
Case under appeal	4 (2,2)
Refugee	1 (0,5)
Planning to apply for asylum	1 (0,5)
Housing Status at 24 Months	
Contribute to rent or own residence	150 (82,4)
Not able to contribute to rent	32 (17,6)
English Language Proficiency	
Requires an interpreter	66 (36,3)
Does not require an interpreter	116 (63,7)
Education	
College education or college degree	52 (28,6)
Less than a college education	130 (71,4)

Despite the fact that roughly half of Kovler Center clients were symptomatic for anxiety and depression at 24 months, 86.6% of all clients tracked had fewer symptoms of anxiety and depression compared to intake. A similar proportion (83.1%) had fewer symptoms of post-traumatic stress at 24 months compared to intake.

Table 2 shows the results from paired sample *t* tests comparing changes in HSCL and HTQ total and sub-scale scores from baseline to 24 months. Clients

Figure 1: *Change in Mean HSCL and HTQ Scores from Intake to 24 Months*

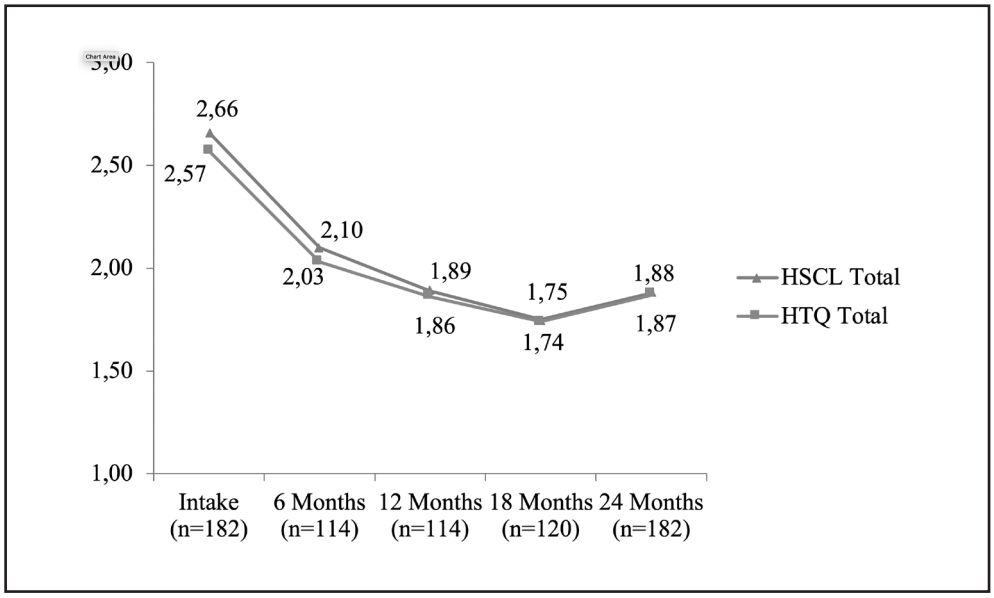

Figure 2: *Change in the Proportion of Clients Who Were Symptomatic for Anxiety, Depression, and Post-Traumatic Stress from Intake to 24 Months*

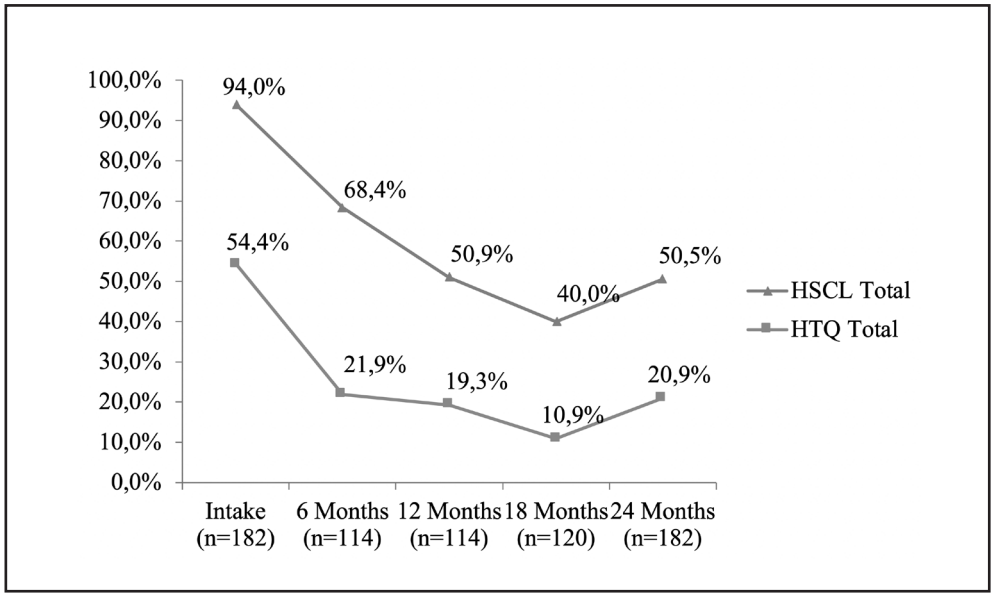

Table 2: *Change in Clinical Measures Between Intake and 24-Month Re-administration*

Measure	n	Mean Intake	SD Intake	Mean 24-Months	SD 24-Months	T	Cohen's d	p
HSCL Anxiety	182	2.49	0.70	1.77	0.65	12.52	.93	<.001
HSCL Depression	182	2.77	0.66	1.93	0.71	14.27	1.06	<.001
HSCL Total	182	2.66	0.62	1.88	0.66	14.55	1.08	<.001
HTQ DSM-IV	182	2.78	0.62	1.93	0.67	14.26	1.06	<.001
HTQ Total	182	2.57	0.61	1.87	0.63	13.07	.97	<.001

Note: HSCL scores represent average score for total and each subscale of the Hopkins Symptoms Checklist-25 and HTQ scores represent average scores for total and a subscale for the Harvard Trauma Questionnaire.

demonstrated a statistically significant reduction in clinical symptoms of anxiety, depression, and PTSD (p = <.001) while receiving treatment in the Kovler Center program. Further, the elevated Cohen's d scores show large effect sizes, indicating strong relationships between the pre- and post- measures.

As previously mentioned, in addition to tracking clinical symptoms of anxiety, depression, and trauma, Kovler Center tracks several non-clinical indicators of functional well-being via its MKC WBQ. In order to compare the non-clinical indicators from baseline to 24 months, which were categorical, McNemar's test for paired proportions was used (see Table 3 below).

With regard to legal status, there was an increase in the percentage of clients who applied for asylum at 6, 12, 18, and 24 months compared to intake. More importantly, there was a significantly greater percentage of clients who had secure legal status (granted asylum, permanent legal residence, or U.S. citizen) at 24 months compared to intake; 11.5% had secure legal status at intake compared to 38.5% at 24 months.

Stable and adequate housing is always a major concern for Kovler Center clients. Homelessness and unstable housing situations understandably complicate efforts towards symptom reduction and improved health. However, there was improvement in the housing status of many of the clients. The proportion of clients who contributed rent to either their own apartment, home, or shared space, or who owned their home, increased significantly from 25.3% at intake to 82.4% at the 24-month interval. There was also a reduction in the percentage of clients living in shelters or other non-ideal housing (e.g. garage, storage room, etc.) at the 12, 18, and 24-month follow-ups, compared to intake.

Employment status also improved for many clients. Three in ten (29.1%) had authorization to work at intake, compared more than three-fourths (79.7%) at 24 months. More impressively, whereas 19.8% of clients were employed in either a full-time job, part-time job, or were self-employed at intake, 74.7% were employed at the 24-month interval.

Kovler Center clients' personal relationships also improved. When asked to describe their satisfaction with their

Table 3: *Change from Baseline to 24-Month Re-administration Among Functional Indicators from the MKC Well-Being Questionnaire (WBQ)*

	Baseline (Intake) N (%)	24-Month Re-administration N (%)
Legal Status		
Secure (granted asylum, refugee, legal permanent resident, U.S. citizen)	21 (11.5)	70 (38.5)**
Housing Status		
Able to contribute to rent or own home	46 (25.3)	150 (82.4)**
Employment Status		
Authorization to work (work permit)	53 (29.1)	145 (79.7)**
Employed (full time, part-time, self)	36 (19.8)	136 (74.7)**
Interpersonal Relationships* **		
Satisfied with interaction with friends	123 (76.4)	152 (91.0)*
Satisfied with interaction with family	118 (70.7)	156 (90.2)*
English Language Ability		
Speak English well (somewhat/very)	107 (58.8)	104 (57.1)
Read English well (somewhat/very)	121 (66.5)	137 (75.3)*
Physical Health (Currently Have)		
Chronic/frequent migraine headaches	141 (77.5)	73 (40.1)**
Pain in joints	108 (59.3)	83 (45.6)*
Pain in neck/shoulders	90 (49.5)	77 (42.5)
Pain in lower stomach	72 (39.6)	57 (31.3)
Pain in back	120 (65.9)	108 (59.3)
Numbness in arms, legs, feet, or hands	72 (39.6)	56 (30.8)
Racing heartbeat	113 (62.1)	58 (31.9)**
Difficulty breathing	81 (44.5)	40 (22.1)**
Night sweats	88 (48.4)	36 (19.8)**
Digestive problems	77 (42.3)	43 (23.9)**
High blood pressure	26 (14.3)	36 (20.0)
Diabetes	13 (7.1)	15 (8.3)

**<.001; *<.01, McNemar test; ***The sample size for this variable is less than 182 because some clients report having no friends or family with whom they interact.

relationships with friends and family, the percentage of clients who replied "satisfied" or "very satisfied" increased from 76.4% to 91.0% and from 70.7% to 90.2% with regard to friends and family, respectively.

The proportion of clients who reported they spoke English "somewhat well" or "very well" does not appear to improve much over time. For clients with another primary language, more sizeable progress is made in their ability to read English while in the program.

The domain of physical health improved for several conditions as well. Compared to intake, there was a significant reduction in the percentage of clients who reported experiencing migraine headaches, joint pain, racing heartbeat, breathing difficulties, night sweats, and digestive problems at the 24-month interval. Specifically, the percentage of clients experiencing migraines dropped from 77.5% at intake to 40.1% at the 24-month re-administration, while the proportion of clients reporting a racing heartbeat declined from 62.1% at intake to 31.9% at 24 months. Conversely, the proportion of clients with hypertension increased over time. At intake, 14.3% of clients reported hypertension, which increased to 20.0% at 24 months.

The above analysis demonstrates marked improvement in both clinical and non-clinical measures. Thus, the association between specific variables and clinical outcomes will be subsequently explored. Table 4 below illustrates the correlation between potential predictor variables and HSCL subscale scores for anxiety and depression and the HTQ subscale score for PTSD at 24 months. Partial correlation and partial eta squared were used to control for baseline subscale scores.

Several variables were associated with clinical improvement on the three subscales. Lower HSCL anxiety scores at 24 months were associated with: (1) shorter wait times between initial assessment and program admittance (individual treatment plan completed), (2) English language proficiency, (3) stable employment, (4) stable housing, (5) fewer services (medical, psychological, social), and (6) fewer medical problems while in the program.

Lower HSCL depression scores at 24 months were associated with: (1) stable housing, (2) fewer medical services, and (3) fewer psychological problems. Additionally, Kovler Center clients from Middle Eastern or Asian countries had higher HSCL depression scores at 24 months compared to clients from Africa, Europe, or the Americas.

With regard to post-traumatic stress, lower HTQ-DSM-IV scores at 24 months were associated with: (1) shorter wait times between initial assessment and program admittance, (2) stable housing, and (3) fewer psychological problems.

In sum, clients who were in an unstable housing situation at 24 months were more likely to have symptoms of anxiety, depression, and PTSD compared to clients with more stable housing. Longer duration between intake and the first individual treatment plan was associated with greater symptoms of anxiety and PTSD at 24 months. Clients who required more medical services were more likely to be symptomatic for anxiety and depression at 24 months and clients who had more psychological problems were more likely to be symptomatic for depression and PTSD at 24 months. Additionally, clients who were more likely to be symptomatic for anxiety at 24 months were: (1) not proficient in the English language and required an interpreter, (2) not in a stable employment situation, (3) more likely to

Table 4: *Association Between Predictor Variables and Psychological Distress at 24 Months (n=182)*

	HSCL Anxiety	HSCL Depression	HTQ DSM-IV
Gender[1]	.00	.00	.00
Age at intake[2]	.09	.11	.08
Marital status (married/not married)[1]	.00	.00	.00
Level of education (college/no college)[1]	.00	.00	.00
Region[1]	.04	.07*	.05
Number of days between initial intake and program admittance (initial ITP)[2]	.19*	.12	.17*
Interpretation required[1]	.07**	.02	.02
Secure legal status while in program[1]	.02	.02	.02
Religion (Christian/non-Christian)[1]	.01	.00	.02
Stable employment[1]	.04**	.01	.01
Stable housing[1]	.04*	.05**	.03*
Number of services			
Medical[2]	.21**	.15*	.13
Psychological[2]	.19*	.14	.12
Social[2]	.15*	.09	.07
TOTAL[2]	.22**	.14	.12
Total number of medical problems while in program[2]	.15*	.11	.15
Total number of psychological problems while in program[2]	.13	.15*	.21**

Note: *correlation is significant at the .05 level (2-tailed), ** correlation is significant at the .01 level (2-tailed)
[1]Partial Eta Squared, [2]Partial Correlation.

have had a greater number of medical problems, and (4) more likely to have received greater numbers of psychological, social, and total services compared to clients with fewer symptoms of anxiety. There was no association between gender, marital status, level of education, religion, age at intake, or having a secure legal status and symptoms of anxiety, depression, or PTSD at 24 months.

Next, all of the potential predicter variables from the correlation step were included in a Generalized Linear Mixed Model (GLMM) with all five time points where clients were assessed (intake, 6, 12, 18, and 24 months).

Table 5 below contains output from a GLMM model with HSCL anxiety, HSCL depression, and HTQ PTSD subscale scores as the dependent variables. Anxiety scores were .61 *SD* lower at 6 months, .90 *SD* lower at 12 months, 1.09 *SD* lower at 18 months, and .97 *SD* lower at 24 months, compared to anxiety at baseline. Clients without a secure legal status displayed anxiety scores .20 *SD* higher than clients with a secure legal status. Additionally, for each additional *SD* of psychological problems participants had while in the program, anxiety was .13 *SD* higher. The Intraclass Correlation Coefficient (ICC) shows that 41.8% of the variance in anxiety is explained by the individual.

Table 5: *Mixed Model Predicting Anxiety, Depression, and PTSD Symptoms in Treatment Center Participants*

	Anxiety		Depression		PTSD	
	B	*p*	*B*	*p*	*B*	*p*
Time 2 (6-Month) [a]	-.612	<.001	-.840	<.001	-.929	<.001
Time 3 (12-Month) [a]	-.897	<.001	-1.082	<.001	-1.132	<.001
Time 4 (18-Month) [a]	-1.090	<.001	-1.199	<.001	-1.292	<.001
Time 5 (24-Month) [a]	-.974	<.001	-1.109	<.001	-1.155	<.001
Gender (Female) [b]	.105	.256	**.203**	**.021**	.119	.178
Age at intake	-.054	.309	-.002	.969	-.046	.343
Marital status (not married) [c]	.053	.654	.074	.532	.028	.798
Education (no college education) [d]	.051	.597	.050	.586	.078	.390
Region = 5 (Americas) [e]	.168	.416	.098	.711	.054	.837
Region = 4 (Asia) [e]	.421	.081	.291	.151	.279	.267
Region = 3 (Europe) [e]	.148	.459	-.021	.918	.048	.817
Region = 2 (Middle East) [e]	.616	.089	**.952**	**.031**	**.823**	**.040**
Days between intake and ITP	.039	.472	.038	.420	-.005	.914
Interpretation not required [f]	-.213	.061	-.168	.143	-.163	.128
Legal status (no secure legal status) [g]	**.202**	**.035**	**.289**	**.002**	**.215**	**.014**
Religion (non-Christian) [h]	.031	.835	.026	.862	-.021	.887
Employment (no stable employment) [i]	.198	.108	.045	.689	.120	.291
Housing (no stable housing) [j]	.015	.910	.131	.322	.077	.561
Total medical services	.004	.929	.053	.274	.031	.396
Total social services	-.179	.261	-.157	.310	-.226	.113
Total psychological services	-.020	.849	-.002	.985	.023	.820
Total all services	.290	.208	.189	.408	.236	.243
Total medical problems	.073	.181	.037	.516	.067	.218
Total psychological problems	**.127**	**.006**	**.133**	**.005**	**.143**	**.001**
N	711		711		711	
Respondents	182		182		182	
AIC	1693.363		1632.860		1630.646	
BIC	1702.407		1641.904		1639.690	
ICC	.418		.444		.404	

Note: [a] Compared to baseline (intake); [b] Compared to male; [c] Compared to married; [d] Compared to some college education/college degree; [e] Compared to Africa; [f] Compared to interpretation required; [g] Compared to secure legal status; [h] Compared to Christian; [i] Compared to stable employment; [j] Compared to stable housing.

Depression scores were .84 *SD* lower at 6 months, 1.08 *SD* lower at 12 months, 1.20 *SD* lower at 18 months, and 1.11 *SD* lower at 24 months, compared to depression scores at baseline. Female participants had depression scores .20 *SD* higher than male participants. Clients from the Middle East demonstrated depression scores .95 *SD* higher than clients from Africa. Clients without a secure legal status displayed depression scores .29 *SD* higher than clients with a secure legal status. Additionally, for each additional SD of psychological problems participants had while in the program, depression was .13 higher. The Intraclass Correlation Coefficient (ICC) shows that 44.4% of the variance in anxiety is explained by the individual.

PTSD scores were .93 *SD* lower at 6 months, 1.13 *SD* lower at 12 months, 1.29 *SD* lower at 18 months, and 1.16 *SD* lower at 24 months, compared to PTSD scores at baseline. Clients from the Middle East demonstrated PTSD scores .82 *SD* higher than clients from Africa. Clients without a secure legal status displayed PTSD scores .22 *SD* higher than clients with a secure legal status. Additionally, for each *SD* of psychological problems participants had while in the program, PTSD was .14 *SD* higher. The Intraclass Correlation Coefficient (ICC) shows that 40.4% of the variance in anxiety is explained by the individual.

As previously mentioned, in conjunction with tracking the progress of clients with respect to symptoms of anxiety, depression, PTSD, and functional well-being, Kovler Center gathers and tracks feedback from clients via satisfaction surveys.

In addition to rating Kovler Center staff and service on specific attributes, clients were asked an open-ended question about the services that had been the most helpful to them while in the Kovler Center program. Although they reported myriad services that were helpful to them, medical services (including primary care, medication, medical insurance, psychiatric services) and mental health services (including counseling, psychotherapy) were cited most often. Other program aspects considered helpful were the staff (professional, caring, friendly, responsive), legal assistance (assisting them in the asylum process), and assistance with dental needs, transportation, and food.

Conversely, clients were asked about ways in which Kovler Center could improve or create better client experiences. Approximately six in ten could not, or did not, offer any suggestions for improvement. Those who did offered suggestions such as Kovler Center staff could be better at: (1) following through on appointments/plans, (2) assisting with housing and employment issues, and (3) assisting them with medical issues. They also said they would like to see wait time for services reduced.

Discussion

This study has expanded on the existing, but limited, research on the evaluation of torture treatment programs using a quasi-experimental, one group, pretest-posttest design to measure outcomes. Several prior studies have shown program effectiveness in terms of clinical symptom reduction but have measured symptom changes over shorter periods of time (Raghavan et al., 2013; Stammel et al., 2017) and/or have not measured anxiety, depression, and PTSD symptom changes together (Birck, 2001; Kivling-Boden & Sundbom, 2001; 2002). Our approach was to investigate Kovler Center program efficacy up to 24 months, which is considered to be

the duration for clients who matriculate through the core program.

In general, clients demonstrated significant improvement in both clinical and non-clinical measures while in Kovler Center's multidisciplinary treatment program. Clients saw a notable reduction in symptoms of anxiety, depression, and PTSD from intake through 24 months of treatment, with the greatest improvement occurring within the first six months, but continuing throughout.

Moreover, clients improved in a number of functional well-being domains while in the program, some of which have been shown in the research literature on torture treatment to be associated with clinical outcomes, such as employment (Carlsson et al, 2006a;2006b; Kivling-Boden & Sundbom, 2001; 2002). Among this sample, employment status improved significantly as clients received work permits and were able to find part- or -full-time employment. They were also able to secure stable housing as they became able to contribute to rent and move out of temporary living situations. It is important to emphasize that despite the significant increase in the proportion of clients employed while in the program, Kovler Center clients generally struggle to find adequate, steady employment.

Kovler Center clients became more satisfied with their personal relationships during their time in the treatment program. Many of those with limited English proficiency skills demonstrated improvement in this area even though they were often less generous when evaluating their own English language ability.

Clients experienced a reduction in a number of physical ailments while in the program. The prevalence of psychosomatic experiences such as migraine headaches, bodily pain, racing heartbeat, night sweats, breathing difficulties, and digestive problems decreased significantly from intake to 24 months in the program.

Clients did not see comparable improvement with regard to diabetes or high blood pressure. Research has demonstrated direct links between the experience of trauma, or PTSD, and both hypertension (Heim & Nemeroff, 2001; Kibler et al., 2009) and diabetes (Kinzie et al., 2008) or comorbid conditions such as obesity (Vieweg et al., 2007). In some people these chronic conditions may also be explained by the natural process of aging or poor dietary choices that, once onset occurs, are often irreversible.

A number of variables were significantly correlated with clinical outcomes at 24 months. Stable housing was associated with clinical improvement for anxiety, depression, and PTSD. Stable employment was also associated with anxiety, as well as English language proficiency, number of medical problems while in the program, and the number of services received while in the program (medical, psychological, social). The number of days between intake and program admittance was associated with both anxiety and PTSD.

The number of psychological problems participants experience while in the program predicted symptoms of anxiety, depression, and PTSD; the greater the number of diagnosed psychological problems, the higher the measures for anxiety, depression, and/or PTSD. Thus, despite program intervention, participants with multiple psychological problems are less likely to see a decline in their symptomology for anxiety, depression, or PTSD. However, the reduction in these clinical outcome measures over time is far greater in magnitude than the effect

of psychological problems; participants with fewer psychological problems can expect to see their symptoms of anxiety, depression, or PTSD decline more rapidly compared to participants with more psychological problems.

Legal status was also a predictor of symptoms of anxiety, depression, and PTSD; participants with a secure legal status (e.g., granted asylum, legal permanent resident) were more likely to experience positive clinical outcomes compared to participants without a secure legal status. This finding is consistent with previous research on torture treatment programs (Hill & Everson, 2016b; Raghavan et al., 2013), although these did not employ a GLMM.

This is an important finding but a challenge for treatment centers who have participants going through the asylum process. Wait times for asylum hearings have been increasing over the past few years and it is now uncommon for Kovler Center participants to receive asylum while they are in the 24-month program. Even though a significantly greater proportion of Kovler Center clients have a secure legal status at 24 months compared to intake, of the 161 clients in the sample who did not have a secure legal status at intake, only 50 (31.1%) did so upon program completion. It is evident from participants statements during follow-up interviews the difficulties and frustrations of the asylum process are negatively impacting their well-being. Therefore, it is important to take special note of this political and legal phenomenon, monitoring it as research to evaluate the program.

Clients from the Middle East were more likely to experience symptoms of depression and PTSD while in the program compared to African clients. This difference might be explained by the fact that Kovler Center has a more difficult time providing interpreters for Arabic-speaking clients than, for example, French-speaking clients. Difficulty finding interpreters for certain languages often results in participants experiencing longer wait times for services and program admittance.

The finding that women are more likely than men to demonstrate higher depression measures is consistent with other research on survivors of torture (Spiric, et al., 2010) and trauma (Haskell, et al., 2010).

The GLMM allowed determination of the variables predict clinical outcomes over time in participants who were in the treatment program. The Intraclass Correlation Coefficient suggests that there is a substantial amount of dependency in anxiety, depression, and PTSD scores within individuals, which is to be expected in longitudinal studies.

Through the Kovler Center's holistic approach to torture treatment, staff are able to address, at least to some degree, many of the variables that impact client well-being. For example, steps can be taken to ensure that interpretation services will continue to be utilized and more efforts will be made to find interpreters for less common languages (e.g., Arabic, Tigrinya, Nepalese, Mongolian) to offset delayed services and longer wait times to program admittance. Second, staff can continue to connect clients to community resources that assist them in finding English as a Second Language classes to improve their English proficiency, stable employment and stable housing. Finally, Kovler Center therapists and primary care staff will continue to provide the mental and physical health treatment services that clients report are most important to them.

Limitations

A key limitation to this study is the lack of a control group; either true or quasi. However, as stated in the literature review this is consistent with the evaluation of torture treatment programs because of the ethical dilemma of denying some people needed intervention. This is especially true for torture treatment programs that generally operate with an ethos to provide treatment to every survivor who requests care (Jaranson & Quiroga, 2011).

An alternative to utilizing a true control group is to implement a quasi-experimental design with two groups--an experimental group and a control group--whose subjects are not randomly assigned to either one. The control group serves as a comparison group. This also has limitations as the two groups may be very different at baseline. A potential comparison group could be wait-listed clients whose outcomes are measured at a specific time and compared to the experimental group. Although Kovler Center does have a wait list, most clients are eventually admitted to the program within three months. Therefore, this option would not have been very useful for our purposes since they would not have been available for comparison at the first follow-up which occurs at six months.

In the absence of a true control group, it is impossible to rule out the impact of variables on treatment success that are outside of the treatment program. For example, symptom reduction and clinical improvement could be a product of the passage of time. However, by implementing a GLMM approach an attempt was made to account for time by controlling for autocorrelation. Further, clients have told Kovler Center staff anecdotally during the re-administration interview process that other factors, for example, attending a welcoming church, living with friendly people who have taken them in, living with relatives or people from their home country, and finding housing, employment, or other services and programs on their own without Kovler Center assistance, have been helpful in their recovery. That said, Kovler Center clients most often report that the medical assistance and mental health therapy they receive has been most helpful to their improvement. This is consistent with symptom reduction while in the treatment program. It might be worthwhile to add a question to the satisfaction survey related to influencing factors outside of Kovler Center as survivors do note these factors that have been helpful.

It is desirable to know which specific services, what type of treatment modality, or which therapist characteristics, if any, have greater impacts on clinical improvement than others. As stated previously, although all staff and clinical volunteers are oriented to the philosophical pillars and to Judith Herman's model, pro bono psychotherapists follow a number of therapeutic approaches and utilize interventions based on what the individual survivor presents, making it a challenge to tie any outcome to the therapeutic approach. And yet, in utilizing Herman's stages even in combination with diverse forms of trauma treatment, this provides a valuable orientation to the concerns of torture survivors and could be measured as such (Gorman, 2001).

There are certain variables that may impact treatment success, such as age at first experience of torture or duration of torture that were not included in our model because this information was lacking for some of our earliest clients being tracked. Going forward,

the importance of these variables will be explored as they relate to program success. Many data points related to torture history have been recently added to the intake evaluation in the EHRS.

In tracking outcomes, a slight increase in clinical symptoms for anxiety, depression, and PTSD from 18 months to 24 months was noted. McFarlane and Kaplan (2012) reviewed 40 studies from 1980 to 2010 and found that most treatment effects lasted from 3 to 18 months. It may be that clients receiving services at 24 months are those most in need of services. It could also represent increased stress due to the length of time for adjudication of their asylum cases. It is important to explore this further because it may also be evidence that there are diminishing returns on the effectiveness of treatment for torture survivors beyond 18 months. If this found to be the case, it would be critical to Kovler Center and other torture treatment centers that have limited resources.

Lastly, this study could have benefitted from a larger sample. In the methodology, it was stated 41.3% of all clients eligible for re-administrations complete one at 24 months. However, since Kovler Center does not require the completion of re-administrations in order to receive needed care, it can often be challenging to persuade clients to participate. There are many reasons for their lack of participation in these interviews, including the fact that many are busy with school, work, family life, etc., at this point in their lives. Others may find the follow-up interviews triggering to their anxiety, depression, or PTSD. Further, some clients are simply not engaged in services and their case remains open for the sole purpose of ensuring there are no problems with their pending legal case. In the future better ways will be sought to encourage participation more consistently in the re-administrations, perhaps by providing additional incentives.

Conclusion

Despite some limitations to this research, as well as the ethical and practical challenges in conducting rigorous scientific studies of torture survivors, torture treatments centers are encouraged to conduct any, and as much research as possible, in order to build on the limited existing research literature (Jaranson & Quiroga, 2011). The impact of social factors in a torture survivor's well-being demonstrates the relevance of our multidisciplinary or holistic approach. Other researchers have shown the importance of a comprehensive approach (e.g., wraparound) to treating survivors of torture, focusing especially on non-clinical factors such as housing, employment, and immigration status (Kira, 2002).

It is also important to point out that the goal, or mission, of Kovler Center is to help clients improve and not necessarily become asymptomatic for clinical measures of anxiety, depression, and PTSD. Even though many clients are still symptomatic for clinical symptoms after 24 months of intervention, this is not uncommon for torture survivors (Birck, 2001). More importantly, the vast majority of clients have demonstrated significant improvement compared to when they entered Kovler Center for treatment. Some have suggested that when studying torture survivors, it might be more important to look at functioning as an outcome, rather than the level of clinical symptoms (World Health Organization, 2001).

For torture survivors, rehabilitation is a complex and recurrent process because their situation is often chronic and their course of recovery is often set back by recurrence of symptoms, as many factors

can trigger clinical symptoms. It is also challenging for treatment centers to formulate a treatment plan that meets the needs of people from many different countries and cultural backgrounds.

The findings of this research are important to the field and are consistent with findings of other studies on torture treatment programs. Despite the lack of a control group the treatment program is helping Kovler Center clients recover in many ways. Increasing the evaluation period to cover the entire duration of program intervention at Kovler Center (e.g., 24 months) aids staff in appropriately assessing the program's success and expands on the existing research in the field of torture treatment.

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Testing the validity of ICD-11 PTSD and CPTSD among refugees in treatment using latent class analysis

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Key points of interest

- The ICD-11 proposal for PTSD and CPTSD is supported in a culturally heterogenous sample referred for treatment at a Danish facility.
- The majority of referrals qualified for a diagnosis of CPTSD, suggesting that more comprehensive treatment paradigms than those offered for PTSD alone is required for this population.

Abstract

Introduction: The WHO has proposed posttraumatic stress (PTSD) and Complex PTSD (CPTSD) as trauma-related 'sibling' disorders in ICD-11. The proposal has received support from research among clinical and community samples alike but only a few studies have tested the validity of these disorders in a sample of refugees using the International Trauma Questionnaire especially designed for assessment of ICD-11 PTSD and CPTSD.

Methods: Latent class analysis was used to test the validity of the ICD-11 PTSD and CPTSD distinction in a heterogeneous group of 284 highly symptomatic refugees registered for treatment at a Danish treatment center.

Results: A two-class solution fit the data best. One group reported elevated levels of PTSD-symptoms and symptoms of affective dysregulation, and one group reported elevated levels of symptoms corresponding to CPTSD. The CPTSD group was considerably larger than the PTSD-group.

Discussion: The current study supports the ICD-11 distinction between PTSD and CPTSD in a sample of treatment-seeking refugees. The assistance of interpreters was needed for some of the participants which affected the reliability of the assessment.

Conclusion: The ICD-11 proposal for PTSD and CPTSD is supported in a heterogenous sample of refugees using the ITQ.

Keywords: PTSD, Complex PTSD, refugee, ICD-11, International Trauma Questionnaire

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Introduction

The United Nations High Commissioner for Refugees (UNHCR) estimates that every two seconds, a person is displaced due to armed conflict or persecution, making the current estimate of 68.5 million forcibly displaced people at the end of 2017 the largest number of refugees the world has ever witnessed (UNHCR, 2018). Out of these, an estimated 25.4 million people were refugees and 3.1 million were asylum seekers, meaning that over 1/3 of displaced people worldwide have fled their home-country due to human rights violations. In 2018, a total of 3.120 asylum-seekers arrived in Denmark, bringing the number of forcibly displaced persons hosted in Denmark specifically up to 47.927 people (UNHCR, 2018).

While estimates vary, between 30 % and 44 % of refugees are presumed to be survivors of torture (DIGNITY, 2019; US Dept. of Health and Human Service, 2019), and research has established that refugees report a broad history of exposure to potentially traumatizing events (Tay, Rees, Tam, Kareth & Silove, 2018) as well as high rates of common mental health problems such as anxiety, depression and posttraumatic stress disorder (PTSD, Bogic, Njoku & Priebe, 2015; Fazel, Wheeler & Danesh, 2005; Silove et al., 2018). Consequently, a systematic review estimated that refugees could be up to 10 times more likely to qualify for a diagnosis of PTSD than age-matched comparison groups of the general population (Fazel, Wheeler & Danesh, 2005), and only experience moderate recovery from mental health difficulties during the first decade after immigrating (Tam, Houlihan & Melendez-Torres, 2015). In conjunction with findings from Denmark suggesting that refugees have spent an average of 14 years in the country before accessing specialized mental health care services (Competence Centre for Transcultural Psychiatry, 2015), the provision of adequate and timely mental health care to forcibly displaced persons is a pivotal concern to be addressed in countries hosting and rehabilitating asylum seekers and refugees.

For the 11th revision of the International Classification of Diseases (ICD-11), the World Health Organization (WHO) has proposed two sibling disorders; PTSD and complex PTSD (CPTSD) (Maercker et al., 2013a; Maercker et al., 2013b) to enhance the cross-cultural validity and clinical utility of diagnoses following exposure to extreme stress. PTSD is comprised of three symptom clusters designed to capture the core elements of posttraumatic stress responses: re-experiencing in the here-and-now; avoidance of internal and external reminders of a traumatic experience; and a sense of hypervigilance. Each symptom-cluster consists of two symptoms, thereby representing a considerable downsizing of the diagnostic criteria compared to previous and current conceptualizations of PTSD (APA, 2008; 2013). CPTSD is composed of the PTSD diagnosis and three additional symptom-clusters representing disturbances in self-organization (DSO): affective dysregulation, negative self-concept, and disturbances in interpersonal relationships (Maercker et al., 2013a; Maercker et al., 2013b). This thereby encompasses broader and more pervasive posttraumatic symptomatology that was previously described under the DSM-IV diagnosis 'Disorder of Extreme Stress Not Otherwise Specified (DESNOS)' and frequently diagnosed in refugees (Palic, 2013). Currently, several studies support the proposed ICD-11 PTSD and CPTSD factors structure in clinical and community populations alike (Brewin et al., 2017)

Research has shown that CPTSD is more commonly reported than PTSD following prolonged exposure to multiple severe traumatic experiences from which escape is difficult or impossible (Brewin et al., 2017; Hyland et al., 2017b; Maercker et al., 2013a). Hence, CPTSD might be particularly relevant when describing posttraumatic responses among refugees exposed to organized violence, war and persecution (Murphy, Dokkedahl, Elklit & Shevlin, 2016). Some studies have examined CPTSD in refugee samples, yielding prevalence rates of PTSD ranging from 20 % to 32.9 % and prevalence rates of CPTSD ranging from 21 % to 50.9 % (Grossman et al., 2019; Hecker, Huber, Maier & Maercker, 2018; Hoffman et al., 2018; Nickerson, Cloitre, Bryant, Schnyder, Morina, & Schick, 2016; Shevlin et al., 2018). Additionally, most studies conducted on the validity of ICD-11 PTSD and CPTSD have provided preliminary evidence for the validity of the CPTSD construct within samples of treatment-seeking refugees (Nickerson et al., 2016; Palic, Zerach, Shevlin, Zeligman, Elklit, & Solomon, 2016) and resident refugees (Frost, Hyland, McCarty, Halpin, Shevlin & Murphy, 2018; Tay, Moshin, Rees, Tam, Kareth & Silove, 2018), whereas one study of resident refugees found that the factor structure of ICD-11 PTSD fit the data well, while the CPTSD factor structure did not (Tay, Rees, Chen, Kareth, and Silove 2015). The findings cited above were however limited in examining CPTSD in refugees due to the reliance on measures not specifically designed to measure the ICD-11 diagnoses of PTSD and CPTSD.

Recently however, the International Trauma Questionnaire (ITQ), a self-report questionnaire used to measure the ICD-11 diagnoses of PTSD and CPTSD,was developed and validated with the specific purpose of identifying and distinguishing ICD-11 PTSD and CPTSD (Cloitre, Roberts, Bisson, & Brewin, 2013; Cloitre et al., 2018). The ITQ has shown satisfactory reliability across international community and clinical trauma-exposed populations alike (Karatzias et al., 2017), and recently, two studies have examined the validity of ICD-11 PTSD and CPTSD in a sample of treatment-seeking refugees. Valliéres et al. (2018) found support for a two-factor higher order model consistent with the ICD-11 proposal using confirmatory factor analysis in a homogenous sample of Syrian refugees resettled in Lebanon. Likewise, Hyland et al. (2018) replicated evidence reported across different countries for individual symptom profiles consistent with the ICD-11 proposal for PTSD and CPTSD (Murphy et al., 2016) using latent class analysis in Syrian refugees resettled in Lebanon.

Currently, Hyland et al. (2018) and Valliéres et al. (2018) appear to be the only published studies using the ITQ to investigate the validity of the ICD-11 proposal for PTSD and CPTSD among refugee populations. This thereby contributes to extending existing evidence for the cross-cultural validity of the constructs in culturally homogenous samples. Clinics offering mental health care to refugees are however often faced with culturally diverse samples of care recipients, and while a recently published study used the ITQ to identify specific predictors of ICD-11 PTSD and CPTSD among a culturally diverse sample of refugees in Switzerland (Hecker et al., 2018), it appears that no published studies has yet tested the validity of ICD-11 PTSD and CPTSD using the ITQ in a culturally heterogenous sample of treatment-seeking refugees.

Study aim

The purpose of the present study is to examine the distribution of ICD-11 PTSD and CPTSD symptoms among a culturally heterogenous sample of treatment-seeking refugees by using latent class analysis (LCA) and the ITQ. Based on existing evidence, we hypothesized that the LCA would identify classes corresponding to the diagnostic criteria of ICD-11 PTSD and CPTSD. A secondary purpose of the study is to explore the relationship between class-membership and demographic and trauma-related variables.

Methods

Participants and procedure

The current study is based on a consecutive sample of patients referred to Rehabilitation Center for Torture Survivors – Jutland (RCT-Jutland), a specialized treatment center in Denmark. The RCT-Jutland provides treatment to refugees who have been exposed to organized violence or assaults (such as war, torture and persecution) in another country. Conditions for being offered treatment and concurrently inclusion criteria for the current study were: having obtained legal residence in Denmark; and a referral from a general practitioner or psychiatrist for assessment and treatment for trauma-related mental health problems. Exclusion criteria were the absence of Danish health-care insurance or legal permission to stay in Denmark; and the presence of a primary psychotic disorder requiring psychiatric treatment. Upon referral, patients are enrolled in an assessment program that includes standardized measures at baseline (intake), end of treatment, and at 9 months follow up. The ITQ was implemented in the assessment program from December 2015 onwards, and the participants for the current study was composed of patients referred for treatment between December 2015 and April 2018 who were asked to complete the ITQ at enrollment. Hence, baseline data from the assessment formed the data for the current analysis using the ITQ-assessment from a total sample of 284 patients. Interpreters were provided according to language and needs: Assistance from an interpreter was required for 69.9 % (n = 197) of the participants. The mean age of the participants was 40.94 years (SD = 9.77, range = 17-68 years), and 52.5% of the participants were men (n = 149). A total of 24 nationalities were represented in the sample across 6 different regions: The Middle East (n= 177), South-Eastern Europe (n= 80), Caucasus (n= 8), Asia (n= 7), Africa (n= 7), and Northern Europe (n= 2). The most frequently represented countries were Syria (Middle East, n = 122), Bosnia (South-Eastern Europe, n = 50), Afghanistan (Middle East, n = 25) and Kosovo (South-Eastern Europe, n = 21).

Respondents came to Denmark in the years from 1986 to 2017. The median year of arrival was 2011, and data on year of arrival was missing for n= 20 participants. Most respondents were married or living in a registered partnership (73%, n = 205), had one or more children under the age of 18 (77.9 %, n = 208), did not have Danish citizenship (86.1 %, n = 242) and had never worked in Denmark (47.3 %, n = 134). 8.8 % of participants did not provide any information on employment. The study was conducted in accordance with the Helsinki Declaration and was approved by the Danish Data Protection Agency. Written informed consent was obtained from all participants.

Measures

Demographic information: Basic demographic information was gathered using questions selected specifically for the

assessment at RCT-Jutland. The available information for the current study included: gender of the participant (male/female), age in years, year of arrival in Denmark, country of origin, marital status, parental status (children under age of 18/no children), citizenship status (Danish/non-Danish) and occupational status (having ever worked in Denmark).

ICD-11 PTSD and CPTSD: The International Trauma Questionnaire (ITQ; Cloitre, Roberts, Bisson, & Brewin, 2013; Cloitre et al., 2018). It includes one item per symptom of PTSD and CPTSD as displayed in table 3. CPTSD is comprised of PTSD and DSO. All items are rated using self-report on a 5-point Likert scale (0 = *'not at all'*, 4 = *'extremely'*), and an item was considered endorsed if the patient indicated a score ≥ 2 (*'moderately'*). The ITQ also includes an open-ended question assessing the index trauma and time since the index-trauma. Only the subjectively rated most severe trauma was reported for each participant. The ICD-11 Trauma Questionnaire was translated into Danish by Ask Elklit (2015) and into Bosnian and Arabic using a back-translation procedure with trained and experienced interpreters and clinicians. If the participant was not able to read Danish, Bosnian or Arabic during the assessment, a trained clinician would read the items aloud and the interpreter would translate the questions and answers, after which the clinician would record the answers. Likewise, the questionnaire was read aloud to participants who were illiterate. The ITQ was completed as self-report by 29.4 % (n = 80) of the participants and read aloud to 70.6 % (n = 192) of the participants.

The psychometric properties of the ITQ have previously been validated in clinical and community samples alike (Ben-Ezra et al., 2018; Hyland, Shevlin, Fyvie & Karatzias, 2018; Karatzias et al., 2017; Murphy et al., 2016). The internal reliability as measured by Cronbach's α was acceptable in the current sample: PTSD: .74; Re-experiencing: 0.70; Avoidance: .62; Hypervigilance: .55; DSO: .83; Affective dysregulation: .53; Negative self-concept: .82; Disturbed relationships: .73, CPTSD (full scale): .84. As the reliability coefficients for hypervigilance and affective dysregulation were slightly lower than desired (for an overview of studies investigating the ICD-11 conceptualizations, see Brewin et al., 2017), reliability for these scales was investigated separately for participants receiving assistance from an interpreter in completing the questionnaire.

Statistical analysis

The analysis was conducted in two linked phases: First, item endorsement for each of the PTSD and DSO-domains was computed using the cut-off-value ≥ 2 (Karatzias et al., 2017). A latent class analysis (LCA) was conducted to test whether patterns of item endorsement corresponding to the diagnoses of PTSD and CPTSD could be identified in the sample. LCA is a statistical method used to assess the presence of unobservable homogenous groups in the data based on item-response patterns. It is particularly well-suited for identification of latent psychological constructs such as psychological traumatization that is unobservable per se, but the presence of which may be detectible through observable data related to the construct (Murphy, Houston & Shevlin, 2007). LCA assumes that the associations between observed data points can be explained by a finite number of unobservable homogenous groups of individuals that are mutually exclusive (Debowska, Willmott, Boduszek & Jones, 2017). These are referred to as

latent classes. In this case, the presence of psychological traumatization is inferred by the endorsement of two specific patterns of co-occurring symptoms consistent with PTSD and CPTSD. Two steps are involved in conducting LCA. Firstly, unobserved relationships between the patterns of endorsement of symptoms of posttraumatic stress is identified by exploring the relative fit of a range of models describing unobserved groups in the data. As per the recommendations of Debowska et al. (2017), we tested the fit of a 1- through 6-class model. The relative fit of the models is decided based on a range of fit indices described below. Upon identification of the best fitting model, LCA assigns each participant to one of the latent classes on a probabilistic basis depending on the match between the individual response pattern and the latent classes' response patterns. As this classification is probabilistic in nature, model entropy is estimated as a standardized index reflecting the classification accuracy of individuals under the different models. All models are estimated using robust maximum likelihood (Yuan & Bentler, 2000) and to avoid solutions based on local maxima, 500 random sets of starting values were used with 100 final stage optimizations. The relative fit of the models was compared using the following parsimonious fit statistics: the Akaike Information Criterion (AIC; Akaike, 1987), the Bayesian Information Criterion (BIC; Schwarz, 1978), and sample size adjusted Bayesian Information Criterion (ssaBIC; Sclove, 1987). These estimates can be used to compare competing statistical models of the latent structure of the same data to the observed sample distribution in the data. Lower values indicate better fit of the statistical model to the observed data. The Lo-Mendell-Rubin adjusted likelihood ratio (LMR-A; Lo, Mendell, & Rubin, 2001) and bootstrapped likelihood ratio-test (BSLRT, McLachlan & Peel, 2000) was used to assess whether models with additional classes constituted a statistically significant improvement in describing the data compared to the previous models. When a non-significant value ($p > 0.05$) occurs, this suggests that the model does not provide a statistically significantly better description of the data compared to the previous model. Finally, the entropy of each solution was assessed to evaluate the accuracy of the classification of individuals. Entropy is reported on a standardized scale with values that are closer to 1 indicative of better classification (Ramaswamy, DeSarbo, Reibstein, & Robinson, 1993). A Chi-square (χ^2)-test was used to validate the best fitting class solution with probable diagnosis computed according to the ICD-11 criteria[1].

Finally, the relationship between class-membership and 8 covariates were tested by means of the R3STEP auxiliary variable approach in Mplus (Asparouhov & Muthén, 2014). This approach estimates the relationship between predictors and class-membership while taking into account the imperfection of classification of individuals as indicated by the entropy values. The R3STEP procedure is analogous to a logistic regression using latent class-membership as dependent variables and covariates as independent variables. Covariates included age, gender, citizenship-status, type of index-trauma, marital status, occupational status, need for interpreter, time since trauma and region of origin. Categorical variables with more than two categories (region and time since trauma) were dummy

[1] Readers looking for a more comprehensive introduction to LCA are referred to Murphy, Houston and Shevlin (2007).

coded before the analysis. There were no missing data on the PTSD items, and four participants had missing data on the DSO items corresponding to 1.4 % (AD and DR). Missing data was handled using maximum likelihood estimation in step 1 of the analysis. There were between 0 % (age, gender) and 10 % (occupational status) missing data for the correlates. Missing data was handled using listwise deletion in step 2 of the analysis. All analyses were conducted using two-sided hypothesis testing with a p-level of < .05. All analyses were conducted using Mplus version 8.1 (Muthén & Muthén, 2018) and SPSS version [25].

Results

Table 1 presents the results from separate Cronbach's alpha analyses for respondents requiring the assistance of an interpreter versus the respondents comfortable filling in the questionnaire on their own.

Table 1: *Reliability estimates of ITQ hypervigilance and affective dysregulation subscales.*

	Hypervigilance	Affective dysregulation
No interpreter	α = .61 (n = 81)	α = .61 (n = 82)
Interpreter	α = .53 (n = 195)	α = .48 (n = 191)
All participants	α = .55 (n = 278)	α = .53 (n = 275)
Inter-item correlation, All participants	r = .38	r = .36

Note: α = Cronbach's alpha. r = Pearson's r.

The frequencies of index trauma-types are presented in Table 2. Male participants were significantly more likely to report torture or imprisonment as index trauma, whereas female participants were more likely to report having experienced war as index trauma. The ITQ-item endorsement-rates are presented in Table 3. Notably, both symptom endorsement and symptom severity were high with each item endorsed by a majority of the participants, and the average symptom score ranging from 2.46 ("moderately" – "quite a bit") to 3.31 ("quite a bit" – "extremely"). There were no statistically significant gender differences in endorsement of symptom clusters.

Table 4 displays the LCA fit statistics. The best log-likelihood value was not replicated for classes five and six even after increasing the number of random starts to 5000 and final stage optimizations to 1000, suggesting that the models might be mis-specified for the current data (Geiser, Eid, Nussbeck, Courvoisier & Cole, 2010). Of the remaining models, the 2- and 3-class models displayed the lowest AIC, BIC, ssaBIC and log-likelihood values, and both represented a statistically significant contribution over their predecessor as per the LRM-A and BSLRT-values. The 3-class model had higher entropy-values, suggesting better classification of cases than the 2-class model, whereas the 2-class model displayed a 9 point lower BIC-value, bordering on the suggested cut-off for "very strong" evidence in support of the model with the lowest value (10 points, Raftery, 1995). Upon inspection of the 2- and 3-class solutions, it was evident that both models identified a class characterized by elevated risk of all symptoms (a CPTSD-class), and

Table 2: *Frequency of index trauma-types in sample.*

Trauma-type	Total % (284)	Male % (149)	Female % (135)	χ^2 *, p
War*	81.7 % (232)	78.6 % (114)	90.1 % (118)	6.74, .01
Torture*	7.4 % (21)	13.1 % (19)	2.3 % (3)	10.97, .001
Violence	3.5 % (10)	2.1 % (3)	5.3 % (7)	2.11, .15
Witnessing death	7.4 % (21)	6.9 % (10)	8.4 % (11)	0.22, .64
Imprisonment*	13.4 % (38)	22.8 % (33)	3.8 % (5)	20.8, .001
Military service	1.4 % (4)	2.8 % (4)	0 % (0)	3.69, .06
Fleeing	6.7 % (19)	7.6 % (11)	6.1 % (8)	0.24, .69
Death of a close one	6.7 % (19)	5.5 % (8)	8.4 % (11)	0.89, .35
Other	10.9 % (31)	11.7 % (17)	10.7 % 14)	0.07, .79
Time since trauma				
Less than 6 months	1.8 % (5)	-	-	-
6-12 months	1.8% (5)	-	-	-
1-5 years	34.8 % (98)	36.2 % (54)	32.6 % (44)	0.417, .52
5-10 years	12.8 % (36)	13.4 % (20)	11.9 % (16)	0.158, .69
10-20 years	17.7 % (50)	18.8 % (28)	16.3 % (22)	0.304, .58
More than 20 years*	31.2 % (88)	26.2 % (39)	55.7 % (49)	3.393, .06

Note: *significant difference at $p<.05$ across gender on endorsement; % = Valid percent; test of differences: Pearson's χ^2 asymptotic sig. (2-sided). Data was missing for 8 respondents.

a class characterized by elevated risk of endorsing symptoms consistent with PTSD and affective dysregulation. The third class identified in the latter model represented 2.9 % of the sample that presented with elevated risk of endorsing DSO symptoms only. As the 2-class solution (in bold) was deemed the best description of the data based on the BIC value. Nylund et al. (2007) have shown that classes comprising less than 5% of the sample can cause problems with model convergence and since the BIC includes a penalty for model-complexity and therefore is the preferred information criterion for identifying the best-fitting model (Nylund, Asparouhov, & Muthen, 2007). Entropy-values for the 2-class solution remained within an acceptable range and the posterior probabilities ranged from 0.893 to 0.970 (Ramaswamy et al., 1993). The profile plot and probabilities for the two-class solution are shown in Figure 1.

Probability of endorsement indicates the likelihood that participants in the respective class have endorsed the item in question. This probability ranges from 0 to 1, where 0 equals that participants in the class did not endorse the item, whereas 1 equals

Table 3: *Endorsement of ITQ-items measuring PTSD and DSO.*

ITQ		% (n)	Mean (SD) (range: 0-4)
PTSD			
Re-experiencing		95.1 % (270)	
Re1	Upsetting dreams that replay part of the event or are clearly related to the event?	91.5 % (260)	3.14 (1.1)
Re2	Powerful images or memories that sometimes come into your mind in which you feel the event	89.8 % (255)	3.10 (1.14)
Avoidance		95.4 % (271)	
Av1	Avoiding internal reminders of the stressful event experience (for example, thoughts, feelings, or physical sensations)?	91.1 % (257)	3.18 (1.06)
Av2	Avoiding external reminders of the stressful event experience (for example, people, places, conversations, objects, activities, or situations)?	88.6 % (249)	3.07 (1.2)
Hypervigilance		97.2 % (276)	
H1	Being "super-alert," watchful, or on guard?	88.9 % (248)	3.12 (1.2)
H2	Feeling jumpy or easily startled?	92.2 % (261)	3.31 (1.04)
DSO			
Affective dysregulation		93 % (264)	
Ad1	When I am upset, it takes me a long time to calm down.	87.9 % (246)	2.89 (1.28)
Ad2	I feel numb or emotionally shut down.	83.6 % (230)	2.46 (1.56)
Negative self-concept		75.4 % (214)	
Nsc1	I feel like a failure.	71.2 % (198)	2.77 (1.36)
Nsc2	I feel worthless.	69 % (191)	2.62 (1.4)
Disturbed relationship		87.3 (248)	
Dr1	I feel distant or cut off from people.	79.1 % (219)	2.77 (1.36)
Dr2	I find it hard to stay emotionally close to people.	80.1 % (221)	2.62 (1.4)

Note: Valid percentages reported.

that all participants in the class endorsed the item. Class one (N = 247, 87 %) was the largest class and was characterized by high probabilities of endorsing all symptom clusters. This class was labelled "CPTSD". Class two (N = 37, 13 %) was characterized by elevated reports of re-experiencing, avoidance, hypervigilance

Table 4: *LCA fit statistics*

Classes	Chi^2(df), p	AIC	BIC	ssaBIC	LMR-A (p)	BSLRT (p)	Entropy
1	209.95 (51), >0.01	929.52	951.42	932.39	-	-	-
2	57.42 (48), 0.165	840.61	888.05	846.82	100.37 (0.0001)	102.91 (0.000)	0.82
3	24.67 (42), 0.984	824.08	897.06	833.64	29.78 (0.0049)	30.53 (0.0000)	0.87
4	20.51 (35), 0.976	832.39	930.91	845.29	5.55 (0.4309)	5.69 (1.0000)	0.88
5	13.90 (28), 0.998	839.68	963.75	855.93	6.61 (0.0649)	6.76 (0.6667)	0.90
6	7,90 (21), 0.996	848.84	998.45	868.44	4.74 (0.5451)	4.86 (0.6667)	0.91

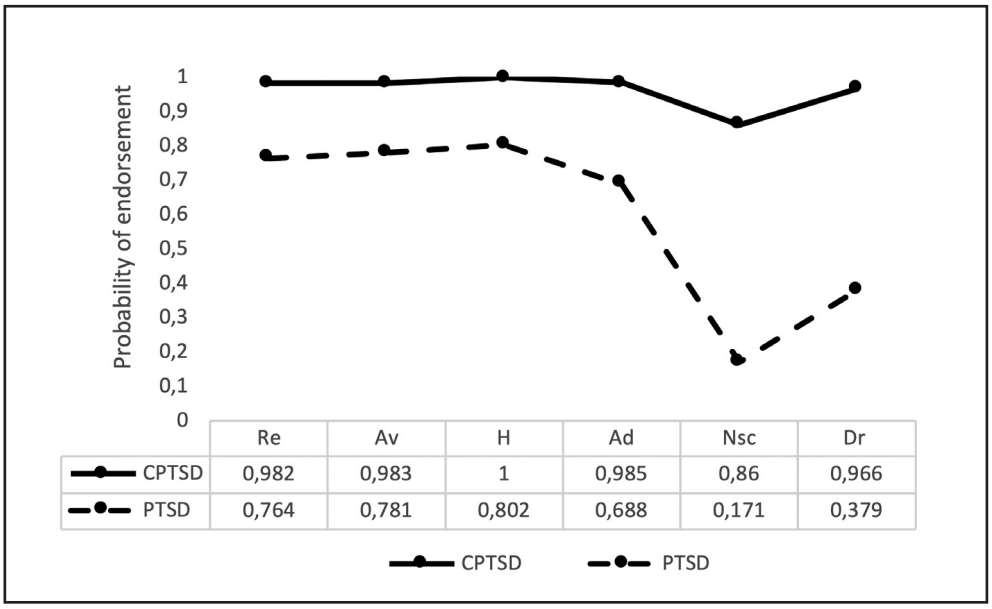
Note: Chi2: Pearson Chi-Square Test of Model Fit for the Binary and Ordered Categorical (Ordinal) Outcomes. *df* = degrees of freedom. *AIC*: Akaike Information Criteria, *BIC*: Bayesian Information Criteria, *ssaBIC*: Sample-size adjusted Bayesian Information Criteria, *LMR-A*: Lo-Mendell-Rubin adjusted likelihood ratio test. *BSLRT*: Bootstrapped adjusted likelihood ratio test.

and affective dysregulation, as well as comparably lower rates of negative self-concept and disturbed relationships. This class was labelled "PTSD".

Operationalizing the diagnostic criteria for CPTSD and PTSD based on symptom endorsement alone, 190 participants (66.9 %, n = 98 men) met the diagnostic criteria for CPTSD and 71 participants (25 %, n = 37 men) met the criteria for PTSD only. Finally, 23 participants (8.1 %, n = 14 men) did not meet the criteria for either diagnosis. Table 5 displays a cross-tabulation of class-membership and probable diagnostic status as per ICD-11.

Significantly more people were correctly rather than erroneously classified in the LCA using probable diagnostic status as a criterion. Standardized residuals can be interpreted in a way similar to odds ratios, however, while odds ratios refer to relative odds compared to overall likelihood of endorsing a category, standardized residuals are normally distributed and interpreted with reference to the standard deviation where values ≥ 1.96 indicate a statistically significant difference between the expected and actual class-count at $p \leq .05$. Notably, most disagreements pertained to the class-membership of the 23 people who did not fulfill a diagnosis using the ICD-11 established cut-offs. Out of the participants with no diagnosis, 8 persons endorsed subclinical CPTSD (all DSO-symptoms and 2 PTSD symptoms), and 7 persons endorsed subclinical PTSD (2 PTSD symptoms). Out of the participants classified with PTSD, 47 (66.2 %) met the criteria for subclinical CPTSD. Out of the participants with no diagnosis, the majority was categorized as belonging to the PTSD class (n = 15), and 8 people belonged to the CPTSD class in the latent class analysis. The latter 8 were identical to the participants endorsing subclinical CPTSD.

Figure 1: *Profile plot and class-probabilities of symptom-endorsement*



	Re	Av	H	Ad	Nsc	Dr
CPTSD	0,982	0,983	1	0,985	0,86	0,966
PTSD	0,764	0,781	0,802	0,688	0,171	0,379

Note: Re = Re-experiencing, Av = Avoidance, H = Hypervigilance, Ad = Affective dysregulation, Nsc = Negative self-concept, Dr = Dysfunctional relationships.

To address the second aim of the study, table 6 displays the results of the logistic regression-analyses.

No significant differences across class-membership were found.

Discussion

The purpose of this study was to examine the distribution of ICD-11 PTSD and CPTSD symptoms and explore their relation to sociodemographic and trauma-related variables in a culturally heterogenous group of treatment-seeking refugees by using latent class analysis (LCA). The LCA identified that the participants were distinguishable based on different patterns of symptom endorsement. Consistent with previous research among non-western populations (Hyland et al., 2018; Murphy et al., 2016), a two-class model reflecting the ICD-11 proposal provided the best fit to the data: a CPTSD class characterized by high probabilities of endorsing all PTSD core symptoms and DSO domains, and a PTSD class characterized by elevated PTSD core symptoms and comparably lower rates of DSO domain scores apart from affective dysregulation. Elevated rates of affective dysregulation in addition to PTSD symptoms are consistent with previous studies reporting elevated probabilities of endorsing hyperactivation among the PTSD class in non-western samples (probability = .64 in Hyland et al., 2018; .45 Murphy et al., 2016). Overall, the participants in the current study reported high intensity and prevalence of symptoms of PTSD and CPTSD, and affective dysregulation was frequently endorsed with 93 % meeting the cut-off criterion for symptoms of this cluster.

Table 5: *Relationship between class-endorsement and diagnostic status*

			Probably ICD-11 diagnosis			Total
			No diagnosis	PTSD	CPTSD	
Class	CPTSD	n	8	53	186	247
		% within class	3.2 %	21.5 %	75.3 %	100.0 %
		Standardized residual	-2.7*	-1.4	1.8	-
	PTSD	n	15	21	1	37
		% within class	40.5 %	56.8 %	2.7 %	100.0 %
		Standardized residual	6.9*	3.7*	-4.7*	-
Total		n	23	74	187	284
		% within class	8.1 %	26.1 %	65.8 %	100.0 %

Note: Overall χ^2 (2) 96.44, p = .000. * indicates a statistically significant difference from expected distribution.

A recent study of the structure of ICD-11 PTSD and CPTSD used network-analysis to show that symptoms of hypoactivation and hyperactivation comprising the affective dysregulation domain of DSO was more strongly related to other symptoms of posttraumatic symptomatology than each other (McElroy et al., 2019). In conjunction with documentation for high rates of common mental health disorders among resettled refugees (Turrini, Purgato, Ballette, Nosé, Ostuzzi & Barbui, 2017), the elevated rates of affective dysregulation among the PTSD class might also be reflective of comorbidity or elevated levels of non-specific distress associated with pre-, peri and post-migration factors. However, more research is needed to explore the relationship between trauma-related factors and specific symptom-clusters of ICD-11 PTSD and CPTSD in refugee samples.

The emergence of a low symptom class has been reported in previous studies using latent class approaches to investigate the validity of ICD-11 PTSD and CPTSD among refugee populations (Frost et al., 2018; Hyland et al., 2018; Murphy et al., 2016). However, the finding of a two-class model as the best description of the data constitutes a reasonable deviation from existing evidence considering that the current study is based on a treatment-seeking sample with cluster-endorsement rates ranging from 75.4 % to 97.2 % reflecting high rates of clinically relevant levels of distress. Indeed, only 23 respondents did not fulfill the criteria for a probable diagnosis of either PTSD or CPTSD, and in the LCA, the CPTSD class was by far the largest. This is consistent with several other studies finding the probable diagnostic rate of CPTSD to be higher than the rate of PTSD in treatment-seeking populations (Cloitre, Garvert, Brewin, Bryant, & Maercker 2013; Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014; Hyland et al., 2017b; Hyland et al., 2018; Karatzias et al., 2016, 2017; Knefel & Lueger-Schuster, 2013; Nickerson et al., 2016), but inconsistent with a recent

Table 6: *Odds ratio for class-membership from logistic regression*

Correlates	Odds-ratio	95 % CI	p-value
Continuous correlates			
Age (years)	0.97	[0.93 – 1.00]	.08
Categorical correlates			
Gender = female	1.23	[0.44 – 3.45]	.69
Foreign citizenship	0.38	[0.01 – 25.57]	.65
Marital status	0.99	[0.12 – 3.45]	.98
Occupational status (ever worked in DK)	0.65	[0.12 – 3.45]	.61
Need for interpreter (=no)	0.4	[0 – 48.73]	.71
Index trauma = war	0.79	[0.24 – 2.48]	.7
Time since trauma			
Less than 6 months	Significance test could not be performed due to small sample-size (n=5)		
6-12 months	Significance test could not be performed due to small sample-size (n=5)		
1-5 years	0.53	[0.15 – 1.91]	.34
5-10 years	0.5	[0.05 – 4.57]	.54
10-20 years	0.73	[0.08 – 6.78]	.79
Region			
Eastern Europe	0.31	[0 – 32.26]	.62
Africa	Significance test could not be performed due to small sample-size (n=7)		
Asia	Significance test could not be performed due to small sample-size (n=7)		
Caucasus	Significance test could not be performed due to small sample-size (n=8)		
Northern Europe	Significance test could not be performed due to small sample-size (n=2)		

Note: CPTSD-class used as reference group for all logistic regression analyses (categorical correlates). *Significant difference. 'More than 20 years' = reference group for 'time since trauma'. 'Middle East' = reference group for 'region'. War as index-trauma has been reported in the current table as it was the most frequently reported index-trauma. No statistically significant differences were identified across class-membership for either index-trauma.

study conducted among treatment-seeking refugees in Switzerland (Hecker et al., 2018). Notable characteristics of the study include that Hecker and colleagues (2018) administered the ITQ as self-report assessment or read it aloud to illiterate participants as in the current study but included the criterion of functional impairment for computation of probable diagnostic status that was unavailable for the current study.

A secondary aim of the current study was to explore relationships between observed class-membership and demographic and trauma-related variables. Although there were no statistically significant differences, age was close to statistical significance at p = .05 with the CPTSD class being slightly older than the PTSD class. Further research is needed to establish whether this trend reaches statistical significance in other samples, as

previous studies have documented an age-related increase in prevalence of ICD-11 posttraumatic stress disorders in a German population sample (Maercker, Forstmeier, Wagner, Glaesmer, & Brähler, 2008). Differences related to age might explained by older generations' more frequent exposure to war (Burri & Maercker, 2014). Notably, previously substantiated predictors of PTSD and CPTSD such as trauma exposure (Hecker et al., 2018; Hyland et al., 2017a), female gender (Hyland et al., 2017c), and time since trauma (Vang, Ben-Ezra & Shevlin, 2019), were unrelated to class membership in the current analysis.

There were no significant differences between observed class membership and type of index trauma. However, previous research among forcibly displaced persons has shown that refugees are exposed to a considerable number of potentially traumatizing events (Elklit, Nørregaard & Tibor, 1997; Fazel et al., 2005), and recent methodological advances has established that person-oriented approaches to modelling trauma exposure are superior to trauma type and trauma-frequencies in predicting the risk of subsequent mental health issues (O'Donnell et al., 2017). Taken altogether, the limited assessment of trauma exposure in the current study, particularly in childhood, might have precluded the adequate modelling of variability in classes due to exposure to specific trauma types that have been reported in previous research (see for example Frost et al., 2018; Hyland et al., 2017a, c).

There were no statistically significant gender differences across class membership or probable diagnostic status. While some research has suggested that women are more likely to exhibit symptoms consistent with CPTSD in clinical and community samples (Hyland et al., 2017a; Karatzias et al., 2017), other studies like the current have failed to replicate this finding (Maercker et al., 2008). Large scale studies have found that the gender-differentiated risk of posttraumatic symptomatology depends on the nature of the trauma (Ditlevsen & Elklit, 2010), and combat, war, and terrorism are reported trauma-types with no gender difference in prevalence of PTSD (Tolin & Foa, 2002). This suggests that the trauma incurred as a result of forcible displacement might constitute a potential threshold of trauma-severity around which gender becomes of marginal importance in predicting variation in posttraumatic symptomatology. Additionally, the high endorsement rates of all symptoms in addition to the high severity of posttraumatic symptomatology in general might constitute a condition under which differences between individuals with different class-membership and diagnostic categories are minimized, as participants with a probable diagnosis of PTSD endorsed between four and five symptom clusters on average, and the participants without a probable diagnosis endorsed between three and four symptom clusters on average (out of a possible six).

Finally, findings from the current study suggested that while assistance from interpreters can be vital to interventions, scale reliability might be compromised when interpreters are used in psychological assessment. However, illiteracy is not uncommon in refugee samples, and concentration difficulties associated with posttraumatic symptomatology (Gil, Caley, Greenberg, Kugelmass & Lerer, 1990) might pose a frequent problem when completing self-report measures in general. In clinical settings, the influence of working with interpreters in therapy has yielded inconclusive results (Palic & Elklit, 2011), but according to Carta, Bernal, Hardoy, and

Haro-Abad (2005) some refugees might feel discomfort due to suspicions of interpreters sharing private information with others, implying a potential for underreporting of some symptoms or experiences. Notably however, assessment of posttraumatic symptomatology among refugees is frequently carried out using verbal provision of questionnaires or using trained interpreters (Grossman et al., 2019; Hecker et al., 2018; Hoffman et al., 2018; Hyland et al., 2018; Murphy et al., 2016; Shrira, Mollov & Mudahogora, 2019; Valliéres et al., 2018), and it appears that this is the first study accounting for the potential psychometric variation in scale reliability associated with this type of provision of the ITQ to a refugee sample. The ITQ-scales however performed adequately with reference to recommendations for inter-item correlation set forth by Briggs and Cheek (1986) and issues related to the use of interpreters are secondary compared to the alternative of not performing any systematic assessment of mental health care needs.

Some limitations to the current study are observed when interpreting the findings. The current study was conducted using a self-report assessment among a highly culturally diverse sample of refugees. Results may not generalize to refugee populations in other countries (Denmark has a restrictive selection policy for refugees) or in other settings, as an inclusion criterion for participation in the current study was referral from general practitioner. Assistance of interpreters was needed for most of the participants which affected the reliability of the assessment as evident by the variability in Cronbach's alpha across the different versions. The variability was however confined within an acceptable range. Participants were recruited at the assessment stage rather than directly before treatment, possibly contributing to greater variability in the diagnostic status of the participants. Probable diagnostic status was calculated without the criterion for functional impairment for the ITQ as this was not assessed in the current study, which is also likely to affect the rates of probable PTSD and CPTSD diagnoses. Future research would benefit from the use of translated and validated versions of the ITQ among refugee populations and from assessing functional impairment.

Conclusions

The current study supports the validity of ICD-11 sibling diagnoses of PTSD and CPTSD among a culturally heterogenous treatment-seeking refugees. The distinction of PTSD and CPTSD is of great importance as CPTSD appears to more accurately describe the symptom profile of this population with clinical implications in terms of intervention-types and -focus. To facilitate further research on the validity of the ICD-11 proposal for PTSD and CPTSD, the ITQ should be translated to African, Middle Eastern and Eastern-European languages to improve clinical utility and overcome some of the potential issues associated with the use of interpreters.

Clinical implications

The high number of participants in the CPTSD class raises some concern regarding the sole use of treatment methods for PTSD in this population. Substantial evidence supports short-term trauma-focused interventions (Foa, Keane, Friedman, & Cohen, 2008), yet research shows only modest reductions in psychopathological symptoms among refugees following treatment (McFarlane & Kaplan, 2012; Palic & Elklit, 2011; Slobodin & de Jong, 2015).

Most patients do not seem to recover fully from PTSD following treatment (Palic & Elklit, 2011), and studies that investigate the efficacy of specific interventions for CPTSD have yet to be conducted, although discussion between scholars appears to convene on the general point that more complex symptom presentations require more complex treatment (Buhmann, Mortensen, Nordentoft, Ryberg & Ekstrøm, 2015; Harlacher et al., 2016). Cloitre et al. (2012) recommended that treatment of CPTSD should include techniques developed and tested for DSO. That is, treatment of CPTSD should include both a trauma-focused approach, as well as attending to affective dysregulation, relation difficulties, and a pervasive, negative self-concept. More research is needed to determine the benefits of specific interventions for PTSD and CPTSD, although evidence from a systematic review suggests that CPTSD treatment can indeed build on successful interventions for PTSD (Karatzias et al., 2019).

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Experiences of gender-based violence in women asylum seekers from Honduras, El Salvador, and Guatemala

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Key points of interest

- Women asylum seekers from Honduras, El Salvador, and Guatemala report systemic gender-based violence in their countries of origin.
- These experiences of violence are associated with significant physical and psychological sequelae.
- A narrow definition of torture by authorities might impede access to international protection.

Abstract

Introduction: Every year, thousands of women flee gender-based violence in Honduras, El Salvador, and Guatemala (sometimes collectively referred to as the Northern Triangle) in an attempt to seek asylum in the United States. Once in the United States, their legal teams may refer them for a psychological evaluation as part of their application for asylum. Licensed clinicians conduct in-depth interviews in order to document the psychological impact of the reported human rights violations. *Method:* Using archival de-identified data from a human rights program, this study gathered the experiences of gender-based violence reported by 70 asylum-seeking women from Honduras, El Salvador, and Guatemala who participated in pro bono psychological evaluation. Descriptive data were analyzed using a modified consensual qualitative research (CQR-M) method. *Results:* These asylum seekers reported exposure to systemic violence, including severe intimate partner violence, as well as physical and sexual assaults, and threats of death by organized criminal groups in their communities. Additionally, over a third of women reported experiences of violence during their migration. The majority of asylum seekers endorsed symptoms associated with anxiety (80%) and depression (91%), as well as trauma and

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stressor-related symptoms (80%). *Discussion:* The results of this study elucidate the many forms of gender-based violence experienced by women in this region, the physical and psychological sequelae of this persecution, and the systemic forces that prevent them from remaining in their countries of origin. The research results also highlight the potential impact of trauma on the women's ability to testify effectively during asylum legal hearings, elucidate factors that may contribute to their resilience in light of the human rights violations they survived, and suggest implications for clinical practice.

Keywords: Gender-based violence, Central America, human rights, refugees, United States.

Introduction

Women constitute an increasing number of asylum seekers fleeing escalating violence in Honduras, El Salvador, and Guatemala, and in 2016 the largest number of defensive asylum applications filed with immigration courts in the United States were from these countries, representing nearly 40,000 applications (Mossaad & Baugh, 2018). Although each of these nations has unique historical, social, political, and cultural realities, women are collectively "fleeing epidemic levels of violence, including gender-based violence" from this region (United Nations High Commissioner for Refugees [UNHCR], 2015, p. 2). The term gender is used to indicate "the social characteristics assigned to men and women," and gender-based violence (GBV) describes "violence that is directed against a person on the basis of gender or sex" (UNHCR, 2003, p. 11).

GBV encompasses a range of abuses including emotional, psychological, physical, and sexual violence, as well as socio-economic violence characterized by discrimination, exclusionary practices, and unresponsive legal processes (UNHCR, 2003). Survivors of GBV may experience a range of acute and chronic physical health outcomes including, but not limited to, physical injury, infection, disease, unwanted pregnancy, and miscarriage. In addition, this violence may lead to symptoms associated with depression, anxiety, trauma- and stressor-related disorders, and suicidality. GBV may also culminate in femicide, or the intentional murder of women (World Health Organization [WHO], 2012). Intimate partner violence (IPV) includes "any behavior within an intimate relationship that causes physical, psychological, or sexual harm" and is one of the most common forms of GBV (WHO, 2012, p. 1). IPV is associated with a range of societal factors including decreased economic and social status of women, absence of women's civil rights, and limited legal protections for violence in marriage (WHO, 2012). Such abuse in Honduras, Guatemala, and El Salvador is largely unchecked by government and law enforcement, and women often decide not to report these incidents, believing that their responses would be futile or because members of law enforcement are a direct source of harm (UNHCR, 2015). Moreover, these nations experience the highest rates of women murdered among countries not at war (Folkerts, Burgi-Palomino, & Buckhout, 2016), and El Salvador had the greatest number of gender-motivated killings in the world in 2013 (Parish, 2017).

Gender-based violence as torture

Nations that fail to protect women and girls from violence that causes severe physical or psychological harm are in breach of their commitments under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

(United Nations General Assembly, 1984) which prohibits intentional acts that cause severe pain or suffering, for purposes including, but not limited to: intimidation, coercion, and discrimination by or with the acquiescence of public officials or others acting in an official capacity. The impact of GBV, torture, or other unaddressed human rights violations is significant; many of these experiences necessitate that survivors flee, having been unable to secure protection in their home countries (Hiskey, Cordova, Orces, & Malone, 2016). Some research has documented the exposure to trauma and experiences of resilience among Central American women in the aftermath of civil wars of the 1970s and 1980s, while other studies have demonstrated increased risk of GBV and IPV in conflict and displacement settings (Stark & Ager, 2011; Wirtz et al., 2014). More recently, there have been studies utilizing interviews to understand the experiences of women who have fled violence in Honduras, El Salvador, and Guatemala living in Mexico (Schmidt & Buechler, 2017) and women from Central America, South America, and Mexico living in the United States (Kaltman, Hurtado de Mendoza, Gonzales, Serrano, & Guarnaccia, 2011).

Another method to capture these women's experiences is through the analysis of physical and/or psychological evidence of human rights violations documented by clinicians as part of the asylum process (Physicians for Human Rights, 2012). Such assessments represent a unique opportunity to investigate the effects of persecution and present information to adjudicators in immigration court (Meffert, Musalo, McNiel, & Binder, 2010; Prabhu & Baranoski, 2012). These evaluations also may have therapeutic value due to the clinician's empathic and supportive stance during the assessment (Gangsei & Deutsch, 2007).

Although men, boys, transgender, and gender-expansive individuals are also exposed to violence in this region (Médecins Sans Frontières, 2017), the purpose of this study was to identify how the experiences of women asylum seekers may be understood through the lens of GBV and the criteria for international protection. Secondary aims were to elucidate the physical and psychological sequelae, as well as migration and immigration detention experiences, of these women in order to inform practice guidelines for clinicians and to increase our understanding of how GBV may affect testimony in the context of application for asylum.

Method

Sample and procedure

We undertook a retrospective, qualitative chart review of medico-legal affidavits using a convenience sample of women who fled GBV in Honduras, El Salvador, or Guatemala and who sought pro bono forensic psychological evaluations from a human rights program as part of their application for asylum. The evaluations were conducted by licensed and trained clinicians who followed the Istanbul Protocol guidelines (UNHCR, 2004). The evaluation process included access to emergency medical or psychiatric services if needed, and all clients were offered linkages to continuity medical and social services. This study was approved by the program's Institutional Review Board and all records were fully de-identified to protect personal health information.

A total of 70 cases between 2014 and 2018 were eligible for analysis. All of the evaluators documented evidence consistent with the women's accounts of ill treatment in their countries of origin. The asylum seekers ranged in age from 18 to 55 years

(*M* = 29.4; *SD* = 6.5). They identified as Salvadoran (*n* = 24, 34%), Guatemalan (*n* = 15, 21%), and Honduran (*n* = 31, 44%). The women identified as Latina (*n* = 60, 86%), Garifuna (*n* = 4, 6%), and members of other indigenous communities (*n* = 6, 8%), and as heterosexual (*n* = 68, 97%) and lesbian (*n* = 2, 3%). They reported no formal education (*n* = 5, 7%), primary school education (*n* = 31, 44%), some high school or high school diplomas (*n* = 31, 44%), and some college or college degrees (*n* = 3, 4%). The evaluations were conducted in both community (*n* = 47, 67%) and detention center (*n* = 23, 33%) settings. All of the women were fluent speakers of Spanish and interpreters were used during the evaluation when appropriate.

Data analysis

Modified consensual qualitative research (CQR-M) is a method to systematically analyze large samples of qualitative data (Spangler, Liu, & Hill, 2012). The research team consisted of three trained coders: one psychologist and two research assistants. Together, the team worked to identify common participant experiences through the creation of domains that organized the data into general themes (Thompson, Vivino, & Hill, 1997) and then categories which provided greater detail (Ladany, Thompson, & Hill, 2012). Throughout the analysis, the team ensured consistency and limited bias by arguing discrepant codes to consensus. After the initial 60 cases were analyzed, the final ten cases were coded and did not yield any new domains or categories; therefore, the team established a "stability of findings" and determined that the data had been appropriately analyzed (Hill, Thompson, & Williams, 1997). Finally, the team assigned frequencies to indicate the level of representativeness of the codes given the study sample. A domain or category was labeled "general" if it represented almost all of the cases (66-70 cases), "typical" if it represented more than half of the sample (36-65 cases), and "variant" if it represented less than half of the cases (5-35 cases) (Ladany, Thompson, & Hill, 2012). Categories with four or fewer cases (5% of the total cases) were determined to not be representative of our sample and are not reported.

Results

The CQR-M process yielded seven domains that organized the data into broad topic areas. A total of 30 categories were added to these domains, which further described the common experiences across the 70 cases. Table 1 contains the domains and categories, as well as their accompanying frequencies.

Education and vocation

Many of the women cited socio-cultural forces including poverty and traditional gender roles as shaping their access to educational and occupational opportunities. They reported they: (a) were forced to leave school early; and (b) experienced child labor.

Forced to leave school early: Most women disclosed that although they wanted to continue to attend classes and planned for professional careers, they were unable to complete their educations. There were some asylum seekers who had graduated high school or attended college, however many others left school at an early age due to a variety of factors, including the inability to pay school fees, or because they became pregnant and were required to care for their children.

Experience of child labor: Most of the women commented that they needed to work at a young age in order to help support their families. They stated that

Table 1: *Domains, Categories, and Frequencies of Asylum Seekers' Experiences*

Domain Category and Frequency	Honduras (*n* = 31)	El Salvador (*n* = 24)	Guatemala (*n* = 15)
Education and Vocation			
Forced to Leave School Early: Typical (63%; *n* = 44)	21	10	13
Experience of Child Labor: Variant (37%; *n* = 26)	13	7	6
Experiences of Persecution			
Gang Violence: Typical (67%; *n* = 47)	18	21	8
Intimate Partner Violence: Typical (63%; *n* = 44)	21	13	10
Family-Based Violence: Variant (37%; *n* = 26)	13	6	7
Forms of Violence			
Sexual Assault: Typical (84%; *n* = 59)	26	20	13
Threatened Death: Typical (83%; *n* = 58)	28	19	11
Physical Assault: Typical (81%; *n* = 57)	26	17	14
Verbal Assault: Typical (71%; *n* = 50)	21	17	12
Control: Typical (57%; *n* = 40)	14	17	9
Harm to Minor Child: Variant (43%; *n* = 30)	15	10	5
Extortion: Variant (34%; *n* = 24)	8	10	6
Threats of Harm to Family: Variant (33%; *n* = 23)	6	12	5
Threats of Harm to Minor Child: Variant (31%; *n* = 22)	11	6	5
Harm to Family: Variant (23%; *n* = 16)	7	6	3
Physical Sequelae of Persecution			
Laceration or Puncture Wound: Variant (40%; *n* = 28)	16	8	4
Blunt Trauma to Head: Variant (39%; *n* = 27)	15	7	5
Blunt Trauma to Body: Variant (36%; *n*= 25)	10	7	8
Gynecological Injury: Variant (31%; *n* = 22)	12	6	4
Burns: Variant (16%; *n* = 11)	6	4	1
Psychological Sequelae of Persecution			
Depression Sxs: Typical (91%; *n* = 64)	27	23	14
Anxiety Sxs: Typical (80%; *n* = 56)	24	20	12
Trauma-, Stressor-related Sxs: Typical (80%; *n* = 56)	26	18	12
Past Suicidal Ideation: Variant (47%; *n* = 33)	11	13	9
Continued Fears for Family: Variant (40%; *n* = 28)	9	11	8
Migration Experiences			
Traveled with Child: Typical (74%; *n* = 52)	24	17	11
Detention: Typical (61%; *n* = 43)	18	12	13
Internal Displacement: Typical (54%; *n* = 38)	18	14	6
Violence During Migration: Variant (37%; *n* = 26)	16	4	6
Hazardous Conditions: Variant (29%; *n* = 20)	12	5	3
Resilience: Typical (73%; *n* = 51)	22	18	11

they harvested and distributed agricultural products; sold homemade or mass-produced food items; worked for local businesses; cooked and maintained the family home; and/or cared for siblings and relatives. Some asylum seekers also reported workplace exploitation including long hours and wage theft, while others explained they were solely responsible for maintaining the home, preparing meals, and raising the children.

Experiences of persecution

The women reported that they experienced: (a) family-based violence; (b) intimate partner violence; and (c) gang violence. The specific acts of violence they experienced are highlighted in the third domain.

Family-based violence: Many of the women recalled that they experienced harm in their families of origin. They reported witnessing domestic violence while living with their parents or extended family, experiencing physical forms of punishment as children that exceeded what they considered to be appropriate discipline, and surviving sexual abuse by fathers, uncles, and cousins.

Intimate partner violence: It was common for the women to report experiences of abuse in their intimate relationships, and much of their experiences reflected elements of "power and control" common to IPV (Domestic Abuse Intervention Project, n.d.). They often indicated that the onset of IPV coincided with their pregnancies and increased in frequency and severity over time. Attempts by the women's families and/or in-laws to intervene were ineffective in securing their safety and asylum seekers noted that IPV was normalized in their communities with the expectation that women "fulfill their roles" by remaining in their relationships.

Gang violence: The majority of women stated that they experienced violence associated with armed criminal groups that committed crimes with impunity, resulting in fears for their own safety, as well as concerns for their families. Most of the women reported that members of Mara Salvatrucha (MS-13) and/or Barrio 18 controlled their villages, cities, and countries, and that the gangs wielded their power through the collection of "renta" (protection tax), threats, kidnapping, sexual assault, forced recruitment, bribes, and murder.

Forms of violence

The asylum seekers noted that, as women, they were especially vulnerable to violence in their countries of origin including: (a) verbal assault; (b) physical assault; (c) sexual assault; (d) threatened death; (e) control; (f) extortion; (g) harm and threats of harm to minor child(ren); and (h) harm or threats of harm to family.

Verbal assault: The women disclosed experiences of chronic verbal abuse including being called "basura" (trash) and "perra" (dog), as well as other gender-based slurs. The asylum seekers also revealed that they were subjected to insults that referenced their real or perceived indigenous backgrounds and identities such as being told to "go back to the mountains."

Physical assault: The women reported that they survived a range of physical violence. One asylum seeker commented that her partner "would throw anything he had in his hand" at her. During the course of the assaults, women also stated that they were "slapped and pushed," had their "hair grabbed and pulled," and were "choked," "punched," "kicked," "burned," "stabbed," and "shot."

Sexual assault: Many of the asylum seekers discussed experiences of sexual violence.

They reported they were forced to perform non-consensual sexual acts and were raped in the context of their intimate partnerships. Other women stated they experienced sexual assault by family members, neighbors, and members of the community, while still others endured kidnapping and repeated sexual assaults associated with "gang rapes."

Threatened death: The women described experiencing death threats in the form of text and hand written messages, phone calls, and face-to-face confrontations. They often reported that they were menaced by knives, machetes, and firearms. In addition, the women also explained that they feared they would be killed during the course of physical and sexual assaults.

Control: The asylum seekers reported a range of experiences of disempowerment associated with GBV, including experiences of economic abuse which often rendered them unable to work to support themselves and their children, because their partners prohibited their employment or because they had to hide from gang members. They indicated that their partners prevented them from leaving their homes, denied them access to a cell phone or control over money, and dictated what clothing and make-up they could wear. When their partners also had ties to organized crime, the women recalled that the gangs aided in the intimidation by engaging in stalking and harassment.

Extortion: The women reported that the gangs in their communities extorted money in the form of "renta" or taxes and that if they owned businesses, were known to have steady work, or had family in the United States presumed to be providing remittances, gang members forced them to pay a portion of their incomes and made death threats if they did not comply.

Harm and threats of harm to minor child(ren): The women indicated that the perpetrators of GBV threatened harm or inflicted injury on their children, which were often cited as the reasons the women sought safety in the United States. In addition, the women discussed their fears that their children would "disappear" or would be "forced to join the gangs."

Harm or threats of harm to family: Lastly, the women noted that their families were targeted with both threats of harm and actual injury. Some women also revealed that their relatives were "robbed," "beaten," "kidnapped," and "murdered."

Physical sequelae of persecution

The women reported sustaining physical injuries as a result of the violence reported above. Many of the asylum seekers stated that they experienced bruising, welts, and burns during physical assaults, in addition to blunt head trauma, broken teeth, or loss of consciousness. In some cases, they described long term sequelae of these head injuries and post-concussion syndromes, including dizziness, headache, neuropsychiatric symptoms, and/or cognitive impairment for a period of time after the assaults. A few women also indicated that they sustained penetrating trauma from being stabbed or shot. Others disclosed being kicked and punched in their abdomens during pregnancy which in some cases led to spontaneous miscarriages. As expected, the women who reported experiencing rape often described injuries to their genitourinary systems including bleeding and pain. Lastly, a few asylum seekers disclosed experiencing forced sterilization.

Psychological sequelae of persecution
The women endorsed psychological distress related to their experiences of persecution including symptoms associated with: (a) anxiety and (b) depression; as well as (c) trauma and stressor-related symptoms and (d) past suicidal ideation. The women also discussed (e) continued fears for family.

Anxiety symptoms: The asylum seekers endorsed symptoms related to anxiety, including feeling fearful, worried, nervous, restless, and tense. In some cases, their distress was directly related to a lack of safety following an experience of violence; for example, one woman commented "my door is made of tin, anyone could easily break in."

Depression symptoms: Almost all of the women reported symptoms associated with depression including low mood and diminished interest in activities. They also disclosed problems with memory, attention and concentration, which negatively impacted their functioning, as well as tearfulness, with one woman noting, "I cry easily when alone." In some cases, their distress was described in more spiritual terms, as exemplified by one woman's comment, "My soul hurts."

Trauma and stressor-related symptoms:
The majority of the asylum seekers reported trauma and stressor-related symptoms. They described a range of intrusion symptoms including being "flooded by memories," as well as nightmares of being chased or attacked. Symptoms also included cued physiological distress when reminded of the trauma. For example, one woman noted, "I sweat, I tremble, I become fidgety," while others reported experiencing a "racing heart." They reported avoidance of external reminders of the traumas and endorsed alterations in cognition and mood. In addition, some women described experiencing increased arousal and reactivity, including sleep disturbances. Others indicated that the violence "changed" them and reported feeling ashamed, embarrassed, and humiliated by their experiences.

Past suicidal ideation: Some of the women reported past thoughts of killing themselves following their experiences of GBV. They also reported that their thoughts of suicide increased in response to fears of deportation and the belief that they would be murdered if forced to return to their countries of origin. In many of the cases, women cited their families, children, and faith as protective factors against self-harm, as well as their hopes for building a secure home in the United States.

Continued fears for family: The asylum seekers also noted that they worried for their family members who remained in their countries of origin. One woman commented, "I am worried for my children, what will happen to them?" while another remarked that the gangs "kill people who defy them." Some women described continued threats, and others expressed concern that their flight to the United States made their families especially vulnerable to reprisals by gang members.

Migration experiences
The women described migration experiences characterized by: (a) internal displacement; (b) travel with their child(ren); (c) hazardous conditions; (d) violence; and (e) detention once in the United States.

Internal displacement: The women explained that they initially attempted to hide within their countries of origin. However, because their governments and law enforcement officials were unable and/or unwilling

to protect women from GBV, their experiences of violence continued. They described the police as "absent," "corrupt," and "not powerful enough" to effectively address IPV or combat organized crime. Others feared retribution, because "the gangs know if you go to the police and they will kill your whole family."

Traveled with their child(ren): Almost all of the women fled with at least one of their children. Notably, the asylum seekers forced to leave children behind reported distress associated with having to decide which children to take with them. They often cited their inability to secure the money necessary to bring all of their children as the primary reason they had to leave some in the care of family. Some were motivated to shield their girls from GBV, as exemplified by the statement, "I brought my daughter, [because] I did not want this to happen to her." Others made the painful decision to take their youngest children, because they were still "small enough to be carried" or had to leave infants too fragile to survive the trip.

Hazardous conditions: Some women reported they were forced to travel by cargo train or hide in vehicle storage compartments during their flight to the United States. One woman explained, "We couldn't see light, just darkness," and another recalled, "I thought we would suffocate." Many women reported little access to food or water and indicated they went hungry to ensure their children were fed. As they approached the United States/Mexico border, they walked through the desert and were forced to sleep outside exposed to the elements. Several women commented that other migrants displayed generosity in light of these dangers and assisted them during their journeys.

Violence during migration: They reported hearing that women were often targeted with violence during the journey to the United States. One asylum seeker noted, "I heard stories about the Zetas and Narcos, they abused women," and another disclosed she "dressed as a man during the trip" to remain safe. The women explained that coyotes, or human smugglers, transported them across borders and described experiences of theft, extortion, sexual assault, and/or threatened abduction or death during their migration.

Detention: Most of the women were initially detained in the United States by Border Patrol agents and were later transferred to Immigration and Customs Enforcement (ICE) custody. The asylum seekers whose children were taken from them by officials reported extreme distress due to these forced separations. They described being detained at the border in "hieleras" (ice boxes), concrete cells maintained at uncomfortably cold temperatures, and in "perreras" (kennels), chain-link fenced enclosures. Some of the asylum seekers were released to the community after a few days, while others were transferred to immigration detention centers. One asylum seeker reflected on the impact of detention by stating, "We don't have our liberty, and that makes us sad."

Women expressed worry related to their immigration proceedings; for example, one woman felt "unprepared to talk," and another commented, "I am scared of them, I am afraid they won't believe me." Some reported concerns regarding their ability to testify effectively, such as, "When I feel nervous, I have memory problems." Others revealed confusion associated with receiving negative credible fear decisions, for example, "Am I missing something? Do I need more words so they will understand?"

Not surprisingly, the women disclosed fears related to the dangers they would face if forcibly returned to their countries of origin. One woman explained, "I feel very fearful, I know what is waiting for me in my country," and another observed, "Now that they know I have escaped, if I return, I am dead."

Resilience

Despite the wide range of human rights abuses these women reported, they also possess a series of factors related to resilience. Many women stated that they found comfort and "strength" in their religious beliefs and focused on their families in order to cope with the violence they survived. Given this, forced separation from loved ones was an oft-cited major stressor. The asylum seekers also ascribed their tenacity to temperamental qualities, such as remaining hopeful: "I have always been a positive woman, I keep going" and "I have to adapt to my new life, everything is different, but I take it as an education." Lastly, some women revealed that their experiences led to a commitment to help others: "The support people have shown me, I am going to pay that back" and "I want people to know that we have to keep fighting, we cannot give up."

Discussion

This study describes the multi-pronged nature of human rights violations that women seeking asylum from Honduras, El Salvador, and Guatemala have encountered; physical and psychological impact of these experiences; threats to their families and children; and systemic forces that compel them to flee their countries. Their histories further highlight how far-reaching and deeply entrenched violence toward women can be in this region, as well as the perils these women may encounter during migration and post-migration, once inside the United States.

The women in our sample presented with current symptoms associated with anxiety (80%) and depression (91%), as well as trauma and stressor-related symptoms (80%), and past suicidal ideation (47%). While these symptoms were not always associated with formal clinical diagnoses, they correlated with significant distress in many of the cases included in this study. Furthermore, these asylum seekers reported sustaining both blunt (67%) and penetrating (40%) trauma during the course of GBV. Given these findings, clinicians should assess for possible exposure to GBV, prioritize mental health screening when caring for this population, and provide culturally-responsive, linguistically-appropriate, and trauma-informed services. In addition, IPV can begin or escalate in pregnancy and is associated with adverse outcomes for both the mother and infant (Cook & Bewley 2008; Bailey 2010). Therefore, increasing access to care for pregnant women and their children can ultimately decrease maternal-fetal-child morbidity and mortality. Lastly, given the resilience demonstrated by the women in this study, clinicians should support factors that increase adaptive functioning and integrate strengths-based approaches into their practices.

The mental health correlates of GBV have implications for asylum seekers' abilities to effectively testify during their credible fear interviews and immigration hearings (Cohen, 2001). Consequently, an assessment of the psychological impact of their experiences of trauma may be essential (Lustig et al., 2008; Scruggs, Guetterman, Meyer, VanArtsdalen, & Heisler, 2016). The asylum seekers in this study reported difficulties with memory, attention, and concentration which are associated with depression, anxiety, and trauma and

stressor-related symptoms. Similarly, the asylum-seeking process is replete with ongoing fears, and increased stress can lead to higher levels of endogenous cortisol that may decrease memory performance (Backhaus et al., 2006). These sequelae may impact the consistency, quality, and quantity of women's testimony (Meffert et al., 2010), and the mental health correlates of trauma should be acknowledged during immigration proceedings and subsequent determinations of credibility.

Furthermore, this study highlights women's reports of the ways GBV can be sanctioned by socio-cultural norms and political structures in Honduras, El Salvador, and Guatemala, including gender inequality and the acquiescence of law enforcement to organized crime. Given the recent legal and political debates over immigration policies related to GBV and gang-related violence in the United States, it is important for asylum adjudicators to understand how country conditions prevent these survivors from finding secure refuge in their countries of origin (Rodríguez Serna, 2016).

A few potential study limitations exist, including that all women in this sample originated from Honduras, El Salvador, or Guatemala, and these experiences of GBV and their sequelae may not be generalizable to women from other nations in the context of their unique socio-cultural-political histories. Future studies should, therefore, investigate the experiences of asylum seekers who have survived GBV in other regions of the world. In addition, the convenience sample and retrospective nature of this study limited the data available for analysis. Finally, this study does not address violence in asylum seekers who identify as members of LGBTQ communities, as our sample size was limited for these groups. However, persecution based upon sexual orientation and gender identity is acknowledged in this sector of asylum seekers (Pérez-Sales & Zraly, 2018).

Conclusion

This study captures women's experiences of systemic violence in a region without effective intervention by law enforcement and government. Article 33 of the U.N. 1951 Refugee Convention and Protocol prohibits *non-refoulement*, or the return of refugees to a country where their lives or freedoms would be endangered (UN General Assembly, 1951). The results of this study suggest that women fleeing GBV in El Salvador, Guatemala, and Honduras meet criteria as survivors of torture and require international protection. Their health and general wellbeing would benefit if they were granted asylum.

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Organizational development with torture rehabilitation programs: An applied perspective

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Key points of interest

- Funders and torture rehabilitation programs are wise to invest in organizational development as an essential aspect of sustainably supporting torture survivors.
- Torture rehabilitation programs benefit from developing staff care policies to prevent burnout, secondary trauma, and turnover that each threaten the viability of the sector.
- Collaboration between varied domains within the organization is necessary for successful organizational development assessments and interventions.

Abstract

Torture rehabilitation has emerged as a field over the past several decades and much of the literature has focused on clinical interventions, related evaluation, and documentation of torture. Less discussed are organizational development initiatives that seek to strengthen organizational effectiveness in order to improve mental health outcomes for torture survivors. Based on applied experience in organizational development with torture rehabilitation programs in post-conflict contexts, the authors explore key organizational development needs in the field of torture rehabilitation, areas of future consideration for international agency donors, and additional future considerations for torture rehabilitation programs themselves. A case is made for organizational development efforts that prioritize time for strategic thinking that includes participation from stakeholders across the organization's functions; staff care policies that prevent secondary trauma and promote wellbeing and retention; clarity surrounding organizational structure and roles; financial management systems that position the organization for growth and fund diversification strategies beyond the project-based international agency funding model. The work requires long-term commitment in terms of technical and subgrant assistance, including an ongoing process of assessing and adjusting approaches. The case examples included are representative of certain key challenges

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that may be addressed to some degree within the parameters of a similar project. While the work of torture rehabilitation is urgent by nature, the authors emphasize the need for practical approaches for the important (but not always urgent) work of organizational development.

Keywords: torture survivor, torture rehabilitation, organizational development, NGOs, capacity building, international development

Problem statement

The field of torture rehabilitation has emerged over the past few decades. During that time, much of the focus of both academic literature and capacity building initiatives has centered on the technical skills and structures involved in providing torture rehabilitation services, the evaluation of varied clinical interventions, and the documentation of cases of torture. Absent from the literature is an examination of overall organizational development needs and approaches. This article, informed by applied experience in organizational development, is intended as a modest contribution to the conversation about the future of torture rehabilitation programs around the world.

The following observations and reflections are from practice with the Center for Victims of Torture (CVT), based in St. Paul, Minnesota, USA, the mission of which is to heal the wounds of torture on individuals, their families and their communities, and to end torture worldwide. CVT's Partners in Trauma Healing (PATH) Project collaborates with torture rehabilitation programs globally to design and implement capacity building plans with the overarching goal of strengthening organizations' capacities to serve torture survivors. One of CVT's contributions to the torture rehabilitation movement was drafting the language for the U.S. Torture Victim Relief Act (TVRA), which passed in 1998 and financially supports torture rehabilitation programs through the United Nations Voluntary Fund for Victims of Torture, Office of Refugee Resettlement for U.S.-based organizations, and United States Agency for International Development (USAID) for international programs.

The PATH project was supported by a cooperative agreement from USAID's Victims of Torture program.

Capacity building, increasingly referred to as capacity development, became an area of interest for CVT because the organization recognized that it cannot and does not need to work in every country that is home to survivors of torture, as there are over 140 torture rehabilitation programs operating around the world. The programs are frequently run by medical professionals, whose elevated status is critical for speaking against torture, and who are interested in developing their administrative, mental health, and evaluation capacities. As such, in 2000, CVT established its first capacity building project to strengthen organizational viability and delivery of services of select torture rehabilitation centers around the world. Since that time, CVT has supported torture rehabilitation programs in over 30 countries.

Historically, the core of CVT's capacity building work was to develop the clinical capacity of organizations to provide quality mental health services. Due to the broader organizational needs that are key for the development and sustainability of clinical capacity, the PATH Project hired program evaluation and organizational development (OD) advisors in 2011 who focus on these areas.

PATH identifies as a capacity building project with a heavy emphasis on the

capacity of staff and processes in the organization that are related to torture rehabilitation programming, while organizational development necessarily takes a higher-level view of organizational structures and systems. As a general rule, the project prioritizes systems over individuals in order for the impact to be longer lasting in the event of staff turnover.

It would be a missed opportunity if we were not to capture the lessons we have learned from organizational development with torture rehabilitation programs, given the lack of resources for this particular mission focus and international development in general. Our hope in sharing these reflections is to elaborate on how organizations that work on torture rehabilitation have additional layers of vulnerabilities and challenges, as well as keen resiliency in a field defined by traumatic experiences, while addressing several questions based on our experiences, particularly since 2011. Our guiding questions are: What are the key OD needs in the field of torture rehabilitation? What should international agency donors consider for the future? What should torture rehabilitation programs consider for the future?

Definition of terms

In addressing these guiding questions, two terms in particular warrant definition. This paper defines organizational development as: "improving organizational effectiveness."

The term capacity building can signal a range of focus areas, methods, and depth of intervention. The PATH Project invests in capacities in the areas of mission and vision, strategic planning, management capacities, communications planning, fund development, and financial management. While capacity building and organizational development are indeed distinct, they are not unrelated.

Organizational development within torture rehabilitation organizations: The PATH approach

Since 2011, the PATH Project has provided organizational development support to more than 15 organizations with torture rehabilitation programs. The design of the PATH Project includes three core domains of capacity building: mental health counseling, program evaluation, and organizational development. The below graphic represents the key components of the process, while also illustrating the iterative nature of the work.

Key organizational needs

Organizational leadership

A critical position within organizational development of NGOs is that of the executive director. In the field of torture rehabilitation, the role of executive director is fraught with challenges. The executive director is responsible for any number of competing demands, which may change and multiply frequently depending on the stability of the external environment in which the organization operates, as well as internal shifts.

In the experience of the PATH Project, those who enter executive director positions often come from a medical or mental health clinical background, and not necessarily a strong background in organizational administration and management. The connection to the general mission of meeting the mental health needs of torture survivors is well-served by this background, and also may necessitate a learning curve in designing and managing torture rehabilitation programs.

Figure 1: *Key Components of the PATH Process*

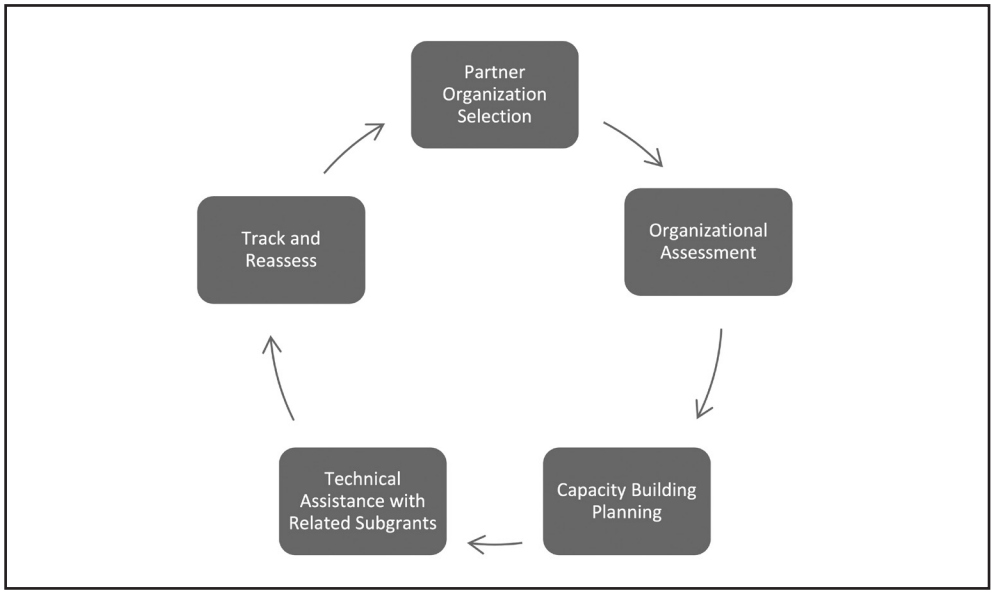

Figure 2: *Key aspects of the PATH Capacity Building Process*

Partner Organization Selection
- Establish criteria for selection
- Distribute call for applications
- Review applications, interview, and finalize selection

Organizational Assessment
- Interdisciplinary advisory team conducts on-site interviews
- Advisory team solicits and incorporates feedback on initial findings

Capacity Building Planning
- Advisory team facilitates capacity building planning process for life of project
- Advisory team facilitates a work planning process for the first year of the project

Technical Assistance with Related Subgrants
- Audit process conducted by CVT finance department
- Assignment of risk level determines how subgrant will be distributed (reimbursement only or otherwise)
- Technical assistance with problematic areas of compliance, such as timesheets and cost share

Track, Evaluate, and Reassess
- Monthly coordination meetings among advisors and project administrators
- Trip reports by advisors and post-visit surveys to partners
- Quarterly reports from partners

Our work in organizational development has also exposed us to the enormous responsibilities on the shoulders of executive directors of organizations with torture rehabilitation programs, both in terms of the programs and their extended families and communities. This appears particularly acute among female leaders who continue to carry the larger share of domestic responsibilities for their families while also steering their respective organization toward financial and programmatic sustainability.

Staff retention is an area of concern that also arises frequently. Quality staff members may leave a torture rehabilitation program for the same reasons as anyone might leave a job. More specific reasons may include in addition to less competitive salaries, unstable funding, and unclear expectations due to a lack of performance management, struggles with secondary trauma, burnout, and security concerns in high-risk environments. Successful torture rehabilitation programs prioritize staff care, non-monetary benefits, and clearly thought-out and disseminated security plans to demonstrate their commitment to creating and sustaining a healthy organization.

A key contribution of the PATH project is how the advisor visits to the partner organization create (or provide an excuse for) time and space dedicated to strategic and evaluative thinking. The people who lead and work within the field of torture rehabilitation frequently work on issues of both high importance and high urgency. Within the important-urgent matrix popularized by Stephen Covey (Covey et al, 1994), constantly working within this quadrant is a recipe for burnout and ultimately results in an unsustainable organization. Another quadrant in the same matrix emphasizes high importance, but low urgency, which includes efforts such as strategic planning, problem solving, and managing change. This is the area of focus for PATH as a capacity building project.

Funding sustainability

A perennial issue for torture rehabilitation programs, and international NGOs in general, is the over-reliance on one or a handful of grants from international agencies. The temptation to continue doing so is understandable: international agencies can provide large sums of money that are difficult to replace in full through alternative funding sources, such as individual donors, social enterprise, corporate sponsorship, or foundation grants. In western contexts, these types of organizations may receive support from their respective governments, but this is not a realistic solution for most of CVT's partner organizations due to low-resource governments, competing priorities, limited interest in the field of torture rehabilitation and mental health in general, hostility toward the work, or insufficient trust in state funding. Despite the obstacles, if these programs are committed to working into the future, beyond the life of the development sector's interest in their particular context, then organizations are wise to engage in strategic thinking on this topic, and donors are even wiser to support them in doing so.

The diversification of funding is not simply a matter of finding a different organization to provide funding. Each type of funding necessitates its own set of knowledge, skills, and relationships. Preparing a grant proposal in response to a clearly articulated Call for Proposals from the U.S. Government, for example, differs wildly from building a broad base of individual donors or advocating for local government support of torture rehabilitation. The process of cultivating those relationships, too, is distinct. Other potential sources of funding include

fundraising from diaspora communities, fee for service from clients, crowdfunding, and social enterprise or earned-income activities, such as fee-for-training or other services, each with its own advantages and disadvantages. Each approach requires significant investment to meaningfully engage.

For years, torture rehabilitation programs have invested their energies in understanding the systems and meeting the requirements of international agencies in the Global North. These agencies are based in low-context cultures where expectations are explicit, but typically shift priorities according to the emergence of conflict in other parts of the world. When the geographic or content interests of those agencies change – and they inevitably do – torture rehabilitation organizations are left without a plan to sustain their work, even at a less intensive level. These organizations benefit from ongoing conversation about that eventuality, so they can make a conscious decision about their vision beyond the life of international agency funding.

Torture rehabilitation programs must also educate donors about what it takes to do this work effectively and sustainably. In order to avoid burnout and secondary trauma, organizations must pay attention to the number of clients per care provider and provide clinical supervision for staff working directly with torture survivors. The costs of meaningful program evaluation may seem high, unless you consider the necessity of good data for improving services, helping clinicians see the impact of their work, and communicating to donors how the interventions change lives. This, of course, is all in service of improved health and functioning of torture survivors.

Organizational structure and systems

Organizations with torture rehabilitation programming struggle to structure the organization around a shared mission and vision. Organizations often take the shape of several small projects housed near each other, each with its own team, sets of activities and indicators, and administrative support. Though it is certainly possible to function this way, and in some ways, it is easier to meet donor requirements, it does not bode well for a collective organizational identity. As a result, organizations may seek ways to create shared management systems and develop a unified organizational identity to better serve the mission.

Related to this is the development of a broad set of systems, including financial, human resources and performance management, monitoring and evaluation, technology, and security. While organizations typically develop a set of policies and procedures out of general necessity, most organizations also find themselves documenting systems at the behest of funding agencies and their specific requirements. This is a particular area of concern for programs that are competing for new types of funding, since their systems may not match the requirements of the funder and thus, they must develop them in order to be considered for an award.

Succession planning for the sake of sustainability

Another complicated topic that organizations in the field consider—or ought to—is that of succession planning for executive and programmatic leadership. The sustainability of the torture rehabilitation movement cannot be discussed without acknowledging two realities: 1) The significant number of founders or founding executive directors who currently run the organizations; and 2) concern about burnout as well as secondary trauma. Without intentional development of staff within the organizations, an exodus

of founders would seriously impact the sustainability of the sector. Similarly, if organizations are not attentive to staff care needs, there is a risk of losing the very staff members who would be well qualified to lead the organization in the future.

The topic of succession planning as relates to executive directors, in particular, intersects with the priority issue of staff care. In our observations, it is not at all uncommon for executive directors of organizations with torture rehabilitation programs to experience negative health impacts that are at least partially related to stress. These impacts lead to decreased effectiveness in their positions and extended absences to recover from illness. In many countries, someone who develops their professional skills to this level is relied on by immediate and extended family for financial support. Additionally, the people in these roles have additional domestic responsibilities at home and leadership roles in the community. It is necessary to recognize and acknowledge such multiple levels of responsibilities and related stresses when working in this field.

Program evaluation

The area of program evaluation within torture rehabilitation programs is an additional challenge for organizations. Many organizations have limited their implementation of program evaluation to that which satisfies funder requirements, including basic outputs such as numbers of clients, sites, and services. Increasingly, donors have asked for outcome data to better understand how clients' lives are improved through services, though they do not necessarily fund it at the level necessary for meaningful data. When evaluation is conducted in a perfunctory manner, or when the results are not communicated back to those implementing the interventions, evaluation is viewed as unnecessary work of little value that does not contribute to their roles.

Developing a culture of evaluation with an organization requires will, leadership, and vision of how evaluation can better serve clients. This includes the facilitation of discussions around how the organization would like to impact the lives of clients. They must answer the basic question: What does success look like for our clients? As part of this, organizations must allocate resources accordingly, since a budget is ultimately a statement of values. If the stated value is for program evaluation, yet the budget does not reflect that, then that unstated value will sabotage the success of program evaluation.

It takes careful thinking to strategically build the capacity of an organization's program evaluation efforts. At the outset, there may be a gap in understanding of what the components of program evaluation even are. Rather, organizations jump to the notion of buying or designing a database before elaborating its theory of change, tools, and data collection methodology, storage, and analysis systems. The lifecycle of a piece of data, after all, begins long before it is entered into a database, and involves the efforts of program managers, program evaluation officers, and executive staff members.

Additionally, in learning to establish and cultivate donor relationships, there is a temptation for torture rehabilitation programs to over-promise success indicators for a project or program. Sometimes targets are too high, outcomes are ill-defined, or are not readily measurable. Organizations must resist the urge to promise unrealistic data when donors make direct requests, because it sets them up for failure or the temptation to misrepresent results in their reports. Over-promising can also result in tension between the proposal writer – who is often the

executive director – and those charged with implementation of programming who may or may not have had a voice in the proposal development process. Rather, organizations should engage in thoughtful dialogue both internally and with donor agencies to create a shared understanding of the purposes of program evaluation, reasonable progress within the given context, life stage, and constraints of the organization, and true costs of doing it well.

Case examples

Following are three anonymized case examples from PATH's experience conducting organizational development with torture rehabilitation in varied contexts.

Case example 1

An organization had over a decade of experience in the field of torture rehabilitation, but remained challenged in various aspects of sustainability. As is the case with many small NGOs, this organization faced two key challenges related to financial sustainability. Chiefly, the fundraising expertise and experience was held almost exclusively by the executive director, instead of a team of people meaningfully engaged in the process. Secondarily, the organization received project-based funding without any general operating support to implement activities.

As a response to the challenge of limited fundraising capacity, and as a way of contributing toward succession planning, the organization sought PATH assistance in developing the structure, processes, and skills of a newly formed fundraising committee. PATH facilitation of the fledgling body resulted in a draft mandate, structure, role descriptions, and steps for key processes. The language emerged from the group's discussions to ensure ownership, rather than adapting an external resource that would be more likely to remain unused on a figurative shelf. As a result, the fundraising committee has a clearly articulated, shared understanding of its function in the organization.

Case example 2

This organization lacked clarity regarding organizational structure and roles. This resulted in problems developing clear processes, including those that impacted clients, such as a suicidality protocol. It also added to divisions between groups of staff, falling roughly along lines of seniority in the organization, and damaged staff morale. The implicit way of doing things was no longer sustainable as it grew from a grassroots organization to a professionalized model.

PATH worked with a core group of staff, including the management team, representatives from various departments, and a mix of both long-time staff and those newer to the organization, in order to make explicit an organizational structure and reporting lines. This provided a clearer way ahead with respect to roles and performance assessment. These challenges were not unique to this organization and the general approach has in fact been undertaken with several organizations.

Case example 3

Several organizations struggled with donor communication about issues that greatly impacted their work. In particular were problems conveying the importance of funding for clinical supervision and program evaluation in order to improve outcomes for clients. Due to pressures to work more with less money, project budgets did not reflect the true cost of carrying out the work well, and also contributed to demotivation of

staff, burnout and secondary trauma, and reduced clinical competence.

Interventions in this area are both singular and cross-cutting. Organizational development efforts consistently included these key voices from management, program evaluation, and clinical domains, in discussions and presentations to counter the tendency to consider them separate and unrelated to the core mission. In meeting with donor agencies, PATH modeled an emphasis on these areas lest they be overlooked by donors as the simple result of unawareness. Finally, these topics are frequently discussed with respect to the subgrant process and during coordination meetings of interdisciplinary advisor and administration teams.

Recommendations and the way ahead

In considering the above, what does this mean in practical terms for donors and torture rehabilitation programs? To answer this, we return to our original questions about organizational development in the field of torture rehabilitation.

Our first question was: ***What are the key OD needs in the field of torture rehabilitation?*** While there are many needs within the field, we base our conclusions on key themes that have emerged through our practice, and which can be addressed through both short- and longer-term interventions. The geographical distance between the PATH project staff and the partner countries is considerable, remote support is not a replacement for in-person collaboration, and the low number of technical assistance visits means that capacity building momentum ebbs and flows; yet, there are ways to build capacity through even short-term (e.g. one week per year) interventions.

These needs can be met only with the corresponding level of support from donor agencies. In order to engage in organizational development – which was defined as improving the effectiveness of the organization – torture rehabilitation organizational development initiatives should prioritize support for **creating space for and facilitating strategic thinking and problem-solving** with a broad representation of staff members, including the executive director. Our experience suggests the power of bringing people together with facilitation to plan, explore, learn, and problem-solve for even short, infrequent periods of time.

Additionally, in order for the torture rehabilitation movement to continue, organizational efforts should further promote the development and implementation of **staff care policies**, including regular clinical supervision. This reduces the expense and disruption of burnout, secondary trauma, and staff turnover. It also supports the possibility of cultivating the management and leadership potential of staff within the organization, thus contributing to succession planning. Organizations are wise to explore and address the barriers to individual self-care practices and organizational approaches to staff care. In many cases, organizations may hold certain conflicting values that sabotage the oft-repeated emphasis on self care. Organizations may expect constant availability of staff members, be unclear in staff roles, provide insufficient training, lack transparency about decision-making, validate a "martyr complex" approach to the work, or struggle with realistic expectations overall. While the notion of work-life balance may not be realistic due to the urgency of the needs that arise in the normal course of operations, the goal could be articulated as work-life integration.

Financial management should be an area of focus, as small, early-stage

organizations often require development in terms of both systems and skills. Often, they are missing critical policies, such as conflict of interest, petty cash, and procurement. Budgets are typically developed and tracked by project and there is no global organizational budget with an indirect expense line across programs and projects. Financial management efforts may also be plagued by other common issues, such as a lack of data security, challenges in collecting timely and quality documentation from field offices, computer viruses, database issues, and staff turnover. There are no simple fixes for these problems and others, but not addressing them can lead to financial malfeasance or elimination of support from funders. It is a matter of identifying and prioritizing the problems as they arise, as well as anticipating those that are inevitable.

On a related topic, **fundraising** for torture rehabilitation programs is expected to be an ongoing challenge, as it is for any organization reliant on philanthropic support, but will be especially problematic as long as the sector relies on international development funding. While there is lip service to the notion of funding diversification, the reality of understanding and tracking donor requirements in terms of program design, implementation, and reporting are far too time-intensive and stressful to allow sufficient space for the exploration of other sources of funding or alternative revenue.

The second question was: ***What should international agency donors consider for the future?*** We believe there are several areas that international agency donors would be wise to consider, as some already have begun, moving forward.

As a rule, we advise supporting capacity building initiatives that do not consist only of more training. It is tempting to assume that the capacity of all domains can be advanced at the same pace, but it is a problematic assumption, as the experience of The Center for Victims of Torture has shown consistently. In the simplest of terms, organizations fall into the life-stage categories of startup, growth, maturity, and sometimes reinvention.

A specific area in which most torture rehabilitation organizations benefit from support is that of **financial management** capacity building. As previously mentioned, torture rehabilitation programs tend to rely on one or a handful of international agency donors, each of which has its own set of indicators and reporting requirements. The net result, in terms of financial management, is separate financial management processes that do not feed into a global budget. This reinforces the separation of programming and evaluation, and contributes to a lack of sufficient overall administrative support for the organization.

Both narrow and deep interventions related to financial sustainability would be advisable, but it is unrealistic and unfair for donors to expect organizations to achieve financial sustainability without a dramatic shift in how development aid works, investment in earned income endeavors, support for relationship-building with prospective funders, and support for the development of relationships with their own governments where feasible.

A related area of opportunity is for donors to **support expert market research and business planning for alternative streams of revenue**. Another area is to provide grant opportunities that allow organizations to engage local organizational development consultants, and/or streamline the subgrant process for external capacity building projects to

support local consultants. This would have the dual benefit of strengthening the local consultant pool, providing more income for cash-poor countries.

International agency donors concerned about the vitality and sustainability of torture rehabilitation should **support and advocate for interventions that reduce impact of burnout and secondary trauma.** This support should include organizational structures, systems, and budgetary line items for clinical supervision found to be key for the health and successful functioning of clinicians. Clarifying roles within the organization is also important for this goal. Indeed, staff who do not have clarity about their position both in general and in relationship to others within the organization are at higher risk of burnout.

Finally, **meaningful investment in program evaluation** that helps organizations understand what is working – and what is not – is similarly important for staff to develop and sustain professional confidence in the impact of their efforts.

Our final question was: ***What should torture rehabilitation programs consider for the future?*** This is an intimidating question as torture rehabilitation programs are already juggling so many competing demands for their time. Nonetheless, there are a few items worth noting.

Chiefly, prioritizing any opportunity to **connect and integrate the various domains of the organization** is recommended. This is highlighted this because there are many occasions in which work is carried out in relative isolation by just one or two people, presumably for the sake of speed and efficiency, but at the cost of quality and sustainability. There is not a single function within an organization that can or should be done completely independent from others. In fact, when a key function is excluded from a process, an organization may unwittingly send a message to those staff members that their work is not valuable, and indeed miss a critical perspective when trying to solve problems. When organizations strive to build understanding of all the efforts within an organization, connections are made that produce better results, ideally including better outcomes for torture survivors.

Torture rehabilitation programs should also work to be sure that their **budget reflects their stated values**, rather than enable inconsistent messages. Organizations often say they value program evaluation, for example, but do not budget appropriately for the necessary staff time, printing expenses, and supportive technology to do so. Similarly, organizations may claim to value staff care, but be unwilling to consider salary schedules and alternative ways to compensate for staff time, expect staff to sacrifice free time for the mission, assign excessively high workloads, or set aside good practices such as clinical supervision for mental health counselors.

Another daunting task for torture rehabilitation programs is to **educate donors on what an effective torture rehabilitation program requires.** This is challenging for a range of reasons, including the inherent power-dynamic in donor-NGO relations and significant cultural differences between Western/Global North funders and programs based in non-Western/Global South organizations, as well as frequent staff turnover at donor agencies, necessitating an ongoing process of education about the work.

Finally, while it is risky for financial sustainability to rely on international agencies as the only source of funding and programmatic growth, as long as torture rehabilitation organizations do so there is a need to **develop the capacity of**

financial structures and systems. Even an organization that has gained considerable experience and growth will face increasing expectations for financial management and transparency. The need to manage funds according to funder, client, cost-sharing, in-kind support, and other factors is necessary to retain donors. Relatedly, organizational board governance may become increasingly important as transparency is prioritized by international agencies who are in turn accountable to elected officials and individual taxpayers.

Lessons learned

Organizational development within the mandate and constraints of this project is replete with lessons learned. While we would be reluctant to state with certainty what from our experiences should not be replicated, there are several areas that have been discussed and debated, reconfigured, and/or kept in consideration for future project modifications.

In the early phases of the work, the various domains that are part of the overall project operated in relative isolation, mirroring what occurs in the partner organizations, including during the planning process. We learned that integrating the domains during planning, implementation, and assessment processes better serves the organization. This approach has been critical in reinforcing the intersections of both structures and systems and promoting a more unified organizational identity, which is important in an environment where project-based funding creates divisions within functions of the organization.

Our approach to hire a psychologist-trainer for an average of a year-long placement with a given organization creates more momentum and day-to-day progress in developing the capacities of the organization. Given the importance of organizational development, we believe it may be wise in some cases to have on-site organizational development and/or program evaluation placements. This modification or addition, though, would introduce additional challenges and should not be made without sufficient contextual analysis.

Organizational development efforts would also benefit from increased in-person visits with partner organizations, beyond the annual visits that have been the norm during the most recent iteration of this work, and more effective use of in-country consultants. While virtual assistance is feasible to some extent, there tends to be greater buy-in and a sense of immediacy during face-to-face visits, perhaps in part due to cultural preferences for relationship-building as well as a human tendency to prioritize what is right in front of us.

Another lesson relates to funding. Some partner organization relationships have been developed for years, but the funding itself has been intermittent rather than continuous. The funding to support staff engagement in organizational development is important for buy-in and sustained effort. Technical assistance without subgrant support is unlikely to be fully utilized, even if we think that organizational learning and development should be sufficient incentive itself. Similarly, technical assistance without long-term commitment will produce little progress due to the relationship-oriented nature of the work, as well as the level of effort necessary to collectively define problems, design solutions, and implement well.

Also related to funding is a lesson regarding the difficulty of working with low-resourced organizations. There is a fine line between identifying organizations that need organizational development support most, and those that have enough capacity to

truly benefit from it. Indeed, if there is not enough general operating or project-based support to work on the core mission, then organizational development efforts are rather beside the point. On the contrary, highly resourced organizations require different types of interventions, including those which are more specialized in a range of areas. As a result, it is challenging to appropriately staff for such varied needs.

Some torture rehabilitation programs have developed within a post-conflict context, while others operate during a time of political instability, current conflict, or as the direct result of a nearby conflict. Organizations operating in contexts of conflict require special consideration, as the instability inevitably impacts the ability of the organizations (and the individuals within them) to think about the medium- and long-term. Additionally, there is the possibility that a greater number of staff members may be directly or indirectly affected by traumatic events.

It would be remiss not to mention the role of culture as a cross-cutting lesson we have learned to date. It would be dishonest to deny the implications of working on a project that is funded by the U.S. Government in a broad range of cultural and sociopolitical contexts. Cultural differences matter in whether there is a preference to make policies and processes implicit versus explicit, for example. Communication styles vary, depending on sometimes cultural distinctions such as directness or power distance. It is impossible to place an individual or organization squarely into a singular culture, but understanding some common areas of distinction is useful for all parties involved.

Ultimately, we have come to understand that organizational development as an external advisor or agency requires ceding control. The organization has the final say in what is changed or not changed, integrated or dismissed, deeply embedded or perfunctorily done. To ignore this reality is to sign oneself up for frustration and disappointment. To accept it is to look for ways in which to listen, offer, collaborate, adapt, and support. The work requires humility over arrogance and patience over imposed urgency.

Conclusions

This article is intended to highlight our experiences in organizational development with torture rehabilitation programs in various contexts around the globe. We endeavored to address three primary questions: What are the key OD needs in the field of torture rehabilitation? What should international agency donors consider for the future? What should torture rehabilitation programs consider for the future?

There are of course more questions and yet more answers, but the preceding pages are a modest summary of our years of experience in this specific field of work. While the challenges are significant, we do not have the option of turning away from them. This work is that of solidarity and optimism. The basis of it requires self-awareness, adaptability across cultures, and an understanding of this unique belief that to heal the wounds of torture globally, we must engage individually. Due to the daily efforts of the torture rehabilitation programs with which we have worked, there is reason to believe that this can be done.

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30th anniversary of STARTTS – NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

Jorge Aroche*

2018 marked the 30th anniversary of STARTTS. Since its humble beginnings in 1988 the organisation has grown and expanded greatly in the last three decades. This storied milestone has created an opportunity for us to reflect, look back at our history and take stock of our enduring achievements. It is also a time to decide how we want our role to continue to evolve in order to meet the current and future challenges that face STARTTS as an organisation. To mark the 30 years of STARTTS, our 30th anniversary celebratory event was held on the 20th of September 2019.

Thirty years of uninterrupted growth has opened up opportunities for organisational transformation, innovation and international collaboration. It has also placed us in a position where we have much to share in terms of expertise and innovative interventions, not just with our colleagues working in the rehabilitation of torture and trauma survivors, but also those working in the wider trauma field.

When STARTTS opened its doors 30 years ago, nobody knew much about healing victims of torture. We had to learn, and in doing so, learning as we did became part of the culture of that young organisation, a culture that endures as STARTTS has matured, and that I have mentioned many times. This learning was always for a purpose, however, to be better at what we do, to get better at this incredibly important task of assisting our clients to have a life after torture and suffering. Thus, continuing to get better, refusing to settle for good enough became another of the many characteristics that define STARTTS, and part of its DNA as an organization. We don't settle for good enough. Not when it comes to helping our clients have a life after torture and trauma. We have been constantly evolving and changing, growing when necessary, in pursuance of this goal. This has been the driving force for the last thirty years, and one that I trust will continue to drive us for the next thirty.

One new forum created to do that is the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) biennial International Conference, which STARTTS spearheaded so successfully in 2017 in Sydney. The success of the first conference was built on by our QPASTT colleagues in Brisbane this past March. The challenge of hosting the next 3rd FASSTT International Conference has now moved to our Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) colleagues

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in South Australia and will take place in Adelaide in 2021.

STARTTS belongs to our clients first and foremost, who provide the inspiration, purpose and meaning to the organisation. It belongs to our friends, colleagues and supporters who play key roles in all the successes we have, to the refugee communities and the local community at large, who provide the context for healing in which STARTTS can do its work, and it belongs to Australian society at large, a society that continues to acknowledge the need to assist torture and trauma survivors to have a life after a torture, and chooses to make the resources available to make this possible. We should all be very proud of this, particularly in the current global context.

Thank you for being here with us, thank you for supporting us on this 30 year journey. Thank you for continuing to inspire us, so that we remain as committed to our work and as eager to tackle new challenges as we were thirty years ago.

Jorge Aroche.

Barbara Chester Award 2019

Mary Fabri, PsyD *

From Left to Right:
Shari Eppel from Zimbabwe 2000 BCA recipient
Juan Almendarez from Honduras 2001 BCA reipient
Allen Keller from the United States 2003 BCA recipient
Mary Fabri from the United States 2009 BCA recipient
Sana Hamzeh from Lebanon 2019 BCA recipient

The Hopi Foundation, a non-profit organization in Kykotsmovi Village, Arizona, honors the life and work of Dr. Barbara Chester, torture rehabilitation pioneer, with an award for outstanding practitioners who assist torture survivors, their families, and communities. The 2019 Barbara Chester awardee was Dr. Sana Hamzeh, Clinical Advisor of the Restart Center for Rehabilitation of Victims of Violence and Torture in Lebanon. The event took place on October 5th 2019 in Moenkopi, Arizona.

The morning workshops shared experiences of healing through the use of cultural traditions, pilgrimages, and exhumations as a tool for transformation. The afternoon award program included keynote remarks by Dianna Ortiz, a survivor and co-founder of Torture Abolition and Survivor Support Coalition. She described the event, "This weekend has given me the courage to dare to believe the impossible: looking beyond pain and distress may lead to the uncovering of a calm, healthy and an unblemished soul surrounded by hope and tranquility. Perhaps healing from torture is, indeed, possible."

Dr. Hamzeh, nominated by her friend and colleague, Suzanne Jabbour, spoke eloquently about the moral obligation providers come to feel, "I am here to give the hundreds of torture survivors I have worked with throughout the years, a voice. I am giving my voice to their pain, needs, fears, hopes, strength, resilience and survival stories." She also voiced the feeling that Barbara Chester Awardees share when they learn of their receiving the award, "a realization that our hard work and efforts can, and will be, recognized" that then renews our hopes and motivations.

The Barbara Chester Award is given every three years and nominations are solicited from around the world. Past awardees are: Shari Eppel of Zimbabwe (2000); Juan Almendarez of Honduras

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(2001); Allen Keller of the United States (2003); Alp Ayan of Turkey (2006); Mary Fabri of the United States (2009); Naasson Munyandamutsa of Rwanda (2013); and Diana Kordon of Argentina (2016). Sana Hamzeh of Lebanon (2019) is welcomed to the family of Barbara Chester Awardees.

The next request for nominations will be in October of 2021 for the October 2022 award that includes a cash prize of $10,000 USD and a silver sculpture featuring Hopi symbolism for healing and Qa Tutsawinvu — freedom from fear of intimidation from any source. Noted Hopi artisan, Floyd Lomakuyvaya, handcrafts the award.

Please be ready to nominate a dedicated and tenacious practitioner for the 2022 Barbara Chester Award. http://barbarachesteraward.hopifoundation.org/home

Medical involvement in torture in Syria

Peter Jones*,**

Sir,

The culmination to the pitiless war in Syria is taking place with the carve up of the rebel province of Idlib and Kurdish regions of Northern Syria. In parallel to its remaining military objectives, the Syrian regime is making incremental steps towards normalization and political rehabilitation. The recent convening of a Syrian Constitutional Committee in Geneva through the United Nations underscores the continuing effort to achieve a political settlement.

In Syria, years of deference to authoritarian rule, repression and subservience have contributed to an environment that is both conducive to, and tolerant of torture. During the conflict some physicians will have been, perhaps unwittingly, drawn into ambiguous and sometimes compromising situations during the management of patients who have been ill-treated and tortured. Pressure and coercion may have been brought on individuals and their families to cooperate with the authorities. Some physicians holding certain psychosocial characteristics and underlying cultural and political influences, typically in the military, have actively participated in torture. Previous well-known instances where this has happened have occurred in Chile (Harvard, 1986) and more recently in the United States-led "War on Terror"(Crosby & Benavidez, 2018).

The hideous and undeniable proof of torture in Syrian hospitals has been widely documented (galicia24horas, 2015). A report of the United Nations Human Rights Council from early in the conflict notes "…collusion between military hospitals and various security agencies in the use of torture…obstruction of medical care… Doctors were ordered to keep victims alive so that they could be interrogated further" (United Nations, 2013). One military doctor photographed "a hip-high pile of corpses in the inner courtyard near the mortuary… dozens of meters long and two or three layers high" (Reuter & Scheuermann, 2014). False death certificates have been issued (United Nations, 2016). A man who sought to retrieve his brother's body at another military hospital in Harasta, witnesses, "The dead were lying on top of each other in eight or nine layers…in the basement, in the courtyard, in the hallways, everywhere" (Reuter and Scheuermann, 2014). Other allegations detailing unnecessary surgical procedures at military hospitals including the aggravation of pre-existing injuries and beatings during ward rounds by "security" forces; one of whom used an iron bar to smash patients' skulls on their hospital beds (Loveluck & Zakaria, 2017).

Precedents exist regarding the prosecution of medical personnel involved in torture; following the end of the Second World War, the "Doctors' Trail" took place in Nuremburg. Twenty doctors, mostly from the military, were convicted of war crimes and crimes against humanity, including the President of the German Red Cross (Mitscherlich & Mielke, 1949). More recently, professional associations have

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intervened to sanction practitioners; in Chile (Harvard, 1986) two doctors were struck off and in Greece (Amnesty International, 1977) a doctor was sentenced to a seven-year prison term. Following collusion between the American Psychological Association and the CIA in the War on Terror, three top officials "resigned" or "retired" (Ackerman, 2015).

The World Psychiatric Association has taken a stand by issuing a position statement on the participation of psychiatrists in the interrogation of detainees that stipulates that psychiatrists should "not participate in, or otherwise facilitate the commission of torture of any person under any circumstance" (Pérez-Sales et al., 2018). In addition, individuals who witness torture and ill-treatment have a duty to report it to "person or persons in a position to take corrective action." The American Psychological Association has similarly issued a statement regarding torture (American Psychological Association, 2009). In Syria, international laws and declarations applicable in armed conflict outlawing torture, including the Tokyo Declaration on medical involvement in torture, (World Medical Association, 1975) have failed to prevent war crimes, and probable participation in crimes against humanity by physicians (United Nations, 2016). None of the doctors implicated in torture are likely to be brought to justice by Syrian national authorities. In addition, current supranational structures are insufficiently robust to intercede, as has been previously recommended (Rubenstein & Bittle, 2010).

The medical profession needs a mechanism to investigate and take action against doctors who violate universal medical ethics. Enforcing action against torture requires a body that is independent of the participation of National Medical Councils. Complicity and even collusion between the national governments and medical bodies, for instance during the War on Terror, illustrates how difficult it is to rely on individual professional associations to remain impartial (Crosby & Benavidez, 2018). There equally needs to be a balance between exposing the, at times, heinous crimes of some doctors and the right to a fair trial which must be unquestionable.

Syria is far from being the first country where some medical personnel have transgressed universal ethical codes. What is important is that lessons are learned regarding the international failure of the current system to investigate, call to account and sanction those doctors who are proven to have participated in torture.

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Psychological torture

Nimisha Patel*

Dear Editor,

I read with great interest your latest thematic issue focused on sleep deprivation, described in the editorial as a method of psychological torture. During the last couple of years, I have noticed the concept of psychological torture appearing more frequently in the Torture Journal and most recently also in a global consultation issued by the UN Special Rapporteur on Torture to gather information for his next report on the same topic.

Reflecting on my nearly 30 years of experience as a clinical psychologist providing rehabilitation support to torture survivors and documenting torture, I am compelled to express my concern and increasing alarm at the use and promotion of the concept of "psychological torture." My concerns are for two reasons.

First, it seems that the drafters of the UN Convention against Torture (United Nations, 1984) demonstrated insight and foresight in focusing the international definition of torture on the severe physical and psychological *pain and suffering* experienced by survivors rather than on the nature of the different acts that can inflict such suffering. This approach achieved three crucial objectives: (a) It placed the survivor and their experience of what they endured at the centre of understanding of what is torture; (b) it explicitly acknowledged the severity of their pain and suffering; and

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(c) it provided longevity to the definition of torture in a world where methods of torture frequently change, multiply, mutate and evolve, while recognising that whatever those methods, or however they are named or euphemistically described or defended by states, one of the key elements in defining torture is the severe physical and psychological impact on survivors.

Health professionals working with torture survivors have spent the last 35 years trying to persuade judges and other decision-makers to recognise and give effect to this important statement and it seems that collectively in our field, we are increasingly successful achieving consideration of both physical and psychological pain and suffering in their decision-making. I think we all agree that there is still a long way to go but it seems we are heading in the right direction. However, the promotion of the concept of psychological torture both directs gaze to the question of which method is torture (and which is not) – methods which are ever-changing and defended by perpetrators for their own gains; and it shifts the focus away from the *impact* on survivors and their families. It thereby affirms, however unintentionally, the views of conservative judges and political and other decision-makers in their historic focus on the act over the impact. An important and dangerous consequence is that whilst isolated "wins" in debates in specific contexts may be seen as "victories," the global impact of such a shift in focus would be detrimental for survivors in obtaining justice or other legal recognition of the severity of the ill-treatment to which they have been exposed and appropriate and quality support, and rehabilitation to rebuild their lives.

Second, one of the greatest achievements of health professionals working against torture is the globally recognised Istanbul Protocol (United Nations, 2004), which provides an inter-disciplinary manual and standards for the effective documentation and investigation of torture. The entire premise of the Istanbul Protocol is that torture can only be effectively documented if lawyers, doctors and mental health professionals work together; and if forensic medical examinations always evaluate physical and psychological signs of torture, regardless of the type of allegations that are being evaluated. Despite the clarity provided by the Istanbul Protocol, many states still document and investigate allegations of beatings, executions or use of stress positions, for example, by exclusively examining physical symptoms—and not engage or heed mental health/psychological expertise at all. Unfortunately, conceptualising or defining certain practices as psychological torture opens up questions of how to categorise certain acts or methods, rather than focusing on the impact (of multiple methods often used simultaneously) as indicated in the international definition of torture; and it risks reinforcing an approach of binary categorisation (physical *or* psychological) which contradicts international consensus and best practice established over decades, as contained within the Istanbul Protocol.

The authors contributing to the latest issue of Torture Journal identify a very important problem – that psychological aspects of torture are poorly understood and under-recognised by decision-makers. If we are to contribute to improving this situation, we need to focus our efforts on meticulously assessing, documenting and explaining the psychological impact of all types of torture practices on survivors and their families, and their variations in each specific individual and family and their specific context. This can help reinforce the global definition of

torture and our hard-earned consensus on best practices in documenting and investigating torture, to ensure justice and reparation for survivors and their families.

References

United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984

United Nations Office of the High Commissioner for Human Rights. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ('Istanbul Protocol'), HR/P/PT/8/Rev.1./2004

CORRIGENDUM

Corrigendum to: Pérez-Sales, P. (2019). The 6/24 rule: A review and proposal for an international standard of a minimum of six hours of continuous sleep in detention settings. Torture Journal, 29(2), 1-10. https://doi.org/10.7146/torture.v29i2.116321. It is stated that in Sadretnidov v. Russia the "European Court of Human Rights found a violation of Article 3 of the Convention as the applicant had only six hours of sleep per night" (p. 6). It should instead say that the "European Court of Human Rights, despite no violation being found in that case, found that a minimum of six hours of sleep per night was required before Article 3 of the Convention was breached."

The above error has been corrected in the online version of the Journal and will be corrected in the printed version.

https://doi.org/10.7146/torture.v29i3.118024

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