

Beyond statistics – sharing, learning and developing good practice in the care of victims of torture

Edited by Elise Bittenbinder



**BAfF, Bundesweite Arbeitsgemeinschaft der Psychosozialen Zentren für
Flüchtlinge und Folteropfer, the German Association of Psychosocial Centres
for Refugees and Victims of Torture**

Berlin 2012



"Beyond statistics – sharing, learning and developing good practice in the care of victims of torture" has been compiled by BAfF, the German Association of Psychosocial Centres for Refugees and Victims of Torture.

BAfF, Bundesweite Arbeitsgemeinschaft der Psychosozialen Zentren für Flüchtlinge und Folteropfer e.V.

Paulsenstr. 55/56, 12163 Berlin, Germany

info@baff-zentren.org, www.baff-zentren.org, www.european-network.org

Tel: 030 31012463, Fax: 030 324 8575

Project partners:

Equator Foundation,

Nienoord 5, 1112 XE Diemen, The Netherlands

info@equatorfoundation.nl; www.equatorfoundation.nl

Telephone: +31 20 840 7676, Fax: +31 20 625 3589

ICAR-Foundation, Medical Rehabilitation Centre for Torture Victims

70 Bld. Unirii, Bl J5, 030836 Bucharest, Romania,

icar@icarfoundation.ro; www.icarfoundation.ro

Telephone: +40 21 3212221, Fax: +40 21 3275474,

Primo Levi Association

107, avenue Parmentier, 75011 Paris, France;

primolevi@primolevi.org; www.primolevi.org

Telephone: +33 1 43 14 88 50; Fax: +33 1 43 14 08 28;

URVT, Unit for the Rehabilitation of Victims of Torture – Future Worlds Centre

5 Promitheos St., Office 4, 1065 Lefkosia, Cyprus,

www.urvt.org,

Telephone: +357 22873820, Fax: +357 22873821,

Mobile: +357 99092677, +90 5338700798

XENION – Psychosoziale Hilfen für politisch Verfolgte e.V.

Paulsenstr. 55-56, 12163 Berlin, Germany

info@xenion.org; www.xenion.org

Telephone: +49 30 323 2933, Fax: +49 30 324 8575,

ZEBRA, Interkulturelles Beratungs- und Therapiezentrum

Schönaugürtel 29, A-8010 Graz, Austria,

www.zebra.or.at

Telephone: +43 316 8356300; Fax: +43 316 83563050

Text and language editors: Lisa Breitschuh and Michael Lawton

Cover picture: "father and daughter " by a Sudanese refugee girl

Publication: Von Loeper Verlag, Karlsruhe

ISBN

This book is published with the support of the European Refugee Fund of the European Union and is the result of the project "Developing European standards of documentation, assessment, training, prevention and lobbying in the work with most vulnerable refugee groups (victims of torture and human rights violations) in order to evaluate and facilitate good practice." This project was funded by:

The European Refugee Fund of the European Commission



Contents

- 1. Introduction**
 - 1.1. Background.....8
 - 1.2. Objectives and working process.....10
 - 1.3. The project partners11
 - 1.4. This publication and its contribution to networking11

- 2. Methodology**
 - 2.1 Overall process.....13
 - 2.2 Research methodology.....14
 - 2.3 Self-evaluation.....17
 - 2.4 Outcome mapping and external evaluation.....18
 - 2.5 Networking and dissemination: bi-national meetings19

- 3 Inventory of Working and Treatment Methods offered by the centres**
 - 3.1 Introduction to the Inventory.....22
 - 3.2 Structure of the Inventory.....22
 - 3.3 Results
 - 3.3.1 Methods used by the centres.....23
 - 3.3.2 Objectives and indicators of achievement.....25
 - 3.3.3 Indicators.....26
 - 3.3.4 Summary of SWOT analysis.....27
 - 3.4 Conclusions.....32

- 4 Framework for Quality Assessment**
 - 4.1 Introduction to the Framework.....35
 - 4.2 Structure of the Framework.....38
 - 4.3 Evaluation of the Framework.....52

- 5 Practice examples**
 - 5.1 Equator Foundation.....55
 - 5.2 ICAR Foundation.....57
 - 5.3 Primo Levi Association.....60
 - 5.4 Unit for the Rehabilitation of Victims of Torture.....64
 - 5.5 XENION.....66
 - 5.6 ZEBRA.....69

| | |
|--|-----------|
| 6 External evaluation | 74 |
| 7 Conclusions | |
| 7.1 Key issues and challenges..... | 77 |
| 7.2 Bi-national meetings..... | 80 |
| 7.3 Staff care/staff protection..... | 80 |
| 7.4 Integration or socio-cultural (re-)affiliations?..... | 86 |
| 7.5 Discrepancy between individual conflict analysis and institutional quality assessment | 88 |
| 7.6 Directions for future research..... | 89 |
| 8 References..... | 91 |
| Appendices | |
| Appendix 1: Description of the core centres and information on bi-national partners..... | 93 |
| Appendix 2: Framework for external evaluation and anticipated outcomes..... | 107 |

We want to dedicate this publication, as we did the last, to the survivors of torture: our clients, who so often amaze us with their extraordinary resilience. They trust us with their stories, and privilege us with their trust. We have learnt much from them about the strength of the human spirit.

The BAfF (German Association of Psychosocial Centres for Refugees and Victims of Torture), as the coordinator of the project "Beyond statistics – sharing, learning and developing good practice in the care of victims of torture," would also like to thank everybody who has collaborated in developing and preparing this publication.

We would like to express our special appreciation to our associated researcher Marie Thompson for pulling all the detailed information together. She provided guidance in setting up the framework for the Inventory and was endlessly patient with the different procedures of all the partners. At the same time she forced us into precision and form, so that she could put all the material into a sensible frame, creating a rich overview from which we could draw conclusions.

We would also like to thank the team of the Primo Levi Association for their willingness to take the ideas developed during this project further and discuss them, so that Beatrice Patsalides Hofmann was able to draft the chapter on staff care.

Thanks also to Nimisha Patel for her discussions on outcome evaluation and whose expertise on professional and innovative research issues was greatly appreciated. Her input made a big difference to the final product.

Lisa Breitschuh provided valuable technical and language support and kept the communication between all of us going so that nothing got lost in translation.

Special thanks go to our partners, the five other participating European centres, whose teams have been prepared to critically analyse, document and reflect on their daily work with survivors of torture and have thereby played a key role in making this project possible. Special thanks to:

Sibel Agrali and Beatrice Patsalides Hofmann, Primo Levi Association, France

Uta Wedam and Doris Rummel, ZEBRA, Austria

Esther Schoonbeek, Pim Scholte and Dr. Marie Thompson, Equator Foundation, Netherlands

Dr. Camelia Doru and Prof. Dr. Erik Holst, ICAR Foundation, Romania

Dorothee Bruch and Dietrich Koch, XENION, Germany

Vicky Germanakou, Tonia Loizidou and Periklis Papaloucas, URVT, Cyprus

Thank you all for your professional commitment in being prepared to take the risk of joining us in this project for an inter-institutional self-evaluation. The insightful histories of your centres and your inspiring good practice examples are the heart of this publication.

All the participating organisations would like to express their appreciation to PD David Becker of the International Academy (INA) at the Free University of Berlin and Professor Brandon Hamber of the University of Ulster in Northern Ireland. Both of them provided expert guidance in setting up the framework for the quality assessment and evaluation and helped us to develop the specific methodology for this project.

And, finally, we would like to thank the readers of this publication, who, we hope, will ensure that our recommendations for the improvement of procedures regarding victims of torture in Europe are implemented.

Elise Bittenbinder,
Chairperson of BAfF,
Psychotherapist with XENION, Psycho-social centre for victims of torture in Berlin

1. Introduction

According to the United Nations High Commissioner for Refugees, 235,900 refugees registered asylum claims in the European Union in 2010 – the last year for which statistics are available. The evidence suggests that the figures went up by about 15 percent in 2011 as a result of the unrest in the Arab world. Many of those refugees will have found themselves in reception camps, some of which are bursting at the seams. Some will have succeeded in making their way further into the various countries of the EU, where they will have been distributed to different parts of the country, according to appropriate administrative directives. No country or county wants to find itself with more than its fair share of refugees. And every country or county wants to have fewer refugees this year than it did last. Anything else is seen as a failure of policy. But, in this book, we want to look beyond the statistics which are the main tool for considering the issue of refugees in the domestic politics of European nations. We want to show that behind the anonymous figures are people – many of them survivors of torture trying to start a new life after horrific experiences that have changed their lives and left them with scars that might never heal. Some of them need help and rehabilitation in order to be able to dare to trust in themselves and others again and to find a new sense in life. If we want data, it's not primarily to measure the level of "threat" which the numbers of refugees pose to our societies, but to help us provide better services for them. So the data we have collected for this project is descriptive and qualitative, rather than statistical, giving us a better evidence base to help us provide torture survivors with access to what is, after all, their right: the highest quality of care and rehabilitation.

1.1. Background

This publication is based on a project conducted by six European institutions working with survivors¹ of torture and human rights abuses, funded by **the Refugee Fund of the European Commission**. The project's aim was two-fold: firstly, it aimed to evaluate the institutions' working and treatment methods as well as their methods of staff care, and to develop guiding principles on the basis of that evaluation. Secondly, the project sought to disseminate the findings and the evaluation methods to similar institutions in other European countries and, beyond that, to **the European Network of Rehabilitation and Treatment Centres for Torture Survivors** to attain a wider impact.

Most European rehabilitation and treatment centres for torture survivors were established by health professionals committed to human rights. Between them, the centres have vast experience and knowledge about how to assess and manage the problems of torture survivors. The centres have coalesced into a vibrant professional network² and the network has become an important vehicle which the centres use to

¹ The term survivor and victim are used interchangeably throughout this publication, in recognition of the fact that victims have been subjected to a human rights violation, but also survived.

² See www.european-network.org

share knowledge and to collaborate on improving services to their clients. The network has helped them enhance and strengthen partnerships and cooperation between experts, establish common principles of good practice, and disseminate innovations. Its philosophy lies in defining common standards while respecting and fostering the diversity of its members and promoting an interdisciplinary approach.

However, one challenge for all centres has been how to foster such collaboration at the same time as carrying out their core task of providing services under intense resource constraints, in a highly complex socio-political context and under an increasingly harsh economic climate. Most of these centres offer their services outside the mainstream statutory healthcare provision, and, in the face of the constant financial constraints they face, any resources which are available are prioritised for direct care and treatment for torture survivors, and not for formal evaluation or research activities.

The European Refugee Fund of the European Commission has made it possible for the centres to address this situation by supporting this research project, so that the centres have been able to begin to define what they could do to improve and develop a meaningful approach to evaluation and to collect information on clients' progress. By supporting the dissemination of the project's results, the Fund has ensured that the project will have a sustainable effect.

This project was a continuation and expansion of an earlier project, in which five centres, coordinated by the BAfF, undertook to define good practice for documentation, assessment, training, prevention and lobbying in the work with the most vulnerable refugee groups – those who are victims of torture and human rights violations. The project was conducted between 2008 and 2010 and was remarkable in its approach: the participating centres jointly developed good practice guidance by critically evaluating their own work, and then developed guidance together by systematically reflecting on the results. This first project was pioneering for the European Network (as its first extensive, formal collaboration) as well as for all the institutions involved: they created an inter-country and inter-disciplinary exchange, developing and applying a particular method of self-evaluation and providing recommendations for the benefit of the wider community of European institutions working with torture survivors and refugees.

The current project, conducted between 2010 and 2011, built on and expanded the earlier project, by compiling an inventory of practice methods used by the participating institutions, and by examining methods of care and treatment, as well as approaches to staff care. Further, the project aims to disseminate the findings by initially introducing them to other European treatment centres (which were not participants in the project) and by reaching out to other institutions which are conducting related research in the field. Thus, one new feature of this project was that each of the core project partners established contact with another European institution for the care of victims of torture and introduced it to the method of self-evaluation during a bi-national meeting, guiding it towards the application of the method in its own centre. Another new aspect of the current project was a qualitative research study which was conducted to appraise the suitability and effectiveness of the self-evaluation method. By conducting and disseminating one qualitative method of applied research and its outcomes to the wider community of practitioners and researchers, the project aimed to promote practice-based evidence as a means of ensuring a high standard of care for torture survivors in Europe.

1.2. Objectives and working process

Over the last three decades, vulnerable refugees, including survivors of torture, have been offered rehabilitation, treatment and care in psychosocial and medical treatment centres all over Europe. These centres adopt a holistic approach, offering medical and psychological care, legal advice and social assistance to torture survivors; they train health personnel in order to improve the quality of treatment and rehabilitation, and organising structures for mentoring and voluntary work to support their clients' integration and affiliations into a new life. The centres are mostly organised as independent, non-governmental organisations (NGOs) drawing on a very broad range of working methods, extensive experience and varied knowledge.

Unfortunately, their precarious financial situation as NGOs is exacerbated by insufficient (or no) public funding – and this in an environment in which mainstream services for torture survivors are inadequate or simply do not exist. This adds enormous pressure on staff, whose work, which is anyway highly complex, emotionally difficult and demanding, has to be supplemented with onerous, daily tasks to help ensure the financial security of their services.

The ultimate aim of the project was to develop a common approach for working with victims of torture in a European context. An overarching objective of the project was to combine and draw on the array of expertise of the practitioners in the field by using a participatory research evaluation model. It was intended that such an approach would allow the participants to share their expertise, while using a qualitative research approach to collect and document the data in the form of both an Inventory of Working and Treatment Methods and a Framework for Quality Assessment, both of which would take into account the different contexts in which services were provided. As stated earlier, the development and dissemination of good practice in service provision for torture survivors were crucial aspects of this project. In addition, the project sought to generate interest among other European centres and service providers which would lead them to use self- and peer-evaluation as an effective tool for scrutinising and developing their care for survivors and for their own staff.

The detailed methodology of the project is presented in Section 2, but overall, the key stages of the project were as follows:

- Develop a framework to share experience and service-related data via joint working meetings with two staff members from each of the organisations involved in the project.
- Develop an Inventory of Working and Treatment Methods, which was to include methods of staff care.
- Develop and implement a Framework for Quality Assessment of qualitative data and good practice examples of client work.
- Establish a research framework for collecting data for the Inventory of Working and Treatment Methods in the partner centres.
- Hold two Team Days and a Study Day for each team in which they should use the method of self-evaluation to analyse and map working and treatment methods and staff care.
- Establish small working groups in each partner centre to provide data for the Inventory and to identify practice examples to be used for the Framework, with the guidance of the internal evaluator.

- Share and disseminate experience, methods and findings in bi-national meetings with organisations new to the method, and then bring all the information back to a core partner meeting for further discussion.
- Disseminate findings and learning points on improving data collection and research methods through presentations at the European Network.
- Conduct a final symposium for core partners to discuss data, good practice examples and the tools which have been developed, to reflect on the outcome of the overall process and reach conclusions, with the guidance of the external evaluator.
- Publish and disseminate findings.

1.3 The project core partners

The five European institutions which participated in the original project mentioned above continued their cooperation for this second project, and were joined by another treatment centre from Cyprus. The core partners were:

1. Equator (Amsterdam, Netherlands)
2. ICAR Foundation: Medical Rehabilitation Centre for Victims of Torture (Bucharest, Romania)
3. Primo Levi Association: Treatment and Support for Victims of Torture and Political Violence (Paris, France)
4. XENION: Psychosocial assistance for the politically persecuted (Berlin, Germany)
5. ZEBRA: Intercultural Centre for Counselling and Therapy (Graz, Austria)
6. Unit for the Rehabilitation of Victims of Torture (URVT), Cyprus Neuroscience and Technology Institute (CNTI) (Lefkosia, Cyprus)

The project, conducted between June 2010 and November 2011, was coordinated by the BAfF, the German Association of Psychosocial Centres for Refugees and Victims of Torture.

1.4 This publication and its contribution to networking

Everybody advocates collaboration and networking, and professionals in this field are no exception: they are acutely aware of the risk of being isolated, overwhelmed and unable to do everything that needs to be done to ensure quality practices. There is a shared sentiment, and a shared aspiration, that by working together, new ideas can be developed which will be better than any one centre or professional could produce alone. However, in reality, networking is more complicated, as professionals with skills, experience and conviction in their own approach want to maintain that approach. They want to maintain the particular nature of the diversity of services which has evolved in their own centres, developed in response to the needs of their clients and societal context. Nonetheless, we are convinced that by working together,

practitioners can develop guidelines for good practice which will allow them to work more effectively within their chosen framework – hence this publication.

But the question arises: how does networking function in a concrete way – in a step by step, work-in-progress approach where there is collective sharing of and reflection on working methods, as well as on the "networking process" as a whole?

This book seeks to de-mystify this process of professional networking and "working together." It demonstrates progress made and presents a conceptual framework, illustrating the consensus which was finally achieved, sometimes through a process which included controversy and intense debate.

We hope to show what networking may mean in real-life working conditions, in that it opens unexpected diversions and options. We share the practical framework in which this project proceeded, in terms of time, resources and financial commitments, and show that networking is an energy-intensive process of raising ever more questions. It includes the need for openness, discussion and negotiation in order to achieve a common approach which can move us further forward in our work.

Chapter 2 presents the methodology employed – a qualitative approach using a method of self-evaluation and outcome mapping together with all six partner organisations and their bi-national partners. Data was collected and reflected on, and the participants peer-evaluated each other's working and staff-care methods. The process was also intended as an innovative method of dissemination between the ten European centres involved as core or bi-national partners.

Chapter 3 focuses on one of the tools used in our methodology – the Inventory of Working and Treatment Methods. The outcome of this process of collecting data is summarised and a preliminary analysis presented in the form of a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats), which provides an overview of the key issues, including differences, emerging from this work.

In Chapter 4 we present the Framework for Quality Assessment we applied to our work. It illustrates this process with case examples which also highlight the variety of working methods used in the core partner centres and draw attention to key learning points.

Chapter 5 presents case studies in a more narrative form, each from one of the partners, to demonstrate how the Framework was applied to reflect on and self-evaluate the quality of the clinical work undertaken.

Chapter 6 presents the overall process of the external evaluation of our work in this project, from planning to implementation.

In keeping with our view that evaluation is not just about expected or final outcomes, but also about the process itself, the final Chapter 7 discusses not just the expected outcomes but also unexpected outcomes, closing with some conclusions and reflections on staff care, socio-cultural re-affiliation and on research designs for rehabilitation centres working with torture survivors.

2. Methodology

2.1 Overall process

The evaluation research process began with a meeting in Graz, Austria, in July 2010 with the six core partners, joined by the external and internal evaluators as well as the research coordinator. The meeting focussed on the specific methods and tools to be applied and agreed a time frame for the activities to be carried out in the individual centres.

In the following months during 2010, each participating institution (the core partners) held a Team Day in its centre in order to reflect with team members on its activities, and to assess those activities according to a set of indicators of achievement agreed by all partners. The tool used for this was the Framework for Quality Assessment (see Chapter 4). At a later stage, an additional Study Day was held in each centre where the project research coordinator completed the Inventory of Working and Treatment Methods which each team had prepared during its Team Day.

A conference held in Warsaw in January 2011 provided the partners with an opportunity to present and discuss their work in progress and to prepare the next steps. The Inventories of Working and Treatment Methods of each centre had been collated by the research coordinator and this was discussed. Additionally, the core partners contributed to a conference held by the Polish treatment unit, the International Humanitarian Initiative Foundation (IHIF), which invited Polish government officials to discuss the situation of refugees in Poland.

Following this conference, each partner held a second Team Day, this time focussing on the methods of staff care in place or deemed desirable in each centre. The results were added to the Inventory of Working and Treatment Methods.

At the annual conference of the European Network of Rehabilitation and Treatment Centres for Torture Survivors in Amsterdam in May 2011, the partners presented and discussed their work in progress with the Network members.

In the following months in 2011, bi-national meetings were held by each core partner. This involved members of each partner identifying another centre in Europe working with torture survivors which had no previous involvement with the project.

The following "bi-national partners" agreed to participate:

- 1 Freedom from Torture, Medical Foundation for the care of victims of torture, London, England (bi-national partner to Equator Foundation, Netherlands)
- 2 CIR, Consiglio Italiano Per I Rifugiati, Rome, Italy (bi-national partner to ICAR Foundation, Romania)
- 3 Unit for the Rehabilitation of Victims of Torture (URVT), Cyprus Neuroscience and Technology Institute (CNTI), Lefkosia, Cyprus (bi-national partner to Primo Levi Association, France)
- 4 International Humanitarian Initiative Foundation, Warsaw, Poland (bi-national partner to XENION/BAfF, Germany)

5 The Rehabilitation Services for Torture Survivors, Oulu Deaconess Institute; Finland (bi-national partner to ZEBRA, Austria)

The Cypriot organisation URVT, the only one of the core partners which had not been involved in the predecessor project, did not feel itself ready to lead such a bi-national partnership, and chose to act as a "recipient" in this part of the project.

Meetings were held between each core participant and its bi-national partner, the method of self-evaluation was introduced and data collected and discussed.

Finally, a symposium held in Nicosia, Cyprus, in September 2011 provided a platform for final discussion of the findings including information from the bi-national meetings.

As in Warsaw, the occasion was used for a small conference organised by the Unit for the Rehabilitation of Victims of Torture (URVT), to which the core partners contributed. The URVT invited Cypriot government officials to whom it presented the project findings, in order to emphasise the importance of the European context in working with refugees. The URVT hoped to convince their government that Cyprus falls behind European standards on many issues, partly because of the failure of the government to offer financial support to the organisation, which was under threat of closure.

Throughout the project, members of the participating centres introduced the project, its methods and its emerging findings to a wider community of professionals and practitioners working with torture survivors and refugees across Europe. The project's method and findings were presented in lectures, workshops or seminars held at universities, academic institutes and conferences, in training events conducted with colleagues in the health professions, in cooperation with medical or psychotherapeutic associations, and in briefings or lobby meetings with local, national and international officials or politicians (for some examples, see Chapter 2.5). As a final step, the results of all these activities and discussions were brought together in the form of this publication.

2.2 Research methodology

In deciding our approach to this research process we considered the complex and controversial area of the evaluation of rehabilitation and treatment services for torture survivors. Despite the fact that the torture rehabilitation field is now in its third decade (which most would agree is still relatively early in a field), little outcome research has been completed. Studies of the efficacy of different treatment approaches and of the indicators to measure successful outcomes are few and all have limitations³. The tasks and complexities involved in conducting meaningful evaluation of torture rehabilitation services are often obscured by critics unfamiliar with the breadth of what is involved in "clinical," interdisciplinary work, and the conditions in which such work proceeds, with torture survivors who may also suffer many other difficulties as a result of being asylum seekers or refugees. Jarason et al. (2007) suggest that the main difficulties related to limited outcome research in this field are:

³ Jaranson, J. M., & Quiroga, J. (2011). Evaluating the services of torture rehabilitation programme: History and recommendations. *Journal of Rehabilitation of Torture Victims and Prevention of Torture*, 21 (2).

- Evidence-based treatments exist for symptom clusters but not for complex problems;
- Rehabilitation of torture survivors is not equivalent to treating PTSD or depression;
- Rehabilitation centres for torture survivors offer multi-modal approaches to improve the lives of survivors in many ways; and
- Clinicians avoid brief treatments, recognising the enormity of clients' experience and their consequences⁴.

This project sought to use detailed peer-evaluation to explore the complexity of the methods used in the treatment or rehabilitation of torture survivors, and to attend to the context in which this work – and the concomitant data collection – takes place. This project, like the preceding project on which it builds, arose precisely from a recognition of the increasing need to evaluate work with torture survivors in a way which takes into account all the complexities of clinical work as well as the practical, methodological and ethical challenges of research with a very vulnerable population from diverse cultures, language backgrounds etc.

In particular, the project sought to contribute to practice-based evidence lacking in this field. Practice-based evidence is distinguished from empirical evidence by its emphasis on including in its findings the experience of those working in the field. In our case, the contribution of all partners was able to bring to the project an enormous wealth of experience from many years of work with torture survivors; and during this project, the partners used a rigorous, systematic method of self- and peer evaluation to articulate what they considered to be "good practice," key learning points and standards on which all services for torture survivors could be based.

The process of agreeing a methodology between partners involves intensive discussion on how best to identify common principles while capturing differences amongst partners and their work. Furthermore, integrating systematic, rigorous research with the practical conditions of working in the field presented another challenge, particularly since the participants all worked in diverse settings with different socio-cultural and political contexts. In this research project we were both the researchers and the researched: in a systemic way, we included loops of reflection which were then developed further by external evaluation and a follow-up procedure with the external evaluator, which enriched the process of reflection and knowledge building.

During these discussions, we used what we have described as an **Inventory of Working and Treatment Methods**, a tool for self-evaluation which became a tool for sharing, reflecting, documenting and peer evaluating the treatment and working methods in use by partner centres. This was then subjected to a further qualitative analysis (SWOT analysis) of these findings.

SWOT analysis is a technique originally devised by Albert Humphrey for use by businesses and marketers to analyse factors which influence a company either favourably or unfavourably towards achieving a certain objective. These factors are inherent **S**trengths and **W**eaknesses, as well as externally mediated **O**pportunities and **T**hreats. SWOT analysis thus offers a way of presenting data about an organisation in a structured way which enables an overall perspective (see Figure 1). In this project SWOT analysis was applied to consider internal as well as external factors which either facilitate or impede the care and treatment process, creating a

⁴ Jarason & Quiroga (2011), p.102.

more differentiated and more realistic representation of the practical conditions of such work. Some examples of the facilitating and impeding factors identified during the current project are described in section 3.3.4⁵.

| | Beneficial to the objective | Harmful to the objective |
|------------------------|------------------------------------|---------------------------------|
| Internal origin | Strengths | Weaknesses |
| External origin | Opportunities | Threats |

Fig.1 Schematic structure of SWOT analysis

The **Framework for Quality Assessment** was another key research tool used in this project (see Chapter 4 for a detailed description) and was the basis for the presentation of three exemplar cases for each centre. Briefly, each case was analysed in detail as part of the quality assessment framework, using the model of conflict analysis. This model examines conflicts on four levels: those of the subject, his or her cultural affiliation, political participation and political economy. The initial idea of specifying clear-cut objectives for the treatment of each of these cases was modified to fit the reality of work in the treatment centres so that the cases are now examined in terms of desired outcomes, unexpected and expected outcomes. Assessing the treatment centres' work on the basis of individual conflict analysis is a hallmark of the qualitative aspect of the research since it better reflects the treatment centres' holistic approach to each individual client.

Some discussion pertained to the question of whether the inventoried methods should be measured against indicators of "achievement," and if so, which indicators would be best suited. In a field of work so consistently influenced by external factors it seemed inappropriate to assess the fulfilment of strict internal objectives. Instead, the partners opted for a set of "softer" indicators which reflect the values underlying the work with survivors (e.g. "Did the chosen treatment contribute to increased participation of the client?"). They were included in the Framework for Quality Assessment as a means to assess the appropriateness of the treatment process implemented in each of the three exemplary cases (see Chapter 4). The indicators were updated again at the conference in Warsaw after the Inventories and Frameworks had already been worked on by the centres – an illustration of the ongoing and creative self-reflection the participating institutions underwent in this project.

⁵ The complete SWOT analysis, integrated into the documentation of the inventory of each centre, can be viewed under <http://www.BAfF-zentren.org/index.php/aktivitaeten-und-projekte/eff-projekt-2.html>

2.3 Self-evaluation

As described in detail in the publication of the precursor project's results⁶, self-evaluation is a method which allows for a comparison of institutions with very different characters and needs. These arise from the diversity found in the conditions of their work, including the political context they work in, national law, the nature of their client population, and the financial constraints they work under. A comparison is possible despite this diversity by way of feedback loops between the institutions: firstly, each centre turns "inwards" to closely examine its own realities and context; then it turns "outwards" to consider its results together with those of the other centres.

More usually applied in the context of international development work⁷, self-evaluation is an assessment tool which is used to diagnose institutional problems, as a first step in the formulation of improved interventions. At the core of the self-evaluation method is the active participation of those who are being evaluated. It has the potential to benefit the staff of the treatment centres by developing their capacity for evaluative thinking, on top of yielding insights which can be utilised to improve working conditions and outcomes.

To ensure a common approach across the different institutions, the following principles guided the evaluation process:

- **Evaluation should ensure the participation of those being evaluated.** To be useful, evaluation needs to produce relevant, action-oriented findings. This is fostered by sustained involvement and ownership by the members of the organisation throughout the process.
- **Evaluation processes should develop capacity in evaluative thinking and imply practical empowerment.** Whether those involved are managers, programme staff or project partners, evaluation should increase their capacities and their comfort with evaluation. Exclusive reliance on external expertise can limit an organisation's ability to be clear and specific about its goals and to learn and apply lessons. Specific strategies can be built into evaluations that are explicitly aimed at fostering these organisational characteristics.
- **Evaluative thinking adds value from the outset of a project or programme.** Evaluative thinking can make a project or programme more effective by helping to clarify the results to be achieved, the strategies that will contribute to their achievement, and the milestones that will demonstrate progress. This is true from design through to implementation.
- **Evaluation should meet standards for ethical research and evaluation quality.** In order to ensure the validity of the evaluation findings, accepted social science research methods and procedures should be followed. The quality of evaluation is assessed against four internationally accepted standards: utility, feasibility, accuracy, and propriety.
- **The decision to evaluate should be strategic and not routine.** Evaluation is designed to lead to action and can contribute to decision-making and the

⁶ Bittenbinder, E. (Ed.) (2010). *Good Practice in the Care of Victims of Torture*. Karlsruhe: Loeper.

⁷ See Lusthaus, C., Anderson, G., & Adrien, M. (1997). Organisational Self-Evaluation: An Emerging Frontier for Organisational Self-improvement, Knowledge and Policy. *The International Journal of Knowledge Transfer and Utilization* 10 (1).

formulation of strategy at all levels. To ensure evaluation provides useful findings, the centres must be selective in determining what issues, projects and programmes are to be assessed and at what time.

- **Evaluation should be an asset for those being evaluated.** Evaluation can impose a considerable time and resource burden on team members and their participation should not be taken for granted. They should benefit from the process and should have control over the evaluation agenda when they are the intended users.

Following these principles for self-evaluation, two Team Days and a Study Day were held in each centre. Their format was developed jointly by the partner institutions at the initial project meeting. During the **two Team Days**, the teams in each centre evaluated their own methods for delivering care and treatment, as well as their methods of staff care (Chapter 7.3.). The results were then discussed with the other centres and fed back again into the individual centres' teams. The aim was – as well as reflecting systematically on the parameters of the work done by the centres with a view to improving the quality of care – to prepare the input for both the Inventory of Working and Treatment Methods and for the Framework for Quality Assessment. For the latter, each team presented three client cases analysed according to Conflict Analysis (for more details of this method please refer to Chapter 4) and was guided by and received feedback from the internal evaluator. During the **Study Day**, for which the project researcher visited each centre, the Inventory of Working and Treatment Methods was compiled. Thus, the centres developed a permanent discussion and reflecting process, both nationally and internationally, in which, by discussing their differences, they began to understand their commonalities. Ongoing documentation of the evaluation process allowed them to review and verify their insights as well as the process itself.

2.4 Outcome Mapping and External Evaluation

A key aspect of the methodology adopted is described as "Outcome Mapping," which was used to "map," analyse and evaluate outcomes of Team and Study Days, as well as to evaluate the overall progress of the project.

Outcome Mapping is a method developed⁸ to capture and comprehend the different forms of interaction between professionals and the organisations they work in. It was originally designed and tested by the International Development Research Centre of Canada, one of the leading organisations in the field of evaluating development work.

The method is considered suitable for self-evaluation research such as in this project which deals essentially with people and their interactions with each other, their environment and the society they live in. The innovative aspect of this method is the re-orientation, away from a focus on assessing the final product or result of a project, towards a focus on changes in behaviour and in relationships, as well as changes in the methods employed by the people and organisations that are directly involved in a project.

⁸ Earl, S., Carden, F., & Smutylo, T. (2001). *Outcome Mapping: The Challenges of Assessing Development Impacts*. International Development Research Centre, Ottawa, Canada; See also Bittenbinder, E. (2010). P.18

In summary, Outcome Mapping focuses on capturing deliverables based on the vision of the human, social and societal transformation and changes which can be influenced by the project. Thus, the method focuses on assessing results such as changes in (working) relationships within the organisation, changes in activities, and changes in (working) relationships with partners or other actors who can actually be influenced through the work which we had been carrying out in the project. This focus was adopted throughout the project: from planning and implementation to completion. For example, the Team Days and Study Day involved a detailed analysis of conflict situations and focussed on aims for interventions, activities etc. Moreover, attention was paid to the development and documentation of desired and expected "outcomes." A series of questions was used to guide the discussion during and after analysis. It contained factors which were seen to influence the process as well as desired or expected changes (see Chapter 6 on Evaluation and Outcome Mapping). Elements of outcome mapping were also used as a method of analysing conflicts and working and treatment methods. They are found in the Framework for Quality Assessment and form the basis for the presentation of practice examples.

To ensure the project met its wider goals, an external evaluation of the project was undertaken which also used Outcome Mapping methodology as its basis. For a description of the process and findings of the external evaluation see Chapter 6. An important feature of this evaluation was that the external evaluator did not only evaluate the final results of the project, but also accompanied the process as an observer, being present at three meetings (kick-off meeting, interim meeting and final meeting) and providing feedback to the partners on their implementation of the project and on progress towards their self-defined aims.

2.5 Networking and dissemination: bi-national meetings

In the predecessor project, the core partners had developed good working relations and had benefited from their common learning process. The current project arose from a commitment to build on this learning process by applying a method of dissemination which would have a participatory style and contribute to the work of the European Network of Rehabilitation and Treatment Centres for Torture Survivors as a whole. The process of dissemination took many forms throughout the project and was one of its key features, involving the sharing of experience with peers, and self- and peer evaluation.

An important aim was to foster and respect diversity amongst colleagues, whilst working towards common guiding principles. The project therefore planned to use the newly developed method of (self-) evaluation and of agreeing good practice. To this end, it was agreed that each partner would identify and form a collaboration with a specialised treatment or rehabilitation centre for torture survivors in another country and engage in a process of mutual exchange and sharing of experience by visiting its team. The method used for the exchange was a form of the self-evaluation which the core partners had used in their own work in the project so far, and which now would include the experience of the new partner centre as well. The principles of the

concept of self-evaluation were also made accessible to them, as were the conclusions and recommendations we summarised in the Bucharest Protocol⁹.

This method was sufficiently flexible to allow for the specific needs of the bi-national partner organisations, and it was intended that such an approach would provide the option for the bi-national partner of participating in the ongoing learning process. In practice, the process of finding a bi-national partner for each core partner varied for different reasons. For instance, the URVT in Cyprus decided that it did not feel ready to make a "dissemination exchange" to another centre, and preferred to be itself the object of such a visit (by the Primo Levi Association). Some project core partners chose to approach new services in order to support their efforts to set up a centre (for example, XENION from Germany visited IHIP in Poland). Others were approached by members of the European Network because they had expressed an interest in taking advantage of this opportunity to learn of the method and results as a tool for their own evaluation or research (for example, The Rehabilitation Services for Torture Survivors in Oulu, Finland, visited by ZEBRA from Austria).

Details of the core participants and their bi-national partnerships can be found in Appendix 1; a summary follows:

1. The Equator Foundation met key staff members of Freedom from Torture/Medical Foundation in London who provided an overview of the Medical Foundation's activities and the theory behind them. Within the framework of these individual meetings, members of the Equator Foundation introduced the previous and current projects, and discussed some aspects of the potential and limitations of the method.
2. The ICAR Foundation met Consiglio Italiano per i Refugiati in Rome, where they discussed differences and parallels between treatment centres in Italy and Romania, regarding their political contexts and other more specific aspects. Members of the ICAR Foundation reported on their experiences from the European project and led an exercise to demonstrate the method of conflict analysis.
3. XENION travelled to Warsaw where they met their partners in the newly founded International Humanitarian Initiative Foundation. They outlined the theoretical concepts utilised in the projects and also provided a practical exercise: a client case was analysed and a realistic intervention plan (which took into account the limited resources available) was developed and discussed – bearing in mind the good practice experience and recommendations provided by the project. In addition, meetings were organised with a local official and with health care personnel in facilities for refugees and asylum seekers. Members of XENION also provided practical guidance on interviews with clients and on report writing for courts and other legal purposes.
4. Members of ZEBRA liaised with Oulu Deaconess Institute/The Rehabilitation Services for Torture Survivors in Oulu, Finland. The organisations introduced themselves to each other; and the methods of the project were presented by ZEBRA with the help of a practical exercise and then discussed. In addition, the two centres spoke about a potential future extension of the project involving other European centres.

⁹ See Bittenbinder, E. (Ed.) (2010) p.103.

5. Members of the Primo Levi Association travelled to Nicosia, Cyprus, where they met members of URVT who had already been introduced to the method of self-evaluation and had become project partners. In this case, the frame of the bi-national meeting was used for in-depth discussion of current issues such as financial difficulties and for the discussion of treatment-specific questions. At the request of their Cypriot partners, the Primo Levi Association shared some of their experience of using psychoanalysis. Furthermore, the importance of combining political and clinical work was discussed.

In addition to the bi-national meetings, all partners took other steps to disseminate the project method and its emerging findings to colleagues in the field and in the wider health professional and academic communities. Partners used existing links or created new links with universities, training institutes and professional networks in their countries to present the project, its aim and its findings to professionals working directly or indirectly with survivors of torture. Self-evaluation as a tool for organisations working in international development was incorporated into seminars and lectures held by members of the partner institutions, for example, at the universities of Graz, Klagenfurt, Ulster, Amsterdam and Berlin.

The project was also presented in training events conducted with colleagues in the German Human Rights Institute; during a seminar for physicians in Chisinau, Moldova; at Reseda, the French network of treatment and support centres of victims of torture in exile; to the International Federation of Medical Students Association in Copenhagen, Denmark; to the Association of Family Physicians of the Romanian Medical College; to the Italian Network for Asylum Seekers and VOT's. It was also presented at conferences such as the 12th European Conference on Traumatic Stress in Vienna; a national conference conducted by the research and training unit for trauma at the Hospital of Saint-Denis, Paris; and at a Conference for Survivors of Torture in Cyprus. The findings were also introduced during briefings and meetings with officials at the annual meeting of the UNVFVT in Geneva, at meetings with the National Agency for the Prevention of Torture, the Federal Office for Migration and Refugees in Germany, the Integration department in Graz, Austria, the Coordinator of Asylum Service of the Ministry of Interior, Cyprus, and representatives of UNHCR, Cyprus.¹⁰

¹⁰ To see the complete list of these activities, please visit the website of the BAfF → Aktivitäten und Projekte → Promotion and Dissemination of Good Practice:
<http://www.BAfF-zentren.org/index.php/aktivitaeten-und-projekte/eff-projekt-2.html>

3. Inventory of Working and Treatment Methods offered by the centres

3.1. Introduction to the Inventory

The primary aim of the Inventory was to gain an overview of the treatment methods and staff care methods used by the six core participating organisations. Initially the Inventory was intended as a simple tool to list the methods (psychosocial, psychotherapeutic approaches, techniques, self-care etc.) used by the organisations. Through discussions in the planning stages and in the course of using the tool in practice it became evident that the Inventory could be a means not only to list the methods used, but also to highlight and explore internal strengths and weaknesses as well as external threats and barriers to the delivery of particular methods. The Inventory was adapted from a Logical Framework model, enabling centres to reflect on the rationale underlying their methods and the extent to which they were able to meet their objectives, and to make explicit the many aspects of their work which had become implicit over time.

Data collection involved each centre completing the detailed Inventory with respect to its own organisation. The project researcher visited each centre to oversee this process and to maintain consistency in approach¹¹. Once all six inventories were complete the researcher collated the data for two purposes. Firstly, a detailed Inventory pertaining to each centre was compiled, resulting in an extensive document capturing the characteristics of the methods used by each centre (see section 3.3.1 for more detail). This served as a tool for centres to document the many ways in which they were working to achieve their aims. Secondly, the Inventory data was used to tabulate and provide an overview of the methods used by all six participating organisations. The latter was intended to serve as a reference tool for others working in the field, academics and funding bodies. The summary table renders invisible the detail and evaluations captured in the individual inventories of each centre, but highlights the main methods used by six centres.

3.2. Structure of the Inventory

The Inventory comprised twelve sections. The first eight sections sought an outline of the methods offered and their underlying rationale. The last four sections invited the participating centre to qualitatively evaluate its approaches with respect to how it believed these methods to be effective in achieving its organisational aims.

Information was sought under the following headings:

1. Service type

¹¹ The description and analysis presented in this chapter are based on collated Inventories undertaken by Dr. Marie Thompson.

2. Method
3. Activity
4. Job title of person providing the method
5. Individual/group basis
6. Frequency and duration
7. Method used in isolation or in combination with other methods
8. Objectives
9. Indicators of achievement
10. Means of verification
11. Strengths and weaknesses
12. Opportunities and threats

3.3. Results

Unfortunately, it is not possible to include all the inventories of all the centres in their richness and details in a publication such as this one, though some examples from the inventories are provided to illustrate the findings¹². We summarise and draw some conclusions from the findings below.

3.3.1. Methods used by the centres

All centres provide assessment, psychological care, social work, legal and medico-legal counselling, advocacy and lobbying, and staff care. This confirms that clinical work (or "rehabilitation") in this context in practice means not only medical treatment, but includes a variety of different services and assumes a holistic approach. However, the ways in which centres deliver these services differ depending on the ethos of the centre, the resources and structure of the organisation, the nature of local contacts, and the political context and human rights or legal context in which the work is embedded. Thus, it is clear that the local or country variation in service methods, design and delivery has evolved in response to a complex set of contextual factors, and that these variations should be respected in any detailed consideration of what is needed, for whom and how best these services can be delivered. As such, each centre has developed its service methods in an organic way, reflecting on what was helpful and relevant to its client population and effective in contributing to some change for clients. The variability in service methods is not a shortcoming, but a strength to be reinforced, with each centre reflecting on what has helped the lives of its own clients to improve.

It is important to note here that the aim of this project was not to investigate treatment efficacy but the overall quality, including impact and effectiveness of the methods

¹² The detailed inventory of each partner centre can be viewed by visiting the BAfF website at 'Aktivitäten und Projekte' →Promotion and Dissemination of Good Practice:

<http://www.BAfF-zentren.org/index.php/aktivitaeten-und-projekte/eff-projekt-2.html>.

In addition, an illustrative inventory, though not comprehensive, can be found in the foldout at the back of this book, containing a selection of working and treatment methods from different centres.

used by centres – addressing the question "what helps bring about changes?" Key to this approach was the process of self-evaluation to map outcomes such as changes in (working) relationships within the centre, changes in activities, and changes in (working) relationships with partners/other actors. The detailed inventories and the practice examples provided (see Chapters 4 and 5) highlight how the service methods were seen to be effective.

One of the variations in practice which became apparent was the issue of who undertakes intake assessments. Our view is that intake procedures seem to correspond with the nature of management: for example, where a centre is managed by psychologists, intake assessment is conducted by a psychologist or psychotherapist. Centres which had a more medical focus are structured in such a way that a medical doctor or psychiatrist conducts the initial assessment. Those services which include a broad range of professional backgrounds report that intake assessments are conducted by professionals with a range of professional backgrounds.

All centres reported advocacy and lobbying as being a part of their role, but they conducted it in different ways and the findings reveal a variety in how centres define it. Some centres have a particularly strong focus on the task, addressing health or social issues at local, national and international level. Other centres accept invitations to speak publicly about the needs of their clients, others address the issue more within the field of academia, and yet others collaborate with asylum officials and governmental bodies or decision makers and stakeholders. Most centres also provide expertise to other persons and institutions working in the field.

Some centres have a strong legal and medico-legal focus and conduct much of this work internally. The majority out-source this work, though they take on the initial responsibility of assessing internally the need for such intervention. All centres conduct medico-legal reports relating to their clients.

While all centres deliver psychological treatment, the model of psychological intervention differs across the organisations. Stabilisation, supportive counselling, and pain management are methods used by all centres. Five of the six centres use psycho-education, four use trauma-focused therapy and two centres use a psychodynamic psychotherapy model. All centres use social work as a method of intervention and in all cases this work is conducted by a social worker internal to the organisation.

Five centres offer crisis intervention despite the fact that none of them had originally intended to do so. The nature of the presenting issues and challenges faced by this client group makes crises likely, and thus centres have adapted to accommodate this need. These five centres offer assistance in crisis by conducting a risk assessment and either managing that risk internally or referring to more appropriate institutions or agencies.

All the centres valued medical treatment, and were able to ensure that their clients received it where necessary. Medical methods included physical and psychiatric examination and/or treatment. The extent to which the centres offered such services reflects their structure. Two organisations are managed by medical doctors and these centres deliver medical intervention within their centre. Three organisations have a medical doctor to whom they can refer or whom they can invite for consultation. One cooperates with an external medical service.

Four of the centres provided training and education to a range of other professionals working with the client group. Those receiving training included interpreters, health

professionals, lawyers and police as well as other organisations and professionals working to address the needs of the client group.

Cultural integration is a term which refers to a wide-range of interventions, including a broader range of strategies than those of traditional social work, aimed at helping people who have moved into a new cultural environment to find their place there. Three centres offer cultural integration as defined in these terms. Methods include, among others, a mentor scheme (offered by one of the centres) where volunteers mentor clients with the purpose of helping them connect and integrate culturally within the host country; and groups aimed at assisting with language acquisition and adapting to the host culture (offered by one centre). During the course of the project the partners began to feel that the term "cultural integration" was too narrow and instead adopted the term "socio-cultural (re-)affiliation" (for further explanation see Chapter 7.3), although the Inventory was drawn up with the original definition.

Other therapies and methods offered by three centres included art therapy, music therapy, a support group for children, a running group, psychomotor therapy and body work. Physiotherapy is offered internally by two centres.

All centres noted that they recognised the importance of staff care (for more details see Chapter 7.2). All centres offer supervision and hold team meetings as part of their staff care methods. Five centres emphasised that they valued and attended to the professional and personal development of their staff, and four centres focussed on the working climate and staff benefits. Some centres have quite specific ways of offering staff care, for example, by offering art therapy and relaxation sessions for staff, or ensuring that staff have the chance to be involved in high-level decision making.

3.3.2 Objectives and indicators of achievement

Whilst the previous section outlined the ways in which the organisations work in terms of their working and staff care methods, the questions which remain include: Why do they work in this way? What were the organisations hoping to achieve by implementing a particular method?

Responses relevant to these questions are noted in the Inventories under the heading of objectives. Each method relates to a number of objectives and thus to include them all in this report is not possible and interested readers are referred to the Inventories available on the web¹³. By way of illustration however, a number of broad objectives for the methods employed by centres emerge, some of which are outlined here, in the order of priority as agreed in discussion with the core partners.

- Symptom reduction and/or acceptance of symptoms¹⁴.
- Clients are heard and psychologically contained
- Empowerment of clients
- Justice
- Validation of clients' human rights
- Safety for clients

¹³ <http://www.BAfF-zentren.org/index.php/aktivitaeten-und-projekte/eff-projekt-2.html>.

¹⁴ It is generally acknowledged that it may not always be possible to heal the psychological after-effects of torture.

- Stable immigration status
- Family reunification
- Facilitation of entitlements (social, legal)
- Cultural integration in the context of clients' own cultural identity
- Socio cultural (re-)affiliation: integration in the context of exile and own cultural identity
- Social integration
- Increased public, professional and political awareness of the rights and plight of the client group

3.3.3. Indicators

As part of the project methodology and process, each core partner organisation was encouraged to think about how it gauged whether or not the methods used were effective and contributed to change for clients. Responses are documented under the "Indicators of Achievement" section of the Inventory. A sample is given below.

Indicators of achievement, described by organisations, pertaining to daily social life and social activities include:

- Improved self-management of symptoms
- Client starts to work or study
- Client seeks support to help manage symptoms before symptoms deteriorate too far
- Client manages boundaries of therapy (e.g. attends appointments on time)
- Manages daily life
- Takes care of children
- Client finds balance between affiliating with new socio-cultural aspects and environment or groups while being able to (re-) affiliate with original socio-cultural context.

Indicators of achievement pertaining to care, treatment and follow-up include:

- Strong therapeutic relationship
- Attention to self-care
- Client can identify a goal and takes steps towards the goal
- Client can think about the future
- Shift in narrative from victim to survivor
- Acknowledgement that children will be different culturally from themselves
- Acknowledgment (legal, official or by society)
- Public apology from government

Organisations documented the ways in which they could verify the indicators of achievement in the "Means of Verification" section of the Inventory. A sample of these methods of verification is included below:

- Client report

- Staff report
- Scores on self-report tools
- Other agencies' report
- Number of hospital admissions
- Medication prescription

3.3.4. Summary of SWOT analysis: Strengths, Weaknesses, Opportunities, Threats

In order to evaluate the results of the Inventory as a whole we used a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats). The strengths are considerable and can be built upon, and the opportunities present a capital which is and should be further exploited. However, a series of internal weaknesses are highlighted and the external threats considered.

The following table highlights key strengths, weaknesses, opportunities and threats and is not comprehensive. It is noteworthy that each factor was defined in relation to a particular service type or activity and it is therefore not necessarily applicable to all methods.

Strengths

- Centres have highly experienced professionals on their staff
- Cohesive teams have committed, motivated and dedicated staff
- Systematic and structured service models have been developed over years, function reliably and can be flexible and responsive to changing needs and contexts
- Core activities include prevention activities, clinical activities and human rights activities
- Centres understand complexity and offer multidisciplinary and holistic services which are adapted to the various needs of clients (legal, social, psychological and medical)
- Different specialist professionals are available within the team/centre
- Innovative therapeutic approaches are developed in the country context of centres – services which are sensitive to the tension between the cultures of the clients and the host society
- Treatments are offered which do not rely on language or verbal communication alone
- Centres have well-trained interpreters
- Centres address specific needs of client group which cannot be met elsewhere and reaching wide range of clients
- Centres have extensive knowledge of other agencies, referral routes, rights and entitlements relevant to client group
- Centres are respected by and have good relationships with human rights NGOs

Weaknesses

- Insecure legal, economic and social and situation of clients makes definition of "progress" in treatment difficult, multifactorial and complex
- Staff are under severe pressure, often struggling with very limited resources, and unable to develop and engage in additional activities which could support clients and the centre staff
- Appropriately trained and experienced staff are difficult to find and most need additional specialist training
- The precarious and emotionally-charged social, legal, welfare and health situation of clients can lead to burn-out among staff
- Insecurity of funding can lead to inefficient organisational structures and processes
- Project-based funding makes long-term planning of services difficult

Opportunities

- Centres are respected in the field by health professionals, allowing for appropriate referral and interventions when clients' health is at particular risk
- Specialist knowledge about torture and treatment and rehabilitation approaches is disseminated to mainstream health and social services
- Documentation of torture and client data (anonymised) is amenable to academic research, which can support demands for improved resources
- The centres are all members of national and international professional networks, enabling the exchange of knowledge and experience, and its dissemination to other fields
- Centres in this project are highly committed to collaboration and partnership – and open to change and learning through and with others
- Where the right to work exists for refugees, centres are eager to take advantage of it to help improve rehabilitation process for clients

Threats

- Demand for services is overwhelming and centres have to select clients to whom a service can be offered, leaving some to be referred elsewhere, if appropriate services exist
- Staff have to resist client dependency arising from the clients' uncertain legal, social, welfare situations
- Staff face ethical dilemmas where treatment is a condition of residence permission
- Centres are under increasing pressure to provide professional reports for legal procedures, making further demands on scarce resources for treatment and rehabilitation
- Limited or no competence in mainstream health services in dealing with this client group means centres have to adopt a mediation and bridging function, which is often resource-consuming
- Funding is not awarded for core tasks, so that treatment and psychosocial services have to be based on insecure, short-term project funding
- Mainstream services exhibit a general lack of cultural and political sensitivity and understanding of clients' experiences of torture, including gender-based persecution, contributing to non-disclosure by clients; and to limited or no access to appropriate services
- Prejudice, culture of mistrust and general hostility towards this client group hinders effective lobbying for appropriate services and asylum/other legal and

| | |
|--|---|
| | <p>healthcare procedures which will take into account vulnerability and special needs</p> <ul style="list-style-type: none"> • Insecurity of funding makes it difficult to recruit or keep well-qualified professionals so that centres have to rely on freelance staff who are relatively less experienced in, and less knowledgeable about, torture and related treatment and rehabilitation |
|--|---|

There is much commonality across centres with respect to the factors affecting the organisations and indeed many of these factors affect the methods and activities offered by centres. The differences between centres reflected the political and social context of individual countries, the length of time organisations had been established and their financial resources.

Strengths of centres

In the analysis and discussions of all the partner organisations and the project evaluators, there was consensus that the centres have highly experienced multidisciplinary professional teams, with staff who have an enormous commitment to improving the health and well-being of their clients. This is underpinned by a common understanding that investment in improving the psychosocial situation of clients and in preventative measures should be paramount. All centres expend significant energy in contributing to prevention and human rights activities alongside treatment and other psychosocial activities.

A significant strength also lies in the sophisticated awareness and understanding of the complexity of the situation in which clients find themselves – they look back on experiences of extreme trauma, and live in a current context of lack of safety, legal insecurity, ongoing hardship and social exclusion. As a result, centres have developed a multi-disciplinary and holistic way of working which allows for an approach adapted to the various needs of clients (legal, social and medical), and which attends to the nuances and complexity of past and ongoing experiences of trauma, marginalisation and hardship.

Working with well-trained interpreters was perceived by the centres as not only a necessity where torture survivors have sought sanctuary in a country with a different linguistic background, but also a particular asset in working methods reliant on verbal communication, such as psychotherapy. However, despite the importance placed by the centres on the need for professional interpreters, their use is far from standard in mainstream health and social care provision. Interpreting often does not only involve translating language but includes aspects of cultural interpretation, where ideally, interpreters can form a bridge between a client's culture and the host society. Being able to communicate with the help of an interpreter therefore gives a voice, both symbolically and literally, to the client. While the use of interpreters is essential for communication, it can sometimes present difficulties (when, for example, the interpreter belongs to a group from the client's home society which the client perceives as inimical).

In some cases interpretation is simply not available in the language of the client, yet centres endeavour to provide a service in whatever way possible to those in need. Many centres offer treatments that do not rely on language, such as body therapy, art therapy, or a running group. Further, the centres are ideally placed and their staff knowledgeable and skilled in ensuring that the specific needs of torture survivors which cannot be met elsewhere (e.g. by mainstream services) are addressed by

some other service, and where this is not possible, that such clients are helped to gain access to other agencies, using the staff's knowledge about referral routes and entitlements. This referral process is typically two-directional, the centres also being accessible to a wide range of clients referred to them by human rights NGOs as well as by mainstream health services. As a result, the centres are highly respected by the institutions, many of which rely on them to manage difficult and complex cases.

Weaknesses of centres

There is consensus that the clients' highly insecure situation impacts on their health, and this can make it very difficult, and ethically challenging, to set a rigid end-point to treatment or other services. For the same reasons, it is difficult to measure progress, where it is hard to define the overall level of functioning or well-being when many unpredictable and multiple factors outside the sphere of influence of the client or carer impact on the life and well-being of the client.

One result of this situation is that staff resources at the centres are often severely stretched, with staff juggling to meet the needs of clients who experience repeated crises. This leaves little or no time for self-care or other staff care activities, such as self-reflection, inter-vision or supervision meetings. Nor is there enough time for additional activities which could support clients as well as the team, such as creating protected spaces for regular feedback among colleagues regarding staff members' experiences.

A related problem for centres is the need to be highly selective in staff recruitment, since not everyone is able to fulfil the centres' special requirements. This often means there is an increased need for specialist training for new recruits, which again is labour- and time-intensive. With respect to cultural needs and gender sensitivity, it is not always possible to find specifically male or female therapists or interpreters in all languages. Services are then offered under severe constraints, whilst still seeking to meet the needs of the client in an optimal way.

Unfortunately, these challenges, along with the enormous demands of working with clients who have precarious life situations, can be overwhelming and may lead to burn-out in staff, resulting in high turnover – a far from ideal situation in a field in which specialist competencies, understanding and knowledge are in scarce supply.

Service delivery in the centres is further complicated by the perpetual insecurity resulting from the funding strategies of donor organisations. For example, instead of being able to prioritise service delivery and treatment and care of torture survivors, highly qualified health professionals are obliged to spend an increasing proportion of their time writing funding applications. Further, as a result of the differing requirements of various funding organisations, staff may have to run several accounting, monitoring and reporting systems which are time-consuming and an inefficient use of their skills. Project-based funding can also make it difficult to plan ahead or develop a long-term strategy with respect to services and working methods, as well as preventing staff members from making appropriate plans for their own careers and professional development in the field.

Opportunities for centres

The specialist centres are recognised in the field by professionals as well as by health, education and social authorities and have developed strong links with NGOs and agencies working with refugees. Some have a good and active cooperation with

their government offices for asylum and refugees. Such relationships allow for interventions when clients may be at particular health risk during the rehabilitation process. These links and professional collaborations present an important opportunity for an exchange of knowledge (relating to culturally-sensitive treatment, professional assessment, documentation and reporting of torture and human rights violations, as well as to treatment and care). Such exchanges are made with mainstream health and social services through regular training sessions and/or when referring to general practitioners. In some cases such training has been used to transfer knowledge, in order to address trauma resulting from other causes such as environmental disaster, crime etc.

Another important opportunity identified is in the use of data now available through documentation of torture and of work with asylum seekers and survivors of torture. Anonymised client data published on the condition of victims of torture and their rehabilitation needs has increased awareness of the need for human resources to provide rehabilitation and prevention services, as well as inviting specific research questions.

The project's participating centres are all members of national and international networks of professionals working with torture survivors. The current project is an example of such international collaboration and exchange, which the partners perceive as a rich and unique opportunity in networking, through which they can learn from each other's expertise by exchanging experiences and collaborating to form a strong, coherent and informed voice for lobbying work. Networking via this project also presents an opportunity to transfer knowledge and experience to countries and centres which are only now starting to develop this work.

One issue over which the partner centres have very little influence is the legal framework determining asylum seekers' rights. The right to work and access to employment are opportunities which the centres in some countries value highly since they allow at least some clients to create a livelihood, to reduce their dependence on others, to find a meaningful activity and thereby possibly even to improve well-being.

Threats facing centres

The demand on the centres is overwhelming and centres have to be very selective in determining to whom they offer services and whom they refer to other agencies, if, indeed, there are agencies offering appropriate services. Very often the specialised centres are seen as the experts but also as the last resort when individuals or families are in an extremely vulnerable situation and other agencies cannot help any more. As a result of the insecure conditions under which clients live, dependency on professional services is difficult to avoid. Clinical decisions about which services a client should be offered and for how long are complicated enormously in cases where a client's right to remain in the host country on humanitarian grounds is dependent on his or her being in treatment. This places centres and their staff in highly conflicted and ethically challenging situations: rejecting a client's genuine need for treatment can result in harsh consequences for the client, but taking the client on will place further pressure on the centre – which may already be prioritising a small proportion of the many people who are genuinely in need of services.

Centres which are able to provide health professional reports for the asylum determination authorities and courts find themselves under ever-increasing pressure as the most vulnerable asylum seekers – among them survivors of torture – are

increasingly expected to provide psychological or medical reports to support their asylum claims.

Added to this is the threat which arises from the fact that mainstream health and social services have limited, or in some cases no, competence in dealing with torture survivors, including those who are particularly vulnerable. The general lack of cultural and political sensitivity in mainstream services and understanding of clients' experiences of torture, including gender-based persecution, can contribute to clients failing to disclose their experiences of torture, so that they fail to receive access to the appropriate services to which they ought to be entitled. Centres then have to adopt a mediating and bridging function to ensure mainstream services are accessible, but this role places further demands on already restricted resources of centres.

A significant threat is the difficulty of measuring progress in treatment where there are a multitude of criteria involved: client motivation, the social and legal context, possible health crises, amongst others. An added complexity is that symptoms or presenting psychological problems often have strong cultural specificities relevant to planning and offering treatment.

Meanwhile, in the wider world, centres have to deal with the exclusionary nature of political discourse and a negative, hostile attitude towards clients by the public where there is a general culture of mistrust towards asylum seekers, including those who are torture survivors. Appeals for openness may be met with uncertainty and fear on the part of the public, especially where clients are in need of material assistance, and may have additional special needs. This is an even bigger problem for newer EU countries which have little experience as host countries. Such general hostility towards this client group can also hinder effective lobbying for appropriate services and legal and healthcare procedures which take into account the vulnerability and special needs of this group.

Finally, an overarching threat to the centres is their perpetually insecure funding which makes it difficult to recruit or to retain appropriately qualified and experienced professionals. Centres have to rely on freelance staff who are relatively less experienced in, and less knowledgeable about, torture and the related treatment and rehabilitation.

3.4. Conclusions

In summary various conclusions can be drawn from the analysis of the Inventory of Working and Treatment Methods:

- Possible outcomes of working methods include symptom reduction, improved quality of life, level of function and coping, social support, and client satisfaction with services. These are in keeping with traditional approaches to treatment outcome evaluation.
- Although all the partners have in place "other" activities (mentoring, language courses, self-directed activities¹⁵ such as philosophical discussion groups, or

¹⁵ Sveaass, N. (2000). *Restructuring meaning after uprooting and violence. Psychosocial interventions in refugee receiving and post-conflict societies*. Oslo: Unipub.

Sveaass points in her study to the effectiveness of and the need for a combination of psychological help with other kinds of assistance and defines three complementary categories as most effective:

women's groups and activities for integration and participation in the wider community, prevention activities, etc.) and find that those are often extremely important and create the basis for effective treatment, very little has been done to find appropriate measures to define or evaluate their impact. The partners agreed that this is an area that should be further developed in future studies. While self-directed activities are seen as an important element of psychological health (countering the effect of torture, which aims to destroy identity and social affiliation) the political and social realities in most countries are directed towards exclusion. Encouraging such activities is therefore one of the most difficult and least appreciated tasks carried out by the centres because of the restrictions created by legal boundaries (no right or restricted possibility to work or receive training, etc).

- Overall it is difficult to determine outcomes specifically in terms of the impact on the client's health, because specific changes cannot reliably be attributed to a single intervention. Often interventions and services are offered by professionals working in a multidisciplinary way. Where there are methods in place to measure treatment outcome, the measurement takes place at the end of the overall package of care, but focuses only on the treatment activities. This is due to the lack of appropriate methods to evaluate the impact of the other activities.
- Services for the rehabilitation of torture victims vary in the specific types of therapeutic interventions utilised, target groups reached, duration of the rehabilitation process, economic resources, specification of goals, professionals and staff employed permanently or as freelance or volunteer (unpaid) staff, data collection capacities, and how staff communications are organised.
- While all centres think that advocacy and lobbying are an important part of their work, there is a great variance in how centres define them. The target group varies and includes civil society as a whole, professionals working in health, social and educational services and professional associations, politicians and specifically the asylum offices/authorities.
- Rehabilitation for victims of torture is widely seen as an important element in ensuring human rights. The work of the centres is praised for its contribution and respected in the field by health professionals, who refer clients when their needs cannot be met by the skills in the mainstream services. The centres' findings are used by the courts, and their documentation is used by policy makers. But at the same time, the exclusionary nature of political discourse and a negative, hostile attitude towards clients by the public make it hard to lobby for adequate resources for specialist centres. This is a paradox that needs to be addressed by society as a whole and cannot be solved by the centres alone.
- The design of services and the working methods adopted are largely shaped by the client group and its specific needs as well as by the unique country context of the centre. This may make direct comparisons less meaningful and generalisations difficult to draw. Nevertheless, this diversity provides a unique opportunity to share experience, innovations in service design and working methods. The sharing of the strengths, weaknesses, opportunities and threats facing centres in their work is a fruitful way to identify learning points and to energise and stimulate other innovations. Our experience shows that these

psychological assistance, integrating models which strengthen a sense of community, and self-organisation.

innovations will be welcomed by colleagues despite their being besieged by highly demanding work in a difficult context, with insecure resources.

4. A Framework for Quality Assessment

4.1. Introduction to the Framework

As is apparent from the Inventories of Working and Treatment Methods completed by the partners, staff in the centres are engaged in a continual assessment and evaluation of their work, to ensure that their services are relevant to their client group, and responsive to their needs and the context in which they live. The central aim of this collective evaluation within each centre is to offer the best possible services to clients. This task is not easy because of the nature of the work and the structural, contextual, resource and time constraints which impact on the evaluation. Where resources are limited and the demand for services high it is understandable that there may not be the time and financial resources to carry out thorough evaluation. The task is made more difficult by the nature and complexity of the services provided, which are offered often simultaneously and are specific to each client's situation and needs. In this context, any specific outcome cannot be simplistically attributed to a specific intervention.

This is a general problem when trying to analyse psychotherapeutic and social interventions, essentially because the factors which influence and determine behavioural and emotional changes are manifold. These issues become even more complex when dealing with emergencies in which the individual problem and the socio-political context are visibly and permanently intertwined. For example, do the post trauma and depressive symptoms of an asylum seeker who has experienced torture diminish because he/she has received a specific therapeutic treatment, or because he/she has received permission to stay in the host country, or because there has been encouraging news from home in which a family member who was thought dead in fact has survived? On the other hand, how do we judge a therapeutic process that has evolved very positively, until the client receives news that he/she will be deported against their will from the host country within the next few days? When symptoms reappear, would that mean that treatment was ineffective or poor?

To address some of these challenges the centres chose a qualitative approach to assess the quality of their working and treatment methods. This approach uses elements associated with outcome mapping methodology¹⁶; aspects of the approach developed by the partner centres in our previous project¹⁷; as well as aspects of the method of "psychosocial conflict analysis"¹⁸ which combines the psychosocial approach¹⁹ with "do no harm" analysis²⁰. The rationale for this methodology as it has

¹⁶ Earl S., Carden, F., & Smutylo, T. (2001). *Outcome mapping. Building learning and reflection into development programmes*. IDRC Books. For further details see Chapter 5.

¹⁷ Bittenbinder, E. (2010) Pp. 18-30

¹⁸ Becker, D., Groninger, K., & Luzar, C. (2012). *Psychosocial Conflict Analysis*. Luzern: Fastenopfer (forthcoming)

¹⁹ Becker, D. & Weyermann, B. (2006). *Toolkit: Gender, Conflict Transformation & the Psychosocial Approach*. Bern: Swiss Development Cooperation.

²⁰ Anderson, M. B. (1999). *Do No Harm: How Aid Can Support Peace – or War*. Boulder/London: Lynne Rienner Publishers

been adapted for our use is that it is impossible to give final "proof" in terms of cause (intervention) and effect (treatment outcome) for the reasons given earlier, but that a good description of the key issues and needs of the client, combined with a process-oriented documentation and analysis of how these issues and needs have developed in the course of treatment, makes more sense and enables a richer assessment of the quality of the work undertaken.

There is a consensus amongst professionals working in the field (and supported by a voluminous literature) that torture survivors, including those who are refugees or asylum seekers, have a multitude of difficulties and that their needs are multidimensional, including medical, psychological, social, political, cultural and legal aspects. Therefore, the first challenge is to conduct a comprehensive assessment of the presenting problems, in reference to all relevant dimensions. The key dimensions we identified include: individual/subjective, cultural affiliation, political participation and political economy. These four dimensions overlap and define what we refer to as the "conflict landscape" in which all of us exist (see Figure 2). To speak of conflict here is deliberate because it allows us to always look at the client as a person in relationship. By using the concept of conflict landscape we also take a deliberate step away from the traditional health approach of focussing on deficit, and a step towards viewing each person with respect, as someone who is dealing with complex conflict situations. Conflicts in and of themselves are not good or bad, they simply *are*. It is the way they manifest and are dealt with that makes them part of a process of growth or destruction²¹.

Our approach to the afore-mentioned dimensions is pragmatic, and in keeping with others' conceptualisation²² we define them as follows:

(1) Individual/subjective: There is always an individual and subjective dimension to the issues and needs which clients present: for example, in their suffering they experience conflict with themselves, with their memories, or their friends and family. Traditional medical and psychological approaches, such as diagnosis, often address this dimension. However, very often no attention is paid to the centrality of the need for recognition and acknowledgement in all our interactions with others²³. Most of our clients are not only severely traumatised and experience high levels of anxiety, depression and other difficulties, but they also feel that those in their social context (including the wider society, governments etc.), and sometimes even they themselves, do not fully acknowledge what has happened to them and the injustices they have experienced, or that their suffering is properly respected.

(2) Cultural affiliation: Individuals are inevitably born into cultural communities. They develop their identity not only as individuals but also in terms of affiliation to a group with a value system, which shapes how they form relationships, life expectations etc. Groups give us a sense of belonging, but at the same time they imply boundaries in

²¹ It is interesting to note that the political sciences (e.g. Norbert Ropers (Austin, A., Fischer, M., & Ropers, N. (Eds.) (2004). *Transforming Ethnopolitical Conflict. The Berghof Handbook*. Wiesbaden: VS Verlag.), psychology (as in the works of Freud) and philosophy (as in the works of Marx) all have a positive vision about conflict. In different spheres they all define conflict as a key element of growth, development and change. Paul Lederach defines the issue as follows: "Conflict transformation is to envision and respond to the ebb and flow of social conflict as life-giving opportunities for creating constructive change processes that reduce violence, increase justice in direct interaction and social structures, and respond to real-life problems in human relationships." (Lederach, J. P. (2003). *The little Book of Conflict Transformation*. Intercourse: Good Books.)

²² Becker, D., Groninger, K., & Luzar, C. (2012)

²³ See: Honneth, A. (1996). *The Struggle for Recognition: The Moral Grammar of Social Conflicts*. Cambridge: Polity Press.

relation to other groups. Most people are affiliated with different groups simultaneously, which means that – and this is a significant point – an individual's culture cannot be reduced to just religion or nationality in terms of group affiliation. However, many of our clients bring with them the issue of cultural affiliation, particularly as asylum seekers and refugees who have to some degree lost their affiliations and have to confront the challenge of establishing new ones.

(3) Political participation: Political participation is not just a question of voting for a democratically elected government. Political participation refers to the extent to which people determine and influence the social situation in which they live. Do they have power over the social processes which affect them, or are they disempowered? Can they influence their destiny or do others determine what happens to them? Political participation is understood in broad terms: how empowered or disempowered people are in the social context in which they live.

(4) Political economy: Whilst psychological suffering is not limited to poverty, the relationship between poverty and suffering would be hard to refute. In relation to torture survivors it is therefore always necessary to explore and analyse the impact of their material situation, including how they survive financially, and what their livelihood consists of. We speak deliberately of political economy here, instead of just "economy" or "material issues," because the material situation of a family is more than the amount of money they have. It is also what they think they should have, as well as what the market economy they live in forces them to live on and invites them to hope for. For example, in some very poor regions people may believe that it is more important and desirable to have a television than to buy basic clothes. In this sense, we view material issues as linked to the political landscape, hence the term political economy.



Figure 2. The Conflict Landscape

4.2. Structure of the Framework for Quality Assessment

In view of the conceptual framework we adopted, we developed an approach to assessing the quality of our working methods which included the following steps:

1. **Conflict analysis:** Providing a detailed description of the client and his/her issues, in reference to the four conflict dimensions. Very consciously we refrained from making simplistic diagnoses here and instead we presented a broad picture of the client, with explicit links to the relationships in which he/she exists and which shape his/her suffering.
2. **Desired outcomes and objectives:** Describing briefly the desired outcomes from the perspective of the clients and the basic objectives of the professionals for the treatment or working method.
3. **Service types:** Describing the type of services offered to the client.
4. **Methods:** Describing the method(s) employed.
5. **Activities:** Describing the specific activities within the methodology adopted with the client.
6. **Outcomes:** Documenting the expected and unexpected changes following interventions in reference to the different conflict dimensions.
7. **Quality assessment:** Judging how we think the service we offered to the client has enhanced:
 - recognition and empowerment (client's right to self-determination²⁴),
 - multi-affiliation and diversity in communities (belonging to different groups and acting in different contexts),
 - conflict capacity,
 - respect and adequate use of limits and boundaries,
 - healthy ambivalence (e.g. acknowledgement that his/her wounds will not heal at the same time as the need to get on with life, to integrate traumatic experience and to be able to grieve),
 - equality, and
 - whether the method was context oriented/process oriented.

In summary, the Framework for Quality Assessment was used as a method of understanding how the services as a whole have contributed to a useful change process for the client.

Of course this kind of detailed analysis is too resource-intensive to mean that it can be done routinely with every client. Nonetheless it is a method which could be used in selected cases, either after a service or therapeutic process has ended, or as an ongoing process, for example in team meetings or supervision, where each of the dimensions and changes are discussed as a case progresses. By performing such

²⁴ See also Sveaass (2000)

an evaluation at the end of a process it is possible that many issues may emerge which were ignored or were not apparent at the outset. Similarly, where assessment is conducted as an ongoing evaluation, it may be apparent how the findings of the conflict analysis may change with time, and how such a continuing analysis can strengthen the quality of the work undertaken with the client.

The overall objectives of the Framework are to provide a tool to examine if and how the services offered correspond to the conflicts of the client; to describe what happened during the treatment; and finally to evaluate the expected and unexpected outcomes which were observed and how they corresponded to the original objectives of the service or working methods. Unexpected outcomes are, of course, not necessarily negative; they merely record unforeseen developments which occur with or without the help of the treatment or services.

The judgement on the quality of our case work (step 7 in the Framework) builds on the preceding six, which together enable a rich, in-depth qualitative analysis of the progress of one case. The evaluation as to how the services or working methods enhanced changes in the areas noted earlier is a descriptive summary, but at the same time it is an evaluation based on the core ethical values and principles of the centres. These values are intended to be incorporated in the working methods and services offered to each client. For example, where recognition and empowerment are key aspects of the desired outcome, the question has to be asked if and in what way the method used has been empowering. Some interventions, even with the best intentions, may not have that effect: if a client is sent to see a lawyer without being given an explanation as to why, then the aim of the intervention may be empowerment, but the method adopted can have the opposite effect. Similarly, when a client is prescribed medication without explanation, the aim may be to help the client, but the application of the method can be disempowering. The predominant (and often exclusive) focus on symptom reduction in many therapeutic models is often simplistic in its neglect of other dimensions – such as recognition and empowerment – which are of equal value and importance to clients.

In discussion and application of the Framework for Quality Assessment we reached the consensus that our aim in empowerment was not to "push" clients to solve all their problems, but to enhance their capacity to deal constructively with them. At the forefront of our work is the question "How can we respect each client and how can we acknowledge and accept their limits and the limits of our capacities to help them?" One of the key elements of all traumatic processes is a tendency to divide the world in a black and white fashion, into total destruction and supposed total well-being, into total omnipotence and total impotence. Healthy ambivalence in this sense does not mean ambiguity, the incapacity to tell good from bad or a disposition to accept injustice. Instead it allows the (re)construction of a capacity to link good and bad, to see many colours, to integrate one's experience and to be able to grieve.

Finally, our view is that treatment and working methods with torture survivors must always incorporate context; be process-driven; and understand equality as a basic human value.

All the core partners who participated in the project completed the Framework for Quality Assessment in relation to two cases and discussed the results within their own teams and with the other core partners. In the following, six case examples are presented, with a summary of the analysis in accordance to the Framework for Quality Assessment described above.

Case Example 1:

| | |
|--|---|
| <p>Summary case description including conflict analysis</p> | <p>Female from an Eastern European country, her husband has a severe metabolic illness, four children. Referral to psychotherapy after an in-patient stay at a psychiatric clinic. Diagnosis (clinic): somatic form of depression, many physical symptoms. Asylum seeker. For three years subsidiary protection.</p> <p>Subjective dimension: Many physical symptoms, afraid that she might have an unknown dangerous disease; different states of panic, panic attacks. Existential fear that her husband's disease is getting worse. The illness is a taboo subject within the family, communication problems; sharing the burden is not possible; emotions of helplessness and weakness. Afraid of collapsing, afraid of going mad; feels pressure to be the provider for three children and the sick husband, which means she has to assume a new role. No assured stay in host country, fear to have to leave the country if she has no work.</p> <p>Cultural affiliation: Isolated within the refugee community; only limited support from some very close friends; language skills of host country still limited. Problem with jobs, working full-time not possible for her, too much stress led to dismissal every time. Problems with hospital, where her husband is treated; he lost the doctor he trusted, he received insufficient information concerning his disease, no interpreter there; family doctor doesn't know much about this disease, problems with strong medication. In reference to the centre: her husband was also receiving psychotherapy at the centre but this is no longer possible because the disease has worsened and he is too weak to come.</p> <p>Political participation: Unclear how long subsidiary protection will last, has to be applied for every year, very insecure general situation and strong dependency on helping institutions and social services.</p> <p>Political economy: Family has little money, if she cannot work, then there is no money for the children.</p> |
| <p>Desired outcomes / objectives</p> | <p>Subjective dimension: Help her to establish a trustful relationship; help her to understand and to accept her symptoms; help her to deal and live with the consequences of her husband's illness; help her overcome her fear and diminish her physical and psychological symptoms.</p> <p>Cultural affiliation: Learn language of host country; integration; find work; find a rhythm and structure for everyday life (with children, illness of the husband).</p> <p>Political participation: Clarify asylum status; get specialised adequate treatment for husband; get financial help for the husband's illness.</p> <p>Political economy: Solve financial problems.</p> |
| <p>Service types</p> | <p>Subjective dimension: Individual psychological treatment, psychotherapy; psychiatric consultation; bodywork</p> <p>Cultural affiliation: Social work</p> <p>Political participation: Legal advice</p> <p>Political economy: Social work</p> |

| | |
|---------------------------|--|
| Methods | <p>Subjective dimension: Building a therapeutic relationship; analysis of her symptoms and context of her symptoms; psycho-education</p> <p>Cultural affiliation: Networking; psychosocial care</p> <p>Political participation: Networking with other institutions (employment office, hospitals)</p> |
| Activities | <p>Subjective dimension: Stabilisation; crisis intervention, referral; inpatient stay in psychiatric clinic</p> |
| Outcomes | <p>Expected outcomes: Reduction of symptoms; she is able to work and has held different jobs; she is earning money; children are well integrated in school; good contact with teachers.</p> <p>Unexpected outcomes: Problems with treatment of her husband's disease; influence of her husband's disease on the whole family.</p> |
| Quality assessment | <p>Subjective dimension: Client developed a trustful relationship with all the colleagues involved at the centre: psychiatrist, body therapist, social worker and especially the psychotherapist.</p> <p>Cultural affiliation: Social integration was possible thanks to networking with different organisations, especially with regard to finding work; it was then possible for her to find jobs she was able to do.</p> <p>Political participation: Client felt more informed and ready to handle her legal affairs and all the things she and her husband have to do connected with her husband's disease.</p> <p>Political economy: The financial situation of the family is stabilised.</p> |

Case Example 2:

| | |
|---|---|
| Case description including conflict analysis | <p>Male, 40 years old, from African country, married, wife and 5 children remain in country of origin; first contact with centre for intake March 2008, began treatment with female psychologist July 2008 – on-going.</p> <p>Arrested during demonstration for democracy, detained, tortured, as a result severe arm/hand injury, other physical and serious psychological symptoms.</p> <p>Subjective dimension: →Patient v. (psychic representation of) aggressor/torturer, conflict which causes traumatic memories to be experienced as attacks on the mind, and which causes patient's wish/intention to have his arm amputated. Resulting symptoms: repetitive nightmares and insomnia, psychotic and paranoid ideation, anxiety, hyperarousal, depression, feelings of helplessness and defeat causing in turn desire for violent revenge, distrust, social isolation.</p> <p>→Patient v. external "trigger" figures representing aspects of persecution (policemen, persons in uniform, psychotherapist, as represented in a dream) provoking flashbacks, panic attacks, feelings of rage/fear. →Patient towards family members who remained in country of origin (wife, children) and live in danger, poverty, illness, or unknown circumstances, causing anxiety, depression, guilt, remorse, aggressive feelings turned towards self.</p> <p>Cultural affiliation: →Patient v. "black people" embodying aggressors,</p> |
|---|---|

| | |
|---|--|
| | <p>and triggering fear. Distrust of other black/African people in host country. →Patient v. home country government forcing patient into exile and separation from family. → Patient v. representatives of "medical culture" in host country that omitted to acknowledge prime psychological aspects of his severe bodily injury. →Patient v. other residents/refugees whose needs and conflicts he experienced as intolerably intrusive. →Sense of cultural isolation. Absence of links to community of origin in host country. No contact with local community organisations.</p> <p>Political participation: →Patient v. immigration authorities who rejected his initial asylum application and appeal. →Patient v. representatives of social agencies/his lawyer whose neglect caused patient's asylum appeal to be rejected because it had been improperly filed. →Patient v. host country immigration authorities that are organised in a confusing and inefficient way, causing asylum seekers to be infantilised, sometimes stigmatised and humiliated.</p> <p>Political economy: →Patient v. legislation in host country that prohibits asylum seekers from working and that disallows non-residents from collecting benefits for invalidity that patient would otherwise be entitled to. Lives in economic precariousness. Does not legally have the right to work and cannot find undeclared work either. Consequently cannot send money back home to family, who live in even greater precariousness and illness, causing patient internal conflict and guilt.</p> |
| <p>Desired outcomes / objectives</p> | <p>Psychological: Establish treatment alliance including trust in centre's staff; achieve lessening of paranoid ideation and psychotic symptoms, acceptance of physical handicap and progressive mourning of bodily integrity. Acceptance of life in exile. Enhancement of trust in caregivers (as a start), subsequently in fellow residents and others encountered – including people from African countries (blacks). Restore sense of agency and lessening sense of victimisation. Increase his sense of his own responsibility to take charge of daily demands of life in exile (asylum procedure, contact with social services, contact with family left behind).</p> <p>Medical: Initial medical interview and assessment, medication evaluation (patient previously cared for by general practitioner and hospital practitioner – surgeon.) Coordination of medical treatment and tailoring of medication regimen. Referral for necessary diagnostic examinations (medical imagery) and lab work. Ongoing contact with surgeon in respect to potential subsequent interventions for injured arm and hand as well as consultation and support. Referral for physiotherapy. Reverse the patient's prejudice against medical doctors (by showing sensitivity to the psychological dimensions).</p> <p>Physiotherapy: Body image integration (reintegration of arm/hand into body image) and stabilisation. Relaxation and establishment of subjective relationship to situationally/psychically co-determined experience of pain. Develop sense of embodied subjective agency. Work with torture-related sense of bodily alienation, disembodiment, rigidity, hyperarousal, anxiety concerning physical integrity and pain.</p> <p>Legal: Interview and assessment of legal needs. Preparation for appeal</p> |

| | |
|----------------------|---|
| | <p>court hearing and achievement of asylum status. Gaining recognition at the legal level that patient was effectively tortured and forced into exile by the government of his country of origin. Long-term goal: Family reunification.</p> <p>Socio-economic: Securing long-term housing. Achieve invalidity status and related benefits. Secure training for jobs suitable for him with regard to his handicap. Find a job in compliance with his physical challenges.</p> |
| Service types | Psychological, medical, physiotherapy, social work, legal assistance. |
| Methods | Psychoanalytic psychotherapy, medical services, physiotherapy, social services, legal services. |
| Activities | <p>Psychological: (Initial phase) Interview and assessment of patient's psychological condition (rule out acute psychosis) and needs. Given time frame (psychotherapist's departure on vacation for 1 month) assessment of treatment feasibility (as opposed to hospitalisation or referral to urgent care). Psychotherapy (1x weekly): Securing treatment alliance and minimal psychological stabilisation. (Subsequent phase) Identification of and working through core psychic conflicts. Create psychic space allowing for progressive distance from intrusive and traumatic experiences, and facilitation of thinking about experience of bodily alienation in order to delay patient's precipitate enactment of arm amputation by surgeon. Facilitation of mourning process on multiple levels. Referral to medical treatment, social work, legal support. Psychological attestation for asylum court appeal.</p> <p>Medical: Initial assessment performed in such way as to allow psychological dimension of physical trauma to emerge and be stated by patient. Medication, evaluation (patient previously cared for by external general and hospital practitioners). Patient examination. Coordination of in- and outpatient medical treatment. Prescription of tranquilisers, antipsychotics, sleeping medication. On-going treatment and referral for physiotherapy. Medical certificate for asylum court appeal. Referral to court-certified M.D. for evaluation regarding medical certificate for special health-related grant of status.</p> <p>Physiotherapy: Massage, work on body image integration and stabilisation, kinetic exercises, pain awareness and modulation, relaxation, breathing. Referral for swimming pool activities and exercises.</p> <p>Legal: Assessment of legal needs. Preparation for appeal court hearing; deal with the error by the lawyer who omitted to send his appeal due to misunderstandings between various parties. Accompany patient to police hearings and asylum-related appointments. Inform patient about legal rights and procedures. File appeal against authorities' order to leave French territory and file appeal against court order dismissing patient's asylum claim.</p> <p>Social: Help with paperwork related to achievement of invalidity status and related benefits (rejected). Request assistance for lawyer's fees for appeal of second rejection (granted). After forced departure from</p> |

| | |
|--|--|
| | asylum seekers' hostel, secure other assisted housing opportunity (successful). Help cover patient's transportation needs, and occasional needs for food, clothing. |
| Outcomes and quality assessment | <p>Expected: Treatment alliance established, including trust in centre's staff and comprehensive understanding of patient's multidimensional problems → enhanced recognition/acknowledgment</p> <p>Patient's spelling out of paranoid ideas allows for distinction between traumatic memory fragments and current fears of arrest and persecution; as a consequence lessening of paranoid ideation and psychotic symptoms, acceptance of physical handicap and progressive mourning of bodily integrity; enhancement of bodily flexibility and sense of trust and agency in relation to his body, physical pain reduction, increased tolerance for ongoing distress and sadness caused by separation from family and for anxiety related to occasional not knowing family's whereabouts, regular participation in all therapeutic activities and assumption of responsibility for medication regimen, increased capacity to withstand the ongoing flow of information revealing conflict in his country of origin without regression to psychotic symptoms, ability to tolerate stressful living situations and uncertainty about future as well as long waiting periods and rejection of asylum claims → enhanced agency and conflict capacity.</p> <p>Development of occasional relationships with fellow residents → enhanced sense of cultural belonging.</p> <p>Maintenance of self-initiated, ongoing contact with family in country of origin and affirmation of his paternal role and function → equity.</p> <p>Unexpected: Relatively rapid cessation of psychotic symptoms even after discontinuance of antipsychotic medication. → enhanced recognition and acknowledgment.</p> <p>Clinical team recognises limits and pitfalls of multidisciplinary model, in the sense that this case introduced an overload of reality demands and anxiety related to the impossibility of securing patient's asylum status (a feeling repeatedly shared in team meetings) which seriously interfered at times with the psychotherapist's capacity to maintain a psychic space for the patient and herself. Recognition in team meetings how patient had split and projected fragments of his pre-trauma life onto different team members in order to protect himself from having to deal with certain conflicts related to his personality and his past.</p> |

Case Example 3:

| | |
|---|---|
| Case description including conflict analysis | <p>Male, 29 years, from southern European country, belonging to ethnic minority group. Persecuted for both ethnic and political reasons. Member of a political party later outlawed. Beaten by security forces. During his military service was beaten with electric cables and police sticks, humiliated, his arms were trampled with boots, he suffered reverse hanging (strappado).</p> <p>Subjective dimension: Mental and physical problems → Client v.</p> |
|---|---|

| | |
|--------------------------------------|---|
| | <p>authorities & ethnic majority in the country of origin; torture during his military service → impact on his situation in host country; fear of authorities, claustrophobia → Client v. father (father abandoned the family, refugee in a different country); communicates with the rest of the family in home country (mother, two younger brothers and a sister) → Client v. new context: feeling lonely and depressed to the extent of mutilating himself. Feeling powerless in the face of the challenges of adapting to new situation. → Client v. physical limitations and pain: knee injury reduces mobility and causes pain.</p> <p>Cultural affiliation: → Client v. host country: typical vulnerable asylum seeker situation. Problems with language and different cultural norms → Client v. the rest of the refugee community: contact only with own nationals, difficulty in adapting, privacy issues → Client v. interpreter (lack of professional interpreters, lack of trust).</p> <p>Political economy: Economic and material problems with regard to host country regulations: living in refugee camp, with free movement outside camp and permission to work because he has been in the country for more than 12 months. But client v. job market: cook by profession; difficult to find legal work – employers reluctant to hire people with time-limited ID.</p> <p>Political participation: Politically disempowered as an asylum seeker without control over own destiny → Client v. immigration administration (only general questions about his trauma during interview) → Client v. legal system (judges not specialised, insufficient study of case).</p> |
| Desired outcomes / objectives | Reduce pain and improve mobility; reduce depression; stop self-mutilation; increase self-confidence; cultural and professional empowerment; empower client legally; obtain asylum for client. |
| Service types | General medical; physiotherapeutic; psychiatric; psychological; social counselling; community work (volunteers); training; social; legal. |
| Methods | General medical assessment; physical assessment and appropriate intervention; psychiatric assessment and appropriate clinical intervention; general assessment of psychological needs and appropriate intervention; assessment of cultural needs; decision on intervention strategy; assessment of language capability; social counselling; legal counselling; assessing legal needs; deciding on intervention strategy. |
| Activities | Laser therapy, electrotherapy; psychopharmacotherapy; psychotherapy; supportive counselling; psychoeducation; elements of narrative exposure method; cultural and intercultural activities; recreational activities; language classes; assessment of social and legal needs; decision on intervention strategy; information about rights according to family, health, labour, housing and education legislation; gather documentation, register claim, represent client in court; medico-legal certification (physical); medico-legal certification (psychological). |
| Outcomes | <p>Expected: Pain in the knee reduced; mobility improved.</p> <p>Unexpected: Sponsor found for the psychiatric medication; depression symptoms reduced; self-mutilation stopped; self-confidence regained; tendency to individual and cultural isolation overcome through improved</p> |

| | |
|---------------------------|--|
| | language skills and employment; socio-economic situation improved by employment as translator/interpreter; trust re-established in legal advice; clarification of legal situation; case got through first court with negative result; access secured to next level: result pending. |
| Quality assessment | <p>Subjective dimension: Appropriate medical and psychological therapy provided for both physical and mental problems. Outcome: Physical and mental symptoms reduced or disappeared.</p> <p>Cultural affiliation: Appropriate training in local language and exposure to local culture provided. Outcome: gainful employment obtained outside his professional background indicating start of social integration.</p> <p>Political participation: Relevant action taken. Outcome: Objective not achieved but the asylum case has been accepted by appeal court with possibility of eventual success.</p> <p>Political economy: Appropriate social and legal counselling provided. Outcome: legal employment obtained – but outside his professional background – easing economic problems.</p> |

Case Example 4:

| | |
|---|--|
| Case description including conflict analysis | <p>Male, asylum seeker from middle eastern country, married with 3 children all in host country. Applied for asylum May 2009. Claim: abducted and tortured in 2006 for two days, by people belonging to a religious group (Shiites) controlling the area he lived in.</p> <p>Subjective dimension: High anxiety regarding lack of status, feelings of mistrust; sadness; guilt towards immediate family members and feelings of worthlessness; being distant from the immediate family members, feeling under pressure for not being able to meet his wife's and sons' needs.</p> <p>Cultural affiliation: Not belonging to the host culture, doesn't speak the language at all, difficulty making friends and forming relationships.</p> <p>Political participation: In need of legal consultation regarding his rights, feels afraid to express his ideology openly.</p> <p>Political economy: Unemployed – in constant need of social welfare benefits, lack of transportation.</p> |
| Desired outcomes / objectives | Leave the reception centre. Receive welfare assistance and psychological support for himself and his family. Decrease the intensity of depressive and PTSD symptoms. Become fully aware of his rights regarding his social needs. Find accommodation. Gain access to the health care system. Cope better with trauma. Receive welfare benefits. Receive the appropriate treatment for his health problems. Rebuild relationships with immediate family, adjust and integrate into the host society. |
| Service types | Social, psychological, legal, medical. |
| Methods | Social counselling/assessment, social Integration, psychological |

| | |
|-------------------|--|
| | assessment, psychotherapy, psychological support, legal assessment, legal assistance, medical assessment, medical advice/referral. |
| Activities | <p>Psychological: Recording of client's social and psychological history. Spent time in sessions building a robust therapeutic relationship; promoted trust by using active listening, paraphrasing and summarising. Person-Centred Approach (PCA)²⁵ techniques were used to provide the three core conditions (unconditional positive regard, empathy and congruence) in order to treat his depressive symptoms. CBT techniques were used in order to address his PTSD and depression. CBT techniques include: explanation of the model of how thoughts, emotional responses and physiological responses interrelate and they affect behaviour; finding realistic coping mechanisms and applying them in his life. Used relaxation sessions and taught him how to apply relaxation techniques (i.e. controlled breathing); used many diagrams in the sessions in order to portray what the therapist wanted to emphasise. The therapist accompanied the client's eldest son and his mother to the meeting with the headmaster of the school in order to resolve problems in the child's behaviour.</p> <p>Social: Recording of social history: needs were identified and prioritised. He and his family were helped to leave asylum seekers' reception centre – contacting landlords, help with finding accommodation. Resolving problems regarding welfare services and labour office through contacting officials as well as employers. Contacting and using other institutions' services in order to resolve client's problems. Introducing available language courses to the client.</p> <p>Medical: Made an appointment with a female gynaecologist for his wife and dealt with her ongoing treatment.</p> <p>Legal: Recording personal details, claims and facts relating to his case. Consultation on his legal rights and advice regarding his case. Letter to the responsible authority noting that he is an alleged victim of torture and his case should be prioritised for case assessment – referred to the Medical Committee²⁶ for examination. Escorted at the initial interview conducted by the asylum service. Escorted at the Medical Committee examination.</p> |
| Outcomes | <p>Expected: Left the reception centre – found a house for himself and his family. Enrolled in language lessons. Problems with the employment office were resolved after the social counsellor arranged appointment with a government doctor and he obtained a written diagnosis of his problem, suggesting that he is not able to work – welfare benefit was granted for the family. Coping with his depressive and PTSD symptoms; managing his daily anxieties and stressors and lack of confidence regarding being in a different culture; facilitated meetings regarding his son's disorder.</p> <p>Unexpected: Wife's unexpected pregnancy caused additional stress to the client. Client was examined by the Medical Committee which concluded that he is not a victim of torture – a decision that goes</p> |

²⁵ Person-centred approach developed by Carl Rogers.

²⁶ The Medical Committee is the official medical committee of the Cypriot state in charge of examining alleged victims of torture and of concluding whether they show signs of torture or not.

| | |
|---------------------------|--|
| | against the Unit's findings and assessments. |
| Quality assessment | Treatment enhanced recognition and empowerment and conflict capacity through analysis of social and legal situation and psychotherapeutic treatment. But overall dependency and situation of disempowerment continued because of legal situation (denial of refugee status and torture). |

Case Example 5:

| | |
|---|---|
| Case description including conflict analysis | <p>Subjective dimension: Male, 53 years old, from north African country, posttraumatic stress, depression, suspicion, rigid personality, compulsive behaviour, high level of ambition, difficulty dealing with authorities, depression and dependent behaviour of wife.</p> <p>Cultural affiliation: Wishes to be a respected and assimilated member of host country society, but stigmatised as a North African. Ashamed of his African background.</p> <p>Political participation: Activism for justice in general, and for safety and a good social climate in his neighbourhood; experienced helplessness, degradation and security in the past in northern Africa and currently at his work and in the neighbourhood.</p> <p>Political economy: Income went down because of sickness and he wishes to take care of his family financially.</p> |
| Desired outcomes / objectives | Reduce PTSD symptoms, anxiety and depression. Increase insight into personality traits that hinder recovery and cause stress. Regain trust in himself and others. Find fulfilling work/activities. |
| Service types | Psychotherapy, medication, occupational therapy, psychomotor therapy, sociotherapy. |
| Methods | EMDR, NET, running, partner/relationship counselling, training mindfulness |
| Activities | Group therapy, individual sessions |
| Outcomes | <p>Expected: Reduced symptoms (depression, avoidance, nightmares, reliving traumas), (partly) regained trust in himself and others, increased insight into effect of his rigidity and high ambitions on himself and others, start orientation on other work.</p> <p>Unexpected: Loss of (over-)weight, became role model in the therapy group, high level of activity, high drive to find other work, started partner/relationship counselling.</p> |
| Quality assessment | Potentially not enough focus in treatment on social situation of client, therefore surprise at his use of the centre as a social development space; as a result, treatment possibly too focussed on symptom reduction and not enough on issues of cultural integration and activation; nevertheless, recognition and empowerment were enhanced as was his capacity to integrate and to protect his identity, thus enhancement of affiliation and diversity. Context and process orientation could have been better. |

Case Example 6:

| | |
|--|---|
| <p>Case description including conflict analysis</p> | <p>Eastern European girl, 15 years old: After helping a local family during the war, the client's family was heavily threatened and abused by the secret service. Members of the extended family disappeared, her father had to go into hiding; she witnessed the abuse and rape of her mother and was threatened and physically abused herself. The contact with the perpetrators often took place in school. She fled with her mother; father and brother were left behind.</p> <p>Subjective dimension: Was kidnapped at a young age. She does not know whether and how to be close to people and trust them without getting frightened. Client always wants to be next to her mother, doesn't leave home alone. → Conflict with mother: mother wants her to go to school, she is reluctant/afraid. → Inner conflict: wants to be close to mother yet doesn't want to be a burden. Mother also has been tortured and is suffering. Client tries to give mother relief, tries to hide her own problems. → Inner conflict: trauma and related sleep disturbances, flashbacks, avoidance, nightmares, sadness, tension, fear, loneliness. → Inner conflict: guilt towards her brother who was left behind and guilt over having survived. Conflict with father: reproaches him for having left the family; hatred.</p> <p>Cultural affiliation: Cultural problems: missing the familiarity of her home country. Feeling of not belonging, of being foreign, not knowing rules/habits in host country. Fear of contact with other people and difficulties with concentration and learning preventing her from learning the language of host country and from showing interest in possibilities of social/cultural integration.</p> <p>Political participation: Uncertain status leads to restricted rights, living in hostel with little money leads to social isolation. Also fear of deportation.</p> <p>Political economy: Family has little money. They have reduced possibilities of participation. It took many months of hard work to get payment for the treatment accepted by the youth welfare office.</p> |
| <p>Desired outcomes/objectives</p> | <p>Subjective dimension: Help the client to establish a trustful relationship, help her to understand what happened to her, help her to accept and understand her symptoms, attain the ability to control symptoms, reducing feeling of guilt and dysfunctional cognitions ("I cannot trust other people any more," "I'm not allowed to be happy while my little brother is missing").</p> <p>Reduce feelings of hatred towards father (who was not in a position to protect the family); expose her carefully and gradually to traumatic events in order to reintegrate traumatic experience into her general life cycle.</p> <p>Cultural affiliation: Integration, especially in school and leisure activities, establish social relationships, learn language of host country, normalise everyday life (structure of everyday life with responsibilities, activities).</p> <p>Political participation: Establish mentorship, contact with youth</p> |

| | |
|----------------------|--|
| | welfare office (girls group), clarify asylum status. Political economy: Obtain funding for her treatment. |
| Service types | Social work, legal assistance, psychological diagnosis, psychological counselling and psychotherapy. Medical advice and referral to specialist (gynaecologist and psychiatric support). |
| Methods | Psychosocial assessment, legal assessment, social assistance, psychotherapeutic assessment, psychological counselling of mother, family therapy, individual psychotherapeutic treatment for girl. Socio-cultural support through personal mentor for girl. |
| Activities | <p>Social: Documentation of life events/history that led to flight. Identification of psychosocial needs. Accompaniment and assistance during legal procedure. Help with finding social and health services, especially gynaecologist for mother and girl. Help with finding appropriate accommodation. Contacting and helping with schooling for girl. Introduction to language course and social activities for mother and daughter.</p> <p>Socio-cultural integration or (re)affiliation: Within the mentoring scheme a young woman was found as a mentor for the girl to help her link with peer activities in her new community.</p> <p>Legal: Intake assessment of client's details and history, consultation on legal rights and advice. Communication with lawyers concerning specific issues that were not taken into account at the initial interview (i.e. rape). Professional psychological report in cooperation with gynaecologist and psychiatrist to support legal claim. Support of appeal against asylum authorities/court hearing.</p> <p>Psychological: Recording and documentation of biographical and traumatic life history. Assessment and psycho-diagnosis of mother and daughter. Two sessions of family therapy with mother and girl, two individual sessions with mother to support careful separation.</p> <p>Psychotherapeutic treatment of girl: The therapeutic treatment had several stages, overlapping or interchanging: in the first stage relationship with the client was established: providing a secure setting for mutual trust. Another stage aimed at stabilising the girl's self-esteem and rediscovering her own strengths and capabilities after severe disruptions to create a feeling of sufficient safety – a precondition to engage with traumatic experience. Because of her psychological violation the girl also required careful psycho-education to understand the impact the traumatic experience had had on her and also about the process of the treatment. In a further stage some of the traumatic experience could be addressed and partially integrated on a cognitive and emotional level. Individual stress and anger management techniques were explored in order to help solve the problems in her relationship with her mother and at school.</p> <p>Medical support: Mother and daughter were assisted with access to health services e.g. by providing a qualified interpreter to accompany them.</p> |
| Outcomes | Expected outcomes: Improved understanding of PTSD symptoms (sources of fear and consequences of avoidance); reduced avoidance |

| | |
|----------------------------------|---|
| | <p>of school, leading to her attending school every day, later without assistance of mother or brother; improved sleep, could sleep alone in her own room; improved self-monitoring; starting to develop coping mechanisms for traumatic memories; starting to cope with the situation of missing brother and father; development of activity and structure in everyday life: found new friends and community of other people from her community; moved into better accommodation, then found new flat.</p> <p>Unexpected outcomes: Symptoms were so serious that additional psychiatric support was needed but couldn't be found; after first stabilisation and control of most problematic symptoms, the client abandoned therapy; close links to other girls in school linked to country of origin and to refugee community hindered her motivation and efforts in learning language of host country.</p> |
| <p>Quality assessment</p> | <p>Subjective dimension: Client developed a trustful relationship toward psychotherapist, social worker and especially the volunteer who spent much time in the family (helped in finding a school, supported in crisis, helped with homework and learning host country language). These relationships and supporting systems increased her autonomy and her possible courses of action despite her traumatic experiences and restricted living conditions. Knowledge about symptoms and their context and the subsequent confrontation with fear-releasing situations (school, being alone, sleep) resulted in reduced anxiety and avoidance-behaviour. Resource-oriented process enabled her to establish social relationships (school, community) and participate in social/cultural life. Imagination strategies enabled her to stay in contact with missing little brother without psychic breakdown. Fast stabilisation hindered further processing of traumatic experience and resulted in restricted capacity for dealing with conflicts. Conflicts and unpredictable problematic situations are threatening to her and cause stress and helplessness.</p> <p>Cultural affiliation: Development of social relationships, links to her community and group activities were very supportive and empowering for client; they enabled participation and autonomy within the limits of her psychic illness and restricted legal status.</p> <p>Political participation: Could be improved slightly by the supporting mentor who helped and informed client and family, thereby empowering them.</p> <p>Political economy: Could not be improved, family got negative decision in their asylum application. Uncertainty regarding further residence and legal status.</p> |

4.3 Evaluation of the Framework for Quality Assessment

It is clear from the case examples provided in the preceding section that the Framework for Quality Assessment lends itself to varying levels of analysis and

interpretations. Whilst all centres use the same basic approach, some are more explicit than others (for example note the differences between case examples 2 and 5); some analyse quality in reference to the different conflict dimensions (see case examples 1, 3 and 6), whilst others make direct reference to some of the values described earlier (see case examples 2 and 5); and some case examples are more conflict-focused in the case description than others.

Generally speaking, one can conclude that although there is room for a certain amount of variability in the interpretation of the Framework for Quality Assessment, there is a basic coherence in the method of assessing the quality of the cases which makes them broadly comparable. Interestingly, the Framework made it possible to describe succinctly a rather broad set of issues and then to show what has happened to these issues after various types of intervention were offered. On reflection, it also seems that although the "conflict language" may at first seem strange, the framework for analysing the conflict landscape is effective in providing a qualitative overview of the case, the treatment or working methods applied and the outcomes, as well as providing a vivid overview of the complex and multiple contextual problems the centres have to deal with in the course of their work with a single case.

On the basis of this summary documentation, there is much that could be discussed in more detail, amongst the centre staff, the project partners and with others. In **case example 1** there seems to have been a positive development, although what originally appears to be a complex presentation of asylum/refugee-related problems with a specific reaction to the illness of the husband, then also becomes a social and cultural problem with certain entrenched, persistent dimensions. The individual psychological problem of the client changes, a certain general empowerment takes place, but it becomes apparent that the client faces a chronic situation which she will have to manage and which cannot be resolved in psychotherapy. In **case example 2** the case presented is very complicated: on the one hand there is impressive progress with the client who has severe symptoms, but, as the team notes, at the end there is "an overload of reality demands and anxiety related to the impossibility of securing the patient's asylum status." This is a very common conflict situation experienced by professionals working with torture survivors who are asylum seekers – a situation which is complex and invites further reflection and analysis. In **case example 3**, in spite of the overall positive view of the team in relation to the case presented, there remains a severe, enduring problem, namely the insecurity of the client regarding his asylum status and the impact of this on his well-being. The lack of "success" here is not a "fault" or a shortcoming of the team or their interventions (and in fact their intervention improved his legal situation), nevertheless the chronically insecure legal situation has influenced the psychological well-being of the client. **Case example 4** shows dramatically how the centre has done everything possible to help the client but that, in spite of that, the client's legal situation entailed a continued process of disempowerment which had an adverse psychological impact on him, which the centre staff could not stop or prevent. In this sense, this case example accentuates the point that psychotherapeutic work is not and cannot be the only level and type of intervention for torture survivors and that other services, such as legal services, play a significant role. **Case example 5** illustrates an interesting development where the interventions did not specifically focus on the social and the cultural empowerment of the client, though such an outcome became apparent. The client assumed a role in the therapy group which went beyond addressing his own specific health problems, and focused on social integration and his capacity to use the protected space of the centre to facilitate the individual process of assuming

control of his life again, which the centre staff recognised and facilitated. **Case example 6** demonstrates a broad approach of psychological, social and legal help and the importance of the work with the accompanying volunteer. It also highlights how a client's own community may manifest as a somewhat closed and excluding group, which can in fact make the process of integration more difficult.

In all these cases there is food for thought and deeper analysis: it is a key function of the Framework that it should provide an overview in a structured way, but leave open opportunities for deeper reflection on the work undertaken. In examining the case examples it is possible to identify some overarching issues:

1. Difficulties presented by clients are most often connected to all of the conflict dimensions in the conflict landscape: the individual and family level; cultural affiliation; issues of political participation and social and political self-determination; and material and economic issues.
2. Intervention methods therefore include a much wider range of activities than is usual for psychiatric and psychological disturbances.
3. Working and treatment methods and intervention plans combine a health approach and a human rights approach.
4. Working and treatment methods and intervention plans combine clinical approaches with social work and a certain level of community orientation.
5. Working methods and intervention plans constantly need to be adapted and thus are subordinated to the challenges of trans- and intercultural communication.
6. Outcomes may be difficult to predict because the client's conflict context develops constantly, giving rise to unexpected outcomes.
7. The social context of the host country is more often a part of the conflict landscape than part of the solution for clients.
8. Outcomes often demonstrate positive results not only as a result of therapeutic interventions but also as a result of reinforced human rights, justice and social security.
9. Working methods, treatment strategies and intervention plans are most effective even in continuing difficult circumstances if they enhance and underline the right to self-determination (empowerment) of the client, if they facilitate acknowledgement of the client and his/her wounds and enduring suffering, and if they facilitate cultural diversity and affiliation.

5. Practice examples

In this chapter we share case examples from our clinical practice with torture survivors, for readers who prefer a more narrative form. We present one case study from each centre; in some cases this is the same case as in the brief descriptions in Chapter 4, in others new examples have been chosen where they were thought to add significantly to the presentation of Conflict Analysis. All of them are presented according to the stages of Conflict Analysis which was used as part of the Framework for Quality Assessment to discuss each case amongst the core partners. As discussed in Chapter 4, Conflict Analysis entails a description of the conflicts a client is involved in at different levels with different conflict parties (individual/family level, cultural level, level of political participation, level of political economy). In addition, the care and treatment methods applied in each case are appraised in respect of how far they contributed to the "overarching aims" for working with torture survivors (described in chapter 4.3 "Evaluation of the Framework").

5.1 Equator Foundation (*Esther Schoonbeek, Willem F. Scholte*)

The client is a 53-year-old man from a North African country. He lives in the Netherlands with his wife and children and he used to work as a geography schoolteacher. He was referred to Equator Foundation by the AMC (Academic Medical Centre in Amsterdam) where he was being treated for a second depressive episode. The depression started when he was insulted by one of his pupils because of his nationality. Moreover, the client was suffering from PTSD, which probably resulted from the physical and sexual abuse that took place during his adolescence and imprisonment in his home country. The client suffered a complicated childhood: his father died early, his mother was diagnosed with borderline disorder, and he had to live on the streets between the ages of 11 and 14.

Equator Foundation offered him a group day treatment programme including occupational therapy, psychomotor therapy, medication and simultaneous psychotherapy (Eye Movement Desensitisation and Reprocessing [EMDR] & Narrative Exposure Therapy [NET]). Currently, after about one and a half years of treatment, he is quite active and planning to start his own enterprise. His current therapy consists of running therapy and partner relationship counselling.

Conflict analysis

Subjective dimension (Individual/ family level)

As a result of his history the client developed complex posttraumatic stress and depression, with feelings of distrust towards others in general and authorities in particular. Additionally, the client experiences panic attacks in small public spaces where he cannot escape. His personality is rigid and compulsive, which can be seen

as his coping style to prevent past memories from emerging, bringing with them depressed feelings. His problems are amplified by the fact that communication with his wife is marginal as he avoids talking and thinking about his problems. In spite of this, he has a strong wish to be healthy.

Cultural dimension

The client has made a lot of effort to be a respected and assimilated member of Dutch society, but experiences stigmatisation for being North African. He experiences feelings of shame towards his African background.

Dimension of political participation

For a long time, the client repeatedly experienced conflicts with the justice system: he was imprisoned in his home country for being a political activist and he is still often preoccupied with political issues such as the problems of the young people in his current neighbourhood. He still actively strives for justice and a positive social climate in his work as a schoolteacher and as a street coach. As part of this work, however, several incidents have occurred which made him experience powerlessness, degradation and insecurity, feelings that are well-known to him from his past in northern Africa.

Dimension of political economy

The client does not have any major financial problems; he lives in a large house and has the opportunity to travel. Nevertheless, his income is diminishing (due to sick leave) and he wants to be able to provide enough for his family. This leads to feelings of depression, as he experiences a loss of status in his family and in his social environment.

Treatment objectives and services offered

Subjective dimension

Initially the goal of treatment was to treat the PTSD. He was treated in a group and received psychotherapy (EMDR and NET). More specific sub-goals included regaining **trust** in other people (group members) through sociotherapy²⁷, treating the **depression** with medication (provided by a medical doctor), and reducing or improving his ability to cope with his **rigid personality**, also with the help of sociotherapy. Partner/relationship counselling was offered with the aim of increasing communication between the client and his wife and to strengthen their relationship.

Cultural dimension

Cultural struggles such as being discriminated against were often discussed during sociotherapy. By sharing and discussing his experiences he learned to deal with them a bit better. He also gained insight into his rigidity and the consequences of it

²⁷ Sociotherapy is a therapeutic group approach which has been adapted to the refugee client population and has the aim of finding a constructive daily routine or prospects for employment after the termination of treatment.

for himself and his environment. In addition to this, he took on an important supportive role in the group.

Dimension of political participation

The client was assigned to a buddy, an Egyptian refugee from another North African country whom he supported and assisted with practical affairs. Furthermore, the client set goals together with the occupational therapist to become active again in his daily life and to focus on work. The occupational therapist proposed that he might become a (homework) tutor but he was not interested in the job at that time. He started getting involved in sports and a theatre group. These activities helped him regulate his feelings of stress and tension.

Outcomes/ Conclusions

As expected, the treatments led to a reduction of his symptoms (e.g. depression, avoidance, nightmares, reliving traumas), increased his insight into his tendency to have high expectations and to be overly rigid, and helped him understand better how to deal with this.

The unexpected results were that even though he does not want to teach again, the client has a strong drive to work and wishes to have a proper role in society. He wants to improve the relationship with his wife and wants to break down his control mechanism. He has lost a lot of weight by doing sports and by eating more healthily.

The treatment mainly focussed on symptom reduction and possibly not enough on the client's social situation, so it was a positive surprise to see that he used the centre as a social development space. Despite the fact that improving the client's cultural integration was not a priority objective, the client's basic recognition (by his social environment) and his empowerment were enhanced, as was his capacity to integrate and to protect his identity.

Equator's team later thought that they could have introduced him to Amnesty International where he might have become a volunteer writing letters on behalf of victims of human rights violations. This way he could have done more with his dedication to political justice. This could be an idea for the future.

The team members who were involved in the treatment agree that there were several personality traits that made it pleasant to work with this client. They are convinced that his intellectual level, likeable character and motivation had a strong influence on the treatment.

5.2 ICAR Foundation (*Camelia Doru, Erik Holst*)

This case example of a torture victim of the repressive communist regime in Romania may serve as an example of the special challenges presented by the long-term consequences of systematic persecution and the marginalisation of individuals who have opposed a repressive political system.

In 1952, the client, a male Romanian citizen aged 23, was arrested due to what were considered "anti-communist activities." He suffered systematic beating and foot

whipping (falanga), was humiliated, made to sign false confessions, and received threats against family members.

He was sentenced to eight years detention which he served in three different detention centres – a mine, a prison and a slave labour camp – where he experienced extreme cold, limited food, and poor hygiene facilities. In one of the centres he was deprived of any communication with the outside world and held in solitary confinement. After he served his sentence he was detained for further interrogation for another two years. The client first came to ICAR Foundation's newly opened rehabilitation services at the age of 64 years. He was retired and living alone after the death of his second wife seven years previously. He had a son from his first marriage who had immigrated to France, and a grandchild to whom he had a close relationship.

Conflict analysis

Subjective dimension (Individual/ family level)

The client came to ICAR Foundation at the age of 64 with multiple physical health problems. Some of these were clearly related to his experience as a victim of a long period of detention under inhuman conditions. Others were related to age, but were most likely precipitated or accelerated by the physical deprivations and psychological pressure suffered during this period. His mental health problems clearly originated from both the initial and the continuing psychological pressure exerted on him by the security and penitentiary officials during the 37 years between his first arrest and the fall of the communist regime in 1989.

During detention the client had developed chronic hepatitis C and now presented with fatty liver disease, in addition to a wide range of other medical problems including diabetes mellitus type II, digestive disorders, chronic ischemic heart disease. He finally developed colon cancer which was diagnosed too late for therapy, and this led to his death in 2010.

He was diagnosed with mental health problems in the form of anxiety and depression.

Cultural dimension

In spite of his not belonging to a different nationality or ethnicity compared with the majority of the population, the client faced marginalisation even in the post-communist society, and he had to reintegrate into a society from which he had been excluded.

Dimension of political participation

As a Romanian citizen, he recovered his political rights after 1989 – even if his criminal record was never cleared. As a member of the Association of Former Political Prisoners he was part of a pressure group that obtained some benefits for this group.

Dimension of political economy

Despite his decreasing mobility he managed to be fairly self-reliant. From 1990 on he received an additional pension as a former political prisoner but otherwise never received appropriate reparation for his sufferings during the communist regime. His accommodation was secure but his income was very modest and ICAR did not feel that his case had any chance so long as there was no law on reparations specifically dealing with victims of political persecution. The relevant law came into force too late for him.

Treatment objectives and services offered

Subjective dimension

Medical intervention: In-house medical examinations and therapies (e.g. ultrasound, massage etc.), as well as external referrals for diagnostic services and surgery and medical pharmacotherapy were offered, to manage his physical health problems, including liver disease, diabetes and heart disease, as well as to provide terminal care for his cancer.

Psychological intervention: Lifestyle counselling and anti-depressive psychotherapy were offered to relieve his anxiety and depression.

Dimension of political participation

Social intervention: In order to break the client's isolation there was an urgent need to provide a welcoming environment, an interest in his past experiences, and involvement in activities beyond narrow clinical interaction.

To this end, ICAR offered clinical outpatient consultations but also involved him in special events like the celebration of the UN day for victims of torture. In the last stage of his life ICAR also assisted him in his home when he was no longer able to come to the Foundation.

Legal intervention: Posttraumatic care for victims is closely related to the recognition of their sufferings and advocacy for the other pillars of reparation: *Restitution, Compensation, Satisfaction and Guarantees of non-repetition*. These aspects of reparation therefore also became essential to the ICAR Foundation's rehabilitation efforts. As part of this, ICAR started a court case against the Romanian state in 2003, demanding moral reparation for victims of political repression during the 45 years of communism. At the end of the legal battle, the president made a historic declaration condemning the communist regime as criminal and offering an apology to its victims and their families.

Moreover, the ICAR Foundation requested through the minister of justice a law on reparations specifically dealing with victims of political persecution under the communist regime; the law eventually entered into force in 2009.

In the interim the ICAR Foundation started a strategic litigation initiative where a limited number of cases were reviewed with the aim of bringing them before the court to request reparations according to international standards. The client's case was reviewed for possible inclusion, but it was finally decided that the long period since the initial human rights violations had occurred would probably make the case less likely to succeed.

Outcomes

What the ICAR Foundation could provide was appropriate medical care in a sympathetic environment for the client's physical and mental problems. As it turned out, these eventually involved major surgical interventions which could only be provided in hospitals, but here too ICAR's physicians used their inter-collegial network to secure optimal care. ICAR staff also provided optimal post-operative and eventually terminal care.

The interventions also contributed to enhance empowerment of the client in demonstrating that he was not forgotten, alone or unappreciated. However, ICAR's interventions were not able to bring about true justice and equality of treatment – except for ensuring that the client got top-quality medical care, normally reserved for more privileged citizens. The interventions enhanced the client's self-esteem and made him feel more accepted and recognised, without solving the basic problem that the people responsible for his suffering were still in power, while their victims survived at the margins of society.

5.3 Primo Levi Association (*Beatrice Patsalides Hofmann*)

The following practice example summarises the methods applied and results achieved after four years of multidisciplinary therapeutic work undertaken with a 40-year-old male patient from an African country whose difficulties can be considered representative of the Primo Levi care centre patient population.

Introduction

The Primo Levi Centre (PLC) considers each patient²⁸ first and foremost as an individual human being endowed with a unique family and life history – a human subject determined by both conscious choices, beliefs, and attitudes as well as unconscious dynamics and conflicts – who, due to a particular set of circumstances at a particular moment in life, has been victimised by perpetrators of intentionally inflicted, political violence. Patients at PLC are usually refugees (with legal status) or asylum seekers (current or former) whose legal, social, economic, political, and medico-psychological condition is determined by a variety of factors, some of which can be positively influenced by therapeutic and other interventions, and others which, at best, are only indirectly modifiable through institutional efforts of lobbying and advocacy.

Among the factors not directly modifiable by treatment efforts are the adverse effects of the constraints of the asylum procedure prohibiting applicants from working, and the absence or inadequacy of housing as well as social and legal support. Whilst these constitute major obstacles to rehabilitation, we do not consider them here, since the issues are addressed in the outreach and lobbying work of the Primo Levi Association, and not directly by the care centre.

The core experience that most PLC patients share is a more or less severe physical and/or psychological traumatising, which is sometimes cumulative (traumatising

²⁸ While the other partner centres refer to clients, PLC prefers to use the term patients.

in both home and host countries). The trauma history of patients is mostly complex and implies, beyond the sudden and catastrophic dismantling of their physical and psychological integrity, profoundly disabling losses in respect of their social and economic status and their ability to act as individual and political agents, as well as a sense of being cut off from various social linkages and networks which normally provide a framework for the individual's sense of self (family, ethnic, religious, and political group affiliations, linguistic, clan and village communities etc.).

The PLC treatment approach is invariably multidisciplinary and is based on psychoanalytic principles that consider the individual as the centre of agency, self-determination and self-knowledge across different dimensions (psycho-physical, socio-economic, cultural, political, religious, etc.). In order to acknowledge the key value of cultural identity as rooted in the mother tongue, PLC provides primary language interpreters in all treatment approaches throughout the process of rehabilitation according to patients' requests.

Patient presentation

A 40-year-old man from an African country, married, with his wife and children remaining in his country of origin, was referred to PLC initially for psychological treatment to address debilitating psychological symptoms including severe insomnia, nightmares, and psychotic, paranoid symptoms. The patient had been arrested in his country during a demonstration for democracy, then detained and tortured. As a result he suffered a severe injury that caused permanent disability and pain.

Conflict analysis

Subjective dimension (Individual/family level)

The patient's paranoid ideation played out as an ongoing conflict with the internalised representation of his torturers causing him to experience traumatic memories as attacks on the mind, and resulting in the patient's reiterated wish and firm intention to receive surgical intervention in order to remove the hurting body part. Further traumatic symptoms such as repetitive nightmares and insomnia, anxiety, hyper-arousal, depression, feelings of helplessness and defeat caused the patient to isolate himself from others due to feelings of profound distrust and a fear of his own aggressive impulses which seemed at moments uncontrollable. The patient's traumatic memories were permanently "triggered" by figures or situations representing aspects of his persecution (policemen, persons in uniform, physical closeness or bodily contact with others); the fear of others in general extended to "helping" figures as well (psychotherapist, medical doctors) since, at that stage, no one seemed trustworthy. The patient's sole preoccupation revolved around the potential surgery: he hoped thus to rid himself of the "agent-cause" of his traumatic experience, flashbacks, panic attacks, and disturbing feelings of rage and fear. The patient's family situation aggravated his social isolation and feelings of guilt, remorse, and depression, since he had left his family in a situation of potential danger, poverty, illness, and general political upheaval. He thus felt physically (as a result of his injury) and symbolically castrated, humiliated and deprived of his parental authority.

Cultural dimension

Socially and culturally the patient considered himself to be a pariah, and was suspicious in particular of all black people who seemed to him to embody the aggressor, triggering paranoid fear. The patient felt enraged against the government of his home country whose military forces had destroyed his relatively well-adjusted life and had forced him into exile, depriving him of contact with his family. He also attributed the first rejection of his asylum request to the ill will of a black interviewer who had invalidated his torture history. In conjunction with this rejection the patient felt again disempowered and deprived of socio-cultural and political agency. He also felt neglected by representatives of the French "medical culture" who had omitted to acknowledge prime psychological aspects of his severe bodily injury. Humiliated and discouraged by these experiences of rejection, the patient felt hostile towards his fellow residents in the asylum seekers' hostel whose needs and conflicts he experienced as intolerably intrusive.

Dimension of political economy

The patient had lost a self-sustaining business in his country and was facing poverty due to French asylum law, which prohibits asylum seekers from working. In addition, because of several rejections by asylum and other French courts over several years during his application and appeal process, the patient was never allowed to collect disability benefits that he was arguably entitled to. Despite his reiterated wish he was not yet admitted to job training activities since admission was contingent on refugee or other legal status.

Dimension of political participation

The patient remained in an ongoing conflict with French immigration authorities who rejected his initial asylum application and all appeals, due, in part, to a mistake in procedure. He felt deprived of all political agency since his participation in the struggle for democracy in his country had been cruelly thwarted. He felt he had sacrificed his health and physical and mental integrity to a struggle for democracy which now appeared hopeless, and this left him with a sense of bitter disappointment and failure.

Treatment objectives and services offered

Subjective dimension

An evaluation of the feasibility of treatment by the centre (as opposed to hospitalisation for acute paranoid psychotic symptomatology and potentially hetero-/auto-aggressive behaviour) was initially conducted by the **clinical psychologist**; psychological stabilisation was achieved via a successful treatment alliance that fostered in the patient a minimal sense of trust in the caregiver and lessened his persecutory ideation; this factor seemed crucial for the success of any further treatment interventions.

The psychologist initiated a referral to the team's **medical doctor** with the goal of evaluating current medication, conducting a medical assessment and coordinating medical treatment provided for in other venues (especially the surgical treatment) in accordance with the patient's concerns and anxieties.

The objective of having the patient gradually accept his physical disability as part of his altered body image (a way of accepting his traumatic experience as part of his life history) motivated the ensuing referral to the **physiotherapist**. The physiotherapist approached the patient with relaxation and subtle movement exercises intended to initiate a sense of bodily agency and to reveal to him his capacity to subtly change his physical experience of arousal ("sense of agency"²⁹). Physiotherapy was integrated with the objectives of the psychotherapeutic and medical interventions. These were to increase the patient's sense of subjective participation in his experience of bodily alienation, disembodiment, rigidity, hyper-arousal, pain, anxiety concerning physical integrity and fear of encounters with other people. Through his psycho-somatic experience he became increasingly aware that (unconscious) defensive, dissociative strategies that had been lifesaving at the time of traumatisation were no longer serving their initial purpose, but were rather inhibiting his capacity to relate to his affective life and to other people.

Dimension of political economy

Referral to the **social worker** was aimed at helping the patient manage the transition from the asylum seekers' hostel (from which he was ejected once his appeal had been rejected) to a more long-term housing situation that should secure a sense of physical stability in the midst of his highly precarious legal situation. The social worker also initiated and accompanied a claim for disability benefit, which had the same objective (*physical and economic agency*).

Dimension of political participation

A concurrent referral to the **legal advisor** was made to assess the patient's legal needs and prepare him for the appeal court hearing. This legal accompaniment included on the one hand support for the patient in formulating a concise and well-argued response in respect of his asylum claim, but also meant, on the other hand, helping the patient tolerate, manage and work with the emotional conflict and high arousal evoked by his a priori rejection by the court (*conflict tolerance*). The legal advisor, in cooperation with the social worker, also advised the patient in regards to the procedures of family reunification into which the patient strongly invested as a long-term goal.

Outcomes

Over the course of a four-year treatment the patient came to see how formerly life-saving dissociative defences (psychotic ideation, disembodiment, etc.) were now keeping him isolated and unable to engage in relations with other people, keeping him also out of touch with his capacity to call on and use his internal resources. Instead of using tactics increasing his insomnia (e.g. listening to Radio Africa all night to follow the political crisis in his home country) because of his paranoid fear of falling asleep, the patient became progressively less fearful and able to calm and contain himself physically and emotionally. Growing trust in his capacity to regain some sense of control over his life and actions – trust that he also extended to his caregivers – allowed him to think through his life history, whereby he reconnected

²⁹ Instead of empowerment, the PLC prefers to talk about "sense of agency."

with parts of himself he had previously believed lost or dead. Through a process of prolonged mourning, the patient faced the loss of his bodily integrity and physical ability, realising that, while it was irreversible, it did not mean a complete loss of personal integrity and life capacity. His tolerance for ongoing distress and sadness caused by the separation from his family increased, and he exerted great efforts to stay in touch with and reassure his loved ones through a third person. His psychological flexibility and tolerance for ongoing anxiety and physical pain was matched by a sense of greater bodily flexibility enhanced by the physiotherapeutic exercises that he regularly applied.

The patient succeeded in establishing a greater trust and self-confidence through the experience of being listened to by all caregivers, as well as through the interventions of both the social worker who had helped to secure long-term housing and the legal advisor who had accompanied him to all major asylum hearings and police stations. Despite acute and ongoing stressors (rejection of all appeals, no monetary resources, ongoing physical pain and failure of surgical procedures, ongoing unrest in his country, illness and poverty of his family) the patient was able to maintain relatively stable psychological and social functioning and he reliably adhered to treatment protocols. Socially, the patient formed a few relationships with compatriots (while still staying away from close or intimate relations) and took the initiative to visit libraries and parks in the city, gauging very accurately what he needed for his psychological equilibrium.

Summary and critique

Despite these apparent successes, the everyday reality of the patient's life did not much improve, except for his having achieved appropriate housing and successfully averted deportation. When compared with his former life his current life lacks some very important elements – economic independence, the sense of belonging to one or several social groups, among them his family – and the patient continues to suffer from political marginalisation, and from the unresolved issues of pain and the threats of further surgery. The treatment interventions, while being effective at the individual level, have not reached the problem of social integration and relationships with his peers and compatriots which are still fraught with suspicion and seem to be on hold. This patient might benefit from some group-oriented activities that PLC has not been able to offer thus far, and the absence of which may have contributed to the patient's ongoing sense of isolation and withdrawal.

5.4 Unit for the Rehabilitation of Victims of Torture (Periklis Papaloucas)

The case example presented here is of a 35-year-old man from a country with a totalitarian, repressive government. He applied for asylum in 2008. He was arrested, imprisoned and tortured due to his political activities as a member of a political group opposed to his government. He was detained for three months during which he was subjected to severe acts of torture. He was referred to URVT by the asylum service.

Conflict analysis

Subjective dimension (Individual/ family level)

Symptoms of PTSD were apparent. He suffered from intense intrusive thoughts and paranoid ideation having lost any ability to trust other people. Feelings of anger, agitation, mistrust, sadness, depression and embarrassment were prevalent. In terms of physical health he had some serious issues such as loss of weight due to malnutrition and osteo-muscular pains as a direct result of torture. He was also a hepatitis C carrier.

Cultural dimension

The cultural situation presented additional stressors. His family back in his home country was pressuring him to get married as that was expected of him. At the same time, his isolation from the host community did not allow him to get involved with other individuals. This was made additionally difficult due to his poor knowledge of Greek and English.

Dimension of political economy

His severe psychological issues and cultural isolation were also a source of financial problems, since they made it difficult for him to find work after his release from detention, forcing him to depend on welfare allowance. This was sometimes delivered with a delay, rendering him unable to cover his basic needs.

Dimension of political participation

Feelings of fear were present and permanent since he felt threatened and targeted by the embassy of his country of origin, prohibiting him from taking any active part in any kind of political activities.

Treatment objectives and services offered

Having in mind all the obstacles the client was facing, the team decided to take certain steps that might contribute to his smooth transition into a better life. Specifically, certain *principal aims* were set in order to achieve this outcome. These were the need for psychological stability, physical health improvement, empowerment, and release from detention, connected to obtaining refugee status.

Subjective dimension

The need to reduce the client's severe psychosomatic symptoms by getting him to accept psychopharmacological treatment from a psychiatrist was of paramount importance. Another crucial need was to strengthen his ability to take decisions about his life independently, giving him the opportunity to empower himself.

Psychological Stability: Initially his compliance with the treatment was low, and he did not attend sessions regularly. However, every time he felt the need to discuss something urgent, he would request an appointment with the therapist. After being convinced to take medication, his paranoid ideation was controlled. The intensity of

anxiety and PTSD symptoms was decreased. The client started making plans and setting goals for his future. Unfortunately, his severe psychiatric condition and the numerous relapses he was experiencing were a trigger for multiple and frequent setbacks in his overall situation.

Physical Health Improvement: The client's health was generally assessed after being referred for specific examinations by the medical director of the Unit. Stable treatment for his health problems was managed as regular access to health care was achieved.

Dimension of political participation

In the socio-legal dimension, release from detention and the chance subsequently to live on his own were thought to be essential to his rehabilitation process. The URVT'S Social Advisor offered assistance by contacting landlords; this was only possible because the client received a welfare allowance. Of major importance was the necessity for a second interview with the asylum service. During the initial interview the client was psychologically unstable and unfit to undertake such a crucial interview.

Release from detention – Refugee status: The client was finally released from detention but his appeal and a second interview with the asylum service were still pending. Finally, he decided not to wait any longer in Cyprus and returned home.

Empowerment: The liaising activities of the social advisor secured housing and food for the client; his basic needs were covered with the help of local organisations. Eventually, the client was following the procedures for receiving services without the need for help from anyone else.

Conclusion

In conclusion, the client showed improvement in some areas of his life. This was made possible because of both the staff's and the client's determination, hard work and perseverance. Unfortunately though, two serious issues remained. The nature of his psychopathology was a crucial factor that would not allow satisfactory rehabilitation. But also, the official procedure for acquiring asylum is tremendously time-consuming, a situation he was not able to endure, forcing him to abandon his attempt. He returned to his country of origin and URVT lost contact with him.

5.5 XENION (Dorothee Bruch, Elise Bittenbinder)

The case presented here is that of a 30-year-old Kurdish woman who was persecuted in her home country for her political activities. She was imprisoned and suffered physical torture and rape in prison, as well as having to witness physical abuse of others. She sought refuge in Germany and after four years of uncertainty was granted refugee status. She suffers from schizophrenia which was aggravated by the traumatising events. She attempted suicide and as a consequence was hospitalised in Germany for several months.

Conflict analysis

Subjective dimension (Individual/ family level)

The client suffers from auditory hallucinations, delusions, nightmares, intrusions and panic attacks. Being raped at an early age without previous sexual experience had confused her sense of intimacy, resulting in her having great difficulty knowing whether and how to be close to someone without fear. The client struggles to distinguish symptoms of her schizophrenia from symptoms of her traumatisation, yet it is very important to her to understand her situation and her symptoms. She defines herself to a great extent through the illness which has become the centre of her life. This makes it hard for her to interact with others, a condition which is furthermore hindered by her prevailing mistrust and devaluation of other people. As a consequence she is very isolated, despite her strong wish to find friends, find a job and to regain control of her life. Devaluation and mistrust also affect the relationship with doctors, carers and therapists – for instance, two interpreters have declined to work with her because of it. The client is estranged from most members of her family (except her mother) and has serious conflicts with her sister, who was the one to introduce her to political activities in the first place. Her sister still lives in Turkey and is politically active, while the client has difficulty coping with the demands of daily life, and she suffers from this discrepancy.

Cultural dimension

As a result of mistrust and devaluation of others, particularly of people from her own country, the client remains largely isolated and does not participate in either the Kurdish or the German community. Moreover, fear of contact with others and problems with concentration have largely prevented her from learning German, limiting her options for participation in cultural and integrative activities. A lack of intercultural competence among the mainstream health professionals (e.g. in hospital) who have treated her before has created difficulties in diagnosing and distinguishing between posttraumatic symptoms and psychotic symptoms. This has, at best, not helped her to understand her situation and symptoms.

Dimension of political participation

The client's ability to actively participate in any community is limited by her psychological problems: she does not trust others, is occupied with her illness, has difficulty concentrating and suffers from panic attacks as well as delusions. As a result, she was (and she felt herself to be) very dependent on her carers, especially in the early stages of treatment, because she was unable to master daily life by herself. A professional personal assistant has been assigned to her and in addition she receives support from a volunteer mentor. Despite her current psychological state, the client is a very political person and suffers from being unable to be politically active in her home country. She therefore felt "at home" in XENION in part because she could voice her political opinions freely and felt "politically understood" there. Before she came to XENION, the client had been living for four years in uncertainty regarding her legal status and her right to remain in Germany. Had there been a professional assessment of her psychological problems early on, the asylum process could probably have been facilitated and shortened. As it was, her unresolved personal situation was prolonged, contributing also to a protraction of her symptoms.

Dimension of political economy

The client is unable to support herself financially due to her psychological symptoms as well as her lack of proficiency in German. She is living on state social benefits. It took close to one year for the health insurance system to approve the treatment at XENION (not including interpreting). Financial constraints within XENION meant that during this time the psychotherapeutic treatment had to be interrupted.

Treatment objectives and services offered

Subjective dimension

The client wished to regain control of her life, which included finding a way to manage her symptoms, especially her panic attacks. She had a strong desire to understand her symptoms better and to integrate the traumatic experiences into her life, with the aim of eventually being able to live with them. She also wished to establish social contacts and take up a job.

The chosen form of therapeutic intervention had the aim of treating the personal boundaries of the client particularly carefully by respecting her conception of her illness as well as offering information about the consequences of torture and possible steps of rehabilitation. The client responded very well to imaginative methods, hypnotherapy and some elements of EMDR. These interventions were embedded in a systemic approach and always had to be linked with psycho-educative explanations because it was considered to be extremely important for the client to understand the processes she was going through. Building a trusting relationship with the therapist was an important initial step which also paved the way for more trust in other people.

Given the very volatile and vulnerable state of the client, especially during the initial stages of treatment, stabilisation was given priority over confrontation with the trauma. When the traumatic experiences were brought up in the later stages, this was always carefully planned with the client and happened entirely at her own pace.

Cultural dimension

In combination with the psychotherapeutic interventions, social work inputs were aimed at establishing living conditions which were more independent of outside help, helping the client to normalise her life. By establishing contact to suitable group activities such as art therapy and a language class, the client was supported in her desire to develop social contacts, find meaningful activities and gradually re-affiliate with society. The latter was further supported by establishing contact with a German volunteer mentor who meets with the client regularly.

Dimension of political participation

An important initial aim was to clarify the client's asylum status. Besides this, appropriate specialised help was provided with a professional personal assistant as well as a volunteer mentor. The client was supported in finding a language school and in getting involved in leisure activities. Beyond these practical issues, the psychotherapist worked with the client to develop a new perspective and aims for her life which were more realistic in her current situation.

Dimension of political economy

XENION's staff aimed to secure funding for the client's treatment and for the interpretation. With the help of the personal assistant, the mentor and the psychotherapist, the client tried to find employment in a setting suitable for persons with mental disorders but did not succeed.

Outcomes

Over the course of her treatment, the client was able to contact her family in her home country, and she was visited by her mother once in Germany. With the help of the staff she found a flat and has moved in with a friend. There were a lot of conflicts in relation to that, but she managed to solve them to some extent. She gained an improved understanding of her psychotic condition and its interaction with her traumatic symptoms. Moreover, she developed a capacity to handle her illness and managed to stay in regular contact with doctors and carers. She developed the motivation to take part in group activities and has joined a specialised language course for traumatised persons (at XENION). These developments, although not to be taken for granted, were in line with the treatment objectives and thus can be considered "expected outcomes". A number of unexpected developments included the fact that the client succeeded in obtaining German citizenship with the help of her personal assistant and her mentor, and was able to visit her family in Turkey.

Unfortunately the client's psychological stability remained vulnerable. This is especially critical since very early on in the treatment programme she had attempted suicide and had to be hospitalised for several months. However, against the expectations of the therapist, she took up therapy again afterwards and has continued since for two years.

5.6 ZEBRA (*Uta Wedam, Doris Rummel*)

This case example is intended to give an insight into our interdisciplinary therapeutic work based on the assumption that traumatised refugees, due to their exceptional present and past living conditions, need a comprehensive offer of services for rehabilitation.

Refugees live in a transitional phase marked by changes in various areas of life: the consequences of political violence, war and torture; the ongoing process of trauma that continues even after the escape from the home country; as well as the psychological and physical sufferings and the various losses which remain a part of them. Our holistic approach demands interdisciplinary thinking and hence a multidisciplinary team.

Presentation of the client: The client, a 30-year-old woman from Kosovo, was seeking asylum when she came to ZEBRA for the first time in 2006. A psychiatrist referred her to ZEBRA for psychotherapy after an in-patient stay at the regional Sigmund Freud psychiatric hospital. She fled to Austria with her husband and her three boys

aged between 5 and 11. The family had to flee because her husband was persecuted during the war in Kosovo and his life was still in danger. The woman experienced the war as severely traumatic and she had already had psychiatric care in her home country.

Conflict Analysis

Subjective dimension (Individual/ family level)

The client presented with a somatic form of depression with several physical symptoms that had already been checked medically. She also frequently experienced panic attacks and different states of panic. She was afraid of having an unknown dangerous disease, afraid of collapsing, afraid of losing her mind, and she harboured an existential fear with respect to her husband who is suffering from a rare immune disease. Furthermore, she was afraid of having to leave Austria. The reasons for some of her symptoms can at least partly be attributed to the overwhelming strain exerted on her by external factors.

At the beginning of her therapeutic process she generally described her current state and mood in terms of her physical symptoms. Pain originated mainly in the stomach and continued to the heart, she felt pressure on her head and in her ears. She reported a feeling of narrowness and inability to breathe, most notably around her throat. At times she had a sense of suffocating, sometimes she had to vomit. She was often afraid of her own or her husband's death. The terminal illness of her husband constitutes one of the main anxieties of her life. He is very ill and cannot live without strong medication, which his body sometimes cannot tolerate. She was worried about a possible suicide since he had in the past voiced this intention in a farewell letter. She is also afraid that his disease could change for the worse since the doctors cannot give an exact prognosis. His disease, which is rare and requires special treatment, is a taboo subject within the family and at the same time it triggers rage, fear and grief. The pressure she described repeatedly in terms of physical symptoms corresponds to the pressure caused by exterior circumstances she was exposed to:

- no assured stay in Austria (subsidiary protection has to be prolonged each year)
- existential fears (husband, herself) lead to emotions of helplessness and weakness
- awareness that she alone has to bear the responsibility for her family

In her new society she has to play an entirely different role from that which she played back home; now she has to be the provider for her three children and her sick husband. This situation leads to a big inner conflict between needs, wishes and expectations on the one hand and realistic opportunities on the other.

While both husband and wife grieve over everything they have lost, neither of them is able to communicate their ambivalent emotions. Each of them tries to spare the other any additional trouble and does not want to be a burden. They are unable to share the tragic facts of their two lives, leading to a protracted lack of communication between them.

Cultural dimension

Although she has no other family members in Austria (her parents are still living in Kosovo, her siblings live all over the world), the family gets support from acquaintances from their own culture community. In accordance with her new legal status (subsidiary protection) she is allowed to work, which is important to her. On the other hand she often has problems with her jobs due to her psychological status and this puts serious pressure on her. She needs psychotropic drugs, which is one of the reasons she cannot sustain full time work, and sometimes this leads to her losing her job.

The family has problems regarding communication with professionals in the health care system. Because of his rare disease the husband has to be treated at a special clinic in Vienna. That leads to many difficulties: it is very costly to get there from Styria, there is no interpreter available in the hospital so she has to interpret even though she doesn't understand German very well. This causes either misunderstanding, or else she is afraid of telling her husband the whole truth about his condition. He has so far had two courses of treatment and, because of a change in the doctors looking after his case, he has lost his trust in them and the hospital. Moreover, although his general practitioner is not very knowledgeable about this disease, it is he who has responsibility for reducing the dosage of the medication whenever the physical state of his client requires it.

Dimension of political participation

The subsidiary protection was a big step towards the possibility to stay in Austria permanently. At the moment they have to apply for renewal each year.

Dimension of political economy

The family has little money. She is allowed to work because of her subsidiary protection but the money she earns is not enough for a family of five. She is constantly afraid of losing her job in case the family loses their family assistance payment, on which they depend.

Treatment objectives and services offered

Subjective dimension

At the beginning of the psychotherapeutic treatment the focus was on building a trusting therapeutic relationship and on helping her to understand her symptoms in relation to her current life-situation. Among other things we focused on the reduction of symptoms, especially her various anxieties, and on helping her with the process of grieving. She had experienced many painful losses, for example those of the family members she had left behind. Another goal has been to support her in dealing with her husband's illness, including building awareness and the ability to cope consciously with the situation, and empowering her to take on responsibilities (for herself and the children). The treatment can only be effective if the therapists manage to actively engage the client in the therapeutic process. For this reason we work with skilled **interpreters** in order to create an atmosphere in which confidence could be established. The interpreters are available for the whole interdisciplinary team.

The psychotherapist referred the client to the team's **psychiatrist** in order to manage and coordinate her need of psychotropic drugs. Our psychiatrist also works at the psychiatric hospital and she can initiate in-patient treatment for our clients when necessary, as was the case for this client. According to a prior agreement between the client, the psychotherapist and the psychiatrist, the client received in-patient treatment for two weeks after a mental breakdown. A **physiotherapist** was also consulted due to the client's physical pains. The goal was to help her relax and develop self-perception and body awareness conducive to achieving a positive physical state.

Dimension of political participation & political economy

The first member of ZEBRA's staff to meet the client was the psychotherapist. After the initial assessment the psychotherapist decided to involve the **legal advisor** and the **social worker** in the treatment because of the client's complex and manifold problems and needs. The legal advice pertained to her legal needs and her residence rights in Austria. It was particularly important to provide her with information about the asylum procedure and to accompany the family with legal expertise during this process. Social work was aimed particularly at securing invalidity benefits for her husband.

Outcomes

The client has been in treatment for three years. The frequency of the psychotherapeutic sessions changed according to requirements, e.g. during a crisis related to the sudden worsening of the husband's state of health, further appointments were arranged.

The client made use of the opportunities independently and learned how to handle her distress, grief and symptoms. She appreciates psychotherapy because she sees the opportunity to speak about her current state of mind as well as the fears and worries about which she doesn't want to speak to her family. During therapy she has learned to cope with her symptoms. She can speak about them freely and has stopped feeling as if she was going mad, because she has realised that she can take responsibility for her state of mind and her body by taking the symptoms seriously and reflecting on them with various kinds of therapeutic help (psychotherapy, psychiatric consultation, physiotherapy). She has described the way in which the interdisciplinary approach taken at ZEBRA had helped her take the various steps she had to take herself. She said it had helped her develop the physical and mental capacity she needed for her work (e.g. she started working part-time, without overstraining herself with a full-time job). With the help of the social work and the legal advice she felt well supported and informed in her daily life and daily responsibilities. This in turn led to the feeling of security she needed, specifically with regards to her residential opportunities.

Summary and critique

This practice example points out how important and helpful interdisciplinary cooperation can be, but it also illustrates the limits which even an interdisciplinary

team faces in the treatment of traumatised clients. These limits can be found in socio-political circumstances that clearly reflect the client's current living conditions and the power structures in society, as well as internal and psychological processes. It makes clear how vulnerable this client group is. Their mental and physical scars may never heal, and there is a constant risk of renewed traumatising by unexpected negative experiences. Still it is possible for her to perform at work despite her psychological distress and her husband's illness. In spite of that she still experiences emotional pain and cannot live entirely without psychotropic drugs. She still feels thin-skinned, vulnerable and insecure.

There are limits that must ultimately be accepted, and it is always a challenge for individual therapists and professionals to experience this powerlessness. It is therefore particularly important that this task is carried out by a team or even an entire institution. The collective perceptions of colleagues offer a diversity of interpretations which are very valuable for determining the next support steps. This way the entire team can be used to provide needed support, also when crises in the lives of the clients triggers a crisis-ridden behaviour among those responsible for dealing with the case.

Using this approach, care for the client is enhanced and a more comprehensive assessment can be provided. Through the commitment of the team, the carers themselves will also be able to take a clearer position on the case, and this is helpful to the team's own work, as well as for presenting the case to external parties.

6. External evaluation: Outcome Mapping

Outcome mapping³⁰ was chosen as the basis for appraising the outcome of the evaluation process itself and to clarify goals, activities, and progress towards anticipated results of the project as a whole.

At the heart of the Outcome Mapping methodology, which was originally conceived for use in the field of international development, is the view that development is accomplished through changes in the behaviour of people; therefore, people and organisations are the central concepts of Outcome Mapping. The uniqueness of the methodology is its shift away from assessing the macro products of a programme (e.g., policy relevance, poverty alleviation, reduced conflict) to focus on changes in behaviours, relationships, actions and/or activities of the people and organisations with whom a development programme works directly, thus the posits of the methodology can be logically linked to programme activity.

In this project Outcome Mapping was not implemented in its entirety, but rather adapted for the specific task at hand, which was for it to be used at the programme and organisational levels as a monitoring system and to evaluate on-going or completed processes. A learning-based and user-driven view of evaluation was taken, guided by principles of participation and interactive learning, and encouraging evaluative thinking throughout the process.

The adapted Outcome Mapping process was introduced at the initial project meeting through a participatory discussion led by the external evaluator. At this meeting a series of questions – based on the Outcome Mapping method but not restricted to it – was developed and this was used to build the evaluative framework (see below). As a result of the fact that the project participants had used the method in a previous project³¹, the discussion during this project focused on what in Outcome Mapping methodology is called the "boundary partners," in other words, those the participants can directly influence through the project. The core project partners were asked to identify the boundary partners and then outline what changes were being sought with them. The changes were then structured into a set of outcomes which became known as the evaluative framework.

The **evaluative framework** consists of categories of key desired outcomes (see Appendix 2). Importantly, the project participants, in accordance with the Outcome Mapping methodology, compiled their own set of desired outcomes for the project. They were structured so that the various desired outcomes were linked directly to specific boundary partners – in this case, for example, partner organisations, health professionals, donors etc. Outcomes were also graded in terms of those the partners would "expect to see," those they would "like to see" and those that, if achieved, would make the project participants consider the project "to be an unparalleled success." The external evaluator explained that, in any project, outcomes in the "expect to see" category should be achieved, at least some of the "like to see" outcomes should have been achieved, and if any of the third level outcomes were achieved this would have been very welcome (a bonus, if you wish) but not a necessarily expected result.

³⁰ See Earl et al. (2001)

³¹ See Bittenbinder, E. (2010), p. 18.

This framework then served as the template³² against which the project was finally evaluated from an external perspective by the external evaluator. At each of the subsequent meetings participants were reminded of the framework and they were asked about the degree to which the outcomes had been achieved. At each meeting, the framework was also further refined. At the final meeting of the core project partners over two days in Cyprus, participants dedicated time to addressing the degree to which they felt that the outcomes (as specified in the evaluative framework) had indeed been achieved. This information was then used to draft the final external evaluation report.

In addition to the use of the evaluative framework for the external evaluation, a series of other questions was addressed consistent with the Outcome Mapping approach. These were questions that sought to better understand and evaluate good organisational/project practice, for example, whether the participating organisations:

- sought or developed new ideas, opportunities, and resources;
- received ongoing feedback from key informants;
- assessed and potentially (re)designed products, services, systems, and procedures as a result of the project;
- created spaces for feedback from those whom the project sought to influence;
- whether results were being disseminated effectively throughout, highlighting any innovations coming from the project; and
- whether the project had ensured that organisational/project reflection was built in to the process.

The evaluator, by being present at meetings, was able to assess the answers, and also interviewed the lead partner about the issues. The issue of added value of the project was also considered. In addition to this, the external evaluator reviewed the degree to which the wider indicators set out in the project proposal were met; these were:

- adherence to the time table
- development of a qualitative questionnaire on care and treatment methods
- information flow between partners
- quantity and quality of data collected in all participating centres
- efficiency of analysis of data/usefulness of result
- comprehensiveness of the developed Inventory of Working and Treatment Methods and recommendations for staff care
- the number of persons who were reached through the project
- whether the relevant target group was reached
- the content of the feedback offered by the target group

Overall, the external evaluator came to **the conclusion** that the Outcome Mapping framework allowed the partners to reach consensus about the macro-level changes (outcomes) they wanted to achieve (and whom they wished to affect through them) and the strategies to be employed to do this. It also provided a basis for subsequent discussions with partners to negotiate programme intentions and to help the programme develop a monitoring system and establish an evaluation plan. Outcome

³² See Appendix 2

Mapping was a useful and appropriate tool to chart goals, activities, and progress toward anticipated results. In addition to this, the evaluator also assessed the objectives and outputs as laid out in the original proposal. Broadly speaking the external evaluator's review came to the conclusion that the objectives of the project had been achieved.

7. Conclusions

This section presents some of our main conclusions from this project. We reflect on what we learnt and the challenges we face – the same challenges, of course, as are faced by other centres providing treatment, care and rehabilitation services to torture survivors.

7.1 Key issues and challenges

The right to rehabilitation?

Rehabilitation for victims of torture is widely acknowledged as a human right but its implementation does not in practice match the standards required by the EU in its directives³³. The reality is that in most European countries, services for the rehabilitation of torture survivors exist independently of state support, and the majority of these services have emerged in response to the absence of publicly provided provision. In many cases centres have grown up at the same time as asylum legislation was getting tighter and harsher. At the forefront of many of these services are health professionals committed to human rights, offering services in difficult and uncertain contexts, financially supported by insecure project-based funding. Their existence has only partly answered the question which still has to be

³³ EU Directive laying down Minimum Standards for the Reception of Asylum Seekers 2003/9/EC; Report from the Commission to the Council and to the European Parliament on the Application of the Directive COM(2007) 745; Green Paper on the future Common European Asylum System COM(2007) 301; and Amended proposal for a Directive of the European Parliament and of the Council laying down Minimum Standards for the Reception of Asylum Seekers COM(2011) 320.

Article 15 of the Directive states that Member States shall provide necessary medical or other assistance for persons with special needs and Article 17 defines those groups of vulnerable persons: minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence. Article 20 states that member states shall ensure that persons who have been subjected to torture, rape and other serious acts of violence receive necessary treatment of damage caused by the aforementioned acts. The report from the Commission to the Council and to the European Parliament COM(2007) 745 states: "Identification of vulnerable asylum seekers is a core element without which the provisions of the Directive aimed at special treatment of these persons will lose any meaning" and the Green Paper on the future Common European Asylum System COM(2007) 301 stresses: "Serious inadequacies exist with regards to the definition and procedures. ... (M)ember States lack the necessary resources, capacities and expertise to provide an appropriate response to such needs." In the newest amended proposal of 1.6.2011 for the Directive COM(2011) 320, it is stated that addressing the special needs remains a problematic issue, and that the proper identification of those who belong to vulnerable groups has a bearing on access to appropriate treatment. Subsequently Article 22 states that a appropriate mechanism is to be installed to identify needs and Article 25 sees more of an obligation on the part of states to provide services than Article 15 of the existing Directive: it says that torture victims *must* receive treatment, refers specifically to PTSD as one of the conditions to be taken into account, and requires access to be made available not only to medical, but also specifically to psychological treatment.

addressed by the state and the centres: how can this vulnerable population gain access to health and social services as well as legal assistance and other rehabilitation services? Our study highlighted how difficult it is for centres to provide and sustain services for torture survivors, yet how determined and professional the attempts of colleagues are, as they work to reach those who are vulnerable and who would otherwise not be able to access health services.

Academic/professional discourses related to research

There are many controversies surrounding appropriate research methodologies for the evaluation of interventions with torture survivors. There will be consensus that it is desirable to assess services for their effectiveness, but, in the absence of agreement on a minimum set of shared desired outcomes, it is hard to know what measures to adopt. There are not sufficient indicators to measure the efficacy of the different treatment approaches and successful outcomes.

And then there's the ethical question of whether one should conduct any research at all on torture survivors – even if attempts are made to make that research appropriate and culturally sensitive, and to take into account the wider reality of their lives. After all, survivors need to be protected from any questioning which might add to their suffering or re-traumatise them. And it seems scarcely right to question clients if one is unable to offer them any treatment. And even where one can do so, the interests of research could undermine the interests of that treatment.

At the same time, there is still a lack of clarity and consensus on what the intended outcomes of rehabilitation are or should be, and research may be able to help here, providing, in the end, an improved quality of service to our clients. Our research approach is distinctively and deliberately qualitative, seeking to provide an innovative approach to evaluating our own work and that of our peers, with a specific set of values and a specific framework. We would argue that this approach to evaluating therapeutic work with torture survivors should be considered a valid way to seek to answer the questions we all wish to address: what helps, and what can we do that is helpful in facilitating the change process for torture survivors? We hope that in detailing our approach here we have shared some of the richness and depth which it has made possible, in enhancing not just our own individual practice, but also the practice of our centres, based on the process of learning together, with our peers.

Developing measures to capture complex outcomes in complex services

There is widespread consensus in the field that we should be assessing the outcomes of our work. It seems to us that one of the key challenges is how to develop and use a range of measures which enable us to grasp the complexity of outcomes (negative and positive, expected and unexpected) in the light of the complexity of the services provided. For this, we need to work together to better define indicators of outcomes, learning from developments in other fields, wherever relevant.

The aim of our work was to share and disseminate our way of working and our learning points. In this regard we have shared one approach to outcome mapping which would be a useful adjunct to complement other ways of evaluating services for torture survivors. This is not to ignore the fact that staff in most centres are already extremely stretched and the demand for their services far outstrips supply, leaving staff under sustained strain. Any attempts to evaluate services must take into account

what is realistically achievable in day-to-day work, particularly where most centres lack staff with appropriate research expertise.

Support and care for the professionals working in the field

Our approach led to many discussions on the need for and nature of staff care methods in the centres. We would suggest that staff care methods are crucial to quality services, and that, without adequate support, quality is likely to suffer. Staff care methods can be diverse, as our study has shown, but the common feature is that they provide a safe space for reflection and discussion of work with clients and relationships in the organisation, so that support can be given and received, struggles and uncertainties shared and explored, and creativity and innovations nurtured.

For us, the process of engaging in this project was a form of staff support. We learnt that the whole process – collecting data, describing it to each other, discussing our approaches, our differences, challenges and ideas – both validated and acknowledged the difficulties and satisfaction we experience in our work. We hope that the process of dissemination which we have initiated, now reaching at least twelve organisations directly working with torture survivors as well as many other colleagues, will mushroom and that we can continue to learn from each other in our self- and peer evaluations. However, we are only too aware that the intensive type of dissemination meetings we held, such as the bi-national partner meetings, are time-consuming, despite all the participants welcoming the in-depth professional exchange they made possible. The process of self- and peer evaluation supported staff in their own reflections on their work, and team members commented that they felt encouraged to participate in future research if it adopted a similar qualitative approach.

Human Rights work and advocacy and legal advice

It is apparent from the study that human rights activities, legal advice and advocacy are represented in many centres, and there's a broad consensus that such work is necessary, both to improve torture survivors' health, and help in the process of striving for redress. The question of redress is closely related to the question of redemption and the need for justice of the victims. We found that some of us wanted to include those philosophical, ethical or religious questions which indeed often mark a stage in many of the psychotherapeutic processes that we experience. So those issues are relevant on the individual level of our clients, for the caregiver and for the institutions. One challenge in outcome mapping and evaluation is how such activities can be evaluated with meaningful indicators.

Balancing strengths and difficulties in evaluations

It became apparent during the course of the project that any approach to outcome mapping and evaluation of quality should allow for an acknowledgement of the strength, resilience and creativity of clients, as well as that of the centres, and that evaluation should not only focus on difficulties and deficits. In this sense, evaluation is most helpful in facilitating change, and more meaningful, when it takes a balanced approach to understanding the whole person, and the whole service, in context.

Additionally, there are three areas of learning for us which are addressed in more detail in the following sections.

7.2 Bi-national meetings

As already mentioned, although the need and effectiveness of networking is widely advocated, in reality it is not easy to find ways in which networking can be put into practice in a way which allows for diversity, is open for the equal participation of all partners, and is also effective and outcome-oriented. In this project we had decided to use bi-national partnerships as a means of dissemination.

All core partners agreed that this would be an appropriate and participatory method of dissemination, but we were not agreed on how to collect information from the bi-national partners and what to offer, or share, from our side. In the end, self-evaluation (see Chapter 2.3) was seen by most as an ideal way of sharing information, allowing the collection of data and the use of the tools we had used ourselves (such as the Inventory and Framework for Qualitative Assessment), while also being open enough to allow for the in-depth exchange of information. Self-evaluation allowed us to learn in a reflective way by looking at our own working and treatment methods as well as at those of our bi-national partner and, by comparing, learn from each other.

The bi-national meetings were experienced as particularly helpful in disseminating the examples of good practice in the care of torture victims which had been compiled by the participants. As a result of their positive experience, the core centres agreed that one aim for the future will be to create a space for transnational networking by using self- and peer evaluation. They agree that the methods used can indeed help other centres working with victims of torture and political violence, giving them the opportunity for professional exchange and improving practice, as well as for comparing methods and collecting data which may be amenable to further research or academic study. There was one drawback: even under the conditions of this project, there was still not enough time to exchange experiences and expertise in as much depth as we would have liked, though we learnt that such collaboration is essential if we are to support and facilitate further research in this field, and to develop our expertise in working with torture survivors.

In summary, we feel that the process of dissemination we adopted was helpful in three ways:

- It provided dedicated staff time for professional reflection with colleagues who were "external," but also extremely experienced in the same field, making the exchange very vivid, professional and effective;
- It created a joint learning process with a new structure for internal reflections, which simultaneously allowed collaboration and peer evaluation;
- It fostered European-wide collaboration in collecting detailed data.

7.3 Staff care/Staff protection³⁴ (*Beatrice Patsalides Hofmann and Elise Bittenbinder*)

³⁴ The reflections and conclusions presented in this chapter were written by Beatrice Patsalides Hofmann and Elise Bittenbinder after discussions with the team of Primo Levi Association and incorporating contributions made during the partner meetings of this project.

For the last twenty years the notion of "staff care" has received increasing attention in the field of humanitarian aid where organisations have recognised the importance of maintaining the physical and psychological well-being of staff members who may be exposed to serious dangers and psychological stress. The concept of "staff care" has since come to be considered essential also for caregivers employed in institutions responsible for the rehabilitation of victims of human rights violations. These caregivers are equally seen to be exposed to very high stress levels caused by their patients' severe trauma experiences and precarious living situations.

This section provides an overview of the ways in which the six core project partners conceptualise and evaluate the notion of "staff care" (or, rather, "staff support," as some suggested); it explores the needs we have identified and the methods we have implemented, the shortcomings we have to report, and the recommendations we propose for "good enough" practices.

"Staff care": concept and critique

"Staff care" is today generally defined as the "attitudes and actions that institutions take to promote the well-being of their staff, and that staff take to promote the well-being of themselves and each other."³⁵ Staff care is thus divided: there are measures taken by the institution, and measures taken by staff. In our discussions we focused on institutional mechanisms, but also considered critically the concept of "staff care."

On the one hand the concept reflects real concerns regarding work-related stress levels that have been reported by staff in trauma centres worldwide; on the other it seems to both exaggerate the particular nature of "stress" experienced by staff working with victims of political violence and, more importantly, inaccurately displace the main cause of work-related "stress" – taking it away from the political/economic and social dynamics that impede proper functioning of care-giving institutions and putting the responsibility on to alleged patient/caregiver vulnerabilities. Provocatively, one might see the concept as a reflection of current fashionable paradigms operating in "victimisation-prone societies" that not only infantilise adult professionals by inviting them to identify as "victims," allegedly "traumatised" in turn by their patients' trauma, but that also establish undue parallels between actual victims and caregivers, who supposedly, due to a "secondary traumatising," are similarly in need of receiving "care."

The very notion of "staff care" thus needs to be defined much more exhaustively, since it potentially de-contextualises and displaces the real problem – namely the lack of care, support, attention and socio-political inclusion given to both the care-giving institutions and the refugee and asylum seeker populations – by national government officials and funding distributors. We would suggest that a discussion of "staff care" should first focus on a political analysis of the allocation of resources and of the social distribution of tasks it defines³⁶, since the great majority of caregivers in the centres report being stressed not so much by client/patient characteristics, but more by working conditions and the socio-political exclusion that the caregivers and their clients both experience.

³⁵ See: Porter, B. & Emmens, B. (2009). Approaches to staff care in International NGOs. People in Aid – Inter-Health (web journal). September 2009:

[http://www.interhealth.org.uk/editpics/File/Approaches to Staff Care in International NGOs.pdf](http://www.interhealth.org.uk/editpics/File/Approaches%20to%20Staff%20Care%20in%20International%20NGOs.pdf)

³⁶ Laugier, S. (2006). *Le care: Enjeux politiques d'une éthique féministe*, *Raisons publiques*, 6.

While all six centres agreed that working with victims of persecution and political violence was taxing, at times even exhausting (especially for new members of staff, who need a lot of guidance and time for discussion and feedback from more experienced staff members), the reasons given for "burnout" or exhaustion originated rather more often in institutional and socio-political problems (lack of funding and instability of work conditions and subsequent pressure in management) rather than in individual conditions or the victims' traumatic symptoms or history. This does not mean that severely traumatised clients do not have an emotional effect on the therapists and social workers who deal with them.

Torture rehabilitation was initiated and continues to be carried out today mainly by health professionals who are dedicated and committed to human rights. It is often this dedication and commitment of staff – and what some of them sometimes are able to see as the privilege of participating in the transformation of suffering³⁷ – which gives them the energy that balances the level of stress. At the same time, such dedication can carry its own risk, when carers lose sight of their own limits and work themselves to exhaustion. This danger needs institutional containment and can mostly be dealt with effectively with good supervision structures.

In summary it is the combination of insufficiently structured and poorly supported institutional conditions, ongoing political mistreatment of clients and the uncontrollable aspects of their suffering which finally constitute the professional threat and burnout risk for the people who work with them. Nevertheless this cannot and should not be compared to the suffering of the clients.

Specific, potential work-related stressors justifying the need to protect caregivers

Therapeutic work with traumatised victims of political violence is highly stressful for several reasons that pertain to different dimensions: the complexity of the trauma associated with political violence, the very taxing and at times traumatic conditions of the refugee's border crossings, the stressful and, for some, traumatic experience of the asylum application (with its rejection said by many victims to be "worse than the torture"), and the immensely hurtful conditions of social, political, and economic exclusion that asylum applicants have to face in host countries. The traumatic sequelae of intentionally inflicted, state-sponsored, political violence – a trauma which is "man-made," unlike those brought about by a natural disaster – include not only symptoms of "posttraumatic stress," but also symptoms of complex PTSD, as well as depression and personality changes. In addition to their complex trauma, patients are adversely affected by stressors related to exile, multiple loss, serious relational disruptions, and highly precarious, economically deprived living conditions. In other words their trauma and experience of persecution lie not really in the past (hence the terminological error in the concept of "post-traumatic" stress), but are on-going processes, which the therapist witnesses and participates in.

³⁷ Saakvite, K.W. & Pearlman, L.A. (1969). *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: Norton.

Pearlman, L.A. (1995). Self-Care for Trauma Therapists. In Stamm, B.H. Ed. (1995) *Secondary Traumatic Stress. Self-Care Issues for Clinicians, Researchers and Educators*, Sidran Press, Lutherville, Maryland. Pearlman writes: "Those who voluntarily engage empathically with survivors to help them resolve the aftermath of psychological trauma open themselves to a deep personal transformation. This transformation includes personal growth, a deeper connection with both individuals and the human experience, and a greater awareness of all aspects of life." (P. 51)

This complex traumatising of victims is thought among some professionals in the field to exert a potentially "traumatising" effect on caregivers because of the allegedly "contagious" character of the traumatising.

Related to this is the notion of "vicarious traumatising," which implies the reactive emergence of (post-) traumatic symptoms (insomnia, nightmares, exhaustion, etc.) in caregivers, and is said to lead to the state known as occupational "burnout."

"Burnout" is a psychological term for a syndrome characterised by long-term exhaustion, diminished interest, or cynicism in relation to one's work, resulting in reduced professional efficacy.

We recognise that the effects of the above-mentioned client characteristics can disturb and at times overthrow the therapist's psychological and emotional equilibrium, especially if he/she lacks peer support and professional exchange, regular supervision settings in which he/she can process and reflect on the repercussions of this kind of traumatic exposure, and, behind all that, sound and specific professional therapeutic training, including experience of personal therapy.

For professional "burnout" to occur it seems, however, that the impact of the clients' trauma and case specifics alone do not suffice. We rather believe that if "burnout" occurs it reflects the compounding effects of the client's circumstances as well as the ongoing burdening of the therapist by inadequate institutional support structures.

As we have learned from our study, some institutions providing care to victims of political violence suffer from more or less serious institutional problems and shortcomings some of which may reflect (or repeat) more or less directly the dynamics involved in political violence itself.

Enrique Bustos³⁸ was one of the first therapists to describe how severe traumatising through political violence – violence that is systematically planned and conceived with the objective of reaching beyond the victimised individual to the targeted community (family, religious or ethnic minority, political party etc.) – impacts not only the caregiver who is treating the victim but also affects the care-giving institution as a whole.

In the view of some, this effect has taken on the characteristics of a thoroughgoing "institutional PTSD," encompassing phenomena and mechanisms that pertain to the traumatising factors inherent in the dynamics and strategies of political violence. This notion seems a misnomer since it uses the pathology as an analogy applying to the institution instead of identifying the factors causing the problems (here, the political, social, and economic circumstances that facilitate political violence and repressive regimes). Just like the original PTSD concept, it tends not to focus on the traumatic context, on the situation, on the etiological process, but declares the symptoms to be the essence of the illness. Nevertheless it points out crucial institutional dysfunctions that can also be considered as effects of structural pressure on care-giving institutions. Such dysfunctions may include problems in communication (isolation of staff members), problems in leadership (difficulty in handling dynamics of power and authority), difficulty in implementing clear limits and roles resulting in chaos and an unstructured work environment (boundary violations), institutional myths of heroism and polarisation ("us" against "them"), self-sacrifice, lack of mutual confidence, persecution of dissenters, ongoing crisis-mode functioning etc.

³⁸ See for example Bustos, E. (1990). Dealing with the Unbearable: Reactions of Therapist and Therapeutic Institutions to Victims of Torture. In Suedfield, P. (ed.) *Psychology and Torture*, pp. 143-163. New York, Hemisphere Publications.

However there is a difference in as far as this disorganised mode of institutional functioning, highly "stressful" in itself, is reinforced in the case of the centres by a variety of adverse socio-political and economic conditions which create an atmosphere of ongoing uncertainty among staff. These uncertainties relate to the institution's lack of funding, lack of public recognition, ongoing tensions with asylum administrations and conflict with restrictive government politics, marginalisation of care-giving institutions and their personnel – in ways which mirror the marginalisation of asylum seekers and refugees in host countries.

Summary of work-related stressors identified by the six partner centres

The centres' analysis of the impact of the above-mentioned stressors on their clinical and administrative work originates in a socio-political and economic viewpoint which also serves as anchor point for the assessment and analysis of the concept of "staff care." In that respect, the current study is unique and innovative.

In contrast to some statements by clinicians quoted in the professional literature, staff members in the current study did not report suffering from symptoms of "vicarious traumatisation" but may have experienced or witnessed colleagues experiencing periods close to "burnout." All participants did, however, list **lack of stable funding** as the primary cause of staff discontent, since it led to organisational instability, lack of job security, potential high staff turnover (if funding is only allotted to time-limited projects), high work load and resulting time pressure, and sometimes expectations by the institution's leaders that staff would provide pro bono or "volunteer" work beyond their paid hours.

In second place after lack of funding, most participants identified as the other main stress factor a **lack of structure and transparency**, whereby institutional leaders – and, therefore, staff – tended at times to have problems maintaining limits and boundaries. Although the work environment was by some appreciated as "warm," supportive, mutually respectful and "open" for spontaneous interpersonal interactions, the ongoing role confusion in some centres seemed detrimental to staff's sense of efficacy and peace of mind. This went along with demands on some staff to perform tasks outside the realm of their training and experience (for example, caregivers being asked to participate in fund-raising or advocacy and communication activities). Furthermore, schedules were at times not respected (for example, time allotted for case discussions was devoted instead by administrators to solving organisational problems). These transgressions of institutional frames and schedules created a sense of strain and dissatisfaction among staff.

The third issue which was raised was that of **problems in communication**, both between levels of administration/leadership and caregivers and among caregivers themselves. This causes some staff to feel isolated and not sufficiently valued in their work (this is a problem specifically in centres that operate on more than one site). Internal communication problems were reported by nearly everyone, and often concerned lack of time to discuss clinical case material, but also for the exchange of information and informal discussions between clinical and administrative staff (as well as with organisational leaders). Communication problems were seen as negatively impacting work efficacy and team atmosphere, stemming from an ever-present time pressure and demanding (at times, excessive) workload on the one hand, and occasional conflict between caregivers and the administrative hierarchy on the other. Communication and professional exchange between caregivers and other professionals in the field did not seem to give rise to problems for staff.

Inventory of existing models and structures of staff care/staff support in the six partner centres

All six centres had addressed staff care issues before participating in this study. They have formalised structures for staff care to different degrees, depending on funding, institutional policies and culture. General agreement was expressed regarding the importance and necessity of implementing ongoing staff care in all centres, while opinions about the possible forms that staff care was taking or should take varied greatly.

Some centres which felt that institutions should be responsible for regular monitoring of staff stress via formal assessments stressed that institutions have a responsibility to "take care" of staff. Others maintained that this model represented an undue infantilisation of adult professionals whose professional training ought to give them the competence to request the means from the institution to support themselves (via additional supervision, leave time, temporary reduction in work load etc.) when needed. As a consequence, representatives of the latter opinion suggested replacing the term "staff care" (which in their opinion implied a misleading parallel between patients and caregivers) with the more neutral term "staff support."

a) Institutional structures for staff care/staff support

Structures created by centres take into account the previously mentioned stressors and are aimed at improving institutional structure and transparency, at containing and processing difficult clinical case material, providing regular and formalised communication among caregivers as well as between caregivers and the administration, team building, ensuring professional training, career advancement, job security and benefits, as well as allowing communication and exchange with other professionals in the field.

- All centres had schedules for regular staff meetings, supervision and intervision (professional internal peer reflection on clinical case work without an external supervisor) in which clinical difficulties could be discussed and resolved. Supervision by an external professional (and, for some, coaching for the centre's leadership) were said to help maintain a critical distance to the at times quite strenuous institutional and clinical case dynamics.
- Multidisciplinary working as a treatment philosophy is supported by all centres. However, the separation of disciplines is seen as a main factor of staff protection, in that clear boundaries between disciplines maintain the integrity of each caregiver's realm of intervention, thus allowing him or her to keep to personal and professional boundaries.
- All centres allow for informal meetings that facilitate the exchange of information, team building and individual support for work-related and/or personal concerns.
- Specific team-building meetings or activities (shared meals, team days, relaxation and art therapy sessions, informal gatherings) occur in most centres and are said to contribute significantly to improved team atmosphere, openness, sense of solidarity, mutual trust, and establishment of common ethical values and "team spirit."

- All centres allow staff to participate in professional training or career advancement activities, and encourage participation in national and international conferences so as to share work experience with colleagues. Caregivers are also supported in engaging in activities that facilitate an intellectual and emotional processing of their clinical experience (through teaching, writing, public speaking...) which, in turn, supports acts of testimony thought to be essential in this particular clinical field. For some caregivers, testimony is considered an integral part of their clinical work, which they see as being not entirely separate from political action.

b) Self-care

Only one centre reported on self-care. Caregivers described family and friends as main sources for personal support, as well as physical activity, sports, and leisure time. Some found an important resource in the therapeutic work with individuals who were seen as inspirational and resourceful; client contact was experienced by some as highly meaningful and constituted a source of personal satisfaction.

In-depth personal therapy experience and psychotherapy training were considered by some not only a mandatory prerequisite for psychotherapists, but also a very helpful resource (in terms of preventive self-care) for all caregivers, allowing early recognition of potential stress and identification of conflict-solving strategies.

Suggestions for improvements in staff care/staff support

Suggestions as to how to improve existing staff support followed the analysis outlined above, concentrating on an improvement of institutional structures, role clarification, respect for and maintenance of personal limits and institutional boundaries, clear planning and structuring of staff meetings, improved long-term planning to guarantee institutional longevity and financial stability, improvement of intra-institutional communication and strengthening of positive feedback mechanisms, increased attention and time/space for clinical case discussions, and well-planned staff support activities (team days, or other team-building activities, corresponding to each centre's staff culture).

Clearly, the results of the present study suggest that improvements in staff support/staff care are contingent on successful lobbying and fundraising activities, since work-related stressors are perceived to originate primarily in precarious economic conditions. These damage both institutional stability as well as clients'/patients' capacity to stabilise their lives.

7.4 Integration or socio-cultural (re-)affiliations?

Besides trauma and the psychological or medical problems which may follow, there are many other consequences that arise from torture and persecution. These may become evident, for example, in the way a person experiences a change in personal identity and in social functioning as an individual in a family. In clinical practice these effects are often more difficult to deal with because they are frequently enduring, with very profound, longer term secondary consequences, such as restricting a person's ability to form relationships at school or work, or to maintain family relationships.

These secondary consequences can well exacerbate existing feelings of isolation, poor self-esteem and hopelessness.

Every person exists as a social being and has a consciousness as a "social self," and so it is inevitable that this social self is likely to be affected by the destruction of a former identity and the world a person has lived in. As individuals we live in social systems and networks and we perceive ourselves as persons with hopes, wishes, desires, goals, irritations, problems etc. Our identities are shaped by and inextricably linked to others. Out of our need for others in the shaping of our identities arise multiple possibilities for conflict: there may be tensions between our own personal abilities and our desires or the options available to us, or our development or our actions may be restricted by our environment and the social context. As humans we also need love, recognition and encouragement in order to develop. We know and have learned again in recent history that deprivation of such human interaction leads to traumatising and in extreme forms amounts to torture. Our experience of suffering or deprivation influences how we react to threatening or excluding situations and how we develop coping mechanisms or resilience. Conflicts can be suffered and experienced as an individual but are shaped by groups, which means that they always have both a subjective and a social aspect.

Everybody is born into cultural communities. People develop their identities not only as individuals but also in terms of affiliations to groups with value systems, including ways of forming relationships and life perspectives. They are shaped by ethnic, national, religious and socio-economic definitions, which draw boundaries between groups of belonging. Cultural identity is not necessarily national identity – but very often cultural affiliation is still seen as relatively fixed and bound to tradition. In most cases though, multiple affiliations exist. A person might have a particular religion, belong to a specific ethnic group and be a citizen of a specific country. Frequently, it is cultural affiliations and attributions which are the focus of conflicts and a society may deny or suppress one of the multiplicity of cultural affiliations maintained by its members. Very often such denial of identity goes along with a denial of rights and participation, and, in extreme cases, that can lead to persecution and torture.

In our European democracies we assume active participation of the population and we see self-determination and self-realisation as important social goals. Related to the notion of participation is the concept of integration which implies that there is a society into which one can integrate. This assumes a static society into which individuals have to find their way. In reality, society is not static or homogenous and we have to recognise that integration is a more complex process. If society is not mono-cultural, the question is: who has to integrate with whom? It is not only the foreigners, refugees and asylum seekers who have to integrate. The host society also has to demonstrate openness and a capacity to allow the integration of foreigners – who arguably are now a part of the host society. We may ask: how does society relate to diversity or to the multiplicity of cultural affiliations? If in a diverse society, certain groups are assumed to have no place, but to remain "outsiders," then integration becomes a problem for the whole society.

The tension between belonging and being allowed to be different is important not only because it may lead to conflict but also because it infuses anxiety and fear – fear of being excluded, isolated or having to live in ghettos. If on the other side we accept diversity and varied affiliations as reality, we can also agree that they constitute the social identity of a society which will not be fearful of an influx of such complicated identity-holders as, for example, a Yessidic Kurd from Georgia or a Christian Tutsi Rwandan.

In dealing with complex social identities, there are two dangers which society has to avoid: the demand for total assimilation, resulting from an often populistically expressed fear of the loss of one's own sense of social identity; and its opposite: the total recognition of difference as the only definition of identity, so that people remain in the isolation of their cultural ghetto. We need the recognition of differences and diversity as well as a new approach to the notion of belonging and the concept of social boundaries.

It is for the reasons above that the core project partners preferred to use the term "socio-cultural affiliations" or "socio-cultural re-affiliations" to describe what is usually described as "integration." The host community needs to affiliate to the new situation created by the new challenges presented by the arrival of refugees and the different socio-cultural environment they bring with them. We use the term "re-affiliation" because many torture survivors (including those who are asylum seekers or refugees) need to re-affiliate with society altogether, and now, in their new situation, their re-affiliation will have to be with a new socio-cultural identity in a new society.

Those who have suffered severe trauma have in most cases also lost a sense of their social self or social identity. In many cases it is this loss that makes it so difficult to overcome trauma-related psychological difficulties, because the situation of a torture survivor and the concomitant restrictions (including additional restrictions related to being a refugee) do not help with the task of restoring social identity. Socio-cultural affiliations have to be re-established, but with the additional challenge that the task has to be accomplished within a new socio-cultural context, where for example, a different language may bring monumental challenges to identity. To illustrate this point, one client said, "I have lost myself because I have lost my humour. My humour is based on my language, so I have lost my humour because I have lost my language. I am a different person now: a person without humour because I cannot express it any more."

7.5 Discrepancy between individual conflict analysis and institutional quality assessment³⁹

One of the key tensions during this study arose when we as the core partners tried to assess the quality of the different aspects of our work. There was a discrepancy between, on the one hand, our effectiveness in analysing conflicts, verifying methods of treatment and related activities and, on the other hand, the absence of indicators to evaluate our work in general – not just the "clinical" aspects, but also those which were aimed at fostering inclusion and a sense of justice for the client, and which have a considerable impact on outcomes (expected and unexpected).

We were able, using the Framework for Quality Assessment, to usefully analyse the problems presented by clients in terms of their conflicts, as we have described in Chapter 4. We also found a way, using the Inventory of Working and Treatment

³⁹ See also Boia Efraim Junior (2007). *Psychotherapie mit Kindersoldaten in Mosambik: auf der Suche nach den Wirkfaktoren (Psychotherapy with Child Soldiers in Mozambique: Searching for Effective Factors)*. Aachen: Shaker Verlag. Pp. 124-132. When analysing the different dimensions of the specific situation that influence the outcome of psychotherapeutic treatment, he points to material conditions, the lack of perspective in future life and the psychosocial support of the community as crucial factors.

Methods, to describe the different treatment methods we use, and discovered in the process that for many of the centres these included a much wider range of activities than is usual in treating psychiatric or psychotherapeutic patients. These included human rights activities, which may have been in the form of support for clients during their court hearing, or intervention in the asylum procedure by means of expert clinical reports, or engaging in particular advocacy work. Similarly, we found that many treatment strategies in our centres combined clinical activities with social and sometimes community work, such as a mentoring programme to assist participation in wider society. Unsurprisingly, in our systematic analysis of the various levels at which conflicts occurred, there emerged a collective acknowledgement of something we all face in our daily clinical work: the social context of the country in which the torture survivor now lives (in other words, irrespective of whether the torture survivor is a citizen of that country or a refugee) is often more a part of the problem than the solution – and this is one reason why an approach to the provision of services is warranted which addresses the totality of the torture survivor's life and well-being, and does not just focus on symptoms.

We reached agreement on what we saw as indicators for successful treatment, which included the reduction of symptoms but went well beyond that. Other positive outcomes were identified and discussed, which crucially were not only, or even mainly, a result of specific therapeutic or social interventions, but were the result of reinforced human rights, justice or social security measures. We do not yet have an appropriate common approach to establishing indicators which will show the effect of these achievements, which are also part of the outcome of our work.

The consensus which emerged was as follows: treatment strategies are most effective – even in continuing difficult circumstances – if they enhance and underline the right of clients to self-determination and empowerment and if they facilitate cultural diversity and affiliation between the clients and the host community. In that regard, we agreed that psychotherapeutic treatment and social support must be integrated if they are to have a positive impact on well-being. But one challenge remains: the identification of how and when those activities should be offered to ensure maximum positive effects.

Our study of staff care methods in the centres showed that we do not yet have the right tools for the quality assessment of staff care methods used in the institutions we work in. This is serious given that staff work with severely traumatised clients and there can be a high risk of burnout. We hope that the method of self- and peer evaluation can be further developed to address this issue in more detail.

7.6 Directions for further research: Research into transformation?

Despite the prevalence of torture and its well-documented consequences for health and other areas of well-being, only recently have we begun to see an increase in academic interest in the study of torture and in the approaches used to treat, care for and rehabilitate survivors. Nevertheless, research with torture survivors may have important implications for human rights work and other legal issues, as well as for psychological theories, health assessments, traditional classification systems and treatment methods for traumatic stress responses.

In our view, this study provides direction for further research in three main ways. Firstly, the literature regarding treatment of victims of torture is sparse and that which does exist focuses on pharmacological treatments and psychological interventions. These are only two of a range of methods which have been identified by our study as being currently used by organisations working with the client group. Research addressing the effectiveness of other methods such as legal, social, physical and cultural interventions would be an important contribution to the field.

Secondly, the literature assessing treatment methods in this client group typically utilises outcome measures focused on symptoms. But the improvement of symptoms is only one of a number of aims of intervention which this study identifies. The field would benefit from the development of outcome measures aimed at capturing the varied objectives of methods used, and to capture the level of overall functioning of victims of torture, not just in terms of their symptoms.

Thirdly, this study indicates that for the most part organisations specialising in work with torture survivors are basing their interventions and service models on practice-based evidence – what they have seen and learn in daily practice with torture survivors. The overwhelming constraints on their resources mean that they have limited capacity to undertake appropriate research, despite their experience in the field and their knowledge of the social, cultural, political and legal context of work with torture survivors. There is widespread consensus that we need to continually improve our practice, but there are regular debates, within our organisations as well as outside, as to how far research activities can be justifiably prioritised over direct treatment or services or prevention activities, bearing in mind the limited resources with which we work. Ironically, funders are increasingly and legitimately asking how we can demonstrate that services are effective and cost effective, while only being willing to provide funds for the direct care of survivors or prevention activities.

This study points to the need for the development of guidelines based on scientific evidence as well as practice-based evidence, as advocated by Montgomery and Patel⁴⁰. Teaming the results of a mixed-methods research project together with practice-based evidence would be a much-needed contribution to the field and would be potentially useful in other fields. In agreement with Montgomery and Patel we ask: "can we encourage and value a range of epistemologies and methodologies, and therefore what we value as 'evidence'?"⁴¹ We endorse their view that "research in this field should aim to be relevant to the very complex social, cultural, political and legal context in which torture survivors live, access and utilise healthcare and other rehabilitation services, and it should be ethical and genuinely respectful towards those whose lives we hope to help improve. In this regard, we must not lose sight of the primary reason why we are striving for a better evidence base – to ensure that we provide access to the highest quality of care and rehabilitation to torture survivors, which is their right, not a privilege."

⁴⁰ Montgomery, E., & Patel, N. (2011). Torture rehabilitation: Reflection on treatment outcome studies. *Torture*, 21.

⁴¹ Montgomery, E., & Patel, N. (2011). Pp.141-145.

8. References

- Anderson, M. B. (1999). *Do No Harm: How Aid Can Support Peace – or War*. Boulder/ London: Lynne Rienner Publishers.
- Austin, A., Fischer, M., & Ropers, N. (eds.) (2004). *Transforming Ethnopolitical Conflict. The Berghof Handbook*. Wiesbaden: VS Verlag.
- Becker, D., Groninger, K., & Luzar, C. (2012) *Psychosocial Conflict Analysis*. Luzern: Fastenopfer (in press).
- Becker, D. & Weyermann, B. (2006). *Toolkit: Gender, Conflict Transformation & the Psychosocial Approach*. Bern: Swiss Development Cooperation.
- Bittenbinder, E. (Ed.) (2010). *Good Practice in the Care of Victims of Torture*. Karlsruhe: Loeper.
- Boia, E. Jnr. (2007). *Psychotherapie mit Kindersoldaten in Mosambik: auf der Suche nach den Wirkfaktoren*. Aachen: Shaker Verlag.
- Earl, S., Carden, F., & Smutylo, T. (2001): *Outcome Mapping: The Challenges of Assessing Development Impacts*. International Development Research Centre, Ottawa, Canada.
- Earl S., Carden, F., & Smutylo, T. (2001). *Outcome mapping. Building learning and reflection into development programs*. International Development Research Centre, Ottawa, Canada.
- European Commission (2003), Directive laying down Minimum Standards for the Reception of Asylum Seekers (2003/9/EC)
- European Commission (2007), Report from the Commission to the Council and to the European Parliament on the Application of the Directive. COM(2007) 745
- European Commission (2007), Green Paper on the future Common European Asylum System. COM(2007) 301
- European Commission (2011), Amended proposal for a Directive of the European Parliament and of the Council laying down Minimum Standards for the Reception of Asylum Seekers. COM(2011) 320.
- Honneth, A. (1996). *The Struggle for Recognition: The Moral Grammar of Social Conflicts*. Cambridge: Polity Press.
- Jaranson, J. M., & Quiroga, J. (2011). Evaluating the services of torture rehabilitation programmes: History and recommendations. *Journal of Rehabilitation of Torture Victims and Prevention of Torture*, 21 (2).
- Laugier, S. (2006). Le care: Enjeux politiques d'une éthique féministe. *Raisons publiques*, 6.
- Lederach, J. P. (2003). *The little Book of Conflict Transformation*. Intercourse: Good Books.
- Montgomery, E., & Patel, N. (2011). Torture rehabilitation: Reflection on treatment outcome studies. *Torture*, 21.

- Pearlman, L.A. (1995) *Self-Care for Trauma Therapists*, in Stamm, B.H. Ed. (1995) *Secondary Traumatic Stress*.⁴² *Self-Care Issues for clinicians, Reserachers and Educators*, Sidran Press, Lutherville, Maryland.
- Porter, B., & Emmens, B. (2009). Approaches to staff care in International NGOs. *People in Aid – Inter-Health* (webjournal), September 2009
[http://www.interhealth.org.uk/editpics/File/Approaches to Staff Care in International NGOs.pdf](http://www.interhealth.org.uk/editpics/File/Approaches%20to%20Staff%20Care%20in%20International%20NGOs.pdf)
- Saakvite, K.W., Pearlman, L.A. (1969). *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: Norton.
- Sveaass, N. (2000). *Restructuring meaning after uprooting and violence. Psychosocial interventions in refugee receiving and post-conflict societies* (Doctoral thesis). Oslo: Unipub
- UNHCR 2010: Asylum Levels and Trends in Industrialised Countries 2010:
<http://www.unhcr.org/4d8c5b109.html>.

APPENDICES

Appendix 1: Core partners and bi-national partners

A) Core partners

ZEBRA, Austria: A holistic approach to the needs of traumatised people

Summary: ZEBRA, founded in 1986 with an initial focus on the counselling of imprisoned refugees, has expanded since then to include psychotherapeutic treatment, an outreach clinic, legal counselling, and language promotion. Physiotherapy, social work and medical treatment are also essential parts of the institution. Refugees from ex-Yugoslavia in the province of Styria have constituted an important client group. Between 2005 and 2007 ZEBRA ran a project called "Improvement and development of treatment and counselling for survivors and victims of torture in Styria," supported by the EU. The project was awarded the Styrian prize for human rights in 2007.

ZEBRA, the intercultural consulting and therapy centre, has existed since 1986 as an independent and non-denominational institution in Graz.

The origins: The starting point was an Amnesty International symposium about torture and rehabilitation in 1985, in which many European centres from various countries participated. The various concepts of the existing centres were compared and it was agreed that an approach restricted only to medical and clinical aspects was insufficient, leading to the choice of a multi-professional and interdisciplinary approach, networked with other institutions. In 1986, ZEBRA was founded with the support of the then mayor of Graz.

Development of services and cooperation: At that time, ZEBRA was the only institution in Graz that offered professional consultation and care for refugees and migrants. As a result of the precarious legal situation of refugees (i.e. with no proper asylum procedure and with refugees often being detained to await repatriation), the main emphasis was put on the counselling of imprisoned refugees.

In 1990, the first cooperation contract for the counselling of migrants with the Employment Office AMS (Arbeitsmarktservice) was set up. ZEBRA organised workshops, seminars and meetings on training and education. In 1991 the first "ZEBRATL," a professional journal for asylum and migration issues, was published.

From 1997 to 1998, ZEBRA and several other organisations brought the exhibition "Verbrechen der Wehrmacht" ("Crimes of the Wehrmacht") to Graz and organised a

wide variety of seminars and further education events connected with the exhibition. The re-appraisal of the past and the confrontation with Austria's recent history and its involvement in National Socialism have been a significant element in developing political awareness about issues related to the refugees of today.

The outbreak of the war in ex-Yugoslavia saw a wave of refugees coming to Austria, and this led to a greater public recognition of the issue of refugees and concern with their fate. In 1993, ZEBRA received a request from the province of Styria to provide counselling for Bosnian war refugees.

In 1996, psychotherapeutic treatment was established as an additional service. A psychotherapist was employed and freelance therapists were taken on. Particular emphasis was put on outreach, providing mobile psychotherapeutic treatment in hostels in Styria for refugees from Bosnia and later on from Kosovo. In 1997 ZEBRA worked with other institutions to provide care for unaccompanied adolescent refugees. In the same year, ZEBRA opened a second office.

The outreach clinic for migrants developed further and began to offer mother tongue counselling. In cooperation with the AMS, ZEBRA supported the integration of people searching for work into the employment market. Counselling of asylum seekers focused on legal advice and assistance through the asylum procedure.

Services and activities: In 2002, new premises and co-operations led to restructuring and a new concept. The legal advice service was integrated into the counselling centre; the rehabilitation centre and the therapy team were expanded and new offers such as language promotion were provided.

In recent years, it has become widely understood that traumatised refugees need comprehensive rehabilitation as a result of both their traumatic experiences and their current situation. Psychotherapy, social work, physiotherapy, as well as medical and psychiatric treatment, are essential parts of our institution. Today, the core team consists of five psychotherapists, a social worker, a consultant psychiatrist, two physiotherapists and a pool of interpreters.

Since 1999, ZEBRA has been involved in projects funded by the EU within the framework of the EQUAL directives (2003-2007). Among them have been basic education and literacy provision for unaccompanied refugee minors and a project which helps refugees to integrate into the community. From 2005 to 2007 a project called "Improvement and development of treatment and counselling for survivors and victims of torture in Styria" was supported by the EU, which involved intensive cooperation with the "Landeslinik Sigmund Freud." The project was awarded the Styrian prize for human rights in 2007.

ZEBRA, Interkulturelles Beratungs- und Therapiezentrum

Schönaugürtel 29, A-8010 Graz, Austria

www.zebra.or.at

Telephone: +43 316 8356300; Fax: +43 316 83563050

Equator Foundation, the Netherlands: Linking mental health recovery to social integration

Summary: The Equator Foundation has its origin in 2003 as a part of the Department of Psychiatry of the Academic Medical Centre at the University of Amsterdam hospital. In 2007 it became an autonomous institution, with a medical-biological psychiatric approach. It provides day-care and outpatient treatment programmes in the Netherlands, as well as psychosocial support programmes in African post-conflict areas. Services include psychiatric and psychosocial care with special expertise in posttraumatic psychopathology, social and legal counselling, psychomotor therapy, medication and more.

Origins: The Equator treatment programme was established in 2003 within the Department of Psychiatry of the Academic Medical Centre at the University of Amsterdam hospital with financial aid from the European Refugee Fund. In 2007 the department chose to focus on a medical-biological psychiatric approach. In May 2009 Equator moved out and became an autonomous agency as the Equator Foundation, and found a new institutional base in the holding foundation Arq, an expert centre for psychological trauma.

General: Equator Foundation provides psychiatric and psychosocial care to survivors of war and political violence and to victims of human trafficking. It applies an approach which simultaneously aims at mental health and social connectedness. In the Amsterdam region, Equator provides day-care and outpatient treatment programmes for traumatised refugees. Equator also implements psychosocial support programmes in post-conflict areas in Africa. It carries out research into the effectiveness of the aid provided, and considers education, training and development as essential in its mission.

Equator's guiding principles are that mental health care for survivors of war, political violence and human trafficking has to apply an individual trauma perspective as much as a focus on the social aspects of the experiences and current situations of clients, and that expertise gained in aid provision in contexts outside Western Europe has to feed into working methods for migrants in the Netherlands.

Consequently, staff expertise combines the areas of posttraumatic psychopathology, cross-cultural psychiatric diagnostics and treatment, intercultural communication, human rights issues, and social and ideological movements. Through a combination of working for the treatment programme in Equator and going on field missions for humanitarian aid organisations some staff members also have international experience working in mental health and psychosocial programmes in a variety of low income and post-conflict countries.

Currently the Equator Foundation, in cooperation with national counterparts, carries out community based psychosocial support programmes in Rwanda and DR Congo. These programmes aim at mental health recovery, social re-bonding and social functioning and include research on their effects. In the past Equator has participated in studies in Tanzania and Zaire (both 1995), Afghanistan (2004) and Sierra Leone (2004), and is currently involved in a worldwide study of humanitarian aid workers (coordinated by CDC and Antares Foundation).

Treatment programme: Equator provides psychiatric and psychosocial care for refugees and asylum seekers and victims of human trafficking who suffer trauma-

related psychopathology. Treatment methods comprise: individual supportive counselling or trauma-focused psychotherapy (CBT, Narrative Exposure Therapy, Testimony therapy, EMDR), medication, stabilisation groups, psychomotor therapy, psycho-education, information and orientation on Dutch society (group work), language training, individual social and legal counselling, occupational therapy (group), social integration support (individual), and preventive groups (verbal and physical working methods).

The day-care clinic runs a multi-disciplinary and multi-component 3 days per week. Clients can participate for a maximum period of 6 months. Treatment occurs largely in group sessions. Psychiatric and psychological treatment components focus on coping with traumatic memories. A main element of the programme is shaped by a form of sociotherapy, a therapeutic group approach which has been adapted to the refugee client population – finding a constructive daily routine or prospects for employment after the termination of treatment.

Equator also offers outpatient treatment in the form of a women's group mixing psychiatric and psychological treatment with strategies to foster social integration. The variety of methods applied might be trauma-focused or might address depressive symptoms, or use body-oriented methodologies. Also female victims of trafficking might be referred to the programme for diagnostics and treatment if needed.

Number and origin of clients: Over the past years, the average total number of clients included in the programme at any point in time was 120. These originated from a broad spectrum of countries in four different continents.

Staff: The Equator team comprises 2 directors (a psychiatrist and an anthropologist/occupational therapist), 2 psychologists, 2 medical doctors, 2 sociotherapists, 2 psychomotor therapists, 1 social worker, 1 occupational therapist, 2 researchers and 1 secretary. Almost all staff work only part-time for Equator.

Boundary partners: Equator Foundation is engaged in a number of activities in cooperation with outside partners such as the Amsterdam Coordination point Human Trafficking (ACM) and the Works Foundation and project (a satellite foundation of Equator Foundation), which aims to act as a bridge taking clients from care-dependency toward social independence and to help traumatised refugees successfully engage in occupational integration. Equator also has its local partners in Rwanda and Congo, with whom it implements psychosocial support programmes specifically designed for populations living in post-conflict areas.

Research: Equator carries out academic research projects to evaluate and measure treatment and programme outcomes.

Significant recent trends

Over the past year the government of the Netherlands has substantially changed its policy with respect to financing the national health care system. As a consequence, the mental health care of survivors of torture is faced with three major problems, notably: 1. the costs of use of interpreters for client contacts will no longer be

financed. 2. clients will have to pay their own contribution of 200 euros for mental health care on top of the insurance fee. 3. the first 220 euros of the costs for health care for each individual will not be reimbursed by the insurance companies.

In light of these developments Equator Foundation faces serious ethical dilemmas and anticipates a decline in the number of referrals.

Equator Foundation, Nienoord 5, 1112 XE Diemen, The Netherlands
info@equatorfoundation.nl; www.equatorfoundation.nl
Telephone: +31 20 840 7676; Fax: +31 20 625 3589

ICAR Foundation: A Romanian human rights initiative in a transitional political climate

Summary: The ICAR Foundation was created in 1991 and expanded over the years to comprise three centres, one in Bucharest, one in Iasi and one in Craiova. It is still the only institution providing qualified assistance to torture survivors in Romania. In one of its recent efforts towards rehabilitation for victims of state injustice, ICAR supported a court case accusing the Romanian state of failure to protect the life of and investigate the death of a man assaulted by cellmates during a 40-day prison term. The case was taken before the European Court of Human Rights which, in January 2011, decided in favour of the applicants. The ICAR Foundation offers medical assessment and treatment, psychological, social and legal counselling, as well as classes for language learning and cultural orientation.

Origins: The ICAR Foundation is a Romanian NGO, created in 1991 and registered in 1992. Its first rehabilitation centre opened in Bucharest in 1993, a second in Iasi in 1995, and a third in Craiova in 1998.

ICAR is still the only institution providing qualified assistance to torture survivors in Romania, i.e. people who fought in Romania for a democratic and open society during the political repression of 1945-1989 and who experienced torture, violence and other inhuman treatment in communist prisons. The foundation's basic goals are to improve the health of these survivors, help them become integrated into a normal social life and prevent future acts of torture. ICAR's demonstration of respect for survivors also represents an important step towards healthy political reconciliation, which the organisation considers the least a society can do for them when their torturers go unpunished.

ICAR started this struggle at a time when, despite an apparent political transition, torture survivors were still ignored and treated with disdain by both the State and much of the population. ICAR succeeded gradually in getting the State to assist in providing first the physical premises for torture treatment centres, and then the right to free medicine prescribed by ICAR physicians, but only for basic care and services.

This was however much more than a battle for services for torture survivors, or a search for government funding. The State's reluctance to support the needs of torture

victims is symptomatic of a much deeper problem of democracy. Torture victims are living in a country where their torturers have escaped with impunity, many still occupying influential positions in society.

In its concern with the long overdue and still unmet need for some form of moral rehabilitation for victims, ICAR opened a court case in 2003 requiring the Romanian State to acknowledge the extensive human rights violations committed by the former communist regime and to make a public apology to the victims of this regime and their families. Supported by an increasing number of civil society organisations and individuals this request led the new centre-right President to establish a Commission for the Analysis of the Communist Dictatorship in Romania in 2006. Based on the Commission's report the President declared the previous regime illegitimate and criminal, and the requested public apology was made to its victims on behalf of the Romanian State.

More recently, ICAR supported a court case accusing the Romanian state of failure to protect the life of and investigate the death of a man assaulted by cellmates during a 40-day prison term. The case was taken before the European Court of Human Rights which, in January 2011, decided in favour of the applicants.

It has been a long battle which is not yet over, but ICAR's successes to date show the power of persistence and creativity, and the importance of a stubborn unwillingness to give up on the struggle for quality services for its clients.

Significant recent trends

A very serious development is that the sustainability of services is under threat. While the number of survivors of political suppression in Romania is getting smaller with time, ICAR is now receiving an increasing number of torture victims among asylum seekers from repressive regimes in other countries. This has required a reorientation of activities towards this group, which in most cases are located in reception and accommodation camps. ICAR has therefore established its presence both in the main centre in Bucharest but also – as a pilot project initially financed by ERF – in centres along Romania's borders with Moldova, Ukraine and Serbia.

The services for torture victims among former political prisoners have from the start received financial support from both the UN and the EU but never from the Romanian State, because the Ministry of Health does not see the need for specific services for this group, claiming that the public health services has the capacity to deal with any medical problem they may have. It is therefore seriously problematic for ICAR that the European Commission has decided no longer to fund services to victims who are citizens of an EU country. They claim that according to international and European human rights law, it is the responsibility of each member state to provide reparation including medical rehabilitation to victims of state human rights violations of its own citizens, disregarding the fact that none of the former communist EU member states has lived up to this expectation. The few centres in EU member states engaged in assisting such victims are now forced to consider closing down. The UN Voluntary Fund for Victims of Torture is still willing to support this activity but can only cover a certain part of the budget. If the necessary matching funds cannot be found from other donors the activity cannot be sustained.

As a result of this development ICAR has with a heavy heart had to close its centre in Iasi, the second largest city in Romania, from April 2011, and the centre in Craiova may soon follow. The centre in Bucharest will hopefully be able to continue to provide

services for both asylum seekers and refugees, for which EU money is still – at least in principle – made available to member states through the European Refugee Fund. However, obtaining ERF grants depends entirely on the Ministry of Interior's willingness to provide matching funds. Since ICAR is the only institution in Romania with experience in providing medical rehabilitation to torture survivors we should expect funding of this kind, but we failed to obtain it in 2011. Thus even the centre in Bucharest may not survive.

ICAR-Foundation, Medical Rehabilitation Centre for Torture Victims

70 Bld. Unirii, Bl J5, 030836 Bucharest, Romania
icar@icarfoundation.ro; www.icarfoundation.ro
Telephone: +40 21 3212221; Fax: +40 21 3275474

XENION, Germany: The starting point is the story and the reality of clients' lives

Summary: XENION, founded in 1986 as the first German institution targeted at this group and originally staffed by volunteers, represents the interface between health-related provision and a human rights approach to support. It has expanded to provide psychotherapy, social and legal counselling, medical advice and language classes. An important element of XENION's concept is the integration of traumatised refugees into the community: it has set up a network of legal guardians for unaccompanied minors and a mentoring network. XENION is a founding member of the BAfF, the umbrella body for German psychosocial centres for victims of human rights abuses.

Origins and history: In the 1980s there was no provision within the German health system of professional help for political refugees and victims of torture or human rights abuses. In 1986, this situation led a group of German and foreign doctors, psychologists, social workers and psychotherapists who had been repeatedly confronted with the needs of refugees to found the XENION Association. It was staffed by volunteers and was immediately faced with a flood of refugees seeking help.

XENION was the first institution for this target group in Berlin, and it had the support of Amnesty International and the medical associations. From the beginning the centre was an interface between health-related provision (including psychosocial, psychological and medical treatment) and approaches to human rights work. This was a logical consequence of its involvement with politically persecuted survivors.

XENION received its first public funding from the Berlin Department for Health and Social Services, as well as from the "World Solidarity" Foundation, in 1988. Two years later the European Community became a main financial supporter, guaranteeing its work over years and allowing the centre to develop. XENION adopted an integrated approach, using various coordinated psychotherapeutic and social methods in its work.

In 1991 XENION started a special project for young refugees. In addition to psychotherapy, the young people are offered advice on vocational training and some training to prepare them for work. In the same year, XENION entered a deeper conceptual exchange with similar initiatives in other member states of the European Community.

XENION was one of the first organisations in Germany to promote a public discussion of multicultural and multiethnic approaches in psychiatry and the proper use of trained interpreters in that field. In its discourse with the professional health community, XENION persisted on two points which were highly controversial at the time: firstly, not only those who are themselves survivors or victims can advise and help others, and secondly, psychotherapy and counselling can be done with interpreters if the interpreters are properly trained. The question of which qualifications are needed to work in a trans-cultural setting led XENION to offer a special training programme for interpreters in 1992 that was unique in Germany.

In 1997 the centre became a founding member of the "Bundesarbeitsgemeinschaft der Psychosozialen Zentren für Flüchtlinge und Folteropfer e.V." (German Association of Psychosocial Centres for Refugees and Victims of Torture) or BAfF, the umbrella body for German psychosocial centres for victims of human rights abuses. In 2004, it hosted an annual BAfF conference with the topic: "The dispute over professional reports: torture victims and refugees from war in the legal machinery". The discussion which ensued in the professional world led to the development of guidelines for professional reports on traumatised refugees, and to the establishment of training courses for doctors, psychologists and psychotherapists in how to draw them up.

Another important element of XENION's concept is the integration of traumatised refugees into the local community. Social networking was seen as a bridge towards involvement with the society and as part of the healing process. A mentoring project was founded under which trained volunteer mentors support clients of XENION and other young adult refugees in their daily life. In 2003, XENION started the AKINDA network for legal guardians ("**A**usländische **K**inder in **D**eutschland – **A**llein"; "Foreign Children in Germany – Alone") – organising legal guardians for unaccompanied refugee minors living alone in Berlin.

Since 2005, XENION has been collaborating with the Medical Association and the Psychotherapists' Association in professional training for therapists, psychologists and doctors. It has also started training judges and other associated professionals.

Transnational cooperation: a commitment to networking is an important aspect of XENION's transnational exchanges which started in 1991. Among others, XENION collaborated in a German-Bosnian-Kosovar professional exchange in 1998-2000, and since 2005 in an exchange with Chechnya and Russia. More recently it has established links with Poland.

XENION's working concept is to support its clients in issues related to health, social rights and asylum and residence status. It considers itself a human rights organisation whose objective is not only the treatment and counselling of refugees but also the provision of help for them to achieve their rights and to live a life which is as independent and integrated as possible. Our working concept places the individual and his/her story at the centre of its concerns.

Staff: Staff include psychotherapists, a psychiatrist (not in house), social workers, project coordinators, a coordinator for the youth and mentoring project, and administrative staff. Some of them are employed full or part time and some (eight psychotherapists and 16 interpreters) work on a freelance basis. In addition XENION has an IT advisor, a supervisor and an organisation and team developer.

Significant recent trends

During the last two years, XENION has seen significant reorganisation of its funding structure: An organisation called Friends of XENION was founded which has succeeded in acquiring private donations. At the same time, one of the main local funding bodies as well as donors at EU level are withdrawing funds. Fundraising is thus requiring a much larger proportion of resources. The reduced contribution from institutional donors is paralleled by a diminishing interest among the public in human rights work, and this has led XENION to look into ways of allocating more resources to political lobbying in the future.

In terms of XENION's care and treatment programme an important step has been taken by establishing a Berlin-wide network (BNS, Berlin Network for the Identification of Vulnerable Asylum Seekers) with other specialised institutions. The BNS aims to increase coordination in the systems for identification and referral of vulnerable beneficiaries to the right services. Moreover, an art therapy project has been launched and an existing volunteer project run by XENION (a mentoring scheme for refugees) has seen an ever-increasing inflow of volunteers.

In 2011, the BAfF, including XENION and the other German centres, was awarded the Diotima prize for an outstanding contribution to psychotherapy in Germany.

The name XENION stems from Greek and means "hospitality in a foreign place."

XENION – Psychosoziale Hilfen für politisch Verfolgte e.V.

Paulsenstr. 55-56, 12163 Berlin, Germany

info@xenion.org; www.xenion.org

Telephone: +49 30 323 2933; Fax: +49 30 324 8575

Primo Levi Association, France: Multidisciplinary care and support for victims of torture and political violence

Summary: The Primo Levi Association was founded in 1995 and combines four areas of action: direct treatment and support, training, communication and advocacy. Victims of torture and political violence can receive medical, physiotherapeutic and psychological services, as well as social and legal aid. Training is offered in France and abroad for the staff of asylum seekers' hostels, teachers, school directors etc. In order to share its experiences and to bear witness, the association produces publications and provides internet access to a specialised documentation centre. Primo Levi administrators also

initiate lobbying and advocacy work, and participate in relevant campaigns on a national and international level.

Origins: The Primo Levi Association was founded 17 years ago by five French NGOs (Amnesty International, French section; ACAT – Christian Action for the Abolition of Torture; Médecins du Monde – Doctors of the World; Juristes sans Frontières – Jurists beyond Borders; and Trêve, a small group of healthcare professionals who had previously worked with torture victims). The association provides an institutional framework to offer treatment and support to victims of torture and political violence. By choosing to name the association after Primo Levi, a survivor of Auschwitz and author of "If This is a Man," the founders wanted to honour the power of his testimony, the rigour of his ideas and his refusal to accept the existence of inhuman, cruel and degrading treatment. The association has four areas of action; the first – direct treatment and support for those who have experienced torture and political violence – provides the content and legitimacy for the other three: training, communication and advocacy.

The Primo Levi care centre

Treatment and support are provided in a multidisciplinary health-care centre. Victims of torture and political violence can receive medical, physiotherapeutic and psychological services, as well as social and legal aid.

Patient numbers: The Primo Levi care centre receives and treats more than 300 patients a year from over 40 countries, regardless of their legal status in France. It delivers more than 6,000 consultations for adults, children – including unaccompanied minors – and families who have suffered torture or political violence in their country of origin and who are currently living in exile in France.

The staff of the care centre includes: 1 receptionist, 1 person responsible for admissions (intake interviews), 3 half-time general practitioners, 1 part-time physiotherapist, 6 half-time clinical psychologists (all psychoanalysts), 2 part-time social workers and 1 full-time jurist. Every year interns in psychology, social work and law come to complete their training at the centre.

The characteristics of the care centre

- **A consecrated setting** – "for victims of torture and political violence" in which patients feel that the specific nature of their traumatic experience is recognised: the services offered are adapted to their needs and are organised so that patients are at all times at the centre of the treatment.
- **A multidisciplinary approach and interdisciplinary teamwork** – in order to meet the needs of patients, the care centre promotes an integrated approach: a wide spectrum of services is available under one roof. Considerable time is allocated for weekly team meetings and informal exchange between staff members to enhance coherency in the treatment and support offered to patients.
- **Professional interpreters** – though it implies substantial cost, the Primo Levi Association insists on working with professional interpreters in order to

establish quality communication between patients and staff in all spheres of intervention.

- **Caring for children, adolescents and families** – a change in the profile of adult patients (a growing number of families) and the increased presence of single, unaccompanied minors have led the clinicians to rethink the way in which unaccompanied minors, as well as children who are often present but forgotten by adults, are received at the centre. They are seen directly by a psychotherapist without any preliminary admission interview.
- **Taking the time that is needed** – "standard" trauma doesn't exist. Each person is uniquely affected, depending on his/her past life experiences, character, weaknesses, defences, social support system and many other aspects. The patients guide us. They determine the duration of treatment. Nothing can be done without them, or regardless of them. Time is undoubtedly one of the most important assets that a specialised centre such as ours can offer: being available and attentive, giving patients the time they need to get to the heart of the matter. The Primo Levi care centre stands for a qualitative approach that is respectful of patients' temporality. The average duration of treatment is currently two and a half years.

Training activities

The Primo Levi Association provides training, in France and abroad, for professionals who are involved in the reception and treatment of the various needs of persons who have suffered political repression and other grave violations of human rights (health care workers, social workers, education professionals etc.). Abroad, training has taken place or is ongoing with Algerian and Chechen professionals, as well as with teams from Lebanon and the Democratic Republic of Congo.

Communication and Advocacy

To inform and testify in order to share experiences and to bear witness the association produces publications (a 20-page quarterly, *Mémoires*, and a monthly newsletter) and provides internet access to a specialised documentation centre (koha.primolevi.org). We also initiate and participate in media and other types of campaigns to raise awareness and to bring relevant issues to the attention of national and international political figures.

Coalition partners: in this context, the Primo Levi Association participates in several coalitions: the French coordinating coalition for the right to asylum (CFDA), the Observatory on health rights for foreigners (ODSE), the European Network of Rehabilitation Centres for Survivors of Torture and Reseda, the French speaking network of care centres.

In 2004, the Primo Levi Association received the **Human Rights prize** awarded by the French Republic in recognition and support of the activity of the care centre.

Significant recent trends

In the last few years the Primo Levi care centre has seen its patient population evolve gradually to include more and more families. A growing number of people envisage escape from persecution and a new life in exile as a family. Though a majority of the

patients seeking care and support at our centre are still usually single and/or alone in exile, there are now more and more members of the same family requiring attention and treatment on an individual basis. This also corresponds to the changing profile of the provenance of new patients: though almost 60% of patients still come from the south – sub-Saharan French-speaking countries in Africa, such as the Democratic Republic of Congo and Guinea – those that arrive in France as a family are mostly from the east – Chechnya, Kyrgyzstan, Kosovo. While most of the children used to be "unaccompanied minors," three quarters of those who are now seeing a psychologist for therapy are living within their families in exile.

For the last couple of years the Primo Levi Association has been seeking solutions for the upcoming challenge regarding the sustainability of its finances. Indeed, after 2013 the Primo Levi Association will no longer be receiving EuropeAid financial support for its activities, which currently makes up 40% of its present budget. Time and energy has consistently to be devoted to finding new sources of funding, encouraging more private donors to give, and to give regularly. Meanwhile, the Association has been more and more involved in advocacy, through networking and through its own initiative of preparing a comprehensive overview document, due for March 2012, to raise awareness of the plight of torture victims in France and the specific care they need. This document will become an advocacy tool to be used throughout the coming year in order to seek political support and consequent public funding.

Primo Levi Association

107, avenue Parmentier, 75011 Paris, France

primolevi@primolevi.org; www.primolevi.org

Telephone: +33 1 43 14 88 50; Fax: +33 1 43 14 08 28

Unit for the Rehabilitation of Victims of Torture (URVT)

Summary: The Unit for the Rehabilitation of Victims of Torture operates under the umbrella of the Humanitarian Affairs Unit of the Future Worlds Centre. It was created in 2006/07 and offers medical services and certification; psychological care and support; as well as legal advice and social assistance to victims of torture and their families. Furthermore, it aims to strengthen existing government and non-government services for the early identification of victims of torture among refugees and asylum seekers in Cyprus and to ensure their care. It is the only rehabilitation centre of its kind in Cyprus. Unfortunately, due to funding problems, URVT is set to halt its operations by the end of 2011 without the expectation of being able to relaunch them in the near future.

Origins and history: The Unit for the Rehabilitation of Victims of Torture (URVT) is an independent unit that operates under the umbrella of the Humanitarian Affairs Unit of the Future Worlds Centre (an NGO which was originally founded as the Cyprus Neuroscience & Technology Institute in 1991).

URVT's creation came at a time when refugee and asylum seekers' issues were becoming more evident in Cypriot society. That became obvious just after Cyprus' entry into the European Union in 2004 and after the numbers of asylum seekers began to increase rapidly. Thus, URVT started as a groundbreaking programme, helping torture victims and their families who are asylum seekers and refugees to rebuild their lives and help them integrate into the local society. URVT was established in June 2006 and commenced its full operation in 2007, offering medical services and certificates, psychological care and support, legal advice and social assistance. It worked in very close cooperation with a network of volunteer service providers, medical professionals and interpreters.

Trademarks: URVT is dedicated to assisting victims of torture and trafficking, asylum seekers and refugees, together with their families, by providing multidisciplinary treatment and rehabilitation services. It aims to strengthen existing government and non-governmental services with regard to the early identification and care of those refugees and asylum seekers who are victims of torture. It is the only rehabilitation centre of its kind in Cyprus, and it was founded precisely as a result of the need to identify and provide specialised assistance to survivors of torture through their asylum procedures and their stay in Cyprus.

More specifically, URVT, during its initial stages of existence, offered holistic assessment to each of its beneficiaries: assessment of health, psychological, emotional and social well-being, legal status and legal protection needs. It also offered social support by assisting beneficiaries to obtain their rights; it provided psychological treatment by means of psychotherapy and counselling to victims and their families; legal aid by providing legal advice and assistance; medical care by offering examination, accurate documentation of the consequences of torture and medical reports and referrals as appropriate. URVT is also actively working to stimulate public awareness on issues relating to its client group, by disseminating information through media, web and events, by organising and participating in activities and by networking with local and international organisations and experts. URVT has so far treated 115 victims of torture or family members.

Significant recent trends

Upcoming closure: During the four years of its operation URVT had to undergo crucial restructuring several times as a result of funding problems. At the end of 2011, URVT had to cease its operations, without any prospect of a relaunch in the near future. As a result, victims of torture in Cyprus will no longer have access to a full range of rehabilitation services.

Offering a second chance to survivors of the unspeakable barbarity which is torture remains an ongoing struggle. It is littered with hurdles and challenges, which obstruct both victims and carers. That however, should not be an excuse for standing still and doing nothing to prevent it or heal its consequences.

URVT, Unit for the Rehabilitation of Victims of Torture – Future Worlds Centre
5 Promitheos St., Office 4, 1065 Lefkosia, Cyprus
www.urvt.org
Telephone: +357 22873820; Fax: +357 22873821
Mobile: +357 99092677; +90 5338700798

B) Bi-national partners

Each core partner teamed up with a partner organisation, referred to here as the bi-national partner, each of which is described below.

CIR, Consiglio Italiano Per I Rifugiati, Rome, Italy (Partnered with ICAR)
Via del Velabro 5/A, 00186 ROME, Italy
cir@cir-onlus.org; www.cir-onlus.org
Telephone: +39 06-69 20201 14; Fax: +39 06 69 20 21 16

International Humanitarian Initiative Foundation (Fundacja Miedzynarodowa Inicjatywa Humanitarna) (Partnered with XENION)
Łowicka St. 51/6A, 02-535 Warsaw, Poland
biuro@ihif.eu
Telephone: +48 530999907; Mobile: +48 693333956; Fax: +48 22 8495509

Freedom from Torture, Medical Foundation for the Care of Victims of Torture,
(Partnered with Equator)
111 Isledon Road, Islington, London N7 7JW, United Kingdom
www.freedomfromtorture.org
Telephone: +44 207 697 7777; Fax: +44 207 697 7799

Oulu Deaconess Institute, The Rehabilitation Services for Torture Survivors
(Partnered with ZEBRA)
Isokatu 41 A 13, 90100 Oulu, Finland
iina.jorma@odl.fi
Telephone: +358 50 3125739

URVT, Unit for the Rehabilitation of Victims of Torture (see under core project partners) (Partnered with Primo Levi Association)

Appendix 2: Framework for Evaluation and Anticipated Outcomes (*Brandon Hamber, external evaluator*)

In line with the Outcome Mapping methodology, participants outlined a number of groups and individuals whom they felt the project could directly influence ("boundary partners"), e.g. project participants, professionals, and new partners. Some of this data was extracted from the original proposal. Below are the anticipated outcomes against which the project was measured in the final external evaluation report. They are grouped according to the actors/boundary partners they pertain to.

Project participants/Centres

- The project would expect to see three meetings with partners and a final symposium taking place and to see an in-depth exchange of information and experience taking place.
- The project would expect to see an Inventory of Working and Treatment Methods identified, as well as staff care strategies and recommendations, and the distribution of results in the form of a report.
- The project would expect to see the development of a document that provides an overview of successful methods and outlines recommendations for improved standards.
- The project would expect to see greater appreciation of the complexity of each other's work, highlighting what is similar between contexts but also what is different.
- The project would expect to see all partners staying throughout the project and engaging actively.
- The project would expect to see the development of a future research agenda documented in the final report
- The project would like to see an increase in the efficiency of the cooperation within the European Network.
- The project would like to see the centres more connected to similar centres in other countries.
- The project would like to see participating partners implement good practice, the Inventory, staff care approaches and recommendations.

Professionals/volunteers working in each centre

- The project would like to see the knowledge gained in the project leading to better cohesion of the teams at home.

New partner organisations

- The project would expect to see new countries/centres introduced to the self-evaluation method and results of the project.

- The project would expect see the development of new relationships with professionals in the field.
- The project would like to see new countries/centres taking part in the project and development of an inventory of their methodologies that reflects their work and approach.
- The project would like to see professionals, especially in newly established centres, using the report and results.

International/national/professional persons/bodies

- The project would expect to see the report that outlines the Inventory of Working and Treatment Methods, as well as staff care strategies and recommendations, distributed to national and international professional bodies and persons.
- The project would expect to see the report and results of the project distributed to existing professionals and to the European Network in different formats.
- The project would be considered an unparalleled success if lawyers, judges, officials, migration authorities, decision makers and politicians were using the report and results.

National healthcare services/social services

- The project would expect to see national health care services/social services better informed about the existence of the various participating centres and the complexity of their work.
- The project would like to see better recognition by national health care services/social services of the work of the participating centres.
- The project would like to see an improvement in working relationships with national health care services/social services.
- The project would be considered an unparalleled success if national healthcare services/social services changed their practice as a result of the report and results.
- The project would be considered an unparalleled success if national health care services/social services approached the participating organisations asking for training based on the report and results, and provided appropriate resources for such training.

Donors/EU

- The project would expect to see the project evaluated successfully and seen by the donors as a valuable contribution to work in this area.
- The project would like to see an increase in awareness by the ERF of the work of the participating centres and its complexity.
- The project would like to see our own approach and evaluation method taken into account by the EU.
- The project would be considered an unparalleled success if the project resulted in a coherent strategy for our activity across the EU.

- The project would be considered an unparalleled success if financial support from the EU for this type of work increased and applications submitted were supported.
- The project would be considered an unparalleled success if it led to a larger diversity of donors and consequent core funding.
- The project would be considered an unparalleled success if it led to a decrease in the bureaucratic demands of funders, allowing for more flexibility in work.
- The project would be considered an unparalleled success if the EU enforced relevant directives.

Clients

- The project would expect to see client feedback built into the assessment of different working methods, and this to be reflected in the final report.

43

Immigrant authorities

- The project would like to see an increase in awareness by immigrant authorities of the work of participating centres and its complexity.