Evaluating the Effect of Intervention by Centers Rehabilitating Survivors of Politically Motivated Torture

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Since the 1970s, programs and centers for the rehabilitation of politically-motivated torture survivors have been helping survivors in their countries of origin and in countries of both initial and final resettlement. The earliest programs were in South America: Chile, Argentina, and Uruguay. Centers were then founded throughout the resettlement world: Europe, Australia, and North America, as well as in other areas where torture was or had been practiced: the Middle East, Africa, and Asia. In 2005, at least 235 treatment programs were identified worldwide [1] and more have subsequently been established.

Despite the long history of torture rehabilitation throughout the world, only a small fraction of torture survivors actually receive treatment. Financial support for services never comes close to meeting the need. It is increasingly important for torture rehabilitation centers to demonstrate to funders that the resources are used most efficiently and effectively to help survivors.

Studies of the efficacy of different treatment approaches and of the indicators to measure successful outcomes have been few and often problematic. Nearly all of these outcome studies have limitations such as the lack of control groups, varying definitions of diagnostic criteria, poor or absent validation of assessment instruments, small sample size, and other factors [2].

The effects of torture on the individual have interacting social, political, cultural, economic, medical, psychological, and biological dimensions. Nearly all clients have major psychiatric disorder, most often posttraumatic stress disorder (PTSD), depression or both. The course is usually chronic with exacerbations and remissions. They may have multiple medical problems, notably hypertension and diabetes. Survivors have multiple social problems: financial, housing, raising children, domestic strife, social isolation, etc. Since the needs of survivors are many, programs have generally adopted a multidisciplinary approach.

The evidence that torture has psychiatric consequences is overwhelming. In a meta-analysis, [3] undertook a systematic review and meta-regression of the prevalence rates of PTSD and depression in the refugee and post-conflict mental health field. Adjusting for methodological factors, reported torture emerged as the strongest factor associated with PTSD. For depression, significant factors were number of potentially traumatic events, time since conflict-reported torture, and residency status. [4] Provided a comprehensive and critical summary of the literature about the development and maintenance of PTSD following civilian war trauma and torture. They found good evidence of a dose-response relationship between cumulative war trauma, torture and development and maintenance of PTSD. [5] Reviewed the percentage of traumatized persons with PTSD or significant symptoms in population-based surveys or case-control studies (Ns > 100) and, in contrast to Johnson and Thompson, found rates as high as 43% current and 74% lifetime [6]. The severity and protracted nature of torture do seem to negatively correlate with recovery [7,8]. Because of the complexity of the survivors and their circumstances and their individual prognostic factors, controlling for confounding factors is nearly impossible.

The best approach to evaluating the efficacy of the program is a multidimensional, multidisciplinary measure of individual outcome. The choice of measurement instruments should be based on the specific objectives, outcomes, type of intervention implemented, and information needed, all of which will be unique to each program. Several authors have defined some of the criteria for selecting a measurement or indicator for consumer outcome [9-12]. Instruments selected should be valid, reliable, standardized, translated and back-translated, and culturally equivalent, criteria which are rarely met. [13] compiled a list of available and commonly used instruments. Among possible outcomes are symptom reduction, quality of life, level of function, coping and resilience, social support, and client satisfaction. The most frequently measured outcomes include medical and psychological symptoms, level of functioning or disability, quality of life, and client satisfaction.

For ethical reasons programs are unwilling to allocate a random control group, in spite of the fact that the efficacy of the interventions is not proven. The problem is how to design acceptable experimental studies in the absence of a control group.
[13], in their desk study, chose to categorize the types of studies according to the classic text by [14], as follows: **Descriptive, Experimental, Quasi-Experimental Pretest-Posttest (One Group)**—including retrospective chart reviews; **More than One Group Randomized; More than One Group Non-Randomized; Qualitative (Phenomenology; Ethnography; Grounded Theory)**. In this study, they included the 25 studies in [1] and added more than 45 additional and more recent studies for a total of more than 70.

Outcome research in torture is challenging, but it still is possible to conduct valid research. When torture treatment centers conclude that is not possible to use random control groups, then the only option is to use quasi-experimental designs. Most published studies have used pre-post evaluation with one or more groups to measure the efficacy of the therapeutic intervention. For those studies with comparison groups, few are randomly selected, most are non-random. These latter designs permit inferences of the benefits of the study groups. Before selecting the best instrument and research design, each center should analyze the population receiving care in their program, the types of treatment delivered, and the outcomes they want to measure, even if only descriptive or demographic data is available.

**REFERENCES**


