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"The Center for Victims of Torture International Service's department: An analysis and evaluation of the department's four objectives"

Introduction

The Center for Victims of Torture operates treatment centers in several different countries. While there is a singular, overarching goal to heal victims of torture and war trauma in all its treatment centers, CVT faces challenges in implementing its policies in a variety of locations. Each site has an array of ethnic groups, languages, cultural norms, and history of conflict. We believe that in order to succeed in the face of such challenges, international nongovernmental organizations need to be adaptive and flexible without diluting their strengths and values while forming and implementing their policies. We, the authors, are interns at The Center for Victims of Torture and much of the information we garnered for this paper was through personal interviews with staff at the organization.

This paper addresses the following questions: How does the implementation of the four operations of CVT's International Services department vary by location, what might be the reason for this, and how, if at all, does this affect the efficacy of the operations and the common goal of CVT to heal the mental and physical wounds of torture? This paper considers international treatment centers by comparing them to CVT's domestic

program and the changes required to the original program design in order to achieve their goals in different countries. This paper is organized to first provide the background of CVT, then the International Services department, and the International Services' activities. Each section of activity will provide examples of activities and then explain specific differences in sites that were adapted to meet differences on the ground. We believe that it is vitally important that the treatment achieves its intended effects, but psychiatric symptoms are not easily quantifiable. With this in mind, this paper also has a meta-evaluation of how CVT measures the effectiveness of its mental health treatment, and for this purpose a clinical outcome is defined as *"a characteristic of the consumer that, according to the theory and goals of the services, can be reasonably expected to change as a result of the consumer's receiving them* (Lyons et al 1997)*."*

The purpose of the paper is to provide an evaluation of the International Services department within CVT as well as offer thoughtful recommendations as to how the department and the organization may improve their operations.

Background

The primary goal of the Center for Victims of Torture (CVT) is to help survivors overcome the debilitating effects of torture and war trauma as soon as possible. This involves treating psychological maladies resulting from torture as well as providing direct social services to help the survivor regain his/her place as a functioning member of the family and society. CVT defines torture as the intentional and systematic infliction of physical

or psychological pain and suffering in order to punish, intimidate or gather information. Their definition is based off Article I of the United Nations Convention Against Torture (1984) and the World Medical Association Declaration of Tokyo (1975). Other and common types of torture include rape, dismemberment, and individuals being forced to witness or even partake in killing of family members. Measuring the effect of treatment is largely dependent on social norms because the symptoms manifest themselves in the form of abnormal behavior. Social norms are especially important when the cultural differences between countries are heavily informed by the people's own experience with internal conflict. The kind of torture that CVT most often sees in its field work is politically motivated; partisan militants targeting individuals based on ethnicity, district, or religion reflects the competing interests in the country's political structure.

People that have been traumatized suffer lasting symptoms that interfere with their ability to live normally. Trauma is best defined as an event that involves a single experience, or an enduring or repeating event or events that completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved with being tortured. The sense of being overwhelmed can be delayed by weeks, years, even decades, as the person struggles to cope with the immediate circumstances. Trauma is defined by the American Psychiatric Association as the person has been exposed to a traumatic event in which both of the following have been present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror (309.81

DSM-IV). There is frequently a violation of the person's familiar ideas about the world and of his or her human rights, putting the person in a state of extreme confusion and insecurity. This is also seen when people or institutions depended on for survival violate or betray or disillusion the person in some unforeseen way (DePrince, A.P. & Freyd, J.J., 2002). The symptoms can manifest themselves in a variety of illnesses and disorders such as psychosis, problems with intimacy, major depressive disorder as well as anxiety, demoralization, stress, fear pain, somatic troubles, and Post-Traumatic Stress Disorder (PTSD) (Silove & Steel, 1998; Edvall-Dahlgren et al., 1989). On a larger scale, survivors' trauma keeps them from participating in the normal social structures.

International Services is the department of CVT that specializes in establishing and running treatment centers overseas under the CVT name. There is a different department of CVT titled International Capacity Building that works with existing treatment organizations to help improve their operations. International Services approaches its work through four main objectives: Training Psychosocial Counselors, Community Sensitization, Direct Client Services, and External Training.

CVT

During his first term as governor of Minnesota, Rudy Perpich wanted to use his office to promote human rights. He “commissioned” ideas for human rights initiatives from

Minnesota Advocates for Human Rights and Professor David Weissbrodt at the University of Minnesota Law School. The most ambitious of the ideas brought forth was of the establishment of the first treatment center in the U.S. for torture victims. Governor Perpich embraced the idea and began to act. He went to Copenhagen, Denmark, to visit the first treatment center in the world, the Rehabilitation Center for Torture Victims, and appointed a task force to determine whether such a center would be feasible in Minnesota.

The Center for Victims of Torture works to heal the wounds of torture on individuals, their families and their communities and to stop torture worldwide.

- *CVT Mission Statement*

Although the governor's office laid the groundwork, when CVT opened for business in 1985, it was an independent, nongovernmental organization. For the first two years, clients were treated at the International Clinic of St. Paul Ramsey Medical Center. Eventually CVT moved the treatment center to a Victorian house along the Mississippi River. Keeping in mind the sensitive condition of the clients, great efforts were made to minimize furnishings that had institutional connotations. Although florescent lights and rooms with corners at 90 degree angles may be commonplace, it is believed that the slightest resemblance to the locations where trauma occurred (e.g. holding cells) has the potential to re-traumatize clients. CVT does not view a client in a limited perspective as only a torture survivor, but as a person with a symbiotic role in his or her family and

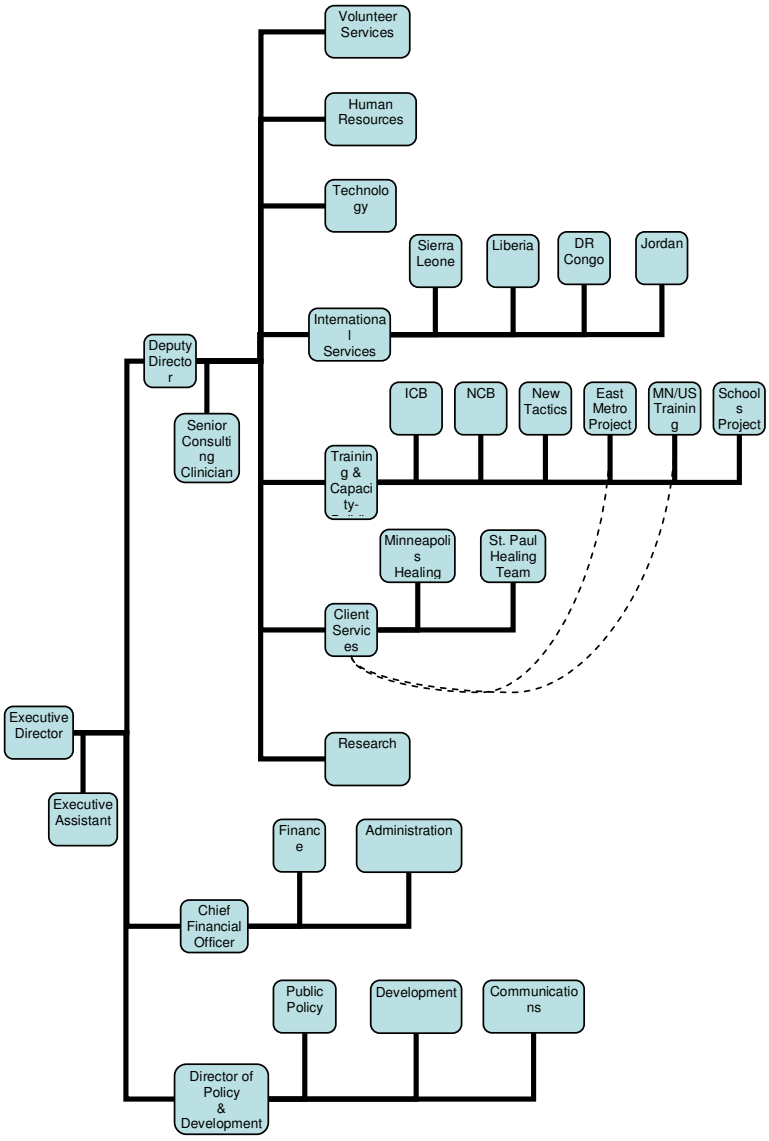
community. When the house in Minneapolis was being renovated, the community (both businesses and individuals) reciprocated the conviction that there is a place for CVT in the neighborhood by contributing a significant amount of materials, funds, and labor.

After the treatment center in Minneapolis was established, CVT began to develop more operations in order to better fulfill its mission. CVT began training health, education, and human services professionals how to recognize symptoms of trauma in order to enhance its referral network and thus increase the accessibility of services to those who need it. CVT conducted clinical research into the effects of torture as well as developments in treatment methods. Also, the Policy and Development Department began advocacy for public policy initiatives in Minnesota, the U.S., and internationally.

CVT began working in Guinea in November 1999 to address mental health problems experienced by traumatized adult and child refugees who fled civil wars in Sierra Leone and Liberia. In the aftermath of war, there were 20,000 refugees in the Albadaria region of Guinea, nearly all of whom had survived or experienced torture and trauma such as being forced to watch brutal executions, militant groups carving their groups' initials into victims' flesh, and pressing girls as young as seven into service as sex slaves. CVT not only provided immediate, direct care to thousands of survivors, but also began to build a local care network by training camp residents as paraprofessional mental health care providers. As the refugees began to return home, CVT opened operations that followed the shifting population centers in order to continue providing direct services to the effected population. The next treatment center to open was in Sierra Leone in fall

2001, followed by new treatment centers in Liberia in April 2005, Democratic Republic of Congo in 2006 and the latest facility opened in Amman, Jordan in October 2008 to treat Iraqi refugees. CVT closed operations in Guinea in March 2005, following repatriation into Sierra Leone and Liberia by the refugee population CVT had served in Guinea.

Diagram 1



International Services

The International Services Department of the Center for Victims of Torture is directly under the control of the Deputy Director of the organization. As seen in the organizational chart in Diagram 1, other areas of responsibility for the Deputy Director include the domestic healing services at the Minneapolis house and St. Paul house and the Training and Capacity Building Department. Even though International Services and the Training and Capacity Building Department report to the same person and the work of the departments is complimentary, there has been little cooperation on project or direct involvement with the other departments' work. This year marks the first time that the two departments are working on a project together.

CVT's International Services department works in areas where torture and war have resulted in widespread devastation of the community. The trauma experienced by victims of torture and extreme violence, such as being raped multiple times or severely beaten for information, drastically alters their ability to handle even the most basic daily life functions. In medical terms this meets the definition of a disorder; that is: emotional or behavioral symptoms that occur in response to a specific stressor and impede a person's social or occupational functioning and their ability to maintain normal relationships. Survivors can experience insomnia, panic attacks, self-hatred, and suicidal

thoughts or tendencies. The most common diagnoses include PTSD, major depression disorder, or a combination of both disorders.

The colloquial use of the terms trauma and depression belies the severity of these debilitating medical conditions. Symptoms of PTSD include re-experience, such as flashbacks and nightmares; avoidance of stimuli associated with the trauma; increased restlessness such as difficulty falling or staying asleep; anger and hyper-vigilance.

A person suffering from major depressive disorder usually experiences a profound and constant sadness that permeates every aspect of his or her life as well as an inability to experience pleasure in activities that are normally enjoyable. Someone afflicted with depression may be preoccupied with thoughts and feelings of worthlessness; inappropriate guilt or regret; helplessness; hopelessness; and self hatred. Other symptoms include poor concentration and memory, withdrawal from social situations and activities, reduced sex drive, and thoughts of death or suicide. Although not reflective of all cases of depression, it is not infrequent to see extreme instances where a person may not shower for months, neglect his or her children's care, or abstain from eating for abnormal periods. Insomnia is common: the typical pattern is that a person wakes very early and is unable to get back to sleep. Hypersomnia, or oversleeping, is less common. The person may report multiple physical symptoms such as fatigue, headaches, or digestive problems; physical complaints are the most common presenting problem in developing countries according to the World Health Organization's criteria of depression. Family and friends may notice that the person's behavior is either agitated

or lethargic. In severe cases, depressed people may have symptoms of psychosis such as delusions or, less commonly, frightening hallucinations.

Without help, survivors are unable to resume normal activities or participate in the rebuilding of their community. CVT International Services recognizes that a person who has once been traumatized is more likely to be traumatized by other challenging events; a refugee who was once tortured or otherwise severely violated and forced to flee is more likely to become detached during the time of another hardship, suffer from flashback and hyper-restlessness and experience the aforementioned depressive and anxiety symptoms.

Given that the effects of torture are primarily mental and physical, it is not hard to forget how the individual fits into the bigger picture. Healing survivors of torture and war trauma is integral to the process or rebuilding a post-conflict society. At the confirmation hearing for Alberto Gonzalez in January 2005, CVT Executive Director Doug Johnson spoke of the externalities of torture:

> *We know that torture can profoundly damage relationships between family members and between the victim and the community. This level of trauma affects future generations, as we see higher rates of suicide and depression among the children of survivors. Torture is said to be one of the most effective weapons against democracy as survivors usually break ties with their community and retreat from public life.*

The hiring and training of members of the local community as Psychosocial Counselors ensures that care providers are culturally sensitive and that after CVT's time ends in the host country, there will continue to be mental health resources in the area. CVT targets those communities with "high" numbers of survivors and few sources of help such as in post conflict or refugee camp situations. While working directly with survivors, CVT is also helping build the local capacity to meet mental health needs beyond the tenure of their projects. This entails working with both governmental and nongovernmental organizations as well as individual leaders of the community to raise awareness of the prevalence and effects of torture. Since mental health issues may not be familiar to wider communities, the hope is that people with stature and influence in the community will effectively inform their constituents. The effect of this outreach is twofold: 1) to help recognize the symptoms and refer potential clients to CVT and 2) to improve the ability of others to engage with victims of torture and trauma.

Decision-making process

The International Services Department previously operated with an informal decision-making process for establishing and creating new programs. A couple of years ago a more formal decision-making process was established by the Board of Directors to streamline the process. Although it is outlined as a linear process, many of the processes overlap and do not always occur according to the timeline of the process.

The program design can vary, but all follow the four objectives of the International Services Department: 1) Training of Psychosocial Counselors, 2) Community sensitization, 3) Direct Client Services, and 4) External training. The process starts with a set of strategic criteria that have been set by the board for the purpose of keeping current on a broad pool of candidate sites. These criteria include, but are not limited to:

- Whether the country contains a population from which Client Services draws clients, i.e., trauma and torture survivors.
- Whether there are large numbers of refugees or Internally Displaced People.
- If the conflict destroyed whatever mental health services that previously existed in the region.
- Whether the situation moved beyond conflict.
- Whether the region experienced or was close to civil conflict.
- Whether other NGOs in the area believe there is a need for CVT's services.

For a candidate to qualify to be in the pool, only one of the above criteria needs to be present, but analysis is still conducted based on the entire breadth of criteria.

A few countries are selected from the pool of candidates for further assessment. The process for determining whether or not to do an assessment depends on the situation in the country, if there are torture survivors present, if there are other NGOs present to meet the basic needs of the population, and whether or not there is encouragement from possible funders, such as the State Department's Bureau of Population, Refugees,

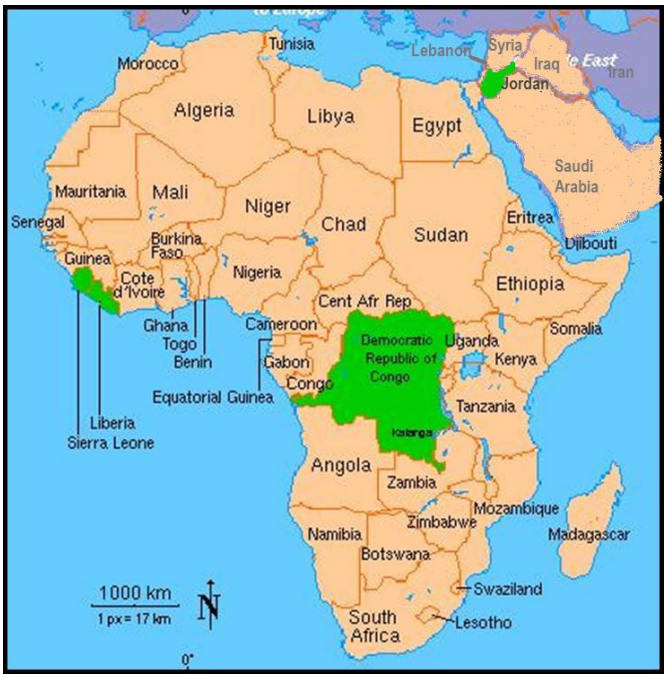
and Migration. Although not part of the official decision-making process set by the board, another concern taken into consideration by CVT staff is whether CVT already has a presence close by and if staff members think it is possible to find staff within the country and expatriates willing to travel there.

CVT's initial assessment looks at whether there are "enough" torture survivors in the country or region. CVT does not operate with a specific number or percentage of population to establish whether or not this criterion of "enough" torture survivors is met. Instead, CVT operates with the assumption that if the country has had a war or civil conflict there will be a substantial number of torture survivors. It is also often the case that potential partner NGOs already on the ground will notify CVT if they encounter great numbers of assumed torture survivors. The assessment also attempts to determine whether the area is secure enough to start up a new center. As far as security goes, CVT looks at specific factors such as the presence of UN forces in the area, good communication infrastructure, easy ways to get out of the region on short notice, and if there have been recent attacks on other NGOs in the region. A third concern of the initial assessment is to determine whether other complimentary NGOs are in place already and if these NGOs encourage a CVT program in the country, whether the program can be designed and implemented effectively, and if CVT's headquarters is able to support a new project and if so, whether that program fits with the organization's long-term goals (Lewison, Edie. Personal interview. 9 April. 2009)

If the initial assessment finds that the country in question presents a feasible opportunity to fulfill CVT's goals, then the prospective project is recommended. The executive director has the final say in whether or not to recommend the project, and it is he who presents it to the board. After a recommendation has been made, CVT makes donor requests, creates and designs the program, and negotiates with funders. Following the recommendation and board approval, a proposal is created.

International Services Activities

International Services provides mental health services in an effective, efficient and sustainable manner so that survivors of torture and trauma can resume their normal life. International Services consists of four main objectives and within the framework of these, each center adapts their program to match the needs of its victims.



Training Psychosocial Counselors:

The duration and geographical range of the civil wars in Liberia, Sierra Leone, Democratic Republic of Congo and Iraq have affected an enormous number of people. For example, CVT's press release regarding its Jordan project estimates that there are over 100,000 Iraqi refugees living in Jordan who have suffered torture or war trauma. The affected population in the African sites is similar in quantity and prevalence. Because of the massive number of people who have been affected, CVT's international treatment centers hire a majority of their personnel from the local population and train them in-house to work as psychosocial counselors (PSC), whose job responsibilities entail facilitating talk therapy groups for clients.

CVT hires expatriate clinicians to run the PSC training. The first part of training is identical in each country; the PSCs are given two weeks of formal classroom lessons directed by the clinicians in torture and trauma rehabilitation. This involves basic interpersonal skills and learning about technical aspects of psychology and trauma. The former involves teaching PSCs how to empathize, communicate effectively, differentiate/name feelings, and intervene with traumatized adults, among many others. Some of the technical facets of trauma include child development and trauma,

effects of mass war on psychosocial functioning, and recognizing symptom clusters. Symptom clusters are the variety of symptoms that an illness manifests itself. Individually the symptoms may not indicate that there is a larger problem, but a client that presents several of the aforementioned symptoms associated with depression could then be prescribed the appropriate treatment plan. The client intake is conducted in a conversational manner, so PSCs are expected to amalgamate their interpersonal skills with their technical expertise to effectively explore the client's history while recognizing when they should retract in order to avoid re-traumatizing the client.

Following the initial two weeks of classes, such as "Principles of Trauma Treatment," the trainees change to an observational/experiential learning model by shadowing more experienced PSCs as they facilitate groups over the course of two to three weeks and go about their customary duties. In this time they are trained on group facilitation, problem solving counseling, and coping skills. The PSCs receive daily supervision and feedback on their performance from the expatriate clinicians (Lewison, Edie. Personal interview. 25 March. 2009).

Then the third phase of training is usually left to be determined by the clinician; this portion is usually tailored to emphasize topics that have already been covered and to teach a new topic in monthly supplementary training sessions (e.g. treating rape victims) in which the clinician has particular expertise. Some of these topics have included ethics, secondary trauma – when counselors are affected by other people's experiences, and advocacy. The PSCs receive accreditation for their training; some of

the former PSCs have gone on to work as counselors in the Truth and Reconciliation Commission of Sierra Leone.

Minnesota: Both the domestic and foreign treatment centers have highly skilled clinicians, but in the Minnesota treatment centers the clinicians do not take on training responsibilities. Instead, CVT hires individuals who already have the necessary skills, accreditation, and familiarity with psychological trauma. In anticipation of an influx of a new population, CVT prepares its staff with historical and cultural information relevant to their duties.

Guinea, Sierra Leone, and Liberia: The civil wars in West Africa left the educational institutions in ruin, so the PSCs in these areas do not have university degrees. The education levels, in general, are lower than in other countries where CVT operates. Many of the PSCs have been victims of torture themselves. While the education levels may be lower, there is a tradeoff in that the PSCs will not have to be trained to be culturally sensitive to the client population in the same manner that Minnesota staff would need to be. Also, the personnel costs make up the largest expenses for the treatment centers, so the financial restraints prevent the African treatment centers from replicating the staff composition in Minnesota. The budget constraint has a silver lining in that CVT is able to provide services for a greater number of clients by hiring

PSCs at a lower wage than they would by allocating more of the budget to clinicians' wages (Lewison, Edie. Personal interview. 25 March. 2009).

While the problem of rape in other client populations is common, the prevalence was so much higher that the training in Liberia puts special emphasis on dealing with the particular symptoms of rape trauma syndrome. Similarly, after opening the treatment center in Freetown, Sierra Leone, the staff decided that a special program was needed to deal with the abundance of clients that had been victims of human trafficking in forced labor or sex slavery.

Democratic Republic of Congo: Roughly half of the PSCs hired have university degrees in occupational psychology. The University of Kinshasa does not have a clinical psychology program, but CVT is currently working to expand the university's capacity by designing curriculum. CVT will also share its expertise in dealing with torture survivors to university faculty. While the education level is certainly higher in DR Congo than in the West African sites, there is an additional challenge presented by the brutality and pervasiveness of gender-based violence. While gender-based violence is certainly a serious problem in other conflict areas, Anthony Gambino, a consultant for the Council on Foreign Relations, has recently stated that the reports from DR Congo are far worse than any other country. He spoke of victims being forced to rape family members or men and women being raped with various weapons (CFR conference call April 23rd,

2009, 11:00 AM). The PSC training has been adapted accordingly to deal with the DR Congo's horrific violence by emphasizing the need for rapport before delving into the clients' trauma history.

Jordan: Before the treatment center in Amman opened, CVT staff took steps to ensure that they would be ready for operating in a culture that they did not have experience with. The staff are all native Arabic speakers except for one American clinician and CVT staff and the Jordan hires communicated about how best to put CVT's goals into practice. The treatment center opened in October 2008 and since then there has been an open dialogue about how to adapt the training to meet the specific needs of the Iraqi clients.

The environment for the Amman treatment center is the first international treatment center in an urban area. The education base is much higher than in the previous projects. This results in CVT hiring more specialists with PhDs and Masters. Also, the client population in Amman is more transient given that it is illegal for the Iraqis to work and they have no source of income. In the short time that the treatment center has been open, the staff has found that the clients frequently move to less expensive areas. There is an additional problem that many of the Iraqis are in the country illegally. So the training of the Amman staff includes learning ways to lower the barriers to follow-up, much of this involves rapport building as well as providing bus fare. Also, there are some

cultural taboos in Arab culture that provide significant obstacles in treatment. The CVT staff has found that the stigmas attached to rape, mental health, and torture are more problematic than in the other host countries.

Community Sensitization

Training and community awareness raising activities are held in communities in order to bring attention to the prevalence and effects of torture, to help community members such as teachers, religious and local leaders know what they can do to help others, and to help identify potential clients. The activities particular to community sensitization are designed to impart similar interpersonal skills that are taught to the PSCs as well as a basic level of understanding of mental health problems. Community sensitizations do not seem to have a specific quantity of recipients that distinguishes the operation from the PSC training. While the material being taught is very similar, the community sensitizations target a broad audience, not just CVT hires. Some of the specific activities include radio broadcasts, sports event with CVT signage, dramatic performances, or the annual commemoration of the UN International Day in Support of Victims of Torture.

Community sensitization ameliorates the fractious effects that torture has on the greater community. Educating the community about mental health will provide a more

empathetic environment that will ease the withdrawn survivors' reintegration into society. The program also helps CVT to reach those most affected. Usually those who take the initiative to seek out CVT's mental health services are not suffering the most, and the ones who have the greatest need for mental health services are more solitary. The hope is that the community eventually develops an understanding of the symptoms of torture and war trauma as well as the services that CVT provides, individuals are more able to recognize warning signs in others.

The community sensitization is meant to give community members an opportunity to learn and discover for themselves valuable information about an issue which has far reaching effects. The sensitizations strive to foster learning as opposed to simply teaching. It is not necessary to persuade people about the benefits of the agency, but let them freely choose when they have enough information to make a decision on their own. Community sensitizations are sometimes designed by suggesting problems to community leaders and having them design a program that would be engaging and well received by the wider community. Generally, the topics chosen are issues that resonate throughout the community, such as former militants living in the community, the effects of war, or the effects of rape. Whatever form the event takes (sporting event, music performance, etc.) there is a discussion afterward that provokes thinking about root causes and solutions.

Minnesota: Every June 26th the treatment center in Minneapolis hosts an event in honor of the UN International Day in Support of Victims of Torture. The event includes food, a short play, and a distinguished speaker. Attendees are encouraged to write a prayer or a message on a piece of paper that gets placed with a newly planted tree. Clients, clinicians, office staff, volunteers, and other members of the community are encouraged to attend. The event reflects the organization's value on community.

Guinea, Sierra Leone, and Liberia : Activities address the prevalent issues, like child soldiers and latent militants by raising awareness amongst youth groups and encouraging people to give up illegal arms. Sensitizations are often public events were people are gathered by going door to door or enticing large groups with a bullhorn in public spaces to attend. In Calaba Town, Sierra Leone, CVT organized an event that included a peaceful march through the town, a dramatic performance by students, a communal meal, and a screening of a documentary about the Truth and Reconciliation Commission of Sierra Leone.

The previous year there was a rally in Tombudu, Sierra Leone at the site of a mass killing during the war. Police officers, teachers, youth groups, women and military officers marched through town wearing shirts bearing an anti-torture message, "Together Against Torture." Once at the town hall there were speeches, PSCs singing songs condemning torture and short plays by students re-enacting events from the war.

Afterwards, there was a candlelit procession to the Tombudu War Memorial where Muslim and Christian leaders offered prayers for those killed in Tombudu. The evening ended with a screening of the Truth and Reconciliation documentary.

Democratic Republic of Congo: A community leader from a distant area asked for a community sensitization program in their village. CVT's staff in DR Congo could not travel to conduct a sensitization at the time so the community sent several people to the CVT treatment center to be trained to conduct sensitization events. The treatment center staff took on this training session in addition to their regular responsibilities. The training focused on the types of torture and war trauma and the effects of those events. Training also included coping skills and resources people could use to relieve some of the pain and stress of the post-traumatic symptoms, such as talk to others, do things they enjoy, remind themselves that they are not alone and that what happened to them was not their fault. The group of trainees was instructed on how to conduct sensitizations to impart this information to the community. The supervising clinician commented that the PSCs were determined to pass on what they had learned to the visiting trainees and they felt that it helped to reinforce what the PSCs already knew. The clinician commented that, "This group of PSCs was incredibly committed, and they worked very hard that weekend. I heard not one complaint, and I was very proud of their work."

Jordan: The aforementioned differences in Jordan present an entirely different challenge to CVT. The nascent program is still trying to determine the best way to conduct community sensitizations in an area whose culture is significantly different than the African areas. So far there has been a public gathering in protest of torture in Iraqi prisons (Lewison, Edie. Personal interview. 25 March. 2009).

Direct Services

The general purpose of direct services is to provide counseling in order to improve the mental health of torture survivors. Direct services include individual counseling and group counseling. Which method is used usually depends on the location of the center or the kind of clients they see. Many clients cope well and improve from group counseling, but for those who are unable to attend group sessions or express a need for greater privacy individual counseling is available. The individuals who receive individual counseling will often join small groups for counseling at a later point, phasing out the individual counseling. This practice is particularly prevalent in the African centers where CVT lacks the capacity to offer long-term individual counseling and the clients usually respond well to group settings. Small groups consisting of 10-20 clients receive counseling for 10-12 weeks. Each group is formed based on age and gender. The group is led by one or two PSCs depending on their level of experience. Each meeting is 2 hours weekly, with the understanding that group members are to get together for

support outside of the formal once-a-week meeting at least once or twice each week. Every group follows a cycle of treatment that goes through various issues that clients may struggle with. At the end of the group cycle the clients are finished with the "formal" counseling from CVT, but they still partake in community and psychosocial activities.

Minnesota: CVT's center in Minnesota differs greatly from the centers abroad. The most obvious difference is that this is where the organization's headquarters are located. Secondly, Minnesota's general and mental health infrastructure is much greater than that of the abroad locations. As a result of these two factors it is easier to research, plan, and implement a program in Minnesota than any other location. All the major decision makers are within close distance and thus the process can be more streamlined and therefore much faster.

When a torture survivor comes to CVT in the U.S he or she is met by a multi-disciplinary intake team consisting of psychotherapists, social workers and nurses. The team will then decide on a treatment plan. This plan might include physical therapy, massage therapy, or counseling all depending on the client's needs. The client may not receive treatment from CVT directly. If the intake team believes that the victim can get the necessary treatment in local hospitals, clinics or other agencies s/he will be referred

there. CVT will take the survivors whose needs are most severe and who will not be able to find the treatment necessary outside CVT.

The triage used to determine treatment also includes determining if the person is indeed a torture survivor by UN standards. Only those whose experience falls within the legal definition will receive treatment from CVT. This is a very different approach from the programs abroad, where most everyone who approaches CVT with experiences of trauma or torture will receive some kind of treatment by the organization.

Mental health in the U.S focuses on quality rather than quantity and this is reflected in the length and breadth of the victim's treatment program. The average client stays with CVT for about two years, but it is not unusual for clients to receive treatment well beyond that.

One of the ways CVT provides counseling is through small groups. This method is not usually applied in the U.S, however. The domestic clients only receive individual counseling, but may engage in other 'psychosocial activities' such as events and outings arranged by CVT with a group. The main reason why the domestic program focuses on individual counseling is that there is an expectation that in the U.S. health care system treatment takes place through individual counseling, thus this is expected both by other partners in the system as well as some of CVT's clients. Due to the high level of human capital as well as the integrated system of referrals CVT has thus far been able to offer individual counseling (Hubbard, John. Personal interview. 15 April. 2009).

Guinea: In the summer of 1999, the U.S. State department requested that CVT conduct a mental health needs assessment of the refugee population in the camps surrounding Guéckédou in Guinea. Reports indicated that much of the refugee population appeared too depressed to take advantage of the programs and services offered by NGOs in the area. The needs assessment suggested that a significant number of the refugees were in need of a mental health intervention in order to make use of the existing NGO programs (Miller and Rasco 2004)

Opening a center in Guinea proved challenging, not just because of the resistance the organization met from the Guinean government, but also the severity and high occurrence of torture among the refugees. The Guinean government refused to acknowledge the existence of torture, and CVT was therefore unable to operate with the name 'Center for Victims of Torture'. In addition, government officials required bribes to issue the necessary paperwork for the establishment of the center. CVT refused to provide the bribe and was therefore never legally in operation in Guinea. CVT was, however, mostly left alone and able to provide services to the refugees.

Once CVT got to Guinea it soon became clear to the clinical staff that there was hardly a person that had not in some way suffered traumatic experiences or torture. Many were forced to witness rape of family members, executions of friends and family, and they had constantly been confronted with the sight of dead bodies strewn around. Others

had limbs cut off, or the letters RUF or AFRC carved into their chests or arms by the rebel forces. Children were abducted and forced to partake in massacres of their own towns or family. Girls as young as seven years were taken as sex slaves or raped repeatedly. Some of the survivors had even been forced to commit cannibalism of their own dead.

The severity of the experiences and number of victims led to the development of community programs and targeted intervention of those individuals whose experiences had left them unable to engage in daily activities. The victims were divided into three categories, each with its own set of interventions designed to meet their needs. Level I victims required medication or hospitalization and many of them were therefore referred to other organizations equipped to provide that specific form of treatment. For Level II survivors, group and individual counseling was set up as well as family interventions. Level III survivors participated in large group activities and community sensitization programs, such as participating in role-play groups and traditional cleansing ceremonies.

The situation in Guinea was severe enough to warrant a long-term program, but there was no local capacity to provide any form of long-term treatment. As a result of this the idea of training peer counselors was introduced. The intention was to keep expatriate staff on location until it could be demonstrated that there was enough local capacity to ensure the survival of the program and quality of services.

The original location of Guéckédou was overrun by rebels in 2000 and the camp as well as the program was forced to relocate to Kissidougou (a location further inland). The move forced the program to change in order to address the fear and stress the move induced in the refugees. However, once in its new location the program reinstituted their original services as well. The center in Guinea closed in 2005 since most of the refugee population served moved back to Sierra Leone and Liberia.

Sierra Leone: By 2001, the situation in Sierra Leone was stable enough that many refugees decided to return home. In September of 2001, CVT opened its doors in Sierra Leone. Like the program in Guinea, this program was established in refugee camps, but the focus of the work was different from that of Guinea. The center in Sierra Leone was established to address the mental health problems of repatriating refugees.

Several PSCs from the Guinea camp returned to Sierra Leone and started working with CVT in its new location. However, the repatriation camps in Kenema were closed in 2002, forcing the refugees to return to their homes and forcing CVT to once again change focus and location. The center is now in the Kono district, in the eastern part of Sierra Leone. The Kono district was among the regions that was hit hardest by the regional conflicts. When the conflict in Liberia once again regained momentum, many Liberians fled to Sierra Leone and into the camps where CVT worked. The focus of the center's work adapted to meet the challenges of this new refugee group.

The center in Kono has worked closely with the Ministry of Health and the Ministry of Education in Sierra Leone to provide training and referral services. From this cooperation CVT has managed to establish college accreditation for the training PSCs receive from CVT.

Due to the limited capacity of the center, most of the Direct Client Services is small group counseling. Individual counseling is available, but to a lesser extent. The goal is that all clients participate in small groups, so the clients who need individual counseling will usually be sent to a group once the individual counseling has alleviated whatever concerns the client might have had in regards to participating in small groups.

Liberia: In the latter part of 2004 the United Nations High Commissioner for Refugees began repatriating Liberian refugees. In 2001 the conflict in Sierra Leone began to subside and many of the Sierra Leonean refugees returned to their home country. At the same time the civil war in Liberia again broke out in full force and thousands of refugees fled to Guinea. In the final two years of the program in Guinea (2003-2005) more and more of the refugees in the camps were Liberians. When the center in Guinea closed in 2005 a new center was opened in Liberia. The program in Liberia was closely modeled after the program in Guinea.

During the civil war more than one million Liberians fled and later returned home. This massive influx of refugees, many of whom have experienced some form of torture or

trauma led to the creation of CVT Liberia. The two main objectives of the center in Liberia are providing direct client services through individual and group counseling as well as the training of PSCs to increase the center's capacity. Due to the experiences of the survivors the work in Liberia has an additional focus on gender-based violence and crime.

Democratic Republic of Congo: CVT opened its center in Katanga, DRC in late 2006. The genocide in Rwanda carried over into the eastern part of the DRC, and resulted in a five-year regional war from 1998-2003. The program in DRC is run in collaboration with the United Nation High Commissioner for Refugees. The UNHCR runs the refugee camp in Katanga, but it offers no mental health treatment programs of its own and thus the two organizations now collaborate to offer a more holistic specter of services for the refugees.

The work that is done at the center in DRC is similar to that of the other African centers. Most of the client services are in form of small group counseling with individual counseling for those with greater needs. The prevalence of gender-based violence in DRC led to the introduction of a pilot project that provided clients with couples-therapy. This project was initialized in the summer of 2008.

Jordan: The launch of the war in Iraq in 2003 has resulted in millions of Iraqis fleeing their homes and entering neighboring Jordan and Syria; 500,000 of these refugees are believed to be in Jordan. Much of the Iraqi refugee population has suffered human rights abuse, and according to UNHCR as many as one in five Iraqis in Syria suffered some form of torture. Similarly, the Human Rights Office of the UN Assistance Mission for Iraq report increased evidence of violent torture in Iraq.

The center in Amman was established in an effort to help highly traumatized Iraqi refugees in Jordan. Because of the precarious situation of the Iraqi refugees in Jordan, i.e. the refugees are not recognized as legal immigrants or asylum seekers by the Jordanian government, much of the center's focus lies in direct client services.

Unlike the clients in Africa, a majority of the Iraqi refugee population is well acquainted with the concepts of mental health and counseling. This, in addition to generally higher levels of education has resulted in higher expectations from the Iraqi survivors than their African counterparts. Most of the clients prefer and expect individual counseling, both because that is the model they are familiar with and due to fear of group gatherings since most of the refugees are in Jordan illegally. Because of this expectation of individual treatment, CVT will likely have to continue to alter their direct client services program substantially from that of the African centers.

The Jordan center is situated in Amman, a city of some 2,500,000 people (U.S. State Department). This particular location has brought with it additional challenges as it can

be extremely difficult or time consuming for clients to come to CVT for counseling appointments and in particular for family counseling sessions. A large number of Iraqi refugee clients are in Jordan illegally, so clients are reluctant to risk being deported. Any kind of public gathering such as group counseling sessions is avoided by the Jordanian refugees and because of this, CVT does home visits to conduct family counseling as well as some individual counseling.

External Training

CVT conducts training of community and religious leaders, government employees, and NGO staff in an attempt to teach them about torture and its consequences, as well as improve the services they offer. The training is of particular importance in the locations where the victims are shunned or stigmatized due to religious or cultural beliefs. Another aspect of this training lies with CVT's belief that a sustainable program is dependent on incorporating local tradition and wisdom in treatment.

Training of government employees such as police, security forces, and government officials is particularly important to prevent the use of torture as well as creating an understanding of why it should be prevented and punished. It also aids in the efforts of legitimizing mental health work in the countries where this is not already the case.

CVT is highly reliant on a referral system to identify torture survivors and ensure treatment that falls outside of CVT's capabilities. Longer term it is also of importance because CVT hopes to create functioning mental health care agencies that are capable of continuing its work beyond the presence of CVT.

The trainings do not follow a strict template, but are generally very similar across centers. Each training session is facilitated by CVT staff and this staff conducts pre and post-testing of the participants to measure knowledge gained. The stated goal is to achieve 'an above 25% increase in knowledge gained, compared to the baseline'.

Minnesota: CVT has a great referral system in Minnesota. This is in part due to the 'Minnesota Mainstream' project in the 1990s. The project sought to create awareness of torture as well as establish partnerships with hospitals and local agencies.

There has not been any substantial training effort since the 'Minnesota Mainstream' project, but partnerships have continued since then. Physicians and nurses at local hospitals have been trained in how to recognize symptoms of torture and local leaders in specific neighborhoods of Minneapolis have been involved in projects intended to create awareness as well as training of medical and social services professionals on working with torture survivors.

Africa: In Guinea, Sierra Leone, Liberia and the Democratic Republic of Congo much of the torture inflicted on the victims was conducted by representatives of the government. Training has therefore proved to be extremely important in these areas. In Sierra Leone the training of government officials has contributed to the cooperation between the Ministry of Health, the Ministry of Education, and CVT. In addition, CVT conducts regular training sessions with local municipal leaders on the issue of human trafficking.

The trainings have also resulted in collaborative programs with other NGOs. In Liberia a collaborative effort has been set up with the Truth and Reconciliation Committee to provide training and support to participants. Additionally partnerships have been established with the American Refugee Committee to provide counseling to the Gender Based Violence staff. In Liberia, CVT has also been part of a task force that allowed them to meet with other NGOs, Ministry of Health staff, and hospital staff. As a member of the task force CVT was an integral part in developing a mental health policy for Liberia. Although, they conducted no formal trainings in or through the task force, the creation of a comprehensive mental health policy will be able to provide awareness and educate people on the issue of mental health and torture.

External training sessions cover a variety of topics, but they tend to focus on recognizing and properly reacting to people who have experienced trauma or torture. An example of such a training would be the training sessions conducted with the Rescue Alternatives Liberia (RAL) in Monrovia. CVT conducted a two-day training on understanding and

working with clients who have been affected by torture, trauma or gender-based violence. Additional topics covered included the impact of torture, identifying and working with substance abusers, and rehabilitation techniques with perpetrators of violence.

The focus of the trainings varies by location. This is in part due to the nature of the conflicts that have occurred in the area, the relationship that CVT has with the host government, and in part based on partnerships with other NGOs. In the Democratic Republic of Congo there are few international NGOs to work with, so CVT mostly conducts trainings with local civil society organizations.

Jordan: The center in Amman is still in the start-up phase, and it has yet to receive final registration with the Jordanian government. Until that happens, the center will not be allowed to conduct any formal training. The plan for the center in Amman includes broad awareness raising and in-depth training on torture rehabilitation and evaluation of the effect psychotherapy has on symptoms. CVT staff will conduct targeted training of Jordanian professionals on how to provide appropriate services to torture survivors within the framework of their profession. Other training will include improving other organizations' program evaluation. It is expected that the trainings in Jordan will be at a more advanced level than the trainings conducted by the African centers, as both the

PSCs with CVT and the other service providers and partners in Jordan tend to come from backgrounds with higher education.

Project Selection

Comment [Peter Y1]: Is this more suitable? Perhaps we need an introduction for this section, or maybe that would be redundant.

Comment [NS2]: Is it okay if this heading just says "evaluation"? for some reason I don't really feel comfortable saying it's CVT's evaluation methods as it is both that and our evaluation of CVT.

Deleted: CVT's

Deleted: Methods

After a program has been approved by the board, CVT staff and the board of directors develop evaluation strategies for the program. This often includes determining specific numbers or levels of PSCs trained, community sensitizations conducted, clients treated, and external trainings performed.

Decision-making process: It was our hope that we could look at another torture treatment organization's decision-making process in order to provide a useful comparison and perhaps gain a better understanding of whether or not CVT's process is representative of similar organizations and where improvements could be made. However, the decision-making process of an organization is not public knowledge, and we were unable to find a detailed description of the process from other organizations. Our evaluation is thus solely based on our perception of the efficiency and efficacy of CVT's decision-making process.

It seems that the formalized decision-making process for CVT is both thorough and appropriate for the work; however, the thoroughness limits the organization's ability to

quickly respond to calls for proposals. One way to mitigate this problem would be for CVT to assign resources and people for rapid response evaluation teams for requests for proposals, allowing for either fewer substantial initial assessment trips or devoting the resources necessary to get the assessments and proposals completed within a shorter time span.

In addition, the importance of having capable and willing staff for newly created projects should be included in the decision making process. Also, nearby assistance from other CVT offices should be formally incorporated into the decision-making process since a successful implementation is contingent on the organization's ability to staff and provide support to new programs. Since this is already a concern that is usually considered, it should be fairly easy to make it an official requirement in the decision-making process.

Training PSCs: PSCs are asked to absorb a great deal of information as well as become adept at interpersonal activities such as facilitating group discussions and recognizing during a discussion when a client is in danger of being retraumitized. Some PSCs have no knowledge base of mental health issues whereas others identify symptoms of mental health in a manner that is not congruent with what CVT considers best practice. It is important that the mental illnesses and disorders of the clients are recognized as medical conditions that can be treated. If a PSC were to regard the mental illnesses and

disorders to be caused by witchcraft or to deny that they are medical conditions would be detrimental to the efficacy of the treatment. Supervisory clinicians conduct qualitative evaluations of the PSCs and report their findings in anecdotes and numeric scores.

Clinicians are concerned that PSCs become less mechanical in their work, such development is seen as a signal that the PSC draw on their knowledge of mental health rather than single interventions they have seen. The clinicians also assess the effort of PSCs to learn the material during training. The PSCs' knowledge base is reported on a numeric scale indicating a satisfactory knowledge base to meet their responsibilities. CVT aims for 75% of PSCs demonstrate reasonable competence in core skill areas by the end of the 12 month training period per supervisory clinician records, test results, and formal evaluations which will be conducted semiannually:

- Basic knowledge of mental health
- Sexual torture
- Conducting community sensitizations
- Co-facilitating training in at least one mental health subject area
- Appropriate record-keeping
- Co-facilitating small-group and individual counseling
- Assessment skills

- Identification of trauma symptoms

PSCs are then evaluated at regular intervals after their training is complete. Any deficiencies are addressed in subsequent monthly and quarterly trainings.

Community Sensitization: The impact of large group activities (e.g. a radio broadcast about persistent nightmares) is difficult to assess, but focus group discussions are conducted every six months to determine increases in knowledge. Attendance records are kept, and in most cases they include indication of participation levels. Aside from formal reports, CVT staff collects anecdotal evidence of the effect of sensitizations. This information is communicated to the International Services staff in the Twin Cities in regular field reports. One such testimonial from a village chief about the impact of community sensitizations on his village: “There has really been a change in people’s way of thinking. They have hope especially after the sensitization. I used to have worries, too, but that has changed. Just your presence has given people hope. There has been a change in the thoughts they express.”

Direct Client Services: One of the big obstacles in attempting an evaluation of direct client services comes from what we are trying to evaluate. When we look at the

outcomes of mental health treatment we are basically measuring a subjective experience. How treatment is experienced varies greatly depending on the client's expectation coming into the program. As mentioned previously, the client expectations seem to vary greatly between the African centers and the center in Jordan. If the same treatment template was implemented across the board it is likely that the Iraqi refugees in Jordan might report less satisfaction with the program than the clients in Africa.

International Services assesses the outcomes of treatment by measuring a change in the client's symptoms. A symptomatic assessment usually involves *"the collections of valid and reliable data on the presence, intensity, and duration of psychopathological symptoms* (Sederer and Dickey p.3)". Sederer and Dickey suggest that three major considerations are kept in mind when measuring outcomes: 1) the source of the outcome information; the patient, the provider, and the significant other group. Each of these groups represents different, but significant aspects of the treatment outcome. 2) The timing of the outcome assessments; the timing of the evaluation substantially impacts the findings. Three major phases of timing are baseline measurement, short-term follow-up, and long-term follow-up. 3) The nature of the population from which the data is derived; clinical domains, background and demographic information can enhance the value of the data collected and broaden the types of analyses available.

The International Service's measurement of program outcomes is based on the Hopkins Symptom Checklist (HSCL). The HSCL consists of a 25 symptoms checklist that measures symptoms of anxiety and depression. Part one of the HSCL measures anxiety symptoms

and part two measures depression symptoms. Each question has a scale of four categories; "Not at all", "A little", "Quite a bit", "Extremely", which are ranked 1-4 respectively. The result of the HSCL is calculated in two ways; the first score is an average score from all 25 questions, the second score is an average of the depression questions. The total score is believed to be highly correlated with severe emotional distress and the second score is correlated with major depression (Harvard Program in Refugee Trauma website)

The demonstrated validity of applying the HSCL in both the global North and South (Syed et al 2008) makes it an ideal tool for CVT who measures outcomes of treatment both in the U.S and in the field. Because the context and methods of assessment can greatly affect the accuracy of any measurement (Sederer, Dickey pp 162-167), it is important to take great care to consider elements such as the treatment setting, community and cultural norms, and the structure of the assessment method when performing an evaluation of outcomes. In Jordan this consideration resulted in a change in the intake form. The question regarding drug and substance use has been taken out of the intake form due to the severe punishment for such behavior in Jordan. Beyond this change, the evaluation form remains the same across all international centers.

There are studies that have shown that the Hopkins Symptom Checklist in interview format for dealing with illiterate populations can be related to a possible under-reporting in symptoms by clients compared to using the HSCL for self-reporting. However, another study by Lavik et al looking at the use of self-reporting in psychiatric

studies of traumatized refugees found that the Hopkins Symptom Checklist has a substantial validity in detecting the general level of symptoms and social dysfunction, and that self-reports of the subjects coincide with the clinician's overall evaluation.

The evaluation form used by CVT was first developed from experience with West African clients in Minnesota. The items on the intake form were selected by consensus through a series of meetings with an international team of local paraprofessionals and expatriate clinicians with experience from Guinea and Sierra Leone. Because the original intake form was in English, two individuals fluent in English and the local language worked together to reach a consensus on the translation. Following the translation, a group of eight to twelve PSCs met to reach consensus on the wording in the translation. After this, another two fluent readers translated the new document back into English. This was then compared to the original evaluation form. Any discrepancies were discussed and re-translated until the back-translated form agreed with the original form.

Data on symptoms is first collected at intake, prior to receiving any services. At client intake groups are formed based on gender, age, case history, or other demographic factors. There are 10-12 clients in each group with 1-2 Psychosocial Counselors. The Psychosocial Counselor specific to the group is the one that does the client evaluation. Each Psychosocial Counselor receives training on how to perform interviews. This is especially important due to the fact that many of their clients are illiterate and would be unable to fill out forms and self-report without the help of the Counselors. Depending

on the capacity of the center and the staff, a clinician may go with the Counselor to perform interviews.

After the interview has been conducted the results are transferred into a 4-category Likert scale. The clinician is in charge of double-checking all the data before the person responsible for the database enters the data into SPSS. After all the data has been entered the clinician is responsible for conducting a final check. The evaluation is then repeated after one, three, six, and twelve months. Due to the environment CVT operates in, it is common that the follow-up evaluations have fewer clients than the initial intake. The counselors and PSCs follow up with those who drop out of the program by going to their homes. This is also the way in which they conduct follow-up for the evaluation. How many times, or with what frequency staff might go out to someone's home depends on where the program is located. In refugee camps, the clients are usually within reasonable distance for staff to go out to the home several times. For the programs located in villages clients may live far away and for that reason the staff might not go back out until they have heard from others that the client still lives there or has returned from wherever they might have been last time CVT went to his or her house. A doctoral thesis written by Daniel Hess at the University of Minnesota (2008) looked at the drop-out rate for the International Services programs in Guinea and Sierra Leone. He found that of the original 4010 clients assessed at intake in Guinea and Sierra Leone, only 1186 were still partaking in CVT activities or were available for evaluation after three months. At this point it is impossible for us to determine whether

Hess's findings are reflective of the other sites, as CVT International Services does not currently have data that reflects historical trends or site by site comparison.

Hess found in his literature review that following exposure to trauma, including torture, survivors frequently manifest symptoms of Post Traumatic Stress Disorder, depression, anxiety and somatic problems. He also found that those refugees who had been victims of torture tended to have higher levels of symptoms than those who had not been exposed to torture. Hess also found that analysis indicates that treatment is effective for survivors of torture.

The most important findings of Hess, in relation to this paper, are what he found regarding change in symptoms during treatment and at follow-up. Hess's analysis found that he could not conclusively prove the efficacy of treatment since clients weren't chosen at random nor were they randomly assigned to a counseling group or control group. The passage of time appears to be a factor in decrease in symptoms, but the study also found that time alone cannot account for the decrease in symptoms. The CVT dataset that was used by Hess spans from 2001-2006. Given the assumption that most of the clients were exposed to trauma and torture at historically the same time and assuming that time was the sole factor to decrease symptom levels we would expect symptom levels to be higher for those entering the program at an earlier time than those entering it later. However, mean intake scores for symptom levels became higher over time, thus substantiating the claim that there must be more than the passage of time that causes the decrease in mean scores found after one and three months.

Additionally, when compared, the mean scores for the treatment participants improved while the mean scores for the untreated traumatized refugees did not make the same progress.

We cannot say with certainty whether or not the treatment CVT provides carries over into improvement in symptoms, but it seems that there is reason to believe that the treatment is not without effect. The evaluation that CVT conducts is more extensive and thorough than that of most other NGOs working in the same regions or in the same field (Hubbard, John. Personal interview. 15 April. 2009). Even if the evaluation is unable to prove the efficacy of CVT's work, it does suggest that the treatment provided by CVT is correlated to a decrease in symptom levels. What the evaluation does prove though, is that it is possible to collect substantial data from a transient refugee population, which in turn suggests that it is possible to conduct more thorough assessments and evaluations of mental health care in the future.

Joshua Breslau, an expert on PTSD, criticizes the imposition on non-Western people of a narrative in which trauma moves through memory to eruption in symptoms. He claims that this depends, in turn, on modern Western conceptions of the self as constituted through continuities of memory (2004). He also criticizes the political aspect of PTSD work that seems to mark one group as completely innocent victims and one side as cruel perpetrators. He also criticizes that much of the treatment is focused on drugs that are researched and sold by pharmaceutical companies. CVT's intake forms are created by a dialogue between CVT staff, the expat clinicians, and local hires. Since local social

norms are factored in to CVT's assessment of symptoms, it seems harsh to say that CVT simply imposes them. It would be more accurate to say that CVT is deducing how to recognize the symptoms of PTSD. As for politicizing mental health care, CVT operates in areas where the torture has been perpetrated has an undeniable political motivation. CVT's treatment centers abroad are clearly responding to a political situation without driving a particular political agenda in the host countries. And lastly, health care professionals are not overzealous in prescribing drugs as the only solution, but the fact is that in acute cases of depression and psychosis, pharmaceuticals are almost always the only way to manage the mental illness. The broad, over-simplification that overemphasized medication as the primary treatment is problematic is alarmist. The hints of ulterior corporate motives are not constructive in any way. Breslau does not suggest an alternative and it would be hard to imagine procuring psychiatric medication from a source other than a pharmaceutical manufacturer.

External training: The goal of CVT is to issue a pre- and post-test at each training session conducted. The organization has determined that the tests ought to show at least a 25% gain in knowledge going from the pre- to the post-test for trainings to be deemed effective. These tests are the only measures currently in place to evaluate the efficacy of the external training objective. This is problematic for a couple of reasons. When the 25% increase in knowledge fails to be achieved it is mostly because the agency or partner being trained already has a large amount or relevant experience in the field and extensive knowledge of mental health and torture. Since these partners come in with

such a high level of knowledge it is substantially harder to increase their knowledge base by 25%. It seems pertinent to ask whether or not the reason why it is difficult to increase their knowledge is because they are knowledgeable to the point where there is little more to teach, or if it is due to the quality of those doing the trainings.

In July 2008, CVT in Sierra Leone organized a training session for the Family Support Unit of the Sierra Leonean police department and the Ministry of Social Welfare, Gender and Children's Affairs on the topic 'Interviewing Victims of Human Trafficking'. After the two-day training session was completed, CVT conducted the post-test and found a 16% gain in knowledge compared to the pre-test. This training session illustrates the problem. The attendees to the training session had already received training about Human Trafficking from other NGOs such as UNICEF and the Faith Alliance Against Slavery and Trafficking, however, it is difficult to assess if the relatively high knowledge level among participants caused the knowledge gain to be substantially below desired level or if it is due to the trainers conducting the session.

In the Democratic Republic of Congo the levels of illiteracy among CVT's clients and external partners are at such a level that it negatively affects CVT's ability to perform pre- and post-test at training sessions. It is nearly impossible to do written evaluations. Only about half of the training sessions have been evaluated in the past. This practice has changed, and CVT now tries to perform evaluations consistently.

CVT conducts training sessions for the main purpose of sharing knowledge. For this reason they are sensitive to how people might perceive a pre- and post-test. To some, it is intimidating to be presented with a test, and when that is the case, CVT often chooses to forego the evaluation all together. This might be the right decision to foster partnerships and strengthen relationships in the field, but it seriously damages the validity of the evaluations that CVT does conduct because it excludes those who self select to not take the evaluation.

Recommendations:

- After evaluating the International Services program it seems abundantly clear that although CVT attempts to implement a template for each of its sites, the organization is not afraid to tailor each center to the specific needs of the clientele and the constraints of the location. International Services staff takes great care in garnering information from its clients and practitioners in the field. This is vital to ensure that the treatment centers are effective since a great deal of the maladies manifest themselves in emotional and social characteristics. The decision-making process of the board and the organization serves as a good tool to determine where the organization should go next. However, it does seem odd to us that the concern about whether CVT has a presence close by and whether it seems feasible to find local staff and expatriates willing to travel there, is not

formally incorporated with the decision-making process. The ability to find people willing and capable of working in the area seems to be an integral part of the decision-making process and should not be left out of the formal framework.

- The Center for Victims of Torture is a relatively small organization with some 70 employees. However, it appears that there is not much overlap or cooperation across departments, which could prove to be beneficial. This year is the first time that International Services has worked closely with the Training and Capacity Building department, and the collaboration has revealed that each department has distinct ways of operating. Future collaboration could be more efficient if both departments had the same procedures. Although this is only one case, it seems to indicate that the organization might need to streamline some of the operations or open up for more cooperation between departments.
- We found that the training of PSCs does a good job of educating people about mental illness and imparting the necessary interpersonal skills that will help them become effective counselors. The training has been designed by clinicians to help members of an affected community enhance their existent knowledge of mental illness and interpersonal skills to an expert level that will continue to help the community well after CVT's project in that country stops. CVT's evaluation of PSC training is rigorous and ensures that any gaps in a PSC's knowledge are appropriately addressed. It is clear from the meticulously planned training that there is a great deal of concern that the PSCs learn their practice the correct way the first time around. We feel this is especially important considering the PSCs

key role in the recovery of the clients. Since CVT's treatment centers are only able to treat a small part of the affected population, our recommendation is to seek funding specifically aimed for training, or funding that has less restrictive mandates to allow for an expansion in the number of PSCs trained while ensuring the same quality of training.

- Within the framework of the four main objectives, our evaluation found that there is not a robust mechanism for gauging the impact of community sensitizations. The anecdotal evidence provided in the clinicians' reports seem to show that it is effective, but a more thorough evaluation that quantified the effects could help improve the sensitization programming. There could be a scale to assess knowledge in the same way there is a scale to record clients' symptoms. While some of CVT's indicators for success specify a number of attendees, there does not seem to be much discussion about why the attendance was lower than the goal, what could change, or if smaller group size impacts learning. Also, the reports contain extensive details on the successes, but there does not seem to be the same treatment given to negative outcomes. We conclude that any efforts to improve the sensitizations would need to take a sober consideration of both positive and negative aspects.
- The direct client services evaluation indicates that the treatment has a positive effect, but the dataset used is not sufficient to make conclusive statements. We can say safely however, that the collection of data gathered by CVT in the field proves that it is possible to collect substantial amounts of data on transient

populations such as refugees. It seems pertinent to suggest that in the future CVT should attempt to do more thorough evaluations. We would also suggest that the data already compiled should be organized in a more purposeful way to reflect historical trends as well as site-by-site comparison. This documentation can then be used to strengthen the overall program of the International Services department by finding out what the organization is doing well and what needs improvement.

- The external training that International Services conducts is important for achieving the long-term goal of building proper mental health infrastructure in locations where it is currently lacking. It is problematic that the evaluations performed in conjunction with the trainings are not done consistently, because that affects the credibility and validity of the results. In order to prove that CVT does not conduct selective reporting, the organization will need to improve their routines and perform evaluations with more regularity.
- It is our recommendation that the Center for Victims of Torture look for funding specifically dedicated for evaluation purposes. We realize that this is easier said than done, but we strongly believe that dedicated funding for evaluation would greatly improve the evaluation work of the organization as well as confirm the importance of mental health care for vulnerable populations.
- In order to fully utilize funding resources we would suggest that there be more communication between the departments of the organization about their ability to assess potential sites so that CVT may respond to requests for proposals

quicker. The sometimes slow organizational response to requests for funding can cause the organization to miss funding opportunities that could greatly enhance their programs, the delivery of the programs, and the evaluation of them.

- As we were writing this paper we were fortunate to receive a lot of information from CVT. Although extremely helpful, we found that there was sometimes a lack of consistent and uniform language. For example, the Psychosocial Counselors are also referred to as Psychosocial Peer Counselors and Psychosocial Agents. It was our understanding that these terms all referred to the same thing so we suggest that the organization choose one term and stay with it to avoid confusion. Related to this, we also suggest that the organization improve the CVT website. Finding information about specific activities, programs, or departments is not available in an intuitive manner. There is no index of the subdivisions of the website, the category headings do not connote what information they hold, and some of the information is redundant. This would be especially important now that CVT is establishing a center in Jordan where the organization is less known. A functional and informative website could greatly enhance the ability of the organization to establish a presence in the area and provide the clients and public with information about CVT's work.

Work Cited:

American Psychiatric Association. The Diagnostic and Statistical Manual of Mental Disorders. 4th edition. Concord: American Psychiatric Publishing, Inc., 1994

Breslau, Joshua. "Culture of Trauma." Culture, Medicine, and Psychiatry 2004: 113-126.

DePrince, A.P. & Freyd, J.J. (2002) The Harm of Trauma: Pathological Fear, Shattered Assumptions, or Betrayal? In J. Kauffman (Ed.) Loss of the Assumptive World: a theory of traumatic loss. (pp 71-82). New York: Brunner-Routledge.

Gambino, Anthony. Council on Foreign Relations conference call. 23 April. 2009. 11:00 AM

Harvard Program in Refugee Trauma. < http://www.hprt-cambridge.org/Layer3.asp?page_id=10>

Hess, Daniel. *The Mental Health Sequelae and Treatment Of Massive Community Violence in West Africa.* Minneapolis. University of Minnesota, 2008.

Hubbard, John. Personal interview. 15 April. 2009

Lavik, Nils J. et al. "The Use of Self-Reports in Psychiatric Studies of Traumatized Refugees: Validation and Analysis of HSCL-25." Nordic Journal of Psychiatry 53.1 (1999): 17-20.

Lewison, Edie. Personal interview. 25 March. 2009; 9 April, 2009

Lyons, John S. et. al. The Measurement & Management of Clincal Outcomes in Mental Health. New York: J. Wiley, 1997.

Miller, Kenneth E. and Lisa M. Rasco, eds. The Mental Health of Refugees Ecological Approaches to Healing and Adaptation. Mahwah, NJ: Lawrence Erlbaum, 2004.

Pedersen, Thomas. Community-Based Intervention Beyond "The Clinic in the Bush": Anthropological Reflections on Armed Conflict and Community Healing. TORTURE Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture. Volume 13, November 2003.

Sederer, Lloyd I. and Barbara Dickey. Outcomes Assement in Clinical Practice. Baltimore: Williams & Wilkins, 1996.

Syed, Hammad. R et al. "Concordance Between Hopkins Symptom Checklist (HSCL-10) and Pakistan Anxiety and Depression Questionnaire (PADQ), in a Rural Self-Motivated Population in Pakistan. " BMC Psychiatry 22 July 2008. 18 March 2009 http://www.biomedcentral.com/1471-244X/8/59

Wilson, John P. and Boris Drozdek. Broken Spirits: The Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims. New York: Brunner-Routledge, 2004.

U.S. State Department, (2009, 02). Background Note: Jordan. Retrieved May, 2009, from Background Note: Jordan Web site: http://www.state.gov/r/pa/ei/bgn/3464.htm