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Addressing the Needs of Survivors of Torture: A Pilot Test of the Psychosocial Well-Being Index

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ABSTRACT
Survivors of torture experience numerous psychosocial stressors that threaten individual well-being in resettlement. This study reports findings from a pilot test that applied the newly developed Survivors of Torture Psychosocial Well-Being Index. The study used a case-level mixed design to assess survivor psychosocial well-being across 16 life domains from intake up to 18 months. Ecological systems theory grounds this study. Participants demonstrated increased well-being as evidenced by statistically significant change on the mean ratings of their total scores. Three case examples illustrate the instrument. Practice applications, lessons learned, study limitations, and future directions are presented.

KEYWORDS
Assessment; case management; immigrant; psychosocial; refugee; torture; well-being

For the first time since World War II, ongoing global conflict has resulted in more than 60 million displaced people worldwide (United Nations High Commissioner for Refugees [UNHCR], 2015). As war, poverty, and oppression force the global migration wave, many stateless people continue to suffer the effects of political violence. For the estimated 1.3 million refugee survivors of torture (SOT) now living in the United States (Center for Victims of Torture [CVT], 2015), environmental stressors associated with exile, resettlement, and acculturation continue to threaten individual health and well-being (Kira, 2002; Miller & Rasco, 2004).

While the needs of SOT are varied and diverse, the hallmark of this population is the experience of displacement characterized by ecological change and upheaval. Yet despite a growing body of literature that addresses the physical and psychological sequelae of torture on individual functioning (Kira et al., 2012), there has been relatively little examination regarding how different psychosocial environmental factors affect survivor rehabilitation.

Current knowledge suggests that restoring the bio-psycho-social-spiritual functioning of SOT requires an integrated system of care (Haenel, 2015; Winter, 2011). Such care requires ecological systems thinking in order to harness a range of community services necessary for providing coordinated, compassionate, and
comprehensive support during SOT resettlement (Kira, 2010). Utilizing the psychosocially oriented person-in-environment (PIE) perspective as part of systems theory (Bronfenbrenner, 1986), torture treatment direct-care professionals typically screen, assess, and evaluate the needs of SOT in different life domains in order to develop, implement, and monitor targeted treatment interventions.

Unfortunately, existing assessment instruments that address psychosocial well-being seek universality and do not fully appreciate the breadth and complexity of common environmental stressors that affect SOT psychosocial functioning. As a result, the majority of assessment instruments used in torture treatment focus on survivor health or mental health to the exclusion of many other essential life domains (Jaranson & Quiroga, 2011; Montgomery & Patel, 2011).

To address this gap, the authors have created a new practice instrument designed to evaluate and assess a broad range of psychosocial needs that SOT experience during resettlement. The purpose of this paper is to present the findings from a small pilot study that applied the Survivors of Torture Psychosocial Well-Being Index (SOT-PWI) at the SOT program of the International Institute of Connecticut (IICONN) located in Bridgeport, Connecticut.

**Background**

Although the practice of torture has been openly condemned throughout the world, Amnesty International reports that torture and other inhumane acts are still widely practiced in more than half of the world’s countries (Amnesty International [AI], 2014). The experience of torture has intersecting social, political, cultural, economic, medical, psychological, biological (Jaranson & Quiroga, 2011), legal, and spiritual dimensions that affect the individuals, their families, and the communities in which they live. At the individual level, torture is a multilateral type III trauma designed to traumatize the body and the mind (Silove, 1999). Although post–traumatic stress disorder and major depressive disorder (Momartin, Silove, Manicavasager, & Steel, 2004) are the most common psychological diagnoses among SOT, torture rehabilitation is not equivalent to treating only these mental health disorders (Jaranson, Ekblad, Kroupin, & Eisenman, 2007). For individuals seeking safety outside their country of origin, SOT often present a complex constellation of symptoms further complicated by cultural variables and post-migration factors including immigration legal issues, economic challenges, diminished social networks, shifting power dynamics, bereavement, and other prolonged stressors (Basoglu, Jaranson, Mollica, & Kastrup, 2001). Torture can also contribute to and result in different forms of family disruption as torture can be experienced as a family trauma and transmitted to children, spouses and intergenerationally (Kira, 2002). Finally, because collective fear has long-lasting consequences on all forms of group behavior, Barudy (1989) also describes torture as a sinister ecological tactic used to incite community dysfunction and decomposition by recreating a social order colored by suspicion, shame, and secrecy.
While the adverse effects of torture on health and mental health of SOT have been documented (Johnson & Thompson, 2008; Kirae et al., 2012), the effects of psychosocial environmental factors in SOT rehabilitation remain an area of inquiry for treatment professionals (Miller & Rasco, 2004; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). Ongoing research has shown that various resettlement factors pose continued risk to individual health, mental health, and overall psychosocial well-being (Miller & Rasco, 2004). Such factors include age (Ehrensaft, 2008), gender (Schubert & Punamäki, 2011), race/ethnicity (Miles & García-Peltoniemi, 2012), personal outlook on life (Hernandez, Gangsei, & Engstrom, 2008), language and communication competencies (O’Hara & Akinsulure-Smith, 2011), ability to carry out activities of daily living (Sjölund, Kastrup, Montgomery, & Persson, 2009), substance use (Johnson & Thompson, 2008), access to community health and mental health treatments (Steel et al., 2009), employment and income (Porter & Haslam, 2005), educational achievement (Oliver, Haig, & Grote, 2009), housing and community safety (Kidd, McKenzie, & Abai, 2014), transportation and environmental mobility (Engstrom & Okamura, 2004), child care (Halcón, Robertson, & Monsen, 2010; Sansani, 2004), social support (Isakson & Jurkovic, 2013), and immigration legal status (Piwowarczyk, 2007).

Studies have shown that a supportive post-trauma environment can lessen negative traumatic responses following torture (Quiroga & Jaranson, 2005). For example, Gorst-Unsworth and Goldenberg (1998) conducted a cross-sectional study and quantitatively examined the impact of numerous social factors on a convenience sample of 84 Iraqi male SOT living in the United Kingdom who were experiencing a range of psychological sequelae. The authors found that subjects’ perceived level of affective social support had a greater protective effect than any other factor including mental health treatment. In a narrative qualitative study examining a convenience sample of 28 Bosnian refugees resettled to the United States, Miller, Worthington, Muzurovic, Tipping, and Goldman (2002) found that higher levels of depression were significantly related to post-migration stressors such as loss of community, separation from family members, lack of environmental mastery, and poverty. Miller et al. (2002) recommended that building new social networks and promoting psychosocial support (such as providing housing, income, education, and other concrete supports) early in resettlement may help refugees lessen mental health impairment and strengthen psychosocial functioning.

In 2011, Schweitzer et al. conducted a cross-sectional study that examined the contributions of gender, pre-migration, and post-migration factors on a convenience sample of 70 Burmese refugees in Australia. Schweitzer et al. (2011) found that post-migration living conditions such as employment, housing, environmental mastery, and social support, as opposed to pre-migration trauma, more reliably predicted participant anxiety, depression, traumatization symptoms, and somatization. Although gender had no effect on their findings, an earlier cross-sectional study by Schweitzer, Melville, Steel, and Lacherez (2006) found that gender did have an effect on resettlement in a snowball sample of 63 Sudanese refugees in...
Australia. In the 2006 study, female Sudanese refugees experienced more difficulties in their mental health adjustment (PTSD symptoms, depression, and anxiety) during resettlement than male refugees. However, both studies (Schweitzer et al., 2006, 2011) showed that post-migration living conditions had significant and more important consequences to refugee mental health adjustment than pre-migration trauma.

Most recently, Kalt, Hossain, Kiss, and Zimmerman (2013) conducted a systematic review of 23 studies on the needs of asylum seekers (including SOT) in high-income host countries. The authors used small nonrepresentative samples to document the significant correlations between post-migration psychosocial needs and mental health. Upon completion of the review, Kalt et al. suggested that more research is needed to better understand the connections among post-migration variables, including gender and legal status in order to produce more generalizable results.

Considering the evidentiary need for SOT safety and stability after migration, clinical case management has long been recognized as an important component of torture treatment (Winter, 2011). Unfortunately, the reluctance to define the term case management within social services has led many professionals to understand this specialty as “a ubiquitous intervention approach,” often assuming case managers to be “traffic coordinators of services or goods” (Kanter, 2010). Although care coordination, service navigation, and facilitation of goods and services do play a role in torture treatment, it is the integrated, multisystemic knowledge specific to the PIE perspective that defines case management’s contribution to torture treatment (Manoleas, 1996). For the purposes of this paper, the authors will use the term clinical case management to refer to the type of case management provided to SOT in the torture treatment setting. This term has been defined as:

… a modality of social work practice that, acknowledging the importance of biological and psychological factors, address[es] the overall function and maintenance of the person’s physical and social environment toward the goals of facilitating physical survival, health and mental health, personal growth, and community functioning. (Kanter, 1989, p. 361)

By acknowledging the triangular relationship between the client, the case manager, and the environment, clinical case managers address a variety of psychosocial needs by developing targeted interventions that address micro-level (individual and personal), mezzo-level (family and community), and macro-level (wider societal) environmental barriers (Kanter, 2010). Within such environmental contexts, clinical case managers may take on different roles, such as a “problem solver, advocate, broker, planner, community organizer, boundary spanner, service monitor, record keeper, evaluator, consultant, collaborator, counselor, and expeditor” (Weil & Karls, 1985). Manoleas (1996) has also proposed that case managers act as “cultural brokers” for multicultural clients during their adaptation to new living environments. Therefore, by providing an array of services designed to facilitate the intra- and interpersonal power of individuals, families, and communities, clinical case managers are uniquely well-positioned to screen, assess, and measure the psychosocial well-being of SOT during resettlement.
While the ability to measure and evaluate SOT psychosocial well-being in response to service provision has many positive implications, a comprehensive measurement instrument currently does not exist. Mainstream social service assessment tools are typically normed for U.S.-born populations entitled to a range of government services and benefits unavailable to the large number of SOT (Piwowarzycz, 2007; Kalt et al., 2013). Tools that have been developed for cross-cultural populations are also limited in scope. For example, the Current Adaptive Functioning Index-Cross Cultural Version (CAFI-XC) addresses only eight categories of client functioning. It also remains unclear whether this tool has been scientifically validated as the authors of a 2014 study have recommended the instrument’s revision (Ross-Sheriff, Gomes, Berry-Edwards, Dailey, & Amri, 2014). Alternatively, the World Health Organization’s Quality of Life instrument (WHOQOL) is an interdisciplinary assessment tool that focuses primarily on mental health. Unfortunately, this scale is not developed in such a way as to help direct service providers to identify and assess a broad range of psychosocial needs to inform service delivery. Some providers have used the Family Resource Scale (FRC), which includes a range of psychosocial needs, but the scale does not quite fit the needs of SOT as the items focus on the psychosocial needs of U.S.-born families (Van Horn, Bellis, & Snyder, 2001). Until additional tools are developed, research will continue to be informed predominantly by physical health or mental health measures that do not capture the integrative nature of holistic SOT care.

In an attempt to better address the psychosocial needs of SOT, the authors conceptualized, constructed, and tested the SOT-PWI with 31 adult individuals who sought SOT services at IICONN. Formed in 2012, IICONN’s SOT program provides SOT with in-house clinical case management and legal services and trains outside agencies to provide mental health and health services. In doing so, the SOT program employs a cooperative service delivery model that replaces many expert-driven services with collaborative partnerships in an effort to develop community strengths. Although this model has many benefits, IICONN struggled early on to assess SOT improvement because of the lack of relevant evaluation tools. In creating this tool, the authors’ study was guided by two main research questions:

1. When using the SOT-PWI to evaluate clinical case management service delivery, do selected SOT participants demonstrate increased psychosocial well-being over time?
2. Do individual characteristics such as gender and legal status of SOT participants significantly differentiate their ratings on the SOT-PWI assessments?

Methodology

Procedures for study design, sampling, and data collection

This study used a case-level mixed design method (Creswell, 2014) for piloting the application of the SOT-PWI. More specifically, the study collected quantitative
(retrospective and prospective) SOT-PWI scores on a small sample of SOT receiving torture-related treatment services at IICONN from one clinical case manager. The clinical case manager also provided qualitative feedback on the piloted application of the SOT-PWI.

Before the study commenced, the clinical case manager was apprised of the study’s intent, voluntarily agreed to participate, and was trained by the lead author to use the SOT-PWI to rate SOT clients on their level of psychosocial needs from the case management intake until 18 months of service delivery or until case closure.

The study ran from July 2014 to December 2014. During this time, the clinical case manager rated adult clients who were enrolled in SOT services at IICONN from October 2012 through December 2014. The clinical case manager began by rating four SOT clients prospectively from their July 2014 intake, through 6 months of service until December 2014. The case manager also rated 27 additional SOT clients who were enrolled in torture treatment services at some point between October 2012 and July 2014 and who continued to receive services through the end of December 2014. Based on case record information, the case manager rated these clients retrospectively up to July 2014 and then again prospectively as they continued to receive SOT services through the end of 2014. In total, the study provides information on the SOT-PWI application with 31 SOT adult clients who were part of a convenience sample as part of the regular caseload of one clinical case manager. It is important to note that this study did not seek any direct input from any SOT being rated for three main reasons. First, the authors were concerned that direct client input may influence the clinical case manager—for example, a client might score their living situation to be worse than it actually was in order to get more services or attention from the clinical case manager. Second, the instrument does not yet have an established inter-rater reliability. Third, the instrument is not set up as a questionnaire for clients to report their answers directly to specific questions; rather, it is set up as a tool for trained professional providers to gain information on different client needs via dialogue with clients. Although the lack of client feedback is an unavoidable constraint in the current study, such client input would be valuable and will be considered in future SOT-PWI testing.

According to the SOT program work flow at IICONN, confirmation of SOT program eligibility is followed by a clinical case management intake. At this time, the clinical case manager conducts a semistructured interview that covers various psychosocial needs across various life domains common to SOT. During this process, the clinical case manager was instructed to ask SOT about their needs in the 16 selected life domains identified by the SOT-PWI to learn more about client needs and goals. After the intake interview was completed, the clinical case manager used the information provided by SOT participants to rate their current level of psychosocial well-being according to the category criteria outlined by the instrument. To protect SOT confidentiality, the study assigned a numeric code as a substitute for IICONN’s identifying client code and the numeric study code was placed on the hard copy of the SOT-PWI. When the SOT-PWI ratings were
completed, the lead author provided the de-identified results to the second author, who entered the data into a password protected and de-identified Excel spreadsheet accessible only to the authors in the study. The study protocol was approved by IICONN and the authors’ university internal review board (IRB).

In the study, during the time frame in which the clinical case manager assessed and rated clients, the clinical case manager also assisted SOT with a variety of tasks including but not limited to linking survivors to community services and managing various crises, providing client advocacy and psycho-education, conducting additional behavioral assessments with other instruments or scales, facilitating referral for such assessments, teaching life skills for independent living, and offering ongoing emotional support and guidance. At the end of the study, the clinical case manager debriefed the lead author on the application of the SOT-PWI.

**Description of the instrument**

The pilot version of the SOT-PWI instrument is an adaptation of the Snohomish County Self-Sufficiency Matrix, created in 2004 as a human services assessment and measurement tool (Snohomish County Self-Sufficiency Task Force, 2004). Spearheaded by the lead author’s field experience, the authors of this study used the matrix design to identify 16 life domains. These domains reflect psychosocial environmental factors (Bronfenbrenner, 1986) that can be influenced by torture treatment service delivery (Manoleas, 1996), and are also recognized by research as essential for SOT rehabilitation (Quiroga & Jaranson, 2005). The conceptual selection and inclusion of the domains took place prior to the study. Collaborative input from a program evaluation consultant funded by the National Capacity Building (NCB) project was later incorporated into the SOT-PWI rating scale. The NCB project is the technical assistance arm of the Office of Refugee Resettlement’s SOT program, designed to provide continued capacity building and training to U.S.-based organizations serving SOT.

The 16 selected life domains in the SOT-PWI included ratings on food, housing, safety, language and communication, transportation, physical health needs, mental health needs, substance use, activities of daily living, access to social services, support system, community involvement, employment, income, and child care. The SOT-PWI measurement procedure required that each life domain was rated along a 10-point Likert scale ranging from *In-crisis* (1–2) to *Vulnerable* (3–4) to *Stable* (5–6) to *Safe* (7–8) to *Thriving* (9–10). The 10-point rating was selected as a way to methodologically increase the understanding of the variance that exists in the gradual changes among SOT (see Figure 1).

In this study, SOT participants were rated on all life domains and SOT-PWI total scores were derived from the sum of these life domain ratings. The child care life domain was adjusted so that SOT participants without a need for child care received full credit in order to equalize their rating in comparison to SOT who did have a child care need. The expected range of minimum to maximum total scores for the
SOT-PWI was between 16 and 160 points. More specifically, total scores with 16–32 total points reflected a person experiencing many crises; scores with 33–64 points suggested a vulnerable situation with many barriers; scores with 65–96 points, a stabilizing situation; scores with 97–128, safer conditions within the SOT environment; and scores with 129–160 points suggested that the survivor was thriving.

**Characteristics of rated SOT participants**

The 31 SOT study participants were 58% males and 42% females. Ages ranged from 18–67 years. Thirty-five years was the median age of SOT participants at intake. Countries of origin included the Democratic Republic of Congo (55%), Haiti (11%), Guatemala (13%), Eritrea (6%), Syria (6%), Sierra Leone (3%), Colombia (3%), and Nigeria (3%). Immigration legal status varied among participants. At the time of program enrollment, 65% survivors identified as asylum seekers; 19%, as refugees; and 16%, as asylees. Almost two-thirds (65%) of the sample were primary survivors (the client was the intended target of torture), 23% were considered secondary survivors (a close family member was the intended target of torture), and 13% were both primary and secondary survivors of torture. The most commonly reported forms of torture included beatings, psychological threats, deprivation, sexual humiliation and rape, wounding, burning, and witnessing the torture of others. Per U.S. immigration law, individuals seeking asylum are ineligible for most state and federal benefit programs including housing assistance. Upon intake, asylum-seeking participants described various living conditions ranging from homelessness to providing a service (such as child care) in exchange for room and board. Asylee clients described mostly stable housing conditions, often living with family members or friends they had met in the United States. Participating refugee clients were provided with private housing via IICONN’s refugee resettlement program, funded by the Office of Refugee Resettlement.

**Data analysis**

To analyze data, the authors used the IBM Statistical Package for Social Sciences (SPSS), version 21(IBM-SPSS, 2015). As the data was derived from a convenience
sample of SOT participants, the authors used nonparametric inferential tests for analyzing mean comparisons on the SOT-PWI along with Bonferroni correction to the statistical significance \((p < 0.05)\) for the number of tests being conducted.

**Results**

To address the first research question, the authors first compared the mean total scores of the SOT-PWI ratings via the *prospective* and *retrospective* status of SOT clients using the Mann-Whitney test for two independent samples. This analysis revealed that there was no statistically significant difference \((p > 0.05)\) between the means of the SOT-PWI scores of the solely prospectively rated participants and the mixed prospectively and retrospectively rated participants. Given these results, the authors opted to combine the data into one sample. This analysis also revealed that SOT clients rated prospectively had data only for the first 6 months, and since they did not statistically differ from the retrospective mixed group participants, SOT clients rated prospectively were included.

To better understand the progress sample participants made over time, the authors profiled the mean SOT-PWI scores at each time period (see Figure 2).

During this process, our analysis also revealed that the sampled clients had complete data for different lengths of time. More specifically, all 31 clients had complete data from intake to 3 months. At 6 months, 87.1% of participants had complete data; 25% had complete data at 9 months; 52%, at 12 months; 42%, at 15

![Figure 2. Profile of means on the SOT-PWI by time period of provided services.](image-url)
months; and 26%, at 18 months. Given this information, the authors opted to examine the first research question using these time-period groupings. To address how participants may have changed over time according to their SOT-PWI scores, the authors used the nonparametric Friedman test for repeated mean comparisons within each time period (see Table 1). These results revealed that the aggregated participants within each time period had significant changes ($p < 0.001$) on the mean ratings of their total SOT-PWI scores over time. Further examining the pairwise comparisons between each paired mean, results revealed that most progress (or significant change) was accomplished between intake and 6 months. Although there were some changes after 6 months, those changes were somewhat smaller.

To address the second research question, the authors conducted mean comparisons of the SOT-PWI for each time period based on SOT gender and legal status. To compare the participants’ ratings on the SOT-PWI for each time period by their legal status, the authors combined the current refugees ($n = 19$) and asylees ($n = 3$) into one group as they had acquired legal status in the United States by program enrollment. Within the data, these two types of participants did not immediately differ from each other on their ratings on the SOT-PWI. The authors then compared the refugee/asylee group with asylum seekers. The mean score

<table>
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<tr>
<th>Group</th>
<th>Intake</th>
<th>3 Months</th>
<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
<th>15 Months</th>
<th>18 Months</th>
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<td>35.63 (7.14)</td>
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<td>34.44 (6.06)</td>
<td>39.81 (5.74)</td>
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<td>39.54 (6.29)</td>
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*Nonparametric Friedman test.

*Participants in the time group period have all data for the entire period.
ratings on the SOT-PWI across different time periods can be seen in Table 2 for gender and Table 3 for legal status. Results show very slight differences in mean ranks on the SOT-PWI for gender and legal status in the first two time periods. Males showed slightly higher mean ranks at intake and 3-months compared to mean ranks of females on the SOT-PWI. Similarly, refugee/asylee with legal status in the United States had slightly higher mean ranks at intake and 3-months compared to mean ranks of asylum seekers. Subsequent time periods did not reveal any other differences on either variable.

To better understand the progress of SOT participants, the authors also conducted a qualitative examination of three SOT cases derived from their debriefing with the clinical case manager. The name of each SOT has been disguised and identifying details have been changed or removed to ensure client confidentiality.

### Table 2. Comparison of mean ranks on SOT-PWI by SOT gender (N = 31).

<table>
<thead>
<tr>
<th>Time Perioda</th>
<th>Status</th>
<th>N</th>
<th>Mean Rank</th>
<th>Zb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake (N = 31)</td>
<td>Male</td>
<td>18</td>
<td>18.72</td>
<td>-1.97</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>13</td>
<td>12.23</td>
<td>1.97</td>
</tr>
<tr>
<td>3 Month (N = 31)</td>
<td>Male</td>
<td>18</td>
<td>18.72</td>
<td>-1.97</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>13</td>
<td>11.23</td>
<td>1.97</td>
</tr>
<tr>
<td>6 Month (N = 27)</td>
<td>Male</td>
<td>16</td>
<td>14.84</td>
<td>-0.64</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>11</td>
<td>12.84</td>
<td>0.54</td>
</tr>
<tr>
<td>9 Months (N = 25)</td>
<td>Male</td>
<td>16</td>
<td>13.56</td>
<td>-0.51</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>9</td>
<td>12.00</td>
<td>0.64</td>
</tr>
<tr>
<td>12 Months (N = 16)</td>
<td>Male</td>
<td>10</td>
<td>8.45</td>
<td>-0.06</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>6</td>
<td>8.58</td>
<td>0.96</td>
</tr>
<tr>
<td>15 Months (N = 13)</td>
<td>Male</td>
<td>9</td>
<td>6.83</td>
<td>-0.23</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>4</td>
<td>7.38</td>
<td>0.82</td>
</tr>
<tr>
<td>18 Months (N = 8)</td>
<td>Male</td>
<td>4</td>
<td>4.88</td>
<td>-0.44</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>4</td>
<td>4.13</td>
<td>0.69</td>
</tr>
</tbody>
</table>

aParticipant has complete data for the time period.
bNonparametric Mann-Whitney test for independent samples.

dComparison cannot be performed on empty groups.

### Table 3. Comparison of mean ranks on SOT-PWI by SOT legal status (N = 31).

<table>
<thead>
<tr>
<th>Time Perioda</th>
<th>Status</th>
<th>N</th>
<th>Mean Rank</th>
<th>Zb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake (N = 31)</td>
<td>Refugee/Asylee</td>
<td>11</td>
<td>20.64</td>
<td>-2.11</td>
</tr>
<tr>
<td></td>
<td>Asylum Seeker</td>
<td>20</td>
<td>13.45</td>
<td>0.03</td>
</tr>
<tr>
<td>3 Months (N = 31)</td>
<td>Refugee/Asylee</td>
<td>11</td>
<td>20.64</td>
<td>-2.11</td>
</tr>
<tr>
<td></td>
<td>Asylum Seeker</td>
<td>20</td>
<td>13.45</td>
<td>0.03</td>
</tr>
<tr>
<td>6 Months (N = 27)</td>
<td>Refugee/Asylee</td>
<td>8</td>
<td>16.38</td>
<td>-1.01</td>
</tr>
<tr>
<td></td>
<td>Asylum Seeker</td>
<td>19</td>
<td>13.00</td>
<td>0.31</td>
</tr>
<tr>
<td>9 Months (N = 25)</td>
<td>Refugee/Asylee</td>
<td>7</td>
<td>13.21</td>
<td>-0.09</td>
</tr>
<tr>
<td></td>
<td>Asylum Seeker</td>
<td>18</td>
<td>12.92</td>
<td>0.93</td>
</tr>
<tr>
<td>12 Months (N = 16)</td>
<td>Refugee/Asylee</td>
<td>4</td>
<td>10.00</td>
<td>-0.73</td>
</tr>
<tr>
<td></td>
<td>Asylum Seeker</td>
<td>12</td>
<td>8.00</td>
<td>0.47</td>
</tr>
<tr>
<td>15 Months (N = 13)</td>
<td>Refugee/Asylee</td>
<td>4</td>
<td>7.38</td>
<td>-0.23</td>
</tr>
<tr>
<td></td>
<td>Asylum Seeker</td>
<td>9</td>
<td>6.83</td>
<td>0.82</td>
</tr>
<tr>
<td>18 Months (N = 8)</td>
<td>Refugee/Asylee</td>
<td>0</td>
<td>0.00</td>
<td>†</td>
</tr>
<tr>
<td></td>
<td>Asylum Seeker</td>
<td>8</td>
<td>4.50</td>
<td>†</td>
</tr>
</tbody>
</table>

aParticipant has complete data for the time period.
bNonparametric Mann-Whitney test for independent samples.
cRefugee/Asylee has acquired a legal status in the United States.
Case 1

Angelica is a West African tourist visa holder in her late 40s who was tortured by police owing to her involvement demonstrating for free and fair presidential elections. Upon intake, Angelica identified housing as her major concern. Angelica explained that she was currently living with relatives but she was not allowed inside the apartment when the family was not home. Angelica did not know anyone else in the community and was entirely dependent on this family to meet her basic needs. Angelica also revealed that she had recently sought medical treatment from a hospital emergency room because of complications regarding a chronic health condition. Upon release, she was given a prescription for medication that she could not afford to buy and did not understand how to fill. At the end of the intake, Angelica was encouraged to meet with the SOT staff attorney to learn more about the political asylum process.

Angelica’s case manager contacted a community agency that agreed to provide Angelica with a temporary room until alternate housing could be arranged. After a few weeks, Angelica met a West African family who agreed to provide her with housing in exchange for child care. Angelica was connected to a health clinic and her new primary care physician was able to stabilize her condition. Angelica’s case manager enrolled Angelica in a medication assistance program to help her access the medication she required. Angelica met with the staff attorney who briefed her on the asylum process. Understanding Angelica’s claim to be credible, the staff attorney connected Angelica to a pro bono lawyer who agreed to represent Angelica. Angelica’s total scores on the SOT-PWI from the intake period to the ninth month of services is as follows: 50-67-84-92. These scores reflected Angelica’s progress from a vulnerable rating to a stable rating on the SOT-PWI.

Case 2

Solomon is a single East African man in his early 30s who was resettled to the United States in 2014 after many years in a refugee camp. Military officials tortured Solomon after his attempt to resist forced military conscription. According to his refugee-processing paperwork, Solomon needed a surgery to reset broken bones that did not properly heal. As a single man, Solomon had difficulty connecting with other community members and reported regular, daily isolation. Although Solomon had work authorization, he did not feel prepared to work until he received medical treatment. Solomon expressed interest in attending English as a second language (ESL) classes.

Solomon’s case manager helped Solomon schedule a surgical assessment and coordinated transportation so that Solomon was able to successfully attend all of his health appointments prior to surgery. The case manager used agency resources to make sure appropriate interpretation and document translation was provided as needed. Despite a number of bureaucratic delays, Solomon ultimately received the surgery that has provided him with greater mobility and decreased pain. To increase
his community involvement, Solomon was connected to a volunteer position at a thrift store. Solomon was also enrolled in an intensive ESL class, where he began meeting other refugees. After his surgery, Solomon was hired by a local store as a part-time stock clerk. Following the 18th month, Solomon’s total scores on the SOT-PWI were as follows: 68-70-79-91-111-118. These scores reflected Solomon’s progress from a vulnerable rating to a stable rating by the ninth month and then further improvement to a safe rating by the 15th to 18th months on the SOT-PWI.

**Case 3**

A former teacher, Kofi is married man in his mid-50s from Central Africa. In response to Kofi’s political activism, rebel soldiers tortured both Kofi and his family. Kofi fled to a neighboring country where he experienced xenophobic attacks. Although Kofi was granted political asylum in spring 2014, he continued to experience nightmares and flashbacks. Upon intake, Kofi identified his primary goal as locating his wife and children and bringing them to the United States.

Kofi’s case manager connected him with the Red Cross family tracing services. After speaking with his case manager, Kofi agreed to attend individual therapy sessions at a nearby community-based mental health clinic that has received special training from IICONN to work with torture survivors. After 6 months, the Red Cross informed Kofi they had found his wife and two of his children in an East African refugee camp. Kofi was connected to the SOT program attorney who filed family reunification paperwork. Kofi’s mental health symptoms significantly decreased as he prepared for his family’s arrival although the case manager anticipates that the family will need additional support upon reunification. Kofi’s total scores on the SOT-PWI from intake to 12 months were as follows: 44-59-74-81-88. These total scores reflected Kofi’s progress from a vulnerable rating to a stable rating on the SOT-PWI.

During the debriefing discussion, the clinical case manager was asked about the process of using the SOT-PWI as a measurement instrument for assessing and documenting client needs. The case manager noted that (a) the broad matrix structure of SOT-PWI was comprehensive and helped to identify many essential psychosocial needs, (b) the repeated 3-month schedule for the SOT-PWI assessment was an appropriate amount of time to document client progress and allowed for a systematic approach to tracking and monitoring client needs, and (c) the rating system helped to “red flag” clients in crisis until their situations had stabilized. Further, the case manager suggested that the rating system be simplified, with each level of need representing one score on the Likert scale. Lastly, the clinical case manager expressed an appreciation for a tool that could be used by providers in different disciplines and could systematically document the needs of SOT in different programs. This qualitative discussion further highlighted the importance of ensuring the inter-rater reliability of SOT-PWI with different service providers as a future area of study.
Discussion

Based on the results of the pilot study, the SOT-PWI has a wide range of micro-level, mezzo-level, and macro-level applications. As an assessment tool, torture-treatment providers, including clinical case managers, would be able to use the tool to identify client needs, prioritize goals, and document individual progress over time (Orme & Combs-Orme, 2012). In tracking SOT scores, the SOT-PWI category criteria provide guidance when measuring individual life domains. Total client scores can also be unpacked for evaluation purposes. This information can be used to reinforce and reflect upon client strengths, abilities, and skills and even to change therapeutic targets for improving client outcomes (Bloom & Britner, 2012). Regularly reviewing the progress that clients make on the SOT-PWI offers a valuable opportunity for a collaborative client-provider dialogue and partnership that give credence to client-centeredness and timely access to resources and support in service delivery.

The SOT-PWI measuring system also lends itself to comparing progress in psychosocial well-being with different kinds of SOT clients based on important subgroup characteristics (e.g., gender, legal status, language and communication capabilities) known to impact SOT rehabilitation. Future prospective research studies using larger sample sizes would make it possible to determine which factors or variables may predict or hinder SOT client psychosocial progress. Such information is considered necessary for best practices in delivering client-centered services (Bloom, Fisher, & Orme, 2009) and in program-focused evaluations (Rossi, Lipsey, & Freeman, 2004; Thurston & Ramaliu, 2005).

From a management perspective, the SOT-PWI can help program leadership determine what kinds of rehabilitation services are most beneficial to SOT. For example, when “client isolation” was identified by the SOT-PWI as a primary concern among several female SOT, IICONN’s SOT program responded by creating a female-oriented psychosocial task group designed to connect SOT women with each other and their new community. By systematically assessing SOT client needs in multiple domains, it is possible to identify where additional resources are needed and how to effectively employ those resources in a timely manner. Finally, as a measurement tool, the SOT-PWI could be used to identify trends within the larger SOT population. In turn, the data could be used to synthesize knowledge of SOT functioning at multiple levels and, thus, inform community partners, donors, funding organizations, and local policy makers about survivor needs, progress, and eventual outcomes in resettlement.

The pilot study revealed a number of practical lessons. (1) Although the measurement system using 1–10 rating points for each psychosocial domain on the SOT-PWI made conceptual sense in the beginning of this study, during the debriefing period, it became clear that the rating system of this instrument should be simplified; that is, the rating system would be adapted to assess psychosocial well-being along a 4-point continuum encompassing “crisis,”
“vulnerable,” “stable,” and “safe” (see Figure 3). The last category, “thriving,” was removed as it was felt that such a stage would be hard to achieve within the typical time frame of most program services. (2) The debriefing discussion also revealed that additional domains could be added to the SOT-PWI. For example, the domain “access to health care” often precedes the receipt of physical and mental health services and needs to be assessed separately. (3) Although the clinical case manager in this study had considerable experience assessing and providing services to SOT clients, the authors recognize that a specific training manual will need to be developed in order to ensure that the SOT-PWI is applied in a systematic manner by professionals with different levels of education, professional skills, and direct service expertise.

**Study limitations and future research considerations**

While the pilot study demonstrated many useful applications of the SOT-PWI, the study also has a number of limitations. The results of this pilot are unique and not immediately generalizable to other SOT participants as only one case manager was responsible for applying the SOT-PWI with a small sample of SOT clients at one program site. On the one hand, it is important to recognize that this effort has helped to systematize SOT-PWI application protocol. On the other hand, it is important for the SOT-PWI to be further tested with many different kinds of case managers from different torture-treatment programs in order to ensure instrument validity, inter-rater reliability, and implementation stability. Such testing plans are in progress.

Another study limitation was our need to score clients retrospectively. Although the testing did not reveal any statistical difference between scores of retrospective and prospective ratings, the authors recognize that the case manager may have been subject to “social desirability” bias or internal pressure to demonstrate increased client progress. Further, during this pilot, the authors also did not test for the difference in SOT-PWI scores in relation to the accomplishment of client-specific goals (e.g., gaining employment or receiving political asylum), but such factors are recognized as variables that could affect survivor overall psychosocial well-being (Kira et al., 2012; Kalt et al., 2013). The current study also did not seek direct client input or satisfaction on provided services. Such feedback is considered
valuable for judging implementation of service delivery and, thus, would be useful to examine in prospective application of SOT-PWI.

The study was also limited by the sample sizes of subgroups in making quality quantitative data comparisons. For example, in the comparison of the SOT-PWI ratings by participants’ legal status across different time periods, our analysis was limited by the fact that the study included only three asylees. These individuals were then combined with the refugees when making the comparison to asylum seekers. It is important to acknowledge that because our analysis was limited by the sample size, we were unable to observe any differences in SOT-PWI ratings among refugees versus asylees. Our results need future research replication with larger sample sizes as refugees and asylees often have different paths to the United States and may be subject to different psychosocial environmental factors (Kalt et al., 2013; Kira et al., 2015). Finally, as the SOT-PWI is under further development, future validity, reliability, and generalizability trials will be needed to determine the scientific validity of this tool.

Conclusion

Holistic torture treatment requires a dedicated cohort of interdisciplinary service providers to address individual needs of SOT across multiple life domains. While most service delivery focuses on the individual SOT, system-level interventions can have as great, if not a greater, impact on overall survivor psychosocial well-being. In order to build a democratic society, programs serving vulnerable populations need to show service impact by documenting and evaluating the results of their work (Forgeard, Jayawickreme, Kern, & Seligman, 2011). As SOT programs continue to compete for funding, the development and application of the SOT-PWI can help providers to help survivors meet their needs, harness their potential, and enhance their lives by enacting social reform aimed at removing service barriers, decreasing inequality, and promoting social justice.

References


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